In the News

Hats-off to AMDIS

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Congratulations to AMDIS for saying what many of us believe and promote, but had feared was falling on deaf ears or been drowned out by politics and ego. It's not surprising that the "Boston Docs" known MD-centric view of the world (healthcare and IT) produced a largely MD-centric, "CPOE first" meaningful use strategy. Hopefully this attitude was rejected when Version One of MU was sent back to the drawing board the day after the first draft was issued.

Chasing ARRA money already put some hospitals on a dangerous path to drop everything in hurry up mode to "install" CPOE without examining physician workflow, decision making, cultural and change management needs, and foundational applications. Some EMR companies and their advocates encouraged this — some unwittingly, others with an eye on increased or accelerated quarterly revenue recognition, the metric vendors are held to (incented by), particularly public companies.

For CPOE to be more than an automated requisition generator, MDs need to get tangible value, including the ability to make better informed decisions based on more timely data (not meaning the computer is making decisions for them). Since ancillary systems were ground zero for hospital clinical automation, lab and X-ray results are almost always online before or with CPOE.

What may not be present is assessment data entered by nurses, ideally at the point of care in near real time, e.g. allergies, height/weight, vital signs, I & O, nurse-collected lab values, and an accurate medication record. That is critical data for clinical decision support (CDS) for MDs in ordering. Not having these data available wastes MD time and steps and results in suboptimal or even unsafe ordering decisions. If data is not easily retrievable (preferably "pushed" to MDs in the ordering process at the right time), physicians are forced to look for paper charts, call for information, chase nurses down, or make ordering decisions without important or current information.

In addition to providing a clear path to CPOE, automating the eMAR/BCMA has greater potential impact on med error reduction than CPOE. Not killing or harming patients would seem a primary goal to improve quality of care. MDs and RNs make approximately same number of errors, but pharmacists or RNS catch 50% of MD errors downstream whereas 98% of RN errors reach the patient. And, nurses work for hospitals and are more easily corralled (in theory), thus making clinical and business sense to start with foundation pieces first.

Hopefully Drs. Glaser and Halamka (and Blumenthal) are listening. Some have recommending staging implementations as if it's a pecking order — doctors first! To be effective, CPOE needs to be part of a bigger strategy –patient-centric, outcomes (not IT) focused, with staged functionality and a 21st century interdisciplinary care team approach that respects all caregivers' roles and contributions.

For the good of all, we want CPOE to be embraced by MDs, but also for MDs and US healthcare reform to be more inclusive and patient-centric. I speak as clinical consultant, former EMR vendor exec, and RN who worked with first commercial EMR in a hospital with near 100% CPOE in early 1970s. CPOE is hardly a new phenomenon, yet some MDs and vendors act as if it started with them. We've known for decades how CPOE can be implemented successfully. Now's the time to really get this right.

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