JOINT MEDICAL EXECUTIVE SKILLS PROGRAM

CORE CURRICULUM AND COMPETENCY MODEL

Eleventh Edition, November 2022

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DEVELOPMENT OF THE JOINT MEDICAL EXECUTIVE SKILLS PROGRAM CORE CURRICULUM

The Joint Medical Executive Skills Program (JMESP) Core Curriculum began in 1996 with the Services medical departments and the Office of the Assistant Secretary of Defense, Health Affairs (OASD/HA). A joint group formed by these organizations created a common core curriculum to assist in the individual development of the executive skills needed by military medical treatment facility (MTF) commanders, lead agents, and lead agent staff members. The group accomplished this task by identifying the behaviors one would expect of a highly qualified incumbent. Panels of subject matter experts (SMEs) working in conjunction with current and former MTF commanders, curriculum developers, and military medical department representatives structured the behaviors and documented them as competencies in the first edition.

The subsequent editions have documented changes that resulted from the review of the competencies and behavioral objectives. Review board members update the competencies to meet the current state of military medicine. See Appendix A for the historical chronology of the JMESP Core Curriculum. This Eleventh Edition was revised with the guidance and expertise of a review board, JMESP working group members, and invited guests who convened for the specific purpose of reviewing and updating the core curriculum. Work was accomplished in a 3-day session facilitated by personnel from the Joint Medical Executive Skills Institute (JMESI), a branch of Defense Health Agency, Education and Training Directorate.

These Executive Skills competencies are applicable to all leaders in the military medical departments. They are required prior to the assumption of duty as an MTF commander or director. They also guide the development of market directors and key staff serving at the MTF, Market, or Headquarters level. In this document, the term “senior leader” is used to collectively describe those persons to which the Congressional direction for demonstration of these competencies applies.

In this edition, the number of competencies is reduced from 36 to 28. Additional changes were made to the competency descriptions and subordinate behavior statements. These 28 competencies are grouped into five domains with related competencies comprising each group. The JMESP Competency Model on the following page depicts the domain name in bold with the associated competencies listed below.

JMESP COMPETENCY MODEL		
MTF Commanders/Directors	Market Leaders	Key Staff Members

Military Medicine	Leadership and Organizational Management
• Military Mission • Medical Doctrine • Readiness of the Medical Force • Emergency Management and Contingency Operations	• Leadership • Strategic Planning • Organizational Design • Decision Making • Change Management • Conflict Management • High Reliability
Health Law, Policy, and Ethics	**Health Resources Allocation**
• Public Law • Medical Liability • Medical Staff By-Laws and Oversight of Clinical Practice • Regulations • Accreditation and Inspections • Public Health • Research and Investigation • Ethics	• Financial Management • Human Capital Management • Labor-Management Relations • Materiel Management • Facilities Management • Information Resources Management
Effective Communication	
• Interpersonal Communication • Public Speaking • Strategic Communication	

Each competency is described or defined on the subsequent pages. The competency is further qualified by a list of behaviors that persons possessing the competency should demonstrate. The behaviors are statements rather than learning objectives. At the Joint level it has been preferred to leave the definition of the two remaining elements of learning objectives (conditions and standards) to those who will construct courses and lesson plans to teach the relevant subject matter. For the tenth addition, a code was added at the end of each behavioral statement that reflects the decision of the board as to where this topic should be included within a learning

continuum for medical executive skills competencies. The code indicates at what point in a member's career he or she should receive instruction on each topic in support of development of the respective competency. The codes are as follows: B (basic), I (intermediate), A (advanced), S (Service or other mandatory training), E (experiential). For further explanation of the codes and what they represent, refer to the Tenth Edition summary in Appendix A.

Appendix A provides a historical chronology regarding the development of the JMESP Core Curriculum and Competency Model and discusses the ten previous editions and the major revisions in content that were brought by each edition.

Military Mission

The Military Health System (MHS) exists to support the National Military Strategy.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Understand national security and national defense strategy to apply Defense Planning Guidance to the MHS mission. (I, A, S)

2. Use joint planning process and operational readiness capabilities to support the Combatant Commander. (S)

3. Evaluate the relevancy of data, summarize and provide recommendations for force medical protection and sustainment. (S)

4. Coordinate and collaborate with line commanders to optimize individual medical readiness and provide appropriate health care across the continuum. (S)

5. Evaluate health services support for operational requirements (OPLAN missions). (S)

6. Understand the role of MHS in Global Health Engagement. (S)

Medical Doctrine

Medical doctrine provides fundamental principles by which medical forces guide their actions in support of National Military Strategy. Medical doctrine provides a common perspective and requires judgment for appropriate application. These principles may apply to full spectrum operations, including joint, combined, coalition, and inter-agency operations.

Senior leaders must demonstrate the following behaviors at the application level:

1. Identify, interpret, and apply current medical doctrine applicable to the military mission. (S)

2. Integrate Joint and Service-specific medical doctrine, culture, organization, and strategies in support of National Defense Strategy. (S)

3. Utilize current lessons learned repositories to evolve medical doctrine, requirements, and capabilities. (I, A, S, E)

Readiness of the Medical Force

Readiness of the medical force incorporates those daily and periodic activities that maintain the members' knowledge, skills, and abilities. This is augmented by courses, hands-on training programs, and exercises designed to develop, enhance, and maintain military medical skills. Military readiness training includes individual, collective, and unit training experiences required to ensure health care personnel and units are capable of performing operational missions.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Plan, resource, direct, evaluate, and document medical readiness training and exercises of the total force in the area of support. (S)

2. Implement current medical policies, plans, and doctrine. (S)

3. Validate medical unit readiness reports from individuals to collective capabilities. (S)

4. Identify and address skill gaps between garrison and operational requirements, utilizing internal and external education and training to ensure a competent, current, and ready medical force. (S)

Emergency Management and Contingency Operations

Emergency management and contingency operations include the preparation for and delivery of medical services and the recovery from unanticipated events (e.g., natural disasters, terrorism, or global military operations).

Senior leaders must demonstrate the following behaviors at the application level:

1. Apply international, interagency, Joint and Service-specific contingency planning processes. (S)

2. Direct the development, implementation, integration, and evaluation of the medical unit response plan for contingencies. (S)

3. Integrate managed care support contractors into medical unit contingency planning as appropriate. (I, A)

4. Articulate the roles and relationships between the MHS and local, regional, state, national, and international disaster response plans and assets, to include non-governmental organizations. (I, A)

5. Execute the concepts of Defense Support of Civil Authorities (DSCA) as required. (S)

6. Integrate the National Disaster Medical System, the Civilian Military Cooperative Assistance Program, and the National Response Framework into medical unit readiness and mobilization exercises and plans. (S)

7. Execute patient distribution plan for large scale operations in support of Combatant Commands. (S)

Leadership

Leadership is influencing others to accomplish the mission. It requires a complex set of skills and values to work with and through others.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Display personal conduct consistent with core military values and highest professional standards. Consistently treat others with dignity and respect. (B, I, A, S)

2. Demonstrate multiple leadership skills, traits, and behaviors including, but not limited to the following: (B, I, A, S)
   - Enthusiastic and optimistic attitude
   - Appropriate stewardship, followership, and ambassadorship
   - Exemplary personal and professional ethics
   - Shared vision
   - Empowering and developing subordinates
   - Commitment to personal development and lifelong learning
   - Political astuteness
   - Coaching and mentoring
   - Modeling a healthy lifestyle
   - Promoting self and organizational resiliency
   - Setting priorities
   - Critical thinking
   - Obtaining input from subordinates and considering different points of view
   - Taking decisive actions and making informed and timely decisions
   - Encouraging and taking calculated risks
   - Gaining commitment and organizational buy in
   - Effective communicator
   - Celebrating accomplishments
   - Clearly articulating leadership philosophy

3. Adapt leadership roles and styles as appropriate to the situation. (B, I, A, S)

4. Develop positive organizational climate, culture, confidence, and trust among members. (B, I, A, S)

5. Understand and leverage diversity to build collaborative teams and interdisciplinary relationships. (B, I, A, S)

6. Ensure effective oversight of projects, programs, and initiatives. (B, I, A, S)
7. Accept responsibility and accountability for actions of the organization. (B, I, A, S)
8. Enforce standards and ensure accountability of subordinates. (B, I, A, S)
9. Project command presence (e.g., inspires respect, has credibility, and is approachable). (B, I, A, S)
10. Seek and accept feedback on how his or her actions affect others' performance. (B, I, A, S)
11. Treat failures as opportunities for learning and reward success. (B, I, A, S)

Strategic Planning

Strategic planning is a forward looking, proactive process for assessing the total environment, establishing direction, and developing execution strategies consistent with MHS strategic goals and in support of mission requirements.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Lead the planning and management process and ensure alignment of facility priorities, goals, and initiatives with strategic plans. (I, A)

2. Conduct situational and environmental analysis using validated tools to understand the position of the organization. (B, I, A)

3. Identify and leverage key stakeholders' input to strategic plans. (I, A)

4. Evaluate strategic alternatives to achieve the desired end state. (I, A)

5. Select, implement, and assess strategic plans. (I, A)

6. Promote innovation and remove barriers to advance strategic plans. (B, I, A)

7. Prioritize organizational objectives and milestones to support strategic plans. (I, A)

8. Collect and utilize timely and accurate data to support the strategic planning process. (B, I, A)

9. Apply strategic communication to ensure effective implementation of strategic plans. (B, I, A)

10. Understand resourcing in support of strategic plans. (B, I, A)

Organizational Design

Organizational design is the configuration of the organizational elements (i.e., people, structure, governance, technology, subsystems, processes, mission, and values).

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Understand organizational structure. (B, I, A)

2. Identify strengths and weaknesses of different organizational structure design options. (I, A)

3. Align the organizational design to support the mission. (I, A)

4. Establish strategic partnerships and affiliations to optimize organizational design to accomplish the mission efficiently and effectively. (I, A)

Decision Making

Decision making is the process of analyzing, prioritizing, evaluating, selecting courses of action and alternatives, and implementing a decision relevant to the situation.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Identify, prioritize, and analyze the problem or issue. (B, I, A, S)
2. Understand and apply an appropriate, validated, military or other decision-making framework to include risk assessment. (B, I, A, S)
3. Employ tools and techniques in support of data-driven decision making. (B, I, A, S)
4. Evaluate outcomes of the decision-making process for appropriateness and effectiveness. (B, I, A, S)

Change Management

Change management is the ability to anticipate and manage organizational change efficiently and effectively.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Recognize types, stages, and psychological aspects of change. (B, I)

2. Utilizing a systems perspective, assess the environment, decide what needs to be changed, and determine the willingness and ability to change. (B, I)

3. Develop a strategy for externally or internally driven change. (I, A)
   - Communicate the need and the process for change.
   - Create and champion a shared vision of and a climate for change.
   - Identify change agents.
   - Develop a transition structure to manage the change process.
   - Anticipate and develop strategies to deal with resistance to change.
   - Navigate the political dynamics of change.
   - Establish metrics for measuring outcomes of change.

4. Implement change strategy. (I, A)
   - Market the change strategy.
   - Remove obstacles.
   - Create short-term wins.
   - Provide tools, methodology, resources, support, and incentives to sustain the change effort.

5. Monitor the change process, solicit feedback, evaluate progress, and make adjustments as necessary. (I)

Conflict Management

Conflict management involves the identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality and the effective use of communication, negotiating, and listening skills. It also requires leaders to accept conflict as a result of human interaction.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Identify sources of conflict (e.g., individual, group, organizational, or environmental). (B, I)

2. Select and use effective strategies (e.g., competing, collaboration, resolution, or mediation) for managing conflict and its consequences as the situation requires. (B, I)

3. Consider multiple perspectives and pursue consensus. (B, I)

4. Treat conflict as an opportunity for learning. (B, I)

High Reliability

Ready Reliable Care is the Defense Health Agency's (DHA) approach to increasing high reliability across the MHS. It builds on the existing work and best practices of the service medical departments and the DHA. Ready Reliable Care works across clinical and non-clinical settings to drive better outcomes for patients, staff, and the enterprise. High reliability principles and practices create a culture of continuous learning and process improvement throughout the organization. Leaders shape and enable culture, planning, improvement, and sustainment to produce trust and teamwork with the goal of achieving zero preventable harm.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Understand the history and guiding principles of high reliability organizations and their applications to healthcare. (B, I, A)

2. Model behaviors and apply strategies that foster a culture that focuses on improving health care access, quality, safety, transparency, and patient engagement. (B, I, A)

3. Enable a culture that applies the following Ready Reliable Care Principles: (B, I, A)
    - PREOCCUPATION WITH FAILURE: Drive zero harm by anticipating and addressing risks
    - SENSITIVITY TO OPERATIONS: Be mindful of how people, processes, and systems impact outcomes
    - DEFERENCE TO EXPERTISE: Seek guidance from those with the most relevant knowledge and experience
    - RESPECT FOR PEOPLE: Foster mutual trust and respect
    - COMMITMENT TO RESILIENCE: Leverage past mistakes to learn, grow, and improve processes
    - CONSTANCY OF PURPOSE: Persist through adversity towards the common goal of zero harm
    - RELUCTANCE TO SIMPLIFY: Strive to understand complexities and address root causes

4. Promote Ready Reliable Care domains of change within the healthcare organization: (B, I, A)
    - LEADERSHIP COMMITMENT: Prioritize Ready Reliable Care at all levels of leadership
    - CULTURE OF SAFETY: Commit to safety and harm prevention

- CONTINUOUS PROCESS IMPROVEMENT: Advance innovative solutions and spread leading practices
- PATIENT CENTEREDNESS: Focus on patients' safety and quality of care experience

5. Apply current methodologies and tools in support of high reliability principles. (B, I, A)

Public Law

For the MHS, public law includes all laws that specify requirements in areas such as public health, patient consent, patient rights, patient entitlement, and environmental standards.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Seek legal and other counsel as appropriate. (S)
2. Ensure compliance in order of precedence with all applicable Federal, state, and local laws, and identify violations, taking appropriate corrective action. (S)
3. Identify and take appropriate actions concerning constitutional freedoms. (S)
4. Ensure compliance with laws related to international settings. (S)
5. Identify responsibilities related to contingency operations. (S)
6. Understand the role of the National Defense Authorization Act (NDAA) in shaping the MHS structure, function, and funding. (S)

Medical Liability

Medical liability includes tort and criminal offenses that may incur risk to the health care facility or individual providers.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Understand the role of the medical legal consultant and the health care resolution specialist. Utilize both proactively and in support of appropriate responses. (B, I, A)

2. Seek legal and other counsel as appropriate. (B, I, A)

3. Understand and ensure compliance, when applicable, with the following: (B, I, A)
   - The Federal Tort Claims Act
     - Types of actions, defenses, and damages
     - Personal immunity, right to representation, and requirement for cooperation
     - Administrative claims process and the use of expert medical reviews and/or reviewers
   - The Military Claims Act
   - The Feres Doctrine
   - The Gonzalez Act
   - The Consolidated Omnibus Budget Reconciliation Act
   - The Privacy Act
   - The Health Insurance Portability and Accountability Act

4. Identify potential liability regarding participation in memoranda of agreement and/or understanding (MOA/MOU) and other agreements. (B, I, A)

5. Identify situations requiring medical malpractice reporting under the Health Care Quality Improvement Act (DoD and Department of Health and Human Services MOU). (B, I, A)

6. Ensure compliance with the rules regarding the confidentiality and handling of medical, quality assurance, risk management, and peer review records. (B, I, A)

7. Identify potential medical liability issues regarding the following: (B, I, A)
   - Negligent selection, review and retention of providers
   - Vicarious liability and enterprise liability (e.g., managed care, wrongful acts of others, and utilization management)
   - Ostensible agency, and apparent authority
   - Standards of care in the following:
     - Criminal background investigations
     - Staffing levels

- Personnel training
- Medical judgment

8. Identify circumstances that require the reporting of the following: (B)
   - Abuse, neglect, and exploitation of children, elderly, and disabled
   - Medical examiner cases
   - Criminal behavior

9. Apply risk management strategies. (B)

Medical Staff By-Laws and Oversight of Clinical Practice

MTF Commanders/Directors are responsible for the practice of both privileged and non-privileged clinical staff. Medical staff by-laws outline the conduct and privileges of the medical staff. The by-laws are typically developed and amended by the medical staff using The Joint Commission and/or other approved external accrediting organizations' requirements regarding medical staff governance.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Identify responsibilities concerning military, civilian, and contract clinical staff in accordance with Service-specific guidance regarding the following: (B, I, A, S)
   - Applicable accrediting bodies
   - Credentialing and privileging process
   - Adverse actions
   - Adverse reporting requirements
   - Criminal background investigations
   - National Provider Identification
   - Disruptive behavior policies
   - Impaired provider policies

2. Understand National Practitioner Data Bank reporting and querying requirements. (B, I, A)

3. Understand and ensure due process. (B, I, A)

Regulations

Regulations, as a generic term, include all Federal (including DoD and Service-specific), state, and local policy that affect medical operations.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Identify, interpret, and apply policies necessary to operate in an MHS environment. (B)

2. Understand and communicate changes in beneficiary entitlements, departmental policies, and the Managed Care System that are implemented through OASD/HA or DHA memoranda or other federal directives. (B, I)

3. Issue organizational procedures and policies that are necessary to implement regulations and other guidance when required. (I)

4. Understand and communicate needs regarding insurance coverage and programs such as third-party collection, TRICARE rules, resource sharing, and agreements for DOD/VA integration activities. (B, I)

5. Understand and communicate the proper execution of the Managed Care Support Contract. (B, I)

6. Direct an effective medical evaluation and Integrated Disability Evaluation System in compliance with current regulations and guidelines. (S)

Accreditation and Inspections

External accreditation is an evaluative process performed by an accrediting agency that is an objective review of processes and practices within an organization. These accreditations are sought by medical facilities for various reasons, the most important being the assurance to the facility seeking accreditation that it meets healthcare quality standards. Inspections provide feedback to leaders so they can make decisions that will improve the organization. The focus is on measuring compliance against established standards to ensure that the organization as a whole can function effectively.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Ensure compliance with requirements of applicable inspecting entities. (B, I, A)
2. Determine when it is appropriate to seek external consultation. (B, I, A)
3. Understand the roles of accrediting organizations. (B, I, A)
4. Foster a culture of continuous compliance. (B, I, A)
5. Direct appropriate follow-up actions to address non-compliance. (B, I, A)

Public Health

Public health is the science of protecting and improving the health of people and their communities. The goal is to ensure force health protection to establish common, quality, health practices across the DoD.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Employ epidemiological surveillance tools to monitor community and force health protection and prevention programs. (S)

2. Enforce public health standards and infection control procedures to prevent and control disease transmission. (S)

3. Consult with public health experts and advise supported commanders on operational impact. (S)

4. Effectively integrate programs, concepts, initiatives, and recommended best practices. (S)

Research and Investigation

Research and investigation require compliance with multiple regulatory agency requirements, and federal, state, and local laws concerning the use of human and animal subjects.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Understand the capabilities and requirements of research and investigation. (B, I, A)
   - Improve health status and standards of care
   - Add to the professional body of knowledge

2. Understand institutional review board processes and organizational alignment. (I, A)

3. Comply with federal, state, and local regulatory requirements with regard to, but not limited to, the following: (I, A)
   - Resourcing
   - Institutional regulatory entities (e.g., institutional review board)
   - External relationships (e.g., industry, academia)
   - Data sharing agreements

4. Articulate on-going research and investigation efforts. (I, A)

5. Understand and evaluate proposed protocols, presentations, and publications for operational security, organizational impact, and potential strategic communication issues. (I, A)

Ethics

Ethics consists of the processes, structures, and social constructs by which the rightness or wrongness of actions is assessed. Ethical decision-making is the process of resolving ethical dilemmas. Personal ethics is the basis on which individuals determine the rightness or wrongness of conduct. Professional codes of ethics represent articulated group or association statements of the morality of the members of the profession with regard to their professional roles. Organizational ethics describes the structures and processes by which an organization ensures conduct appropriate to its mission and vision. It is typically formalized in a code which addresses such matters as marketing, admission, transfer, discharge, pricing and billing, and describes the ethical dimensions of the internal and external relationships the organization has with its staff, contractors, educational institutions, and payers.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Act consistently with an understanding of the discipline of ethics. (S)
   - Categories of health care ethics (i.e., personal, professional, organizational)
   - Major ethical theories and generally accepted principles of medical ethics (autonomy, beneficence, non-malfeasance, justice)
   - Appropriate ethical decision-making methods

2. Comply with the Joint Ethics Regulation, the Procurement Integrity Act, and other directives as indicated. (S)

3. Develop and promote a culture and climate that supports: (I, A)
   - Creating an environment where ethical issues and diverse ethical views are freely discussed.
   - Taking timely and appropriate action when moral or ethical norms are violated.
   - Recognizing positive examples of ethical behavior in difficult situations.
   - Providing safe avenues for people to give feedback on the ethical atmosphere of the institution and its reputation in the community.
   - Minimizing constraints that contribute to ethical conflicts.
   - Requiring broad, continuing education be provided to staff on ethical issues and concerns

4. Establish a consultative process for ethical problem solving within the institution, providing professional staff and administrative support using a committee, a team, or consultants to assist in making judgments requiring: (I, A)
   - Personal moral beliefs.
   - Personal rights and duties.
   - Organizational obligations.
   - Choices taking into account economic, legal, ethical analysis and quality of care.

- Determination of what is "acceptable," "proper," and "just" when trade-offs have to be made among competing values or principles.
- Recognition of appropriate and inappropriate actions regarding the attraction, acceptance, and disbursement of property offered to the government.

5. Use an accepted ethical decision-making model to resolve moral conflicts. (B, I, A)

6. Establish a climate through counsel and sound policy for the resolution of bioethical conflicts. (B, I, A)

Financial Management

Financial management includes operating in a managed care environment, maintaining financial records, controlling financial activities, identifying deviations from planned performance, managing the acquisition and contracting processes, and strategic resourcing.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Understand the funding required for strategic plans through the management of input to the Planning, Programming, Budgeting, and Execution system (PPBE) cycle (e.g., Future Years Defense Program, Program Objective Memorandum). (I, A)

2. Manage spend plans and differentiate among the types of funds available in order to utilize various funding streams. (I, A)

3. Seek opportunities and methods to gain positive return on investment of resources and the application of funding opportunities, e.g. business case analysis. (I, A)

4. Develop, direct, and evaluate the business plan: (I, A)
   - Direct the evaluation of programs in strategic plans to include risk and outcome evaluation.
   - Direct effective health care resourcing in a resource-constrained environment.
   - Direct the analysis of decisions to achieve most effective uses of constrained resources.

5. Safeguard funds and assets through fiscal compliance, audit readiness, statutory requirements, internal controls, and avoidance of unauthorized commitments. (B, I, A)

6. Promote use of benchmarked metrics to monitor and enhance financial performance. (B, I, A)

7. Maximize the collection of other reimbursements. (B, I)

8. Differentiate the data systems and relationships to understand and maximize the timely and accurate documentation and review of workload and productivity. (B, I, A)

9. Understand the principles of the acquisition and contracting processes and seek contracting guidance as appropriate. (B, I)

10. Assess resourcing budget to meet mission requirements and request resources (money and/or manpower) as necessary. (B, I)

11. Prioritize resources to meet operational requirements, deliver healthcare, and manage capacity. (E)

Human Capital Management

Human capital management includes the recruitment, development, staffing, management, retention, and transition of Total Force personnel.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Manage personnel strength: (B, I, A)
   - Comprehend manpower authorization system and documents.
   - Assess current staffing level against projected requirements to determine needs.
   - Direct appropriate actions to realign over-strength, fill shortages, or outsource.
   - Monitor status of activities to resolve personnel staffing issues.
   - Leverage various alternative manning solutions to include partnerships, managed support initiatives, total force, etc.
   - Apply recruitment and retention strategies.
   - Integrate all personnel into operations.
   - Encourage individuals to engage in positive health behaviors.

2. Ensure effective, efficient, and fair hiring and onboarding processes. (B, I, A)

3. Review training status to determine priorities and resource accordingly: (B, I, A)
   - Provide education and training opportunities to ensure competent staff.
   - Provide mechanisms for staff to attain and maintain appropriate certification and/or licensure.
   - Provide opportunities for professional growth and development.

4. Direct comprehensive performance management processes: (B, I, A, S)
   - Establish quality standards for performance counseling, feedback, plans, and evaluations in personnel development.
   - Establish and maintain effective awards and recognition programs.
   - Educate, mentor, and encourage career path development and succession planning.

5. Ensure appropriate due process and disciplinary actions. (B, I, A, S)

6. Assess command climate and take appropriate actions to foster a high level of morale and job satisfaction. (I, A)

7. Understand policies related to civilian personnel management. (B, I, A, S)

8. Comprehend transition assistance policies and programs. (S)

9. Understand Total Force management: (S)
   - Integrate Active and Reserve components and DoD civilians and contractors into military medical operations.
   - Understand and disseminate deployment, mobilization, and demobilization policies for all assigned personnel and organizations.

10. Assess current staffing level against projected requirements, capabilities, and policies to determine needs. (B, I)

Labor-Management Relations

Labor-management relations are the interactions between management, unions, and civilian staff employees in the bargaining unit. Senior leaders should establish and foster cooperative and productive labor-management relationships that are committed to pursuing solutions that promote increased quality of work life and productivity, customer service, mission accomplishment, efficiency, employee empowerment, organizational performance, and military readiness. They include collective bargaining, the ability to recognize and implement fair labor practices, deal effectively with union negotiators, and handle grievances productively.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Make decisions based on a clear understanding of employer and employee rights within the labor management relations framework. (B, I, A)

2. Understand the general collective bargaining process and its applicability for employees, supervisors, and managers in the Federal workplace. Identify negotiable versus non-negotiable issues at the federal, state, local, and host nation levels. (B, I, A)

3. Seek expert advice when appropriate in legal, labor relations, and union matters. (B, I, A)

4. Ensure the use of appropriate channels and procedures to process grievances, Equal Employment Opportunity (EEO) complaints, unfair labor practice filings, and appeals of disciplinary actions. (B, I, A)

5. Understand the local labor relations climate and local collective bargaining agreements. (E)

6. Ensure adequate representation in installation-union negotiations which impact the organization. (B, I, A)

7. Ensure consideration of alternative conflict and dispute resolution procedures and interest-based bargaining approaches in dispute resolution. (B, I, A)

8. Foster a mutually supportive work environment. (B, I, A)

Materiel Management

Materiel management includes accountability and stewardship in managing, cataloging, requirements determination, procurement, distribution, maintenance, custody, storage, and disposal of supplies and equipment.

Senior leaders must demonstrate the following behaviors at the application level:

1. Adopt cost-effective methods that comply with current policy, rules, and regulations governing the procurement, distribution, maintenance, and disposal of pharmaceuticals, supplies, and equipment. (B, I, E)

2. Optimize life-cycle equipment management practices (e.g., acquisition, maintenance, sustainability, and effects on labor, re-supply, and outcomes). (B, I, E)

3. Understand the principles of contracting rules and types of contracts. Seek expert advice when appropriate. (B, I, E)

4. Safeguard and ensure appropriate accountability and use of government supplies and equipment. (B, I, E)

5. Ensure compliance with current rules and regulations governing the procurement, handling, and disposal of regulated hazardous and infectious materials and medically regulated waste. (S, E)

6. Optimize interoperability and standardization of supplies and equipment. (B, I, E)

7. Ensure war reserve and emergency management resources are mission ready and used appropriately. (B, I, E)

8. Recognize appropriate and inappropriate actions regarding the attraction, acceptance, and disbursement of property offered to the government. (B, I, E)

Facilities Management

Facilities management is the maintenance and upkeep of real property, such as a building, structure, or utility system. It includes ensuring compliance with applicable regulations (e.g., Occupational Safety and Health Administration, National Fire Protection Association, and Americans with Disabilities Act requirements) and oversight of facility design, renovation, and construction.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Ensure compliance with applicable accrediting agencies, regulatory requirements, and other standards with respect to the environment of care and life safety. (E)

2. Integrate physical plant and infrastructure systems needs into the facility master plan, contingency plans, and long-range financial plans. (E)

3. Make management decisions using the respective facility budgeting process for preventive maintenance, minor and major repairs, unspecified minor construction, and renewal and military construction programs. (E)

4. Ensure real property maintenance programs include proper accountability and documented maintenance sustainability (e.g., life-cycle programs, housekeeping programs). (E)

5. Coordinate facilities requirements with base operations management. (E)

6. Assure adequate physical security in coordination with installation security. (E)

7. Optimize energy and environmental conservation initiatives. (E)

Information Resources Management

Information resources management (IRM) is the process of managing information technology (IT) resources to accomplish agency missions and to improve agency performance. This includes information and related resources such as personnel, equipment, funds, IT, and other enabling technology.

Senior leaders must demonstrate the following behaviors at the application level:

1. Direct the appropriate use of integrated IRM to improve care and services, management, support processes, outcomes, and readiness. (B, I, A)

2. Comply with appropriate governance rules and regulations. (S)

3. Use information systems to support decision-making. (B, I, A)

4. Understand life-cycle management for information systems. (E)

5. Utilize Risk Management Framework to implement safeguards for information and information systems security. (E)

6. Ensure that IRM planning and operations appropriately address privacy and confidentiality requirements (e.g., HIPAA). (E)

7. Lead adoption of virtual health solutions, health informatics systems, electronic health records systems, and standardized IRM practices. (B, I, A)

8. Manage telecommunication systems used in the delivery of healthcare. (E)

Interpersonal Communication

Effective communication occurs when the receiver understands the sender's intended message. Interpersonal communication relies on formal and informal channels established between sender and receiver.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Choose an effective communication style and medium based on task, message, and audience characteristics (e.g., generational and cultural differences, organizational constraints, managerial preferences and abilities, and normative influences). (B, I, A)

2. Solicit and incorporate feedback, ideas, comments, and suggestions from others. (B I, A)

3. Use and accurately interpret verbal, nonverbal, written, and electronic communication. (B I, A)

4. Actively listen and draw out others' ideas, views, and feelings. (B, I, A)

5. Identify barriers to effective communication. (B I, A)

6. Apply the appropriate use of silence. (B I, A)

7. State clearly what is desired or expected and use clarification techniques (e.g., metaphors or analogies) as needed. (B, I, A)

8. Provide timely and effective feedback. (B, I, A)

Public Speaking

Public speaking is the art of effective verbal communication with an audience.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Choose message, language, content, and length appropriate for the audience and subject matter. (E)

2. Select presentation types (e.g., informational briefings, persuasive techniques, motivational techniques, question and answer sessions, or open forums) and prepare for the expected audience and venue. (E)

3. Present well-organized material. (E)

4. Elicit participation and feedback when appropriate. (E)

5. Seek opportunities for assessing and improving public speaking skills. (E)

6. Recognize protocols and constraints when speaking in public. (E)

Strategic Communication

Strategic communication is the development, integration and evaluation of key themes and messages utilizing effective communications tactics to deliver a clearly defined message using multiple means to targeted audiences.

Senior leaders must demonstrate the following behaviors at the <u>application</u> level:

1. Identify the communication goal and develop a message to achieve the end state. (I, A)

2. Select the appropriate communication medium to reach the target audience. (I, A)

3. Coordinate with the Public Affairs Office (PAO) and applicable organizations prior to communicating significant events. (I, A)

4. Communicate to the organization the importance of respecting protocol and practicing public diplomacy for distinguished visitors. Effectively manage these key leader engagements to impart the strategic message. (I, A)

5. Conduct an effective media engagement. (I, A)
   - Rely on PAO to help shape the message and the engagement.
   - Understand rights as the interviewee.
   - Prepare talking points and deliver key messages.
   - Contemplate the question and deliberate the response.

6. Follow all DoD guidance on the use of social media. Leverage social media in the communications plan. (I, A)

7. Educate staff on communication guidance and prepare them for interacting with the media to maintain a consistent message. (I, A)

8. Effectively apply the concepts of risk and crisis communication. (I, A)

9. Cultivate effective relationships with stakeholders (e.g., local, state, and federal), respond effectively to inquiries, and maximize the use of media when appropriate. (I, A)

HISTORICAL CHRONOLOGY OF THE JMESP CORE CURRICULUM

In 1996, the Service medical departments and the Office of the Assistant Secretary of Defense, Health Affairs (OASD/HA) jointly formulated a core curriculum to assist in the individual development of the executive skills needed by medical treatment facility (MTF) commanders, lead agents, and lead agent staffs. They accomplished this task by identifying the behaviors one would expect of a highly qualified incumbent. Panels of subject matter experts (SMEs) working in conjunction with current and former MTF commanders, curriculum developers, and Service medical department points of contact structured the objective behaviors and documented them in the first edition of this report.

The first edition of the JMESP core curriculum was a key milestone in satisfying the 1992 Congressional mandate that MTF commanders must be able to "demonstrate the administrative skills" necessary to command MTFs. It also responded to the 1996 Congressional direction that the Secretary of Defense:

> *". . . implement a professional educational program to provide appropriate training in health care management and administration to each commander of a military medical treatment facility of the Department of Defense who is selected to serve as a lead agent."*

The acronym "MTF" was changed to healthcare management organization (HCMO) throughout the core curriculum to reflect medical treatment facility and TRICARE lead agent responsibilities.

Each of the 40 executive skills competencies was described in the first edition of this document and the desired behavioral objectives were listed for each competency. Three panels, or focus groups, initially investigated the competencies. The final panel met in June 1996 and investigated 22 competencies in a one-week session. It recommended regrouping all 40 competencies – a particularly appropriate step given that the six competencies added after the 1994 MTF Commander Survey had not been assigned to groups. The last panel also recommended renaming and re-defining some competencies. The Joint Medical Executive Skills Development Group (JMESDG) at their 3 July 1996 meeting approved the resulting competency names, definitions, and groupings. Thus, the first edition of this core curriculum was established.

JMESP Core Curriculum – Second Edition

The JMESDG recognized that curricula require maintenance. They understood that the first edition was published before the Military Health System (MHS) had gained significant experience with TRICARE. Therefore, the JMESDG directed the Joint Medical Executive Skills Working Group to undertake another review and update of the competencies that would result in the second edition of the core curriculum. Their guidance stipulated that the number of competencies should remain at 40 through the addition of behavioral content where necessary. This guidance expressed the need for stability in the number of competencies as other associated tasks (e.g., competency tracking systems) were being considered.

The working group, augmented by a lead agent, another former MTF commander, and tri-Service SMEs, met at the Army Medical Department Executive Skills Technology Center, Fort Sam Houston, Texas, May 12-15, 1998, to review and update the first edition of the Executive Skills Core Curriculum. The revised curriculum also responded to the original question: "What behavior(s) by a lead agent or MTF commander would you accept as evidence of demonstrated competency?" It included updated views on lead agency, TRICARE operations, and the MHS.

In addition to reviewing and revising the descriptions and behavioral content of the competencies, the participants also made judgments concerning competency grouping to reflect MHS emphasis. Their determinations for the most appropriate names and grouping of the competencies are documented below.

Military Medical Readiness	**General Management**
• Medical Doctrine • Military Mission • Joint Operations/Exercises • Total Force Management • National Disaster Medical Systems Management • Department of Veterans Affairs Role • Medical Readiness Training • Contingency Planning	• Strategic Planning • Organizational Design • Decision Making • Change and Innovation • Leadership
Health Law/Policy	**Health Resources Allocation and Management**
• Public Law • Medical Liability • Medical Staff By-Laws • Regulations • External Accreditation	• Financial Management • Human Resource Management • Labor-Management Relations • Materiel Management • Facilities Management • Information Management

Ethics in the Health Care Environment	Individual and Organizational Behavior
• Ethical Decision-Making • Personal and Professional Ethics • Bioethics • Organizational Ethics	• Individual Behavior • Group Dynamics • Conflict Management • Communication • Public Speaking • Public and Media Relations
Clinical Understanding	**Performance Measurement**
• Epidemiological Methods • Clinical Investigation • Alternative Health Care Delivery Systems	• Quality Management • Quantitative Analysis • Outcome Measurements • Clinical Performance Improvement

Finally, the academicians and subject matter experts agreed that a core curriculum should provide an indication of the proficiency level deemed necessary for each competency. The Second Edition incorporated a modified version of Bloom's Taxonomy of Educational Objectives at three levels (familiarization, basic understanding, and full knowledge). The Second Edition taxonomy was limited to cognitive behaviors. Many of the skills expected of MHS leaders require synthesis, evaluation, and application of knowledge, not just understanding. Upon further analysis, the Virtual Military Health Institute, now JMESI, concluded that the taxonomy should be improved to better represent the skill levels intended. This revision more fully expressed aspects of skills application and expertise that could be authoritatively displayed by one who is extensively well qualified.

JMESP Core Curriculum – Third Edition

The Third Edition introduced a refined cognitive taxonomy for establishing knowledge levels and experience into the Core Curriculum. The taxonomy of the Second Edition dealt only with cognitive knowledge; while it helped to call attention to different levels of knowledge required, it did not incorporate the role of experience. The Third Edition expanded the knowledge levels after Benjamin Bloom's *Taxonomy of Educational Objectives: Handbook I, The Cognitive Domain* (1956), a widely regarded definitive work. The Executive Skills Core Curriculum specifies performance behaviors, beyond possessing knowledge. The revised cognitive taxonomy incorporated knowledge and its application in performance of executive level skills expected of the MTF commander, lead agents and senior staff.

The taxonomy changes from the Second Edition to the Third Edition of the Core Curriculum were as follows:

Second Edition Taxonomy	Third Edition Taxonomy
Familiarization	Knowledge
Basic Understanding	Application
Full Knowledge	Expert

The three levels of the revised taxonomy were established as knowledge, application, and expert. Descriptions of each follow.

Knowledge

Facts: Cites findings; recalls pertinent names; identifies relevant facts; recalls and uses theories, events, and sequences; correctly uses area vocabulary.

Comprehension: Discusses alternatives; solves problems; makes accurate decisions based on historical facts; has full command of area vocabulary, technical terms, concepts, and principles; explains area to others.

Analysis: Examines elements; classifies examples into concepts and principles; detects important facts and influences, and explains complex actions and relationships; tests hypotheses.

Synthesis: Uses concepts and principles to select among alternatives; plans and brings together elements to create a comprehensive action or plan.

Evaluation: Compares and judges alternatives and conflicting opinions; judges adequacy of others' recommendations, decision, and plans.

Application

Determines and applies appropriate knowledge, makes decisions and takes action. Solves

problems independently. May not feel comfortable or confident acting completely independently in new situations. May rely on others for expertise and decides when consultation is necessary.

Expert

Becomes expert with experience in applying knowledge to situations. Takes independent action with complete confidence. Writes publication quality articles in fields of expertise. Interprets and judges the work of others.

The candidate for command must first learn the knowledge of each of the eight areas of the Core Curriculum. The levels of knowledge above are all necessary for command- level behaviors. It is not sufficient to learn a few facts and then attempt to perform the expected behaviors at the command level. Career counselors, curriculum designers, and the student all have a responsibility to see that prospective commanders have the knowledge required. The knowledge can be obtained from existing courses from both military and civilian sources. While applying the knowledge will likely begin in an academic setting, most application experiences will take place in job assignments. The level of the expert cannot be attained in an academic setting; there, one can only learn *about* being a commander. One must have the knowledge and then have applied the knowledge in a variety of real-life settings to become an expert. It is experience in performing that makes an expert.

JMESP Core Curriculum – Fourth Edition

The Fourth Edition was revised with the assistance of the current and former MHS members. The group specifically considered additions relating to readiness andhomeland security issues, patient safety, and others. The Information Management competency was renamed Information and Technology, and Alternative Health Care Delivery Systems was changed to Integrated Health Care Delivery Systems to better reflect the operational concepts of managed care as it is implemented by TRICARE.

JMESP Core Curriculum – Fifth Edition

The Fifth Edition is the result of revisions recommended by a team of Deputy Surgeons General nominees with input from others involved with implementing the JMESP. The team was tasked with identifying the critical issues in the MHS, recommending changes to reflect Executive Skills competencies required of MHS senior leaders in the current environment, and reviewing the taxonomy designations.

The top ten critical issues identified by the group, using a nominal group technique, formed a basis for reviewing and updating the curriculum and are as follows (not in rank order): budget and control fluctuations, cost versus patient satisfaction and quality, a joint environment, readiness, contracts, leader development, integration and team building, infrastructure needs, retention, and multiple missions. The “Clinical Understanding” domain was eliminated and the competencies therein moved to “Performance Measurement and Improvement.” The “expert” taxonomy level requirement was eliminated and the eight competencies so designated are now required at the “application” level. This decision was based primarily on the view that individuals develop competency at the expert level while serving in, but not necessarily prior to assuming, leadership positions.

The Health Law/Policy competencies were reviewed at the TRICARE Management Activity level by specific request of the Core Curriculum Review team.

JMESP Core Curriculum – Sixth Edition

The Joint Medical Executive Skills Institute conducted a review of military medical executive education competencies on July 29-31, 2008 at Ft. Sam Houston, TX, resulting in the Sixth Edition of The JMESP Core Curriculum. Review board members were nominated by the Deputy Surgeons General for each Service. Other participants included members of the JMESP working group and invited guests who provided additional subject matter expertise and discussion of current topics. Participants prepared for the review by studying the current list of competencies, the categories, behavioral objectives, and cognitive levels. An updated core curriculum emerged as the participants raised and resolved questions about current issues, needs, and practice. A summary of the changes to the core curriculum follows.

The competencies that make up the core curriculum are arranged into seven domains. The name of the first domain, "Military Medical Readiness," was changed to "Military Medical" to encompass the complete category. Medical Readiness Training is one competency within this domain. Also, within the Military Medical domain, two competencies were combined, changing the number of competencies from 40 to 39. "National Disaster Medical Systems Management" and "Contingency Planning" were combined, and the competency was named "National Disaster and Contingency Planning." Additionally, the review board elected to reword three other competency titles. "Ethical Decision-Making" was renamed "Ethical Foundations" and "Communication" was renamed "Interpersonal Communication." "Public and Media Relations" was renamed "Strategic Communication" to reflect a broader perspective, which includes media and public relations as well as risk communications. The term "Medical Treatment Facility" (MTF), which was used in previous editions has been replaced in this edition with the term "medical unit." Last, additional objectives were developed to reflect the specific behaviors which senior leaders must demonstrate.

JMESP Core Curriculum – Seventh Edition

The seventh edition of The JMESP Core Curriculum was compiled as a result of the military medical executive education competency review held June 14-16, 2011 in San Antonio, TX. Fifteen review board members discussed and updated the existing Core Competencies. Review board members represented the Army, Navy, and Air Force, and were MTF commanders and key leaders who were nominated by their Deputy Surgeons General for this task. The review board heard presentations from JMESP working group members and subject matter experts, who were available throughout the review. The event was managed and facilitated by the JMESI staff. The resulting changes to the Core Curriculum, and consequentially, to the competency model, are described next.

The review board ensured that the Core Curriculum reflects joint missions. The competency "Joint Operations" was deleted as a stand-alone competency; instead, joint and interagency language was added appropriately throughout all of the competencies.

The competency "Ethical Foundations" was also deleted as a separate competency. The content and behaviors did not change. This information was added to the competency "Personal and Professional Ethics."

Three quality assurance competencies were combined as one in order to capture the entire process as one competency. "Quality Management" was renamed as "Quality Management and Performance Improvement," which includes the descriptions and behavior statements that were previously listed in "Quantitative and Qualitative
Analysis" and "Outcome Measurements."

Additionally, five competencies were renamed to reflect current operations, policies, and/or missions. These changes are listed in the table below. Overall, the updates resulted in the number of military medical executive skills competencies changing from 39 to 35.

2008 COMPETENCY	2011 COMPETENCY
Disaster and Contingency Planning	Emergency Management and Contingency Operations
Change and Innovation	Change Management
External Accreditation	Accreditation and Inspections
Individual Behavior	Personal and Professional Individual Behavior
Epidemiological Methods	Population Health Improvement

JMESP Core Curriculum – Eighth Edition

A Joint Medical Executive Competencies Review was conducted August 4-6, 2014 at Fort Sam Houston, TX, following the current pattern of a triennial review. The result was a collection of current medical executive competencies and behaviors which is used to structure medical executive skills education and training. The updated competencies were presented in the Core Curriculum, Eighth Edition.

The work was completed by a review board consisting of 19 Army, Navy, and Air Force Service representatives. The group received read-ahead material and interacted with the JMESI staff in preparation for this task. During this meeting, they completed a line by line review of the existing competencies. Three subject matter experts representing different organizations addressed the board members to provide relevant information regarding competency-based education, leadership development, and current topics in medical executive skills. In addition, subject matter experts reviewed five of the competencies regarding ethics, labor-management relations, and information management and technology, and provided their input to review board members. The JMESI staff facilitated the review and provided information on the history of the JMESP competencies.

To summarize the results of the review, the competency number remained at 35. Titles of four competencies were changed as follows. “Medical Readiness Training” was changed to “Readiness of the Medical Force.” “Personal and Professional Individual Behavior” was changed to “Individual Behavior.” “Clinical Investigations” was changed to “Research and Investigation.” “Integrated Health Care Delivery Systems” was changed to “Integrated Healthcare Systems.” Also, the definitions of seven competencies were updated, and the behavioral objectives of 21 competencies were changed.

JMESP Core Curriculum – Ninth Edition

The Joint Medical Executive Skills Institute held a review of military medical executive education competencies June 13-15, 2017 at Ft. Sam Houston, TX, resulting in the Joint Medical Executive Skills Program Core Curriculum, Ninth Edition. Nineteen review board members were selected to participate, representing Army, Navy, and Air Force medical corps. Other participants included members of the JMESP working group and invited guests who provided additional subject matter expertise and discussion of current topics. Participants prepared by reviewing the 2014 competency model and Core Curriculum. Participants raised and resolved questions about current issues, needs, and practice, resulting in the updated competency model and core curriculum. A summary of the review outcome follows.

The Core Curriculum is arranged by domains, competencies, and behavior statements. The organizational structure of the seven domains remains unchanged. The domains are Military Medical, Leadership and Organizational Management, Health Law and Policy, Health Resources Allocation, Ethics in the Healthcare Environment, Individual and Organizational Behavior, and Performance Measurement and Improvement.

The review board considered a new competency and determined that it was a necessary addition, changing the number of competencies from 35 to 36. The competency High Reliability was added to the Leadership and Organizational Management domain. The focus is behaviors that senior leaders must know and apply to enable the MHS goal of achieving zero preventable harm.

Three competencies were renamed to reflect current operations, policies, and/or missions. The changes are listed in the following table.

2014 COMPETENCY	CURRENT 2017 COMPETENCY
Medical Staff By-Laws	Medical Staff By-Laws and Oversight of Clinical Practices
Human Resource Management	Human Capital Management
Information and Technology Management	Information Resources Management

Additionally, 16 competency definitions were updated. Regarding the competency behavior statements, five new behaviors were added, 10 were deleted, and 60 were revised.

As a final point, the performance level for the Bioethics competency was changed from knowledge to application level. In keeping with Bloom's Taxonomy, application incorporates knowledge and necessitates determining and applying appropriate knowledge to make decisions and take action. With this revision, all competencies now specify senior leaders must demonstrate the behaviors at the application level.

JMESP Core Curriculum – Tenth Edition

The JMESI held a review of military medical executive skills competencies November 19-20, 2019 at Ft. Sam Houston, TX, resulting in the Joint Medical Executive Skills Program Core Curriculum, Tenth Edition. Fifteen review board members were selected to represent the Army, Navy, and Air Force medical departments. Other participants included members of the JMESP working group and invited guests who provided additional subject matter expertise. Participants prepared by reviewing the 2017 Core Curriculum. Participants reviewed the competencies with the intent of developing a learning continuum for Military Health System leaders. In addition, the board recommended a few changes to the core curriculum behavior statements. A summary of the review outcome follows.

The organizational structure of the seven domains remains unchanged. The domains are Military Medical, Leadership and Organizational Management, Health Law and Policy, Health Resources Allocation, Ethics in the Healthcare Environment, Individual and Organizational Behavior, and Performance Measurement and Improvement. No competencies were added, removed, or changed during this review. The total number of competencies remains at 36. No new behavior statements were added, three were deleted, and seven were revised.

The primary work of the board this year was to review each competency and behavior statement to determine at what point in a member's career he or she should receive instruction on each topic in support of development of the respective competency. The JMESI proposed that three joint curricula (basic, intermediate, and advanced) should be developed to focus on instruction in the joint medical executive skills competencies. The board accepted this premise and further defined the target audiences for each level of instruction as follows:

- Basic: first time clinical leaders within a medical or dental treatment facility
- Intermediate: department-level leaders within a medical or dental treatment facility
- Advanced: pre-command or director course for individuals selected to lead an MTF

The board also determined that not all competencies and behaviors need to be taught within a JMESI course. Some competencies and behaviors should be taught through Service courses (such as Professional Military Education) or other existing mandatory training, while others are best learned experientially through developmental assignments and duties. Additional categories were created to reflect these decisions as the board sorted competencies and behaviors into basic, intermediate, and advanced educational requirements. In addition, the board determined that some competencies and behaviors should be taught at multiple levels with successive instruction focusing on more advanced concepts within the topic.

In the end, the board identified 85 behavioral statements that should be included in a basic course, 99 that should be included in an intermediate course, 85 that should be included in an advanced course, 98 that should be addressed through Service or other DHA mandatory courses, and 31 that should be developed experientially. Each of these decisions is reflected next to the behavioral statements included in this edition of the Core Curriculum using the following codes: B (basic), I (intermediate), A (advanced), S (service or other mandatory training), and E (experiential).

JMESP Core Curriculum and Competency Model– Eleventh Edition

The JMESI held a review of military medical executive skills competencies November 1-3, 2022, at Ft. Sam Houston, TX, resulting in the Joint Medical Executive Skills Program Core Curriculum and Competency Model, Eleventh Edition. Nine review board members were selected to represent Army, Navy, and Air Force. This board also included three representatives from the Defense Health Headquarters: a first for the JMESP. Other participants included members of the JMESP working group and invited guests who provided additional subject matter expertise and discussion of current topics.

The board made significant updates to the competency model to include combining, reorganizing, and in some cases eliminating competencies. The board also eliminated two competency domains and renamed two others. In addition, the board revised or eliminated numerous behavior statements and modified definitions for several of the competencies. The following is a summary of significant changes.

- The Total Force Management competency was eliminated, and its behavior statements were moved to the Human Resource Management competency.
- The High Reliability competency was completely re-written to reflect current DHA policy.
- The Health Law and Policy domain was renamed Health Law, Policy, and Ethics.
- The competencies of Personal and Professional Ethics, Bioethics, and Organizational Ethics were combined into a single Ethics competency. The new Ethics competency was moved to the Health Law, Policy, and Ethics domain. This eliminated the Ethics in the Healthcare Environment domain.
- The competencies of Individual Behavior and Group Dynamics were eliminated.
- The Conflict Management competency was moved to the Leadership and Organizational Management domain.
- The Individual and Organizational Behavior domain was renamed Effective Communication.
- The Population Health Improvement competency was renamed Public Health and moved to the Health Law, Policy, and Ethics domain along with the Research and Investigation competency.
- The competencies of Integrated Healthcare Systems, Quality Management and Performance Improvement, and Patient Safety were eliminated. Some of the behavior statements from these competencies were moved to other competencies such as High Reliability and Regulations.
- The Performance Measurement and Improvement domain was eliminated.

In addition, the board decided to add a glossary of definitions to the eleventh edition, and the references section will be updated with additional recent NDAA legislation that impacted the MHS. The result of the 2022 board's work is a model that includes 28 competencies arranged into 5 domains. This is a reduction from 36 competencies and 7 domains.

2019 COMPETENCY	2022 COMPETENCY
Total Force Management	Eliminated
Personal and Professional Ethics	Ethics
Bioethics	Ethics
Organizational Ethics	Ethics
Individual Behavior	Eliminated
Group Dynamics	Eliminated
Population Health Improvement	Public Health
Integrated Healthcare Systems	Eliminated
Quality Management and Performance Improvement	Eliminated
Patient Safety	Eliminated

Finally, Lead Agents was changed to Market Leaders within the competency model and the document's name was changed to "Joint Medical Executive Skills Program Core Curriculum and Competency Model.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

DHA	Defense Health Agency
DSCA	Defense Support of Civil Authorities
EEO	Equal Employment Opportunity
HCMO	healthcare management organization
HIPAA	Health Insurance Portability and Accountability Act
IRM	information resources management
IT	information technology
JMESDG	Joint Medical Executive Skills Development Group
JMESI	Joint Medical Executive Skills Institute
JMESP	Joint Medical Executive Skills Program
MHS	Military Health System
MOA	memorandum of agreement
MOU	memorandum of understanding
MTF	military medical treatment facility
NDAA	National Defense Authorization Act
OASD/HA	Office of the Assistant Secretary of Defense, Health Affairs
OPLAN	military operations plan
PAO	Public Affairs Office
PPBE	Planning, Programming, Budgeting, and Execution
SME	subject matter expert

PART II. DEFINITIONS

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

Consolidated Omnibus Budget Reconciliation Act. Gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Defense Planning Guidance. A product of the PPBE process planning phase. Defense Planning Guidance reflects the President's National Security Strategy, the Secretary of Defense's National Defense Strategy, and the Chairman's National Military Strategy. It also reflects results of the National Defense Strategy, and the annual Chairman's Program Recommendations. Defense Planning Guidance drives the development of the Program Objective Memoranda and Budget Estimate Submissions.

DSCA. Support provided by federal military forces; DoD civilians; DoD contract personnel; and DoD component assets, to include National Guard forces (when SecDef, in coordination with the governors of the affected states, elects and requests to use and fund those forces in Title 32, USC, status), in response to a request for assistance from civil authorities for domestic emergencies, cyberspace incident response, law enforcement support, and other domestic activities or from qualifying entities for special events. DSCA includes support to prepare, prevent, protect, respond, and recover from domestic incidents. DSCA is provided in response to requests from civil authorities and upon approval from appropriate authorities. DSCA is only conducted in the US homeland.

EEO. Operates to ensure all individuals are provided a full and fair opportunity for employment, career advancement and access to programs without regard to race, color, religion, national origin, disability (physical or mental), gender, age, sexual orientation, genetic information or parental status.

Federal Tort Claims Act. Federal legislation enacted in 1946 that provides a legal means for compensating individuals who have suffered personal injury, death, or property loss or damage caused by the negligent or wrongful act or omission of an employee of the federal government.

Feres Doctrine. A legal doctrine that prevents members of the armed forces who are injured while on active duty from successfully suing the federal government under the Federal Tort Claims Act.

Future Years Defense Program. Displays – by fiscal year – total DoD resources and force structure information for the prior year, current year, budget year, and the following four years (i.e., the "outyears"). It also includes force structure information for an additional three years beyond the four "outyears".

Global Health Engagement. The interaction between the DOD and Partner Nations' armed forces or civilian authorities, in coordination with the U.S. interagency, to build trust and confidence, share information, coordinate mutual activities, maintain influence, and achieve interoperability in support of U.S. national security policy and military strategy.

Gonzalez Act. The Medical Malpractice Immunity Act (commonly referred to as the "Gonzalez Act) shields federal healthcare providers in the armed forces from malpractice liability. This Act substitutes the federal government in as the defendant in these matters.

Health Services Support. All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel.

HIPAA. A federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Just Culture. A system of shared accountability in which organizations are accountable for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner. A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.

Managed Care System. An integrated network comprised of military hospitals and clinics and civilian providers that ensures consistency of care in accordance with statute via policy and regulations, benefit determination, and benefit design.

MHS. Provides direction, resources, health care providers, and other means necessary to foster, protect, sustain, and restore health to Service members and other beneficiaries.

MTF. Any fixed facility of the DoD that is outside of a deployed environment and used primarily for health care; and any other location used for purposes of providing health care services as designated by the Secretary of Defense.

National Disaster Medical System. A federally coordinated medical system, augmenting the United States' medical response capability to assist state, local, and tribal authorities in dealing with medical impacts during major peacetime disasters.

National Practitioner Data Bank. A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

National Response Framework. Provides foundational emergency management doctrine for how the Nation responds to all types of incidents. The NRF is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System to align key roles and responsibilities across the Nation.

Patient Safety. Patient safety involves all activities to minimize the risk of preventable harm, to include establishing a command climate to proactively identify, report with impunity, and reduce potential risks to patients. Patient Safety includes ongoing assessment of patient care, customer feedback, risk management, provider qualifications, utilization review, and the implementation of corrective and follow-up actions, where indicated.

PPBE system. A strategic planning process for allocating resources among the military departments, defense agencies, and other components. The process serves as a framework for DoD civilian and military leaders to decide which programs to fund based on strategic objectives and produces the department's portion of the President's annual budget request

Program Objective Memorandum. A recommendation from the Services and Defense Agencies to the Office of the Secretary of Defense concerning how they plan to allocate resources (funding) for a program(s) to meet the Service Program Guidance and Defense Planning Guidance.

Quality Management and Performance Improvement. Quality Management and Performance Improvement encompass the procedures that emphasize involvement, empowerment, and continuous performance improvement. Effective quality and performance improvement addresses systemic problems and deficiencies.

Risk Management. The process to identify, assess, and control risks and make decisions that balance risk cost with mission benefits.

REFERENCES

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National Defense Authorization Act for Fiscal Year 2019, Public Law 115-232, Section 711 and 712

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