Family Practice Residencies and Their Sponsoring Hospitals: Mutual Interests and Unrecognized Potential

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The 1970s have led to a new and common association in this country between family practice residency programs and an increasing number of hospitals of various sizes and types. At latest count, there are 382 operational family practice residencies in the United States. Of these, the largest proportion (48 percent) are related to university-affiliated community hospitals while 16 percent are associated with unaffiliated community hospitals, 13 percent with university-administered community hospitals, 17 percent with university based hospitals, and 4 percent with military hospitals. Most of these programs are related to hospitals ranging in size from 200 to 500 beds. In some instances, the Family Practice Center (ie, ambulatory base of the residency program) is located in or immediately adjacent to its sponsoring hospital; in many cases, the Family Practice Center is located elsewhere in the community and is functionally related to one or more participating hospitals.

The association of family practice residencies and their sponsoring hospitals meets a number of needs for each party. Through this association the family practice residency acquires a site for inpatient care of its own patients, access to both inpatient teaching services and selected ambulatory services (eg, emergency room), and a linkage to other clinical and teaching resources of the institution. In turn, the participating hospital realizes several important benefits, including (1) some increase in utilization of both inpatient and ambulatory hospital services; (2) maintenance and enhancement of quality of patient care; (3) house staff coverage of inpatients on teaching services, as well as increased capability to respond to and manage inhospital emergencies; (4) augmented opportunities for continuing education for the medical staff; and (5) positive image of the hospital in the community.

Some of the benefits to participating hospitals are intangible and difficult to measure, particularly in instances where the family practice residency is not physically based in the hospital. It is therefore quite understandable in these cost-conscious times

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Table 1. Contributions of Family Practice Residency to Utilization of Hospital Services

	FPC Patients Admitted Directly	FPC Patients Admitted by Referral	Graduates' Patients Admitted Directly	Graduates' Patients Admitted by Referral
Annual Number of Admissions Annual Number of Patient Days Average Cost per Patient Day Estimated Hospital Charges				
Laboratory Charges				
X-Ray Charges				
Total Hospital Charges Collection Ratio				
Estimated Total Income to Hospital				

that some hospital administrators and members of hospitals' boards of trustees may underestimate the potential value of a family practice residency to its sponsoring hospitals.

Perhaps easiest to underestimate is the potential for the family practice residency to progressively expand the primary care base of the participating hospital. This is likely to be of increasing importance to both community hospitals and academic medical centers. Competition among hospitals is certain to become more intense and to threaten the future viability of some hospitals. Some of the trends making this situation inevitable include: (1) growing surplus of physicians in the non-primary care specialties; (2) redundancy of hospital facilities and services in many communities and regions; (3) soaring inflation of medical care costs which is leading to various cost saving initiatives, such as some prepayment systems involving primary care physicians as "gatekeepers"[1]; (4) likely decrease in hospital utilization under prepaid capitation plans (eg, in 1978, total hospital use under United Health Care, a Seattle based independent practice association with primary care physicians serving as "gatekeepers," was 293 bed-days per 1,000 patients compared to 479 per 1,000 patients for Blue Cross[1]; and (5) current goal of National Guidelines for Health Planning to reduce the number of beds per 1,000 people to less than 4 per 1,000 people in a Health Service Area (4.6 in 1976).[2]

There are a number of reasons why the family practice residency can be expected to expand the primary care base of its sponsoring hospital(s) on a long-term basis. A sizable proportion of graduates of family practice residencies locate their practices in the same state, often within 50 to 100 miles of their residency location. Many of these family physicians continue to utilize these hospitals for the care of their patients. It is probably of even more importance, however, to project future hospital utilization by patients seen in consultation or referral by consultants using these hospitals who worked with the former residents during their

training. On the basis of the teacher-learner and colleague relationship developed during the three-year residency between residents and their attending physicians and consultants, a bonding relationship often develops which can establish future referral patterns. It is well known that these relationships often take precedence over geographic and distance considerations. A hospital and its medical staff which has developed positive relationships with a growing group of practicing family physicians can therefore anticipate continuing growth in its catchment area.

Family practice residencies, together with primary care residencies in general internal medicine and general pediatrics, have attracted supplemental federal funding during their start-up years on a relatively high priority basis. Funding from this source, however, was never intended for long-term operational costs, and is now terminating for many established residency programs. The continued viability of these programs is therefore dependent on two principal sources of funding: patient care revenue and hospital support. In some instances, some supplemental state funding may be available, but a solid base of local funding is inevitably required to assure the continued operation of residency programs in all of the primary care specialties.

Some hospital administrators and boards of trustees, faced with the need to carefully cost account all hospital expenditures, may have difficulty in assessing the potential value of a family practice residency to the hospital. In order to quantify the fiscal contribution of the family practice residency to the hospital, it is necessary to consider both direct contributions (hospital and ancillary services for admissions involving program faculty, residents, and graduates) and indirect contributions involving utilization of these services through consultation and referral to members of the medical staff. Table 1 presents some of these factors in a format which can be used to estimate these contributions on an annual basis.

It can readily be appreciated that a growing pool of program graduates will return substantial dividends to hospitals participating in family practice residency programs. On the basis of these projected increases in utilization of hospital services and the fact that a sizable portion of medical education costs are reimbursable from third party payers, it should be quite possible for sponsoring hospitals to fully justify their ongoing support of 40 to 50 percent of total program costs as required for the long-term viability of these programs. Moreover, when one considers the increasingly competitive nature of hospital care in the community, hospitals involved with family practice residency programs can effectively improve their competitive position by assuring an expanding primary care base. In this way, all of the involved parties stand to win: the patient (through increased quality and availability of medical care), the hospital (for the various reasons mentioned above), the medical staff (through increasing use of consultation services), and the family practice residency program itself (through stabilization of a long-term relationship with its sponsoring hospital(s) for the purpose of patient care and clinical teaching).

References

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