Promotion of Family Enrollment in an Urban Family Practice Residency Program

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Although a basic goal of family practice is to provide care for all members of the family, few studies have been done to test the ease of accomplishing this goal. At the Downstate Medical Center Department of Family Practice in Brooklyn, New York, an attempt was made to increase family enrollment by introducing several educational interventions directed at patients and resident physicians.

Family enrollment levels were documented during a study period from June 1981 to September 1982, and again in June 1984. Both before and after the intervention efforts, family enrollment levels remained the same. It was concluded that the educational interventions used were unsuccessful in both short-term and long-term follow-up. Only one subgroup that participated in a specific educational intervention (patient orientation groups) showed an increase in family enrollment.

A primary goal of family practice is to provide care for all members of the family.[1-4] Despite the recognition of the importance of treating individuals within the context of the family, few studies have been done to test the assumptions that underlie this family practice method.[5] A basic assumption in family practice that needs further testing has been noted by Stamps[6]: "Success of family practice is partially dependent on the patient utilizing a family physician in a manner consistent with patterns of utilization that are put forward by the model of family practice." The need to evaluate utilization patterns has led some researchers in family practice, as well as a research study group at the Downstate Medical Center Department of Family Practice, to pose the following questions: To what extent do family physicians actually treat families? What are the variables that affect family enrollment and make whole family care likely?[5,6]

Fujikawa and colleagues[5] studied whole family utilization of specific family physicians in a group private practice outside San Diego, California. The researchers analyzed the extent to which family physicians treated the whole family. A random sample of 500 patients (single-person households were excluded) was used for the study. The investigators found that even though their practice was in a geographic area where high stability of traditional nuclear families was prevalent, whole family enrollment (ie, where other household members identified by the patient as family were under the care of the same physician) did not exceed 28 percent. Whole family care was not found to be influenced by selected patient characteristics such as place of residence, marital stability, length of care, or whether the family physician was residency trained. In an additional 26.2 percent of the patients sampled, however, at least more than one member of the family was seen by the physician of the patient (partial family enrollment). By combining these two figures, 54.2 percent of the patients were members of families in which two or more family members received care from the same physician (combined family enrollment).

Stamps[7] studied the utilization behavior and attitudes of two samples of patients seeking care at a model family practice clinic of the University of Massachusetts Residency Program. A group of 150 patients in 1970 and a second sample of 135 patients in 1975 were selected for the study. In the 1975 sample there were statistically significant changes in patient identification with family practice utilization and in the patients' recognizing that physicians need to have both medical and personal information during patient-phy-

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sician visits. Some education apparently occurred, but a discussion about specific education efforts is absent.

Cohn and Schmidt[8] studied ten neighborhood health centers in Boston. Of the 206 families studied 27 percent had all members of their family seen by physicians at one of the centers within one year of the first visit by a family member; therefore, the whole family enrollment can be considered to total 27 percent. Single-member families were excluded.

Although all three studies cited report on the utilization of their health care systems by families, they provide limited information concerning the factors associated with initiating family enrollment. Fujikawa et al[5] focus their enrollment data on the whole family as the measurement of successful utilization and give but limited attention to partial family enrollment. Stamps[7] suggests that changes in utilization and attitudes might be related to the education of the patients about family practice, but it was not known to what extent the providers (residents and full-time family physicians) had been educating their patients about family practice.

Because the major purpose of the Family Practice Center (FPC) at Downstate Medical Center is to provide residents with supervised experience in the care of families, enrollment of patients in family units is essential to the teaching function of the center. From the patient care standpoint, care of individual patients is enhanced by one physician knowing the whole family group and thus avoiding fragmentation of the family among several health care providers. If family care is beneficial for the patient, the promotion of family enrollment as a goal is necessary for both patient care and residency training in family practice.

METHODS

This study involved a family practice residency program in the Downstate Medical Center in Brooklyn, New York. The study began on September 1, 1981, with two objectives: (1) to increase the number of patients enrolled at the center as whole or partial families to 75 percent and (2) to improve both the residents' and the patients' understanding of family practice as a specialty that emphasizes the importance of using the entire family as the health care unit rather than merely the individual patient. These objectives were to be accomplished by multiple educational interventions designed for both the patients and the resident physicians.

For the purpose of the study, a family was defined as all individuals living under the same roof and considered as family by the patient. Patients were asked to list the names of their family members on a registration sheet when they enrolled at the center. An enrolled family consisted of two or more members of any family registered and coming to the center and being cared for by the same physician. This grouping was called combined family enrollment and was a total of all the patients enrolled in the center as either part families or whole families. Partial family enrollment occurred when some members of a family were enrolled at the center and assigned to the same resident. Whole family enrollment occurred when all members of a family were enrolled at the center and were cared for by the same physician. Changes in family enrollment were documented by using computer data on patients' activities at the center. Family enrollment measures were computed for patients registered and assigned to residents in June 1981, September 1982, and June 1984. The patient population was largely made up of urban, lower socioeconomic persons coming from a variety of minority groups. The Family Practice Center occupies a prominent location in the outpatient department of a university hospital.

It was hypothesized that by enhancing the patients' knowledge about family practice and by teaching the residents about the importance of enrolling and treating families, there would be an increase in family enrollment at the center. A causative hypothesis was not implied, as this was a descriptive study. Chi-square analysis ($P = .05$) was computed on family enrollment measures to test for significant changes.

Several interventions directed at both patients and residents were implemented by the study group.

Resident Intervention

Discussions About Family Practice. Both individual and group meetings were held with residents to exchange ideas about topics of concern and interest about the specialty of family practice. Each resident was exposed to a minimum of eight hours of these discussions.

Lectures. A weekly lecture series in behavioral sciences included several talks on the theme of the family such as family assessment, the genogram in family practice, psychological assessment, systems theory, marital therapy, and working with remarried families.

Role-playing. Residents were encouraged to role play physician-patient interviews that made an attempt to focus attention on developing skills in the interview process.

Case Presentations and Family Interviews. A weekly Balint group was held for a case presentation involving a difficult patient or family by a resident. Several families were interviewed by the behavioral science faculty; these interviews were carried out directly in front of the group or indirectly by use of a one-way mirror.

Family Therapy Consultation and Supervision. A full-time social worker and part-time psychiatrist provided ongoing family therapy consultation and supervision for all residents' patients.

Family Enrollment Statistics. All residents were given a computer printout of family enrollment statistics for their patients so that each trainee could recognize the need for greater efforts toward increased family enrollment.

Family Enrollment Seminars. Two seminars were held to teach the residents how to instruct their patients about family practice and how to enroll other family members into their practices.

Patient Intervention

Informal Teaching and Patient Education. One member of the study group spent about ten hours a week for the 15 months of the study in the patient waiting room to answer questions and to provide information to patients about family practice.

Brochure of Family Practice Center. A brochure was prepared by the study group to explain family practice and the center to patients. The brochure proved to be very popular, and about 3,000 copies were distributed in the 15-month period to both new and returning patients in the Family Practice Center.

Poster and Other Teaching Aids. Efforts were made to decorate the patients' waiting room in a way that reflected a family practice setting. The children's section was stocked with new toys and books, improvements were made in the decor, and informative pamphlets that could benefit center families were made available to patients.

Bimonthly Patient Orientation Groups. Bimonthly meetings were held for new patients. The meetings were well attended with between eight to 12 patients at each session. About 36 percent of all new patients attended these meetings. Refreshments were served at each meeting. At the first several meetings, a member of the study group would give a talk entitled "What Is Family Practice?" and questions would then be answered. Beginning in September 1981 the resident emergency physician in the center for the month was assigned to lead an orientation meeting with new patients.

Meetings with Community Boards and Local Community Institutions. Contact with community board leaders was initiated by a member of the study group to inform the community about the Family Practice Center.

RESULTS

Family enrollment statistics were compiled for residents at three times: June 1981 prior to the inception of the study, September 1982, and June 1984. Data were collected from information stored on a computer obtained from encounter forms and patient registration material. Active patients included all patients who had received care in the Family Practice Center during the prior two years. All members of the same family who came to the center for care were seen by the same resident physician except in rare cases of an emergency when the resident physician was not available. Single-member households were excluded from the study. There were 582 single-member households in June 1981, 24 percent of the resident patient population (Table 1). By September 1982 single-member households increased to 888, 32 percent of the patients. It was necessary to remove this number to get a true measure of family enrollment changes during the study period. For combined family enrollment, using chi-square, no significant change was found from June 1981 to September 1982; combined family enrollment remained about 49 percent throughout the study. Partial family enrollment was about 25 percent of patients from families of two or more registrants, and whole family enrollment was about 24 percent throughout the study (Table 2). Evaluation of long-term changes, from figures obtained from patients enrolled in June 1984,

TABLE 1. CHARACTERISTICS OF ACTIVE PATIENTS IN THE FAMILY PRACTICE CENTER

	June 1981 No. (%)	September 1982 No. (%)	June 1984 No. (%)
Total patients enrolled in center	2,456 (100)	2,800 (100)	3,552 (100)
Patients in single-member families	582 (24)	888 (32)	732 (27)
Patients in multiple member families (target population)	1,874 (76)	1,912 (68)	2,820 (73)

TABLE 2. FAMILY ENROLLMENT DURING THE STUDY PERIOD

	June 1981 No. (%)	September 1982 No. (%)	June 1984 No. (%)
Patients in multiple member families (target population)	1,874 (100)	1,912 (100)	2,820 (100)
Combined family enrollment*	930 (49)	441 (49)	1,430 (51)
Partial family enrollment	454 (24)	481 (25)	708 (25)
Whole family enrollment	476 (25)	459 (24)	722 (26)

**Combined family enrollment equals partial family enrollment plus whole family enrollment.*

again show no significant change in enrollment characteristics.

An interesting finding occurred concerning patients who attended the bimonthly orientation groups. Almost all (124 out of 132 patients) came to these meetings from families of two or more persons. Eighty-four of the 124 individuals (68 percent) were in the combined family enrollment group; 52 patients (42 percent) were in the whole family enrollment group. Although the orientation group meetings seem to be effective in enrolling entire families, no statistical tests were done, as there was no control group or random assignment to the meetings.

DISCUSSION

Family enrollment has been identified as an important goal in family practice. Recognizing the importance of this goal, the investigators attempted to increase family enrollment with interventions directed at residents and patients at a family practice residency program. It would appear, however, that no significant changes in enrollment occurred as a result of these interventions. There are two possible explanations for this lack of change. First, perhaps family enrollment remained the same and was not affected by any planned interventions; this explanation seems to be supported by the findings. Second, there could have been a delay effect in family enrollment. A patient deciding to enroll another family member at the Family Practice Center probably would not do so until that family member saw the physician for a specific health care need. Thus several months or even a year or more could pass from the time of exposure to any of the described interventions before a new member is enrolled. To explore this possibility, family enrollments were examined for 21 months after the interventions ended in June of 1984. Again, no significant enrollment changes were detected.

It was felt by some members of the study group as well as several residents that the initial goal of 75 percent combined family enrollment was unrealistic. In reviewing the literature, most studies show total family enrollment to be approximately 25 percent, partial family enrollment to be approximately 25 percent, and the total of these, the combined family enrollment, to be about 50 percent. These figures were similar to the current study results both before and after the educational interventions.

The most interesting finding was the high number of orientation group patients (68 percent) who enrolled part of their families. Those who participated in leading or observing orientation group meetings were impressed with the excellent questions that patients asked as well as the positive responses that patients had about the experience. Two limitations of this finding were the possibility of a strong self-selection process and the absence of a control group. All new patients were sent invitations to attend these meetings. Those patients who chose to attend might have already had favorable attitudes about family practice. The orientation meetings, however, provided a positive and warm educational atmosphere that was conducive to creating a more personal relationship between Family Practice Center staff and the patients, thus increasing family enrollment. This experience continues to be successful for both the patients and the residents. For the patient, first-hand encounters with physicians from the center in a more informal setting can be enormously valuable. The patient can interact with the physician outside office hours in a more relaxed environment. For the resident, the experience provided an excellent opportunity to learn how to conduct a patient education group and to work toward increasing family enrollment. Such an experience will probably improve skills in this area when the residents go into private practice.

It is recommended that further studies of family enrollment issues be undertaken. Use of the family as one of the important social systems of patient care represents a philosophical basis of family practice[9]; therefore, ascertainment of family enrollment levels and the elaboration of factors that control these levels are important areas of study that should be continued.

References

1. Curry HB: The family as our patient. J Fam Pract 1974; 1(1):70-71
2. Geyman JP: The family as the object of care in family practice. J Fam Pract 1977; 5:571-575
3. Carmichael LP: The family in medicine, process or entity? J Fam Pract 1976; 3:562
4. McWhinney IR: An Introduction to Family Medicine. New York, Oxford University Press, 1981, p 106
5. Fujikawa LS, Bass RA, Schneiderman LJ: Family care in a family practice group. J Fam Pract 1979; 8:1189-1194
6. Stamps PL: Toward the evaluation of family practice: Development of a family utilization index. J Fam Pract 1978; 7:767-779
7. Stamps PL: Changes in patient perceptions toward a family practice: A case study. J Community Health 1979; 4:232-241
8. Cohn H, Schmidt WM: The practice of family health care: A descriptive study. Am J Public Health 1975; 64:375
9. Henao S, Grose NP: Principles of Family Systems in Family Medicine. New York, Brunner/Mazel, 1985, p 7