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Electronic Records: What Are the Keys to Success?



Many healthcare leaders agree that electronic records have the potential to transform America's healthcare system. But only a few of those enthusiasts are responsible for actually implementing electronic medical record (EMR) systems within a hospital or health system. Increasingly, the responsibility for EMR execution is falling to nursing executives. (See page 6 for a definition of EMR.) Nurses who have been working on EMR implementations for years share the secrets of their successes, as well as the pitfalls to avoid. → →

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Special Issue:
Living Through EMR
Implementation

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Get the CFO on Board

Hospital financial executives, who must focus on ROI, may be wary of EMR undertakings because these projects are not immediately cost effective. When problems arise that add cost or time, the reluctant check writer may voice dissent.

“We must help CFOs remember that the clinical folks are the ones making the dollars for the hospital—and that clinicians are often using tools that are archaic,” says Kathryn Wilhoit, MSN, RN, vice president and chief nursing executive at Mountain States Health Alliance, a 16-hospital system in Tennessee and Virginia. She and the system’s chief information officer are jointly responsible for a \$38 million implementation that started in 2004.

When and how to calculate the ROI for an EMR continue to be debated. However, Wilhoit says that healthcare payment trends, which tie reimbursement to quality measures, make that a moot point. “If an organization is not armed to provide valid measures that are delivered electronically, then it’s going to be a very manpower-intensive process to go back and audit records to secure data for quality measures,” she says. “How can a hospital afford not to have an EMR system?”

Keep up the education campaign until the CFO is as committed to the EMR success as you are. “A strong team with financial officers makes us unbreakable,” says Wilhoit.

Set Meaningful Goals

An EMR will be successful only if it delivers meaningful benefits that are obvious to physicians, nurses, patients, and trustees. To do that, the EMR must align with the hospital’s vision for the future,” says Gail Latimer, MSN, RN, FACHE, vice president and CNO for Siemens Healthcare.

“The goal should not be to implement an electronic record,” she says. Instead, Latimer offers three alternative goals that put an EMR initiative into perspective for staff:

- > To provide safer, high-quality care
- > To have information at the fingertips of bedside clinicians so they have the information they need to make decisions
- > To improve our processes and take out redundancy so we can operate more efficiently

Linking the EMR implementation to the strategic initiatives of the healthcare system ensures that you—and others—are focused on an undisputable vision. Then, if problems arise, no one will get bogged down with “why are we doing this any way?”

Think Beyond Nursing

Increasingly, nurses are being asked to be the lead for all clinical components of an EMR implementation, says Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, vice president of informatics for the Healthcare Information and Management Systems Society. That requires representing the needs of pharmacists, physical therapists, and other clinicians with the same fidelity as you represent nurses.

“It’s important to represent the nursing voice because we do that on a daily basis, but we also work with all the other specialties, and they look to us to be the central point people,” she says. “Not only do we understand nursing work flow, but we also understand patient care needs and we understand, at least to a point, the needs of the other specialties.”

An EMR implementation that works for nurses but creates problems elsewhere will not be successful. To avoid this scenario, nurse leaders need to think comprehensively and lead collaboratively. “This responsibility goes much further than people think that a nurse would typically work,” says Sensmeier.

Refrain from Over-Delegating

During her years at Siemens, Latimer has provided consultation on dozens of EMR initiatives, and she sees one major avoidable obstacle that healthcare organizations encounter time and again. “The EMR implementation is not an IT-only initiative; it is also a clinical initiative,” she says. “Strong collaboration among clinical and IT leadership is imperative.”

A hands-off CNO often means an EMR implementation that is more difficult and less effective than it needs to be. By contrast, Latimer recalls a CNO who recently described a smooth EMR implementation at her academic medical center. “She said, ‘For one year, I spent 70 percent of my time focusing on it, and that’s why it was perfect when we went live,’” says Latimer.

Consider a Nurse Informaticist

As the role of nurses in EMR implementation has evolved, the need for special training has become more clear. An estimated 8,000 RNs have advanced education in nursing informatics, and many are board-certified in the new specialty.

Sensmeier says most large hospitals or health systems recruit a nurse informaticist to make EMR implementations go smoothly. Smaller hospitals may not be able to compete for the limited supply of specialists, but they should not launch an initiative without technical expertise on board.

“Sometimes EMR vendors will offer accelerated education to help with this. Or nurses could get some quick continuing education or coursework,” says Sensmeier. “That’s not going to give you the full-blown experience and help that you need for these systems projects, but at least it will give you guidance along the way.”

Fix Processes First

Redesign workflow before the EMR is implemented—and make sure the

information system supports the newly efficient work processes. Keep the word “transformation” in mind, devoting as much time and attention to process improvement as to the technical details of the implementation.

“The electronic record alone is not going to transform your processes,” Latimer says. “You need to evaluate your workflow and your care processes so that you don’t just automate old, and possibly broken, processes currently in place.”

Capture Quality Measures

Many hospitals have been surprised to find that their shiny new EMR systems do not automatically capture quality measures that allow for easy reporting to payers and regulators.

“It becomes our responsibility to be sure that the project does not lose sight of being able to quickly and accurately capture those quality measures that need to be reported to the external bodies. If they are not captured, they cannot be reported,” says Wilhoit.

Have a Change Management Strategy

Nurse leaders must realize that the EMR implementation is more than teaching their staff to learn another software tool, Latimer says. Moving to electronic records adds work to nurses’ already full workloads and, since new functionality is incrementally added to the system, the changes in workflow and software keep coming for years on end.

“It’s one of the major issues that leaders today in health care must deal with—all this rapid change, not only in technology but all aspects of our work,” says Wilhoit.

Too much change causes burnout, so nursing leaders must evaluate their staffs’ capacity to handle additional change and plan the implementation carefully. For

Technology Guidelines for Nurses Executives

Recognizing the nurse executive’s critical responsibilities in electronic medical record (EMR) adoption, AONE offers a set of guiding principles that you can use during the planning, purchasing, implementation, and operating phases of an EMR initiative. To access the principles, entitled *Defining the Role of the Nurse Executive in Technology Acquisition and Implementation*, visit www.aone.org.

that reason, an EMR launch should be carefully timed so that it does not coincide with other new initiatives. Consider getting support from the marketing or communications department to develop a detailed communication plan.

Through good planning, nurse leaders can create an atmosphere in which nurses and other clinicians are eager to be involved in the EMR project, says Wilhoit. “There are ups and downs, highs and lows in any project,” she says. Creating a vision for where we are trying to take the organization is an ongoing process, and having these individuals see that vision, catch it, and try to help make it a reality is a large part of my job.”

Interviewed for this article:



Kathryn Wilhoit, MSN, RN, is corporate vice president, Mountain States Health Alliance in Johnson City, Tenn.



Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, is vice president of informatics at Healthcare Information and Management Systems Society in Chicago, (jsensmeier@himss.org).

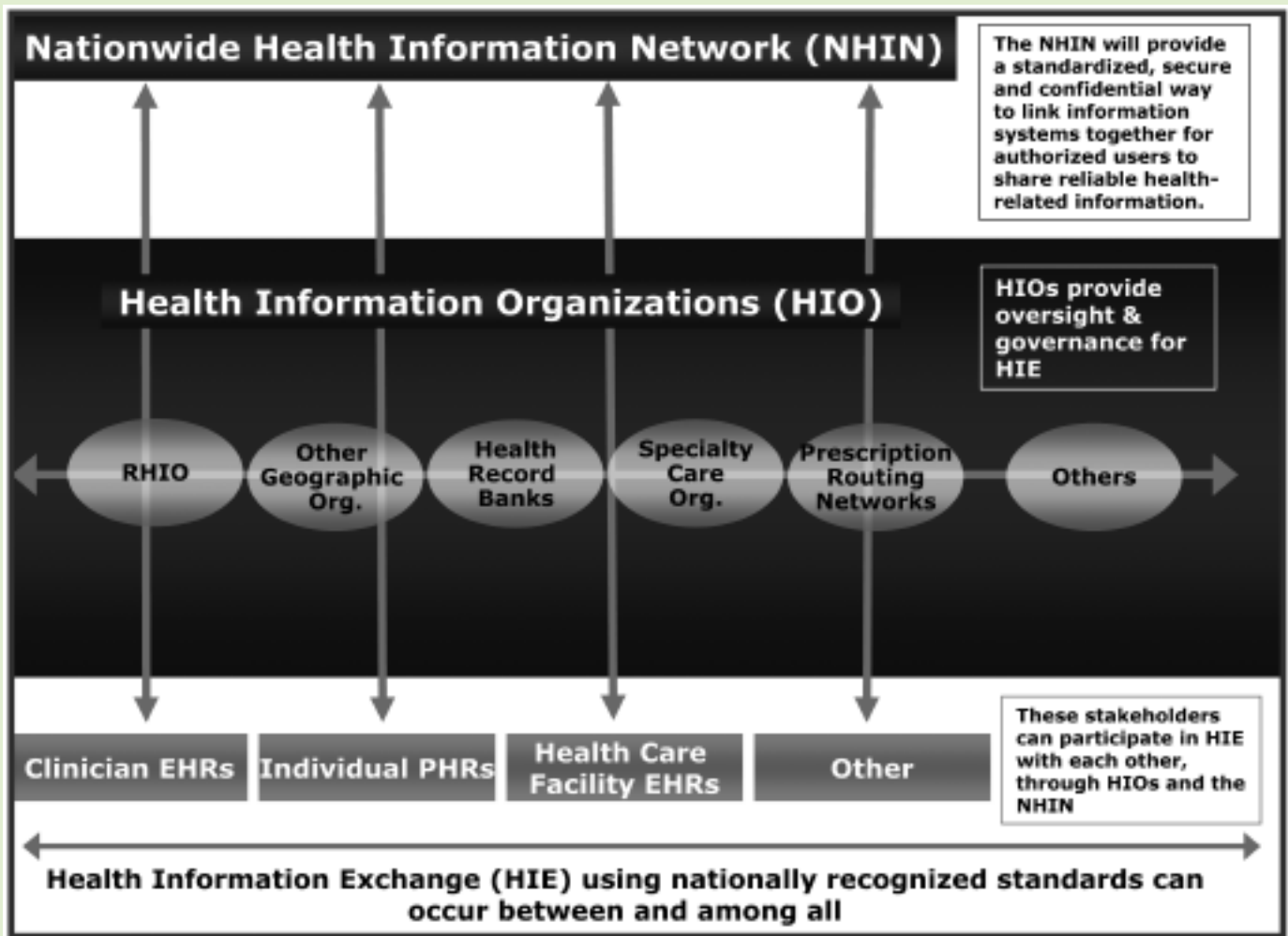


Gail E. Latimer, MSN, RN, FACHE, Vice President and CNO, Siemens Healthcare in Malvern, Pa.

Where Is Your Hospital on the Path to Electronic Records?

About 70 percent of U.S. hospitals have made considerable progress in implementing electronic medical record (EMR) systems, but fewer than 1 percent are using the full capacity that an EMR system offers.

Where Healthcare Is Headed



Source: National Alliance for Health Information Technology.

The national vision, as set by the federal government, is for EMRs to become the building blocks of a nationwide network that allows personal health information to be shared confidentially and securely.

Where Hospitals Are Today

Stage	Description	2007 Final	2008 Final
Stage 7	The medical record is fully electronic. Clinical information is readily shared via electronic transactions or exchange of electronic records with all entities within a health network, including other hospitals, ambulatory clinics, subacute environments, employers, payers, and patients. Data warehousing is in use.	0.0%	0.3%
Stage 6	Full physician documentation and charting, using structured templates, are implemented for at least one patient care service. Level three of clinical decision support provides guidance for all clinician activities via variance and compliance alerts. The picture archive and administration system (PACS) has displaced film-based images.	0.3%	0.5%
Stage 5	A closed-loop medication administration system is fully implemented in at least one patient care service area. The electronic medication administration record (eMAR) and bar coding or other auto-identification technology (such as radio frequency identification) are integrated with computerized provider order entry (CPOE) and pharmacy to maximize patient safety for medication administration.	1.9%	2.5%
Stage 4	CPOE is available for use by any clinician along with more advanced clinical decision support, which relates to evidence-based medicine protocols.	2.2%	2.5%
Stage 3	Clinical documentation (i.e., vital signs, flowsheets, nursing notes, care plan charting, and eMAR) and general order entry are integrated with the clinical data repository for at least one service in the hospital. The first level of clinical decision support is available, allowing for errors to be checked during order entry (i.e. drug-drug, drug-food, and drug-lab conflicts.) Some level of medical image access from PACS is available through an intranet or secure networks outside radiology.	25.1%	35.7%
Stage 2	Lab, pharmacy, and radiology systems feed data to a clinical data repository that physicians can retrieve and review. The clinical data repository contains a controlled medical vocabulary, and clinical decision support/rules are available. Information from document imaging systems may be linked to the system.	37.2%	31.4%
Stage 1	Lab, pharmacy, and radiology systems are installed.	14.0%	11.5%
Stage 0	Some clinical automation is present, but the three major department systems—laboratory, pharmacy, and radiology—have not been implemented.	19.3%	15.6%

Source: Data from HIMSS Analytics™ Database, ©2009.

The EMR Adoption ModelSM, which was developed by the Healthcare Information and Management Systems Society (HIMSS), is a multi-stage adoption model that identifies various levels of EMR implementation—from the most advanced to the least advanced. HIMSS data (N = 5,073/5,166) show the percentage of hospitals at various stages of adoption in 2007 and 2008.

Cures for EMR Implementation Headaches

The potential challenges to rolling out an EMR are many and varied. Below are three implementation headaches. To read more about the solutions, access the full-text case studies at www.hfma.org/boc.

Case Study 1: Adjusting to Bar Codes

Christiana Care Health System, in Wilmington, Del., has been phasing in the use of an EMR system since 2001. But nurses' day-to-day work lives did not dramatically change until the introduction of an electronic medication administration record (eMAR) and bar codes in mid-2007.

Providing thorough training in advance of the implementation was key to a successful rollout, says Theresa Foraker MSN, RN, nurse manager for the Christiana Care's Center for Advanced Joint Replacement. All RNs received eight hours of classroom training. Some nurses were appointed "super users" and received extra training so they could provide needed support to other nurses. And practice scanner and medication carts with bar-coded medications were provided for individual practice sessions.

Case Study 2: Assessing Readiness

An individual's readiness for change indicates whether a person will resist or support a planned change, believes Kathryn Wilhoit, MSN, RN, vice president and chief nurse executive at Mountain States Health Alliance in Johnson City, Tenn. Foreseeing the magnitude of implementing an EMR, Wilhoit commissioned a readiness-for-change survey for physicians and other clinicians to help them prepare—and to help the leadership team understand how to implement the EMR system most successfully.

One key finding: Nurses and other caregivers wanted to hear unit-specific details of upcoming IT changes from their frontline managers rather than formal, broad-based communications and presentations.

Case Study 3: Dealing with COWs

The computer on wheels—or COW—is a piece of equipment that nurses love to hate. Nurses at Wisconsin's Aurora Health Care, had been parking the computer on wheels in the corridor and using it as a "home base" as they moved from one patient to the next.

This workaround was acceptable until the health system introduced bar-coded medication administration in 2007, says Judy Murphy, RN, FACMI, FHIMSS, vice president-IS Applications.

Then, the computer on wheels emerged as an immediate problem. The bar-code reader is on the mobile cart making it necessary to move the cart to the patient's bedside so the nurse can scan the patient's wristband.

After a survey of nurses, the health system decided to go with dedicated laptops in each patient room. "We are settling on a small, less expensive cart with a laptop on it in every room," says Murphy, calling it a "reasonable compromise." ☞

IT-to-Nurse Interpreter

If the terms used to describe electronic records seem confusing, you are not alone. Overwhelmed with healthcare IT definition problems, the federal government hired the Alliance for Health Information Technology in late 2007 to settle on the definitions of several IT terms.

After months of public forums and discussions, the Alliance proposed the following definitions for electronic records. (*Defining Key Health Information Technology Terms*, National Alliance for Health Information Technology, 2008).

Electronic medical record (EMR): An electronic record of health information on an individual that can be created, managed, and consulted by authorized clinicians and staff within one healthcare organization.

Electronic health record (EHR): An electronic record of health information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization.

In the view of the federal government, the principal difference between an EMR and an EHR hinges on the ability to exchange information outside of an organization. An EHR can exchange information across organizations. An EMR does not allow information to be exchanged outside an organization.

A caveat: Remember, not everyone defines these terms the same way as the federal government. It is best to clarify the IT terminology you are using in every conversation to ensure you know what the other party means.

Helping Nurses Transition to EMRs

Reduce fear and negativity with communication and change management strategies.

Our hospital is implementing an electronic medical record, and a lot of the nurses are concerned about the new system. How can I help ease this transition for them?

Sanford: Before you address the changes that come with electronic medical records (EMR), you need to consider how people tend to respond to any major change in their work lives. Most changes are viewed with some skepticism, at least at first.

As a nurse manager, you should review the change management tools and strategies that you have learned in your position. An EMR is a major change for nursing units, whether it's your first electronic charting system or you are changing to a new system. We often assume that people who have already done electronic charting will have an easy time switching, but each system is different and involves process changes, so the same principles apply.

Communication

Most important, you must keep your staff up to date and informed on the transition as much as you can. Second, at the outset, you should determine which aspects of the change your staff will be able to influence and which aspects will be beyond their control.

Once you and your leadership team have determined the areas where staff will have some choice, you must clearly communicate what those areas are. You will likely need to repeat this information throughout the implementation process as well. Then be sure that staff actually has the opportunity to provide input in those areas. If there is disagreement among the staff on certain policies or procedures, be sure to let them know who will make the final decision.

Education

It is essential that you have time for training and education before, during, and after implementation.

To save money on the project, some hospitals skimp on education hours, which will cost them more in the end. Education on the new EMR system should include details on what the system is, what it is expected to do, what it is replacing, what the organization will do if the new system goes down, and how changes will be made. All of this information must reflect the most important underlying point: the reason you are putting the system in. The key question is, how will the new system help improve patient care?

Be sure to let staff know that, during and after the installation, there will be plenty of support from super users and experts to help them use the system. This is where you may be able to take advantage of the expertise of your younger nurses: While older nurses are your experts on patient care, sometimes your younger staff is more comfortable with technology and can provide their coworkers with support in that area.

Process Change

Many nurses may have difficulty accepting the change because they see it as simply "computerizing bad processes." Therefore, before implementing an EMR system, staff and leadership should review patient care and charting processes to see if work flow should be changed ahead of time.

Some processes will definitely require changing. For example, some nurses spend their day on patient care and then do their charting at the end of the shift. However, because this technique relies too heavily on personal memory, it is not as efficient as many believe. With EMRs, nurses will have to chart in real time, so it can be valuable to get nurses into that habit before the EMR system is implemented.

Collaboration with Physicians

Even when nurses are often the first users of EMRs, it will eventually affect physicians and other medical staff. You can avoid political struggles and misunderstandings if you educate those individuals along with nurses. For examples, nurses who have difficulty with the new system may tell the physicians that it is hindering patient care; however, if physicians also understand the system, the two groups can help educate each other through the transition.

As with any change, there are people who will be negative and need extra attention. You can help those people by keeping them informed and ensuring that they have input into some decisions, which helps them feel like they have some control. ☺

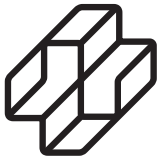


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The next issue (May 2009) of *The Business of Caring* will be the last print issue of the newsletter. After that, we will publish *The Business of Caring* in electronic format only on a quarterly basis. All nurses are now able to access the newsletter at www.hfma.org/boc. We are no longer charging for subscriptions to *The Business of Caring*.

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