What Is a Family Practice Center Worth?

R. Edward Howell
Augusta, Georgia

The article in this issue of the Journal by Kues et al[1] at the University of Cincinnati examines the impact that a family practice center has on the growth and financial stability of an academic medical center. While this is not a new undertaking (Schneeweiss et al[2] have published a similar analysis), it is a concept that is receiving increasing attention in today's health care reimbursement landscape.

The findings indicate that within certain practice situations university-based family practice centers can be positive contributors to the financial and educational base of the academic medical center. In concept I agree; however, the issues go beyond the straightforward and quantitative analysis indicated by this study. Such research must rely on an examination of what are essentially proxy measures of true financial impact. Such measures are limited, given the variety and the rapidity of changes that exist in the current funding mechanisms for health care.

Kues et al have focused on professional and facility billings. As Dr Kues himself acknowledges, there are some basic and inherent limitations in taking this approach.

One limitation is that charges may or may not accurately reflect revenue. As noted by Dr Kues, actual revenue will be dependent on collection rates and payer mix. Many academic medical centers, particularly those that operate large ambulatory care practices, frequently establish facility charges that may be less than the costs of providing service in order to generate a larger patient base. Thus, charges may or may not have a direct correlation to net revenue. Further, generating those charges will also generate costs that may or may not be covered by the revenue received. Since inpatient outliers were not excluded, a catastrophic case could skew the hospital billings figure given in the study sample.

Nevertheless, Kues's study warrants a close and respected review. The basic premise that family practice centers are valuable to academic medical centers, not only from an educational and research perspective but also from an economic and service perspective, is sound. There appear to be several emerging factors, however, that will likely affect the role of the family practice center within an academic medical center in the coming decade.

One factor is the shifting emphasis by third-party payers to primary care. Historically, specialty services with procedure-oriented fees have generated the largest income potential for academic medical centers as well as for health care providers. However, resource-based relative value scale (RBRVS) reimbursement, which is currently being instituted by the Medicare program (and historical trends suggest that other third-party payers will follow Medicare's lead), will in all probability redistribute revenue away from procedure-oriented activity. There will undoubtedly be a reaction from all providers, including academic medical centers, to this shift in payment. Kues contends that family practice centers generate patient volume for this procedure-oriented activity, with the greatest impact being on hospital services. Thus, implementation of RBRVS may change the dynamics of this relationship and may even change the referral patterns observed by Dr Kues.

Another factor affecting the family practice center's role is the expansion of managed care activities. While academic medical centers are generally perceived as high-cost providers, they are also perceived by managed care organizations as reasonably attractive in affording the opportunity to include comprehensive services in a single contract. That is, the managed care corporation can sign a single contract that identifies a whole spectrum of services from primary care to the most tertiary acute care, and brings with it public perceptions of quality.

Managed care corporations are beginning to stipulate in their contract negotiations the need for feeder mechanisms within academic medical centers. Family practice center physicians are being seen in this environment as potential "gatekeepers" who not only care for the general needs of the subscriber but may also serve in a

From the Medical College of Georgia Hospital and Clinics, and the Schools of Allied Health and Medicine at the Medical College of Georgia. Requests for reprints should be addressed to R. Edward Howell, Executive Director, Medical College of Georgia Hospital and Clinics, BI F-224, Augusta, GA 30912-5000.

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resource allocation role. Thus, the family physician will likely determine the amount or magnitude of activity of the procedure-oriented specialists. There is a need to track growth in capitated or other forms of managed health care and the redistribution of income within the academic medical center as a result of this undertaking.

Another element of the study that merits comment is the "external referral leak." In a managed care environment, external referrals not only will be viewed negatively by fellow faculty, but will also be discouraged or perhaps regulated through the managed care contract. Often the leak is rationalized based on a lack of responsiveness or concern over the quality of specific services. With the capacity to leak referrals eliminated, the family medicine program becomes a "driver" in increasing the standards of performance for the timeliness of acceptance of the referral or diagnostic treatment.

The coming decade will see rapid changes in our health care environment. The family practice center within the academic medical center will unquestionably be centrally involved in these changes. Kues et al indicate that for each dollar generated by the family practice center, the academic medical center generates $6.00. While undoubtedly true, this is only part of the story. In today's complex health care financing environment, it may not necessarily be the most important part.

References

1. Kues JR, Sacks JG, Davis LJ, Smith R. The value of a new family practice center patient to the academic medical center. J Fam Pract 1991; 32:571–575.
2. Schneeweiss R, Ellsbury K, Hart LG, and Geyman JP. The economic impact and multiplier effect of a family practice clinic on an academic medical center. JAMA 1989; 262:370–5.

Illness Experience and Treatment: Can We Transcend the Quantitative/Qualitative Dichotomy?

Howard F. Stein, PhD
Oklahoma City, Oklahoma

The character of American medicine is revealed by the stories we tell. Unfortunately, all too often our clinical accounts are merely stories about disembodied lives.[1,2] The articles by Peteet et al[3] and Holt[4] appearing in this issue of the Journal are important because they teach us about patients' experiences. If cancer is *disease*, it is also and powerfully *image*. This image of disease is held and experienced by both patients and practitioners.[5–9]

Wise clinicians (who know their patients better than they know the latest and most prestigious research design) have long cultivated a respect for patient experience and actively elicit it. Ironically, while many busy clinicians understand this and include it almost effortlessly in their practices, researchers have set up "quantitative" and "qualitative" research camps. This dichotomy has removed researchers and the practitioners who emulate them away from the richness of clinical experience. Many in research discount the stories clinicians have patiently gathered over years of practice. The two articles published in this issue remind us of much that we should know but have expelled from consciousness as "unscientific" or "anecdotal."

Physicians know from experience that sample size is not the only path to truth. An *n* of 1 can be profoundly edifying. One Oklahoma farmer taught me to teach residents to ask both "What do *you* think is wrong with you?" and "What are you worried about?" (eg, "I'm worried that I won't be able to plant, plow, or cut"). Another Oklahoma farmer, who was also a family medicine resident, taught me about the effect of farming values and seasonality on timing priorities in rural family health care behavior.[10] For example, during wheat harvest, no matter how sick anyone in the family is (except for infants), no one goes to the doctor. Having a successful harvest is of paramount concern, and every member of the family is needed.

We refract patients' and families' worlds through our own cultural prisms. It is not that an objective world does not exist, but that it is difficult to know when and how we are distorting it through our own needs, wishes, and feelings. In all research, what and who we are defines what we choose to believe and what we choose to discount.

Our modes of inquiry (research) can be shared defenses, or they can be vehicles to help us along on the

Department of Family Medicine, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma. Requests for reprints should be addressed to Howard F. Stein, PhD, Department of Family Medicine, University of Oklahoma Health Sciences Center, PO Box 26901, Oklahoma City, OK 73190.