# EHR MIGRATION

*10 Things That Separate a Smooth Conversion from a Disaster*

Most failed conversions are not technical failures —
they are workflow, communication, and training failures.

Healthcare Operations | EHR Implementation

01

# Map the Real Workflow Before Touching the Software

*Shadow everyone. Front desk, nurses, providers, billing, lab, pharmacy.*

# 1 Map the Real Workflow Before Touching the Software

- Shadow front desk staff, nurses, providers, billing, referrals, lab, and pharmacy — everyone
- Do not rely solely on what leadership thinks staff actually do day-to-day
- Document every workaround, shortcut, and undocumented dependency you find
- Identify tasks that cross departmental lines — these create the most hidden risk

**Biggest mistake:**

- Forcing old, broken workflows into the new system
- Accidentally removing critical shortcuts people depended on
- Building the new EHR around assumptions rather than observation

⚠ **If you skip workflow mapping, you will rebuild the problems your old system had — in a new one.**

02

# Clean Your Data Before Migration

*Garbage migrates beautifully. Fix it before it moves.*

# 2 Clean Your Data Before Migration

**Fix these before migration:**

- Duplicate patients and overlapping records
- Inactive or deceased providers still attached to records
- Bad or expired insurance data
- Outdated or inaccurate problem lists
- Inconsistent naming conventions across departments
- Old templates and order sets nobody uses anymore

- Run data quality reports and establish a cleanup team well in advance of go-live
- Validate migrated data with real end-users, not just IT staff

⚠ **If you skip cleanup, users lose trust in the new EHR immediately — and that trust is very hard to recover.**

# 03

## Build With Frontline Users, Not Just IT

*Your best analysts are already on your clinic floor.*

# 3 Build With Frontline Users, Not Just IT

**Identify and recruit your core build team early:**

- One respected MA who knows the daily floor rhythm
- One nurse who knows every workaround and edge case
- One skeptical provider — if they buy in, others follow
- One billing expert who lives in the revenue cycle

- Involve frontline staff in build decisions, testing, and UAT — not just end-of-project training
- Create a feedback loop so staff feel heard; ignored concerns become active resistance
- If your key influencers champion the new system, adoption improves massively across the organization

⚠ **People support what they help build. Exclusion creates sabotage — even unintentional.**

04

# Reduce Customization Unless Absolutely Necessary

*Every customization becomes future technical debt.*

# 4 Reduce Customization Unless Absolutely Necessary

**Before customizing anything, ask:**

- Is this legally or regulatory required?
- Does this directly improve patient care outcomes?
- Does this improve revenue cycle performance?
- If not — do not build it.

- Customizations break on upgrades and require constant maintenance overhead
- Out-of-the-box workflows are tested, supported, and documented by the vendor

**Classic failure pattern:**

- Organizations recreate their 20-year-old legacy system inside a modern EHR
- They migrate all their old problems and call it a new system
- End result: expensive, fragile, and miserable for users

⚠ **Default first. Customize only when default fails a genuine clinical or operational need.**

05

# Train by Role and by Scenario

*Click-here training fails under real clinical pressure.*

# 5 Train by Role and by Scenario

**Generic training is nearly useless. Train on real workflows:**

- Actual patient check-in / check-out processes
- Refill requests, prior auth workflows
- Referral handling from start to finish
- Lab order to lab follow-up
- No-shows, same-day walk-ins, and schedule changes
- Downtime procedures — EHR outages will happen

- Train each role separately: provider training ≠ MA training ≠ billing training
- Use real (de-identified) patient scenarios, not demo data that looks nothing like your population
- Require competency sign-offs, not just attendance confirmation

⚠ **If staff can only do it in a training environment, they cannot do it under real clinic pressure.**

# 06

## Run a Dress Rehearsal With Live-Like Volume

*Simulation reveals what testing environments never will.*

# 6 Run a Dress Rehearsal With Live-Like Volume

**Simulate a full clinic day before go-live with:**

- Phones ringing with real call volume
- Walk-in patients mixed into scheduled appointments
- Lab results arriving mid-clinic requiring provider response
- Refill requests coming in simultaneously from multiple providers
- Printer and scanner failures — they will happen at go-live

- Include downtime procedures: staff must know what to do when the system is unavailable
- Run the simulation with your actual go-live staffing levels, not ideal headcount

**What you find:**

- Operational failures that no testing environment ever surfaces
- Communication breakdowns between departments under real time pressure
- Missing workflows nobody thought to train on

⚠ **A dress rehearsal is not optional. It is the only way to find what you don't know you're missing.**

07

# Protect Your Revenue Cycle First

*Cash flow collapses fast. Billing failures are existential.*

# 7 Protect Your Revenue Cycle First

**Revenue cycle areas requiring intensive pre-go-live focus:**

- Charge capture — are all encounters generating billable charges?
- Coding workflows — ICD-10, CPT, modifiers, diagnosis linking
- Claim edits and clearinghouse interface testing
- Eligibility verification at check-in
- Denial workflows and appeal processes
- ERA/EOB posting and reconciliation

- Interfaces to clearinghouses must be tested end-to-end with real payer responses before go-live
- Run parallel billing for at least 2 weeks if possible — compare old vs. new system claim output

**Reality check:**

- Organizations can survive clinical frustration for months
- They do not survive 90 days of billing failures and frozen cash flow

⚠ **Revenue protection is not a post-go-live task. It must be ready before the switch flips.**

08

# Expect Productivity Loss for 3–6 Months

*Plan for it. Staff for it. Don't pretend it won't happen.*

# 8 Expect Productivity Loss for 3–6 Months

**Realistic expectations to set with leadership:**

- Providers will be slower — schedule fewer patients initially
- Chart closure will be delayed — plan overtime or documentation support
- Registration times will increase — staff check-in lanes accordingly
- Help desk ticket volume will spike 3–5x in the first 30 days
- Patient dissatisfaction may temporarily increase — communicate proactively

- Build a staffing plan that accounts for reduced throughput — don't hold productivity targets constant during transition
- Set a 90-day and 180-day benchmark to measure recovery against baseline metrics

**Leadership accountability:**

- Pretending efficiency will appear overnight destroys staff morale
- Underprepared teams burn out and leave — turnover costs exceed EHR costs

⚠ **Productivity loss is not a failure. It is a predictable phase. Plan for it honestly.**

09

# Have Floor Support Everywhere During Go-Live

*At-the-elbow support matters more than webinars.*

# 9 Have Floor Support Everywhere During Go-Live

**Go-live support structure that works:**

- Analysts physically present on clinic floors — not in a back office
- Rapid issue escalation path with clear decision authority
- Visible command center with issue tracking board
- Daily issue log reviewed by the full project team
- Twice-daily leadership huddles — morning and end-of-day
- Triage issues in real time: fix now vs. document for post-go-live vs. escalate to vendor
- At-the-elbow support requires your best people — not volunteers or junior staff

**What happens without it:**

- Staff feel abandoned and panic spreads quickly
- Workarounds form on day one that become permanent habits
- Issues go unreported because staff don't know where to turn

⚠ **People don't panic because the system is hard. They panic because they feel alone with it.**

10

# Measure Outcomes After Go-Live, Not Just Completion

*Done ≠ successful. Track what actually matters.*

# 10 Measure Outcomes After Go-Live, Not Just Completion

**Track these metrics at 30 / 60 / 90 / 180 days:**

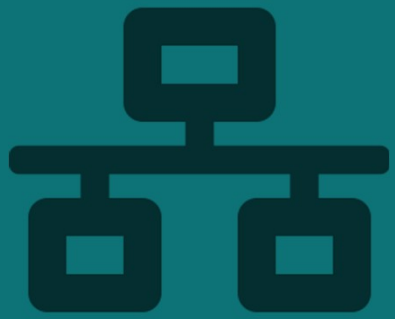
- Chart closure times vs. pre-go-live baseline
- Claim denial rates and first-pass resolution
- Patient throughput and scheduling capacity
- Refill turnaround time
- Portal adoption and patient message volume
- No-show rates and appointment access
- Revenue lag and days in A/R
- Provider satisfaction scores and burnout indicators
- Report metrics to leadership and frontline staff — transparency builds accountability on both sides

**Critical warning sign:**

- Some EHR conversions technically succeed while operationally destroying morale
- Burnout-driven turnover can erase years of institutional knowledge — watch for it

⚠ **A conversion is not 'done' when the switch flips. It's done when performance returns to baseline.**

11



# Bonus Rule for Tribal, Rural & Resource-Constrained Settings

*Interface complexity is the hidden iceberg that sinks timelines.*

# Do Not Underestimate Interface Complexity

**Interfaces that must be inventoried early:**

- Laboratory systems (HL7 orders and results)
- Pharmacy and medication management systems
- Imaging (PACS/RIS) and radiology reporting
- Billing and clearinghouse connections
- Referral management platforms

**Higher-risk interfaces for tribal/rural settings:**

- Public health reporting (IHS, state registries)
- Legacy RPMS modules still in active use
- Hybrid RPMS/commercial EHR bridge environments
- Tribal enrollment and eligibility databases
- Third-party behavioral health or dental systems

**A strong interface inventory at project start saves enormous pain in timeline, budget, and trust.**

# The 10-Point Summary

01 Map real workflows — shadow everyone first
02 Clean your data — garbage migrates beautifully
03 Build with frontline staff — MA, nurse, provider, billing
04 Minimize customization — every change is future debt
05 Train by role and scenario — click-here training fails
06 Run a dress rehearsal — simulate real clinic volume
07 Protect revenue cycle first — cash flow collapses fast
08 Plan for 3–6 months productivity loss — staff for it honestly
09 Put analysts on floors at go-live — not in back offices
10 Measure outcomes — done ≠ successful

***Tribal & rural bonus: Build your interface inventory on day one.***