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Whistling Past the Graveyard– Part IV
"The Film- Flam Man" *–or- "Everything You Always Wanted to Know About Medical Software Implementation, But Were Afraid to Ask!"*

In the previous installment of *Whistling Past the Graveyard – Part III: The Healthcare Software Application Tango, we* examined the complex struggle among the stakeholders of the proposed Management Services Organization (MSO), in the decade of the 1990s, including the software selection committee, numerous potential vendors, and the selection committee's facilitator, resulting, eventually in a semblance of cooperation. Part IV of this retrospective details the steps and setbacks to reach the initial IS software implementation phase of the project and the effects upon the various stakeholders once implementation was achieved.

The plan – a good plan six months in the making - was completely keyed into Microsoft Project with consideration to all inputs: (1) internal human resources; (2) outside consultants; (3) vendors; (4) materials and supplies; (5) financial capital; and, (6) deadlines. Every conceivable phase in the process had all sorts of deadlines, preliminary milestones, goals, objectives, best estimates, and "*drop dead*" deadlines identified. Each step, from installation to the initial "*beta*" run was tested and documented. We tested all of the documentation and documented all of the testing. We had daily, weekly, and monthly reports for hardware; software; bandwidth (e.g., routers, T-1 lines, etc.); and, physical facilities (e.g., server rooms, backup generators, fire suppression, co-location/disaster recovery, router closets, and off-site data backup storage). Reports included task lists; material and supply requisitions; staff schedules; vendor authorizations and coordination; management sign-offs; gant charts; pert diagrams; project completion histograms; work flow charts; and, PowerPoint slide shows for the physicians, documenting every step of the process.

We met to review every report by department, by organization chart management level, and by group practice. We had meetings to plan meetings and to review our project plan. We *presented* it. We *explained* it. We *facilitated* consensus and buy-in. We *educated* all stakeholders as to the trade-offs between complete practice autonomy and the gains in market leverage that would be achieved by organizing to integrate their information systems. We *preached* "*information is power*" from every pulpit. We *prepared, reassured, comforted, inoculated, and cheer-led* our clients silly. Our IS software implementation plan was *comprehensive*, but *comprehensible*. It was *direct*, but *disciplined*. It was *complex*, but *concise*. It was *extensive*, but *encompassing*. It was state-of-the-art for IS/IT project implementation planning. The implementation plan was "*leading edge*," without being "*bleeding edge.*" All in all, it was awe inspiring - truly a thing of healthcare information management systems wonder. Accordingly, it was virtually doomed from the start.

The big day came when we went "*live*." Three practices in the initial two "*go-live*" weeks, followed by four groups of four practices in each of the next "*go-live*" weeks. It did not go smoothly. Nine of the practices had not purged accounts receivable for over three years, and two of those had switched their charge entry procedure from booking the full fee schedule charges to only what the discounted payor allowed. There were 250 unique, distinct payor sources listed in over 4,000 spelling variations, (e.g., "*Blue Cross / Blue Shield of Nebraska*," "*BC/BS of NE*," "*BCBS Anth*," "*Blues NE*," "*Blue Cross*," etc.). The same patient would have 16 different records in various practices, and often, several different records in the same practice. Over 50 percent of the 550,000 patient records had at least one duplicate record; over 100,000 patient records had three or more duplicates, and none of the "*duplicates*" agreed with each other as to address or name spelling (e.g., "*John Paul Jones," "Jack Jones," "J. Jones", "J.P. Jones,"* etc.). Half of the 19 practices had only one fee schedule. Half had from two to 11 fees schedules as their "*charge master*." In essence, in reviewing the "*charge* masters" we soon discovered that "*no one was in charge*" and little about it had been mastered.

Balance forward data conversion required that the old accounts receivables from the respective practices be "*claims resolved*" and collected on the old legacy systems. Therefore, a weekly report would have to be submitted, in a comprehensible and timely manner, according to a strict schedule, to the Central Business Office for updating the balance forward amount on the new MSO IS software system. The practice managers resisted the tight schedule requirements and strict adherence to procedure as an encroachment on their authority and prerogatives. The accounts receivable and collections staff in the practices ran for cover when the

(Continued on next page)

requirement to set a cut-off date for the switch to the new system revealed many previous productivity claims that had never been: (1) coded; (2) charge-entered; (3) electronic claims submitted; (4) secondary billed; (5) claim denial checked or resolved; (6) worked for collection; or, (7) written off. Staff went through all the stages of grief: denial; anger; bargaining; resentment; and, finally (when we would have hoped for acceptance) abject defeatism.

Further setbacks occurred as the practice managers resented the indignity and ignominy of being trained alongside their subordinate staff. Some pouted and others outright disrupted any of the sessions they could. Many of the physicians refused to be trained (if they showed up for training at all) with any non-physician staff in attendance. The executive team, newly recruited and hired for the MSO, jousted for influence, position, and advantage - playing the physicians against the consultants against the vendors against the practice managers. It was a field day for opportunists, with discord, uncertainty, and anxiety creating the ideal breeding ground for Machiavellian machinations - the refuge of scoundrels.

As it turned out, all of these activities that we had gone through to date were the *good* part. The billing package was a new generation code platform, installed in just twelve other locations. Several installers we contacted for reference gave good reviews, but turned out to have been "*beta*" sites (a/k/a "*paid shills*") who apparently had received the software for dramatically reduced cost in return for their support. Some of the pull down menus did not have links to the intended reports, input tables, or help screens. Many of the documentation pages were from previous platforms or versions. The batch program that was designed to delete old posting transactions did not purge the transaction logs, meaning the staff members entering charges overwhelmed the storage and processing capacity, thus shutting down the system on an unannounced basis. Even the software vendor acknowledged that the required purge "*routine*" was still "*under development*."

Three of the four software vendors failed to provide any semblance of meaningful and timely contracted implementation staffing support and training hours. Following oral and written reminders and warnings from us, we turned to the services of our legal counsel to hold one of the vendors to the commitments they had made, with mixed results.

The diversion of staff time for training and loss of productivity due to unfamiliarity with the new system (in addition to resentment and stubborn intransigence), caused the practices to fall behind in accounts receivable collection, from an average of 49 days A/R cycle to over 90 days.

The natives grew restless. Cash reserves began to shrink. Income distribution plans began to dry up. Then - disaster of all disasters - horror of all horrors - seven practices (C-Corporations) had to draw on their lines of credit to meet year-end bonus distributions to make certain all profits were distributed as physician payroll to avoid corporate level (double) taxation. Three physicians resigned and left town. Two betrayed their commitment to their colleagues and became hospital employees. Three out of the few remaining die-hard supporters of the plan (primarily the officers and directors of the MSO) entered into a heated, cocktail-laden evening-long debate over the remaining chances of success by engaging in a shouting and (reputedly) shoving match at the local country club. I'm told the mention of consultant's is what set it off. These were the same physicians who had expressed significant support, encouragement, and gratitude to the consultant coming to their rescue a year and a half earlier. There were calls for our dismissal, and when that failed to pass the board, there were calls for a vote of no confidence in the board. There were threats of lawsuits, broken friendships, and one estranged marriage.

All in all, it was exactly what we had expected.

Oh, somewhere in this favored land the sun is shining bright; the band is playing somewhere, and somewhere hearts are light; and somewhere men are laughing, and little children shout; but there is little joy in healthcare, when your IS plan first starts out![1]

EPILOGUE – "The sun also rises"

Believe it or not, we eventually completed the IS software implementation plan - within six weeks of the original timetable (not bad!), with only 12 percent overage of the original budget (phenomenal!), and with only one vendor lawsuit (settled before trial). Amidst growing staff defections and rising casualties to physician collegiality, we persevered in our assigned responsibilities - facing up to and solving most of the problems - turning over authority to the new management team in stages, and snatching victory from the jaws of defeat. Like itinerant Samurai, we fought the good fight, vanquished all adversaries, made equal enemies of all constituencies, and preserved our independence in achieving the objective of the project. We sailed ahead and brought the project into safe port. We were Farragut and John Paul Jones, Ahab, Jonah, Nemo, and Queeg. We were the Popeye to their Bluto and the Sinbad to their intrigue. We were regular Horatio Hornblowers of the healthcare IS world!

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Within six months, (in response to regulatory pressures related to anti-trust scrutiny) from the hospitals we had converted the 22 independent practices, with a co-owned MSO, into a fully integrated medical clinic, with a single provider number. This was facilitated and enabled by the integrated IS software and produced astonishing gains in achieving data integration as the information/knowledge base to achieve market leverage in managed care negotiations and resisting market dominance of competing hospital systems. All of the gains in market leverage required the output of timely and accurate management information, which the new IS/IT system provided, and of which the previous individual practices' legacy systems (even the largest of them) had been completely devoid. Then, nursing our wounds (and dusting off our self-esteem), heads up, chin out, we collected our fees (well, most of them), thanked everyone for their cooperation (well, sort of) and the opportunity to be of service, turned over the keys (and passwords), and rode off into the sunset.

Two weeks later, we started the process all over again, for another group of desperate, (but grateful) physicians in distress. As we waited to begin our "*kick-off meeting*" with the new client group, our Senior Vice President for IS/IT, always the optimist, expressed his sincere wish that this time, everything would go smoothly and according to plan. I could swear that I heard my father whisper from the grave, "*Son, if wishes were horses, then beggars would ride!*"

Oh well, it ain't easy, but it's a living!

1 Paraphrased from “Casey at the Bat” By Ernest L. Thayer (Harvard 1886). (First appearing in the San Francisco Examiner, June 3, 1988.)

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