Realizing Ambulatory Services' Differences is First Step to Success
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Ambulatory health services have grown explosively during the 1980s. Managing their growth has become one of the principal challenges of healthcare administrators.

Yet the underlying tensions between physicians and management over ownership. and operation of ambulatory services have, if anything, worsened during the decade.

Many hospital managers look at their ambulatory volumes in diagnostic radiology and surgery and conclude that they must be doing something right. In most institutions, ambulatory surgery volumes have doubled to tripled in the past eight years, Many who believed that only 40% of their surgeries -- a percentage that seemed unbelievably high in 1980--could be performed in ambulatory settings are stunned to see that number pushing up into the 60s or low 70s.

Hospital imaging volume also has soared, and as many as 80% of cases using newer technologies such as magnetic resonance imaging are being seen on an ambulatory basis.

Buried beneath these indicators, however, is a more significant trend.

Hospitals' loss. At the beginning of the decade, hospitals controlled more than 98% of all ambulatory surgery. However, according to a recent analysis by the Chicago-based SMG Marketing Group, one in six ambulatory surgical procedures in 1988 was performed in freestanding surgical facilities, and the proportion of non-hospital cases could be as high as one in four by 1990.

In other words, hospitals may have fumbled away nearly 25% of one of the most rapidly growing health service markets during the 1980s. Though comparable data on freestanding imaging centers aren't available yet, my suspicion is that the erosion of the hospital's market share of diagnostic radiology is even more substantial.

Some administrators and policymakers such as Rep. Fortney "Pete" Stark (D-Calif.) have attributed the exodus of services from the hospital to physician greed. The implication is that physician ownership of ambulatory facilities motivated the shift in the site of care.

I think this analysis is wrong.

The growth of freestanding ambulatory services is a broad-based protest movement against the increasing bureaucratization and complexity of the

hospital. Many physicians feel that the hospital has taken on a life of its own and that it no longer works for them.

Physicians have fled the hospital because it no longer meets their needs and the needs of their patients. The hospital wastes their time, consumes them in paperwork, compartmentalizes and fragments the patient-care experience and ends up costing the patient or employer a fortune.

Finding that freestanding facilities offer a more appropriate setting for their practice, away from the critical-care hospital emphasis, has led a large number of physicians out of the hospital.

Bad mix. Ambulatory services and critical-care services are fundamentally different businesses. They can't be successfully commingled. Trying to manage ambulatory and critical-care surgical cases in the same operating suites has pushed ambulatory surgeons out. Because much of their surgery is elective, their cases receive lower priority.

Operating room nurses and anesthesiologists find it difficult to turn rooms over rapidly enough to support ambulatory surgery if they also are attempting to manage three- and four hour operations. Besides, the status hierarchy of most hospitals remains skewed toward the critical-care surgeon, such as the cardiac surgeon and neurosurgeon. These powerful surgeons tend to get their needs addressed first, and their colleagues often get the leftovers.

Trying to manage ambulatory imaging cases in hospital radiology departments geared to patients on gurneys has worked out no better. Scheduling systems are viewed as a nuisance by department managers and technicians who are used to a first-come, first-served queuing for services.

Waiting room for families am tack onto the department and often can't be seen by those who manage the suite. Most hospital radiology departments were designed for horizontal patients with no place to go and lots of time to wait. No wonder ambulatory patients and their families feel lost in the radiology department. It wasn’t designed for them.

While the severity of illness of ambulatory patients is rising, most ambulatory business involves care for the well. Commingling ambulatory and critical-care patients and families in the same facility creates an atmosphere that is threatening and ominous to the well patient.

Well patients don't want to see gray-skinned intensive-care unit patients with tubes in their throats or chests. Ambulatory patients and their families don't want to think about dying and shouldn't have to. Enticing these patients into the non-hospital ambulatory setting that is built to a human scale is an easy task.

Righting the wrong. Hospitals face difficult and perhaps costly decisions in rectifying these problems. Many hospitals are separating ambulatory and critical-care traffic and placing ambulatory services conveniently near parking and physician offices.

Even if services are duplicated, hospitals are creating on-campus ambulatory diagnostic and surgical suites that are geared to families, not to patients on gurneys. These services are being managed by people trained in guest relations or who have good people skills.

As hospitals begin to develop their own off-campus services, they must shed old tendencies to "build first, solicit physician input later." Picking sites that are convenient to patients also is an unfamiliar exercise for healthcare managers accustomed to compelling patients to come to the hospital campus for care.

Although progress is being made in ambulatory-care planning and management, hospitals still lag behind. A tightening of physician payment may slow the exodus from the hospital campus, but the price is a more demanding and difficult working relationship with the physicians who remain.

Ambulatory services may provide most of the incremental revenue and profit of many hospitals during the 1990s. Realizing that ambulatory care is different from care of the prostrate is the first step in the evolution of an effective management response.