The Administrative Residency in a Multi-Institutional System

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MANY GRADUATE PROGRAMS in hospital administration do not have courses in multi-institutional structure, but refer only tangentially to this expanding segment of our healthcare delivery system. The administrative residency offers an excellent opportunity to study multi-institutional systems from within. This article shall define a prototype for the residency experience within a particular type of multi-institutional arrangement, the holding company or umbrella organization.

Is the nonprofit hospital sector in danger of extinction and to be replaced by a system comprised only of public and private hospitals?[1] If there is to be a savior of the nonprofits, it may well be the emergence of the multi-institutional arrangements.[2] The investor-owned chains have used their economies of scale and strategy to create a competitive advantage.[3,4] The economic, manpower, and organizational benefits of the multi-institutional systems at both the institutional and community level have been documented.[5] The importance of multi-institutional systems is reflected in the

[1]Johnson, Richard. "Requiem for the Non-Profit Hospital." *Modern Hospital*, February, 1974, pp. 43-46.

[2]Cochrane, John and Fourkas, Ted, editors. *Hospital Consortia: Are They Just Another Layer of Bureaucracy? Or a Key to Survival?* Sacramento, CA: California Hospital Association, 1979.

[3]Johnson, Donald and DiPaolo. "Multi-Hospital System Survey." *Modern Healthcare*, April, 1981, p. 79.

[4]Lewin, Lawrence; Derzon, Robert; and Margulies, Rhea. "Investor-Owneds and Non-Profits Differ in Economic Performance." *Hospitals*, July 1, 1981, pp. 62-8.

[5]Zuckerman, Howard and Weeks, Lewis. *Multi-Institutional Hospital Systems*. Chicago, IL: Hospital Research and Educational Trust, 1979, p. 12.

statistical indicators of their growth. There has been almost 600 percent growth in the number of hospitals in systems since 1940. This is indicated by information provided by 189 systems which responded to a 1981 survey conducted by the American Hospital Association Center for Multi-Institutional Arrangements.[6] Between publication of the 1980 and 1981 *Directory of Multi-Hospital Systems* there was a 4.8 percent increase in the number of owned, leased, or sponsored hospitals and a 3.5 percent increase in their beds.[7] One-third of all non-federal, acute-care, general hospitals in the United States are currently affiliated with at least one other multi-hospital system.[8]

As multi-institutional arrangements become more important, there develops a need to study them as an entity in the healthcare delivery system. The holding company or umbrella type organization is appropriate for this model because it follows the corporate design of business toward which the health field seems to be moving.[9] Any type of ownership, government, proprietary, nonprofit, or prepaid group practice may adopt the umbrella form of organization. Salient features of the organization are a corporate level, which may be housed in a headquarters separate from any of the hospitals, and a single mission to which institutions with varying degrees of autonomy contribute. It is the oneness of mission in an organization with more than one sub-unit that provides the uniqueness of the multi-institutional administrative residency.

Uniqueness

The freestanding hospital has two levels on which it must interact, the external and the institutional. Multi-institutional systems have an additional, corporate level. Single hospitals may seek affiliations at some point on the De Vries continuum, i.e., sharing

[6]*Data Book on Multi-Hospital Systems*. Chicago, IL: American Hospital Association Center for Multi-Institutional Arrangements, 1981.

[7]*Directory of Multi-Institutional Systems*. Chicago, IL: American Hospital Association Center for Multi-Institutional Arrangements, 1980.

[8]*Ibid*.

[9]Brown, Montague and Lewis, Howard. *Hospital Management Systems*. Germantown, MD: Aspen Systems, 1976.

services, but do not operate with a corporate layer.[10,11] The multi-institutional system has potential for complex internal machinery for the achievement of its mission. For example, under one umbrella may be both large teaching hospitals and small hospitals, a school of nursing, a wholistic health center, retirement centers, and other types of organizations. The organization may provide management contracts, consulting, and shared services (See Figure 1). The multi-institutional system has a greater capital base, manpower, and technical resources for dealing with its environment.

There are advantages in serving an administrative residency in a multi-institutional system. The breadth and complexity of the learning environment offers opportunities which can be suited to individual interests. The resident has the opportunity to see the big picture of healthcare delivery over a geographic region rather than in just one hospital's community. Corporate level staff persons provide technical expertise in their generic areas. Generic areas new to healthcare, such as shared services and acquisitions, are first found in multi-institutional systems. Use of advanced communications and medical technology keeps the resident abreast of developments in the sciences.[12] The resident may meet administrators from a diversity of academic backgrounds, providing broad exposure to individual management styles. The residentcan learn the aggressiveness of multi-institutional organizations, which are dynamic, competitive, and future-oriented.

There are several problem areas for the resident related to size and geographic dispersion which are unique to multi-institutional residencies. The resident must find housing optimally convenient to the hospitals and corporate headquarters. Inter-institutional travel time may become a constraint.

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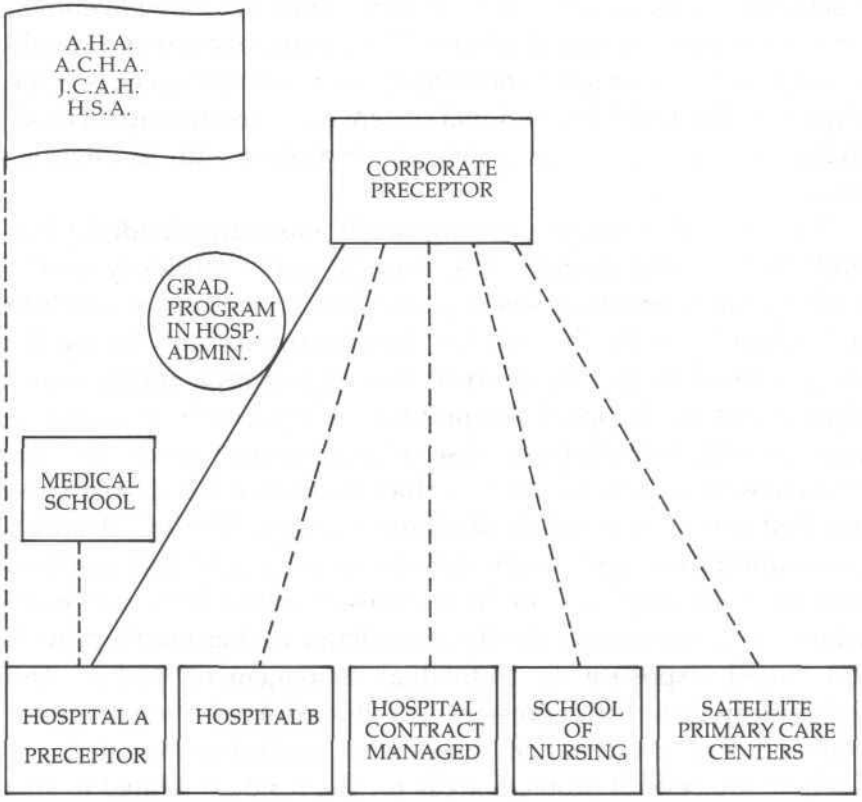
[10]Alford, Elizabeth. "Hospital Association Sharing." in Brown, Montague and McCool, Barbara, editors. *Multi-Hospital Systems*. Germantown, MD: Aspen Systems, 1980, p. 101.

[11]DeVries, Robert. "Strength in Numbers." *Hospitals*. March 16, 1978, pp. 81-84.

[12]Baltzer, David; Gray, Mark; and Pfitzer, Jack. "Teleconferencing May be (Micro) Wave of the Future." *Hospitals*. July 16, 1981, p. 185.

Figure 1. Diagrammatic Representation of the Administrative Residency in a Multi-Institutional System



Solid lines represent the resident's primary relationships.
Dotted lines represent the resident's secondary relationships.

Resident-preceptor relations

Another area of concern is the preceptor-resident relationship. The preceptor is the most important factor in the administrative residency program.[13] It is important that there be a good match of personalities and an acceptance that "I am your resident" and "You

[13]*The Hospital Administrative Residency*. Chicago, IL: American College of Hospital Administrators, 1965, p. 6.

are my preceptor." Otherwise it can be a very difficult year. The resident learns the preceptor's personality and the preceptor also further develops his own.[14] In the multi-institutional system, the selection of the resident may be through a centralized personnel office, a field recruitment staff person, an administrator's contact with a known graduate program, or a student's initiative with the organization. The preceptor should have the opportunity to interview the resident prior to selection. Regardless of the quality of the resident, the organization must remain aware of the importance of assigning preceptors who are dedicated to the educational purpose of the residency and interested in providing mentorship to young administrators. The multi-institutional system may provide two preceptors, one at the corporate level and one at the institutional level.

Educational plan

There is greater need for planning the administrative residency in a multi-institutional arrangement than in a single site residency, because of the added complexity of the corporate layer. This planning will be ongoing during the year to allow for the best use of resources and synchronization of activities. For example, budgeting may be learned at one hospital, after which the resident may work on construction projects at another hospital. At a third hospital he may attend meetings relating to medical school affiliation with an administrator. The resident should outline his strengths, weaknesses, opportunities, and constraints; goals and objectives; and areas of interest at the beginning of the residency.[15] The ACHA Self-Assessment Instrument would provide an objective measure of current knowledge and areas of weakness. The preceptor and resident should combine efforts to design an educational plan which would be submitted to the program from which the resident graduated.[16] The issue of breadth versus depth should be resolved through an optimal pursuit of both extremes of the continuum based on the resident's background and learning ability.

[14] *Ibid.*, p. 9.
[15] *Ibid.*, p. 8.
[16] *Ibid.*, p. 10.

With the concurrence of the preceptor, the resident may want to write his own position description to focus his role. Throughout the planning of the residency, it should be remembered that the primary function of the residency is to be educational, and that service to the organization is secondary.

In accordance with the educational function of the residency, contact should be maintained with the health administration program from which the resident graduated. The educational plan should be submitted early in the year for review by program faculty to assure continuity with the resident's didactic education. Faculty should find opportunity to make a site visit to see the results of student selection, curriculum choice, and teaching efforts in the performance of the resident. The preceptor may be given an adjunct-faculty appointment prescribing his role as an educator. Quarterly formal evaluation of the resident by the preceptor should provide feedback to both the resident and the graduate program.

The resident should be provided with an orientation to both the hospital for primary experience and the corporate level for knowledge of the history and plans of the organization. This will help the resident to understand his/her role. The resident should learn the extent to which policies are applied uniformly throughout the organization.

The corporate level

With the preceptor's help, the resident should determine which areas should be studied at the corporate level and which should be studied at the institutional level. Certain functions, such as finance, are better learned at the corporate level, because the financial control of member hospitals is one matter corporations do very well.[17] Generic areas such as marketing and planning may be best learned at the corporate level, because of the benefits of overall perspective. Board functions and policy development should be learned at the corporate level. The resident should take advantage of opportunities to learn about areas unique to multi-institutional systems, such as corporate structure, acquisitions, and shared services.

[17]Reynolds, James and Stunden, Ann. "The Organization of Not-for-Profit Hospital Systems." in Brown and McCool, *op. cit.*, p. 203.

The healthcare delivery system is becoming considered an industry.[18] At the corporate level, the resident may find good models of the executive role. Corporate level executives make decisions in an environment detached from the biases inherent at the operational level. Many of these senior executives have career experience in hospitals which they will now share from an objective viewpoint.

The institutional level

Knowledge necessary for the resident to make the transition to practicing administrator can be learned only in the hospital. The multi-institutional corporation may develop one hospital to be its residency training site or use a combination of all its hospitals. The hospital phase of the residency in a multi-institutional system has many similarities with that in a freestanding hospital. Rotations through operating departments give the resident an opportunity to experience the "nuts and bolts" of healthcare delivery. One excellent experience, for example, is making rounds with evening and night shift nursing administration. An understanding of the problems faced in the technical core is essential for wise decision making. A good learning activity is familiarization with the manuals of administrative procedure and their operational use in decision making. The resident attends meetings with the preceptor to observe upper level management. The residency year provides opportunity for attending meetings which would otherwise only be seen later in the career. As the resident demonstrates readiness to grow, the preceptor should provide new, challenging experiences.

Rather than a passive experience, the residency should test skills.[19] Projects, also called responsible assignments, should be of variable time range and difficulty.[20] Unplanned spot assignments should be given to test the resident's problem solving ingenuity. Accountability for project completion develops a knowledge of

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[18]Relman, Arnold. "The New Medical-Industrial Complex." *The New England Journal of Medicine*, October 23, 1980, p. 963.

[19]Howell, Edward; Knight, Russell; Long, Russell; Lowe, John, and Williams, Denise. "Fellowships Offer Expanded Views of the Health Care World." *Hospitals*, March 1, 1979, p. 67.

[20]*The Hospital Administrative Residency*. Chicago, IL: American College of Hospital Administrators, 1965, p. 26.

time management, and generic areas, as well as an understanding of how the system works. The opportunities of the multi-institutional system as an educational laboratory are seen when, for example, the resident follows the budgeting procedure through all levels from hospital department to corporate fiscal office.

The multi-institutional system operates in a larger community than a single site hospital. The multi-institutional system therefore develops powerful resources for dealing with the external environment. The resident should participate in regional health planning to learn his/her organization's role in healthcare delivery. Insight into area-wide political processes should be developed. Accompanying the preceptor to local hospital association activities is very helpful. The resident arranges his/her time schedule to attend local Young Administrator's Forum meetings. In fact, the resident's experience in dealing with all external environments should be as broad as possible to enhance formative career opportunities.

Trends

There are two trends in administrative residencies which are applicable to multi-institutional systems: fellowships and specialization. Although a three-month summer externship between the first and second academic years provides some exposure to hospitals, twelve months are really needed as a minimum to develop a concept of multi-institutional system component interactions. An extension of the twelve-month residency is a second year in the fellowship. Fellowships are good for the complex organization because they allow more time for individual and organizational goal satisfaction. The extra time allows more flexibility than in the traditional residency.[21] It also allows more time for the neophyte graduate to mature in administrative accountability . The two years may be divided into periods concentrating on the broad organizational perspective and on the specifics of institutional administration. This may materialize as one year in a traditional rotations/projects residency and one year with the corporate level, learning the broad approach or a specialized generic area. The sequence is left to the organization.

[21]Howell, *et al.*, p. 66.

Specialization focuses the individual on developing skills in an area in which he/she has identified career goals. This corresponds to a trend in graduate programs to track students in areas requiring specialization. A tracking program helps meet the field's personnel needs by responding to the increasing specialization caused by sophistication of the industry. The specialized residency should be well-planned to meet both the organization's needs and the educational needs of the individual. Care should be taken that the individual involved in a planning, marketing, human resources, or financial track is not restricted by lack of exposure to general administrative experiences.

As new trends in the administrative residency evolve, the need becomes apparent for some guidelines from the professional associations to protect all involved parties. This paper is a deductive extraction from two bodies of literature, that of multi-institutional arrangements and the administrative residency. While the body of multi-institutional systems literature is rapidly developing, the administrative residency has been neglected. For example, the last edition of the American College of Hospital Administrators' guidelines for the administrative residency was published in 1965. The diminished interest in the residency may be due to the fact that entrants to the field no longer immediately assume top positions. Orientation to the "real world" is undertaken during the long path up the career ladder.[22] But more realistically, the lack of clinical learning before 1981 was due to the indifference of educational organizations such as the Association of University Programs in Health Administration and the Accrediting Commission on Education for Health Services Administration. Some form of post-Master's clinical program is seen, however, to be of definite value in the preparation of leaders in a healthcare delivery arena involving such complex entities as the multi-institutional arrangement.[23] Because of the different backgrounds of students, graduate programs, and health providers, it may not be wise to

[22]Filerman, Gary. "Educators Revise Training Plan for Administrators in Health Care." *Review of the Federation of American Hospitals*, February, 1978, pp. 24-25.

[23]Wesbury, Stuart. Unpublished paper delivered at the 1981 Association of University Programs in Health Administration Annual Meeting, Washington, DC, April 26, 1981.

outline a uniform residency curriculum.[24] One step in the establishment of suitable guidelines would be reconciliation of jurisdictional issues between the American College of Hospital Administrators and the Association of University Programs in Health Administration.[25,26] Development of a model for the administrative residency could then proceed.

Careers

Does the administrative residency in a multi-institutional arrangement prepare one for administration in an unaffiliated hospital? This twist of the generalist versus specialist issue will become increasingly important in the future as multi-institutional systems continue to grow. Planning of the experience by preceptor and resident must reflect the resident's goals, perhaps as outlined in a five-year plan for career growth. A key to success is for the individual to keep his/her options open.

The growth of multi-institutional organizations will create a demand for systems-oriented managers.[27] Multi-institutional systems will require a different type of leader: one who can look inside and outside the organization and deal with the corporate level at the same time.[28,29] Problems frequently relate to services not performed in the hospital, such as finance and personnel. In these situations, a frequent complaint is that the corporate level does not understand hospital operations.[30] The administrative residency in a multi-institutional system prepares one for this environment, which may be especially difficult for administrators accustomed to less bureaucracy and more independence in a freestanding hospital to accept.

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[24]*The Hospital Administrative Residency*. Chicago, IL: American College of Hospital Administrators, 1965, p. 3.

[25]Hepner, James. "Six Steps Ease Town-Gown Battle for Educators and Practitioners." *Hospitals*, April 16, 1979, p. 112.

[26]Howell, *et al.*, p. 67.

[27]Brown, Montague. "Multi-Institutional Arrangements." in Brown and McCool, *op. cit.*, p. 48.

[28]*Ibid.*, p. 48.

[29]Sheldon, Alan and Barrett. "The Janus Principle." in Brown and McCool, *op. cit.*, p. 496.

[30]Reynolds, James and Stunden, Ann. "The Organization of Not-for-Profit Hospital Systems." in Brown and McCoal, *op. cit.*, p. 201.

How about a career in a multi-institutional system? The first professional position after the residency is vital to progress along the desired career path. Multi-unit corporate systems provide good career opportunities because of the possible exposure to a variety of jobs. It is advisable to stay with the initial employer for a minimum of four to five years. The individual has then survived the "honeymoon" and has had a chance to contribute to the organization. The individual who is ready for career growth can change jobs without developing the reputation of "job hopping." Multi-institutional systems offer intraorganizational mobility with retention of benefits. The individual then has the flexibility to sort out his/her career, whether he/she wants to be a generic specialist, applied specialist, or a generalist.[31] A career in a multi-institutional system would offer as much promise to the individual as this growing sector offers to our entire system of healthcare delivery.

[31]Hepner, James. "Strategic Career Planning: The Generalist Path Toward Becoming a C.E.O." Lecture to the Young Administrator's Forum, American College of Hospital Administrators, 24th Congress on Administration, Chicago, IL, February 19, 1981.

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