Making the Most of HIM Centralization

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By Catherine Valyi; Robin Gann, MHA, RHIA; Carol Liquori, RHIT; and Pamella Marshall, RHIA

Today's healthcare systems have become a hotbed of activity ripe with new trends, opportunities, and roles for HIM professionals. Centralization of HIM services is one of these megatrends that places the profession at the heart of unparalleled change. Driven by value-based payment models aimed at improving patient satisfaction, reducing costs, and increasing quality of care and population health, the centralization of HIM has become a hot topic.

Nearly all HIM departments located in systems, clinics, and ACOs often operate with disparate processes. Given the impact on revenue and reimbursement, the C-suite recognizes centralization as a sound direction to reduce operational costs, establish consistent processes, and eliminate redundancies by fostering lean organizations.

HIM professionals faced with centralizing their departments are beginning to establish best practices and solid, pragmatic advice. In this roundtable discussion moderated by Catherine Valyi, vice president of marketing at HealthPort, HIM professionals discuss their direct experience with HIM centralization, challenges that hinder progress, lessons learned, and strategies for ensuring a successful transition.

Catherine Valyi: Where is your organization in the process of centralizing HIM and what was your approach?

Robin Gann, MHA, RHIA, system director of health information management at CoxHealth: We began [centralizing] in the 1990s after implementing post-discharge scanning of medical records. At the time, there were two different facilities with separate medical record departments managed by two HIM directors. I was asked to assume leadership of Cox North and merged the two medical record departments. Fortunately, they were only six miles apart, which alleviated logistical issues. We also acquired Cox Walnut facility, now Meyer Orthopedic and Rehabilitation Hospital, and immediately merged the HIM departments. That process eased the way for continued centralization as we eventually acquired and merged the HIM departments at our Monett and Branson facilities.

Years of experience and technology makes the process function well. We've always tried to be progressive, allowing people to work from home as appropriate. Having the ability to centralize in one town, backed by technology, provided the potential for optimal support and significant gains in productivity. We've centralized all HIM functions—including ROI, coding, front office, MPI coordinators, and scanning. We serve as the centralized clinical scanning team for both ambulatory and hospitals for the entire corporation.

Pamella Marshall, RHIA, senior director, health information management at Piedmont Healthcare: Piedmont began the process of centralization and standardization in August 2012 when we went live with Epic, bringing together five separate hospitals sharing one e-record. As part of the centralization process, I became the director of HIM for all facilities, while a separate director was designated for three areas—coding, clinical documentation improvement (CDI), and coding quality and education. We've centralized scanning, deficiency analysis, coding, birth certificates, and transcription, and are in the process of centralizing release of information (ROI).

Carol Liquori, RHIT, HIM manager/Epic HIM principal trainer at Lee Memorial Health System: Our centralization process took one and a half years from planning to full execution. We consolidated five individual departments and approximately 100 HIM employees into one off-site business operations location—a former fitness center space in a shopping center. We've centralized medical transcription, CDI, coding, ROI, and HIM operations—analysis, physician incompletes, prepping, scanning, audits. The organization staged the various departments by campus—each scheduled to move at a different time.

The first to move was our Gulf Coast facility—each acute center first, with CDI and coding left at each campus until the end to work out the kinks and streamline processes. To make matters even more challenging, we did this while also implementing

ICD-10.

It's been less than a year since we centralized, and it's an ongoing process. We don't have all the processes worked out yet, but we're reviewing all our policies and procedures to ask "why" we do things the way we do them. We encouraged those reluctant to move to the new location to at least give it a try for a few months. It is important to focus on the positives that can come from change and strive for best practices.

Lisa Whitacre, RHIA, director of HIM and patient information privacy officer at Lee Memorial Health System: We started with a wishlist of what we wanted in our area (i.e., call center, conference and training rooms) and discussed how functions would flow from one area to another. We worked with IT and had every workstation set up the same so it made cubicle sharing much easier.

Valyi: What are the main challenges to achieving HIM centralization and how did you address them?

Marshall: Unlike Robin's advantage of centralizing in a small town, logistics presented a hurdle for us—establishing a centralized location in south Atlanta, a distance away for employees. Top of mind for everyone was the fear of transporting documents off campus via courier to a facility so far away.

In addition, we reduced staff and hours of operation at each facility. This was an adjustment for some of the hospitals shifting from a 24/7 schedule to a much shorter timeframe—8 a.m. to 4:30 p.m., five days per week, no weekends. Staff was used to walking into the department and getting answers to questions after hours and it was a change for them to now call a central phone number for support. Nurses and physicians were especially concerned about receiving efficient services at an off-site location. Once we were able to show them we could adequately support them offsite, tensions eased. Our release of information services are still located at each facility so patients are still able to obtain copies of their records as they did prior to centralization.

Gann: As we centralized hospitals, our local community hospitals were reluctant to give up staff and move to a centralized location. Monett is a critical access hospital, where we shut down HIM because it was easy to centralize processes in Springfield, MO. To help address their concerns, we created a process to assist with their minimal patient walk-ins. If a patient comes in to request a copy of the medical record, Monett staff from patient financial services helps with filling out an authorization—then sends it electronically to the central location for processing, and immediately print via network printers in Monett. Branson is a larger hospital so a ROI specialist from HealthPort is located in Branson. Support from our vendor (ROI remote processing and staff onsite) enables us to offer this service for our local hospitals. Their presence is needed to centralize ROI for all hospitals and clinics—with over 100 physicians in our largest clinic.

Liquori: Communication at all times—throughout the centralization process—is critical. Some staff were anxious about schedule adjustments, costs for extra travel time, learning new processes, knowing who their new "boss" would be. Everyone was affected in some way. It's important to communicate as early as possible—three to six months in advance—and be sensitive to the human aspects of disruptive change.

Other challenges included:

- New costs—At hospitals, most things are provided—not so at a remote site. It all comes out of your HIM budget—new vendors/contracts (i.e., security company, pest control, window washing), bathroom and kitchen supplies, additional equipment (i.e., ice maker, commerical coffee pot).
- New chart couriers/pickups—Since hospital couriers couldn't pick up the new rounding workload, we hired two new full time employees to pick up records at all locations and transport them daily to central HIM for processing.
- Physician reaction—Many physicians wanted us to remain onsite, versus remote. Previously, we had always been available to them. Now they were expected to pose questions by phone rather than in person. We created an HIM call center for physician offices, patients, family, etc.
- Scanning staff physical location, workflow, and shift changes—Management assisted with orientation to the "new" part of town for staff and collated a list of questions and answers to staff FAQs.

Whitacre: Leadership went from managing a campus alone to managing processes with all of us in the same area.

Valyi: What are additional lessons learned and advice you'd offer others?

Gann: Our challenges and problem-solving efforts led to five important lessons:

- Work collaboratively with people at all levels to find and address their pain points.
- Retain staff from local community hospitals and accommodate their needs—allowing coders and transcriptionists to work from home.
- Understand the needs and concerns of the hospital and proactively address their issues.
- Ensure as much transparency with staff as possible. Let them know along the way what you're thinking, where you're going, and what you expect to happen.
- Work closely with physicians toward common goals—offer your support during the transition.

Roundtable Participants' Facilities at a Glance

CoxHealth is a five-hospital system with 954 licensed beds and 83 clinics headquartered in Springfield, MO. The system serves a 25 county region. CoxHealth is one of Springfield's largest employers, with more than 10,000 people employed throughout the system.

Lee Memorial Health System, a not-for-profit, includes four acute care hospitals, two specialty hospitals, 25 OP and primary care physician offices, 1,423 beds, 1,200 physicians, and 12,000 employees, based in Florida.

Piedmont Healthcare is a six-facility private, not-for-profit organization with over 4,000 employees and a medical staff of over 1,100 physicians. Piedmont Atlanta is a 488-bed acute tertiary care facility in northern Atlanta, GA, specializing in heart health, transplant services, and cancer care.

Our achievements have resulted in tremendous cost savings for our organization. We don't have to maintain entire departments at each facility, which continually opens opportunities to reduce expenses. A dollar saved is a full dollar saved versus revenue for many organizations today. Many who charge the dollar don't receive the full value in revenue.

Marshall: We gained insights from some of the same lessons that Robin mentioned. The entire process is a culture change. As we have implemented an electronic health record (EHR) system, the need to have staff onsite doing administrative functions has changed. We see the need to establish a remote workforce and reduce the HIM footprint onsite at the facilities.

Since all five facilities were primarily paper-based prior to implementing our EHR, each facility had its own set of forms. We really needed to focus more on forms design and development, shared forms, and standardization within each entity, prior to going live with our EHR and centralizing our scanning services. Forms standardization across entities is a huge challenge and we are currently working to standardize our remaining forms across all entities.

In addition, administrative and leadership support at each facility is essential. We wanted to make sure that we communicated with leadership on our plan to centralize services at an offsite location and address their concerns upfront. Finally, quality and level of service is always a key concern. We guaranteed it would not change—that we would provide the same level of service.

For example, in our centralized/shared services model, staff can analyze any facility's records. With this approach, we analyze all records within 24 hours of discharge and allocate staff across entities—which we were not able to do in our previous structure. We still have staff dedicated to each facility to provide support for the clinical staff and provider suspension—a reassuring capability for facility leadership and staff.

Liquori: The importance of communication and collaboration cannot be overemphasized. And above all, effective project management is essential. We created spreadsheets for everything by category and maintained the information on a shared drive. We also kept an ROI person at each campus. Most important lesson learned: There is no such thing as planning too much or too early. In the end, the positives outweigh the negatives.

Whitacre: Keeping staff engaged with the progress helps to ease fears and concerns. Acknowledging that their concerns are valid and appropriate and not downplaying them is key to ease apprehensiveness. Have an open house where they can invite

family and friends.

Valyi: How did the centralization process affect your role and responsibilities?

Marshall: My role began as HIM director at Piedmont Atlanta, the largest of five facilities, with responsibility for coding, CDI, and HIM. With Epic go-live and the beginning of centralization in 2012, I assumed a new position as senior director of HIM for all facilities, shifting from a department-specific role to a system-level director.

All five facilities worked independently then—now we have five that are centralized. My management team members are responsible for a function as well as oversight of a facility's (or multiple facilities') day-to-day operations. As our department continues to evolve, I will become more involved in information governance, quality and safety initiatives, and optimization of our EHR—plus strategic planning for HIM.

Liquori: We had six managers in the past, and no longer need that many. Each campus manager was shifted to become a "functional" manager—analysis manager, scanning manager, etc. A transcription manager is housed in a separate room for privacy. In my current role as HIM manager, I've chosen to serve as a special projects manager with no direct reports.

Gann: Throughout my career I've reported to many different VPs—from hospital VP, to CIO, to VP of medical affairs, and now the VP of revenue cycle. While I've always led HIM, my position has continued to change throughout the years. At this point I am the system director of HIM for all hospitals.

During centralization, we had to consolidate our team, and find ways to streamline processes and procedures. I must make sure that everyone understands any decision that needs to be made—effective decisions cannot be made in a vacuum. Working collaboratively is paramount.

One thing is certain—the HIM profession is changing dramatically. Our roles and responsibilities will look entirely different within the next five years. I see technology continuing to advance, allowing greater automation. Requiring people onsite for certain tasks will no longer be necessary. Today, three-fourths of our coders already work from home. We are technologically driven—we can't do anything without IT. Our partnership is invaluable.

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Article citation:
Valyi, Catherine; Gann, Robin; Liquori, Carol; Marshall, Pamella. "Making the Most of HIM Centralization" *Journal of AHIMA* 87, no.2 (February 2016): 26-29.

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