Final Thoughts by Paul Cunningham

Most people might think the defeat of General George Armstrong Custer at the Battle of the Little Bighorn in the summer of 1876 was the worst disaster ever to befall the United States military during the country’s westward expansion when carrying out its Manifest Destiny. They’d be wrong. That distinction belongs to the lesser known Battle of the Wabash River which occurred in November 1791 in western Ohio. There, an ill-equipped General Arthur St. Clair lost more than 600 soldiers at the hands of 1,500 Miami, Shawnee and Delaware Indians. That was almost three times the number of troops under Custer’s command who fell on those grassy Montana hills and flatlands almost 100 years later.

But, we know so much more about the Little Bighorn because of the way the battle has been romanticized. Or, we think we do. As a kid, I knew it as the tale of a heroic, flamboyant General (looking a lot like Errol Flynn with goatee and long blond tresses). In the name of God and country, Custer charged his men, sabers at the up, into the valley of death to the tune of Garryowen, the 7th Cavalry’s Regimental Marching Tune. Only later did I discover the battle amounted to the final chapter in the story of a self-centered egotist, a misanthrope driven by ambition and finally to destruction at Custer’s Last Stand.

Reports on the massacre concluded that Custer made a fatal mix of mistakes trying to leave his indelible mark in history (ironically, he succeeded). He drove his men too hard leading up to the battle, leaving them too tired to fight effectively; he wrongly assumed that the Sioux and Cheyenne warriors would fall back rather than fight (they didn’t); and he split ranks, dividing his men into three smaller groups, giving up the critical mass that could have made a difference.

The fact that he chose to take care of what he thought to be an immediate threat, an encampment of 100-200 hostiles, only to find the largest congregation of Native Americans ever assembled together at one place on the North American continent – a combined force of 4,000 Sioux and Cheyenne – did not help matters. Custer effectively employed the element of surprise, only in reverse. Comedian Bill Cosby nailed the situation in an early-career routine about a referee’s coin toss prior to the battle, à la the ritual preceding a football game. After Sioux War Chief Sitting Bull wins the toss, the ref instructs, “OK, Cap’n Custer, Cap’n Sittin’ Bull says you and your men wait at the bottom of this hill while him and all the Indians in the world ride right down on you.”

Not a single soldier fighting with Custer that day survived, so it’s impossible to confirm, but that is probably what was going through their minds at the time – all the Indians in the world. Custer himself, wide-eyed and facing his own mortality as he prepared to sign-off, may have thought intermittently while firing and reloading his 45-caliber Colt six-shooter, “Perhaps (blam!)…I should have (blam!)…better assessed the (blam!)… consequences of my actions (blam! blam!).”

Good advice there, and not just for military strategists. Among others, it should be an effective lesson learned for hospitals as they explore ways to attack issues like health reform, health information technology (HIT)/exchange (HIE) and the conversion to ICD-10. While the first two may seem to be more immediate and are getting the lion’s share of attention for now, there are dire consequences for overlooking the last one.

True, the initial bonuses associated with “meaningful use” of HIT begin in a few months and payment changes required under health reform (i.e. Medicare’s value-based purchasing program) are fast coming down the track. Both can damage a hospital’s revenue outlook at a time when revenue sources are becoming more precious by the day. So there is a risk associated with not focusing on either one.

However, the new coding system, which won’t go into effect until October 1, 2013, may be more of a hidden threat lingering just beyond the horizon. Preparations will consume time, money and manpower, but the failure to implement the ICD-10 code sets comes at a higher cost. It will create coding and billing backlogs, choke off cash flow, increase claims rejections and denials, lead to improperly paid claims, cause the loss of payer contracts and payments, and finally, punch the sign off button.

In other words, hospitals that do not properly assess the consequences of their actions vis-à-vis ICD-10 conversion may well find themselves at the bottom of a proverbial hill waiting for all the Indians in the world ride right down on them.