CHAOS AND ORGANIZATION IN HEALTH CARE pdf

1: Chaos and Organization in Health Care : Thomas H. Lee :

But in Chaos and Organization in Health Care, two leading physicians offer an optimistic prognosis. In their frontline work as providers, Thomas Lee and James Mongan see the inefficiency, the missed opportunities, and the occasional harm that can result from the current system.

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Center for American Progress,], available at Introduction xv through gradual evolution? Or will they come through revolutionâ€" 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. 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. How market forces are activated is crucial. Our hope is that this book will help shift the balance in the right direction. When she was younger and still teaching William Shakespeare to college students, she knew she was a forceâ€"a passionate, sometimes intimidating teacher who knew how to make her points. Today, she remains imposing. SC leans toward her listeners as she speaks, and they tend to lean ever so slightly backward. In the last few years, she has been diagnosed with three different cancersâ€"chronic lymphocytic lymphoma, then skin cancer, and then lung cancerâ€"and she suffers real aggravation every day from a long list of other conditions, including asthma, arthritis, heartburn, gout, high blood pressure, and hay fever. As bad as those problems might be, SC is most troubled by the strange and scary spell in when she lost her memory. For several hours, she could walk, talk, and thinkâ€"but she could not record new memories. People told her things, and the thought was instantly gone. She asked her partner the same questions over and over. And then, as mysteriously as it began, the spell was over. At the time she thought she was having a stroke. She has not had any recurrences, but she remains unnerved by the episode. Every day, she reads the New York Times and scours legal notices in the local paper for items relevant to her favored causes. But now she also uses the Internet to research her medications and diseases. The work of communicating with those doctorsâ€"and trying to get them to communicate with each otherâ€"sometimes seems a full-time job. SC has a primary care physician and an allergist in the Rhode Island city where she lives. In , she was admitted to the hospital for a total knee replacement, and in , she had two procedures to diagnose and remove her lung cancer, and a third for a bladder problem. During that year, she underwent CT scans of her abdomen, chest, and pelvisâ€"twice for each test. SC takes a lot of medications. She gets chemotherapy for her lymphoma, and takes six medications for her asthma and an annoying cough. She uses other drugs for her arthritis, heartburn, gout, high blood pressure, and hay fever. With all these doctors ordering all these drugs and tests, the risk for confusion seems overwhelming. So far, such problems have been relatively rare, in part because she is such an active and intelligent participant in her own care. Inevitably, though, chaos sometimes creeps in. Her Boston physicians might repeat a test already done in Rhode Island, because it is easier to duplicate the test than track the results down. A medication prescribed by one doctor has a potentially dangerous interaction with a drug prescribed by another. Each specialist tells her that the Chaos 5 cough is not due to a problem in his or her area; no one addresses her issue. In many ways, her medical story captures what is so right about U. Without all those doctors, tests, and prescriptions, her problems would surely be worse. She would probably not be alive at age eighty, let alone reading the New York Times and making local politicians squirm. She feels like her medical care is a train that could go off the tracks at any time if she relaxes her guard. But like most patients, SC does not know what she or anyone else can do to assure that nothing slips through the cracks. Failing Grades The chaos that threatens the care of this patient and so many others may not be apparent from the statistics that describe the U. But the cumulative impact of the problems experienced by individuals like her is a health care system that is the most expensive in the world, yet so far from what one would expect in safety and reliability. Concern that the U. The enduring image from that report was of a airplane full of patients dying every day because of preventable medical injuries. The second report, released the next year, was titled Crossing the Quality Chasm [2]. In the years since, the gap between the health care we expect and what we actually receive has been characterized in painful detail. For about half of these people, the researchers obtained their actual medical records. Just 66 percent of recommended immunizations and 69 percent of recommended drugs were given, and patients with breast cancer received only 76 percent of recommended care interventions. The weakest area was counseling or educating patients, which medical records suggested occurred only 18 percent of the times when it would be expected. One would expect that many medical interventions should be about as routine as airplane pilots putting down landing gear as they approach the ground, but here are the frequencies with which they actually occurred in the McGlynn study: But the results have been meticulously reviewed, Chaos 7 and if anything, they understate the real gaps in quality. The good newsâ€"bad news story turns out to be that poor or nonwhite people have not cornered the market on mediocre health care. Whites were actually slightly less likely to receive recommended interventions than blacks or Hispanics. People with college or graduate school degrees received 56 percent of the interventionsâ€"about the same as the 55 percent rate for those who did not complete high school. The difference in quality experienced by these two types of patients was trivial compared to the gap between ideal care and reality. These two people might never cross paths in U. Instead of comparing U. Think of this approach as grading the U. Using this approach, the performance of the U. Compared with other countries, U. But there are two other major types of errors that are of comparable social concern. Although physicians may not set out to give treatments of little value to their patients, after-the-fact reviews of cases suggest that as many as one-third of some medical interventions may be clinically inappropriate [7]. An example is an allergic reaction to penicillin in a patient with a known allergy to this class of antibiotic. Concern about overuse is driven by rising health care costs, while worries about misuse rise with each press report of patients who receive the wrong drug, have surgery on the wrong site, or have treatment complications that might have been foreseen and prevented. For patients, the impression that U. Perhaps because these challenges seem so formidable, health care leaders tend to specialize in one or at most two of these areas, as if they were separate battles to be fought. Responsibility for patient safety, cost reduction, and clinical quality improvement in hospitals may be assigned to three different people. The wisdom and effectiveness of this division of labor are uncertain. A credible case can be made that these problems share the same root problem: The Overwhelmed Physician Although medicine has advanced rapidly in recent decades, the daily lives of many physicians have changed surprisingly little. They write by hand Chaos 9 usually orders for the tests to be performed and treatments to be delivered that day. They write prescriptions for medications on paper prescription pads. In between patients, they make or take calls from patients, pharmacies, and colleagues. Then at night they carry home a stack of paperwork to be completed by the next day, when the cycle begins anew. Rising from bed in the middle of the night is just one more way in which physicians convey their commitment to patients. Indeed, appearing gaunt and exhausted has never been a professional liability for physicians. Dedication is an expectation with which most physicians remain comfortable; more problematic is the related assumption that they are also all knowing. Of the hours in a week, medical students and young physician trainees might spend 40 of them asleep, and devote virtually all the rest of those hours to learning their craft. At the end of their training, they assume a status in which their orders and advice are rarely questioned. The special role of physicians as all-knowing healers is sustained partly because many patients harbor hopes that their doctors have near-magical powers. But a comparable percentage want to call their physicians by their title and last name e. Smith , just as they also want their physicians to wear white coats [9]. First-year medical students at over a hundred U. According to the U. National Library of Medicine, there were , new articles that were indexed in in its database called MEDLINEâ€"about twice as many as the , new articles published back in the Dark Ages of [10]. Around the country, attendance at hospital teaching conferences is in decline, and subscriptions to medical journals have fallen off. Many older physicians still struggle to stay current with medical science by continuing these time-honored educational activities, but younger physicians know that the game has changed. Even with all these resources, physicians are increasingly aware that as individuals, they cannot know everything they need to deliver state- Chaos 11 of-the-science care, particularly for more complex patients with diseases of multiple systems. One direct result of the growth of medical knowledge is thus the emerging importance of specialty care e. At many academic medical centers, specialists focus on one problem and one problem only. For example, cardiologists are divided into experts on arrhythmia, heart failure, coronary disease, or prevention. All this superspecialization is wonderful when the right patient gets to the right doctor. If you have multiple myeloma, you probably do want to have a doctor whose professional life is completely focused on that disease. Having such a physician will increase the chances that you get the most current therapy, and that he or she will recognize unusual complications or developments right away. For occasional patients, having that superspecialist might be the difference between survival and premature death. On the other hand, the superspecialization of medicine can cause new challenges for patients and clinicians. One is that sick patients often have to see multiple physicians, particularly if they have multiple diseases. In her case, the physicians all used the same electronic medical record EMR , but 20 percent of U. If her physicians had not all been at one institution, what are the chances that each of them would have known what the others were doing and thinking? These specialists may be extremely competent in their narrow area, but extremely uncomfortable outside of it. Conversely, doctors who want to be generalists, such as internists and other primary care physicians, are doomed to knowing less and less about more and more, until they know nothing about everything.

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3: Project MUSE - Chaos and Organization in Health Care

The central argument of this book is that the organization of providers is an essential step in the development of a better health care system. Organization enables providers to bring order to the chaos generated by technological progress.

Additional Information In lieu of an abstract, here is a brief excerpt of the content: Change is needed in health careâ€”and change is under way. With increasing frequency, physicians and nonphysicians are working in teams that coordinate the care of the most complex patients and those with chronic diseases. These changes are being driven by demographic shifts, technological advances, and the demands of an increasingly sophisticated public. The changes are also reinforced by the imperative to deliver state-ofthe -art medicine to sick patients. We see these changes playing out in our own organization and in others around the country. The changes require busy physicians to reconsider their culture and learn new skills. This natural evolution toward a better health care system is encouraging , but are the changes coming quickly enough? For patients and the parties paying for health care, the answer is clearly no. Our rate of organizational improvement is not Chapter 9 keeping pace with the need. If there is a race between chaos and organization, chaos is winning. Although these pressures have been building for decades, a new sense of crisis has emerged. Patients do not understand why their doctors and hospitals cannot remember who they are. They are unsettled when confronted with evidence that their physicians are not really in touch with each other. Patients and the organizations paying for health care want a revolution. They are demanding lower health care costs. Many call for insurance premiums to rise no faster than the consumer price index about 3 percent versus the 9 to 12 percent annual increase in health care premiums most employers have experienced in recent years. They want a health care system that gives patients the care and information that they want, whenever they want it. And they want that better health care system right now. Steady incremental progress or abrupt drastic change? We think there is a middle road that may be more likely than either extreme to produce the improvement needed in health care delivery. Why the Capitation Revolution Failed Calls for change in health care often begin and end with proposals for the transformation of the payment system. To spur the development of that better delivery system, logic would dictate that we need dramatic change in the payment system. Thus, there are two common themes in payment reform proposals. In a prospective payment system, physicians and hospitals pay a price if too many tests are performed or too many high-cost medications are prescribed. The second is to use other levers direct You are not currently authenticated. View freely available titles:

4: Download Chaos And Organization In Health Care

But in Chaos and Organization in Healt The size of the system, the number of stakeholders, and ever-rising costs make the problem seem almost intractable. But in Chaos and Organization in Health Care, two leading physicians offer an optimistic prognosis.

5: Chaos and Organization in Health Care by Thomas H. Lee

Refreshingly frank, non-partisan, and easy to read, Chaos and Organization in Health Care takes on this challenge and lays out a vision for how our system can achieve integrated care. Lee and Mongan are not afraid to take on the sacred cows of the delivery system and they do so in an entertaining way.

6: Chaos And Organization in Health Care |authorSTREAM

The needs for health system change and improved patient safety have been pointed out by policymakers, researchers, and managers for several decades.

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