Mismanaging a Technology Project: The Case of ABC Inc.

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Executive Summary

A common misconception is that technology can solve problems. Very often, the people and processes involved have significant impacts on the success or failure of a particular piece of technology in addressing a problem. This case is a classic example of how not to manage a technology project. It describes how a client, a vendor, and a sub-vendor exercised poor judgment in dealing with one another in applying client-server technology to a project of mammoth proportions. In the end, there were no real winners and the project, which came close to abortion, is now progressing to a slow finish, many valuable months and dollars behind what were originally estimated.

One learns that it is not merely enough getting a customer “involved” in a project from the very beginning. Learning who the key players are, engendering and fostering a feeling of mutual trust and commitment to the end result (i.e., a successful project-development partnership), educating the customer about technology and process re-engineering possibilities, exercising adequate authority and control, and, perhaps, iterative, multivendor-based project design and implementation are all critical elements of a successful technology venture. This case is based on reality. We have, however, changed the identities of the parties involved and other key information to preserve anonymity.

Background

The organization of interest is the State Health Services Department of a state located in the southern region of the United States. The department was formed in the early 1900s. From a 10-person,
the organization grew over the years into a large conglomerate with 125 sub-organizations. Each sub-unit is a County Health Department, located in and serving one of the 125 counties in the state. Today, the entire operation involves 5,500 employees of whom about 900 are doctors.

The organization seeks to provide affordable health care to any and all residents in the state. While it does not deny health care to anyone, regardless of ability to pay, the decision on whether or not a patient is charged is based on the financial standing of the individual. Some patients pay the entire amount due immediately following the visit, others enter into a pro-rated payment arrangement, yet others are treated gratis.

In the urban counties, it is the underprivileged who generally frequent a county’s health department despite the availability of private health care. This is so because the latter is often prohibitively expensive for the uninsured and the underinsured. In the rural counties, however, people of all income groups and social standing try to make use of the local health departments due to the paucity of private health care facilities in such areas. It is only when adequate care is unavailable here that these patients begin looking elsewhere.

While the organization’s goal is to provide affordable health care to one and all, the various sub-units differ in their ability to provide quality care. A substantial part of the reason for this is the inability of the organization to attract and retain appropriately qualified medical personnel and support staff in rural areas. Even in the more urban counties, the salary differential between a doctor employed by the health department and one in the private sector tends to be quite substantial. As such, the department generally attracts professionals with a dedication to the Hippocratic oath and young interns obligated to take up the positions in order to satisfy medical study grant requirements. (Incidentally, a large number of the health department’s medical professionals, particularly in the more rural counties, are also foreign medical graduates who are considerably more resilient about their living and working conditions than United States nationals. This is because, quite often, the conditions are nonetheless better than what their home countries have to offer.)

Given this disparity in medical knowledge at the various County Health departments, the supporting infrastructure also varies considerably. A large number of these units, predominantly in the rural areas, operate with a handful of general practitioners — physicians in family health care, obstetrics and gynecology, and pediatrics — and support staff. Almost all units have some kind of in-house pharmaceutical dispensary facility. The relatively larger, urban units have professionals in almost all specialties, as well as surgeons, on call. These larger units also have in-house medical laboratories, x-ray clinics, and well-stocked pharmacies.

The State Health Services Department is akin to the central office of a large corporation. Prior planning efforts by the department involved very little apart from the vision that a county-by-county, statewide presence was needed. Over the years, the 125 County Health Departments mushroomed all over the state, their growth and operational needs largely determined locally. This commitment to “state-wide presence above all else” has resulted in all 125 units remaining operational even though, as we shortly discuss, a significant proportion of the sub-units are financially weak. The central office’s role in the day-to-day operations of the county units is largely limited to providing a set of general management guidelines and administering the flow of money to units through budget allocations. Each unit is essentially autonomous in almost all respects, notably in terms of interpretation of recommended management principles/practices and the disposition of allocated budgets.

Budget allocation decisions are based on the revenue generated by each unit. Essentially, this implies that a unit’s budget is determined on the basis of the number of patients serviced by it and the types of services provided. As a rule of thumb, the more revenue a unit generates, the more budget it is allocated in the following year. Budgets are used by units for all of their expenses, such as the purchase of medical/office equipment and supplies, hiring and severance of employees, and salaries.