

# IT DISASTERS:

## The Worst Debacles and Lessons Learned From Them

By David P. Hunter and Vincent Ciotti

Most articles about information technology discuss successes, relating how IT helps to lower costs and improve outcomes. Yet most savvy executives know that the IT world is filled with potential land mines and career-ending pitfalls. IT disasters are frustrating, costly and can paralyze an organization. To help others avoid getting caught in their own IT debacle, we share some of the most common IT mistakes an organization can make and some real-world examples of hospitals that have wrestled with these situations. Some of these institutions were able to regroup and turn these catastrophes into IT triumphs. Others were not so fortunate.

### **LESSON 1:** Manage Vendors and Understand Their Motives

The word “partner” has become a hot buzzword in IT. In theory, it is a nice concept. It evokes images of an organization and a vendor working hand in hand for the good of the organization. Ideally, these two entities would work closely to develop a shared vision of project goals and outcomes. However, it is important to keep in

mind that vendors must satisfy their shareholders, so maximizing earnings is a priority. Sometimes, partner vendors can become too much a part of the organization. We worked with one organization whose partner vendor had more than 50 full-time consultants on-site at a cost of \$1,200 per day each for years with no end in sight. Consulting engagements should last for months, not years, and vendors/consultants should have a clear-cut project plan with a fixed endpoint and costs. The IT department at this facility already had on its payroll far more full-time staff than our benchmarks indicate, and their IT costs also were high, but they let their partner vendor talk them into paying even more people and taking on more cost.

Another large, multi-integrated delivery network (IDN) was in deep financial stress, with only a few months’ worth of cash on hand. Complicating matters was the fact that it was preparing for the then-imminent Y2K conversion and attempting to consolidate a wide variety of obsolete hospital

information systems (HISs). A partner vendor convinced the organization that it needed to put in an entirely new HIS, even though the system had never been installed in an organization this large. No conversion was actually needed, as each existing system offered an upgrade path. Y2K had been used by the vendor as an excuse to garner a large project, increasing its revenue and earnings per share at the expense of the hospital. Getting the organization to agree to this unnecessarily rapid conversion is a good example of how some vendors can have undue influence on an organization.

Instead, it is each organization’s responsibility to manage its vendors and negotiate clauses in vendor contracts to protect against cost overruns and open-ended projects. In the above example, the vendor contract had no warranties or remedies for schedule slippages beyond Y2K. Ultimately, the IDN selected a new vendor to outsource the conversion and get costs and staffing levels under control. With input from end users and strenuous contract

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negotiations, a new vendor was hired. The new relationship included remedies, penalties and risk sharing. In the end, the Y2K conversion succeeded and costs were capped or cut. The IDN has since stayed afloat.

**LESSON 2:** Never Outsource the CIO Outsourcing is not always a panacea. Currently, outsourcing almost has become a fad in IT circles as HIS vendors and consulting firms turned to outsourcing as a quick fix for their own revenue and profit challenges. Outsourcing can be an extreme solution because, once outsourced, it is very difficult to get your IT employees back and costs tend to rise with every new project that is outside the scope of the contracted vendor. In the case of a multihospital IDN, outsourcing put the organization in a vulnerable position. This IDN was doing well but wanted to do better. It had a strong management team who hoped to modernize the hospital's systems and implement new applications.

In this case, outsourcing the IT department was a mistake. First, management outsourced to an off-shore firm with seemingly lower salary costs for programmers. While it saved money on the surface, it brought many problems in communicating specifications and obtaining customer support due to cultural and language barriers. In addition, the contract was signed in a rush, leaving service level agreements (SLAs) "to be determined."

These agreements constitute the standards that contracted work must meet for the vendor to be paid. By leaving the SLAs ambiguous, there was no protection for the hospital.

The organization's biggest mistake was outsourcing the chief information officer (CIO) position. This individual, who was an employee of the contracted vendor, also was responsible for approving his own firm's invoices and purchase orders. Costs rapidly climbed because no checks and balances were in place. Because IT is so vital to the core mission of ensuring patient safety, providing high-quality services and maintaining efficient operations, it is critical for the CIO to be employed by the organization. The IDN did hire its own CIO and was able to control project definition and review invoices far better.

**LESSON 3:** Don't Let Vendors and Consultants Drag Out Implementations An academic medical center with a large faculty practice wanted to upgrade its aging HIS. It had purchased a new, state-of-the-art clinical system with electronic medical records (EMRs) and computerized physician order entry (CPOE) components. However, implementation of this new system was taking years, with no end in sight. The CIO was inexperienced in hospital IT (another common mistake) and implementation had become a "feeding frenzy,"

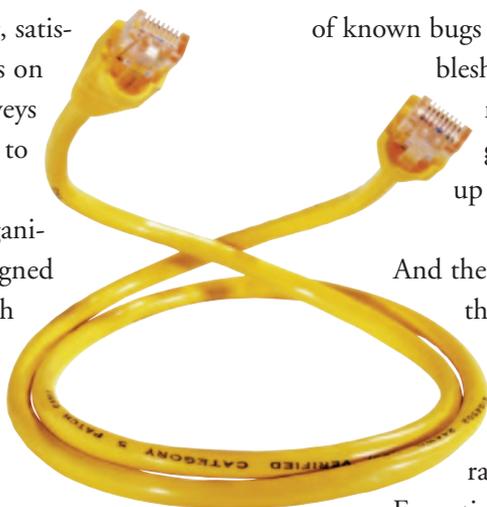
with vendors and consultants charging many millions of dollars in time and materials. They kept building, testing, finding bugs, rebuilding and retesting while no incentives were offered to bring the project to closure. Also, the hospital and practice systems used different vendors with many overlapping applications such as registration and scheduling capabilities. Ultimately, it took more than six years to go live with the new system. A more effective approach would have been hiring an experienced CIO who knew reasonable implementation time frames and who might have negotiated a fixed fee or not-to-exceed cap on implementation fees from both the vendor and consulting firms.

**LESSON 4:** Never Disenfranchise IT Staff From End Users

We often are asked whether it makes sense to centralize IT functions at multihospital IDNs. Sometimes this strategy works, and sometimes it does not. One large, multihospital organization centralized all its hospital IT departments to increase efficiency. Despite a wide variety of hospitals and computer systems throughout the enterprise, a single help desk took all calls for service. The centralized IT analysts tried to learn each system, but users were dissatisfied with their lack of knowledge. We recommended the organization restructure its IT department around the types of hospitals and

systems and split up the help desk staff into separate groups for each system. This allowed staff to specialize in various systems and learn the applications in depth. As a result, user satisfaction increased as IT analysts could specialize in the systems at the hospitals they were responsible for.

At another multihospital IDN, efforts to decentralize, together with client sensitivity training, helped IT staff to be more client oriented and care about the end users. Originally, IT staff at the hospitals reported to managers at a corporate office miles away. They had lost the sense of teamwork and empathy toward their hospital customers, which was apparent when they began to report locally. It became an “us versus them” mentality. Customer satisfaction was at an all-time low. After reorganizing the IT department to have on-site staff who report directly to a hospital IT director and conducting client sensitivity training, satisfaction scores on customer surveys rose from 3.0 to 4.0, on a 5.0 scale. The organization also aligned incentives with objectives by giving cash rewards to IT staff for good survey scores.



### LESSON 5: Buy, Don't Build

Generally, buying IT systems garners more benefits than building them in-house. At one IDN, the CIO convinced management that he could write his own CPOE system with more features than any available commercial system. The system was eventually finished and implemented, but the costs were extremely high and it crashed after it went live. The system was down for several days, during which time nurses and physicians had to turn to paper down-time forms, and runners had to run forms between ancillary departments. It cost the IDN millions in lost revenues, in addition to the high costs of the large in-house programming and support staff who built and supported the system.

When the system crashed, the CIO had no one to turn to for technical support as he would have had if he had purchased a CPOE system from an outside vendor. There was no file of known bugs or experienced troubleshooting team to diagnose the problem and get the system back up and running.

And there is a supplement to this rule: Do not be the *first* organization to use a new system, even if it was bought rather than built. Executives should wait until

all of the bugs in the system are worked out at several pilot hospitals before investing in any piece of new technology.

### LESSON 6: Involve Users

#### Heavily in the Decision Process

It is important to have input from the end users—the nurses, physicians and staff who will be using a system—prior to choosing a vendor. Executives who do not involve the end users enough in the selection process run the risk of the end product being unpopular and ineffectual. In addition, you need to know whether your staff is ready and able to use any particular system. Have they bought in to the new system? Have they been properly trained? Are they mentally prepared for more advanced technology? As much as the need for training and cultural transformation is understood by healthcare leaders today, too often what is provided remains inadequate.

But end user involvement also needs to be managed. If too many people are involved in the process, the end product may be too complicated to install or not be cost effective. Also, vendors may show physicians and nurses all of the software options available, even if they are not necessary for your organization. It is the responsibility of the healthcare leader to look for the optimum price/performance ratio in a new system's modules and options to meet the needs of the

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organization. If you make the new system unnecessarily complicated, it will be more costly, harder to install and prone to difficulties later.

## LESSON 7: Avoid "Visionware"

IT projects are not only difficult for hospitals to bring in on time and under budget but they also are a challenge to vendors. It is far easier to build a PowerPoint presentation with program prototype screen images of a new system than to finish a code and debug it. Almost everyone remembers Windows 95, Microsoft's

first graphical user interface, but how many remember its predecessors, Windows 1.0, 2.0, 3.0 and 3.1, which were replete with bugs, caused system crashes and sold long before they were ready?

Salespeople mean well; they are passionate about how good their new system will be. But their programmers are struggling with the same issues you are—budget cuts, cost overruns, insufficient staffing, changing requirements—and far too often, new systems are

delivered many years and releases later than starry-eyed marketers forecast.

**TECHNOLOGY:** Not the Only Answer Technology brings many benefits to the hospital setting. But technological advances cannot take the place of person-to-person teamwork and communication. Indeed, the use of EMRs and CPOE still can cause patient care problems, many of which are overlooked because these concerns are believed to be addressed by the installation of the computer system.

Complications will always accompany every IT conversion. There has yet to be an IT implementation that did not come with some bugs in the system, delays, cost overruns or user dissatisfaction. It is the responsibility of the healthcare executive to guide the institution through these land mines and minimize any damage that occurs. Many of the lessons gained from IT failures appear obvious in retrospect. Successful organizations will recognize these problems as they occur and adjust to avoid the pitfalls.

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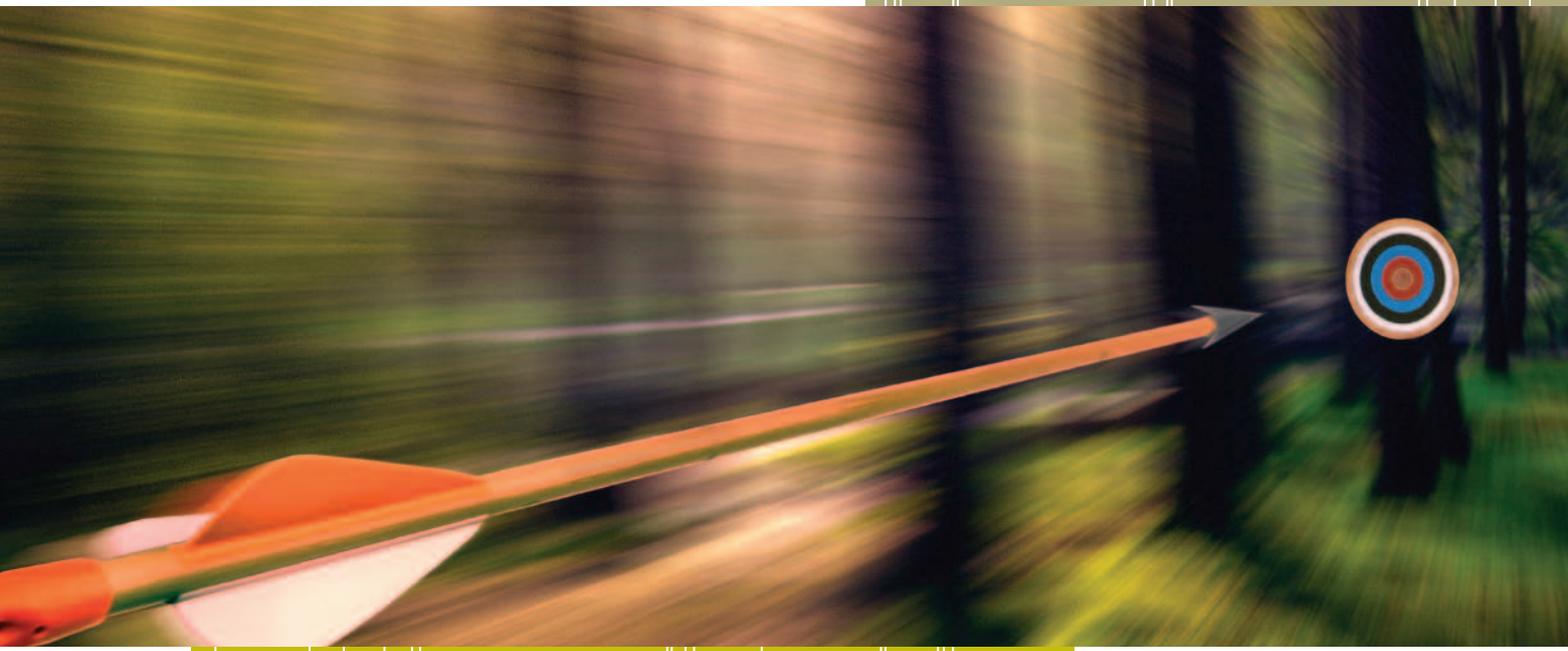
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