EHR GO-LIVE

THE DEFINITIVE EHR GO-LIVE IMPLEMENTATION GUIDE

HCigroup
A Smarter Approach to Healthcare IT
EHR Go-Live
The Definitive EHR Go-Live Implementation Guide

Edited By:
Robert Steele, SVP Delivery/Operations, The HCigroup
Will Adkins, Director, Go-Live Services, The HCigroup
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You have likely used one or more of these terms, or some variant thereof, when describing your perceptions of—or experience with—the Go-Live phase of implementing your electronic health record system.

But Go-Live does not need to be the resource-sapping, bewildering and frustrating experience that you are anticipating, or have endured. You can improve patient care and increase your revenue if you manage your people, processes and technology properly.

Proactive planning built upon inclusive assessment, efficient implementation by experienced health IT experts and ongoing, personalized support, will help you optimize workflow and adoption.

For many years, healthcare facilities have focused on simply getting required information technology in place. But there has been an important shift from installing these technologies to learning how to best use them to achieve outcomes that impact the health of patients across the nation. This shift presents a new set of challenges and opportunities.

Customer expectations continue to exceed the pace of delivery, and they have expanded beyond clinicians and physicians to include executives, management, patients, families and more. Regulatory initiatives are driving information technology roadmaps and informatics teams are implementing new technology at a faster pace. The focus on implementation has left many organizations with a gap in knowing how well users have adopted the technology and whether they have gained the maximum value of their investment.

Increase the return on your investment in your EHR by deploying your people properly, defining your processes appropriately, and using your technology optimally throughout the Preparation, Go-Live and Adoption phases of your installation.
Your EHR Go-Live should be the culmination of months of research, evaluation and planning by a multidisciplinary team comprised of a cross representation of business, clinical and provider management and end-user representatives. But sheer effort alone does not ensure success.

The lack of a comprehensive and coordinated approach to preparing for Go-Live could result in negative satisfaction, adoption and sustainment—as well as perhaps harmful financial outcomes. You do not need to be in the industry long to know that hospitals sometimes experience revenue challenges soon after implementing EHR systems. It commonly takes months for clinicians to get back to their pre-Go-Live patient care loads and for revenue to increase.

The sooner you plan, and the more detailed your planning, the more likely you will avoid the perils of a poor implementation. Identifying leaders for each department or specialty ahead of the build phase not only ensures involvement across the entire hospital, but allows your project team members to have a direct link to concerns that may arise later in the project that need to be addressed quickly or have a high level of complexity. It’s also imperative that you capture information on key pre-live business metrics (such as CPOE percentage or actual revenue vs. expected) in order to provide concrete data on how well, or poorly, your staff are coming along; your vendor may have information to show them how it relates to their peers elsewhere as well.
In this section, we look at how comprehensive, proactive management can help you to speed adoption and preserve revenue integrity.

**PEOPLE**

**Hospital Administrators**

Hospital administrators are vital to set the tone, momentum, and expectations for the entire hospital/health system’s acceptance of electronic charting. They must first believe in the product and the process of converting legacy documentation to modern methods for electronic charting, then stand by the chosen vendor through all stages of the transformation. This may sound simple and obvious however there will be challenges during the phases of adoption that will test even the strongest supporters. Hospital administrators will set an example and motivate others within the hospital system who expect to have their work lives and practices respected and managed properly.

**A lesson in how NOT to Go-Live.**

Poor adoption by physicians and the ensuing problems that it caused for a small hospital in California underscore the implications of weak support by administrators.

There were the usual training opportunities in place, with lots of time to get the staff and physicians up to speed with the product, from a well-established and dependable vendor. However physician training was not mandatory, and ultimately they were not required to use the system. Essentially, administrators for the hospital, which was part of a larger healthcare system, didn’t provide any tangible expectations for the physicians.

As imagined, without training or commitment to moving from paper to an electronic system, the process of implementation deteriorated rapidly. Right away during implementation bright and technically savvy physicians found fault with the software. Reportedly it couldn’t do what they expected and they felt it was too time consuming. In spite of every effort to bring in developers, software engineers, and additional trainers the physicians would find little they could appreciate about the product and quickly lost interest.

Despite efforts by the hospital administrators to rally the physicians back into the system’s use, the physicians eventually mounted such intense resistance that the members of the hospital’s medical board deemed the vendor’s product “unsafe”. Overwhelmingly, the board voted to prevent its use until the vendor could meet certain demands to prove there was no risk in using the product, which by the way, had been proven multiple times with multiple clients over multiple years. Nevertheless, no amount of reassurance would help bring them back. Ultimately physicians at that particular hospital still charted in whatever way they pleased paper or electronic, or sometimes both.

Through this example we see hospital administrators made great attempts to bring the process back into focus, but eventually couldn’t hold their ground. Lesson learned: In a conversion from paper to an electronic system, it is proper for administrators to establish a commitment from the end users by encouraging a contract, and by
mandating the training and use with the physicians. They should also ensure expert and effective support from the vendor. Hospital leadership must stand firm, within reason, alongside the vendor, in support of the process during this kind of change.

**Vendor Representatives**

Time-tested EHR businesses are best suited for providing the most predictable and reliable services throughout the process of implementation. Companies like these have developed databases, established a degree of standardization, and are best equipped to provide skilled resources to support implementation. They know what's expected for them to provide a product that will satisfy client needs and meet the demands of government regulation. Vendors must be willing to work with new client sites in engaging physicians as early as they can in the process so nothing comes as a complete surprise at the time of implementation. In addition, customization of the product is one way to draw physicians' interest. Reasonable expectations can be outlined in software demonstrations. Furthermore, an honest description of what can and cannot be modified could remove any unrealistic demands from the end users.

Vendor representatives must also manage users' expectations. For example, though time saving is the most sought after quality of any EHR, users typically do not experience it right away because of the very nature of changing the process from paper to electronic. Your vendor's representatives should clarify that change is hard, particularly if users fret about compromising productivity.

Here are some particular trigger points for users' pain and suggestions for how your vendor can alleviate the response:

1. **Give users the difficult news up front; Initially using an EHR does slow the workflow down.**

Ways that vendor representatives can alleviate initial change in productivity from a physician standpoint include a couple practical steps if hardware budgets will accommodate the need.

- **Voice recognition software to speed up data entry to replace typing.**
- **Have devices in close proximity and have enough for use, physicians will not go out of their way to find a device.**

The application will never be "perfect" for everyone, and change typically doesn't come quickly with EHRs, but vendors should welcome suggestions for improvement. They also need to offer reasonable customization to the existing software. Showing clinicians how the software can enhance patient care—rather than detracting from it by taking away time—can also be helpful. Vendor representatives may want to integrate a computer into the experience by showing clinicians the patient screens that display graphic trends, or screens that illustrate a point about the importance or severity of a condition, for example. Demonstrating that patient privacy is better protected than with paper systems is beneficial as well. Ask your vendor's representatives to demonstrate how every electronic entry has a date/time stamp that states which provider/clinician opened the record. This is better than currently, where anyone can open the paper record and anonymously view any details.

Your vendor's representatives are key in spreading adoption. Requiring them to advocate on behalf of your EHR implementation as vigorously as they do their product will increase the chances of the EHR success and the latter's use.
**Trainers**

Before you Go-Live, trainers have one obvious responsibility: they’re around to teach and instruct classes and keep your instructional designers from working around the clock. However, they can also help out in a variety of other ways.

An experienced trainer can be a real value add if they’re around during the preparations for training. All applications design and build must be completed prior to training in advance of Go-Live to provide a place for users to work during classes, and often times there are difficult steps that must be completed to do so (like setting up labs to result automatically or dropping charges on training patients for your users).

Since these steps are usually time and order sensitive they must be done right the first time—doing them incorrectly can set an application back days. Additionally, there are so many materials needed in classroom training that it can be difficult to keep them all straight. Quick start guides, training companions, tent cards, and barcodes are just a few examples of materials you would typically see.

Creating poor quick start guides or tent cards can be extremely detrimental to training as any time wasted in class will have a negative impact on the attitudes of your students and the perceived success of the installation; if training is this much of a mess, what are your end users to expect at the Go-Live? This principle extends also to the people teaching the classes—if your trainers aren’t strong in the classroom it certainly won’t look good. By making sure that your trainers are excellent teachers you can make for a smoother class, which not only builds goodwill but instills good habits and end-user preparedness.

**At-the-Elbow Resources**

Hospitals must have the right floor support resources available to manage the needs of the clinical and ancillary staff. Go-Live team members must be capable of providing both solid technical expertise and high-quality customer service during those first critical weeks.

As you begin to plan for your EHR Go-Live, you will need to consider how much staff training has been accomplished prior to the Go-Live and if you will be able to contribute internal full-time super users during back-load and activation. Understanding training and available resources at your facility will greatly impact the numbers, type and requirements of the resources you will need to augment your project. The idea is to accomplish your goal, cover hot spots and maintain patient safety. Overall adoption rates are much faster on floors with strong and engaging support. So, it’s always better to slightly overestimate your support needs and have the contractual flexibility to draw down resources as project leadership determines.

At-the-elbow support resources are the front line for the hospital staff and the face of your project. As such, your resources must be knowledgeable in their modality and radiate a teaching spirit.

**Physicians**

Whether organizations are installing their electronic medical record system or adding enhanced functionality to meet regulatory demands, most of them have a few key goals in mind: increasing revenue, a smooth transition, and happy patients. Just as organizations are feeling the pressure to implement at a faster pace, physicians
are also feeling the pressure to improve quality, reduce costs and maintain a stable revenue stream; often in multiple settings. One sure-fire way to help ensure all of those goals are met is to create engagement with your staff throughout the duration of the installations, and nowhere is that more important than with your physicians. Involve them in designing the things that affect them most—the order sets, documentation tools, and workflows. They are the ones using the system and should be the ones who determine the content within the constraints of policies, procedures, and regulations.

Include dissenters in the process. You know the ones—those physicians who are most vocal in meetings and to their peers about their vehement distaste for an EHR and how it may be detrimental to their provision of patient care. Persuading one or two of those people, especially if they are in diverse specialties, to help with the build and design the system the way they want to see it, is the best thing that can be done. If done correctly, this process can turn dissenters into allies.

As important as getting involvement from dissenter is, also getting it from other influential, knowledgeable physicians is a must: it is imperative to identify those who will invest themselves in the process, those that will ask tough questions and push back if necessary, those that are viewed as leaders throughout the hospital and the ones with the trust of their staff. This is also important during the decision making process pertaining to your organization’s workflows. By bringing them into the decision making process early, you ensure that questions and issues which could be raised with little preparation are brought to the forefront early, and that the involvement of leaders will create buy-in and excitement before you eventually Go-Live.

Once a framework for designing order sets is established and a smaller number of prototype orders sets are designed it’s time to engage end users in some testing, which will help get them acquainted with the software’s look and feel. Over the course of time for this analysis, design, development and testing users will gain confidence and experience with the product and can be early in identifying how it flows with or interferes with their work process.

Lastly, remember that most physicians have not been sensitized enough to the idea of a “work flow”. These are more like buzz words: recognized, but not necessarily understood. Likewise, many technology professionals don’t recognize the culture of the medical community and their lexicon. Nevertheless, they must work closely with the physician to identify best practices; understand the day in the life of a physician and how the work gets done and how departments collaborate with one another to serve the patients. By standardizing as much of the work flow as possible, with close attention to the sequence of events to get work done, the burden of Electronic Medical Recordkeeping and the practice of Computerized Physician/Provider Order Entry (CPOE) can be made lighter and increase the momentum of physician acceptance of this technology.

Familiarity and experience with the software will enhance the use of the strengths of the application in conjunction with best medical practices, and with greater efficiency and value physicians will find CPOE adoption streamlined and more valuable to patient and population health.
It all starts with a great plan. Accessing readiness and determining the best EHR vendor partner are the most critical factors to consider during planning. This partnership will affect all other decisions that are made from this point forward.

Analyzing requirements and defining the goals and objectives for the enterprise are the first steps in planning for a successful and seamless EHR implementation. Once those goals are defined, an EHR vendor can be selected to achieve those goals within the determined timeframe. Developing an all-inclusive project plan that includes tasks, resources and milestones will determine if the timeframe is obtainable with current resource allocation or if outside help is required. The deliverables of this step are essential to maintain an on time and under budget EHR implementation.

Include the following steps in your planning.

1. **Get help.**

Realize that you will learn from the experience and knowledge of others who have implemented EHRs, including peers from provider organizations who had similar perspectives on, and responsibilities in, the process. Look to professional organizations for resources and guidance. Retain consultants and outside implementation professionals who continuously learn from their experience in implementing EHRs.
2. Be inclusive.

Your steering committee should represent your organization’s diversity. Do not emphasize IT over clinicians nor vice versa, for example. They have to go down the path together.

So too, should different providers be represented, such as nurses, physicians, pharmacists and laboratory technicians. As should non-clinicians, like accountants, analysts, billers and schedulers. Include managers and non-managers as well. The front-line, end users who will use the system every day should be involved in every phase, from application choice through implementation and beyond. The process doesn’t end with “Go-Live.” The implementation of an EHR becomes an ongoing day-to-day part of operational life.

Diversify further as you move from your broad steering committee to specific advisory teams. Incorporate nurses from the emergency department, obstetrics/gynecology and pediatrics, for example, when determining how to implement a new system based on work flows. Plan their involvement ahead so that you can maintain care levels by scheduling clinical staff appropriately.

3. Examine your options.

Don’t be content with sales presentations and marketing brochures. Get demonstrations. Push vendors for case studies and references, specifically from organizations similar to yours whose projects were alike in scope. Schedule site visits—at hospitals you want to see. Vendors often are happy to arrange visits to their best sites. Press for access to one where you can get unvarnished opinions.

Vet vendors’ customization processes. Will they connect their EHR to your legacy systems? If so, what will it cost? And how long will it take? Can the physician group responsible for your largest admission base interface with the vendor’s system? If not, will the vendor help connect them? What is the vendor’s process for upgrades? And what do they cost? These are just a few questions, but the more details you get, the more informed the decision you can make.

4. Plan your project.

Once you have chosen your system, set out the time line and milestones. Implementations typically take 16 to 24 months, include targets for each phase. Make them measurable and obtainable, incorporating every phase, from design to Go-Live.

Choose your Go-Live method. Will you go all in with a Big Bang? Putting every department and user online at once? Or will you opt instead for a phased-in approach that staggers activations by departments and users? Each type has pros and cons for your organization.

Look at which type of Go-Live works best for your budget, culture and care environment. You may find it more efficient to staff up for one comprehensive push that brings the organization as a whole online quicker than to use a phased approach that requires prolonged support staffing and ties up meeting space, for example. Or, you may go for the phased Go-Live so that your users can get more personalized support to ease their transition. There is no single right or wrong method.
5. **Manage your project.**

Appoint a project manager to manage the deadlines, mitigate the risks and serve as the project’s champion. They must secure and maintain commitments across the organization, from the C-suite to the floor. Hospital executives cannot delegate their way out of the implementation because the end-users will be looking to them for leadership. Similarly, physicians cannot be excluded from the evaluation phase and then told to start using the system that others chose.

Development of a strong, honest and consistent communication plan is imperative. The horror stories are endless! Begin with “why” you are doing this. Remember the bottom line is “the patient in the bed.” Make it a point to discuss efficiency (“no longer looking for charts”), safety (“up-to-date, real-time diagnostic results available to make on-the-spot care decisions”) and communication (“being able to communicate with other providers to reduce and prevent duplicate testing and potential adverse treatment regimens and combinations”). Convey the benefits for each user group similarly, and for your organization as a whole—and reinforce them whenever possible.

Keeping communication clear and processes smooth are essential in successfully implementing an EHR system. Professionals who have been through Go-Lives before can be invaluable in navigating you through the snake pits, like creating procedures to coordinate lab tests, prescriptions and prescription fulfillment for medications.

Find somebody who can bring a repository of such lessons learned in the industry, and resolve these issues four to six weeks before your Go-Live. The sooner you start, the better you will finish.

**Assessment**

The best way to help in planning and resource allocation is to understand the current Health System’s technological state. By understanding and documenting the current technological state, you are better prepared to reach the required future state. The documentation of the current state technology along with a clear understanding of your EHR requirements will allow for a detailed gap analysis. This gap analysis is used to develop a detailed plan of specific tasks that are required to meet the desired level of technology in the timeframe allocated. That timeframe and number of tasks helps determine if the current resource pool can handle or if outside assistance is required.
It all starts with a great plan. Accessing readiness is the most critical factors to consider during planning. This partnership will affect all other decisions that are made from this point forward.

Key Questions for Go-Live Readiness:

1. How many users will you have? And where will they be?

   Accurately assessing the number of users you will have and their accessibility to at-the-elbow support during Go-Live is vital in determining the outcome of your overall plan.

   Identify your needs based on ratios and models that are compatible with vendor standards. Design a justifiable support ratio for every site across your organization by walking it, recording volumes and staffing levels by modality.

   For example, the vendor-recommended support ratio may call for four support professionals to cover a department with 12 users. But you may need five professionals if those users are dispersed across a sprawling space, thus making it difficult for your at-the-elbow support resources to stay close to each user.

   Or, you may know that you have 100 employees in your radiology department. But did you account for the fact that you are adding 30 users spread across 10 rooms?
Similarly, your IT leadership may not know that part of another department is undergoing construction, and that you will have 25 rooms for it at Go-Live instead of 15 rooms as you do now. Uncovering small departments hidden inside a clinic or identifying needs for staff who require limited support can be large contributors to your Go-Live’s success.

2. **How proficient are your users?**

Numbers alone do not account for how adept your users are at learning new technologies. Identify what internal resources you currently have trained and committed to work in each department. Know what classes your resources have taken to identify exactly where your support gaps exist by department.

Your initial assessment may be that you need three support professionals for a department with nine users, based purely on recommended support ratios. However, if most of the department’s members are experienced technology users then you may be able to reduce their support team to two professionals.

If you can trim the department’s support team, you could assign one of the previously allocated at-the-elbow resources to a unit that could use additional help. You could also pocket the savings of reducing your support team without compromising training. Or, you could maintain the original support team of three at-the-elbow resources, allowing them to collectively give more time to users who are not as adept with technology.

When formulating your response to these key questions, focus on data elements, recording facts as they are, not as you wish they would be, and apply the following principles.

1. **Consider the “facts.”**

Compile numbers objectively, without accounting for how they may affect your budget or whether they will please upper management. Or, demand that your Go-Live consultants do so. You can inform leadership of the need as you perceive it based on your analysis, but it is ultimately up to them to determine the size of the support team.

2. **Budget conservatively.**

Some hospitals have disbursed practically unlimited budgets so that their team does not lack for assistance at Go-Live, perhaps hoping to overwhelm physicians in particular so that they do not complain. Other facilities have literally not provided any budget at all, essentially leaving clinicians and non-clinicians to learn among the challenges that inevitably arise during Go-Live, like printer issues. Optimally, you should fall in between, by providing enough support professionals to speed adoption and accelerate learning—without blowing out your budget.

3. **Be inclusive.**

Do not rely on any one party to set your staffing levels. Include your internal team, EHR vendor and any other third-party participants in your planning to ensure that you account for all perspectives. Your vendors know their products, your consultants bring best practices and your internal team knows
the inner workings of your organization. Together, they can provide the most complete picture and comprehensive solution.

Properly assessing your readiness for Go-Live from the onset will help make your eventual Go-Live successful, thus ensuring that your hard work does indeed pay off.
Establish your command center well in advance as well. Stock it with enough food and provisions to support your team in the long hours, days and possibly weeks ahead. Enable connectivity to users and support resources throughout the organization as well as external vendors so that you can quickly resolve issues.

Evaluate your progress against milestones, like whether 90 percent of users have completed classroom training as they were scheduled to by now. Confirm that policies and procedures have been revised to accommodate each change in workflow.

Confirm that you are broadly searching for any potential problems by answering the following questions.

Have you?
1. Created new workflows and established policies and procedures.
2. Calculated end-user support formulas.
3. Identified super users and trainers, and removed them from their patient care responsibilities during Go-Live and committed them to providing support instead.
4. Performed your gap analysis.
5. Lined up support for every department.
6. Created your support schedule.

Run through your checklists and consult with professionals who have gone through Go-Lives to learn what problems to anticipate and address them before activation. Be frank in your assessments and prudent in deciding whether it is a “go” or “no go.” After you commit to “go,” minimize disruptions in workflow and revenue by addressing these common issues with people and processes.

Go-Live

After you finish developing, training, interface testing and building, you are almost ready to Go-Live. But assessing your readiness again at least four to six weeks prior to activation will help you avoid costly mistakes, like diverting subject matter experts to deal with workflow issues during Go-Live.

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People

Trainers

It’s easy to think that once the Go-Live begins that a trainer’s work might be done, but successful organizations will certainly tell you that this isn’t the case. Actually, it’s quite the contrary: The start of a Go-Live is when your trainers can really shine. By placing them on the floor as end-user support you’re giving your end users access to someone who taught them in class and has an in depth knowledge of the system. With someone at their side questions are getting answered, workflows are being performed properly, and your system is being utilized to the highest degree.

Super users are an excellent resource, no doubt, but a lot of confidence comes from your end users knowing that what they’re hearing is right. It makes them feel better and it will often ease tensions. In addition, your project team will have a direct liaison to the floor and it will be someone that knows the system and can describe what is happening. Having your trainers identify issues also spares your project team from direct visits, leaving them more time to fix other issues, like making needed build and workflow adjustments.

Users

Changes in computer systems can seem extremely drastic to the end user and can lead to major frustrations that could ultimately impact employee satisfaction and patient care and in turn jeopardize the project. When working with users it is very important to remember that these users did not choose a career in or go to school for IT. Users often times see the computer systems they are now being required to use as both a blessing and a curse with a curse being the general consensus for most. With the right attitude from the IT analysts this perception can be changed and the implementation of new hardware and/or software can be much easier for everyone involved.

Getting to the root of why the users are resistant to new technology can have a major impact on the success or failure of a project. Finding and addressing these concerns could be as simple as speaking with and listening to the users, watching their normal workflow or speaking with the managers of each department about the concerns of their staff. Other times it can be a lot more complex but the best way to find and resolve these concerns is to go directly to the source… the users themselves. Many times the end users see changes as just something that someone higher up has decided on in their meetings to save money or address other issues that they see as unrelated to them or their job. Most of these concerns can be overcome very easily if the analyst takes the time to listen and address them directly with the users. Of course this should always be done with great caution to avoid interfering with the user’s normal work functions while always keeping in mind that patient care is always paramount.

Physicians

Having adequate at-the-elbow support for physicians during the actual Go-Live is particularly important. A ratio of one support person to every two providers for the first two weeks with tapering support after that for an...
additional two weeks is recommended. If this is not possible, it is beneficial to have a physician-specific help
desk line where physicians would receive priority for calls made to obtain support.

Also, communication is important throughout the installation, and nowhere is it more important than at Go-
Live. Issues are going to occur and there will be frustration, but making sure end users feel heard and that their
problems are valuable feedback to the EHR is a must. If physicians don’t feel heard, they may abandon the
record and go back to old habits, which is a habit that can be difficult to overcome.

Trust is also necessary at Go-Live, if your physicians and other end users feel that they aren’t being supported
and that the EHR isn’t valuable to them then a lack of buy in and use could hinder the effectiveness of your
program. If you’re coming from a paper world, it is often helpful to be proactive; hiring at-the-elbow support
for your physicians can make a world of difference and can have them feeling the love in a hurry. If your end
users feel heard and trust that the project is the right thing to do, you’ll have lots of buy in which you can parlay
into a successful future.
One of the biggest issues with implementing new software or hardware is that the user doesn’t understand why something new is coming their way when they see the old system as “working just fine.”

This is usually easily overcome by educating the end users with some background information on the new software or hardware to be deployed and why this solution is better than the one that is currently in place. Some of the issues that the new solution is being implemented to address may not have been seen by the user or there may be new regulations that they are unaware of yet. Sometimes a simple explanation will remove some of the doubt and increase understanding of why things change.

Another issue that is encountered with end users is the lack of understanding of how the new product works and how this will improve their current work flow. This can be addressed with education. One of the first steps that should be performed is watching and documenting the user’s current work flow. Then you can allow the user to perform the same work flow with the new system and point out the advantages along the way. This should be used in conjunction with answering the end user questions and addressing their concerns at each step.
The best Go-Live resources have strong problem-solving skills. Every build is unique and it is imperative that your resources work to get to the root of each problem. It is not realistic to expect that your resources know everything, but they should be eager to uncover the issues, be specific and report through the communication process to ensure the user’s concerns have been addressed. If possible, the resource should then follow up with end users.

**Activation**

It’s all in the delivery. Now that all the tasks are completed and the system build has been thoroughly tested, it’s time for the Go-Live. Scheduling resources for the Go-Live coverage is a huge undertaking, when considering the number of resources and hours of coverage. This is especially true when dealing with multi-facility health systems.

Launching an EHR system is an exciting time for a healthcare organization. When EHRs fulfill their promise, the organization can deliver better patient care while using fewer staff hours and increasing collections. However, getting there requires surviving the Go-Live process. Go-Live days and nights can be challenging, especially for organizations that don’t plan in advance. Organizations that are preparing for their Go-Live can benefit from learning from, and avoiding, these 3 common mistakes:

1. **Support and Planning**

   Strong internal planning and communication is key to a successful Go-Live process. Before launching the software, it is vital that procedures for support and escalation are clearly established. If a healthcare provider can’t work the EHR system, he needs to know how to report the error -- whether through calling into a central call center or help desk, using a fallback paper form, or finding a nearby super-user. Organizations with successful EHR launches sprinkle support personnel and super-users throughout the facility for the Go-Live to ensure that everyone has floor support standing by to assist. A key tip is to set up a command center that is staffed with knowledgeable analysts that have computers in front of them for direct support. Go-Lives where analysts are separated from the command center can result in delays and delays in communication can be costly.

   It takes a team to make a Go-Live successful. Continuing to have consultants and analysts available on-site and in the command center helps to ensure that problems get identified and resolved before they significantly affect operations. It also reduces communication breakdowns and eliminates the risk that the on-site IT department will “forget” to use the analysts’ expertise.

2. **Installing and Configuring Hardware**

   It might seem obvious that transitioning to an EHR system requires an organization to have workstations available for its personnel to use while they are interacting with patients. Placing workstations in patient rooms, exam rooms, offices and nursing stations is usually not a problem. However, fitting them into the tight confines of a med room or a crowded central supply area can be challenging. Ensuring that patients in isolation also have conveniently located workstations for the caregivers that work with them is also crucial.
Unfortunately, the availability of workstations is often overlooked. So, here are some of the key questions to assess before Go-Live:

- Are there enough workstations?
- What type of workstations do you have now?
- What are the pros and cons of mobile versus fixed workstations for your facility?
- Will you have enough room in all of your med rooms?
- Do you have a new workflow for isolation patients?

It always seems that there are not enough workstations to go around in the first month post Go-Live. Clinicians are charting at a very slow rate, and work stations will be occupied for long period of times. This is an area you should advise your super-users to be on the lookout for, to offer tips for working around other clinicians and being polite when sharing the stations to keep frustration levels to a minimal. Organizations also typically underestimate the demand for the mobile workstation but they can be worth the investment. There’s a variety of reasons for this; you can imagine the convenience of it.

Hand held Barcode Scanners are the lifeblood of many EHR systems, allowing doctors, nurses and technicians to care for patients and record what they are doing even when it’s not practical to be at a workstation. Scanners need to be preprogrammed and tested before a Go-Live and, just in case, facility IT staff should be trained on how to solve basic programming issues, just in case. While pens, paper and charts don’t need power, handheld scanners do, and strategically locating charging stations is also a key part of a successful EHR transition.

3. Printing

EHRs are only as good as the information that a facility’s staff can get out of them. Given that paper plays a major role in healthcare, even in an electronic facility, properly testing and configuring printers is a must, as is adding enough of them so that they are conveniently located. Seemingly simple issues like properly configuring a printer’s paper trays so that the right information prints on the right type of paper, card or label can have an out-sized impact both on facility productivity and on the success of Go-Live.

It is not unheard of for a frustrated physician to be storming around with a stack of papers in their hands if they had been trying to print their orders and kept hitting “print” over and over again before they received a call from the 2nd floor asking if they had meant to print those on their printer. Printer locations are very easily confused and extremely frustrating to end users.

Another example is where do prescriptions print? A doctor may be rounding on the 3rd floor and forgot he had a patient on the 2nd floor he has to discharge and he goes to print. Do those prescriptions print at the printer closest to the user or at the nursing station on the floor where the patient resides? It’s an institutional decision, but must be made and disseminated before Go-Live. The confusion and frustration could really create problems and resentment.
Here are some “best practices” you really should ignore. Consider what is best for your organization instead.

1. ‘One size fits all support ratio’.

The optimal ratio for your organization depends on variables like the number of end users, their acuity and their proximity to one another and support staff.

If your users are spread over a large floor within a hospital, you cannot just take the number of users and divide it by four or five. Users should be able to quickly access at-the-elbow support, without waiting for them to traverse long hallways or navigate through sprawling offices.

You should also accommodate for different learning paces among users. If you know that your users, or certain ones among them, require more 1:1 at the elbow support, then build in more support staff so that they can get the attention they need without depriving others of needed assistance.

Basing the size of your support team on an arbitrary ratio may keep your budget down, but it could build troubles up. Creating your support team around who needs help, where and when, reduces risk to patient safety and speeds adoption of your new EHR.
2. Super users as trainers.

Even the most experienced super user is no substitute for professional at-the-elbow support staff. Though super users are extremely useful and should be excused from clinical duties during Go-Live so that they can use their combined knowledge of the EHR software and of your organization to help other users, they do not bring the experience of at-the-elbow support staff who may have been through a dozen or more Go-Lives.

A full-time at-the-elbow support professional brings valuable insights and perspectives that can only be gained through experience, as well as advanced technical skills and clinical experience.

For example, if one of your physicians is experiencing a common problem that a software’s training manual does not account for, a cheerful clinician who has seen physicians at multiple organizations frustrated by the same challenge can talk them off the ledge by showing them the solution, and assuring them that they are not alone in their frustration.

With their calming influence that comes from having “been there and done that,” experienced support professionals can bring even your most change-resistant users into the fold.

3. Internal help desk.

Using your information technology team to field support calls during Go-Live can be problematic at best. As good as they may be, chances are that they do not know the EHR system. Nor are they clinicians. With limited time before Go-Live, they cannot be adequately trained to answer questions that will inevitably arise, like, “How do I code for a debridement?”

An internally staffed help desk essentially operates in “catch and release” mode. With little relevant knowledge to fall back on, your internal IT professionals forward rudimentary phone calls to analysts for attention. So, analysts end up providing users with basic training rather than addressing pressing issues that only they can handle.

Conversely, a Tier 1.5 help desk staffed by experienced command center support professionals drastically increases first-call resolution, thereby negating the need to file tickets and forward them to analysts for response. Your analysts can focus on tickets that justify their attention instead of the mundane.

Use outside professionals with advanced training in your particular EHR system for your help desk instead. This allows your internal IT team to continue to fulfill responsibilities not related to implementing the EHR system during Go-Live. Then they can gradually learn the software so that they can adequately support it afterward. They will much prefer this to being thrown into the craziness of the command center at the most stressful time, when they may be asked to help resolve 500 to 1,000 tickets a day in some cases. (See HCI sustain for more information)

In positioning your IT team for success, you can deliver a smooth and successful Go-Live for your organization. Just as no hospital is exactly alike, nor is any Go-Live. Don’t assume “best practices” apply to you, just because they have worked elsewhere. Assess your organization’s readiness for Go-Live thoroughly and objectively. Then create and nurture the support system that is best for your organization, so that your Go-Live goes smoothly.
Not long after Go-Live there tends to be a revelation that supporting this new way to do business may cost more than originally anticipated. At this point the management team is realizing that care can only be given through the enabling technology and that IT’s cost as a percentage of overall expenses has permanently increased.

At this point, many chief financial officers ask their chief information officers to justify enhancements and manage the sustaining support costs. In turn, the CIOs are tasked to hold the operational areas responsible for cost/benefit justification as well as accomplishing the return. Whether you are in the C-Suite, run an operational area or oversee a department, here are some ways to bolster the return on your organization’s investment by bringing people, process and technology together to improve support.
PEOPLE

At-the-Elbow Resources

After the first week it is normal for there to be lulls in support activity. Acuity will begin to rise; nightshifts and weekends can become a little slower for floor support resources. It never fails — there is always someone caught hanging out in the lounge, texting or disappearing for long periods of time.

Resources must be trained on creative ways to fill their time productively. For example, a useful resource will approach staff and ask for permission to either sit alongside or work at the bedside so they can watch how the clinician engages the system. This approach creates opportunities for the resource to provide tips, guidance and shortcuts to the clinician so that they can complete their work more efficiently.

Trainers

Keeping your trainers on as extended Go-Live support in areas that are struggling can help bring users back up to speed and will show your organization’s commitment to making sure that this transition goes as smoothly as possible for everyone, which will help justify expenditures while building goodwill elsewhere. You’ll also receive the added benefit of understanding which workflows may need tweaking and which pieces of build could function better.

Physicians, for example, often learn the steps to get through patient care in the beginning (i.e. “survive” Go-Live), but there are often ways to speed up their day (i.e. “thrive”) by streamlining the steps they have learned. Therefore, it is a good idea to have someone come and “shadow” the providers 4-8 weeks after Go-Live to offer tips and tricks for streamlining their workflows.

PROCESSES

Support

Just when you thought the Go-Live was the last step, along comes the question of support. Once the Go-Live is complete and the decision is made to close down the command center, error resolution and user training continues. As much as one would like to believe that life goes back to normal after the Go-Live event, it is not always that simple. Allocating time for staff to continue the support of the Legacy systems and resolving issues of the new EHR is sometimes overwhelming. HCI has the ability to cost effectively support your legacy applications. Knowing that millions of dollars are invested in an EHR, we understand the importance of having staff focused on the new technology. We have experience working with a broad array of healthcare applications and can offer support to a legacy system that assures trouble-free operation for as long as it remains in service. We understand the importance of the technology investment, and to help ensure success, our resources will be experienced and fully certified in the legacy system as well as any new system being adopting. We’ll keep the legacy system running while you focus on the future. Seamless integration between disparate systems in a hospital and its network is one of the toughest challenges each health systems faces today. Through our
innovative support program outlines below, HCI can help you meet these challenges head on by participating in the project planning, providing assessments, leading your project team or supplementing your staff at every stage of this journey.

**Sustaining support involves more than just a clinical service desk.** A sustaining support model involves looking at every step of the process, from the minute the user reaches out for help to the resolution of that incident and beyond. So in the support cycle, it’s typically the user calling the desk, the desk needing to escalate the question to the application team and then the fun begins. Many times the issue is assigned incorrectly and might bounce around the application team causing great inefficiency. When it finally gets to the right person and gets resolved, the user may be the only one that gets notified as no one is responsible for closing the loop in the process by making sure the trainers, all users and, yes the help desk, are made aware of the change.

You can also continue to analyze and refine the application build itself by using business intelligence and data analytics. Leveraging cross-certified resources to quickly spot root-cause issues and identify improvements in the application can simplify the required support in the long run. From tracing the first call that comes into your service desk, watching it get triaged, treated and eventually released can offer great opportunity to improve process. Strengthening teams for first call resolution, ensuring effective escalation, teasing out training opportunities and closing the loop once a ticket has been truly resolved are key. Your analysts should take a holistic approach, based on data analytics and observation techniques, to tease out ineffective and inefficient steps along the way.

With regard to assisting ticket management, you can use traditional on-site solutions or explore opportunities to partially or fully outsource to a centrally located team. Outsourcing can be effective if the company you engage has properly focused on obtaining benefits from an economy of scale, based on similarities in their customers’ needs. Being able to leverage manpower across multiple clients allows for increased productivity, reduced downtime and savings passed back to customers.
CHAPTER 8

Optimization

Building a proactive strategy for optimization.

Optimization

After the initial Go-Live phase is over, your project will move into the optimization phase. It might feel easy to let your foot off the gas and slow down, either on issue resolution, communication or a mix of the two, but this is typically not a successful approach.

The communication between all departments and the project teams (with a focus on analytics and change management) should continue in order to facilitate both the efficient resolution of existing issues and also to add new pieces to the optimization strategy. If an issue can’t be addressed quickly, or at all, that must be explained to end users – failure to do so can damage the trust that’s so crucial to success. Even though your organization is live, the project truly never ends. This is important to remember – if you’re as serious and proactive to growing your EHR post-live as you are before you Go-Live, you’ll be in a great position to be a leader not only in your area, but in the industry as well.

Unfortunately, many organizations have assumed a reactive approach to optimization and struggle to support it while consecutively implementing new technologies. They spend vast amounts of time and expend great effort evaluating and prioritizing customer requests and complaints, only to be limited by lacking the resources and experienced personnel needed to resolve these issues. As a result, customers lose confidence in the IT department’s ability to meet their needs. This viral response carries through to subsequent initiatives, making it harder to achieve true adoption. In addition, lack of an effective methodology that shows measurable improvement impedes the ability to realize the value of both the immediate optimization efforts and the overall investment.
It is time to start realizing the potential of the EHR and impacting the health of the population, and it all starts with effective and efficient utilization. Putting a proactive strategy in place allows you better manage your staff, to improve customer satisfaction and earn the true value of EHR.

So, what does a proactive strategy for optimization look like?

1. **Optimization is a planned phase of every project.**
   Rarely does an initiative produce the anticipated results on the first pass. Initial training often results in many end users learning how to “get by” in their day-to-day activities. Adoption occurs at a varying pace; therefore, it is important to have a plan in place to address the late adopters. At the same time, if optimization occurs too late, users will have already adopted new sub-optimal workflows, making it more difficult to achieve maximum proficiency. Adding an optimization phase to the project plan following implementation allows facilities to have the resources needed, monitor how they are utilizing the technology and intervene when behaviors can be most impacted.

2. **Needs are identified before customers complain.**
   Many end users who need additional support do not vocalize concerns. Feedback should be sought from a representative sample, not just from those voicing concerns. Users will actively engage if they know there is a dedicated team who anticipates and supports their needs and there is a culture of optimization.

3. **Optimization is built into the IT roadmap.**
   The need for optimization is ongoing and should not be considered a one-time event. Building it into the roadmap as a continuous project and reserving a cross-functional team will allow organizations to respond to new issues in a timely fashion, while implementing additional planned projects.

4. **A methodology utilizing data is used.**
   Data uncovers discoveries not apparent in periodic observations or subjective reports. Developing and reporting metrics shows the value of optimization efforts and helps support staffing for them moving forward. It also illustrates the overall value gained. A well-planned metrics strategy aligns and integrates with other organizational initiatives and goals.

5. **There is a consistent method for prioritization.**
   It may not be possible to meet all of the requests of end users, so managing their expectations is equally important. An effective multidisciplinary governance committee driven by the end users will validate the high-priority needs and alleviate time spent analyzing low-value requests. High-priority items that require a major work effort should be balanced with low-hanging fruit. Once priorities are set, they should be communicated so that all staff are working toward a few common goals rather than working on multiple competing initiatives.

**Change Management Plan**

Not all aspects of a project can be determined in advance. Consequently, changes to the project scope, schedule, budget, quality, requirements, and deliverables may need to be accommodated throughout the life
of the project. The purpose of this plan is to establish and maintain a policy and approach to control project changes as they arise.

Objectives

The objectives of the Change Management Plan are to:

- Establish project change standards, policies, and procedures.
- Effectively manage and coordinate all changes across EHR program.
- Monitor and influence impacts on program’s delivery dates and costs.
- Coordinate all work activities associated with change requests.
- Effectively manage the approved baseline dates and deliverables.
- Eliminate or reduce scope creep.

Change Management controls any additions, deletions, or modifications to the scope, cost, or the project schedule. Investigating a proposed change will allow the EHR Change Control Board (ECCB) to evaluate the effects of a change on budget dollars, schedule, and resources. All requests for change for review must be entered into a Change Request Management Tracking tool.

Approval Process

The steps and timing of the impact analysis for each normal CR is as follows:

1. Once the status of a CR is promoted to “Approved for Analysis” by the ECCB it will proceed to the next process step below.
2. Once all assessments have been completed, the Financial Office (FO) conducts its analysis to determine financial implications both to cost and revenue integrity.
3. If the FMO does not approve a CR for any reason, the FO communicates directly with the Functional Area to which analysis it questions or objects to obtain the clarification the FO requires to complete successfully its impact analysis for that CR. Once the FO approves the CR, the FO flips the Ready for ECCB flag on that CR from “No” to “Yes”.

Ideally, a typical CR lifecycle is two weeks; however, a three-week lifecycle is also acceptable for average CRs.

Emergency Approvals

To process emergency CRs, Submitter will request CR approval from impacted Service Line Area Director. Guidelines must be in place to identify submissions that meet identified criteria to be considered “Emergency” i.e. Patient Safety, Financial/Revenue/Billing Integrity considerations, and Regulatory Requirements are most common.
You must intentionally manage the cultural, behavioral and organizational changes that need to happen to make the EHR fully functional and gain the intended value.

Clinical Adoption revolves around meeting the needs of your clinicians and physicians when implementing new technology, maximizing the efficiency and value gained. Consider these 10 tips for an effective transition to, or utilization of, an existing EHR:

1. **Develop an effective change management strategy beyond Go-Live** that includes staff and providers at all levels of the organization. Executive leadership, management, providers and front-line staff are all key players who need to be engaged with defined roles and responsibilities during and after implementation. An engaged team willing to support the change is the biggest contributor to successful adoption.

2. **Identify executive sponsorship.** The engagement of leadership helps everyone move through the change process and ensures a consistent message to your staff. If leadership is not on board with the change, the staff will be reluctant to support it. Providing leadership with the tools to help reinforce the change improves their ability to engage staff.

3. **Dedicate front-line clinicians and providers to lead the change.** Front-line staff and providers are the key influencers of their peers and will recognize enabling factors and identify potential barriers
before they are operationalized. They are the best source of truth when it comes to assessing adoption.

4. **Conduct workflow analysis and redesign.** Existing workflow issues, if not addressed, will become more visible with technology. Utilize the technology to eliminate redundant, time-consuming processes and consider re-engineering staff roles and responsibilities that are replaced by the technology.

5. **Plan out-of-the-box communication and marketing strategies.** Organizational change is becoming more frequent resulting in the need to continually evaluate and revise communication strategies. Communicate the overall benefits of the EHR implementation and technology to help each member of your staff understand how they will personally benefit by it. Informed staff and providers are more likely to stay engaged and work together to achieve success.

6. **Define and execute a metric plan to measure results.** Clearly define and communicate the factors critical to success and create a metric plan to gauge success and improve your processes after the EHR implementation.

7. **Define and execute a metric plan to monitor adoption and identify follow-up opportunities.** Utilize metrics to monitor adoption and focus on areas of opportunity for further education, system, and/or process redesign. Staff will likely not remember everything that is taught. Metrics allow you to identify and intervene with individuals who may be struggling with the transition and/or help prioritize areas of intervention.

8. **Use an effective, repeatable optimization methodology.** A repeatable methodology to address issues and opportunities allows for a consistent, efficient process. Executives, management, clinicians and providers will be accustomed to a consistent methodology and are more likely to embrace it when they understand and can anticipate it.

9. **Integrate with your clinical IT roadmap.** Expect that optimization will be an ongoing need and efforts will still be needed after the initial “Go-Live” to make it stick. Existing technologies will be constantly replaced with new and improved enhancements, and/or opportunities to improve initial design will be realized. Allocating optimization resources on the strategic roadmap and budgeting process will ensure resources are available to support existing technologies, while new required functionalities are being implemented. Clinicians and providers will have an understanding that there is a dynamic process in place to address their needs.

10. **Engage highly trained staff to execute the methodology.** Ultimately, success depends on having well-trained, well-prepared staff not only inside your practice or institution, but also having an expert team on hand with deep experience in EHR implementation, optimization and adoption. Engaging proven professionals to assist with your efforts and train your staff on a repeatable proven methodology will ensure you are in a place to satisfy your clinicians and providers, serve your patients, and meet regulatory standards.
The biggest disruption in the RCM process is that the vast majority of charges (usually around 80%) are now actually entered by the clinicians themselves. Here is what your organization will probably look like post Go-Live:

- All areas are on a central, enterprise EMR. Best-in-breed systems have been largely retired. Separate interfaced systems may still feed the EMR, but charges flow from these to the enterprise system, and billing is managed centrally.

- Charge codes have been consolidated. Example: A charge code for a debridement is the same across all affiliates and all areas.

- Code requests and updates may still be requested from the departments, but they then need to be managed centrally because another affiliate may already be using the code.

- Clinicians enter most charges themselves through normal, clinical documentation. This is one of the largest transformative changes of an EMR installation. Change management of this area is critical, particularly because it is not always a focus of the vendors themselves.
Examples:

- Documenting that oxygen therapy started and stopped can drop appropriate charge in the background.
- Documenting an immunization correctly can drop the charge for the administration and the medication of that immunization.
- Changing a patient’s status to observation can begin hourly observation charging.
- Documenting that a procedure was performed and some specifics around that procedure can charge for the correct procedure codes. The size of the wound determines the correct debridement code, etc.

Many CIOs and IT departments believe that RCM software also has to be completely updated following an enterprise EHR install to ensure positive revenue outcomes for both the top and bottom line. While some may find this necessary, a massive amount of the benefit garnered by an RCM system can be built for and accounted for in your existing EHR. The fault lies not with the system, but with its implementation.

Key steps in preserving revenue integrity during your install include:

1. Strengthening your existing RCM process and working through any issues. These will only be magnified with a large EMR conversion.
2. Preparing for process changes.
3. Consolidating charge codes across the CDM effectively. Preparing for the change to transition to a central CDM itself if multiple affiliates are moving to the same system.
4. Building a centralized governance system for managing both charging build and the CDM where one did not exist.
5. Creating a change management program around these large disruptions in the charge entry process.
6. Providing metrics, reporting tools, and dashboards to departments’ directors and managerial staff so that they can find issues with revenue generation. With charge generation occurring in all clinics and on all floors, issues may have to be managed locally. A central body can still work with engaged department managers to triage and resolve issues.
7. Training staff on how to enter charges themselves through normal clinical documentation, and training them consistently if there are multiple methods.

Note: Hospital Administration can also take these steps as part of a revenue optimization program after Go-Live.

Properly addressing each of these issues can mean the difference between a flourishing or floundering Revenue Cycle Management process after Go-Live. Correct planning, consolidation, and implementation of your system to ensure that every service, test, or procedure performed is charged for, goes a long way toward correct revenue generation and claims processing.
Contributors to this e-book include:

**Cynthia Petrone-Hudock | Chief Strategy Officer**

Cynthia Petrone-Hudock is responsible for development of new product lines and markets while strengthening internal operations.

As a Fortune 500 executive who successfully bridged a 23-year career within financial services to the healthcare industry, her past is chronicled by fast-track advancement and multi-faceted responsibilities across a full spectrum of core business functions. A visionary strategist known for her strengths in guiding startup, turnaround and high-growth initiatives, Cynthia has repeatedly demonstrated the ability to drive expansion, process improvement, technical innovation and enhancement to quality, while simultaneously reducing spend.

With more than six years of direct experience in electronic health records, most notably Epic, Cynthia has hands-on experience in ambulatory, community affiliation and inpatient settings. Taking into consideration that over 250,000 physicians will be on the Epic system (one of four physicians in the U.S.) when Epic’s current rollouts are complete, Cynthia’s experience working with healthcare system CIOs enables her to develop valuable business insight with regard to clinical transformation and IT optimization.

Cynthia’s academic credentials include an MBA (concentration in management information system) from Drexel University, MA coursework in psychology from West Chester University, and a BSBA (concentration in operations management) from the University of Delaware.

**Robert Steele | Senior Vice President, Delivery/Operations**

Mr. Steele has 36 years of clinical experience and knowledge, as well as 10 years of healthcare IT experience, including standards development, single application and complete EHR implementation.

Most of Mr. Steele’s experience and success has been in a very visible, front line executive role for a large (49 facility), complex, nationwide organization. This included 49 facilities “in-flight,” of which all are complete with Foundation/CPOE implementation that have successfully attested. This equates to touching more than 45,000 end-users, 9 million digital charts, 10 million unique patient records and 24 million digital orders. He has served in both front line and leadership roles in Cerner, Epic, Siemens-Sorian, Allscripts and Paragon systems as well.

Additionally Mr. Steele maintains current day, hands on, clinical expertise as well and knowledge of and promotion of best practice, core measure and quality care initiatives. He is known and recognized as a leader, team facilitator and accomplished expert in many unique environments and markets, many of which require unique assessments and planning in the areas of training/hour requirements and plans, nurse-to-patient ratio considerations and ergonomic/functionality/accessibility stipulations.

In 2012 Mr. Steele was the principal nominator and leader that lead to his team achieving the “Best Hospital IT/Implementation Department” awarded by Healthcare IT. He can be reached at (904) 337-6365 or robert.steele@thehcigroup.com.

**Will Adkins | Director, Go-Live Services**

Mr. Adkins is responsible for leading HCI’s Go-Live project and recruitment teams for HCIActivate. He brings extensive experience in project management and training to healthcare organizations across the country, leading and coaching activation consultants during activation.

In supporting dozens of EHR Go-Lives, he has led qualified resources for multiple vendor products, including
Allscripts, McKesson, Cerner, CPSI, Epic, Eclipsys, Cardinal Health, MEDITECH, HealthStream, Siemens and various others. He has provided onsite project leadership for a variety of multimillion dollar EHR projects. He can be reached at William.adkins@thehcigroup.com.

**Special thanks to:**

**Dr. Richard Paula** is the Chief Medical Informatics Officer at Shriners Hospitals for Children. During his tenure at Tampa General, TGH was awarded HIMSS Level 7 certification Dec 2013, joining only 2.2% of hospitals nationwide in IT infrastructure penetration and use.

**Shannon Stinson, MD, FACEP** looks at how she approaches the issue of physician adoption and satisfaction before and during Go-Live. Shannon is Board Certified in Clinical Informatics and Emergency Medicine and has been involved in several implementations and Go-Lives from her experience as a CMIO at University Healthcare System and as a consultant.

**Chelsea M. Wyatt, CAPM, MBA** is a project manager with extensive experience with hospital revenue cycle reviews and applications. She recently completed two multi-affiliate hospital billing installs, including CDM work, taking a total of eight hospitals with 2,400 beds live at Yale New Haven Hospital and Lifespan Systems. She helped assure that three of the sites returned to revenue baseline just two months after Go-Live, three months faster than typical in the industry for that vendor.

**About the HCI Group**

Recently ranked as one of the fastest growing healthcare companies in the US by INC Magazine, The HCI group is a global health IT company with headquarters in Jacksonville, Fla. and international headquarters in the United Kingdom. HCI offers a broad scope of IT solutions across the world, helping hospitals plan, implement and sustain enterprise information technology systems over the long term. Its services include enterprise IT system implementation and training, and specialty service lines in advisory services, optimization, clinical adoption, integration and testing, Go-Live, and EHR sustaining support.

Learn more about the HCI Group by visiting [http://thehcigroup.com/](http://thehcigroup.com/).