Teaching Case
ComprehensiveCare and the Stalled Adoption of an Electronic Health Records System: IT Governance and Employee Succession

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ABSTRACT

ComprehensiveCare, a multi-specialty healthcare organization, struggles to implement Electronic Health Records. The first adoption failed outright because the customizations made the system unusable. The second attempted adoption has not officially failed yet, but the system fails to live up to the expectations. It lingers on the edge of usefulness: staff members cannot use it in real-time for most things, but the interfaces to the equipment prove helpful. Temporary staff members enter information from the day's work after-hours, which wastes productivity.

In this adoption, IT decides what customizations can be made. In addition, the IT department provides all training for staff members. IT gains the unfortunate moniker of the "no-help desk" because IT chooses to keep the system as close to the default vendor configurations as possible. This creates a system that does not work well with ComprehensiveCare's processes. William, the administrator, and the board of directors must now decide how to manage and leverage IT assets to complete the implementation.

This is the final case in a series of three cases following ComprehensiveCare's adoption of Electronic Health Records. It covers the decision-making necessary for ComprehensiveCare to correct the adoption that is lingering in disuse. This is the final set of decisions required before the adoption ultimately succeeds. This case provides a context that would be most relevant in a graduate level IS management course, an undergraduate fundamentals course, or a project management course.

Keywords: Project management, Organizational system, Electronic health records, Training, Teaching case

1. SUMMARY

Administrator William Shoemaker must deliver an unfavorable annual review of IT Director Philip Jennings. William believes the Electronic Health Records (EHR) adoption is failing because it does not meet ComprehensiveCare's needs. Philip, on the other hand, cites the constant availability of the EHR system to show implementation success. Philip believes that any failures beyond downtime are someone else's responsibility.

The board of directors and William must decide how to implement IT governance as well as create strategies to overcome a strained relationship between the clinical users and the IT department. In the quest for solutions, William discovers that several policies and procedures are in place in IT but that they are outdated.

2. CASE TEXT

2.1 The Annual Review

"Can we get this over with? I have real work to do, and we both know this is just a formality," says Philip, the Director of IT. He is a little incensed that the administrator, William, performs his annual reviews. Philip reports to the board of directors directly through Dr. Shumway, and he does not understand how William in a CEO role should be evaluating Philip's work when Philip is in a CIO role.

"Philip, please," replies William. "We went through this last year. Dr. Shumway has asked me to conduct your annual review. And I assure you I take great care in conducting this review. I do not consider it a formality, and I hope you take it seriously, too."

"Sorry. I'm just trying to get the new phone system tweaked. I only remembered the appointment when my

calendar popped up to remind me." Philip adds, "but we both know I've done an outstanding job in IT this year. We've only had about 15 minutes of downtime total this past year."

"IT is more than just keeping the systems up and running," reminds William. "The EHR project is not going well. It's completely stalled. What's IT doing to fix this?"

"That's not our fault," responds Philip. "The EHR server hasn't crashed once. It's not our fault that the techs won't use it. Seems more like a management problem to me."

"But it is your fault that you are known as the no-help desk now," says William, affronted that Philp would imply that it is his fault.

"EasyEHR doesn't do what people want it to do," defends Philip. "People ask us how to input data, but there's no place to put it. That's not our fault. That's bad software."

"You were supposed to customize the system," says William. "We agreed IT would be in charge of the templates. But instead of creating and adapting templates, you keep telling everyone that EasyEHR is terrible and can't do what they want."

"I know it's before your time, but when we used DocCharts, customization ruined everything," retorted Philip. "We're not going to make that mistake again. The techs are just going to have to learn how to do things the EasyEHR way."

"That's not how it works," interjects William. "And I'm putting you on notice: if you don't get this straightened out in the next three months, you will be looking for a new job."

Philip cannot believe what he's hearing. "This is so unfair. IT is working like a well-oiled machine. A new phone system is being rolled out that will save hundreds of dollars on long distance between the satellite offices, the email server is up-to-date, and a new firewall is in place to keep us safe from hackers. You just don't understand what IT is supposed to do."

"Actually," replies William softly, "I do understand what IT should do. And that is why the board has voted to have IT report to me. Reporting through Dr. Shumway was a temporary measure before I came onboard. The board has asked me to provide more oversight and guidance to IT."

The next day, as Philip is still seething about the injustice of his annual review, he looks at a local job board to explore his options. He notices a job posting. "Wanted: Director of IT for a multi-specialty healthcare organization. Must have experience with EasyEHR. Must also understand the Intrawebs. Company confidential." Philip giggles to himself; he told William that is what everyone is calling the Internet now. He convinced Dr. Shumway to tell the board, and now they all believe it. It is pretty clear at this point: this posting is his job!

2.2 ComprehensiveCare

ComprehensiveCare (CC) is a multi-specialty healthcare organization owned by twelve doctors. It consists of a main physician practice location, an ambulatory surgical center (ASC), and several satellite offices to provide service to the rural towns surrounding CC's main location. Dr. Harris is the managing partner of the board of directors which is comprised of all twelve owners. Three additional doctors rotate between the satellite offices and are paid as employees. The doctors from the main location also rotate into the satellite offices as

needed to provide specialty care. The organizational structure can be found in Appendix 1.

William Shoemaker is the administrator, a role analogous to a CEO. He celebrates his third Memorial Day holiday with CC in a week, which means he has been the administrator for two and a half years. While he enjoys his job and working with the people at CC, he is not content with CC's performance during his tenure. It is not a matter of collections – they continue to steadily rise. It is not a matter of turnover, as CC still experiences a remarkably low rate of turnover. It is not even that anyone is telling William that he is not doing well. William feels morale declining in the clinical staff, and that is what bothers him.

The morale problems seem to be tied to the EHR project. Yet again, the staff's expectations have not been met. The enthusiasm from the launch of EasyEHR has dissipated. The project, which started off strong with dozens of templates being completed, is now relegated to after-hours work for high school interns, much like the first adoption. William suspects that he is only still with CC because the doctors spoke out in favor of EasyEHR at the launch. Jennifer, the prior administrator, can attest that adoption failure can cost someone the corner office. This time, William could not be scapegoated because it was Dr. Harris's idea and the board voted for the software.

One year after the implementation, EasyEHR is not used in the exam lanes. William asks Linda Anderson, the tech lead and Dr. Harris's head tech, why the techs do not use EasyEHR while the patients are being seen.

"EasyEHR isn't easy to use," says Linda. "The layout is so counter-intuitive. We enter blood pressure during testing, but it shows up in the medical history. That may work well for some practices, but that's not where our digital blood pressure monitors are located. And it wouldn't work well here."

"Can't we fix that in the EHR?" asks William. "You'd think that this would be a relatively simple change. Take the blood pressure from one screen and put it on another one."

"I don't know about EasyEHR," answers Linda, "but with DocCharts, Dr. Harris changed that with Philip when creating the templates. But when I asked Philip to fix it for EasyEHR, he told me that it's not how EasyEHR works, so we just need to change when we take patients' blood pressure. But he doesn't understand that the techs that take blood pressure and those that take the medical history are different. And besides, the blood pressure monitors are bolted to the wall. And wired into the EHR for automatic entry into patient charts."

"I'm not sure it would be that big of a deal to move the monitors," says William. "I mean, we have all of the rooms wired."

"That's not the point," responds Linda. "IT is here to help us do our job. We don't work for IT – it's supposed to work for us. And blood pressure is just one example. We've gone to IT at least a dozen times looking for small changes and the answer is always, 'No, you need to learn to do things the EasyEHR way.' What does that even mean? EasyEHR is software, not a healthcare protocol."

"It's like IT doesn't care about us," continues Linda. "They have this software, and if what we want to do isn't easy to do, they tell us to change to fit the software. Well, news flash: we have a reason why we do what we do. This is the

culmination of years of experience. It makes us unique, better than our competitors."

Marilyn Schneider, the billing supervisor, has similar stories to tell. "When we first started using EasyEHR, we noticed that the process of posting payments from large insurance company checks was slow and tedious. So we called EasyEHR and said, 'there's got to be a better way.' And there is. There's a set of sample templates to build from where we can enter up to one hundred payments in one batch. That will save us five mouse clicks per patient, so we'd save about 500 mouse clicks in entering our 100-patient batches. That's at least twenty minutes per batch."

William responds, "Have you told IT?"

"Of course we have," says Marilyn with an exasperated tone. "When I talked to Philip, he said that if EasyEHR really wanted us to do this, they would include it in the standard configuration. He said that if we build from the sample templates, some of the payments might get lost and we'll have no support from EasyEHR. As long as we stick with the standard templates built-in, we know the system will work."

William asks, "So how many batches are we talking about? Because twenty minutes a day isn't that big of a deal."

"If it were one or two," responds Marilyn, "we wouldn't be having this conversation. No, we are talking about ten batches a day each. That's over three wasted hours every day, times the three of us in billing. It's causing us to not have enough time to work the accounts receivable to clear up problems. If the billing charges don't go through the first time, we might try once to fix it, then we just bill the patient. If EasyEHR worked as well as our practice management system worked, we'd be able to really track down the issues."

Head Testing Tech Jonathan Crafton agrees that the EHR is not working well in some cases. "It works great for the equipment where the interfaces are set up. The information is immediately sucked into the EHR. In fact, we are using the interfaces even though the doctors don't use EHR. We just print out the report and stuff it in the paper chart because the format is better than what the equipment provides natively. But for the equipment without an interface, we have to go to five or six screens to enter everything that needs to be punched in. It's a real pain and a huge waste of time."

"Have you talked to IT about it?" asks William.

"What's the point?" replies Jonathan. "I know they told Linda no, and she's Dr. Harris's favorite. And they were rude to Marilyn when she asked about some billing changes they needed. Philip would just tell me no, so why bother? We just make do. But we shouldn't have to. Everyone now calls them the no-help desk. Or the department of no."

Troubled, William mulls over the question of how to manage the EHR adoption so that CC can finally enjoy some benefits from the large investment the practice has made.

2.3 The Board of Directors

"Something has to change," says William. "We aren't failing, but we aren't reaching our potential either. The staff is pretty unhappy."

"I'll say," interjects Dr. Harris. "My techs complained about how much time EasyEHR takes. I tried to give the IT department the benefit of the doubt. Look, I vetted it before we made this move. Everyone else who is using it is doing

well, but here we are dying. I had to let my staff start using paper again. This is ridiculous."

"I agree," says Dr. Moore. "I regret agreeing to move over to EHR. It was painful for the first week and then we went back to paper. Now my techs are afraid of doing anything on the computer because they might have to go back to EasyEHR."

"We did the same," adds Dr. Williams.

"As did we," says Dr. Shumway. "I talked to Philip about the problems when we had our IT meeting. He's convinced that everything is great and that the only step left is to require everyone to use the EHR. But I couldn't get it to work in the exam room with the patients. There are too many screens that I have to go through to find everything I need. It's like someone who has never practiced medicine designed the system."

"They probably did," replies William. "It's our job to have it customized to work for us."

"No," says Dr. Shumway. "It's not our job. It's IT's job. And they are failing. Miserably."

"So get them in line," says Dr. Harris. "You work with them, and Philip reports to you."

"I can't seem to make heads or tails of half of the stuff Philip says," complains Dr. Shumway. "He speaks normally until I ask him a tough question. I can tell he's speaking some dialect of English, but heck if I can make sense of it. The jargon starts flowing thick and strong."

"You asked for this," retorts Dr. Harris with a hint of a laugh. "Now you get to learn geek-speak."

"Isn't it his job to make sure I can understand what he's communicating?" asks Dr. Shumway. "I'm not an idiot, but surely he can explain things so I can understand them."

"Ideally," says William, "but you are likely to have to learn a significant amount of his lingo, or, as Francine so elegantly put it, geek-speak."

"I really would love to," says Dr. Shumway, "but I don't have time. I am slammed with patients every day. I don't have time to go back to school."

Dr. Harris speaks up, saying, "You know, I think the inability of IT to communicate really hindered training. We picked them to be trained on EasyEHR. But they couldn't really explain how the EHR is supposed to work, or why our staff members need to do what they were being trained to do. It was a real disconnect."

"In all fairness," says Dr. Miller, "the last training, the one for DocCharts, didn't go much better. And we spent way more on having the vendor send consultants to train the staff that time."

At this point, Dr. Shumway shrugs his shoulders. "Yeah, maybe that's true. So we've tried having a lot of training provided by someone outside the practice, and now we've tried train-the-trainer, where there are a few people inside the practice. What else is left?"

William says, "Maybe both training types are fine if we have the right people in place. I think we were wrong to select IT to train the staff because IT isn't great at communicating. But from what I hear about Jennifer's attempt with DocCharts, the system was more of a hurdle than the training. Of course, we never really know which is the culprit, do we?"

"That's why communication is critical between the business folks and the IT folks," says Dr. Harris. "Which

brings us back to the discussion at hand: how do we get IT on the same page?

Dr. Shumway asks, "William has an MBA. William, did you take any IT classes while you were at school?"

"I did," replies William. "I had a class about managing IT. Most of it was about creating an IT strategy to support the organization's strategy."

"I'm so glad we hired you, then," says Dr. Harris. "We can use your expertise. I move that we have Philip report to William instead of to the board through Mark."

"I'm not sure Philip will take this too well," says William. "He likes considering himself to be my peer. Having him report to me will probably bruise his ego some."

"It's time we take him down a peg anyway," replies Dr. Harris. "And so what if he doesn't like it? He's not doing very well right now. It's time he recognizes that fact. It's time he shapes up. We blamed Jennifer for DocCharts. But this one is on him. We picked a great EHR. Philip assured all of us that he could make it work. And here we are, paying a bunch of high school kids to enter the data after the patients go home. This is not success."

"You know," muses Dr. Miller, "it's a shame that Shane isn't in IT. I've seen him fix several printing problems when nobody wanted to go talk to IT. He's quite good with computers."

"You're right," says Dr. Shumway. "Something you may not know, Shane has been working with IT a bit, and his login account now has administrative rights on the computers. He's spending about 10 hours a week right now on helping IT. That was Philip's idea. Shane kept asking questions and Philip was impressed. So he basically deputized Shane."

"That's cool," responds Dr. Harris. "And, Mark, you sounded quite geeky to me. I think you're picking up more jargon than you may realize. But does it bother anyone that we already pay for three full-time IT people, and they are robbing us of our testing techs?"

"It doesn't bother me," responds William. "Shane always got bored. That's why he's moved around and done pretty much everything."

"That's fair," says Dr. Brown. "Shane even teched for me for two weeks to substitute for Katy when she had her baby. He seems to love doing different things."

"You know," quips William, "if everyone at CC felt that way, we'd have been on EasyEHR since the first week. I think there's an opportunity here. I knew Shane's worked on most of the equipment, but I didn't know he'd even teched for you, Shannon. That means he understands most of our clinical processes."

"Are you thinking about expanding his role in IT?" asks Dr. Harris.

"Why not?" responds William. "The IT department isn't doing so well with customizing EasyEHR. What if we make Shane do it? We'll give him some snazzy title. I saw other practices call this type of position an EHR Analyst."

"We can't do without him in testing," says Dr. Harris. "Maybe have Shane go half-and-half? That will keep his teching skills fresh, too. So he can update the templates more easily."

"Would you mind," asks William, "if we wait a little while on this? I don't want to drop the bomb on Philip that the board isn't happy with his performance and then push Shane

on his department in a formal role. And besides, maybe I can convince Philip that it's his idea."

"You have three months," responds Dr. Harris. "I want the EHR project back on track by then. And I don't mean by hiring more high schoolers to do data entry. I mean we really need to use EasyEHR."

"Are you giving me an ultimatum, Francine?" asks William.

"No, I'm giving you my expectation. But you can use it to motivate Philip if you need to. An ultimatum may be just what he needs."

"Please take care of Philip's performance review again this year," asks Dr. Shumway. "And make sure you tell him that the board isn't happy and that he is now to report through you. I'll be happy to get those hours back every week now that I don't have to meet with IT."

2.4 Governing IT
After meeting with Philip for his annual review, William calls an emergency board meeting.

"Philip's gone too far," William reports. "Unhappy doesn't begin to describe it. His words were sharp enough, but his face showed just how angry he really was. I'm afraid there may be no walking this back."

"What did you say?" asks Dr. Harris.

"I told him what we discussed," says William. "I told him that the EHR project isn't going well. But Philip insists that, since the system didn't go down, it's not his responsibility."

"Sure, the server didn't go down," says Dr. Shumway, "but would we have noticed if it did? I mean, we don't use the system. What good is a system running when it doesn't do anything useful?"

"This isn't all on Philip," adds William. "The IT department has three people. They seem to be busy, but I can't tell what they do or why they do it. I should know more about what's going on, but the projects I know about – I don't know why IT thinks they are important. Look at the wireless network Curtis installed. Why do we need wireless? None of our equipment is wireless. And it's not open for the patients to use. Who does it help? It's a really slick system with all kinds of capabilities. But we don't use it, so why did IT pursue it?"

"Who authorized buying the equipment?" Dr. Harris asks. "Do you know, Mark?"

"We've given IT purchasing authority up to $10,000," answers Dr. Shumway. "Without it, I was being bombarded for buying mundane supplies because the routine purchasing limit of $50 was too small. Philip made the case that he might have to order a replacement server or network switch quickly if a failure is imminent, so we set the limit based on the average cost of a replacement server."

William informs the board, "I have no issue with IT having some purchase authority independently, but we should budget that more carefully. I think the real issue is that IT is picking what projects to work on, and their priorities may not match up with our priorities."

"Somebody has to take charge of IT," says Dr. Harris. "William, can you handle this?"

"Philip may not like this. But I'm not convinced that it would be all bad if Philip moves on," says William. "He's done some great work, but maybe it's time for a change in IT leadership."

"No," Dr. Harris flatly refuses. "He's been loyal to us, and we'll be loyal to him. Sure, he messed up on EasyEHR, but I think he did it because he's afraid of it going the way of DocCharts."

"He said as much to me during our meeting this afternoon," says William. "He sees saying no to customization as the best way to avoid EasyEHR becoming impossible to use. The irony is that EasyEHR is unusable now, meaning his fear is already realized. But our problem is more fundamental."

William continues, "Having someone making decisions based on fear is not good leadership for IT. As strange as it may sound, IT is least equipped to decide what they should be doing. Their job is to serve the needs of the entire practice. But they get so hyper-focused on operations, on keeping the systems running, that they forget to ask if we need the systems running. Operations are important, uptime is important, but so is strategy. I'm not sure IT has the experience and the broad perspective necessary to be successful in creating their strategy and prioritizing their projects."

The meeting pauses for about a minute as everyone allows William's comment to soak in. The silence is broken by Dr. Shumway. "But Philip doesn't welcome direction. He's pretty stubborn in his view that IT is great. What would happen if he left? Can the rest of IT continue without interruption?"

"I doubt it," says William. "They're pretty compartmentalized. Which is weird when you consider there are only three of them. But Angela does all computer-level changes, Philip works on the servers, and Curtis handles the network equipment and cable. They can pitch in and help sometimes like we saw when we first went live with EasyEHR, but that's not their norm. I doubt very much that Curtis or Angela know enough about how the servers are configured to be able to last through Philip leaving."

Dr. Harris raises the question, "What about consultants? Are there any in our area that know enough to fill in temporarily?"

"That's something I can investigate," William responds. "But I'm not sure how to tell how much a consultant really knows. If we ask Philip to evaluate the consultant, I think he'll think we are trying to get rid of him, which isn't our goal here."

"Let's spin it another way," says Dr. Davis. "What would we do if Philip were to die suddenly? Or to become fully disabled? That's a risk, and always has been, even if we haven't planned for it."

"It's possible that Philip has already planned for something like this, and we just don't know it," says Dr. Johnson reasonably. "We should ask."

"Carefully," adds Dr. Wilson. "Because a conversation about succession planning could easily be interpreted as, 'Hey, we were thinking about firing you but want to make sure it's as quick and painless as possible.' Not a good signal to send to someone so critical to the practice."

"We really don't know if Philip will want to stay if we make the changes we've discussed," says Dr. Taylor. "Let's face it, Philip has enjoyed a lot of latitude in his time here. Adding structure might make him want to leave. And that makes this planning all the more important."

"And difficult," says Dr. Jones. "It's hard enough to plan when things are stable. But if we are in the middle of huge changes, like a new Director of IT, then it would be even more of a moving target."

"All of this is well and good," says Dr. Harris, "but the fact remains that this has been a risk for a very long time. We need to address it."

"If the idea comes from this board, it could be seen as a threat," William suggests. "Maybe I can sniff around and see if this has already been done."

"I'm not sure you have a great relationship with Philip right now," suggests Dr. Harris.

William counters, "All the more reason why I need to work with IT on something everyone can agree on. I need to work through this, and the longer it festers, the harder it will be for us to put it behind us."

"OK, you can work with Philip about some sort of continuity plan, but before you do, I think you need to start collecting applications in case he leaves," Dr. Shumway insists. "I hope Philp stays with us, but if he doesn't, we need to be prepared. Just leave our company out of the listing in case he sees it."

"Are we sure about this?" asks William. "I mean, this could easily backfire. We aren't in a large metropolitan area where a ton of companies could be listing jobs. We're pretty unique."

"That's a risk we have to take," says Dr. Harris. "We have to make changes in IT so they work for us instead of doing their own thing. That brings risk. The only way I see to mitigate that risk is to list Philip's job. Hopefully, we won't even have to review the resumes because Philip will stay. We will be loyal to him. But just in case he isn't loyal to us, we still have to be prepared. I move that we post Philip's job."

The board unanimously approves posting Philip's job, which William completes the next morning.

2.5 Disaster Recovery and Employee Succession
"Is Philip here?" William asks Angela.

"He was here, but he's at lunch right now. Did you really post his job?"

William experiences a moment of panic but hopes Angela did not notice. "Where did you hear that?"

"Philip said you posted his job after giving him a bad annual review. He said you promised him three months and then you posted his job the next morning. Are you firing him? If so, we need to know so Curtis can disable his accounts. That's our policy, and it's especially important for us in IT, as we have rights to so much. I trust Philip and don't think he'd ever do anything stupid, but if he did, it could really hurt us."

"No," assures William, "we are not firing Philip. And I can't comment on Philip's annual review, as those are confidential."

"I had to fix a computer in one of the tech stations and overheard several of the techs talking. Apparently one of the doctors let slip that they were thinking about getting rid of Philip."

"I'm afraid the grapevine is inaccurate as always," retorts William. "But tell me more about this policy you mentioned about disabling accounts."

"It's in our procedures that Philip wrote. We have a few binders of policies and procedures for IT. The one I mentioned is that when an employee is being terminated, we disable the login account and change all of the passwords to a random

password that nobody knows. We archive all of the user's data to an optical backup so we have a snapshot. I'm surprised you didn't know about these, as we are supposed to know about someone being terminated before it happens to reduce the risk that they'd copy or destroy data that belongs to CC."

"I'm impressed Philip created those policies, but no, I didn't know about them. Where are these notebooks, and what else is in them?"

"They're kept in the server room. The three of us have access. They include phone numbers for all of the vendors and service providers we use, instructions on backups, and all of the administrative passwords. Just in case, you know."

"I thought writing down passwords was a no-no," remarks William. "Each training IT gives us reminds us to never write down our passwords."

"IT can reset your password, so if you forget it or if something bad happens to you, we can still access your account. But if we forget a password to an administrative account, we may not be able to recover," Angela explains. "Besides, what if all three of us get hit by a bus when we go out for drinks?"

"So you plan for those possibilities?" asks William. "I had no idea."

"We have a disaster recovery plan. It includes staff turnover, natural disasters, fire, flood, that sort of thing. Of course, if the building burns down, we probably won't care much about making the computers work. We'd have bigger fish to fry, you know? But that's something Jennifer really pushed."

"If this is a Jennifer-era plan, is it still valid?" William questions.

"That's a good point," says Angela frowning. "We've updated the list of vendors and contact people when major changes occur, but we haven't really taken a wholesale look in several years. I guess we ought to update it."

"I would appreciate it if you did," says William. "But, do me a favor, would you Angela? Please make it sound like your idea and not mine. If Philip thinks his job is being posted, it's probably best that I not be seen trying to make it easy to replace Philip. I really hope he'll stay with us."

"Me too," Angela says. "He built pretty much everything here. Trying to manage without him would be tough. I can do some of it, and Curtis can do some of it, but I don't think we could do it all. We just don't have the experience on the servers that Philip has built over the years."

William is lost in thought for a few moments. He thinks about how foolish it is to have no clear succession plan in IT. If Philip never comes back, it's not just EasyEHR's adoption that would suffer. He deals with vendors negotiating contracts, he works on the servers, and he keeps a lot of things running that William only pretends to understand. But with Philip feeling threatened, how can William bring this up now? Anything he does will simply make a bad situation worse. William shakes his head and looks back at Angela.

"On another topic, tell me about Shane. How's he working out?"

"Oh, he's great. He really gets IT, and he knows and is liked by everyone."

"Do you think he'd help out the EHR project? I'm thinking about assigning him to IT half-time to help out with building templates. He seems to have a great rapport with the techs, and he's had just about every job in the clinic, so he has first-hand experience with the processes."

Angela looks at William with surprise, "You don't think we can build the templates?"

"I think you can," says William, "but none of you have ever been a tech. You understand the technology really well, but the clinical aspects have been outside the scope of your responsibilities. I think having someone clinical in IT would help bridge the gap. What do you think?"

"I don't know," replies Angela. "I'll have to think about it."

"Please do."

Philip returns from lunch and addresses William, "Hello, Mr. Shoemaker. Is there's something I can do for you?"

The forced formality is not lost on William. "Hi, Philip," William responds with false hardiness in his voice, "Actually, I came here to talk to you. Do you have a few minutes?"

Philip replies with a shrug, so William follows Philip into his office and closes the door. "Look, I was a bit harsher than I should have been. I'm sorry. Your department does great work. But I haven't provided you with enough information on our strategy. That's on me, and I want to help fix it."

"We're constantly in the dark," complains Philip, seizing on the opportunity. "More information would help us."

"What do you think will be the best way to get this information to your department?"

2.6 Keeping the Adoption On-Track
With all of the distractions William faces in governing IT and dealing with the potential of losing Philip, the EasyEHR project keeps getting pushed to the back burner. The EasyEHR system is fully implemented – it works. But it isn't really adopted; it doesn't work for CC.

But CC's growth depends on completing the project successfully so that CC can enjoy the promised benefits of EHR as well as meet the continually increasing government requirements for meaningful use of EHR systems. Because EasyEHR's adoption depends so firmly on the IT department, the issues seem inseparable. Philip maintains the database and interacts with EasyEHR's vendor. Only Philip really knows how everything is tied together. And if Philip leaves, how will CC cope?

Beyond succession planning, William must also deal with the disconnect between IT and the clinical users. The clinical users are tired of being told what EasyEHR cannot do rather than having options provided for actually addressing CC's needs. In the end, the IT department seems so focused on implementation that full adoption eludes them. William knows that some form of governance may help address the issues and allow the EasyEHR adoption project to get back on track, but what is the best way to address the underlying issues to reach success?

3. REFLECTION QUESTIONS

1. How would you recommend that CC govern IT?
2. How would your recommendation address the problems faced by CC in this adoption?
3. Do you agree with the doctors' suggestion of using Shane to help IT? Do you agree with William's suggestion that the idea become Philip's?
4. How can CC plan for the possibility of Philip leaving?
5. Which is most important: the governance issues, the succession planning, or getting EasyEHR's adoption completed? Why?

AUTHOR BIOGRAPHY

David L. Gomillion is a Clinical Assistant Professor in the Department of Information & Operations Management, Mays Business School at Texas A&M University. He earned his Bachelor of Science degree in Computer Science from Brigham Young University and a Master of Science and a Ph.D. in Management Information Systems from Florida State University. Prior to academic life, Dr. Gomillion served as a Director of Information Technology to a group of physicians, a role similar to a CIO position. Dr. Gomillion's teaching interests include systems analysis and design, networking, cyber security, health information technology, and project management.

APPENDIX 1: ORGANIZATIONAL CHART
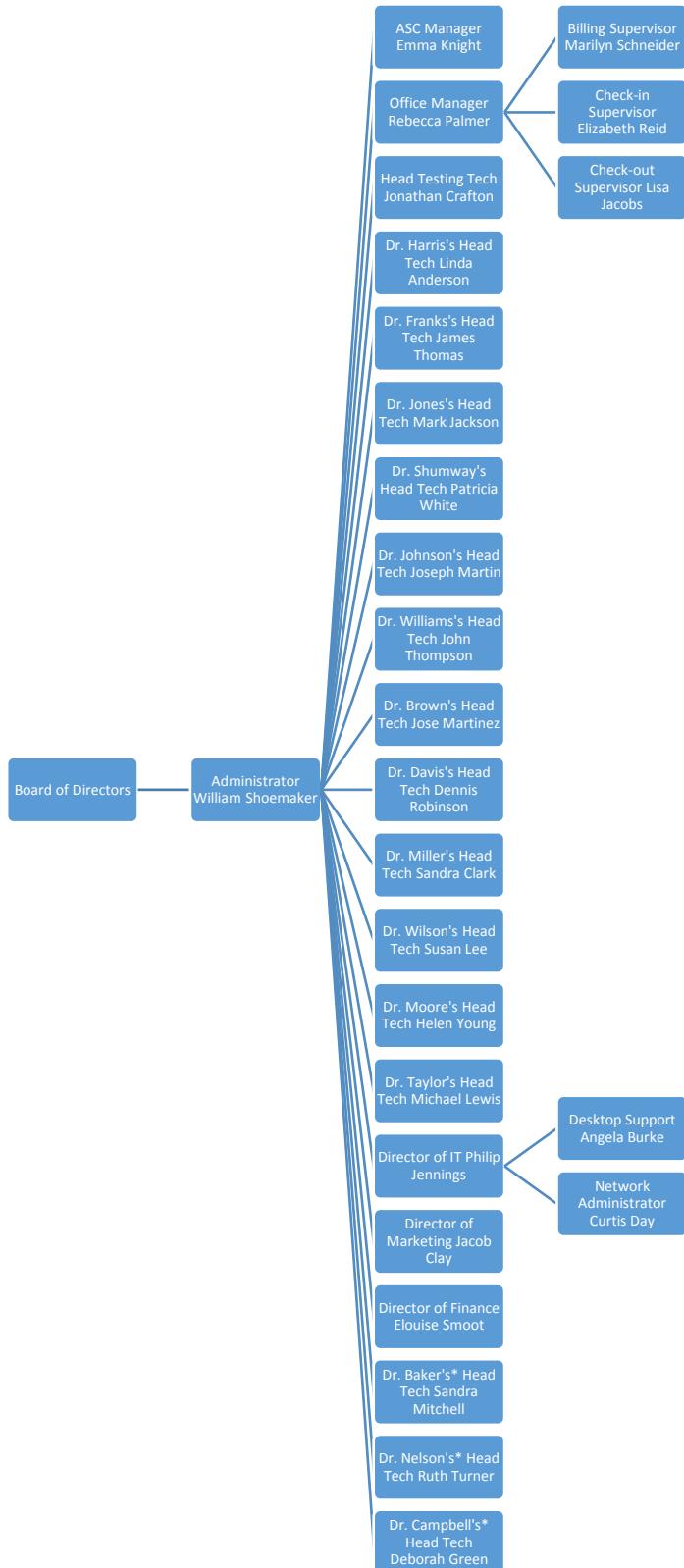
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