

EMR Implementation in Critical Access Hospitals, Small Community Hospitals and Affiliated Clinics

SEVEN CRITICAL ELEMENTS FOR REALIZING YOUR EXPECTATIONS



Table of Contents

Introduction... 2

Setting the stage: What you can reasonably expect from your EMR implementation... 3

Taking control: Seven critical elements for realizing your expectations... 3-8

Summary... 9

Introduction

For many critical access hospitals, small community hospitals, and their affiliated clinics, the process of implementing an electronic medical records (EMR) solution is a journey into uncharted territory. Most know where they're starting and where they want to go, but often have a hazy view, at best, of the landscape in between. Obviously, the hope is to arrive at a destination quickly with as few detours as possible along the way.

This paper shares ideas about what comprises a successful implementation. It is a guide to help you understand what to reasonably expect from the EMR implementation process and key steps to take to ensure a satisfactory experience for everyone involved.

It also lays out seven "critical elements," including detailed recommendations, for realizing expectations.

Inpatient and ambulatory (or outpatient) EMR implementations are similar in many respects, and this document primarily covers their shared characteristics. However, in a few instances, there are notable differences, which are briefly described. For example, under "Critical Element #1," part of the discussion is devoted to differences in the inpatient vs. ambulatory EMR leadership teams.

Lastly, keep in mind that this document should not be considered a detailed roadmap. Rather, the goal is to provide talking points for discussions among your EMR decision makers and with your EMR vendor. By addressing these critical elements proactively, you'll take a substantial step toward achieving a relatively smooth, obstacle-free EMR implementation.

Setting the Stage

WHAT YOU CAN REASONABLY EXPECT FROM YOUR EMR IMPLEMENTATION

In general, hospitals and clinics can readily identify the benefits of an EMR solution, including improved patient safety, a more satisfying overall patient experience, increased revenue through strengthened coding accuracy, faster access to patient data, and new efficiencies gained through the integration of clinical and financial systems.

Less is understood about the implementation process itself. Why? No two healthcare organizations are the same, so it stands to reason that the implementation experience will be unique for each one. However, successful implementations tend to exhibit certain characteristics, such as:

- :: **Clearly defined goals** supporting rationale for the implementation
- :: **Strong leadership teams** who help keep things on an even keel, especially when there are high tensions or disputes
- :: **Voluntary adoption by constituents**, including physicians, requiring a minimal level of mandated use
- :: **Timely, ongoing communications** about what users can expect: major functionality, how their jobs will change or improve, and the timing of deployment
- :: **A smooth transition** from paper to electronic records, or from one electronic system to new electronic system, with little or no disruption to operations and patient care
- :: **On-schedule, on-budget** completion of the implementation

How well your organization does on each of these counts depends on the effectiveness and timeliness of your response to the seven critical elements discussed in the next section.

Taking Control

SEVEN CRITICAL ELEMENTS FOR REALIZING YOUR EXPECTATIONS

Human factors, rather than technological issues, underlie most of the challenges that arise with an EMR implementation. Moreover, once these challenges manifest themselves, they can be extraordinarily difficult to fix. The fabled “ounce of prevention” can go a long way toward heading off problems, as you’ll see in the following seven critical elements of a successful EMR implementation.

Critical Element #1: The Right Leadership Team

The EMR leadership team, also known as the steering committee, can literally make or break the implementation process. “Must” attributes of this team include:

- :: Able and willing to devote sufficient time (typically at least two hours per week) for team meetings and to gather information for the system build and workflow development
- :: A consistently positive point of view toward the solution and implementation process

- :: One lead member who has the responsibility and willingness to make final decisions, particularly when departmental or individual conflicts arise; this person may be a physician for ambulatory implementations and the chief nursing officer (CNO) or other C-level executive in a hospital

Depending on the size and type of facility, the leadership team consists of three or more members from a cross section of backgrounds and departments. Following is an example of an interdisciplinary team for an inpatient EMR implementation:

Project coordinator — responsible for organizing team meetings, establishing ground rules, documenting team decisions, ensuring on-time completion of tasks, maintaining the overall schedule, and securing resources for the team.

Nurse champion (typically CNO) — a thought leader who fully understands the existing clinical workflows and how they translate to electronic records; often serves as a “super user” for the nursing staff (see “Critical Element #4”).

Information technology lead — responsible for deployment and operation of the software and hardware (e.g., workstations, wireless tablets, printers and scanners).

Representatives from other areas — such as pharmacy and dietary, whose departments are part of EMR workflow; other members may include the business office manager and HIM department director.

Physician representative — usually serves in an advisory role.

In most cases, the application vendor will supply one or more implementation specialists who work closely with the internal team at the client site and/or remotely from the vendor’s office.

Ambulatory EMR team members

On the outpatient side, team members will have roles that are similar to those of their inpatient counterparts. Notable differences in the makeup of the ambulatory EMR leadership team may include:

- :: The physician champion plays a central role on the team and with fellow physicians; he or she should be a respected thought leader who understands clinical workflows, can inspire staff to embrace change, and drives consensus.
- :: The clinic manager is instrumental in communicating important information to staff, coordinating staff training and the chart back-load/scanning process, and overseeing the go-live scheduling.
- :: Other members of the team may include representatives from scheduling and transcription, in addition to those from the business office and HIM department.

Leadership team meetings

The frequency of leadership team meetings will vary depending on the phase of the initiative. For example, the team may meet monthly or quarterly to establish EMR workflows, bimonthly during a change process, and weekly during the implementation. Topics may include:

- :: EMR releases and version upgrades
- :: Workflows, particularly those that cross disciplines and departments
- :: How manual processes will be automated
- :: Strategic planning
- :: Mentoring departmental EMR champions

- :: Budget priorities (e.g., replacing hardware, adding modules)
- :: Employee training and orientation
- :: Performance improvement initiatives
- :: Department communications and teamwork strategies, including conflict resolution

Critical Element #2: A Solid Organizational Foundation

A surprising number of hospitals and clinics launch into an EMR implementation without a) well-defined goals related to what they want to accomplish and how they will evaluate their progress; and b) a clear understanding of how automation will alter policies and everyday workflows.

As with any major initiative, an EMR implementation needs the full backing and careful consideration of upper management. This entails, but is not limited to:

Identifying and measuring expectations — The answer to “What’s in it for us?” can vary dramatically from one organization to the next. Some view implementing EMR as merely fulfilling a government mandate — and not much more. Others envision a robust set of outcomes, such as streamlining access to patient information, reducing medication errors, decreasing outside transcription costs, capturing correct charges, or simply enhancing the community’s perception of the provider’s capabilities. Hospitals and clinics may also be accountable to outside stakeholders. For example, a group of rural physician practices received a grant to help fund an EMR solution. However, before final monies were released, the grantor required proof that the solution was translating to improved care for diabetic patients. Whatever your organization’s goals for an EMR solution, be sure to communicate them to everyone in the organization. If applicable, determine how you’ll measure your progress in achieving your goals, and make certain you have mechanisms in place to follow through and to communicate the results.

Making workflow and policy decisions — Without question, an EMR solution changes the workflows that support patient care. Designing your EMR workflows starts with a clear understanding of current practices, processes, and priorities. Then, with the internal leadership team and vendor representatives working closely together, the EMR solution evolves with modified and possibly even new workflows. The aim, of course, is not to simply mimic how tasks are performed in a paper-based world, but to bring about process improvements. Quite often, these new workflows drive policy changes. Here’s an everyday example: With paper-based medical records, a patient admission assessment form may be accompanied by other documents, such as fall-risk and nutritional evaluation forms. After the EMR solution is deployed, a single electronic document may integrate the admission assessment with the supplementary evaluations. This document consolidation necessitates a revision to the hospital’s patient admission policy.

Critical Element #3: Stakeholder Buy-in

Remember the earlier discussion about challenges arising from human factors? Nowhere does the human factor come into play more profoundly than with the acceptance of an EMR solution by the user community. In hospitals and clinics where physicians and employees get on board grudgingly, if at all, it should shock no one when the EMR solution doesn’t

live up to expectations. By contrast, healthcare organizations that place a high priority on stakeholder buy-in generally realize their objectives, and they do it more quickly.

A major impediment is human nature. People tend to resist change, especially if they're intimidated by the new technology. Following are a few common-sense guidelines that can help foster a positive viewpoint:

Be careful about what you say and how you say it. Whether it's a formal communication or hallway chatter, leadership team members and others involved with the project should refrain from making negative comments. Even seemingly benign remarks may be misconstrued by listeners who are negative or fearful. Whenever possible, communicate the end-user benefits of the EMR solution, particularly how it will make life easier and enable people to do their jobs more effectively. Don't sugar coat the challenges an implementation may bring, but a "we're all in this together" mindset can go a long way toward overcoming apprehension.

Demo the solution to end users. The product demo helps persuade management to buy into an EMR solution. Wouldn't a similar presentation have the same effect on end users? Yes, seeing is believing — and accepting. Ask your vendor to create an end-user demo for presentation prior to the start of implementation.

Acclimate users with manageable bites. As discussed later in this paper, most organizations undertake a phased EMR implementation, for a number of reasons. One advantage of a phased implementation is that it eases end users into the new electronic environment. In other words, the EMR solution doesn't seem so overwhelming. Here's an example: A hospital starts with an order entry/order communications module followed by clinical documentation. Staff members become acclimated to the system (navigation, data storage, etc.) in smaller bites rather than having to learn everything at once.

Critical Element #4: Tailored User Training

How you conduct user training depends on several factors, including the size of the facility, the number of people to be trained, their departments and roles, and what their expectations are. Let's look at key factors that go into determining whether to use team or role-based training:

Team-based training, which typically involves an entire patient care team, enables users to visualize an entire workflow from start to finish. They also gain a clear understanding of who will perform specific tasks within the workflow. Team training requires more time than role-based training since you're covering an entire workflow. Be sure everyone is given sufficient time to participate.

Role-based training, as the term conveys, focuses on a set of tasks for a particular role. Because you're addressing only a specific portion of the overall workflow, role-based training usually means shorter training sessions for each participant. However, it also requires more classes and a greater time investment for your trainers to cover all the individual roles.

Essential final step: simulation

Regardless of the method used — and often a facility will use both — the final step in the training process is a simulation. Simulating a patient visit or admission reinforces skills learned in training and helps staff more clearly see the progression of steps in the workflow. Ideally, each member of the team will have at least one opportunity to participate in a simulation.

Physician training

For an ambulatory EMR solution, most physicians will prefer to be trained individually on their part of the solution. However, they need to understand the importance of participating in a simulation with other members of their team. The physician representative on your leadership team can play a key role in influencing his or her peers to accept and follow training protocols.

Access to super users

With any major software implementation, questions persist after the training is completed. Each facility will designate at least one super user who can answer questions and assist other users. The number of super users depends on the size of the facility and the number of departments involved. You want to make your go-to people as accessible as possible. This accessibility should extend to overnight and weekend hours. Frequently, super users are nurse and departmental representatives on the leadership team (refer to “Critical Element #1”). This makes sense because of their involvement in developing the solution; they’re often adept at quickly identifying and resolving the core problem.

Critical Element #5: Supporting Technology Decisions

An EMR solution involves not just software, but the right supporting technology. In fact, the supporting technology you choose and how you deploy it play a significant role in dictating your workflows. Therefore, it stands to reason that workflow and hardware decisions must be made hand in hand. Following are some key questions to answer:

- :: Will clinicians document patient encounters with wired workstations in the exam rooms or with wireless laptops/tablets?
- :: Will clinicians use a microphone and voice recognition software to generate documentation?
- :: What is the process for recharging wireless tablets (if used)?
- :: Where will printers be located?
- :: Where will scanners be located?
- :: Will hospital staff use “computers on wheels” with a wireless system or hardwired PCs located at the bedside or doorway?
- :: Will users present smart cards or biometric identification for logging on to the EMR system?

Your EMR implementation specialist should be able to provide insights and guidance with your supporting technology decisions.

Critical Element #6: A Sensible Go-Live Strategy

For most clinics and hospitals, an EMR implementation occurs in phases. A phased approach offers significant advantages, which may include:

- A more manageable process for those who implement the software and train users
- Easier for users to get accustomed the new system
- Reduced potential for disruptions to operations and patient care
- Less negative impact on revenues

Inpatient EMR go-live considerations

An inpatient EMR implementation usually works best with a phased approach. A hospital will typically partition the implementation by department and/or software module. For example, go-live may begin with the emergency department or surgery and then progress to other areas. Optionally or additionally, you may want to stage your rollout of individual EMR modules. As discussed under “Critical Element #3,” users often feel less overwhelmed if they’re exposed to the software in this staged manner.

Ambulatory EMR go-live considerations

On the outpatient side, the EMR go-live may start with a single physician or a small group of physicians. You may begin by documenting a minimum of two patients per day for the first week, then adding two patients per day until all patient visits are documented in the EMR system. During the first week, accommodate the staff learning process by allocating more time to electronically documented patient visits. You should begin moving other physicians or clinic locations into the new system as soon as possible — don’t wait for the first group to complete its transition to EMR. This phased approach will minimize any negative impact on operations. If you decide to pursue an all-at-once go-live strategy, you’ll want to reduce patient visits by 40% to 50% during the first two to four weeks.

Back-loading historical data

The decision to back-load, or scan, historical patient data can vary dramatically from one facility to another. In a nutshell, it boils down to weighing the time and storage required against the potential benefit to be derived. In deciding how much, if any, back-loading to perform, ask yourself this question: What’s the likelihood of anyone needing this data electronically? Indiscriminate back-loading probably isn’t worth consuming a lot of staff time or computer hard-disk space. Frequently, the facility will perform selective back-loading. For instance, a clinic may scan only the last three echocardiograms for patients with cardiac disease and only the last lab report for patients with no history of abnormality. A hospital may choose to back-load data only from the beginning of a patient’s stay. Your EMR implementation specialist can advise you as to the best avenue for your facility.

Parallel phase before full deployment

In certain situations, especially with inpatient implementations, a parallel phase — simultaneous use of both paper and electronic records — can prove to be a valuable step before full EMR deployment. Generally lasting two weeks, the parallel phase enables you to work through issues you didn’t envision during the planning process. It also creates a low-risk environment for users to make (and learn from) their mistakes.

Critical Element #7: Continual Improvement

Although it's a major milestone, go-live shouldn't represent the final chapter in an implementation. Instead, look at it as a springboard for continual improvement. Following full deployment, the leadership team should continue to meet on a regular basis to discuss difficult issues, fine tune workflows, determine a process for auditing electronic documentation, and coordinate refresher training for users, as needed. These meetings may continue for several weeks. Along the way, solicit user suggestions for making further improvements.

Your EMR solution vendor should play an active role in this process. Of course, you expect online and telephone support services, as well as software upgrades, new releases, and patches. But the vendor's contribution should also include follow-up visits to answer your questions, to assist you with further customization, and, in general, to help you derive the maximum possible return from your EMR investment.

Summary

In a perfect world, every hospital and clinic would have a foolproof roadmap to guide them on their journey to a successful EMR implementation. No such "magic map" exists, of course, due to a host of variables at multiple levels. But recognizing certain critical elements and addressing them proactively can make a big difference in helping you achieve your objectives. This paper identified the following seven critical elements:

1. The right leadership team
2. A solid organizational foundation
3. Stakeholder buy-in
4. Tailored user training
5. Supporting technology decisions
6. A sensible go-live strategy
7. Continual improvement

This paper was created to provide a catalyst for in-depth discussions in your organization as you consider an EMR system. As for filling in the blanks, don't hesitate to tap into your EMR solution vendor. An experienced and service-focused EMR solution vendor will, without question, be an incredibly valuable resource in helping you reach your destination with the utmost confidence in your decisions.

About Healthland

Software and services from Healthland (formerly Dairyland) empower small community hospitals to deliver the best possible healthcare by providing a central repository of patient information in all care settings. Specifically designed for rural hospitals, our solution equips customers with a tool that is uniquely suited to their size and needs.



For more information and to request a demonstration of the Healthland EMR software, visit www.healthland.com/guidecontactus.