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EHR Transitions Don't Require A Big Bang to Be Successful

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Leslie: I am excited about this month's interview with Debbie Fernandez, RHIA, HIM manager at New York-Presbyterian Hospital/Weill Cornell Medical Center.

Patty: Why is that, Leslie?

Leslie: Because in a world where big-bang implementations are the prevailing wisdom, it's refreshing to see a successful organization move at the real pace required for significant transitions. Leaders often develop terrific change strategies and project plans, but fail to think about the time it takes for people to completely internalize new paradigms and transition to a new way of work.

Patty: William Bridges writes in his book [Managing Transitions](#) that it isn't the change that does people in, it's the transition. Transition, Bridges said, is psychological. It is a three-phase process that people go through as they internalize and come to terms with the details of the new situation that change brings about.

Leslie: That's right, and that means transition is on its own timeline, one that is usually longer than any electronic health record (EHR) implementation time line.

Patty: It's evident in my discussion with Debbie that the prestigious organization she works in understands the true meaning of transitions. The organization started early in its journey to the EHR, but it has done so in a way that respects the transition needs of clinicians and the organization's rich history in delivering quality patient care.

Leslie: John Kotter, a leading change management expert, suggests that wave after wave of change is critical to sustaining momentum. I think that is exactly what New York-Presbyterian/Weill Cornell has done so well over the years. They maintain urgency in the organization to keep moving the EHR forward, but do so in a way that doesn't disrupt the work of those who deliver patient care.

Patty: While Leslie was vacationing in the Amazon, I had the opportunity to interview Debbie. Her story is one from which we can draw important lessons about transition. Debbie, tell us a little bit about your role and the facility in which you work.

Debbie: I oversee day to day HIM operations of New York-Presbyterian/Weill Cornell's HIM department. This includes all HIM operations with the exception of imaging, chart completion and coding, which is under the site administrator and another manager in the department. New York-Presbyterian/Weill Cornell is one of five major medical centers that are part of New York-Presbyterian Hospital. It is an 826-bed, acute care academic medical center and the primary teaching affiliate of the Weill Medical College of Cornell University. We have more than 700 physicians within our center. I report to a site administrator who in turn reports to the HIM

director.

Patty: What has been your role in advancing the EHR in your organization?

Debbie: I became involved in the implementation of the document imaging system during the first year after it went live in 1997 when I became the coordinator over the legal and medical correspondence units. Since then, my role as a manager has expanded to include leading the day-to-day operations of the circulation units 24/7, release of information, patient index and behavioral health units of HIM. I work closely with users to help them achieve a comfort level with the electronic record, and work closely with the HIM director and other team members to transition HIM functions to an EHR environment.

Patty: What components of the EHR are implemented at your center?

Debbie: We implemented clinical system components in the mid to late 1990s that include physician order entry, inpatient nursing documentation and ancillary clinical documentation. Results are available electronically and a document imaging component rounds out the EHR.

Patty: When did you begin scanning documents?

Debbie: We began scanning only outpatient records in 1997, followed by inpatient records in 1998 and behavioral health records in 2003. Our volumes are tremendous and it was important for us to keep up with the workload, implement new HIM roles and introduce new ways to access the medical record. We currently scan about 350,000 pages per month.

Patty: As more of the record became electronic, either by scanning or by being created in a clinical system, what happened to the paper record?

Debbie: We made a decision to continue to maintain a paper record and to store the paper record in the file room in medical record folders as we had always done. In earlier stages, the record was a combination of scanned documents and documents printed from the clinical system. The transition was gradual. We continued to pull records as we had done in the past while encouraging clinical care providers to access the record online. We continue to file scanned documents in the file room even today.

Patty: Why not print the record instead of pulling it?

Debbie: We did not want to become a printing service as we were pulling up to 2,500 records per night for clinic visits. We decided it was better to wean people away from paper than have them get used to printing. We did provide printers to patient accounts and patient case management so they could do their own printing. And because our goal is to never compromise patient care, we allow some printing at local workstations. Users have screen print capabilities but not batch printing. We find today that there is very little printing as users are getting used to viewing the record online.

Patty: How many records do you pull today? And when are you going to destroy the paper record?

Debbie: We pull about 20 to 30 paper records per day. The department is moving into a smaller space later this year and at that time we will move into space without a file room. The plan is to scan records and store them onsite for a couple of months, then move them offsite for about a year, and then destroy them.

Patty: Why have you kept the paper record this long?

Debbie: It's been part of our change strategy and a matter of comfort to keep the paper record. It's part of our culture to reach a comfort level before cementing change. Until we had a critical mass of users comfortable going online, the paper was going to be stored in the file room and pulled only when absolutely necessary. Through the years we have worked closely with all users to help them achieve a comfort level with viewing records online. Having watched our progress from the beginning when life was all about looking for charts to where we are today, the change is tremendous. Our concept of the medical record has completely shifted.

Patty: It sounds like you have experienced a real paradigm shift. What significant events facilitated that shift and the weaning away from the paper record?

Debbie: We have really seen a significant change in the last 3 years. In 1999, documents that were being COLD (computer output to laser disk) fed were no longer placed in the paper chart. The only way to view them was online. In 2001, data from our clinical system, which includes physician orders, online nursing notes, nursing flow sheets and ancillary documentation, were no longer printed and charted in the paper record. Basically, the hard copy chart became incrementally less important. Our quality efforts are also meticulous as it relates to indexing and turnaround time.

Patty: What's happening with the HIM staff transition as medical record users are getting used to viewing the record online?

Debbie: Transitioning slowly has enabled us to evolve staff into electronic health information management (e-HIM™) roles. Through attrition we do have fewer staff but their skills are at a higher level. Every HIM employee is required to have solid computer skills, a comfort level within the electronic environment and for many of our positions basic medical terminology. We are leaner without paper records, but staff must be versatile.

Patty: I think your story is unique in that we often want to get out of the starting blocks with aggressive HIM practices in an effort to transition users and HIM departments into the electronic record. Your story indicates that sometimes the best course of action is to slow these initiatives down in favor of bringing people along at the speed that they can accept change. The end result is a lot of buy-in and a change that sticks. Debbie, what is next?

Debbie: Physician online documentation is on the horizon, along with our goal to evolve the EHR to one that can be mined and available in real time.

Patty: Good luck with your move this year and in creating the e-HIM department without a file room!

Leslie: Thank you both for a great interview. It is inspiring to hear how the HIM professionals played such a critical role in reducing organizational anxiety, building trust in the electronic record and easing transition chaos. Thanks Debbie for sharing your story with our readers.

Tune in next month for more on e-HIM transitions.

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