Clinic EHR Streamlines HIM Department

by Mark Hagland

Is your clinic or medical group thinking about implementing an EHR? Plan for plenty of changes—in staffing, processes, and the delivery of care. Here, learn how a variety of clinics weathered the conversion.

When the Mayo Clinic in Scottsdale, AZ, planned to open a new hospital in early 1998, clinic executives decided to create a unified electronic health record (EHR) between the inpatient and outpatient divisions of the organization. What's more, they wanted to open a paperless hospital from the start.

This plan obviously held many implications for the HIM function, recalls Debbie Jaskowski, RHIT, operations administrator at Mayo Clinic Scottsdale, a 300-physician multispecialty group. Because of the complexity of the proposed implementation—opening a new, paperless hospital and converting a paper-based medical record system to an electronic one at the same time—Mayo leadership opted to leave the paper medical record in place on the clinic side at first, Jaskowski says. Two years later, the clinic went live with the EHR system and has enjoyed many benefits as a result. Still, the process was not without a few hurdles.

In this article, we'll look at how Mayo Clinic Scottsdale and other physician groups have made the paper-to-electronic transition and provide valuable advice from those who made it happen.

Changing the Culture

"Mayo has a very significant culture attached to it, and a big part of the Mayo culture was the Mayo [paper] medical record. It's a medical record unlike anything you'd ever see elsewhere in practice," she notes. The odd-sized (about 8 by 6 inches) paper medical record was developed by a Mayo physician 100 years ago and has been a part of the organization's culture ever since.

Shifting to an electronic medical record meant embarking on a complex process to plan the transition and to prepare the physicians to lose a time-honored tool. "We had some existing electronic tools already implemented, including the EHR system on the hospital side," Jaskowski explains.

Despite this groundwork, deploying a full EHR in the clinic was no small task. In fact, the transition took more than a year and required cataloging every single document in the clinic and deciding whether and how to transform that document into an electronic form or process. Many steps were involved, but after two years, the system runs smoothly. And the vast majority of physicians work almost entirely electronically, with just a handful of doctors using some form of paper for parts of the process.

"It's been quite a ride," Jaskowski says. "I've had so much fun doing this." She credits physician leadership in the organization, particularly that of Ray F. Keate, MD, who is chair of the medical records subcommittee and the medical record of the future design team at Mayo Clinic Scottsdale, with guiding physicians toward acceptance of and cooperation with the system.

Keate, a gastroenterologist who has been with Mayo Clinic Scottsdale for nearly 12 years, in turn praises Jaskowski for her leadership and emphasizes the extensive change management process the organization's HIM director has spearheaded. "One of the things that makes a great HIM director or HIM professional, I think, is attention to detail," as well as willingness to manage change, Keate says.

As part of that process, the HIM staff for both the clinic and hospital has decreased to 43 full-time equivalents (FTEs), whereas six years ago, Jaskowski notes, there were 63 medical records people in the clinic alone. For example, the file clerk who handled paper medical records is no longer needed. Most importantly, roles have changed dramatically. As in hospitals that

have implemented EHRs, the remaining staff members have had to upgrade their skill sets, as document scanning, quality control, and process management have replaced the old paper-based functions of file clerks.

Plenty of Reasons to Get on Board

The Mayo Clinic Scottsdale's experience is becoming increasingly common. Industry experts say that a number of large and mid-sized medical groups either have some kind of EHR (sometimes rudimentary), or are considering an EHR implementation. With this transformation, the HIM function is changing as fundamentally in the physician organization setting as it has been in the inpatient hospital setting. Among the key reasons for the shift to EHRs in the clinic setting are:

- **Better technology:** Information technology vendors are designing better applications specifically for the clinical care workflows and needs of the group practice setting
- **Reduced IT investment:** Some of the newer applications are more affordable than they were a few years ago and require lighter infrastructure (particularly those using ASP technology) for support
- **Growing popularity:** The success of hospital-based EHR implementations is spreading to the medical group side, particularly for the many physician groups affiliated with (and sometimes integrated into) hospitals and health systems
- **High labor costs:** Physician groups, like hospitals, are finding that labor costs are simply too high and that automation can eliminate non-essential personnel
- **Efficiency needed:** Physician efficiency is becoming critically important, as reimbursements decline and patient demand rises
- **Demand for space:** Physical space has also become an issue in clinics with booming patient populations, particularly those in high-rent urban markets
- **Pressure to convert:** The shift to electronic data interchange (EDI) for business processes in most medical groups has left clinical care management the last paper-based area for many clinics

That evolution is a natural one, say experts. "If you think about what automated tools are available, most large practices have automated systems for scheduling and billing, and that is the core system that you must have," says Geoffrey Rutledge, MD, PhD, vice president in clinical transformation practice at First Consulting Group. Standalone clinical systems that are not linked to the registration, scheduling, and billing system in medical groups have proven less than effective because of the need to re-identify patients over and over, he says. After years of development work in billing and scheduling, medical groups are ready for true EHRs.

With the arrival of the mature EHR comes a complete change in the functions of the HIM professionals in the medical office, Rutledge notes. "In the final stage at which electronic documentation of the clinical encounter occurs and documents coming into the office are imaged or come into the record electronically, the physical chart itself becomes unnecessary except to hold signatures and other papers not necessary to the patient encounter," he points out. "So the net effect of having a fully automated electronic system is a dramatic reduction of the effort required of the HIM function in a large group practice."

As those at Mayo Clinic Scottsdale have discovered, and HIM directors of medical groups nationwide are finding, the need for file clerks virtually disappears overnight, and the skills sets of existing HIM professionals must be upgraded immediately. In addition, the HIM director becomes a direct change agent, recreating job descriptions, training staff members in new skills, and working with physicians and others in their organizations to align the tasks of the HIM department or function to the new needs of the automated group practice.

Extra Space an Additional Incentive

That's certainly what has happened at Northwestern Memorial Physicians Group (NMPG), the 49-physician multispecialty group affiliated with Northwestern Memorial Hospital (NMH) in Chicago. NMPG, with its eight locations in and around Chicago, has been thriving since it was created several years ago by farsighted NMH executives who saw the need to create primary care and noninvasive specialty care options beyond NMH's immediate reach in downtown Chicago.

When NMPG started down the path to an EHR, the natural option was to partner with the hospital to implement the same EHR software as at NMH, says Carol Slone, RN, director of clinical computing at the medical group. The pilot site for NMPG's EHR rollout, its three-physician Bucktown site, was an obvious choice for the first implementation, because its three doctors and three medical assistants were comfortable with information technology and interested in the project. Moreover, the

satellite clinic was literally running out of space for paper-based medical records storage. The success of the rollout in September 2002, in which the clinic went paperless for the entire patient visit (including for charting, prescriptions, test results online, and document scanning), has continued in NMPG's other clinic sites this past fall and winter.

The doctors are delighted. "When I started by myself, we had plenty of room for medical records. Seven years later, with three physicians, we have absolutely no room for paper charts," says Lyle L. Berkowitz, MD, an internist at the Bucktown location and the key physician champion of the system.

What's more, he says, "With one click on a message, I can check on the last labs, what the notes are...it took a couple of weeks to transition to that. Our medical records clerk used to pull charts, but now she's a scanner. She's much happier, she doesn't have to rush around so much, she's learning computer skills, and she feels more important because of the scanning and messaging." And of course, the doctors' productivity and effectiveness have been enormously enhanced by the system, he emphasizes.

Cyndie Knoll, NMPG's director of operations and supervisor of the HIM function at the organization, says that the initial success of the EHR system in its first locations has led to a chorus of calls for organization-wide implementation as soon as possible. The "nightmare" of increasing space shortages, she says, is heightening the need to employ the EHR organization-wide.

Meanwhile, virtually everyone who worked in the paper medical records area is learning to embrace the new environment, Knoll reports. On the one hand, the paper-based record function is disappearing over time (existing paper records will still be maintained for two years), but there hasn't been a loss of staff. Instead, as at Mayo Clinic Scottsdale, HIM staff members are taking on scanning and document quality assurance functions. Still, she notes, there has been a major shift in human resources thinking in terms of candidates for these new jobs. "We interview more carefully now," she says. "We're not just looking for a person who works for minimum wage any more, we're looking for a higher-level person who can be more responsible, who can communicate better," especially with providers.

Increased Productivity at Every Level

Physician groups that have had EHRs in place longer have seen considerable shifts in functions and responsibilities. Page-Campbell Cardiology, for example, a 14-physician cardiology group in the Nashville metro area, has had an EHR in place for seven years now, says Sherry Young, RHIA, the group's HIM director. With five full-fledged clinics and eight additional outreach clinics across central Tennessee, Page-Campbell was a textbook candidate for EHR implementation.

Functions and staffing have definitely changed, Young notes. "When I started here, we had five employees," she says. "Now we're down to myself, one full-time person, and one part-time person." The HIM department no longer pulls paper charts, Young says, adding that in a few of the outreach clinics without computer access, pulling paper charts is still necessary. The part-time HIM staff member handles all the document scanning, begun in 1998.

Clearly, the number of individuals employed by the organization to perform HIM functions has decreased over time, she says. But the department's capabilities have been significantly enhanced as well. "Before we really became active on the system," Young recalls, "every time we had a phone call or correspondence from another doctor, or a lab came, we pulled charts. Now, all that is on the system, and the doctors can just pull it up themselves. So the turnaround time for handling prescriptions, or patient calls, is instant."

The automation has also led to a leap in physician productivity, which has in turn increased patient volume. In fact, Young says, "if [physicians] were all still dictating and producing paper notes, we couldn't handle it."

Similarly, says Tow Berg, RHIT, director of HIM and medical transcription at the Marshfield Clinic in Wausau, WI, the shift to a full EHR has transformed her department's work and relationships. With more than 700 physicians, 5,000 staff, 41 sites across northern Wisconsin and Michigan's Upper Peninsula, and 1.6 million patient encounters in 2000, the Marshfield Clinic is one of the largest independent physician organizations in the US. The clinic actually implemented a partial EHR in 1985, with the automation of radiology and laboratory results.

But when transcribed notes went electronic in 1992, "it pretty much completely changed our lives and changed our practice," Berg says, shifting her staffers from managing paper to truly managing information. "Now that all the forms are electronic,

we're more concerned with data content," she emphasizes.

In fact, the software that Marshfield clinicians and staff use allows for view customization, so an authorized user interacting with a patient's electronic record can customize how he or she wants to see the information presented.

"So if you're a dermatologist, for example, you probably just want to see the dermatology-related group of documents, and you can create tabs in the electronic patient record to accomplish that," Berg says. This turns her HIM professionals into analysts and, "in some sense, editors." And Berg agrees with her colleagues that as a hiring manager, she now looks for an enhanced skill set and more analytical thinking from potential new hires. In her case, she says, she hasn't cut staff, but she also hasn't increased staff size since 1996, despite a very large increase in patient volume.

Flexibility Is Key

The bottom line, all who have implemented EHRs in medical groups agree, is keeping in mind that developing an EHR is an ongoing process, not a single event. Those organizations that have achieved success have modified their original concepts and plans along the way. As Mayo Clinic Scottsdale's Jaskowski says, "You have to remember to always stay very, very open to all possibilities and options. There definitely is no one-size-fits-all answer for any of this." What's the best way to accept and enable change? "You have to be extremely flexible."

Rule Number One: Embrace Change

All those interviewed agree that there are some very basic things HIM directors and leaders need to keep in mind as their organizations move toward an EHR:

- A transformation of the work of the HIM department is inevitable, so **embracing change is essential**
- Generally speaking, the number of FTEs can be expected to decline, or at most, remain flat. However, **roles will be transformed**, with virtually no need for the minimum wage-level file clerks needed in paper-based systems
- Medical groups tend to face more capital challenges than hospitals when considering EHRs, but they also tend to be less heavy on bureaucracy, so when such systems are approved, the **implementations often can move quickly**
- HIM directors and leaders need to be **involved from the very beginning** to help shape the process and scope of the EHR system
- **Partnership with the physicians**—especially any avid supporters—is critical to success
- Jobs will be redefined, and HIM directors and leaders need to **think strategically** about what will best serve the needs of clinicians and patients when redesigning roles, responsibilities, and reporting relationships
- A growing number of case studies demonstrate that **success is possible** in a variety of environments and management models

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