Building a Successful EMR
Dress Rehearsal Program:
Why it Matters

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Dress rehearsals combine new electronic medical record (EMR) technology with redesigned care processes to demonstrate how well they work together. Done at key points during the implementation project, dress rehearsals identify issues early on, so changes in technology and process can be made in time to retest and refine which in turn increases the likelihood that the EMR implementation will be successful. In addition and perhaps more important to long-term success, dress rehearsals engage care providers prior to system go-live, mitigating pre-go-live anxiety and gaining their buy-in – all critical for demonstrating Meaningful Use.

This white paper describes the different dress rehearsal approaches, outlines the key considerations for planning and execution, and addresses commonly asked questions for building a successful program.

Why a Dress Rehearsal?

For years there have been ongoing debates regarding EMR implementation costs and impacts on hospitals and EMR adoption by caregivers. Although results from a plethora of surveys, interviews, and analysis of specific installs differ in terms of metrics (e.g. percentage of hospitals with EMRs installed and adoption rates), there is consensus on several central themes:

- EMRs are extremely expensive, requiring a substantial capital commitment and operating expense increase;
- EMR implementations are multi-year projects that consume valuable human resources and result in a short-term loss of productivity as users are trained and become comfortable with the technology; and
- Failure is not an option. Demonstrating Meaningful Use and meeting other upcoming CMS changes, all with significant financial impacts and rapidly approaching deadlines, are putting many hospitals’ financial health on the line.

Dress rehearsals are detailed scripted care events that interweave complex processes from different members of the care team with the new EMR technology to simulate real-life experiences.

The analyses also agree on a number of success factors. Topping the list is the realization that EMR implementations are not technology projects. They are care process redesign efforts enabled by technology.

Equally important is the need to engage care providers early in the planning and design process and during training preparation and implementation support. Wrapping all of the pieces together is done during dress rehearsals where care providers can see the decisions they made during the build process “come to life” in scenarios where they are the actors.

“Turning on a new system is like refueling a plane in mid-air. Care doesn’t stop, nurses still have to give meds and change bandages, take patients to surgery and feed newborns. This is happening at the same time they are changing how they interact with information, making quick decisions, protecting patient privacy and acting in an emergency. A real and dramatic challenge.”

David Muntz, Baylor Healthcare, HIT Standards Committee - Implementation Workgroup Hearing on Implementation Starter Kit

Dress Rehearsal – Defined

Different from training and testing, which focus on a specific function or one process, dress rehearsals are detailed scripted care events that interweave complex processes from different members of the care team with the new EMR technology to simulate real-life experiences. They are “performed” by care providers and administrative staff who have been closely involved in the EMR project (called “super users”) and who will be using the system once it goes live. Consequently, they have a truly vested interest in using dress rehearsals to flesh out issues and address them immediately. Dress rehearsals can be done in a number of ways; picking the right approach depends on the scope of the interactions, risk level, and process complexity. The three most common are:

- **Departmental – Scope is narrow, detail is deep.** For example, you may have some significant procedures or diagnoses that do not happen frequently but are so complex that you want to develop a dress rehearsal to make sure all roles and possible outcomes are addressed (e.g. transplants). At one academic medical center, they chose to do a dress rehearsal for liver transplants because the high level of process...
complexity and potential for errors. Department-specific dress rehearsals are usually held within the department, and attendance is limited to the staff that works there.

• **“Day-in-the-life”** – Scope is wide, detail is shallow. Day-in-the-life rehearsals are typically short (less than an hour) and focus specifically on workflows that nurses, physicians, and other clinicians follow during their day. These are usually done as a demonstration in an auditorium setting and are led by a training team member with application team support. Multiple day-in-the-life dress rehearsals can be done in one day, allowing for attendance by multiple clinicians and providers throughout the day.

• **Integrated** – Scope is wide, detail is deep. Integrated dress rehearsals are the most common type and usually last two to four hours. They focus on common workflows with multiple integration points throughout the health system (e.g., patient is seen in the emergency room, goes to radiology for a CT scan, then to surgery, and finally admitted to an inpatient unit). Integrated dress rehearsals are often held in auditorium settings but can be much smaller and held within departments using a workstation on wheels (WOW) and walking from department to department. We recommend that attendance be limited due to the disruption in patient care areas with the WOW approach. To increase participation, some hospitals have been able to use a closed unit or a newly built one that’s not yet opened as the stage for integrated dress rehearsals.

### Preparation and Participation

The keys to successful dress rehearsals are preparation and participation. It has been our experience that when the application teams, site leadership, and super users are fully engaged in both planning and execution, there is greater buy-in up front, and there are fewer calls to the help desk and service tickets after go-live.

#### Preparation

It is important to have one project manager who is responsible for all of the details surrounding the dress rehearsals (e.g., organizing the meetings, rooms, attendees, equipment, etc.). Ideally, the person has a solid understanding of the EMR in order to design scenarios, confirm generic logins for user access, and register rehearsal patients with fictitious clinical data. The project manager should also act as emcee/host for the dress rehearsals welcoming attendees, completing introductions, and setting expectations. Another key project manager responsibility is to identify all issues while keeping the process moving forward.

Diagnoses and workflow processes used in your dress rehearsals should be based on the “80/20 rule” (i.e., those that occur most frequently are the ones rehearsed). Usually hospitals identify these processes by running a report of the top 20 admission diagnoses for the past six months. Several typical examples include a patient seen in the emergency room for abdominal pain and discharged to home or one that involves a patient scheduled for hip replacement surgery who is admitted to an inpatient unit and then discharged to a rehabilitation facility.

Once the assessment of common diagnoses is completed, the project manager will enlist application team members, site leadership, and super users (from the hospitals and/or clinics going live) in the development of scenarios and scripts. This can be a time-intensive endeavor, but it helps assure that accurate workflow from one department to another is included in the rehearsals. Working together to create the script also creates buy-in from both application teams and site leadership.

After scripts are developed, staging needs to occur. For example, if the scenario calls for a patient to come to the hospital for a scheduled surgical procedure, the patient needs to be registered and scheduled for surgery and any pre-op steps that would normally occur should be entered prior to running the script in front of an audience. This detailed preparation is absolutely necessary so end users can see how outpatient documentation connects to inpatient documentation and how patients’ journeys begin long before they come to the hospital. The script example on the following two pages highlights the roles, level of detail, and workflow followed for one medical/surgical scenario.

#### Participation

During a dress rehearsal day, the super users are the “actors” logging into the system and demonstrating the workflow to others in the audience. We found it is critical to have application team members in attendance as “wingmen” for the super users. This assures super users that they are not being left alone...
**Med Surg Script**

**Story for Scenario:** Patient had hip replacement and has already been admitted to inpatient unit. Planning for discharge to rehab facility.

**Patient Name/MRN:** Rehearsal, Medsurg

**Staging Needed:** Operating room team must create patient and complete surgery, and registration team must finish admission before this script begins. Patient is already admitted to inpatient med/surg post hip replacement surgery.

**Summary of roles needed:** RN, Physician, Unit coordinator, Social Service, PT/OT, Pharmacist, Lab tech, Rad tech

<table>
<thead>
<tr>
<th>Step #</th>
<th>Est Time in Minutes</th>
<th>Instruction/Action</th>
<th>Role(s) Involved</th>
<th>Talking Points</th>
<th>Generic Log in</th>
<th>Site Resource</th>
<th>App Team Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>Patient is in the recovery room (PACU) and is ready for transfer (surgeon places post-op orders - sign and hold).</td>
<td>MD</td>
<td>Patient registered in central registration. We start with placing of post-op orders and the transfer process.</td>
<td>Opmd, abc123</td>
<td>Operating Room team, Reg team</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>NOTE: Patient placement will receive notice and begin patient placement process.</td>
<td>patient placement</td>
<td>The unit will see the patient on the expected tab and pull them in. The HUC or the charge does this. PACU calls the floor. The floor has already held the bed.</td>
<td>SHPASR, abc123</td>
<td>Reg team</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>Nurse or HUC goes to the expected tab on unit census, highlight and transfer patient to bed.</td>
<td>unit coordinator or RN</td>
<td></td>
<td>IPUCC OEPCT, abc123</td>
<td>Clinical Documentation</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>1. Adds patient to list. 2. Listens to report 3. Looks at orders, reviews accesses/releases ‘signed and held’ orders. 4. Acknowledges orders and completes admission assessment, first vitals, etc. - using the admission navigator.</td>
<td>med/surg RN</td>
<td>Hospital-at-a-Glance shows which patients are available. All RNs have access in View Only. The Charge RN and HUC have more access to it. This is not the push/pull. That would be in the unit census.</td>
<td>IPRNFV, abc123</td>
<td>Clinical Documentation</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>Unit can access Hospital-at-a-Glance to view open/available beds, staff assignment, attending physician using Hospital-at-a-Glance.</td>
<td>unit coordinator or RN</td>
<td>Charge RN performs</td>
<td>IPCN, abc123</td>
<td>Clinical Documentation</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>Pharmacy verifies orders and makes medication available.</td>
<td>pharmacist</td>
<td></td>
<td>FVRX PHARM</td>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Step #</td>
<td>Est Time in Minutes</td>
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<tr>
<td>7</td>
<td>15</td>
<td>The hospitalist places admission orders.</td>
<td>MD</td>
<td>Hospitalist does med reconciliation.</td>
<td>IPM DFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
<tr>
<td>8</td>
<td>10</td>
<td>RN releases Post-Op Orders.</td>
<td>RN</td>
<td>Lab/Rad Order to be done as a part of the Post-Op Order</td>
<td>IPRNFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
<tr>
<td>9</td>
<td>15</td>
<td>RN obtains medications, scans barcode(s), administers medications, and documents on MAR.</td>
<td>med/surg RN</td>
<td></td>
<td>IPRNFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
<tr>
<td>***</td>
<td>1</td>
<td>HUC notes social service consult on unit log-paper form.</td>
<td>unit coordinator</td>
<td>Paper workflow step</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>Rehab scheduler checks front desk report and schedules PT/OT (day shift). Patients will be accessed from the System List.</td>
<td>PT/OT</td>
<td></td>
<td>PTFV, abc123 and OTFV, abc123</td>
<td></td>
<td>Scheduling</td>
</tr>
<tr>
<td>11</td>
<td>15</td>
<td>Therapist sees patient at bedside/department and documents using evaluation notes and document.</td>
<td>PT/OT</td>
<td></td>
<td>PTFV, abc123 and OTFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
<tr>
<td>12</td>
<td>15</td>
<td>Social services meets with patient and documents.</td>
<td>social services</td>
<td></td>
<td>SWFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
<tr>
<td>13</td>
<td>20</td>
<td>Physician visit – 1. Using Discharge Navigator, places orders using the “Discharge to Other Facility” orderset. 2. Writes order for admit to rehab facility. 3. Nurse or HUC prints out the Interagency Transfer Form (IATF).</td>
<td>physician</td>
<td>Narcotics will print automatically to the printer designated to the local workstation. There is no ePrescribe option.</td>
<td>IPM DFV, abc123</td>
<td></td>
<td>Clinical Documentation and Orders</td>
</tr>
<tr>
<td>14</td>
<td>10</td>
<td>Nurse completes discharge process.</td>
<td>med/surg RN</td>
<td>This is done via Discharge Navigator</td>
<td>IPRNFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
<tr>
<td>15</td>
<td>End of Scenario</td>
<td></td>
<td>med/surg RN</td>
<td></td>
<td>IPRNFV, abc123</td>
<td></td>
<td>Clinical Documentation</td>
</tr>
</tbody>
</table>

*** Not a computer step
and also provides a narrator to talk through the actions that each super user is taking. For example, if a script calls for registering a patient, a registration super user and an application team member stand together in front of the room. The super user logs on and begins the steps of registration, while the application team member explains those steps to the audience. If the next step is for a nurse to complete the admission process, then a nurse super user goes to the front and completes those steps while the clinical team member narrates the next steps in the patient’s inpatient stay. This process continues for every step of the scenario including pharmacy, social work, physical therapy, etc. This is an excellent way for different disciplines to see how their work and clinical documentation impact others.

Dress Rehearsal FAQs

Questions often come up during the planning phases concerning timing, issues communication, and degree of authenticity. While there is no one right answer, the following responses are based on our experience leading a number of successful dress rehearsal projects.

Timing – When and how often should we conduct dress rehearsals?

Day-in-the-life dress rehearsals can start as soon as some basic nursing and physician workflow(s) are built and ready for all to see. One suggestion would be to make these “lunch and learn” sessions and advertise them as much as possible. Reason being: the more often end users see and interact with the system prior to go-live, the more successful your go-live will be.

Integrated and department-specific dress rehearsals should come near the end of training and testing and as close to go-live as realistically possible. These are led by super users, and attendees should have seen the system during training and practiced with it in the organization’s “playground,” or practice environment, prior to attending. When this has occurred, a dress rehearsal offers end users one more chance to interact with the system before go-live, to follow their workflow through the care delivery process, and to understand how their use of the system affects others.

Authenticity – How real should dress rehearsals be?

If you are taking the time to prepare for and execute a dress rehearsal, we recommend that it is as close to real life as possible – namely, using the equipment and following the workflow accurately. However, make sure all of the pieces work in the dress rehearsal environment. The use of interfacing technology, when working smoothly, greatly contributes to end user confidence. When it doesn’t work, it adds to end user anxiety and impacts confidence in the technology.

If you are taking the time to prepare for and execute a dress rehearsal, we recommend that it is as close to real life as possible – namely, using the equipment and following the workflow accurately. However, make sure all of the pieces work in the dress rehearsal environment.

Issue Resolution and Communication – What is the timeframe for issue resolution and how should changes be communicated?

Part of the support crew for a dress rehearsal is a scribe who records any questions or concerns that arise during the dress rehearsal and assigns due dates for resolution. An approach that has proven very successful is to use the time at the end of the session to address these issues. Often times, the experts needed for resolutions are already attending and participating in the dress rehearsal, so with the issues fresh in their minds, resolutions quickly can be identified and approved.

Summary

EMR dress rehearsals “put the new system through its paces” prior to go-live. They offer the opportunity for end users to see the multiple decisions they made during the build process come together in their complex care environment, resulting in identifying issues in time to be addressed and increasing the level of confidence for a success implementation.

Dress rehearsals require valuable care provider, administrative staff, and IT resources. As such, senior level commitment is critical. Our experiences have shown that dress rehearsals need to be led by an experienced project manager who selects that right approach and resources and follows a methodology that encourages participation, questions, and resolution discussions. Besides gaining valuable time and exposure to the new system and processes, the involvement of the broad range of resources – and how they relay the dress rehearsal experience to others – “closes the sale” around EMR adoption and support.
About the Author

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Senior Advisor, Aspen Advisors

Kathy Krypel has over 20 years of experience as an accomplished project manager and clinical advisor to healthcare and IT executives. With a deep understanding of clinical and regulatory requirements and a clinical background in behavioral health, Ms. Krypel has assisted multiple hospital systems in their decision making processes and strategic planning around EMR implementations. Additionally, she brings years of experience in a variety of consulting roles across the lifecycle of an implementation project including project manager, team lead, process design analyst, implementation specialist, and trainer. Through consulting assignments, Ms. Krypel has assisted healthcare organizations including the Cleveland Clinic Health System, St. Elizabeth’s Medical Center, Cedars Sinai Hospital, Texas Children’s Hospital, Children’s Memorial, and HealthPartners. Before joining Aspen Advisors, Ms. Krypel worked at Allina Hospitals and Clinics, Healthia Consulting (now OptumInsight), and Blue Cross Blue Shield of Minnesota. Prior to that, she was a clinical social worker at Abbott Northwestern Hospital and Washington County Community Services. Ms. Krypel holds an MS in Social Science from St. Cloud State University and is a Licensed Independent Clinical Social Worker ( LICSW ).

About Aspen Advisors

Aspen Advisors is a professional services firm with a rich mix of respected industry veterans and rising stars who are united by a commitment to excellence and ongoing dedication to healthcare. We work with healthcare organizations to optimize the value of their information technology investments. Our experienced team is highly skilled in all aspects of healthcare technology. We understand the complexities of healthcare operational processes, the vendor landscape, the political realities, and the importance of projects that are executed successfully – the first time. Every client is important to us, and every project is critical to our reputation. Established in 2006, the firm has grown significantly year over year and was named a 2010 “Up and Comer” by Healthcare Informatics. Our hallmarks are top quality service and satisfied clients; we’re proud that each past and current client is 100% referenceable.

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