Course Learning Outcomes for Unit III

Upon completion of this unit, students should be able to:

1. Explain the rapid growth of ambulatory health care services in the U.S. over the past two decades.
2. Summarize the concept and articulate the value of a Patient-Centered Medical Home Model.
3. Discuss the trend for more “freestanding” medical facilities and services in the U.S. and their own view of the appropriateness of this approach to health care.
4. Determine important trends in physician medical practice in the U.S. and the impact of these trends on delivery of patient care.
5. Describe the role of Physician Report Cards in modern medical practice.
6. Discuss the future of hospital, ambulatory, and medical care in the U.S. and their own view of whether this future is good for patients and good for doctors.

Reading Assignment

Chapter 4:
Ambulatory Care

Chapter 5:
Medical Education and the Changing Practice of Medicine

Unit Lesson

Recruiting and Retaining Doctors

One of the most important roles for any health care leader is building the hospital or clinic medical staff to meet community needs. To say that this is a challenging part of the job is to utter a truly great understatement. Depending upon geography, local economy, and a diversity of other factors, the task of recruiting and retaining physicians is much more difficult for some hospitals than for others. Consider the difference between two real world hospitals.

One hospital CEO is recruiting doctors to a nice, 300-bed community hospital in Southern California. It is near the beach in a community of 100,000 people, with lots of great restaurants and golf courses. The community has a very nice shopping mall and relatively easy access (45 minutes by freeway) to a major city for anything that is not available locally. In this community, there is already a well-developed medical staff, plenty of primary care and specialist physicians on the physician team. The significance of this last point is that the on-call burden for a new doctor joining the facility will be very minimal.

Meanwhile, another CEO of a 50-bed hospital in Montana has an equally important job in recruiting doctors to serve the community. It is a very nice, friendly small town of 10,000 people, beautiful country and great outdoor recreation, but nowhere near a beach nor a golf course. The closest mall is 150 miles. Since the existing medical staff is very small, a new doctor coming to town will be on call every third weeknight and even third weekend, probably for the long haul.

The CEO in Montana has the tougher job of recruiting. But, there is a right doctor for the Montana community, and great CEOs have always found a way to locate that right person and then sell them on the opportunity. Some salesmanship is involved here. Maybe the right doctor for the hospital in Montana is a person who grew up in a rural community and wants to practice in that same kind of setting or whose interest is more hunting and fishing than shopping and dining.
For both of these communities, the right doctor is out there, but he or she is not easy to find. This is why many hospitals with tough recruiting challenges use professional “head hunter” firms to help them find the right doctors. You might think of these companies as “matchmakers” who know the doctors who are out there looking for opportunities and also know the hospitals who are actively recruiting. The role of a company such as these is to create lasting matches that work for both parties. The typical contract calls for the hospital to pay all expenses associated with the search and then to pay 20-25% of the first annual contract to the recruiting firm. Since many physician contracts are in the $200K to $400K range, which puts the recruiter’s fee at $40K to $80K. Typically there are contractual provisions by which the hospital receives part or all of their recruiting fee back if the physician does not stay on staff for a specified period of time (often one year of practice). So it behooves the company to work hard and put together a good, lasting match.

More than a few graduates from health care administration training wind up working in professional recruitment, making matches between hospitals and physicians. Today the severe shortage of nurses, respiratory therapists, physical therapists, and other clinical workers has led hospitals to also engage recruiters to fill some of those positions.

As a rule, hospital boards often do not like the idea of using professional recruiters. Their thought process is “Can’t we just get busy and find a doctor ourselves?” However, the hospital can easily wind up spending more than the recruiter’s fee on marketing and advertising and sometimes still not get a doctor, or at least not the right doctor. For many hospitals, it is better to let the pros handle the search and then focus efforts on evaluating the candidates presented and establishing a long-term relationship with the right one.

No lecture on physician recruiting would be complete without sharing a time-honored adage, which has turned out to be valid. “Recruit the doctor, but retain the spouse.” That holds true regardless of the genders of doctor and spouse. If the doctor is completely satisfied with his practice, the hospital, and community, but the spouse is not happy, the hospital-doctor relationship is doomed. Perhaps the great majority of doctors who have left a hospital over the years have done so upon the demand of their spouses, not because they were unhappy in practice. For example, the may decide that rural Montana is a great place for his or her own career, but the doctor’s spouse may not be happy there.

Additionally, in an attempt to increase income and provide a higher level of patient care, physician investors have established free-standing surgical and ambulatory care centers. These facilities provide specialized services, such as orthopedics, heart surgery, and back surgery. While hospitals state that these organizations “cherry pick” their patients, the services provided seem to be valued by the health care consuming public.

**Ambulatory Care**

The term *ambulatory* refers to a patient’s ability to walk. We say that the patient is *ambulatory* (can walk on his/her own), and that he/she can *ambulate* without assistance.

The medical profession has come to use *ambulatory care* to mean anything that can be done for the patient without admitting him or her to a hospital facility.

These days a remarkable array of ambulatory services is available, including services that never would have been considered safe to perform outside a hospital 20 years ago.

Ambulatory Surgery Centers (ASCs) are certainly a prime example. Today a patient can undergo many endoscopic and surgical procedures at the ASC and then go home the same day. Some of these procedures historically required admission to the hospital for several days or even weeks. Laparoscopic technology is often behind this change.

For example, in open gallbladder surgery, an incision of about six to eight inches is made in the upper abdomen; the muscles of the region are incised to gain access to the gallbladder, extensive surgical closure is required, and the patient experiences considerable pain for several postoperative days. The patient generally requires injectable or IV narcotics for pain control. Open gallbladder surgery requires several days in the hospital, and in some cases a week or more. The laparoscopic gallbladder technique requires only very small incisions, leaving the patient’s abdominal wall largely intact, and the patient can generally go home the same day. The laparoscope is a special instrument connected to a digital video monitor that allows the surgeon to view and remove the gallbladder with minimal invasion.
Some other services that were formerly hospital-based only, but now considered ambulatory; include MRI services and CT services. These diagnostic services are commonly performed in ambulatory “imaging centers,” as they are called. Physical therapy and occupational therapy are also frequently performed on an ambulatory basis today.

Health care managers of the future will not just be managing inpatient care; they will be managing a diversity of ambulatory services. Smart leaders will aggressively place and promote such services throughout the community. It is all about meeting community needs in the most efficient and patient-friendly manner.

Notes: Please make weekly progress on your Management Action Plan (MAP) assignment, which is due for Unit VIII. The MAP will require considerable time and effort and cannot be left until last minute to complete.

Now that you have identified a MAP problem or scenario, please let your professor know if you need any guidance or suggestions as you work through the MAP process. Your professor is available to help as you proceed on your MAP. It is an important part of your MHA level learning at CSU.

Suggested Reading

Click here to access a PDF of the Chapter 4 Presentation.

Click here to access a PDF of the Chapter 5 Presentation.

Learning Activities (Non-Graded)

Use CSU Online Library and your favorite search engine, and research about ambulatory care. In a table, include the following information for each source:

- Authors/organizations
- Titles
- URL
- Description of the websites or articles
- Problems
- Solutions
- References

You can use and modify a table provided for this course. Click here to download a table of Webliography.

Non-Graded Learning Activities are provided to aid students in their course of study. You do not have to submit them. If you have questions contact your instructor for further guidance and information.
### Key Terms

1. Accreditation Council for Graduate Medical Education (ACGME)
2. Ambulatory care
3. Ambulatory surgery center
4. American Board of Medical Specialties (ABMS)
5. Clinical practice guidelines
6. Community health center
7. Flexner Report
8. Freestanding services
9. Mayo Clinic
10. Primary care centers
11. Retail clinic (MinuteClinic)
12. The Patient-Centered Medical Home (PCMH)
13. Urgent care center
14. Women’s center