Second Edition

Advances in Health Care ORGANIZATION THEORY

Stephen S. Farnsworth Mick and Patrick D. Shay
EDITORS

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Stephen S. Farnsworth Mick

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Patrick D. Shay

THE EDITORS

Stephen S. Farnsworth Mick is professor in the Department of Health Administration at Virginia Commonwealth University. He is the former departmental chair and holder of the Authur Graham Glasgow Endowed Chair. He received his BA degree in psychology (1965) from Stanford University and his MPhil (1972) and PhD (1973) degrees in sociology from Yale University. Mick taught sociology at Middlebury College; he also taught public health and health care organization and management at Yale University, Oklahoma University, the University of Washington, the Johns Hopkins University, and the University of Michigan. He is an affiliate professor at the Jean Moulin University Lyon 3, in Lyon, France.

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Patrick D. Shay is assistant professor in the Department of Health Care Administration at Trinity University in San Antonio, Texas, and a doctoral candidate in the Department of Health Administration at Virginia Commonwealth University. He received his BS degree in business administration (2003) and MS degree in health care administration (2005) from Trinity University. Shay has taught health care organization and services at Virginia Commonwealth University. Before his doctoral studies, he worked as a health care administrator for a post–acute care system in Texas.

THE CONTRIBUTORS

Jane Banaszak-Holl is a visiting scientist at Manchester Business School and the University of Aberdeen in the United Kingdom. She is associate professor in the Department of Health Management and Policy at the School of Public Health and associate research scientist in the Institute of Gerontology at the University of Michigan.

James W. Begun is James A. Hamilton Professor of Healthcare Management in the Division of Health Policy and Management at the School of Public Health at the University of Minnesota.

S. Diane Brannon is professor in the Department of Health Policy and Administration in the College of Health and Human Development at the Pennsylvania State University.

Steven B. Clauser is chief, Outcomes Research Branch, and acting chief, Health Services and Economics Branch, Applied Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute.

Roberto Dandi is assistant professor of management at the LUISS Guido Carli University.

Thomas D'Aunno is professor in the Department of Health Policy and Management at the Mailman School of Public Health at Columbia University.

Mary L. Fennell is professor in the Department of Sociology at Brown University, and in the Department of Health Services Policy and Research. She is director of the CV Starr Program in Business, Entrepreneurship and Organizations.

Timothy Hoff is associate professor of management, health care systems, and health policy in the D'Amore-McKim School of Business, Northeastern University.

Timothy R. Huerta is associate professor in the Department of Family Medicine and Biomedical Informatics, College of Medicine, The Ohio State University.

Rosalind E. Keith is a researcher at Mathematica Policy Research in Princeton, New Jersey.

David Knoke is professor in the Department of Sociology at the University of Minnesota.

Roice D. Luke is emeritus professor in the Department of Health Administration, School of Allied Health Professions, Virginia Commonwealth University.

Miriam Plavin-Masterman is a doctoral candidate in the Department of Sociology at Brown University.

Pri Shah is associate professor in the Center for Human Resources and Labor Studies at the Carlson School of Management at the University of Minnesota.

Marcus Thygeson is vice president of Medical Services, Blue Shield of California.

Katie M. White is assistant professor in the Division of Health Policy and Management at the School of Public Health at the University of Minnesota.

Douglas R. Wholey is professor in the Division of Health Policy and Management at the School of Public Health at the University of Minnesota.

Xi Zhu is assistant professor in the Department of Health Management and Policy at the College of Public Health at the University of Iowa.

Jacqueline S. Zinn is professor in the Department of Risk, Insurance, and Healthcare Management at the Fox School of Business at Temple University.

CHAPTER 1

INTRODUCTION: EVENTS, THEMES, AND PROGRESS

Stephen S. Farnsworth Mick
Patrick D. Shay

The chapters in this second edition of *Advances in Health Care Organization Theory* are original essays in the broad realm of **organization theory** applied to **health care organizations**. In the first edition of this book, the authors explored what could be gleaned from the 1990s to inform and update organization theory in health care. The same pattern and goal applied to the *Innovations in Health Care Organizations* (Mick and Associates, 1990): chapter authors probed the events of the 1980s to determine what new might be written about organization theory as it was informed by the events of that time.

We feel the need for a third in a series of books exploring the evolution of organization theory in the health care sector because organization theory in health care remains a work in progress. Although the field is highly developed outside health care and is routinely applied in business and commercial organizations, advances in organizational analysis in health care have lagged behind the general field. This situation exists for a complicated set of reasons.

First, and perhaps most important, studying the health care sector is not a discipline-based activity. The field draws from an eclectic group of disciplines: economics, sociology, organization theory, political science, social psychology, law, engineering, and public health, not to mention all the clinical areas. In short, there has never been, and there

LEARNING OBJECTIVES

1. Understand why advances in theoretically based organizational analysis in health care have lagged behind the general field.
2. Identify the environmental and market forces transforming health care in the United States during the early 2000s.
3. Understand the utility of organization theory to explain how changes and pressures in health care influence notions of how organizations and their environments are interrelated.

organization theory
An abstract systematic explanation of the causes and consequences of different organizational forms and designs.

health care organizations
An organization, usually licensed by state or federal government, that delivers health care, primary, emergency, acute, or long term in nature.

is not likely to be, a single discipline that can claim to represent a full understanding of what goes on in health care. The organization of health care services is an applied area that invites multiple perspectives.

Second, the study of organizations, including health care organizations, has historically been concentrated in sociology departments and, to a lesser extent, business school management departments. It has taken a long time for this focus to find its place in what might be a more natural home of departments of health administration or departments with similar titles. This has had the effect of retarding the progress that might have been made in this field.

Third, and a corollary to the preceding point, within sociology departments, there has often been a disjunction between "medical" sociology and the study of organizations. In the past, medical sociology concentrated more on sociological factors behind need and use of services, correlates of disease and illness, the professions in health care, and the like. The study of organizations was generally set apart from the medical context. So even in the context of sociology departments, there was not much of an integration of medical sociology and health care organizations, with some notable exceptions (e.g., W. Richard Scott at Stanford University and A. B. Hollingshead at Yale University). Taken together, the field developed in a somewhat haphazard way.

Fourth, departments in which health management has been and is taught are relatively new on the academic scene. Most developed only after World War II, and of those, the majority were not established until after the 1970s and 1980s. In short, there have not been many academic homes for prolonged and deep study of health care organizations.

Fifth, active or retired administrative practitioners in the field dominated the initial faculties of health administration departments. Very few academics were involved in the original units, and because of that, the field was imprinted by the practitioners' perspectives emphasizing management practice, case analyses, and an operational focus. With some exceptions, the empirical and theoretical foundations of health care organizational analysis were largely absent when the field was begun.

Sixth, given the relatively recent emergence of academic homes in which health care organizations received specific study and given the dominance of practitioner-oriented faculties, there were few doctoral programs that trained future academics in the subject matter. Most faculty came, and often still do come, from sociology departments and business schools. Many of the first generation of academics interested in health care had no formal training in health care management or even broader health policy. It has taken time for a cadre of people trained in health care management to be educated in the field. Even today, there are few doctoral-level programs

in health care or health services research that even offer training in organization theory and analysis.

Seventh, the dominance of health economics as the central health policy discipline in health care has had the effect of pushing organizational analysis to the sidelines. This is in part because the organization sui generis is regarded as a black box, which is of less interest than the **market forces** affecting it. Today this circumstance is changing due to rising interest in what goes on inside that black box spurred by the patient safety and quality movement that began in earnest with the Institute of Medicine's publication of *To Err Is Human* (1999). Nevertheless, the sometimes profoundly different view of organizations that economics and organization theorists hold, combined with the dominance of the former over the latter in the policy realm, has had a chilling effect.

market forces
The interplay of supply and demand on price and quantity of products and services.

These various and interrelated forces have combined to stunt the growth of theoretically based organizational analysis in health care. This history is a powerful one, and the forces that have existed are difficult to overcome. That is why we continue to offer a book like this, the third in a sequence of volumes that review various areas where organization theory has made interesting and pertinent advances in understanding health care. Despite the slowness of the health care arena in appreciating the strength and insight that organization theory can bring to it, some of the most pressing issues in health care—patient safety, quality, access, and efficiency, among others—are at least in part organizational issues. And, organizational analysis should be able to contribute to their clarification and possible improvement.

So our work continues with this collection of essays in which we explore the first decade of the 2000s to see what new developments and thoughts can be gleaned from changes and events beginning roughly around 2000 through 2012, including the historic passage of the Patient Protection and Affordable Care Act of 2010. Although the span of a decade is a totally arbitrary chopping up of time's arrow, it does provide discrete boundaries for consideration of new twists and turns, some striking, some not, in the health care system that allow holding constant enough of the health care background so that new or renewed perspectives on its organizations can be described and studied.

As readers will discover in chapter after chapter, the first decade of this new century was packed with changes and challenges that we believe have profoundly altered the landscape of organization theory and organizational analysis in health care. Each chapter is testimony to this claim, and readers are invited to see for themselves if they agree. We also note that this book focuses almost exclusively on the United States. This choice is deliberate. The American experience is complicated enough in itself to warrant such

close attention, and many of its institutions are peculiar enough that we felt that this limit was justified. However, we also believe that, with imagination, readers might see cross-national similarities and applications not explicitly developed here. We are aware that by limiting the national context of the chapters in this book, we may also be limiting the generality of what we have written. That said, we continue to hope that we do add to our cumulative knowledge of health care organizations.

Environmental and Market Changes in Health Care in the 2000s

Characteristics of the health care environment of the early 2000s caused many of us to revamp our notions of how organizations and their environments interrelated. These characteristics include continued consolidation of freestanding hospitals into local, regional, and national systems; the proffering of new forms of office-based medical practice such as the patient-centered medical home and accountable care organizations; continued advances in information technology; the establishment of widely available data online on hospital, nursing home, and home health care performance; medical advances in genomics allowing for individualized care; major legislative efforts to increase access to prescription drugs (the Medicare Modernization Act of 2003) and decrease the number of uninsured (the Patient Protection and Affordable Care Act of 2010); the prominence of research and practice advances in the promotion of quality of care and patient safety; the tentative steps to reimburse medical and hospital care based on outcomes performance measures; the awareness of the American public of its vulnerability to natural and man-made disasters stemming from both Hurricane Katrina and the terrorist attacks on New York City's World Trade Center towers and the Pentagon in Washington, DC.

All the while, health care expenditures over the period 2000 to 2010 grew from $1,377.2 billion to $2,593.6 billion, an increase of 88 percent, and per capita spending increased from $4,878 to $8,402 (A. Martin, Lasssman, Washington, Catlin, and the National Health Expenditure Accounts Team, 2012). Although it is true that this growth slowed appreciably during the latter part of the 2000s due to the economic recession, it is also true that these expenditures were at an all-time high in 2009 and 2010 as a percentage of gross domestic product: 17.9 percent (A. Martin et al., 2012). Yet even with this extraordinary level of expense, the US health care system performed at a subpar level compared to most other industrialized nations (K. Davis, Schoen, and Stremikis, 2010). For example, "amenable mortality" rates (i.e., premature death from causes that should not occur if timely and effective health care is rendered) for the United States lagged behind fifteen

other developed nations, and although the trend for the United States was improving, it was not doing so at the rate of most comparable nations (Nolte and McKee, 2011). The apparent contradiction of relatively poor system performance and high per capita health expenditures is perhaps the most disconcerting characteristic of the context within which the following major movements and changes occurred in the 2000s.

Legislation and Regulation

The new millennium began with the health care sector still experiencing the effects of the Balanced Budget Act of 1997 (BBA) and its subsequent refinement, the Balanced Budget Refinement Act of 1999 (BBRA). In an effort to limit rampant growth in Medicare spending, these influential laws brought significant reductions to hospital Medicare payments, introduced Medicare+Choice as a program to receive Medicare benefits through private providers, and scheduled the staggered introduction of prospective payment systems (PPSs) for hospital outpatient services (in 2000) and individual post–acute care settings, including skilled nursing facilities in 1998, home health agencies in 2000, and inpatient rehabilitation facilities and long-term acute care hospitals in 2002. The BBA also included the State Children's Health Insurance Program (SCHIP), constituting a dramatic increase in health insurance coverage for children that extended into the 2000 decade.

Within the health services research community, the years following the passage of the BBA and BBRA witnessed frequent studies of these laws' impact on health care organizations, health care spending, and health care utilization. Common findings included hospital efforts to shift costs (Wu, 2010), as well as internally to contain costs and expand provision of outpatient services (Bazzoli, Dynan, Burns, and Yap, 2004). Following the implementation of SCHIP, the number of uninsured children dramatically decreased as enrollment in public insurance simultaneously increased, yet SCHIP's impact on the health status of children remains in question (Howell and Kenney, 2012; Dubay et al., 2007; Hudson, Selden, and Banthin, 2005). The gradual implementation of PPSs for individual post–acute care settings was also observed to reduce utilization and spending on specific post–acute care settings as each setting's respective PPS was introduced (Buntin, Colla, and Escarce, 2009).

In addition to providers' continued adjustments to the BBA and BBRA at the turn of the century, they also scrambled to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The impact of HIPAA throughout the first decade of the 2000s has included significant and potentially burdensome expenditures by

providers to ensure compliance as well as the advancement of privacy and technology throughout the health care sector (Kilbridge, 2003; Lageman and Melick, 2001).

In 2003, President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), a sweeping overhaul of the Medicare program that made available prescription drug benefits to beneficiaries, replaced the Medicare+Choice program with Medicare Advantage plans, and promoted health savings accounts as a means to motivate consumer direction in health care utilization. Early evidence of the MMA's benefits included an increase in the use of prescription drugs coupled with a decrease in beneficiaries' costs for prescriptions (Lichtenberg and Sun, 2007) as well as reduced health care spending through consumer-directed health plans (Wilensky, 2006). However, these positive results were soon dimmed by criticism from studies indicating a limited ability of health savings accounts to control medical spending (Feldman, Parente, and Christianson, 2007), as well as questions as to the law's effects on quality (Gold, 2009; Buntin et al., 2006). Furthermore, the MMA suffered considerable criticism for its complexity, adding additional uncertainty and confusion to the health care sector (Doherty, 2004). Both sides of the political spectrum expressed degrees of dissatisfaction with the MMA: conservatives voiced their displeasure with the added costs to the Medicare program, and liberals denounced the expanded role of the private sector in Medicare health plans. These partisan stances continued to play a role in health care legislation throughout the remainder of the decade and were particularly felt during the debate and passage of health care reform in 2010.

In Massachusetts, Governor Mitt Romney enacted unprecedented state health care reform in 2006, requiring state residents to maintain health insurance coverage. The legislation quickly contributed to a marked drop in the state's uninsurance rate and improved access to care, yet the law's expenses were higher than advertised and failed to adequately address rising health care costs (Long and Stockley, 2010; Long, 2008; Steinbrook, 2008). At the same time, the health reform introduced in Massachusetts served as a model for the reform that would be introduced to the nation in 2010. In fact, many of the challenges faced by the Massachusetts law—including how to define affordability, implement an individual insurance mandate, work with employers to ensure coverage, and account for the reform's costs and financing (McDonough et al., 2008; Holahan, 2006)—are the same challenges faced by the Patient Protection and Affordable Care Act, which leads us directly to the federal legislation itself.

The Patient Protection and Affordable Care Act (PPACA) of 2010 is unquestionably the most important legislative and policy-relevant reform of the decade and probably the most important potential change to health care

since the enactment of Medicare and Medicaid in 1965. After weathering initial threats of repeal and replacement, the future of the PPACA is now certain: with the reelection of President Barack Obama and the US Supreme Court's upholding the constitutionality of much of the PPACA, the health care sector now confronts the implications of this act. Due to poor organization and faulty computer procedures, there have been widely publicized difficulties of operationalizing the health care exchanges in which insurance options are offered to uninsured applicants. Delays in implementation of several aspects of the PPACA have also arisen, and the consensus among both supporters and detractors of the law is that its implementation has been less than ideal. Nevertheless, by the beginning of 2014, many of the start-up problems had been resolved, and over 6 million previously uninsured people had signed up for health insurance.

The most immediately understandable consequences of the PPACA are now apparent. First, there will be a reduction in the size and proportion of the uninsured population in the United States. Estimates vary, but most projections suggest that the proportion of the uninsured should drop from roughly 17 percent to 7 percent by 2019, representing an increase in the number of insured of approximately 34 million individuals (Foster, 2010). This increase will produce new demand for health services, which could have implications for the service capacity of the nation's health services organizations, the health workforce, and all related organizations and lines of commerce. If uncompensated care is dramatically eliminated, then questions will be raised about the role of nonprofit delivery organizations and their historical tax exemption.

From a variety of perspectives, the PPACA has game-changing potential, with ramifications for numerous parties, including payers, patients, physicians, the pharmaceutical industry, and the medical device industry, to name a few. The reform includes expanded insurance coverage for US residents, strict rules for insurance companies to follow in their provision of coverage and adherence to medical loss ratio targets, reduced Medicare spending, support for medical education and training programs, and the development of several innovative payment and service models to promote cost containment and care coordination, including accountable care organizations, patient-centered medical homes (an approach to primary care delivery emphasizing coordination and teamwork among health practitioners to improve patient access, quality, and outcomes), and bundled payment programs, not to mention the role of safety net organizations such as free clinics.

Although the principal focus of the legislation is the elimination of a large portion of the uninsured, perhaps of most interest to organization theorists is the effort to influence the organization of care delivery, mostly

through the mechanism of so-called accountable care organizations (ACOs). These organizational forms are supposed to combine provider payment and delivery system reforms. The payment reform aspect would consist of performance-based reimbursement approaches and possibly bundled payments as well as shared payer-provider risk models (Delbanco et al., 2011), which combine hospital and physician reimbursement. The organizational reform aspect would allow a flexible melding together of various delivery components depending on local market circumstances so long as three preconditions are met: (1) the provision of a continuum of care that includes at least ambulatory and inpatient care, and possibly post–acute care services; (2) the capacity to develop, implement, and monitor prospectively planned budgets; and (3) sufficient size to be able to report comprehensive, valid, and reliable performance measurement across a wide variety of organizational and clinical activities (Devers and Berenson, 2009).

This portion of the PPACA is voluntary: no organization is required to partake in this program. But recent data suggest that at least three hundred organizational entities have responded positively to the incentives and requirements posed by the ACO component of the act (H. Meyer, 2012), and it appears that there is no singular organizational form that dominates the entities that have responded. In fact, advocates of the ACO have themselves proposed widely varying organizational arrangements as possible ACO participants, with arrangements covering a spectrum of highly decentralized contractual arrangements to more organizationally centralized systems such as a staff or group model health maintenance organization (Shortell and Casalino, 2007). A major question will be whether there is a correlation between certain types of ACOs and desired performance, an issue that will probably become a major policy research focus. Some early results suggest that ACOs may reduce costs and improve quality of care, but there is as yet no discernible trend for ACOs generally (Salmon et al., 2012).

Looking ahead, the nation awaits the intended and unintended effects of the PPACA. Supporters of the legislation have heralded its potential to strengthen the nation's primary care system, improve the coordination and quality of care provided to patients, reduce health care spending, and address many of the health care system's ills. Those who are skeptical of its long-term impact may point to hurdles that reform efforts will have to overcome, including the need to remedy the imbalance between primary and specialty care, the development and organization of health exchanges at the state level, the cooperation of stakeholders to adopt or comply with elements of reform, and the need to increase the health care system's capacity to care for an influx of insured Americans. Despite its promise of addressing a broken US health care system, numerous questions remain:

Will the PPACA realize such lofty potential and truly have an impact in the long run? Will reform efforts succeed at bending the cost curve? Will innovative payment and service models be enthusiastically embraced by patients and providers, or will they be viewed as new wine in old bottles of managed care and integrated delivery systems? Will diverse stakeholders set aside their focused, competing interests and collaboratively work to support meaningful health care reform, particularly in the midst of a contentious and hyperpartisan political environment? The singular sentiment resulting from these many questions is that much uncertainty remains for the future of the US health care system as it anticipates the effects, intended and unintended, of sweeping reform (Doherty, 2010; Monheit, 2010).

The PPACA is not the only important legislative change under the Obama administration. Following his inauguration, two important pieces of health care legislation marked 2009: the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. By reauthorizing SCHIP, CHIPRA extended and expanded coverage for uninsured children and pregnant women while additionally establishing provisions to improve the quality of pediatric care and promote the incorporation of health information technology. Similarly, in an effort to both encourage and enforce the adoption of health information technology, the HITECH Act offered initial incentive payments as well as eventual financial penalties related to hospitals' and physicians' implementation and meaningful use of electronic health records. The aim of this legislation is to encourage widespread adoption of electronic health records and thereby improve the quality, coordination, and efficiency of care delivered throughout the US health care system, simultaneously prompting health care organizations one step further down the aisle in their marriage to health information technology while issuing needed tools to renovate an industry striving to improve its care to patients.

Other Events and Environmental Changes

The introduction and impact of legislation and regulation are only one piece of the US health care industry's story during the first decade of the twentieth century. In many ways, such legislation and regulation were the result of and reaction to numerous events and environmental changes that had already developed.

Disaster Planning and Preparedness

Since 2000, the United States has faced a collection of disasters and emergencies that have shaken the nation and challenged the health care sector

to reconsider how it prepares for the worst. Some of the most notable disasters were the terrorist attacks on September 11, 2001; Hurricane Katrina in 2005; and the H1N1 influenza outbreak in 2009. Collectively these events revealed weaknesses in the infrastructure of delivery organizations and communication across the disaster preparedness community network, and the health care sector and its members have learned from the past successes and failures of providers' emergency responses. Over the past decade, industry, government, and individual health care organizations have gained a better understanding of the importance of disaster preparedness and now stand better equipped to face future threats (Inglesby, 2011; Sauer et al., 2009). At the same time, such events have also highlighted the importance of a health care delivery system that promotes primary care, emphasizes prevention and wellness, ensures access to necessary care, and harnesses the latest health information technology (Lurie, 2009).

Scrutiny of Business Practices

The decade also witnessed heightened concern about business practices across health care organizations. Such practices include compensation of health care executives, direct-to-consumer advertising by pharmaceuticals and medical device companies, hospitals' aggressive billing tactics, and nonprofit hospitals' provision of community benefits and charity care in exchange for tax exemption. From discovery of fraudulent behavior at HealthSouth and Tenet Healthcare to government probes into business practices at HCA and Select Medical, some of the biggest health care organizations have had to defend their conduct, repair their reputation, and assure the public that patient care, not patients' dollars, is their first priority.

Consolidation into Systems and Clusters

The consolidation of freestanding hospitals into multihospital systems during the 1990s has been well documented, serving as an example of widespread horizontal integration throughout the hospital industry. At the turn of the century, health services researchers began to evaluate the impact of such consolidation, finding that the benefits of horizontal integration included improved financial standing and performance for hospitals, while negative effects included consolidated market power and increases in prices (Bazzoli et al., 2004a; Cuellar and Gertler, 2005). Some industry observers called for increased examination of hospital systems organizing at the local market level, including subsystems of national hospital chains (Luke, 1991, 2006; Cuellar and Gertler, 2003). These local hospital systems, also referred to as clusters, were observed to strategically dominate their markets over the course of the decade, becoming the main health care organizational entities

at the local level. Despite their power, their impact on efficiency and quality of care has remained in question. Cuellar and Gertler (2005) found that hospitals' consolidation into local systems failed to improve the efficiency or quality of care delivered, although Luke, Luke, and Muller (2011) later observed some evidence of steps toward improved quality and coordination while acknowledging much room for improvement. Notwithstanding the emergence of local hospital-based clusters as a prevalent organizational form, these entities have been understudied to date, and more research is needed to assess their characteristics, performance, and impact on markets and patient outcomes (Sikka, Luke, and Ozcan, 2009; Luke, 2006).

Health Care Financing and Reimbursement Trends

The first decade of the century also witnessed dynamic perspectives and practices about how health care should be financed and reimbursed. At the turn of the century, industry observers declared "the end of managed care" as a strong public backlash grew out of widespread criticism and distrust of managed care's control of access to services (Mechanic, 2001; Robinson, 2001). Despite evidence of its economic effectiveness, managed care failed in large part due to its dismissal of patients' preferences. As a result, insurers' attention quickly turned toward the consumer and ways to influence consumer behavior (Robinson, 2004).

Consumer-directed health plans (CDHPs) emerged as the next highly touted product design, attempting to control rising costs while preserving patient discretion. These plans typically combined high-deductible insurance policies with health savings accounts (HSAs). Although CDHPs enjoyed strong interest and the support of the George W. Bush administration, others feared potential consequences, including the aggravation of socioeconomic, racial, and ethnic disparities in the US health care system (Bloche, 2007), as well as the promotion of commercial ethics over professional ethics in the patient-physician relationship (Berenson and Cassel, 2009). Some also expected CDHPs to move the US health care system further toward personalization and privatization (Robinson, 2005). Following their introduction, evidence of the impact of CDHPs on medical spending was mixed, with some findings revealing reduced costs (Buntin et al., 2006; Lo Sasso, Shah, and Frogner, 2010) whereas others yielded little support for an association between CDHPs and lower expenditures (Feldman, Parente, and Christianson, 2007; Buchmueller, 2009). Mixed results were also obtained in terms of CDHPs' impact on quality of care (Buntin et al., 2006). Robinson and Ginsburg (2009) suggest that the story of consumer-driven health care mirrors that of managed care in the 1990s, noting that as the first 2000 decade progressed, CDHP forms were altered

from their original vision and evolved to the point where they failed to meet supporters' ultimate aspirations while avoiding the realization of detractors' worst fears. Today, preferred provider organizations (PPOs) are the most popular health insurance product and combine ideals from both managed care and consumer-driven health care (Christianson, Ginsburg, and Draper, 2008; Robinson and Ginsburg, 2009).

Advances in Technology

Each generation and each decade experiences what it believes is "technological revolution." Change that occurs because of technological progress is not unique to any single period of time. Yet each epoch has its unique advances. In the first decade of this century, the health care sector experienced enormous increases in Internet use, particularly in consumer access to information and health education. Any number of Internet-based sources of hospital and health plan performance developed, notably The Centers for Medicare and Medicaid Services Hospital Compare program (www.hospitalcompare.hhs.gov/).

Technological advancements brought change not only to patients' behaviors and their access to information; health care providers were profoundly affected as well. Physicians' and hospitals' investments in computerized physician order entry, electronic prescribing, electronic medical records, and electronic health records increased throughout the decade, all with the goal of improving care quality, reducing medical errors, and easing clinicians' administrative workload. Remote patient management is another heralded technology allowing health care professionals to monitor patients' health status outside the clinical setting, helping to improve chronic disease management, reinforce patients' self-care, and reduce medical expenses (Coye, Haselkorn, and DeMello, 2009). Internet developments such as interactive websites, stealth ads, and social media have transformed how health care organizations interact with health care consumers, and vice versa. Examples include the use of technology to engage in consumer-driven marketing (Rooney, 2009) as well as the utilization of social media sites (e.g., Facebook, Twitter, Wikipedia, blogs) to help manage patient care and enhance communication (Hawn, 2009).

Mobile technology and high-tech devices such as smart phones and tablets were quickly adopted over the first decade of the 2000s, changing how physicians and clinicians communicate with one another and allowing instant access to e-mail accounts, medical and drug references, and the latest medical research (Gamble, 2010). Today increased connectivity means that no hospital is an island, as technological advancements have ushered in the means for organizations and individuals to communicate with one

another effectively and frequently regardless of distance. Efforts to promote health information exchange, in which health information technology is used to share clinical information among health care organizations, have intensified and become an integral component of designs to improve the safety, quality, efficiency, and effectiveness of patient care (Sicotte and Pare, 2010). Health information exchange also facilitates and improves the reporting, investigation, and communication of information related to public health (Shapiro et al., 2011). Perhaps the most defining example of efforts to encourage health care organizations' adoption of health information technology is the HITECH Act's combination of monetary incentives and penalties connected to the implementation and meaningful use of health information technology such as electronic health records. The Congressional Budget Office estimates that by 2019, such measures will have caused a quarter of all physicians and hospitals to adopt electronic health records that would not have done so otherwise (Sunshine, 2009).

Just as technological progress is experienced by each generation, technological transformation is also accompanied by both the problems it solves and those it creates. Touted benefits of health information technology include improved quality, efficiency, safety, coordination, and continuity of care, as well as eliminated redundancies and reduced costs over time. But health information technology requires considerable upfront costs and training, can give a false sense of security and privacy, creates susceptibility to productivity loss in the event of information system failure, and may prompt reduced human interaction between clinicians and patients in some instances. Without sufficient time, resources, or coordination during implementation of electronic health records, their utilization may not be effective or safe, even jeopardizing patient confidentiality and medical information security. In considering whether they should embrace and acquire new advanced technologies, health care organizations are also confronted with considerable uncertainty in the timing of their acquisitions, recognizing the rapid rate of technological development and obsolescence.

In addition to advances in information technology, the health care community witnessed tremendous advances in science during the past decade, perhaps most evident in human genomics and the promise of how personalized medicine could transform how care is provided and received. The sequencing of the human genome has aided researchers in connecting specific genes to disease and drug response. This has translated to personalized medicine as genetic and pharmacogenetic testing allows identification at the genetic level of the individual patient's exact disease or susceptibility to a particular disease, the best treatment or therapy that targets and treats the specific disease, and the most appropriate medications that an individual's body will best respond to (Aspinall and

Hamermesh, 2007; Burke and Psaty, 2007). Such possibilities have generated considerable excitement for how personalized medicine may improve the safety, efficiency, and efficacy of health care. At the same time, numerous scientific, regulatory, and policy challenges stand in the way of the continued march toward personalized medicine, and observers express frustration regarding its slow progress (Hamburg and Collins, 2010; Aspinall and Hamermesh, 2007).

Heightened Emphasis on Quality

At the turn of the century, the Institute of Medicine (IOM) released two groundbreaking reports, *To Err Is Human* (1999) and *Crossing the Quality Chasm* (2001). These reports highlighted the glaring failures of the US health care system in providing uniformly quality care, and they proposed that future reforms should aim to ensure that care is safe, effective, patient centered, timely, efficient, and equitable.

The years following these reports' publications have observed a heightened emphasis on quality throughout the health care sector, including increased examination of patient safety issues among health services researchers (Stelfox et al., 2006), as well as an intensified conversation among health care professionals, organizations, policymakers, and even the general public that has shifted attitudes and established a foundation for improving quality (Leape and Berwick, 2005). One may point to myriad recent efforts to fuel quality improvement in the US health care system: an increased focus on practicing patient-centered care and evidence-based medicine; improved training for health care practitioners and more stringent work hour restrictions for resident physicians; advanced use of Consumer Assessment of Healthcare Providers and Systems surveys; increased promotion of preventive care and patients' roles and responsibilities in improving their health; focused programs relating to quality improvement at both the national (e.g., the National Strategy for Quality Improvement and the National Committee for Quality Assurance certification programs) and local (e.g., the Beacon Community Program and the Robert Wood Johnson Foundation's Aligning Forces for Quality, Transforming Care at the Bedside, and Hospital Quality Network initiatives) levels; and initiatives that have made quality and patient safety more of a financial imperative for hospitals and providers, including public reporting of quality measures, pay-for-performance programs, more demanding accreditation standards, and withheld reimbursement for "never events," largely preventable incidents judged as inexcusable should they happen (e.g., surgery performed on the wrong part of the body).

Efforts not only to improve quality of care but also to transform the culture of quality throughout the health care sector present a