

CURASYNC EXECUTIVE BRIEF No. 002

Beyond Go-Live: Why Stabilization Is an Operational Priority

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Executive Problem

EHR activation marks the beginning of live use, not the end of organizational change. EHR-transition studies describe post-go-live changes in system use, documentation, ordering, usability, workflow, and user experience(1,2).

For this brief, post-go-live stabilization refers to the period in which an organization monitors real-world use of the new EHR, responds to emerging issues, and adjusts support, workflows, and configuration as needed.

Executive Summary

EHR transitions are major organizational changes that require clinicians and staff to adapt workflows while continuing patient care (2).

Post-go-live performance does not follow a single recovery trajectory. Across studies of EHR-to-EHR transitions, productivity declined immediately after go-live, while subsequent clinical, operational, provider, and patient-experience measures varied- some recovered over months, some remained below baseline during follow-up, and others showed little measurable change (2).

Quantitative improvement also may not capture the full experience of stabilization. In a longitudinal mixed-methods study, total EHR time per patient decreased by approximately 29% between months 1 and 12 after activation, while clinicians continued to report workflow inefficiencies, usability challenges, and difficulty completing some clinical tasks during the first year (1).

Organizational response matters during this period. Participants across four U.S. healthcare systems identified personalized training and support, robust internal support, reduced workload expectations, proactive response to emerging challenges, and continued investment after go-live as helpful transition practices(3).

For executive leaders, the evidence supports treating post-go-live stabilization as a governed operational phase- not a passive period of waiting for users to adjust. Leadership should monitor multiple dimensions of performance, identify problems emerging through real-world use, maintain appropriate support, and deliberately transition from activation support to optimization.

Executive Insight

Activation begins implementation. Stabilization determines whether the organization can convert technology into reliable clinical operations.

Evidence Snapshot

Theme	Representative evidence
Recovery is multidimensional	Post-go-live measures follow different trajectories: some recover within months, some remain below

Theme	Representative evidence
	baseline, and others show little change. Provider-experience measures have demonstrated J-, U-, L-shaped, and flat recovery patterns (2).
Support must evolve after activation	Health systems identified personalized support, reduced workload expectations, proactive problem-solving, and continued investment as important transition practices; targeted system modification has also improved specific post-go-live problems (2,3).
Metrics do not tell the whole story	EHR-use measures improved over the first year in one major transition while clinicians continued to report workflow inefficiencies, usability problems, training gaps, and difficulty completing clinical tasks (1).
Effects extend beyond productivity	Transition effects have been observed across clinical quality, patient safety, provider experience, and patient experience, with outcomes differing in direction and duration (2).

What the Literature Shows

1. Post-go-live performance changes over time

EHR transition is not characterized by a single recovery trajectory; clinical, operational, provider, and patient-experience measures may improve, deteriorate and recover, remain below baseline, or show little measurable change following activation (2).

In a mixed-methods evaluation of a major EHR transition, total EHR time per patient decreased by approximately 29% and documentation time by approximately 9% between months 1 and 12 after go-live (1). Order-entry time followed a less linear trajectory, initially increasing from 2.03 to 3.11 minutes per patient before declining to approximately its month-1 level by month 12 (1)

Across four studies examining clinical-encounter or EHR time, all reported immediate productivity declines after transition; productivity returned to baseline by six months in one subspecialty practice (2). In a large health-system study, emergency-department length of stay and wait times increased immediately after go-live and returned to baseline by approximately one year, while new-patient visits and laboratory test orders declined and had not recovered by the end of follow-up (2).

Provider-experience measures also followed different patterns—including J-, U-, L-shaped, and flat trajectories—with the most common pattern being an early decline followed by gradual improvement that remained below baseline at the end of a two-year follow-up period (2).

Executive Implication. Organizations should monitor post-go-live performance longitudinally rather than treating activation-week performance as representative of implementation success. Different measures may

recover quickly, recover slowly, remain below baseline, or show little change- making stabilization a multidimensional assessment rather than a single milestone.

2. Post-go-live support should evolve into optimization

A multisite qualitative study of four U.S. healthcare systems demonstrated that during go-live, participants identified personalized training and support, robust internal support, reduced workload expectations, and proactive response to emerging challenges as helpful organizational practices (3). After go-live, participants emphasized continued investment in organizational change, reinforcing that implementation support does not end when the new EHR becomes operational (3).

The broader literature also demonstrates that post-go-live problems may be responsive to active intervention rather than time alone. In one health system, drug-drug interaction alert burden increased sixfold following implementation but subsequently decreased by 51% after the alerts were modified (2).

EHR-transition research, therefore, describes the post-go-live period as one involving continued sustainment, refinement, and adaptation rather than simply waiting for users and operations to stabilize independently (2,3).

Executive Implication. Post-go-live support should transition from immediate activation support into a structured optimization process. Organizations can establish defined ownership and escalation pathways, identify recurring clinical and operational problems, prioritize them by impact, deploy targeted interventions, and evaluate whether those interventions improve performance.

3. Real-world use can reveal workflow, productivity, and usability problems

Qualitative findings provide a different view of post-go-live performance than quantitative EHR-use measures alone. During a major EHR transition, clinicians described tasks taking longer in the new system, additional clicks, difficulty locating information, workflow inefficiencies, insufficient task-specific training, and usability and functionality concerns (1).

These concerns persisted for some participants during the first year after go-live, even as quantitative measures such as, total EHR time, improved over the same period (1).

The study's qualitative findings also identified variation by role and task, with participants describing training as insufficiently tailored to specific clinical responsibilities and reporting challenges adapting existing work processes to the new system (1).

Executive Implication. Quantitative performance improvement should not be interpreted as evidence that workflows are functioning optimally. Organizations should pair EHR-use and operational measures with direct observation, clinician feedback, support data, and task-specific workflow assessment to identify problems that aggregate metrics may not reveal.

4. Implementation effects extend beyond productivity

A systematic review identified 40 publications examining EHR-to-EHR transitions across multiple domains, including clinical care, provider perspectives, data migration, implementation, and patient experience (2)

Clinical outcomes were not uniformly affected. Across 17 hospitals, EHR transition was not associated with 30-day mortality or all-cause 30-day readmission, while diabetes blood-pressure control declined immediately after go-live across four regions and returned to baseline in two regions within seven to 16 months (2).

Patient-safety measures also identified transition-related effects. Pediatric medication-safety reports increased approximately fivefold in one health system before returning to baseline three months after implementation (2).

Patient experience was similarly important to assess. Some studies found no significant change in patient experience, while others identified deterioration after transition. In one six-site study, patient satisfaction initially declined, returned to baseline between nine and 15 months, and some measures subsequently exceeded baseline by 20 months (2).

Executive Implication. Implementation performance should not be defined by productivity or system use alone. Leadership should monitor a balanced set of indicators spanning clinical quality, patient safety, operational performance, provider experience, and patient experience to identify consequences that may not be visible in traditional go-live metrics.

Executive Discussion Guide

- Which measures will show whether EHR use, documentation, ordering, workflow burden, and support needs are changing after activation?
- Which clinical workflows require focused observation during the early post-go-live period?
- How will the organization identify and respond to persistent usability or training concerns?
- What support resources and escalation pathways will remain available after activation?
- What criteria will the organization use to determine whether a workflow, department, or site has stabilized?

Executive Bottom Line

Go-live is a milestone, not the endpoint of implementation. Evidence from EHR transitions shows that operational, workflow, provider, clinical, safety, and patient-experience measures can follow different trajectories after activation (2). Quantitative improvement may also coexist with persistent workflow and usability problems experienced by clinicians (1).

For executive leaders, stabilization should therefore be actively governed rather than assumed. Health systems should maintain support after activation, monitor performance across multiple domains, identify problems emerging through real-world use, and transition from immediate go-live support to deliberate optimization.

References

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