Implementation Evaluation: HIM Professionals Share Their Experiences Bringing Health IT Online

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by Christina Duggan

HIM departments and IT implementations can change each other for the better. Four HIM professionals share their insights.

We've all heard that famous line attributed to Benjamin Franklin: "Nothing in life is certain but death and taxes." But one other thing is certain—change.

Nowhere is that clearer than in healthcare, where change is constant. To stay competitive, stay compliant, and improve patient care, healthcare is increasingly turning to emerging health IT that radically changes how patient information is captured, processed, stored, and shared.

Implementing health IT changes everything about a facility, from its clinical workflow to its culture. How have HIM professionals not only survived implementations at their facilities but contributed to their success? And how have the implementations changed their jobs? Four HIM professionals share their stories.

"An Implementation on Steroids"

Imagine the grand opening of a hospital during flu season. Then imagine the go-live day of an implementation. Now imagine both events happening simultaneously. Add babies being born and patients needing cardiac catheters, and you've got "an IT implementation on steroids."

Those are the words of Christina Meyers, RHIA, administrative director of health information management and patient financial services at Banner Estrella Medical Center (BEMC) in Phoenix, AZ. BEMC is a high-tech, high-touch facility with 172 private rooms, 24/7 room service, and two data ports per patient room.

Before opening for business in January 2005, with hundreds of IT applications forming a comprehensive health IT platform, Meyers prepared for more than a year, researching successful business models like Disney and Starbucks.

To create buy-in, BEMC held "visioning conferences" with physicians, radiology, nursing, HIM, IT, and patient financial services. "Everyone had a say," Meyers explains. "You need to get the right people to create buy-in."

BEMC's IT department and leaders like Meyers maintained buy-in by holding weekly face-to-face meetings with stakeholders to discuss training, education, testing, and system interfaces. Each meeting was documented, which helped hold people accountable for their part of the project.

"The smartest thing I did was hire people smarter than me," Meyers says. Those hires—the assistant director of HIM and the IT system coordinator—soon became super users, helping develop the system. "In a real-time, concurrent environment, you can't afford to implement processes that are not effective at getting the patient's information to the bedside."

The HIM department now works in a concurrent environment, Meyers says. Instead of waiting until the patient is discharged, HIM staff codes, analyzes, and queries while the patient is still in the facility. "We used to have a post-discharge mentality, but now, post-discharge, we just review and drop the bill."

Other aspects of the environment have changed, too. All of BEMC's coders work from home; even the HIM technician processes images from home. No one is running around to nursing units to pull a record. There are no paper records to pull. Physicians sign off on charts electronically, and they enter medication information directly via computerized physician order entry. "It's like Star Wars," Meyers jokes.

"We wanted a chartless environment and an e-HIM environment," Meyers says of BEMC's conception. "With this mobile, wireless system, patient data is at the patient bedside, improving patient outcomes."

Meyers likes to think of the future of IT and HIM, even beyond BEMC's walls. "How can we make [unaffiliated] systems talk to each other?" she asks. "Pharmacies, doctors' offices, hospitals, nursing homes? We need solutions for regional health information organizations."

Controlling Scope Creep

Scope creep. Two small words that create big trouble. Two small words that represent all the afterthoughts and requirements that sneak into a project once it begins.

The antidote is a good scope document that drives the project and leads to goals and detailed work plans, says Michelle Wieczorek, RN, RHIT, CPHQ, CPUR. Wieczorek is director of e-commerce business development at Saint Vincent Health System in Erie, PA. "First, get buy-in and sign-off from key stakeholders, users, and departments," she advises. "Then, keep reorienting people. More requirements always come up; show that those issues weren't part of the original scope." Of course, changes can be necessary. If so, they must be formally approved, sometimes by the CIO or even the CEO.

In the course of planning implementation of a new document imaging system, Wieczorek admits that convincing medical staff leaders that eliminating eight million images to save conversion time and money "was the most tense presentation" she'd ever done. "The CEO told the doctors that the hospital owns all medical records, that their buy-in and support was needed, and that we would provide statutory required information. We viewed medical staff as customers."

Witnessing a vendor-led IT conversion in the 1980s gave Wieczorek insight into what not to do. "Once the project was done, the outside resources left. There was a void! People wondered, 'Who really owns this? Who's the face of this implementation?'"

Wieczorek began planning the implementation in 2000. "We told people to have confidence and realize the project was managed by people who had a vested interest. Yes, they'd be losing some custom workflows, but when they fired up their PCs, the record would be there." The system went live in 2002. The first phase involved maintaining functionality of the old system; the second phase centered on creating customized workflows.

IT teamed with marketing to hold a breakfast meeting for more than 100 super users, administrators, and other stakeholders. "We celebrated the close of phase 1, our new platform, and our new, flexible system and looked forward to phase 2, when the real fun begins, when we work on functionality. We got them pumped up and asked for their support. It was a 'wow' moment."

Part of the project's success, Wieczorek explains, was understanding and appreciating the capabilities of the implementation team. "There are so many talented people. Hand off deliverables outside the scope of your job to a team member who is more appropriately suited," she advises.

Wieczorek's jump from HIM to IT was a natural progression. "The CIO saw my analytical and problem-solving skills, skills HIM directors use daily. He also saw how HIM directors work with vast groups of customers, staff, [and] physicians."

To Wieczorek, HIM professionals are integral parts of IT implementations. "HIM ensures the quality and completeness of records. HIM cares about the integrity of the medical record and ensures accuracy and accountability," she says. "IT has limited focus and looks to the HIM professional to guide the project as it affects statutory requirements for the legal health record. 'Does an EKG image have good quality? Are all the progress report pages here?' But that's a huge deal to an HIM person. We're only as credible and legally sound as that e-record."

The bottom line, Wieczorek says, is improving care. "IT systems enable our people to treat patients the way we want to treat patients."

Building Teams That Succeed

"In 1997 we were drowning in paper, receiving 120,000 loose documents a week," says Cassi Birnbaum, RHIA, CPHQ, director of health information and privacy officer at Children's Hospital and Health Center (CHHC) in San Diego, CA. Affiliated with UC-San Diego Medical Center, CHHC is a pediatric tertiary care center covering three counties.

Add to the flood of paper the misplaced charts, delays in coding, and unacceptable delinquency rates, and Birnbaum realized that CHHC needed simultaneous access and point-of-care record availability.

This meant more than just document imaging to Birnbaum. "We had a laundry list of requirements," she says, including a robust workflow, point-of-care physician capabilities, Web capabilities, system interfaces, paperless financial services and registration, e-signature capabilities, and access to historical records and complete charts.

In 1997 Birnbaum stated her case for an electronic record by preparing a white paper and a return-on-investment document. She got approval during the 2002 budget year. It took six months to plan the implementation.

Having adequate resources was one key to success. "First, I hired a full-time project manager [and] systems coordinator," Birnbaum says. A dedicated systems analyst in patient financial services was also assigned to the project.

Involving physicians was crucial. "Some resist the technology, even our champions. They say, 'We love this, you do a great job, it'll be great,' but they need to be involved and accountable."

To support physicians in the transition, Birnbaum's team developed training programs, and physicians had to pass competency exams. The team held hands-on sessions, one-on-one training, and meetings where physicians could "play with the technology," Birnbaum says, and choose which devices to use.

The team also solicited feedback. "We worked with users to develop 'conditions of satisfaction' prior to implementation, had midimplementation evaluations, and had users complete report cards afterwards."

The implementation began in 2002 with the ED and off-site urgent care centers, but the big implementation—involving inpatient day surgery, one clinic, and the emergency transport system—took place in fall 2003. "We had good involvement from different areas," Birnbaum explains. "They took ownership." Currently, CHHC is in its final phase of implementation, implementing the final few clinics.

Still, Birnbaum notes, it was not all smooth sailing. "We all reported to the CIO, but it was almost a competition between the applications and IT folks. We competed for resources and projects." The solution was to bring in an outside team-building professional, who worked with the team for six months, meeting four hours weekly. The team-building exercise worked. "After that, we could move mountains!" she says.

Efficiency has increased since implementation. "Before, it could take up to 16 days post-discharge to finish coding due to record receipt and completion. Now it's done one or two days post-discharge," Birnbaum reports. Coders work from home and can query physicians immediately. The delinquency rate went from approximately 45 percent to less than 1 percent, 15 days following discharge.

Looking back, Birnbaum realizes the immensity of the undertaking. "It's easy to underestimate the complexity of this electronic journey," she says. And there is much to learn along the way. "I'm an HIM professional, but I really got to know IT well. Now I understand the connectivity. It's critical to success."

Communicating Change

IMPACT, the name of Northwestern Memorial Hospital's IT project, certainly influenced and impressed the staff. Julie Bryant, RHIA, knows that firsthand.

Bryant is director of information services and medical records at the Chicago academic medical institution, which boasts 1,200 attending physicians and 800 teaching physicians. Strong communications, an emphasis on coaching and clinical guidance, and

a focus on post-implementation follow-through helped make the electronic health record implementation successful. The system was in full swing in 2002.

"We almost looked at this as a marketing project," says Bryant, who worked with both physician services and marketing to communicate the project. They produced carefully designed posters and a monthly newsletter. Each week, they distributed talking points via e-mail to various hospital leaders, announcing upcoming IT implementation happenings. The weekly e-mail encouraged elevator speak, Bryant says.

In addition to traditional training approaches, Bryant created a new position to support physicians—CPOE coach. "We found people to step outside their current role for a while, like nurses and internal trainers. Coaches were at physician training classes and built relationships with them. Each physician group had a dedicated coach," she explains. During the first week of go-live, coaches shadowed their physicians, a "real-time feedback system," Bryant says. During the second week, physicians could access coaches by pager. "Physicians viewed coaches as peers and could admit they didn't know how to do something."

Diagnostic results were already online, so Northwestern Memorial started with nursing documentation and upgraded the lab and pharmacy system to create a strong base. Then came bedside functions, vitals, I&Os, assessments, and electronic medication administration in 2003. Then came ancillary and procedural areas and CPOE and physician documentation by specialty. The latest phase took about 18 months, finishing in late 2005.

Clinical sponsorship was crucial, Bryant explains. "We based the whole implementation on this. Our physician leadership group met monthly; one doc from each specialty. They were key decision makers and gave input." The IMPACT Directors Group, composed of directors from nursing, lab, radiology, ancillary services, and the vice presidents of both quality and information services, met biweekly.

Bryant stresses that day one of an implementation is only the beginning. "You can't just do it and think you're done. You'd have a revolt! You need to show users that changes can and will be made, and have the ability to make incremental workflow improvements." To allow users to make recommendations on system or workflow enhancements, Northwestern Memorial created the Nursing Informatics Council and the Clinical Informatics Council, made up of medical staff and management committee members. The Center for Clinical Informatics will drive the progression of the electronic environment.

The system has had an impact on staff makeup, also. The IT staff moved into Bryant's department several years ago to support the electronic environment. The medical records department was entirely paper-based, "so we reengineered. We don't pull files anymore. Some contractors are doing remote coding. We've increased the HIM data integrity staff." Bryant sees a natural convergence of HIM and IT skills. "It's not that far of a stretch for us. We have the right skill set to migrate to this role."

The key for HIM is to get educated and get involved. "Talk to peers," Bryant suggests. "Find out what people are doing, do site visits, and educate yourself on implementation, products, and project management. And be sure you're in groups and conversations you need to be in."

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