DEVELOPING A NEW GRADUATE PROGRAM IN HEALTHCARE MANAGEMENT: EMBRACING THE TRANSFORMATION OF HEALTHCARE MANAGEMENT EDUCATION ON A PATHWAY TO SUCCESS

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Within a sea change in the structure and process of providing health services, the field of health administration education has moved decisively and concretely from a teaching-centered model of education based on the assumption that knowledge equals competency to a learning-centered model. The learning-centered, or student-centered, model is based on the assumption that competency is related to the ability to demonstrate mission- and market-relevant knowledge, skills, values, and attitudes. This article provides a comprehensive, non-prescriptive approach to the development of a new competency-based graduate program in health administration within an urban-based, private university located in the Southwest United States. The authors describe the structure and process used to align the program's competencies and curricula to the market needs by incorporating the healthcare community's input. The first part of the article addresses the components of the program development framework, including the determination of a program vision and philosophy and the establishment of a program development group and advisory board. The second part concludes with a discussion of the process used in the selection of a competency model and its application to the course curricula.

Keywords: Program Development, Competency, Mission, Advisory-Board, CAHME Accreditation

INTRODUCTION

In 2000 the Institute of Medicine (IOM) published To Err is Human: Building a Safer Health System, a landmark study which focused attention on the need to increase quality of care by reducing medical errors as thousands of American deaths were occurring as the result of preventable medical mistakes (Institute of Medicine, 2000). The study concluded with a clarion call to action and a plan centered on the need to improve patient safety (Institute of Medicine, 2000). In 2001 the IOM produced a follow-on report, Crossing the Quality Chasm: A New System for the 21st Century, which examined the relationship between patient safety and quality from a systems perspective (Institute of Medicine, 2001). In this study researchers expanded the previous focus on patient safety to a more comprehensive examination of the key factors associated with the quality of medical care. This report noted that quality problems were largely systemic and therefore could not be corrected by requiring healthcare providers to work harder at providing the quality of care (Institute of Medicine 2001). The 2001 study identified six factors believed to be closely related to the quality of medical care provided patients on an individual basis and called for all health care organizations to pursue safe, effective, patient-centered, timely, efficient, and equitable care.

The Crossing the Quality Chasm report also recommended that an inter-disciplinary summit be convened to develop a plan to reform health professions education in order to enhance patient care quality and safety. In the summer of 2002, the IOM convened a summit for this purpose. This national meeting, attended by 150 individuals representing various healthcare disciplines and occupations, resulted in the IOM report entitled Health Professions Education: A Bridge to Quality (Institute of Medicine, 2003). This report set forth a vision for all programs and institutions engaged in clinical education, calling for educational reform and recommending the integration of a core set of competencies associated with the following domains: patient-centered care, interdisciplinary teams, outcomes-based practice, quality improvement, and informatics.

Health management educators and practitioners, whose ranks were well represented at the 2003 IOM Summit, were quick to see the need to increase their focus on important educational outcomes, i.e., managerial competencies required by graduates in order to be effective in the workplace (Calhoun, Davidson, Sinioris, Vincent, & Griffith, 2002; Griffith, 2001; Warden & Griffith, 2001). Further, the Joint Commission Whitepaper, Healthcare at the Crossroads stated that accrediting bodies were also providing strong support for outcomes-based, i.e., competency-based, education (2005).

In 2004 the Commission on Accreditation of Health Management Education (CAHME) established the requirement for all CAHME accredited programs to identify a set of competencies related to the program's mission and the types of positions their students would enter upon graduation (CAHME, 2004). The accrediting body further stipulated that the program's competencies would be aligned with specific healthcare management content which, together, would be matched with curriculum (CAHME, 2004).

Within this sea of change in the structure and process of providing health services, the field of health administration education has moved decisively and concretely from a teaching-centered model of education based on the assumption that knowledge equals competency to a learning-centered model. The learning-centered, or student-centered, model is based on the assumption that competency is related to the ability to demonstrate mission- and market-relevant knowledge, skills, values and attitudes.

The concept of competency-based curriculum within management related fields has been in the literature for more than four decades (Boyatzis, 1982; Boyatzis, Cowen, & Kolb 1995l; Lucia & Lepsinger, 1999; McClelland, 1973). However, it was not until the call for a common set of competencies by the IOM in 2003 that health management education programs and associated professional organizations rigorously engaged in efforts to identify and develop comprehensive sets of competencies for the profession of health administration (Calhoun et al., 2002; Campbell, Lomperis, Gillespie, & Arrington 2006; HLA, 2005; NCHL, 2004).

This article describes and discusses the structure and process used to develop a new competency-based graduate program in health administration within an urban-based, private university located in the Southwest United States. Similar approaches have been used successfully to convert existing content-based graduate health management programs to competency-based models (Campbell, Lomperis, Gillespie, & Arrington, 2006). However, published accounts of the structure and process used to create new competency-based programs are believed to be few, if any. This paper is a detailed, non-prescriptive presentation of the framework, process, and outcomes related to the development of a competency-based graduate program in health administration, within a School of Business.

The first section of this paper addresses the components of a program development framework. Key aspects of this framework involve the determination of a program vision and philosophy, the establishment of a program development group, and the development and application of an advisory board. The second section presents the process used in the selection of the competency model and development of the curriculum.

PROGRAM DEVELOPMENT FRAMEWORK

Program Mission, Vision, and Philosophy

A foundational step in the development of the University of the Incarnate Word (UIW) Master of Health Administration program was the formulation of a program vision and philosophy statement built upon a mission that centered on the need for a competency-based curriculum built upon the educational requirements of individuals already working

in the healthcare industry.

The first step in the vision and program philosophy creation process was the appointment of a full-time UIW faculty member with experience in academic program development, administration, and teaching within the field of healthcare administration to lead program development efforts. This individual also had significant experience as a healthcare administrator prior to pursuing a career in academics and had been the director of a nationally ranked graduate program in health administration. The following was used as a guide to draft the initial program vision and philosophy statement.

Drucker's seminal work on the management of non-profit organizations (1990) emphasized the importance of mission clarification in order to answer the following questions: Why does the organization exist, i.e., what is its purpose? In other words, whom does it seek to serve—what need is it seeking to meet? What differentiates this particular organization from those that are similar, i.e., what values characterize the organization and what services will be provided? A multi-dimensional mission component structure developed by strategist Fred David provided a guide that helped answer these and other important mission related questions (2010). The components of David's model used in this process are discussed in the subsequent paragraphs.

Market. Who is being served? The proposed program was to be located in a large urban setting of over one million people, with a Hispanic population of approximately 63%. The university in which the program is housed also draws students from a geographically dispersed rural area to the south of the city. At the time the program was developed, the graduate health administration education market was served by one full-time traditional Master of Health Administration (MHA) program, which offered courses in a traditional 16 week daytime format. The market was also served by two MBA programs, which offered concentrations in healthcare administration. During the time this program was being developed, individuals who worked full-time and wished to pursue an MHA in a face-to-face format did not have the ability to do so.

Targeted Students. The program was designed to meet the educational needs of working adults, especially, those already employed within an economically significant and growing healthcare industry. At the time the program was developed, the healthcare and bioscience industry had an economic impact of $14.3 billion on the San Antonio MSA (Greater San Antonio Chamber of Commerce, 2005). Further, the city had enjoyed an increase of 20,000 jobs from 1995 to 2005, and over 108,000 individuals were employed in healthcare and biosciences organizations in 2005 (Greater San Antonio Chamber of Commerce, 2005).

Program Philosophy. David uses the term Philosophy to capture the values, beliefs, aspirations, and ethical priorities of the organization (2010). The program is located within a faith-based, mission-centered university with well-articulated and accepted core values. This concept is articulated in the Program's values statement provided in Figure 1.
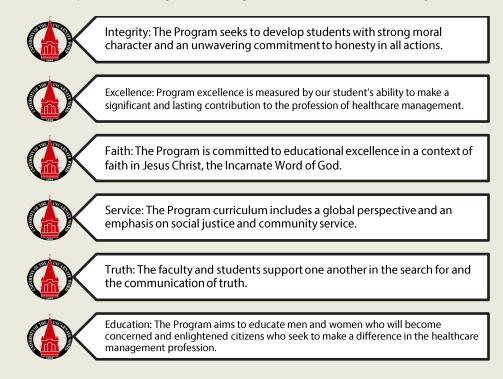
Self-Concept. The term Self-Concept refers to the organization's distinctive competence, i.e., aspects of the program that create a competitive advantage (David, 2010). From its inception, the program was developed to provide a values-based, competency-driven, experientially-oriented health management education. It is this three point practitioner-focused and outcomes-based combination that makes the program distinctive within the San Antonio educational market. As discussed in the next section, this distinctiveness is reinforced by a faculty that may be characterized as practitioner-scholars.

Faculty. It was envisioned from the outset that program faculty would be practitioner-scholars. Specifically, the primary focus of MHA faculty would be on teaching, with a secondary focus on research. Further, it was envisioned that the ideal faculty member would have experience as a healthcare administrator, as well as being qualified academically.

Services. It was envisioned that the program would provide working students the ability to pursue a competency-based, MHA degree delivered in a face-to-face, executive-like format, i.e., part-time, non-working hours, and accelerated 8 week mini-semesters.

Figure 1. Program Values Statement

The Program draws upon the rich history of the Institution that is the University of the Incarnate Word. This relationship guides program direction and provides the value foundation on which the Master in Health Administration Program was developed. The defining Program values are drawn from the institution but manifest themselves in all aspects of the Program. The Program values include the following:

Integrity: The Program seeks to develop students with strong moral character and an unwavering commitment to honesty in all actions.

Excellence: Program excellence is measured by our student's ability to make a significant and lasting contribution to the profession of healthcare management.

Faith: The Program is committed to educational excellence in a context of faith in Jesus Christ, the Incarnate Word of God.

Service: The Program curriculum includes a global perspective and an emphasis on social justice and community service.

Truth: The faculty and students support one another in the search for and the communication of truth.

Education: The Program aims to educate men and women who will become concerned and enlightened citizens who seek to make a difference in the healthcare management profession.

Based on this mission development framework, a Vision and Philosophy statement was drafted (see Figure 2). This document served as the basis for recruiting program development group and advisory board members, as well as for the eventual creation of mission, vision, and values statements for the program.

Working closely with an "industry champion," the program's vision philosophy statement was used as a guide in the recruitment of Program Development Group (PDG) and an Executive Advisory Board membership.

Industry Champion. In the case of the UIW MHA development effort, it was the university president who selected the individual who would lead the program development effort. It was also the president who introduced this individual to a local health industry CEO who would serve in the critical role of industry champion. The local CEO possessed four characteristics that proved critical to the success of the program development effort. First, the individual held a strong belief that San Antonio and South Texas were in dire need of additional healthcare managers in the growing healthcare industry. Further, he believed that high-potential candidates for such positions were already working in the industry but the lacked academic preparation necessary to serve in important management positions. He also noted that these individuals did not have an MHA program available to them, where they could pursue a degree while still remaining employed on a full-time basis. Second, the industry champion had extensive healthcare leadership experience, with over 20 years in the multi-site healthcare services field, to include serving as CEO of four different managed care payer organizations and as CEO of a large Multi-Specialty Physician Group. At the time he joined the UIW MHA program development effort, the individual was the founding CEO of a highly successful clinical trials company and was also serving as Chair of the Health and Wellness committee for one of San Antonio's Chambers of Commerce. Third, he was very well connected within the San Antonio healthcare community, significantly contributing to the PDG's ability to attract well-respected, educationally oriented, healthcare executives to the programs Executive Advisory Board. Fourth, he held a doctorate of science in biostatistics and had experience teaching at the Ph.D. level for a major university.

Figure 2. UIW MHA Vision and Philosophy Statement

It is envisioned that the University of the Incarnate Word Graduate Program in Health Administration will:

Provide an integrated, competency-based graduate program, i.e., one that is focused on developing the skills and abilities as well as fostering the attitudes necessary to perform at a consistently high level within health industry organizations in entry-level management positions.

Meet the graduate education needs of working adults, many of whom are already employed in the health industry, through a high quality program delivered in an executive format, i.e., part-time, non-working hours, accelerated, and using a hybrid delivery system (combination of traditional in-class and online formats as appropriate).

Produce health administrators who are able to conceptualize, critically analyze and compellingly communicate toward a course of action that is in the best interests of those they serve. We seek to produce collaborators motivated by a spirit of commitment to, and compassion for, those they serve.

Be the program of choice for those desiring a faith-based educational experience.

This unique combination of characteristics, unified by a passion to meet the needs of the local healthcare industry through targeted education, allowed our industry champion to significantly influence and contribute to the development of a robust, relevant, and locally supported graduate program in healthcare administration. The most significant contributions of our industry champion, who was formally designated as the program's executive in residence, were in the recruitment of executive advisory board members and in the approach to engaging the board in the identification and development of program competencies.

Program Development Group. Guided by the program vision and philosophy statement, a Program Development Group (PDG) comprised of five individuals was formed. In addition to the executive in residence discussed above, the PDG consisted of four more experienced health administrators, three of whom also possessed doctorates in health services management or research. The fourth was a senior executive and had significant experience teaching health administration at the graduate level. As a group, these individuals represented an average of over 17 years of diverse operational experience as healthcare administrators and a total of 26 years of teaching experience, almost exclusively at the graduate level. This group included a sitting CEO, CIO, and CFO and Deputy Director for Strategy and Programs for a national medical education group. Also in the PDG was an individual with extensive CAHME accreditation site visit experience, as well as experience as a member of the CAHME Accreditation Commission.

Executive Advisory Board. Graduate programs in health administration have a significant and necessarily focused emphasis on the business of healthcare. To further emphasize the connection between health administration and business, the program under study in this paper is located within a school of business. Business program stakeholders, to include faculty, employers, students, and accrediting agencies, provide critical input toward the development of relevant program curriculum directly related to expected program outcomes. Hammond and Moser (2009) suggest that it is especially important to include employers of business school graduates and representatives of local and regional firms with an interest in the success of the business school on advisory boards. Others focused on the development of health administration program curriculum suggest that potential employers bring critical experiential insights to the curriculum development process (de los Santos, Dominguez, & LaFrance, 2011), including the identification of critical environmental trends leading to relevant curriculum (Ireland & Ramsower, 1994). Finally, there is evidence that an advisory board able to provide a diverse stakeholder perspective, may enable academic

ADMINISTRATIVE ISSUES JOURNAL: EDUCATION, PRACTICE, AND RESEARCH

programs to better align educational offerings with practitioner expectations (Leisen, Tippins, & Lilly, 2004).

Understanding the value of Advisory Board engagement, the PFG sought to align program competencies with industry-wide operational expectations. Therefore, they formed an executive advisory board to obtain input from local healthcare executives in the program development process. Board membership was comprised of a diverse cross-section of senior healthcare industry executives, including CEO's and Senior Vice Presidents from San Antonio metropolitan area health system, hospital, group practice, insurance, and health research settings.

Arguably, the PDG and Executive Advisory Board members combined to form a very knowledgeable, educationally focused, group of healthcare administration professionals well positioned and suited for the work of developing a competency-based program in healthcare administration. Once the development team was formed, the next step in the program development process was to adopt a competency model and then identify market specific competencies for entry level healthcare administrators.

Competency and Curriculum Development

Review of existing competency models. Several competency models specific to the field of healthcare administration have been developed, in recent years (Campbell et al., 2006; HLA, 2005; NCHL, 2004). These models vary significantly in the number of identified competencies, ranging from as few as 21 in the National Center for Healthcare Leadership (NCHL) model to as many as 300 in the Healthcare Leadership Alliance (HLA) model (HLA, 2005; NCHL, 2004). The NCHL and HLA frameworks are comprehensive collections of competencies required of healthcare administrators over the course of a career, i.e., from entry-level management to CEO, and were developed by health administration scholars and practitioners working in collaboration. A third competency model developed by the health administration faculty at Saint Louis University (Campbell et al., 2006) was based upon the knowledge, skills, values and attitudes required of entry-level healthcare administrators.

Because the Saint Louis University model was focused on the knowledge, skills, values and attitudes, required of entry level administrators, and because of the perceived comprehensiveness and intuitive appeal of its six domains—Leadership, Critical Thinking, Management, Science/Analysis, Political and Community Development and Communication—the Saint Louis University model was selected as the guiding framework in the UIW MHA competency development process. Still, as described in our discussion of competency development, components of each of the three models influenced and became a part of the UIW MHA competency model.

Managerial Competence. Competence has been defined as the underlying characteristics of an individual that relate to effective or superior performance in a job (Goleman, Boyatzis, & McKee, 2002). Competence is also referred to as a knowledge, skill, ability, or attitude that positions someone to effectively operate within a given business environment and is generally accepted as the standard for measuring appropriate behavior (Chyung, Stepich & Cox, 2006; Jackson et al., 2007). As previously noted, competency-based curriculum has well recognized and sustained support in the literature (Boyatzis, 1982; Boyatzis, Cowen, & Kolb, 1995; Lucia & Lepsinger, 1999; McClelland, 1973). Further, competencies provide an important link between classroom-based learning and outcomes produced on the job (Chyung et al., 2006; Moon, 2007). Finally, they are required to be aligned with curriculum for programs seeking CAHME accreditation (CAHME 2011).

Leaders in the field of health administration education have responded to the IOM call for educational reform by developing competency-based curriculum built upon the demonstrable knowledge, skills, behaviors, and attitudes believed to be critical to managerial effectiveness (Calhoun, Davidson, Sinioris, Vincent, & Griffith, 2002; Campbell et al., 2006). Linking program competencies to important professional criteria requires that classroom experience be aligned with specific competency knowledge, skills, values and attitudes. This then allows programs to quantify and measure the level at which identified educational outcomes, i.e., competencies, have been achieved (Dominguez, Teachout, & LaFrance, 2009).

UIW MHA Competency Model. As previously discussed, developing competency-based curriculum that reflects contemporary, market specific, operational expectations in terms of the knowledge, skills, values, and attitudes of entry level managers requires input from competent educationally oriented healthcare executives. Using a focus group methodology described in a previous work (de los Santos, Dominguez, & LaFrance, 2011), the PDG sought

competency input from its executive advisory board, using the Saint Louis University model as a working framework.

Through an iterative process of information gathering, refinement, review and approval, Advisory Board input was first collected using the six domain Saint Louis University (SLU) framework during a facilitated focus group process. Input was categorized within the SLU framework and then compared and aligned with the competencies from the NCHL, HLA and SLU models to assess the comprehensiveness of the input. The input was found to be most similar with the highly specified NCHL competency model, though several competencies described within the HLA model were also included in the final iteration of the UIW model. A matrix of the Board's input and associated NCHL/HLA competencies and measures was fed-back, reviewed, and modified by the Advisory Board and PDG to ensure relevancy and appropriateness of both the competencies and their associated measures. The final iteration of the UIW MHA Model (see Table 1) consisted of 24 competencies that were targeted to the needs of San Antonio metropolitan area entry-level health administrators and distributed across a six domain framework similar to that used by SLU.

Curriculum Development. The first step in the curriculum development process was to align the 24 UIW MHA specific competencies and associated measures and dimensions with the 19 healthcare management content areas required by the CAHME at the time the program was developed (CAHME, 2007). This was accomplished by the PDG and reviewed and endorsed by the Executive Advisory Board.

Once the Executive Advisory Board approved the competency-alignment matrix, the PDG added a column to the matrix and matched competencies and required content with specific courses. An example of the outcome of the competency, content area, course alignment process is provided in Table 2. (A full list of the criteria required in 2007 is available at http://www.cahme.org/ OfficialCAHMECriteriaFall2008andBeyond.pdf.) This effort culminated in a 15 course, 45 hour graduate degree in health administration.

The final step in the curriculum development process was to sequence the courses. Consistent with the program mission, courses were to be offered in the evening, in 8-week mini-semesters across a 21 month period. Students would be enrolled in a cohort each fall and take one to two courses per mini-semester.

The program was approved by the university in the spring of 2009, and the inaugural class matriculated that fall. At the time this paper was written, the program had graduated its second class. A third cohort of MHA students was one semester away from graduation, with a fourth completing its first year of didactics. Further, the program had participated in a very successful CAHME initial accreditation site visit in October 2012.

CONCLUSION

This paper describes a non-prescriptive structure and process used to develop an integrated competency-based graduate program in healthcare administration. The program focuses on developing the knowledge, skills, values, and attitudes that entry level managers require in order to perform at a consistently high level within South Texas health industry organizations. Critical to the development effort was the use of a mission-driven framework grounded in a clearly articulated vision and philosophy statement. This framework facilitated the effective partnership of a program development group comprised of experienced practitioner-scholars and a diverse, educationally focused, executive advisory board, in the identification and development of market relevant competencies.

Building upon the six domain, entry-level management focus of the Saint Louis University competency model, the University of the Incarnate Word graduate Program Development Group was able to create a market-relevant competency model that incorporated aspects of both the National Center for Healthcare Leadership and the Healthcare Leadership Alliance models. Guided from its inception by the CAHME accreditation process, the Program Development Group was able to use CAHME requirements to align the program's competencies first to required content, and then to curriculum.

The transformation of healthcare is well underway and, along with it, the transformation of healthcare management education. Many have resisted the powerful forces at play in the healthcare industry, preferring to maintain the status quo for as long as possible. At the University of the Incarnate Word, the Master of Health Administration Program Development Group elected, instead, to embrace the transformation, believing that it offers a pathway to success—to making a difference in the lives of the students and the communities we serve. Results to date are very encouraging,

as we have not only enrolled our fourth cohort of students, but we have also participated in a very successful CAHME accreditation site visit and fully expect to receive initial accreditation in the spring of 2013. Still, only time will tell if our efforts will bear lasting fruit.

Table 1

UIW MHA Competency Model

Domain	Competency
Knowledge of the Healthcare Environment	1. Ability to explain issues and advancements in the healthcare industry. 2. Ability to apply the basic principles of economics, statistics, and epidemiology to health care issues. 3. Ability to effectively participate in discussions relating to health policy at the local, state, and federal levels.
Critical Thinking and Analysis	4. Ability to break a situation, issue or problem into smaller pieces or trace its implications in a step-by-step way. 5. Ability to apply complex concepts, develop creative solutions, or adapt previous solutions in new ways. 6. Ability to analyze and design, or improve, an organizational process, including incorporating the principles of quality management and customer satisfaction. 7. Ability to consider the business, demographic, ethno-cultural, political, and regulatory implications of decisions and develop strategies that continually improve the long-term success and viability of the organization.
Business and Management Knowledge	8. Ability to hold people accountable to standards of performance with the long-term good of the organization in mind. 9. Ability to reach mutual agreement, or otherwise acceptably resolve a situation when there is disagreement or dispute among individuals and groups 10. Ability to understand and explain financial and accounting information, prepare and manage budgets, and make sound long-term investment decisions. 11. Ability to implement staff development and other management practices, comply with legal and regulatory requirements, optimize the performance of the work force. 12. Ability to see the potential in and understand the use of administrative and clinical technology and decision-support tools in process and performance improvement. 13. Ability to understand and explain the regulatory and administrative environment in which the organization functions. 14. Ability to monitor a "scorecard" of quantitative and qualitative measures. 15. Ability to understand and learn the formal and informal decision-making structures and power relationships in an organization or industry.
Political and Community Development	16. Ability to consider priorities and values of multiple constituencies. 17. Ability to align one's own and the organization's priorities with the needs and values of the community, including its cultural and ethnocentric values and to move health forward in line with populations-based wellness needs. 18. Ability to demonstrate ethics, sound professional practices, social accountability, and community stewardship.
Communication	19. Ability to facilitate a group; speak and write in a clear, logical, and grammatical manner in formal and informal situations to prepare cogent business presentations. 20. Ability to understand other people including hearing and understanding the unspoken or partly expressed thoughts, feelings, and concerns of others as well as the ability to communicate one's position with others.
Leadership	21. Ability to energize stakeholders and sustain their commitment to changes in approaches, processes, and strategies. 22. Ability to work cooperatively with others, to be a part of a team, to work together, as opposed to working separately or competitively. 23. Ability to persuade, convince, influence, or impress others (individuals or groups) in order to get them to go along with or to support one's opinion or position. 24. Ability to demonstrate strong leadership characteristics including speaking, acting and living as an ethical leader.

Table 2

Competency, Content, and Course Alignment

UIW MHA Competency	2008 CAHME Content Area(s)	UIW MHA Course(s)
Competency 2. Ability to apply the basic principles of economics, statistics, and epidemiology to health care issues.	III.B.1 Population health and status assessment III.B.12 Statistical analysis and application to decision making III.B.13 Economic analysis and application to decision making	HADM 6302 Healthcare Economics HADM 6303 Population Health and Epidemiology HADM 6350 Quantitative Analysis for Healthcare Managers
Competency 3. Ability to effectively participate in discussions relating to health policy at the local, state, and federal levels.	III.B.2 Health policy formulation, implementation, and evaluation	HADM 6380 Health Policy

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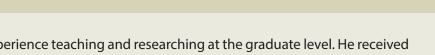
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