

Chaos and Organization in Health Care

Thomas H. Lee, MD, and James J. Mongan, MD

**The MIT Press
Cambridge, Massachusetts
London, England**

© 2009 Massachusetts Institute of Technology

All rights reserved. No part of this book may be reproduced in any form by any electronic or mechanical means (including photocopying, recording, or information storage and retrieval) without permission in writing from the publisher.

For information about special discounts, please email
<special_sales@mitpress.mit.edu>.

This book was set in Palatino by SNP Best-set Typesetter Ltd., Hong Kong.
Printed and bound in the United States of America.

Library of Congress Cataloging-in-Publication Data

Lee, Thomas H.

Chaos and organization in health care / Thomas H. Lee, M.D. and James J. Mongan, M.D.

p. cm.

Includes bibliographical references and index.

ISBN 978-0-262-01353-6 (hardcover : alk. paper) 1. Medical care—United States. 2. Health care reform—United States. 3. Health facilities—United States—Administration. 4. Chaotic behavior in systems. 5. Organizational behavior. I. Mongan, James J. II. Title.

RA395.A3L414 2009
362.1'04250973—dc22

2009013164

10 9 8 7 6 5 4 3 2 1

Introduction

As daunting as the challenges for U.S. health care may be, there is reason for optimism that a delivery system that is much more efficient, reliable, and safe is within our reach. Our optimism is derived not from theory but from our day-to-day work, which ranges from health policy leadership roles to the management of an academic integrated delivery system to hands-on patient care. From this work, we have a frontline view of the good that modern medicine can produce, but also the inefficiency, missed opportunities, confusion, and occasional harm. We see the consequences of a lack of health insurance for individual patients and understand the challenges of making coverage for all work.

Despite the magnitude and diversity of these challenges, we are optimistic because we believe that they share a common “root cause”—and that this root cause is vulnerable to attack. We in fact see signs of real progress in provider organizations around the country, including our own. Simply put, our assessment is:

- The problem is chaos
- The solution is organization
- The question is how we get there

The Problem Is Chaos

It would be good news if rising health care costs could be explained by the greed of specific individuals or companies, because then those individuals and companies could be stopped. And it would be good news if disappointing quality and lapses in safety could be blamed on the incompetence of specific physicians, because then those doctors could undergo more training or their licenses could be revoked. “Bad guys” who are greedy or incompetent do exist in medicine, of course,

but the unfortunate news is that these bad guys play relatively small roles in the creation of our crises in health care.

Indeed, the big driver of our problems is an undisputed “good guy”—progress itself, which when imposed on the fragmented U.S. health care system, produces chaos. Let us explain what we mean by progress, fragmentation, and chaos.

We are lucky to live in an era during which medical science is racing ahead, producing advances that are easily taken for granted—that is, unless you are a patient or doctor. During our careers, we have seen incurable diseases become routinely curable—like the lymphoma that was diagnosed in September 2006 in Red Sox pitcher John Lester, but eradicated in time for him to join spring training in 2007 and pitch a no-hitter in 2008. Fatal diseases like HIV have become controllable chronic conditions with a surprisingly modest impact on life expectancy. And common diseases have become preventable—like heart attacks, the death toll from which has steadily declined because of the widespread use of medications that control blood pressure and cholesterol.

We are not among those who wax nostalgic for the simpler and less costly health care of a generation ago. To be a doctor today is to know there is virtually always *something* you can do for a patient, no matter how sick he or she might be. We like that.

But to be a doctor today—or a patient—is to be overwhelmed by an explosion of new knowledge. That explosion produces multiple options for testing and treating conditions for which there were none just a few years ago. The knowledge explosion also means that giving complex patients state-of-the-art care requires multiple physicians with highly specialized expertise. These physicians need to communicate with each other, and ideally, should develop clear game plans with patients and their families.

Unfortunately, this explosion of knowledge has gone off within a health care delivery system that is poorly prepared to help physicians make the best decisions or work effectively together. Most office visits in the United States are at small practices with one or two doctors, who write prescriptions on prescription pads and store notes in paper charts. These doctors work hard, but they work in isolation, struggling to stay up to date on the best ways to help their patients. Many settle for a more modest goal: just staying one step in front of their patients, who often bring printouts from the Internet to office visits.

An even greater challenge for these isolated physicians is providing *coordinated* care for their patients—a goal that requires knowing what other doctors are doing and saying. A generation ago, these physicians might have seen each other in the hospital, and discussed their shared patients in hallways, lunchrooms, or doctors' lounges. But today there are many more doctors involved in the care of complex patients, and these doctors are frequently in different institutions. And the pace of medical life has accelerated so that these conversations occur less reliably or not at all. The doctors' dining rooms and lounges have disappeared, because no one has time to sit in them anymore.

The result is chaos. There is too much to do and not enough time to do it. There are too many people involved, and they are not actually talking to each other. There are plenty of good intentions and a lot of hard work—but there is also duplication of efforts, dropped balls, mixed messages, and poor coordination.

Patients have to answer the same questions over and over, and still wonder if their providers remember who they are. These patients find themselves confused about issues so basic that they are often embarrassed to seek clarification by asking questions such as “Who is in charge?” “What am I supposed to do next?” and “What medications should I be taking?”

The Solution Is Organization

We believe that the best way to address health care's cost and quality crises is to attack this chaos. Health care spending will inevitably rise as people live longer and breakthroughs occur, but increases can be mitigated if clinicians have help identifying the best strategies for evaluating and treating patients, and if they work in teams that help patients avoid hospitalizations and stay as healthy as possible. These teams should include physicians, nurses, pharmacists, and social workers—as well as patients themselves.

Yet teams need structure, leadership, communication tools, and “playbooks” that are understood by all involved. In short, they need organization, so that patients and their clinicians can work together efficiently and effectively.

We believe that the organization of health care should be a clear and unifying goal in discussions of how health care should be financed, and the roles of consumerism and other market forces. The afflictions of

modern medicine—high costs and disappointing quality—exist in every developed country, which suggests that the method of financing health care is unlikely to provide a solution on its own. And while we have a healthy respect for the potential influence of market forces in health care, we believe that their greatest impact comes from rewarding the performance that can only be accomplished through more organized care.

The concept of organized health care is not an abstract ideal. Around the United States, well-organized health care providers like the Mayo Clinic, Virginia Mason Medical Center in Seattle, Washington, and Geisinger Health System in Danville, Pennsylvania, are adapting management principles from non-health care industries. They strive to become “high-reliability organizations,” and use words like “guarantees” and “promises” to describe their care. Compared to the fragmented mainstream of U.S. health care, these organizations deliver care that is by many measures safer, of a higher quality, and less costly. These “tight” organizations are unusual in that their physicians are generally salaried employees of the parent company. But other organizations (including our own) are watching and learning, and are adapting their approaches for academic medical centers and providers in the community.

A patient who is seeing a physician doesn’t really care whether that physician is a salaried employee or a partner in a group practice. What matters to the patient is the quality of the doctor’s care. Thus, the organizational structure of providers is most important as the context for implementation of a range of systems that lead to the actual improvements in care, including:

- Information systems, such as electronic medical records, that help physicians make better decisions as individuals (e.g., prescribing the most cost-effective drugs) and work well in teams—because their colleagues can see what they have done.
- Team-based care, which allows practices to meet patients’ needs outside of doctor visits. One example is the use of registries to keep track of patients with diabetes, enabling a diabetes educator to contact patients who may not have come in for recent office visits.
- Disease management programs to improve the coordination of care of the sickest and most complex patients—an important approach both to improve quality and control costs, since just 5 percent of patients account for about 50 percent of health care spending.

The potential of these and other systems to improve efficiency and quality is real, but most health care providers have been too fragmented to develop such programs—or even to sign the types of contracts with health plans that would reward providers for doing so. Accordingly, health plans have stepped into the void and done what they could to supply organization to health care. In chapter 8, we describe the contributions made by health plans as well as employers and patients toward improving care through greater organization. We think these efforts are important and valuable, but their impact can be considerably enhanced if combined with organized providers who use systems to improve care.

How Do We Get There?

Our descriptions of organized health care in the second section of this book may be unfamiliar to many readers, but we doubt that its potential value will be controversial. The difficult question is, How do we get there? What policy, market, and cultural changes will accelerate the development of a better-organized, higher-performing health care system?

Our “prescription” is explained in the third section of this book. There is, of course, no single magic bullet. Instead, we believe that multiple strategies should be used with the common goal of encouraging health care providers to become participants in effective delivery organizations, and then encourage those organizations to achieve higher and higher performance.

In an ideal world and a perfectly rational health care marketplace, all Americans might get their health care within tightly structured delivery organizations in which the providers are paid not for the volume of services delivered but rather for meeting the needs of their patient population. We don’t live in such a world, however, and the spread of this ideal model has been limited by a medical culture in which physicians prize their autonomy and patients prize the option to seek care from whomever they choose—even if it is outside their “network” of providers. Tightly organized care is especially difficult to imagine in rural settings, where there are fewer providers, and they are separated by greater distances. Organized care can also be difficult to implement at academic medical centers, which attract patients with more complex illnesses, and in many cases, a strong interest in intense testing and treatment.

Despite these barriers, we should not give up on the goal of organizing U.S. health care to improve its performance. As depicted schematically in the figure below, we believe that the organizational stage of the evolution of providers (shown on x-axis) correlates with the payment methodologies that they can accommodate (y-axis). Physicians in solo practices are uncomfortable with any payment structure other than traditional fee-for-service. But at the other end of the spectrum, tightly structured organizations can assume complete clinical and financial responsibilities for a population’s care under “capitation.” Providers with intermediate organizational structures can accommodate payment methodologies with intermediate levels of risk.

For providers to move from the left to right, and for payment methods to move from the bottom to top, providers need to adopt the systems described on horizontal bars within the figure. Will such changes come

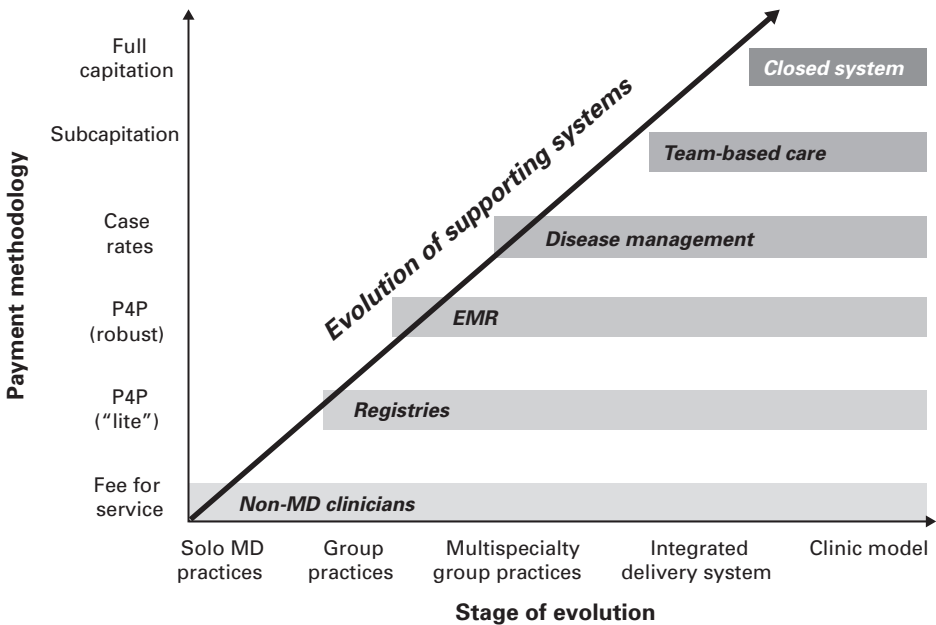


Figure I.1
Evolving reimbursement and care models. P4P = pay for performance; EMR = electronic medical records. (Reproduced with permission from TH Lee and RA Berenson, “The Organization of Health Care Delivery: A Roadmap for Accelerated Improvement,” in *The Health Care Delivery System* [Washington, DC: Center for American Progress, 2008], available at <http://www.americanprogress.org/issues/2008/10/pdf/health_delivery_full.pdf>)

through gradual evolution? Or will they come through revolution—that is, abrupt and drastic change in the payment system? We believe there is a middle road, in which the organization of the provider world can be accelerated without the massive disruptions to care that would be inevitable with sudden major changes in payment methodology. In the third section of this book, we describe how progress of our health care marketplace toward the upper right corner of the figure can be accelerated through the thoughtful use of multiple strategies including public reporting, the flexible use of multiple payment models, and more than a little strong leadership from the provider community.

At its core, this is an optimistic book. In our youths, we were drawn to health care because we believed that medicine could improve the lives of patients. We remain confident in that belief today, and find ourselves similarly hopeful that the progress we see around the country and within our own organization signify that better health care is coming. That health care will be more efficient, more reliable, and safer, because clinicians are using systems that help them make the right decisions, and work more effectively with patients and each other.

How health care is financed is important. How market forces are activated is crucial. Yet we believe the influence of these approaches will be exerted through their ability to catalyze the organization of health care providers—in short, less chaos, more organization. Our hope is that this book will help shift the balance in the right direction.