The Fourth Party: Maximizing the Value of Change

BY GREENCASTLE CONSULTING

The promise of value from clinical and operational transformation is difficult to ignore. With the implementation of new clinical information systems, such as EMRs or computerized physician order entry (CPOE), medical group leaders are doing their part to enhance patient care, improve quality, and reduce costs. So why are so many of these initiatives failing to achieve full value?

No one is fully considering and addressing the business and workflow issues that must be resolved before clinical and operational transformation can occur.

Imagine the following scenario: An eager management team at a mid-sized medical group takes the plunge and purchases an electronic medical record (EMR) system. The practice leadership clearly communicates its objectives and expectations. The IT and support staff have the resources they need to take on the implementation. The vendor is able to focus its expertise on making this extraordinarily complex product function in the unique environment of the group practice. After a few months of well-structured planning, training, and testing, the "go live" date finally arrives. Later, when evaluating the investment against the results, the management team is pleasantly surprised to find that even the most reluctant doctors have wholly embraced the technology. Some of the naysayers are even using the common order sets developed by the clinical team. Patient wait times and throughput are better, and the practice has been able to redirect a file clerk to the more helpful task of patient registration.

Is this the story you've been hearing most often when your peers share their experience with projects that call for major change? According to most experts, probably not. Although there is some dispute over the actual percentage, most industry analysts agree that IT projects are failing at an alarming rate.

A recent survey[1] by AC Group, a healthcare technology advisory and research firm, points to the difference between putting software in place and achieving true clinical and operational transformation. "We surveyed physicians one year after going live with an EMR," says AC Group CEO Mark Anderson. "We asked respondents if they were seeing 80 percent of their patients using the EMR, for example, for review assistance, history and present illness, and generating notes. Seventy-three percent said they were not. We're defining that as a kind of failure."

So what's the solution? Anderson argues that these functional failures are occurring largely because there is

a lack of up-front planning. No one is fully considering and addressing the business and workflow issues that must be resolved before clinical and operational transformation can occur.

When medical groups purchase EMR systems, they want to achieve tangible (and intangible) benefits: improved quality of care, increased revenue realization, and reduced clinical and operational costs. The real value to be gained from technologies like EMRs comes from making big changes in the medical group. Everything is going to change—from the process of scheduling patients, to patient interaction, to clinical decision support, to order entry and management, to patient education, to follow-up and continuity of care—and to achieve value, these changes must be methodically managed.

Successful clinical and operational transformation from IT-centered projects is largely a matter of delivering the five components necessary to achieve maximum value: (1) process integration, (2) change adoption, (3) technology installation, (4) product functionality, and (5) project execution.

Unfortunately, when medical groups use traditional resources and processes to implement clinical or operational change, they face systematic limitations inherent in the typical project's roster of stakeholders. Because of this, these limitations can act as an institutional barrier to success. Value maximization, the real goal, requires full accountability across the above five components.

The Four Parties

Transformational changes extend beyond the typical expertise of any single, major player in a traditional project. In fact, it takes four parties to avoid diluting the full value of the effort.

The first stakeholder group, the Sponsor, represents the leadership team and top management—typically clinically minded, but also responsible for business results. The second, the Internal Resources team, may comprise IT and other non-clinical staff who know the workings of the organization like the backs of their hands. The third stakeholder group is the technology Vendor, itself. While they can and should use their technological and market knowledge to help the organization succeed, the primary charge of the vendor is, nonetheless, technical in nature.

> To assemble the right combination of expertise and ability, medical groups and IPAs should consider the role of a Fourth Party to bring it all together.

All too often, discipline and perspective relating to project management, process improvement, and change management are missing. At one time, when very basic applications sat on workstations with limited connectivity, this was less urgent. But contemporary technologies affect virtually everyone in a given organization, and the impacts on day-to-day workflow require careful consideration. For best results, implementation of EMR, CPOE, and other transformational systems should be orchestrated by skilled project managers, dedicated to the integration of all stakeholder goals.

The Accountability Equation

Projects are often structured to fail because the accountability for success is misplaced. To see how the Fourth Party fits into this complex puzzle, examine the traditional business accountability model from each party's perspective. The accountability equation is simply a formula for evaluating ownership. It states that a person or a group, to be truly accountable, must have authority plus responsibility.

Authority involves the capacity and position to effect a certain change. Authority also entails the power to take action and the ability to make final decisions within one's domain and the ability to garner necessary resources. Responsibility is an obligation for action and results, and implies the capability and capacity to deliver those results.

In adhering to this model for a typical project, management would simply allocate adequate resources (time, knowledge base, personnel, etc.) and participate as an active sponsor to ensure realistic accountability. However, with an EMR installation, the change is more extreme; and the technical project includes high expectations for results. Daily tasks will be dramatically altered across the practice. For example, time-consuming chart-pulling will be eliminated; physicians will receive automated alerts with their lab results; and practice managers will have more time to review charges for the purpose of business decisions.

The more complex the initiative, the more important organizational accountability becomes. The question is: who is accountable for the results?

The Sponsor

Forming the clinical and operational leadership of the medical group, the Sponsor sets goals, initiates the project, allocates resources, and represents the best interests of the practice and clinical end users, as well as patients. By virtue of their leadership position, the Sponsor team has authority over personnel and intimate knowledge of all administrative processes.

On the other hand, these physicians, practice managers, executives, and other experts have many demands on their time. For every four-hour block of time spent planning to transition to a new software tool, they're forced to find four hours elsewhere in their schedules. The opportunity cost of their involve-

Managing Change: Roles and Responsibilities

A Fourth Party is well-positioned to assume ultimate accountability for realizing maximum value from clinical and operational transformation projects. But at the tactical level, roles and responsibilities are distributed logically according to each party's expertise and ability.

Sponsor

Performance with new solution

- Clinical Leadership
- Operational Leadership
- Project Sponsorship
- Resource Commitment
- Decision Making
- Guidance

Internal Resources

Clinical, operational, and technical expertise

- Steering Committee
- Practice Mangement Liaison
- Clinical Liaison
- Administrative Workflow Team
- Clinical Staff Workflow Team
- Provider Workflow Team
- Billing Workflow Team
- Technical Workflow Team

Vendor

Deliver technology product

- IT Product Best Practices
- Tech System Assessment
- Technology Interface
- Standard Templates
- Super-User Training
- User Training
- Software Configuration
- Software Loading
- Support for Testing
- Change Requests

Fourth Party

Ensure value delivery and facilitate adoption

- Strategy–Goal Alignment
- Readiness Assessment
- Program Structure Creation
- Program Communications
- Program Planning and Management
- Integrated Process Development
- Value Management
- Change Adoption Activity
- Vendor Management
- Rollout Management
- Lesson Integration
- Workflow Team Integration

ment is high, so one of their greatest assets is a partner who can use their time wisely and accept accountability on their behalf.

With proper guidance, the Sponsor does not manage the day-to-day project work, asked providing overall leadership for clinical and operational transformation projects. Their contributions toward process integration and change adoption revolve around guidance for practice goals, decisions about process performance, and policies for technology usage. Sponsor decision making must be provided accurately, efficiently, and without redundancy. Although they may possess limited project management experience, they will quickly develop a deep appreciation for that skill set when executed properly.

As it moved toward an EMR implementation in 2007, the Columbia Faculty Practice Organization (FPO) of Columbia University Medical Center in New York brought in a Fourth Party partner early in the process. Greencastle Consulting conducted a readiness assessment and is currently managing EMR rollout.

"Greencastle's overall role has been to make our objectives concrete, translate high-level change into more manageable packets, and make sure the vast majority of physicians will actually use—and appreciate—the new technology," says Michael Duncan, as chief executive officer of Columbia FPO who played the role of Sponsor in this scenario. This allowsed Duncan and his team to concentrate on the operations of the practice group and provide guidance and decisions to the EMR project.

Internal Resources

The make-up of the Internal Resources group varies greatly. Depending on the size and nature of the medical group, it may include IT staff, quality officers, operations managers, or others. Though they may or may not have clinical backgrounds, they are intimately familiar with the business and its support systems.

Precisely because of their organizational knowledge and understanding of processes, Internal Resources typically make up the internal project team dedicated to guide complex IT implementations. Of the five components of clinical and operational transformation, Internal Resources are most likely to be accountable for the technology component and participate in any and all process integration work.

One of the most common pitfalls in health care is treating major implementations like a software installation. Most often, they are not IT projects per se, which explains why this party, by itself, cannot assume the authority it would need for proper project accountability. Asking an IT specialist, for example, to take on guiding significant changes to nursing documentation or defining order sets could easily lead to less-than-ideal project outcomes. The practical knowledge Internal Resources brings is essential and

valuable. But no single individual—or committee, for that matter—can contribute all the necessary domain expertise across revenue management, front-office administration, clinical operations, purchasing, and the many other areas.

Even at larger organizations with sophisticated project management capabilities, the Fourth Party can effectively augment resources and enhance oversight of change management. For a recent ambulatory EMR rollout to 23 hospital-owned practices at Christiana Care Health System in Wilmington, Delaware, Internal Resources worked alongside Greencastle Consulting. "We engaged the vendor for implementation and configuration, but as far as running the overall project, we wanted independence," says Donna James, director of the Christiana Care project management office. "We often want to have greater accountability on projects for managing vendor-related issues and other challenges that may arise."

"We turned to Greencastle Consulting to help pull some of the organizational pieces together, resolve the governance structure, engage the project stakeholders in process design and overall project success, and even set up the organization to handle the operations of the system after project implementation is done," says Christiana Care CIO Steve Hess. "Some of it was standard project management, some was organizational development work to complement our existing resources. In many situations, we turned to them on issues that required expert focus on aligning vision and strategy with end users."

Vendor

For their part, Vendors face a structural barrier. Through no fault of their own, they are less well-positioned than Internal Resources to direct process change, because they are not responsible for results.

One might argue that this is as it should be. Obviously, Vendors have a very strong interest in a successful outcome, and they rightly take responsibility for product functionality. But an EMR vendor is not responsible for increases in charge capture or continuity of care for a patient in a multispecialty practice. As an analogy, consider the role of a chocolatier or florist in February. They can and should guarantee high-quality candy and flowers, but it makes little sense to hand them the accountability for a successful Valentine's Day date.

The Vendor's knowledge of their product, their understanding of best practices, and their past experiences are vital. They manage product best practices, run system assessments and interfaces, provide user and super-user training, and configure software for loading and testing. Their vantage point is simply not ideal for playing the role of project manager in a more complex environment.

So that their clients will be assured of success, Vendors are increasingly embracing the fourth-party model. "With our large-scale projects, we've seen the difference it can make to have another group playing the role of facilitator and coordinator," says Andy D'Ascenzo, director of sales for Cardinal Health's Alaris Products. "When we work with someone who can truly focus on and manage the workflow and process issues, we can make the most of our people's expertise, the customer performs better, and the final result is maximum functional benefit."

Fourth Party

It may seem counterintuitive at first, but by adding a Fourth Party, you make the complexity more manageable. This group's main function is bringing it all together for proper project execution: synchronizing and coordinating the expertise of others.

The Fourth Party takes on authority as an assignment from the Sponsor. As their proxy—and with the skills and techniques well-known in change management circles—the Fourth Party can direct the flow of the project, draw on the right capabilities when necessary, balance resources in a reasonable manner, and, ultimately, concentrate on delivering value.

Given the objectives behind most technology-centered clinical and operational transformation projects, change management is a matter of value maximization or value management. The goal is more than "organizational change with minimal disruption." The key is applying a methodology to merge the expertise of the Sponsor, Internal Resources, and Vendor in such a way that the outcome captures all possible benefit from the effort. In most cases, that means widespread end-user acceptance and organizational adoption of new process workflow and the technology, whether through an EMR upgrade, CPOE installation, or adoption of another information-intensive, complex system.

Bringing in a Fourth Party has the added advantage of demonstrating commitment. When, for example, there are not enough hours in the day for Internal Resources to coordinate other parties or clinician end users get left out of the pre-planning and workflow analysis stages, adoption suffers. Change may happen, but results can be anemic at best. The Fourth Party presence is a strong indication that the organization is assembling adequate resources—a key tenet of change leadership and a positive position from which to launch a project.

It's important to note that the designated Fourth Party does not duplicate expertise. This model acknowledges that the Sponsor, Internal Resources, and Vendor together possess all the necessary know-how. The Fourth Party's expertise is in securing other parties' participation and investment in the outcome. The responsibility of the Fourth Party is to maximize value, by coordinating and synchronizing the participation of experts to perform.

The Fourth Party completes the accountability equation for the owner

by providing capacity and capability to act. The Fourth Party steers towards value by letting each group share its expertise appropriately, coordinating work activities, regulating the resource demands placed on each party, and tracking progress.

Value Maximization

From a total cost perspective, the Fourth Party is easy to account for in the value of a solution. The efficient use of staff during implementation and the dramatically reduced risk of project failure should warrant an investment. The major return on investment, however, is in the speed to benefit realization, widespread value achievement, and reduction of time and extent of initial productivity reductions. To keep it simple, the Fourth Party is about "bang for the buck."

Because processes and systems must be so interconnected, medical groups that excel at adapting during clinical and operational transformation will have an advantage in how they carry out their mission and how they perform as a business. In such an information-intensive field as this one, those medical groups that learn how to manage multiplex change—and maximize its value—will thrive.

Unfortunately, many provider organizations will allocate generously for the selection process and licensing. But their budget process lacks a line item for proper management of the implementation. The irony is that a relatively small investment can ensure the success of a much larger investment. And, the bigger the project, the greater the risk—or reward.

References

1. Mark R. Anderson, FHIMSS, CPHIMS. 2007. *The Digital Medical Office of the Future*, an e-book published October 29, by AC Group, Inc. (www.acgroup.org)

Reprinted with permission of The American Medical Group Association®
©Group Practice Journal June 2008