Reorganizing A Family Practice Center: Strategy To Save A Residency Program At A Financially Troubled Hospital

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Abstract: **The family health center of a family practice training program was eliminated from the county hospital budget following funding cuts, forcing the program faculty to create an independent nonprofit community clinic in which to train residents and provide care to established patients. A county audit of the new clinic after 2 years' operation showed substantial savings, particularly for administrative overhead. This report presents data showing the cost advantages to a small private clinic with faculty management compared with costs in a hospital-managed outpatient clinic; the savings were sufficient to assure continuation of the training program. Increased flexibility under faculty management provided a more realistic teaching environment and new research opportunities. (J Am Board Fam Pract 1991; 4:27-31.)**

Family practice training programs in California narrowly averted a funding crisis in 1989 that could have closed or seriously crippled several of the state's residencies. In response to this crises, the California Academy of Family Physicians is currently searching for new sources of financial support and seeking ways to assist vulnerable residencies.[1,2] This report presents the rationale and data that led to the establishment of a new family health center (FHC) at my institution. Savings were large enough to help the family practice training program weather deep funding cuts at the sponsoring hospital.

It is estimated that approximately 50 percent of family practice programs have one or more family practice centers operated by entities other than the sponsoring hospital, frequently to support a faculty practice plan (C.N. Ramsey, University of Oklahoma, Department of Family Medicine, personal communication). Our FHC went from a hospital-sponsored to a faculty-operated plan to insure survival of the training program. Because our rationale differed from the usual arguments for a faculty-operated FHC, this study is presented to show how other programs in financially distressed hospitals might benefit from the initiatives and ideas we used in making the change from a hospital-operated FHC to a nonprofit community clinic FHC.

Background

In 1981, the county hospital that sponsored our training program was faced with a severe funding reduction. It elected to eliminate the family practice residency to reduce costs. When the decision was announced, the faculty and residents of the family practice department immediately negotiated with hospital and medical school administrators for reinstatement. It was agreed that the residency could continue to operate on a temporary basis while new funding sources were sought. Even though we were allowed to maintain operations, it was made clear that the existing hospital-sponsored family practice clinic could no longer be used for care of patients; elimination of the site was required to meet scheduled reductions in hospital operating expenses.

With the help of state funding agency personnel, local and state AAFP officers and staff, and community family physicians, the program faculty initiated plans for a free-standing FHC. After 1 year of teaching and patient care in a converted dental clinic, we moved into new quarters in a small shopping center across the street from the hospital. A board of directors composed of family medicine faculty was established for the new nonprofit community clinic.

The new facility and organization offered many advantages in teaching environment, pa-

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tient care, operating flexibility, and cost-effectiveness. Attracting sufficient numbers of new patients, however, was a problem because the center was no longer considered part of the hospital's referral system. Our board sought a contract with the county to correct this problem and learned that a contract would be contingent on an audit by the County Department of Health Services demonstrating a satisfactory financial condition. The county's audit indicated that the hospital had saved approximately $360,000 annually by eliminating the FHC as part of the residency. This knowledge, coupled with center management data, which projected financial break-even figures for future operations, prompted a study to compare costs at our former location (site A), which had reopened as an ambulatory care center for the internal medicine residency, with the new FHC (site B).

Study Methods

Data are from the training year 1986–1987. Blueprints for each facility were used to compare total area for patient care, teaching, and program administration. Personnel and payroll computer reports determined staffing patterns and costs. Organizational structure and physician schedules came from documents at the sites and at the sponsoring hospital.

Only "comparable" costs were considered—those patient care costs described as "costs of doing business." They included teaching, staff and management, physical plant and supplies, legal services, licensing, and insurance for the facilities and contents.

Other site A assigned costs that might have influenced the 1981 decision to close the facility to family medicine patients included allocations that supported hospital-provided services and medical administration. In most instances, these noncomparable costs were not proportional to activity or hours of operation but were based on square footage of the facility. For example, at site A, the allocations for diagnostic radiology, laboratory, electrocardiography, drugs charged to patients, pharmacy, and a contract with the medical school amounted to $175,000 per month or $2,100,000 per year. These costs were no doubt shifted to other departments during the time the clinic was closed. However, some of the figures and amounts might have been used by hospital accountants and administrators to justify deleting the facility from the budget when the need arose.

Table 1. Facilities and Services Comparison.

	Site A	Site B
Available space, sq feet	4154	4134
Examination rooms	9	9
Annual visits	12,600	12,400
Laboratory	Yes, limited	Yes, limited
Minor surgery	No	Yes
Flexible sigmoidoscopy	Yes	Yes
Colposcopy	No	Yes
Extended hours	No	2 Eve/wk
24-hour on call coverage	No	Yes
Financial screening	Yes	Yes
Provider full-time equivalents*	2–13	2–7

*Varies with resident-student schedules.

Results

Table 1 shows that annual visits and square footage at the sites for the study year were almost identical. Services were comparable in most respects, an indication that clinical and teaching activities were approximately equivalent. Sources of most patients (wards and emergency department) were the same, and there was no formal or institutional bias in the referral process. Children and pregnant women patients at site B came largely from the community. Although the age-mix was different, patients' socioeconomic and cultural characteristics were similar.

Monthly expenses for on-site personnel are shown in Table 2. Site B has two expense catego-

Table 2. Monthly Expenses, On-Site Personnel.

Category	Site A (Full-Time Equivalents)	Site B (Full-Time Equivalents)
Nursing	$10,334 (4.0)	$ 6,307 (3.2)
Nurse practitioners	$ 7,189 (2.1)	$ 0
Clerical and billing	$ 7,356 (4.0)	$ 6,582 (3.6)
Facility manager	*	$ 3,200 (1.0)
Patient care		
Housestaff	$ 9,167 (4.4)	$ 4,167 (2.0)†
Faculty	$ 850 (0.15)	$ 1,700 (0.3)†
Management—faculty effort	$ 575 (0.1)	$ 5,276 (0.9)†
Ph.D behavioral medicine coordinator	$ 0	$ 605 (0.4)
Total	$35,471	$27,837

*Off-site; included in "Administration," Table 3.
†Paid by hospital.

ries: those borne by the hospital and those paid by the Family Health Center. All site A costs are attributed to the hospital. Costs for faculty time devoted to administrative management are estimated at each facility and are in both cases listed as hospital costs. At site B, one of the full-time faculty acted as chief operating officer, spending the equivalent of one half-time position on center-related matters. Other faculty averaged 1 day per week for center management services other than patient care, e.g., center medical director.

Table 3 lists monthly overhead expenses at sites A and B. Administration at site B includes organization costs, legal and accounting services, taxes and licenses, telephones, travel, meals and lodging, and postage. The management structure comprises a volunteer board of directors, manager, allocation of full-time faculty effort as previously described, and supervisors for the business office and clinic area. At site A, administrative overhead is defined by the county. Management authority is derived from three administrative entities: hospital, medical, and nursing.

Expenses for nursing administration, medical records, and social services (site B, Table 3) are estimates of time and effort allocation. Nursing administration is the responsibility of the head nurse; medical record handling is a clerical and billing activity; and social services are provided by the behavioral medicine coordinator, physicians, nursing staff, and the billing coordinator.

At site A, medical records are moved physically from the hospital's medical record library, transported to the clinic, then later picked up and refiled. Six dollars per chart is the reported cost of this labor-intensive process.

The high costs for administration at site A are an example of excessive expenditures that may accompany three lines of bureaucratic authority to run a small operation. The data indicate that the less complex, self-contained, more flexible structure at site B, with substantial management input by faculty, has cost-saving advantages.

Discussion

Table 4 presents a summary of annual hospital costs. The figures show that the hospital paid $542,270 more to operate a comparable ambulatory site on hospital grounds. Major savings at site B were in overhead and personnel costs, especially for management.

Table 3. Monthly Overhead Expenses.

Description	Site A	Site B
Administration	$25,861*	$ 9,729
Nursing—Administration	$ 3,643*	$ 1,500‡
Depreciation, building and fixtures	$ 419	$ 4,900
Depreciation, equipment	$ 397	$ 976
Service and supplies†	$ 8,945	$ 2,912
Medical record retrieval-filing	$ 5,900	$ 2,000
Social services	$ 3,572	$ 1,200
Total	$48,737	$23,217

*Off-site effort.
†Sum of L.A. county categories, including maintenance, housekeeping, laundry and linen, plant operations, central services-supplies, and nursing inservice education.
‡Estimates.

Other benefits of a faculty-operated family health center included improved teaching environment and increased administrative flexibility. Residents and faculty alike found the new FHC a source of pride, and there was notable enthusiastic approval from patients and hospital colleagues. Important goals of the required practice management curriculum were met as a matter of survival, giving these goals great cogency in the residents' learning priorities. All of us quickly became aware of the cost of equipment, supplies, utilities, and personnel.

Patients also benefited as staff assumed full responsibility for organization and delivery of primary care health services. For the first time, residents (with faculty backup) were available by telephone 24 hours/day because a private answering service was connected to our telephone line. The appointment system was improved and refined. Patients had a waiting area with large windows and pleasant surroundings, and staff, having adopted "private-sector" incentives and attitudes, welcomed patients with newfound enthusiasm.

Under private management, family medicine patients enjoy improved access to care. Data from hospital surveys and internal FHC monitoring

Table 4. Estimated Annual Hospital Costs.

Category	Site A	Site B
On-site personnel	$ 425,652	$200,328
Overhead	$ 584,844	$ 0
Total cost	$1,010,496	$200,328
Hospital revenue	($ 267,898)	$ 0
Net costs	$ 742,598	$200,328
Annual hospital savings	$542,270	

were compared; waiting times for appointments were shorter, and patient visits averaged less time than at hospital-operated clinics. Both faculty and residents were keenly aware of access to care, and it became an area of focus for faculty research. As a result of direct input into office operations and policies, the FHC became our "laboratory" because it was possible for faculty, residents, and staff to experiment with changes that previously had been difficult or impossible to accomplish when the FHC was part of the hospital structure.

Purchasing new equipment, especially expensive items, was more efficient at FHC. Further, when the community clinic received donations from program alumni, friends, and community business establishments, the faculty made a point of using these donated funds for durable equipment, and this instilled a sense of pride in contributors whenever they visited the center. Donations have provided for a computer billing system, phase contrast microscope, colposcope with cryotherapy unit, personal computer for obtaining laboratory data from the hospital, video flexible sigmoidoscope, hemoglobinometer, and laser printer. The FHC has not had to accept substitute equipment as sometimes occurred when the hospital bought high-cost items on bid, and substantial savings have been realized from buying serviceable used equipment.

Conclusions and Recommendations

Financial stress at sponsoring hospitals continues to threaten the viability of some family practice training programs. To the extent that hospitals operate ambulatory care clinics, there may be opportunities for the program to reduce program costs to the hospital. Data from two ambulatory care training sites at our hospital show potential savings of one-half million dollars annually in favor of an independent family health center. Achieving and documenting these savings were important factors in the survival of our family practice residency.

In order for potential savings to be realized, a number of conditions must be met. First, program faculty must be willing to provide substantial "hands-on" effort to bring financial and teaching goals to a common focus in the organization. Second, the hospital must have the ability to eliminate some overhead expenditures, especially for management services, which in our study accounted for almost 60 percent of overhead at the hospital's clinic. Third, there must be a clear understanding between hospital and program leaders that their operations are mutually beneficial. Program directors have long known that the hospital's wards, operating and delivery suites, and emergency department provide essential training experiences. It is propitious that some medical educators and hospital boards also are recognizing the value of ambulatory patient care-teaching sites. These are important considerations for those who must shape the convergent needs at the institutional level. Which institution assumes the major financial responsibility will be negotiated between medical schools and hospital boards: the latter have an opportunity to influence the mix of trained specialists in favor of more primary care physicians if they so wish. Public hospitals in particular may avail themselves of this favorable opportunity if their aim is an improved system of primary health care to the poor.

What is the likely future of faculty-operated ambulatory care teaching sites? According to Perkoff[3] and Rieselbach and Jackson,[4] the need for new facilities is increasing for internal medicine training programs. Goodson[5] raised the question of who will pay for the anticipated increased number of sites and noted that a training site with substantial faculty in management and patient care showed greater financial self-sufficiency compared with hospital clinics. Bertakis and Robbins[6] reported that at their public hospital, access to comprehensive care services reduced both emergency department visits and cost of laboratory tests in comparable patient panels. Lower utilization of those services translates to a monetary saving for the sponsoring hospital. Shine[7] urged development of community sites organized and operated by faculty to meet the need for more ambulatory care teaching facilities and noted an advantage to separating the costs of outpatient care from the hospital. He commented further that hospitals should support the community sites because they receive an economic benefit in the form of shortened patient hospital stays, an advantage under DRG and prepaid plans. Benefits to faculty listed by Shine included several of those noted above for site B.

The experience at site B shows that not all costs for new ambulatory facilities necessitate finding

"new" money; savings achieved through improved operations can be applied to creating new clinics and FHCs. Given that most hospital administrators do not yet view ambulatory care as a primary hospital mission, the strategy of relieving hospitals' obligations for providing ambulatory care and teaching sites through change in fiscal responsibility may be attractive. But how can operational savings be realized in a hospital bureaucracy? Our study shows that management structure is one of the most expensive components, off-site management accounting for almost $30,000 of monthly overhead for one small internal medicine clinic. Some hospital management positions must be eliminated and responsibilities consolidated. Computerized data processing will help maintain the flow of reports and sharing of information needed by hospital administration.

The organization of social services and provision of medical record handling may benefit from decentralization. Social services activities, shared by a variety of professional and nonprofessional staff and aided by a part-time social worker at numerous sites, can reduce the need for separate patient appointments, improve access, save money, and enhance training. A hospital and subspecialty clinic medical record that not infrequently consists of two volumes totaling several inches in thickness may not be necessary at each visit—patients' prescription bottles often provide a surprising amount of useful information. Mizrahi[8] reported that residents often spend excessive time reviewing records at the expense of time devoted to patient care. Weaning housestaff from requiring the complete record at every visit can save both time and money. Residents at site B were reminded that after graduation they would rarely have the hospital record in the office where they see patients.

What will motivate faculty to make the changes suggested? At my institution, survival of the residency was sufficient. In some instances, enhanced income is a factor, but opportunity to conduct research is a powerful incentive for many. The FHC can be a laboratory where faculty exercise managerial control in order to conduct a variety of experiments in health care delivery, adequate motivation for most teachers.

At my hospital, the difference in expenditures for the ambulatory training portion of the residency programs was dramatic. The fact that site B operated at less cost made the difference for having a family medicine program. Each sponsoring hospital or group of hospitals will have a different method of calculating costs of ambulatory care facilities, and revenues will vary according to the patient population served.

Relieving the parent hospital of many costs associated with ambulatory care is a strategy worth considering when program survival is at stake. Some hospitals may be prompted to conduct a penetrating review of outpatient clinic overhead costs. Decisive action coupled with restrictions on cost shifting might provide further real savings.

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