Residency Education

A Study of Closure of Family Practice Residency Programs

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Background: *Between July 1, 2000, and July 1, 2002, the Residency Review Committee for Family Practice had received requests for voluntary withdrawal from 27 residency programs. This number represents a significant increase in the rate of program closure over previous years.* Objectives: *We compared descriptive data on these closing programs and explored factors contributing to the closure.* Methods: *Descriptive program data were collected from the Accreditation Council for Graduate Medical Education, National Resident Matching Program, the American Academy of Family Physicians, and the American Board of Family Practice. Program directors from closing programs were invited to participate in a semi-structured interview to discuss factors contributing to the closure of their program.* Results: *Seventy-five percent of closing programs were community based, median program age was 11 years, board pass rate averaged 98%, and 69% cared for underserved communities. Financial, political, and institutional leadership changes were most frequently cited by program directors as primary reasons for program closure.* Conclusions: *The rate of program closure is increasing, affecting programs that meet most measures of high quality. Quality programs are being lost, and the ultimate impact is yet to be seen. Program directors offer warning signs and advice that is generally applicable to other family practice residency programs.*

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As of July 1, 2000, there were 472 Accreditation Council for Graduate Medical Education (ACGME)-accredited family practice residency programs.[1] As of July 1, 2002, the Residency Review Committee (RRC) for Family Practice had applications for voluntary withdrawal of accreditation from 27 programs that had closed or planned to close between July 1, 2000 and June 30, 2004.[2] These programs represented 5% of all family practice residency programs. Most of these programs have closed or will close soon, two programs have merged, and one closed the allopathic portion of its program.

While some family practice residencies have always closed each year, 27 closures in 5 years represents a substantial increase over previous years.[1,3] From 1988 to 1997, an average of three programs closed annually, but from 2000 to 2002, an average of more than twice this number have closed each year.[4]

This increase in the closure rate suggested a need to assess the types of programs closing and to explore common factors contributing to closure, warning signs of closure, and potential aversion tactics. Previous studies of closures between 1983–1992 found that most family practice residency programs closed for financial reasons.[6-8] Finances may still be an important cause because the Balanced Budget Act of 1997 reduced Medicare graduate medical education payments and resulted in permanent loss of funding for many residency positions.[4,5] These earlier studies and more recent ones have found that flexibility and creative means of generating financial and political support for residency programs are crucial to residency program survival.[9-12] With significant changes in the health care environment, it is plausible that new factors may also be threatening family practice residency programs, and different aversion tactics may be necessary. We compare basic data on closing programs and explore

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factors contributing to program closure. Additionally, we asked about early warning signs of potential problems and tactics to strengthen programs and avert program closure.

Methods

Program Data

A list of all ACGME-accredited family practice residency programs that had applied for voluntary withdrawal of accreditation from July 1, 2000 to June 30, 2004 was obtained from the RRC as of July 1, 2002. Descriptive data regarding number of positions offered through the National Resident Matching Program (NRMP), program director participation in the National Institute of Program Director Development (NIPDD), ACGME accreditation status, program years in existence, board certification exam pass rates, program structure, and hospital type were verified by direct inquiry of the NRMP, the American Academy of Family Physicians (AAFP), ACGME, and the American Board of Family Practice (ABFP). These data were also collected for nonrespondents (n=27). Other descriptive data (program director tenure and underserved focus) were received from respondents (n=17). All descriptive data are reported in Table 1.

Survey Methods

We developed a semi-structured interview tool for the exploratory phase of our study. This tool was pilot tested with three program directors who had experienced program closures prior to 2000. Based on these pilot tests, the tool was modified to create the final interview instrument (available from authors on request).

Program directors from all 27 programs were contacted by phone and e-mail and were invited to be interviewed by phone or to respond to the survey tool by e-mail. Those program directors who elected to participate via e-mail were sent the survey tool as an attachment for completion. Nonrespondents or incomplete respondents were recontacted three times.

One author conducted all phone interviews and manually recorded responses. To avoid listener bias during phone interviews, answers to each question were repeated back to the participant to ensure accuracy of the written response record.

Interview responses were reviewed independently by all authors for common themes. We used iterative discussions to reach consensus on key themes for primary factors contributing to program closure (Figure 1) and warning signs, advice, and aversion tactics (Tables 2, 3, and 4, respectively).

Results

Descriptive Data on Programs

A total of 17 of 27 program directors completed interviews or e-mailed responses (10 by phone and seven by e-mail). One director refused to participate, and nine never responded.

Table 1

Descriptive Data on Closing Programs

Program structure of closing programs*
- Community based, unaffiliated=4 (14.8% of programs)
- Community based, medical school affiliated=9 (33.3% of programs)
- Community based, medical school administered=8 (29.6% of programs)
- Medical school based=6 (22.2% of programs)
- Military=0 (0% of programs)

Hospital type of closing programs*
- Public=6 (22.2% of programs)
- Private, nonprofit=20 (74.0% of programs)
- Private, for profit=1 (3.7% of programs)

Program's years in existence*
- Mean=14.3 years
- Mode=11 years

NRMP % Match (3 years prior to program closure)*
- Mean=57%
- Mode=50%

Board pass rate of program graduates (3 years prior to program closure)*
- Mean=98%
- Mode=100%

Accreditation status of program prior to closure*
- 5 years=6 programs
- 3 years=7 programs
- 2 years=2 programs
- 1 year/provisional=8 programs
- Probation=4 programs

NIPDD training of program director*
- Yes=6 program directors
- No=21 program directors

Program director years of experience as program director
- Mean=6.8 years
- Mode=5 years

Underserved focus at program
- Yes=13 programs
- No=4 programs

* Data on nonresponding programs was obtained from the Accreditation Council on Graduate Medical Education, the National Resident Matching Program (NRMP), the American Board of Family Practice, and the American Academy of Family Physicians databases.

NIPDD—National Institute of Program Director Development

Table 2

Warning Signs Noted by Program Directors

Financial
- Cuts in the budget for the family practice department or other primary care departments
- Cuts in primary care faculty or failure of these individuals to achieve tenure
- Increased visitation by financial consultants to the host institution
- Lack of acknowledgment for indigent care provided
- Feeling of being "unappreciated" or "invisible" to the host institution
- Mention of "downsizing," "rightsizing," or other terms for layoffs
- Discussion of hospital merger (especially if the other hospital has significant debt, or sale of hospital, especially if the buyer is a for-profit institution)

Political/leadership
- Changes in host institution or medical school leadership ("New CEOs close residencies. It's good for them! If you find a good CEO who has been in his/her position for more than 5 years, in a profitable not-for-profit hospital, that is not a take-over candidate [too much money in the bank], then you can have a secure program.")
- Mutual distrust among hospital, university, and residency faculty and worsening of this relationship
- Unsupportive hospital professional and medical staff

Other
- Multiple years of trouble recruiting
- Poor Match results
- Decreased student interest in primary care at the local institution and nationwide

Table 3

Program Directors' Advice to Strengthen Residency Standing

Financial standpoint
- Keep comprehensive records of the program's financial contributions to the host institution (ie, grant money, Medicare graduate medical education payments, referral and downstream revenue, inpatient and outpatient care reimbursement).
- Keep the leadership apprised of the program's financial contributions and community importance (indigent care and improved community relations as a result of program's presence).
- Expand the program's patient base.
- Increase clinic and faculty productivity while carefully assuring an appropriate service/education balance.
- Seek additional sources of new revenue through outside grants and contracts.
- Lobby for state funding parity through legislation.
- Develop proactive strategies to cut program costs where possible.
- Consider other potential host institution options (and arrange to move Medicare-funded positions, if eligible, at least 1 year prior to closure).

Political issues and leadership changes
- Meet with the institutional leadership regularly.
- Remind the institution's governing body how the reasons why they decided to begin a family practice residency program are still valid.
- Develop a working relationship before you need one.
- Report the benefits of the program to the host institution and community (program's role in improving patient satisfaction, improved community perception of quality care, and volunteer activities such as team coaches, health fairs, etc).
- Create a local community advisory board that can respond if the program is threatened.
- Remind medical staff of the role residents play in accepting new patients and providing support for subspecialists (referrals).
- Integrate family medicine faculty in committees and leadership of the host institution and in prominent and powerful local organizations.
- Avoid affiliations with unsupportive universities. (It is preferable to be unaffiliated and independent.)

We found that the average accreditation status of the programs was 4 years, four were on probation, and eight had provisional accreditation. Board pass rates averaged 98% for the 3 years prior to closure at all residency programs, and only four programs had passage rates less than the national average of 96%. More than half of the closing programs had been open for at least 11 years, and 10 programs were more than 20 years old. In the 3 years prior to closure, the average NRMP Match fill rate was 57%. Six program directors were NIPPD trained. Program director tenure averaged almost 7 years. At least 13 programs had an underserved focus and/or serve a patient base with at least 50% of patients receiving public assistance or categorized as private pay (Table 1).

Comments Supporting Primary Reasons for Closure

Respondents' assessments of the primary reason for their program's closure suggest that financial, political, and institutional leadership changes were the predominant reasons for closure (Figure 1). Financial issues were related to both programs and sponsoring institutions. Specific statements supporting financial issues as the primary reason for closure included: "financial trouble with loss of federal grants and medical school resources," "inadequate funding per resident," "decrease GME/IME dollars and being viewed as a 'cost-center,'" "financial problems in host hospital," "huge institutional losses," "insufficient resources to stand alone," "inaccurate valuation of the family practice residency program," and "being seen as a poor investment."

Other quotes pointed to political causes for closure, including "inability to reaffiliate with an appropriate host hospital," "no perceived ongoing need for primary care in the local community," "decreased interest in family practice within the medical school leadership," "corporate irresponsibility," and "inability to merge missions."

Changes in leadership also contributed to many closures. Program directors commented: "new CEO and chairman," "leadership change in the medical school," "change in host institution leadership," and "corporate merger with 100% turnover of administration." Some quotes alluded to the multifactorial nature of many closure situations, such as "egos and dollars," and "We were no longer considered core to the hospital's business or mission plan."

Table 4

Suggested Aversion Tactics and Damage Control

Aversion tactics

- Lobby the CEO, deans, department chairs, local legislators, and community leaders.
- Discuss problems and work together to develop solutions.
- "Be at the table" and come with ideas.
- Try to negotiate with the big parties involved.
- Always cherish and foster local community physician support.
- Call on family medicine supporters to apply pressure to decision makers.
- Hold community meetings to rally support for the program.
- Rally student support.
- Consult the host institution's legal staff early and regularly.
- Inform the state and national offices of the AAFP as soon as possible.
- Ask for help! (eight of 17 programs responded that they used a Residency Assistance Program consultation and found this to be helpful).

Damage control

- Ask the ABFP to waive the continuous enrollment requirement for residents who will need to change programs.

Finally, various informants advised, "There is no manual on how to close a residency program." But, "Keep calm about what is known and what is unknown," "avoid anger responses," "actively prepare to transfer residents," "help people realize that this is an opportunity to chart a new course in one's career."

AAFP—American Academy of Family Physicians
ABFP—American Board of Family Practice

Warning Signs, Advice, and Aversion Tactics

Program directors described many specific warning signs and advice on ways to strengthen the program's position. Most warning signs of impending closure and advice on how to avoid closure fell into the categories of financial issues and political/leadership issues (Tables 2 and 3). When faced with potential closure, program directors suggested aversion tactics and damage control ideas (Table 4).

Discussion

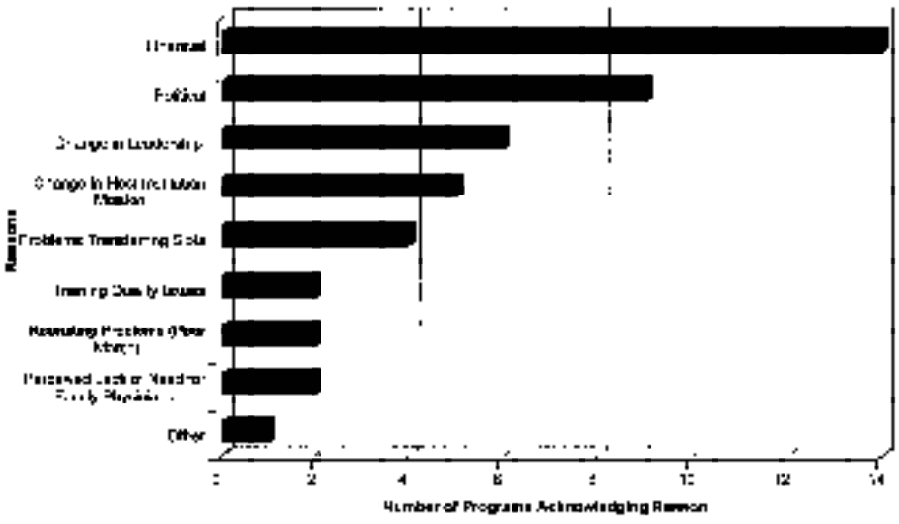
We found that the closure of family practice residency programs does not discriminate based on measures of quality, departmental lifespan, duration of program director tenure, or clinical mission. The majority of closures, however, affect community-based programs and those operating in public or nonprofit hospitals. If this signals a trend in disproportionate closure of community-based and nonprofit hospital-sponsored programs, it may have a greater effect on underserved and rural populations. Community-based programs are not the only ones affected, since six of the closed programs were in medical schools, resulting in serious consequences for both residents and medical students. Closure of medical school programs may further limit the exposure of medical students to family practice as a career option and affect the family practice workforce far into the future.

Financial pressures and problems contributed to the majority of closures (14 of 17 programs). One program director noted, "Residency training is not cheap," and sometimes the "residency program is successful, but the hospital fails," pointing out that the current poor financial condition of many US hospitals is an independent financial threat to family practice residency program viability. Reductions in Medicare GME funding, recent decreases in general Medicare payments, declining insurance reimbursements, and increased care burden for uninsured patients all contribute to hospitals desperately seeking means of cutting costs.[13,14] This financial picture is not likely to change in the near future, and family practice residency programs may remain at risk.

Leadership and political volatility are strongly associated with finances. Changes in hospital leadership and/or organizational vision/mission changes affected 11 of 17 programs, and nine program directors also felt

Figure 1

Primary Reasons for Residency Program Closure



that political issues contributed to closure. At least two programs were closed largely due to a perceived lack of need for and importance of family medicine at the host institution and/or in the local community. Four programs ran into trouble trying to reaffiliate, and two of these closed because of failure to transfer Medicare-funded residency slots within affiliated hospitals in a timely fashion. Given that family practice is no longer the darling of health system business plans, health workforce planning groups, or medical students, all of the above factors are environmental risk factors for closure.

While many factors were out of the program directors' control, they did identify factors that they felt they were able to influence, albeit too late. Program directors advise that family practice programs should begin to "prove their value" before they are threatened. These key informants offered chronic and acute warning signs of potential closure and both strategies and tactics for responding that are remarkably consistent with those gleaned by the Residency Assistance Program.[15]

Limitations

A potential limitation of our study is that phone interviews were not electronically recorded, leading to potential errors in collection of information. However, the same interviewer recorded responses in each case and read the responses back to informants to be sure their words and intent were adequately captured.

Approximately one third of the programs did not respond to requests for interviews, leading to the possibility of bias. While we don't have qualitative responses from these nonresponding programs, we were able to collect the same quantitative data for them, and their program characteristics are similar to those of responding programs.

Conclusions

The increased rate of family practice residency closure bears watching given that the common reasons cited for closure are not changing. The increase in closures appears to disproportionately affect community-based and nonprofit hospital-sponsored programs, and suggests a need to study the effect of closures on underserved populations. Closure of medical school programs is also a concern, given the loss of interaction with medical students and the potential effect on the future primary care workforce. Closure of high-quality, mature programs suggests a need for external advocates to protect these resources from local Darwinian effects. The warning signs are not particularly sensitive or specific for impending closure, and conditions or events cited as warnings by closed programs may be the norm for many viable programs.

It is important to recognize threats of closure, develop creative, proactive strategies to avert an unplanned closure, and if closure seems eminent, be open and honest with all those involved.[8,10,11] Obtaining and maintaining sufficient funding has been and continues to be a key factor for program survival.[16] For the foreseeable future, new requirements, expectations, and regulations by accrediting bodies such as JCAHO, ACGME, and HIPAA will make the GME environment even more challenging.

It is our hope that the advice from program directors at affected programs, as presented in this report, might help other programs to identify, avert, or at least deal effectively with potential program closure. There is a need to develop new advocacy tools and increase awareness of the RAP departmental consultation project to respond before and at the time of real closure risk.

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References

1. Facts about family practice 2001. www.aafp.org. Accessed October 2002.
2. Withdrawn programs active during current year July 1, 2000 to June 30, 2003. Chicago: Residency Review Committee (internal publication), 2003.
3. Kahn NB Jr, Pugno PA, Brown TC. Transferring sponsorship of a family practice residency: financial implications. Fam Med 1991;23(8): 620-3.
4. Schneeweiss R, Rosenblatt RA, Dovey S, et al. The effect of the 1997 Balanced Budget Act on family practice residency training programs. Fam Med 2003;35(2):93-9.
5. Dickler R, Shaw G. The Balanced Budget Act of 1997: its impact on US teaching hospitals. Ann Intern Med 2000;132(10):820-4.
6. Kahn NB Jr, Hughell JE, Brown TC. Financial analysis of a family practice residency threatened with closure. Fam Med 1992; 24(1):49-52.
7. Division of Medical Education, American Academy of Family Physicians. Analysis of residency closures. Leawood, Kan: American Academy of Family Physicians, 2003.
8. Boddie WL, Fowler F, Payne J, Bratt L. Financial crisis in a family practice residency: a successful strategy. J Fam Pract 1989;29(2): 201-4.
9. Matthies F. Reorganizing a family practice center: strategy to save a residency program at a financially troubled hospital. J Am Board Fam Pract 1991;4(1):27-31.
10. Burg FD, Kelley MA, Zervanos NJ. Supporting primary care medical education. J Gen Intern Med 1994;9(4 suppl 1):S104-S114. (Review)
11. Allhiser JN. Enhancing community support for family practice residencies. Fam Med 1995;27(7):431-4.
12. Werblun MN. A contractual model for accountability and financial stability in a community-based family practice residency. J Fam Pract 1985;21(3):228-30.
13. Association of American Medical Colleges, Government Affairs and Advocacy. Prospective payment system: FY 1998 final rule. AAMC summary and analysis. 12-7-1999. Washington, DC: Association of American Medical Colleges, 2003.
14. Medicare Payment Advisory Commission. Medicare payment policy. Coll Rev 2002;June 24.
15. Pugno PA. What to do when faced with the closure of a family practice residency. Fam Med 2003;35(3):170-3.
16. Durrett JP. The relationship between management practices and financing of family practice residency training programs. Coll Rev 1991;8(1):31-55.