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Whistling Past the Graveyard - Part II: The Software Solution
(well sort of a solution, anyway)

In Part I of *Whistling Past the Graveyard – The Scenario,* failed healthcare reform and what lessons might be learned from those mistakes were discussed. The background and scenario of a healthcare entity's IS/IT hardware platforms, networking background, IS/IT software background, and engagement background were discussed. Part II of this series describes the "Software Solution" which was developed to allow a group of physicians to meet the rapid developments of managed care.

We initiated a formal client IS/IT assessment based on "Need, Fit & Risk". As a first step, we sought a determination of the clients' "need(s)" for an IS system by surveying the various stakeholders of the client organization as to their perception regarding primary and secondary uses for an IS system. Responses to the survey indicated a diverse perspective on what the priorities for utilization of an IS system should be. It was noted that physicians appeared to focus more on the system's capacity to facilitate access to income distribution plan and financial accounting states (profit & loss) reporting, and did not include obtaining an understanding of service mix, yield per production of relative value unit, or underlying cost accounting reporting. Practice managers, supervisors, and staff almost universally focused their assessment of "IS needs" on the revenue cycle, i.e., making the process of charge entry, claims submission, secondary and patient responsibility billing, claims resolution, accounts receivable management, and collections, with their related reporting requirements, more productive and efficient. Other stakeholders surveyed included: lenders, as to their requirements for financial status reports to support certain loan covenants related to liquidity and profitability ratios for the practices; the pertinent physician hospital organizations (PHO), Independent Practice Association (IPA) and managed care organization

(MCO) executives, as to requirements related to utilization and treatment patterns among the various physicians and specialties; and, employer/union payor health coalitions as to addressing their quality and cost/benefit "scorecard" concerns.

Convincing our physician clients that the competitive environment, with its regulatory and reimbursement challenges, required a robust, reliable and secure information system that addressed all of these issues and more, presented, at first, almost insurmountable barriers.

The next step was to address the "fit" of an IS system designed to meet as many of the identified needs as practical while realistically addressing issues related to the inevitable organizational inertia and concerns over investment cost (during a time of physician uncertainty because of rapid market change related to reimbursement and regulatory conditions), compounded with an analog background and mindset on the part of most of the client physicians, most of whom had no formal training and many of whom were entirely unfamiliar with the subject of IS. The system needed to be robust in features, flexibility and scalability, while at the same time, acceptable to the owner/investor physicians regarding affordability and practicality in meeting their most immediate needs, with no disruption to their cash flows.

We prepared requests for proposals (RFPs) and submitted them to eight leading software vendors. Ultimately, we selected a portfolio of software applications including: MS Office desktop productivity and email applications; NT Server for local area and wide area network, based on a T-1 network architecture; "Medic Vision", running on IBM RISC servers for the revenue cycle, i.e., coding, charge entry, billing, claims resolution accounts receivable, etc.; and, "Great Plains Dynamics", for the general ledger, accounts payable side of the enterprise, running on SQL server, as well as, "data-warehousing" and "executive information" applications developed using off-the-shelf software tools from "Cognos Suite", e.g., "Impromptu", tying in tables from MS Access database and MS Excel Worksheets; an IMOS managed care contracting "decision support system"; and, an integrated "ask-a-nurse" patient call software application system with approved protocols developed by client physicians board certified in emergency medicine and critical care. Veritas provided backup software, McAfeee provided virus protection, while ScanSoft provided document scanning and Adobe Acrobat was installed for document formatting.

Data dictionaries, full documentation, and training support manuals were developed, while an initial training and ongoing professional development program

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for users, as well as a "help desk" support system were implemented.

We pursued an initial assessment as to the relative "risk" of each software application based on its relative cost and complexity of installation and use. We presented our clients with a "tip of the iceberg" analogy to explain the need to measure the total long term costs of the "system" over the period of its expected useful life, including not only the initial ("above the surface") costs of acquisition of hardware and software with installation, but also, the more substantial ("under the surface") costs of system implementation, training, support, maintenance and other operational expenses. We emphasized the concept that perhaps the most pernicious costs might be the losses related to excessive labor costs per unit of productivity arising out of insufficient initial capital investment, and the costs related to loss of opportunity due to insufficient or delayed decision support information.

We addressed risk mitigation strategies and related issues, e.g., escrowing source code in the event of vendor failure, fully documenting contractual provisions related to licensing, installation, training, support, upgrades, patch/fix, and service pack availability, as well as the renewal provisions of the license, or VAR agreements, and instituting withholds of royalties and support payments to insure vendor performance.

We presented, explained, illustrated, educated, pleaded, cajoled, explained again, responded, retorted, exhorted and generally exhausted ourselves in gaining "buy-in" of as many stakeholders and constituencies as possible for the selection and implementation process. Based on early test batch processing, we decided to abandon any effort to perform a "detail" transfer of data and focused on performing a "balance forward" only process to the new accounting system for patient accounts, and ran out the remaining claims resolution activities utilizing the existing accounts receivable on the legacy systems. We prepared normalized tables of over 250 third party payors, including insurance companies and managed care plans, and normalized the demographic and descriptive data for 550,000 individual patient accounts. We prepared chargemasters for each specialty practice's fee schedule, trained transcriptionists, certified coders, charge entry staff, billing and collection specialists and help desk personnel for the roll out of the new system. We struggled, we prepared, we threw the switch. We *"whistled past the graveyard"* and some among us even prayed.

Stay tuned for: Part III of the series *Whistling Past the Graveyard* –"As the Code Turns."

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