Financial Crisis in a Family Practice Residency: A Successful Strategy

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A family practice residency program in a California public teaching hospital was faced with a financial crisis that threatened its elimination. Hospital officials and medical leaders developed a strategy that resulted in (1) personnel reductions focused principally on hospital overhead departments, (2) reductions in faculty teaching fees, (3) increased resident and faculty productivity, (4) increased patient access to ambulatory areas, (5) decreased utilization of laboratory, radiology, respiratory, physical therapy, pharmacy, and cardiology services, and (6) more favorable contracts with providers for patient care services. The hospital met its financial objectives primarily as a result of collaborative efforts of the hospital management team and a committed faculty vested in the success of the institution.

The development of prospective reimbursement by Medicare and per diem methods by other third parties has placed teaching institutions at risk for cost overruns resulting from a disproportionate number of very ill patients.[1] Public teaching hospitals are particularly vulnerable because of large numbers of indigent patients as well as the additional costs of their teaching programs.[2]

The following report describes the experience of one California public teaching hospital in dealing with a financial crisis that not only threatened its teaching program, but threatened its closure.

A CASE STUDY

Background

Scenic General Hospital is a 134-bed county hospital located in Modesto, California, in the central San Joaquin Valley. The hospital provides all acute care services with the exceptions of obstetrics, cardiovascular surgery, and neurosurgery, which are provided under contract at neighboring hospitals. During fiscal year 1985–86, Scenic General Hospital had 460 employees and a fully accredited residency teaching program in family practice with 20 residents. There were 14 full-time faculty and 293 community physicians on staff. The hospital had an operating deficit in excess of $1.4 million. Each year the hospital deficit had been subsidized from the county general fund.

The Crisis

By fiscal year 1986–87 the county was confronted with its own financial crisis. It had experienced a gradual reduction in its reserves and faced a large deficit. The county board of supervisors directed the hospital officials to present a balanced budget. The problem was compounded by the decision to reduce county funding of the hospital by approximately $700,000. In addition, the Governor of California reduced funds available for the care of county indigents by an additional $300,000.

The hospital officials immediately had to focus their efforts on cost reductions as opposed to revenue enhancements, since rapid changes were necessary. The hospital administrator noted that the budget deficit was approximately equal to the cost of the family practice residency program and initially proposed elimination of the residency program. After discussion with the hospital medical leaders, it was recognized that elimination of the residency program was an unacceptable alternative. The revenue lost

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TABLE 1. FINANCIAL EFFECTS OF RESIDENCY PROGRAM ELIMINATION

Category	Dollars
Expenses eliminated	1,500,000
Revenue lost	
Medicare pass through costs	423,000
Outpatient fees (35,000 visits)	380,000
Grant funds	277,000
Total revenue lost	1,080,000
Replacement costs	
Physician on-call contracts	345,000
Inpatient services	180,000
Outpatient services	186,000
Total replacement costs	711,000
Net financial effect	
Gain (loss)	(291,000)

plus the replacement costs of full-time and community physicians would have exceeded the expenses eliminated (Table 1). Ultimately, it was agreed that the best approach to the crisis was to have each hospital department share in the budget reductions.

Hospital officials and medical leaders recognized that personnel reductions would have a major impact on the budget crisis. To minimize any direct impact on patient care, attention was focused upon the hospital overhead departments. There was agreement that nurses at all levels were essential and would not share in any reductions in force.

More favorable contracts were needed by the hospital with physicians and affiliated institutions that provided services to county indigents. The hospital's funding for indigent care was dependent upon the remaining funds in the county indigent care budget after other providers had been paid.

Management Results

There was a total reduction of 72 full-time-equivalent employees among all departments, representing 16% of the total staff. The overhead departments affected the most were Patient Accounts, Medical Records, Housekeeping, and Dietary Service. Medical Records experienced the greatest staff reduction in part as a result of a transfer of a portion of that function to the Family Practice Center.

The budgets of ancillary departments including Laboratory, Radiology, Respiratory Therapy, and Pharmacy were reduced based upon a projected lower utilization of services by residents and faculty. Lower utilization of services occurred in these areas as well as in Cardiology and Physical Therapy.

TABLE 2. SCENIC GENERAL HOSPITAL OUTPATIENT VISITS (1985–1987)

Department	1985–86	1986–87
Family Practice Center	11,812	16,112
Pediatrics	7,176	9,071
Faculty Medical Group	16,948	20,730
Evening Clinic	8,951	7,588
Obstetrics/Gynecology	9,701	11,069
General Surgery	2,966	2,493
Satellite Clinic	5,158	6,019
Other specialty clinics	9,715	9,052
Total patients	74,427	82,134

The Family Practice Residency Program budget was also affected. The total number of residents was maintained, but hourly teaching fees for full-time faculty were reduced by 10%. Community faculty teaching fees were reduced by 28%. The goal, however, was to make financial adjustments in the program in a way that would not interfere with its accreditation status.

The hospital successfully negotiated more favorable contracts with providers. Surgical fees to providers for indigent care were reduced 37%. One large community hospital that provided indigent services under contract agreed to lower reimbursement. A cardiologist on the medical staff of both hospitals was instrumental in these negotiations. In addition, services to county indigent patients were reviewed for medical necessity by a special utilization review committee of the medical staff. Unauthorized medical services were not reimbursed by the county.

The overall work efforts of staff increased, particularly in Social Services, Medical Records, and in the clinics. The family practice residents increased their patient volume in the Family Practice Center by 36% (Table 2). A part of this increase resulted from a plan to expand the Family Practice Center from 5 to 7 days a week and to triage nonemergency patients from the higher cost Emergency Department to the Family Practice Center. Although primary physician visits increased, visits to surgery and other specialty clinics decreased.

The effect of the management strategy was a total reduction in hospital expenses of $1.8 million and an associated positive cash flow (Table 3). This reduction was enhanced by a new magnetic tape billing procedure that resulted in a one-time reduction in receivables.

How Were Objectives Accomplished?

One of the reasons for the success of the management strategy was the strong sense of collaboration by the man-

agement team. The team consisted of representatives from both the medical staff and hospital administration—the administrator, associate administrator, director of nursing, hospital controller, clinic manager, medical director, assistant medical director, director of Ambulatory Services, director of the Family Practice Residency, chief resident, and the director of Indigent Health Care.

Hospital employees were well aware of the severity of the financial crisis and that jobs were at stake. They knew in advance which areas were potentially targeted for layoffs. As a result, approximately one half of the 72 positions were eliminated by attrition. Many employees found jobs elsewhere rather than waiting to become a part of the reduction in force. Unfortunately, some nurses left during this period at a rate that exceeded the ability of the hospital to replace them.

The widespread acceptance that the crisis posed a real threat fostered an attitude of collaboration between administration officials and the hospital medical staff. Although reductions in physician reimbursement were difficult to recommend, they were accepted. None of the full-time or part-time physicians on the medical staff left during this period. There was acceptance among the medical leaders that personal sacrifices were necessary for both the survival of the hospital and of the teaching program. The full-time faculty members were vested in the success of the institution because of a highly successful faculty practice plan that had existed since 1982.

The Family Practice Residency Program was restructured to increase the residents' ambulatory experiences both as a program need and also as a part of the general plan to shift nonemergency patients from the higher cost Emergency Department to the lower cost Family Practice Center. An adjustment for failed appointments in resident schedules increased from five to eight the average number of patients seen per half-day by each resident. The faculty provided a Christmas bonus for each resident and convinced the hospital administrator to provide additional compensation for residents for their increased efforts.

The reduction in ancillary utilization at Scenic General Hospital was accomplished as a result of two factors. First, all residents and faculty were informed and aware of the need to prudently utilize services. Second, certain services to indigent patients required prior authorization or were restricted. A detailed plan was developed by a special medical staff committee to ensure that indigent patients received essential services.

Problems That Remained

The hospital proved it could have one prosperous year, but it did so in part by delaying issues that inevitably had to be addressed.

TABLE 3. SCENIC GENERAL HOSPITAL OPERATIONS SUMMARY (1985–1987)

Activity	1985–86	1986–87	Variance
Occupancy (%)	61	62	1
Patient days	24,022	24,415	393
Length of stay (d)	5.9	6.3	0.4
Emergency visits	38,241	26,533	(11,708)
Clinic visits	72,427	82,134	9,707
Total revenue ($)	22,523,347	22,250,645	(272,702)
Total expenses ($)	23,967,238	22,138,834	(1,828,404)
Surplus (loss) ($)	(1,443,891)	111,811	1,605,702
Net cash flow ($)	(1,480,282)	642,988	2,123,270

The hospital administration could not ignore the need to address salary issues as well as equipment and plant needs. The family practice residents, for example, had not received a raise for two consecutive years. As a consequence, the residents resorted to collective bargaining and raised issues that might not have otherwise surfaced. Although there were revenues available from hospital surplus to address these issues, part of the surplus was used to pay back a loan used by the county for hospital subsidy in prior years.

Historically, the hospital had depended a great deal upon community providers for specialty services. The relationship with community physicians became a concern because of the lowered reimbursement for indigent care and teaching. Fortunately, only a few community providers withdrew their services from the hospital following the crisis, but they temporarily exposed the hospital to problems with service coverage.

The increased productivity of residents in the Family Practice Center was a highly debated issue. Some residents were concerned that their increased patient load was at the expense of their education and caused them to have less contact time with attending physicians. Others felt that the increased ambulatory experience was valuable and were proud to have been able to have contributed to the success of the institution. The residency program director and medical leaders agreed, however, that the financial crisis afforded the needed opportunity to enhance the ambulatory experiences of residents as well as help fulfill institutional needs. Although a total projection of 800 visits per resident per year was within the accreditation guidelines, this issue pointed out the difficulties associated with balancing resident educational needs with the needs of the institution.

Finally, it was recognized that the hospital could not survive by cutting its costs from year to year. There remained a strong feeling that any further reductions would impair the ability of the institution to provide quality services and would result in some service reductions.

DISCUSSION

The new competitive environment has raised questions as to whether public teaching hospitals can attract patients on a competitive basis, maintain financial support for their teaching programs, care for indigents, and remain financially viable.[2,3] All of these issues confronted Scenic General Hospital and were compounded by a financially ailing county.

The initial proposal by the hospital administrator to consider eliminating the residency teaching program was a "quick fix" approach to the hospital budget crisis. This strategy was not unknown for financially distressed teaching hospitals. The residency budget represented a large and very visible item. Although the residency program eventually shared in the budget-cutting process principally through lowered teaching fees, the hospital medical staff leaders had to promote and defend the value of residents to the institution.

The full-time faculty was vested in the success of the institution and played a crucial role in helping the residents through the crisis. The faculty shared in the mission of the hospital primarily because of their participation in an academic faculty practice plan with a mission of service and teaching. Historically, practice plans have been beneficial to the nation's medical schools.[4] The experience at Scenic General Hospital, as well as the experiences in Baltimore[5] and in New York,[6] suggests that faculty practice plans can play a major role in the public teaching hospital.

The funding of postgraduate medical education may become a more difficult challenge for public teaching hospitals as revenues decrease. Increasing the productivity of residents in handling large service needs could help public hospitals meet financial goals, but could also create residency accreditation problems. The alternatives, unfortunately, could include the reduction or elimination of residency teaching programs and, ultimately, hospital closure unless residents and faculty can contribute to the survival of the institution.

It is probable that more public teaching hospitals will face similar crises in the future and some may close, with adverse consequences for the populations they serve.[7] Based on the Scenic General Hospital experience, ongoing collaboration between administration officials and the medical staff appears to be crucial to the survival of the public teaching hospital and its programs.

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