Health Care USA
Understanding Its Organization and Delivery
Chapter 4
Ambulatory Care
CHAPTER OBJECTIVES

• Provide familiarity with the major components and functions of the ambulatory care system in the context of the overall delivery system
• Highlight major developments in the evolving ambulatory care system with respect to physicians, hospitals and consumers
Overview

• Medical care not requiring overnight hospitalization

• Continuing volume shift from hospitals
  – Advanced technology → safety improvement
  – Payer incentives to decrease inpatient stays
  – Consumer & physician preferences
Components of Ambulatory Care (1)

• Private Medical Office Practice
• Non-physician practitioners
• Hospital-based (clinics, emergency departments)
Components of Ambulatory Care (2)

• Freestanding Services
  – Primary care
  – Urgent care
  – Retail clinics
  – Ambulatory surgery
  – Community health centers
  – Public health
  – Not-for-profit agencies
Trends

• Physician and corporate ownership
  – Diagnostic Imaging
  – Treatment facilities, e.g. renal dialysis & cancer infusion
  – Same day surgery centers
  – Urgent care and retail clinics
• Revenue shifts from hospitals
• Drive toward comprehensive care through “medical homes”
FIGURE 4-1 Number of Outpatient Visits in Millions, 1996-2006.

*Sources: CDC/NCHS, National Ambulatory Medical Care Survey; National Health Statistics Reports, No. 8, August 6, 2008.*
FIGURE 4-2 Age-adjusted Ambulatory Care Visit Rates by Setting: United States, 1996 and 2006.

Source: CDC/NCHS, National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey; National Health Statistics Reports, No. 8, August 6, 2006.

*Significant change (p < 0.05).
Private Medical Practice Volume

- Predominant Mode: 902 million visits/year (compare to 119 M ED visits)
  - 58% visits to primary care physicians
  - 22% visits to surgical specialists
  - 20% visits to medical specialists
Transition to Physician Group Practice

- Until 1930’s solo practice predominant
  - 1932 Committee on the Costs of Medical Care*
    Report recommended group practice as economically efficient, promoted insurance as a means to improve access
  - *A blue ribbon panel of public health professionals, academicians and economists
Reactions to Committee Report on the Costs of Medical Care: 1930s-1950s

- AMA condemned recommendations for group practice and salaried physicians as "unethical"
- GHI establishment (1937) erupted legal battle; AMA expelled GHI-salaried physicians and "blacklisted" them with hospitals; D.C Medical Society & AMA indicted & found guilty of conspiracy to monopolize medical practice
Continuing Opposition to Group Practice

• Physicians sought membership in evolving group health plans as local medical societies attempted and failed at obstructing group practices
  – Group physicians were ostracized and denied hospital privileges
  – Opposition subsided by 1950s due to legal challenges and physician shortage
Transition from Solo to Group Practice - 1960s

- Social & lifestyle changes of the ’60s
- Medical specialization
- Medicare & insurance complexities
- Office technology costs and overhead spawned economies of scale opportunities
Group Practice Features

• Single & multi-specialty groups
  – After hours and vacation coverage
  – Informal collegial consultation
  – Informal system of peer review
  – Share office overhead
Patient-centered Medical Home

• Team-based model of care led by a personal physician providing:
  – continuous and coordinated care throughout a patient’s lifetime including arrangements with other professionals for preventive, acute and chronic illness and end-of-life assistance
Patient-centered Medical Home Origins

• First described by the American Academy of Pediatrics (1967); American College of Physicians and American Academy of Family Physicians (2004)
• wide recognition of inadequate care continuity, safety, and quality
• increasing pressures to reduce costs and waste
• support from physicians, health plans, government
Other Ambulatory Care Practitioners

• Licensed professionals in independent practice: solo or group, single or multidisciplinary practices

• Dentists, podiatrists, psychologists, optometrists, physical therapists, social workers, nutritionists
Hospital Ambulatory Care-Early

• 19th century: clinics poorly equipped & staffed, often remote “dispensaries”
• Served community’s poorest & charitable Mission
• Teaching sites for medical students
• Staffed by low-ranking physicians often to earn admitting privileges
Hospital Ambulatory Care-Now

• Serve community poor-Safety Net
• Teaching sites
• Primary and specialty care
• Profitable referral centers: acute care and ancillary services; 30-45% revenue
• Well-equipped and staffed
Traditional Teaching Hospital Clinics

- Organized into specialty areas for teaching & research purposes; “anatomic” orientation
  - Patients benefit from sophisticated care
  - Specialty orientation causes discontinuity
Hospital Clinic Evolution-1980s

- Primary care as “core” with salaried, not volunteer, physicians
- Improved care coordination
- Specialty services to attract paying patients
Hospital Emergency Departments (1)

- Staffed and equipped for life-threatening illness and injury; physician & nurse specialists
- 119 million annual visits - 227/minute
- Community “safety nets”
- Much inappropriate use
FIGURE 4-4 Percent Distribution of Emergency Department Visits by Immediacy with Which Patients Should Be Seen.

- Nonurgent: 12.1%
- Semi-urgent: 22.0%
- Urgent: 36.6%
- Immediate: 5.1%
- Emergent: 10.8%
- No triage or unknown: 13.4%

Hospital Emergency Departments (2)

- Visits increasing: older population, more uninsured
- Number of EDs decreasing
- 13% of visits result in hospitalization
- Visit rate of uninsured 43% higher than insured
FIGURE 4-5 Number of Emergency Department Visits per 100 persons by Expected Source of Payment: United States, 2006.


Note: Error bars are 95% confidence intervals. The denominator for each rate is the population total for each type of insurance obtained from the 2006 Nation Health Interview Survey. More than one source of payment may be recorded per visit. SCHIP is State Children’s Health Insurance Program.
Free-standing (non-hospital-based) Services

- **Ownership**: hospitals, MD groups, independent for-profit, not-for-profit single entities and chains
- **Development**: consumer demand, managed care initiatives, technological advances
Primary Care Centers

• Started by hospitals in 1980s to:
  – Capture new market share
  – Refer for inpatient admissions
  – Increase ancillary service volume
  – Respond to patient & insurer demands
Urgent Care Centers (1)

- First in 1970s
- 8,000+, 100 new/year/100 million annual visits
- Ownership: for-profit, physician groups, managed care organizations
- Primary care physicians, nurses, ancillary services, e.g. lab & radiology
- After hours, non-emergency
- Episodic care
Urgent Care Centers (2)

- Locations attract self-pay, insured: 55% suburban, 25% urban, 20% rural
- American Academy of Urgent Care Medicine (est. 1997) advocating residency training & specialty recognition
- Insurers usually reimburse
Urgent Care Issues

• Hospitals: Cull paying patients, leave the poorest for hospital emergency departments and clinics

• Physicians: Discourage relationship building with primary physician and continuity of care
Retail Clinics (1)

- Since 2000, rapidly growing entities
- 1000 sites: pharmacies, retail stores
- Smaller scope than urgent care; conditions not requiring disrobing
- Software manages specific diagnoses
- Staffing: Nurse practitioners, physician assistants; MDs on-call
- Strong patient acceptance
Retail Clinics (2)

• Strong insurer & employer acceptance; some insurers waive/lower co-pays
• Academy of Family Physicians recognizes need and physician opportunities; urges referrals, quality guidelines
Retail Clinic Issues

• AMA 2007: urged investigation for conflicts of interest (RX, other sales), disruption of physician/patient relationships, co-pay waiver unfair to physicians still required to collect
Ambulatory Surgery Centers (1)

- Established in 1970s
- Anesthesia advances: primary driver
- New operative technologies
- 34.7 M annual visits
- 2008: 5,149 Medicare-certified centers; 2000-2007: 7.3% increase in numbers
Ambulatory Surgery Centers (2)

• 90% physician-owned; 21% have hospital ownership interest; 3% entirely hospital-owned
• Medicare & private insurer mandates pushed development
• Hospital opportunities for profitable space conversions
FIGURE 4-6 Rates of Ambulatory Surgery Visits by Facility Type, United States, 1996 and 2006.


*The rate of ambulatory visits includes ambulatory surgery patients admitted to hospitals as inpatients for both 1996 and 2006. As a result, the data differ from those presented in the 1996 report.
Benefits of Ambulatory Surgery
Benefits & Quality

- **Patients:** access, fewer complications, quicker recovery
- **Physicians:** convenient staffing and scheduling, less competition for facilities
- **Accreditation:** Medicare, Joint Commission, Accreditation Association for Ambulatory Health Care, American Association for the Accreditation of Ambulatory Surgery Facilities; 43 states require licensure
Federal Community Health Centers (1)

- 1960s: U.S. Office of Economic Opportunity; urban and rural
- 2008: $1.9 billion grant, Bureau of Primary Care, Dept of HHS
- 2008: Served 20 million in 1,200 centers with 7,500 sites
Federal Community Health Centers(2)

- Multidisciplinary teams; education, translation, pharmacy, transportation, etc.
- Link, refer: WIC, social work, public assistance, legal services
- 2/3 patients uninsured or Medicaid
- Revenue: Medicare, Medicaid, private insurance, sliding fee scale payments
Federal Community Health Centers (3)

• Administering organizations: local government health departments, units of community organizations, stand-alone not-for-profit agencies

• 2009: $ 600 M Recovery Act Funds to expand/enhance 85 centers
Public Health Ambulatory e Services - History

- Originated in charitable tradition of community responsibility by municipalities & states, colonial period-1800s
- State & local governments’ roles & public health developments led to tax-supported departments of health
Public Health Ambulatory Care Services-Evolution (1)

- Services in which private medicine had little interest:
  - Disease screening
  - Immunizations
  - Health education
  - Infectious disease case finding & control
Public Health Ambulatory Care Services-Evolution (2)

• Filled gaps for services for needy & Medicaid patients:
  – Family planning
  – High-risk obstetrical care
  – High-risk pediatric care
  – Well-baby care
  – Dental services
Public Health Services Today (1)

• Public health departments with local, state & federal funds:
  – Disease screening & health education
  – Immunizations-adult & child
  – Communicable disease case finding and control
  – School-based services
  – Home health care
Public Health Services Today (2)

- Primary care for children & adults
- Child Health Insurance Programs
- Bio-terrorism/public hazard response
Emergency Preparedness

• 2001 terrorist attacks
  – $5 billion to states to strengthen infrastructure
    accompanied by many new demands & state budget crises

• 2009 H1N1 threat
  – Public health response currently under study;
    preliminary reports suggest communication gaps
Not-for-profit Agencies (1)

• Not-for-profit organizations, governed by volunteer boards of directors
• Cause-related, often grass-roots origins
• Disease and/or cause specific Missions
• Usually tax-exempt, 501(c) 3
• Education, counseling, medical care, advocacy
Voluntary Agencies (2)

- Single corporations or affiliates of national organizations
- Funding: government & private foundation grants, private donations, Medicare, Medicaid, private insurance, sliding fee scale
- Repositories of community values & charity, fill gaps for special need populations and cause advocacy
Conclusions

• Continued expansion: technology advancements and business niche opportunities
• New entities challenge traditional providers
• Consumer and market-driven preferences gain influence