I've been thinking...

Terror, Error, Meaningful Use, and Mercy
September 2012

I've been thinking about terror, error, Meaningful Use and mercy.

Eleven years into the Afghan war, the August 22, 2012 *Seattle Times* headline reported, "2,000 U.S. dead in war, as new dangers emerge"—a statistic disturbing to hawks and doves. Then this September 11, a year after the Ground Zero memorial opened in New York, the American Embassy in Libya was stormed, and the U.S. ambassador was killed. We feel outrage, honor the dead, sympathize with their loved ones, and pray for peace.

However, while our emotions well up over lives lost from acts of terror, we must not care any less about lives lost from error. If estimates in the Institute of Medicine's November 1999 *To Err Is Human* report have held true, during the same eleven years, preventable hospital medication errors cost America more than 77,000 lives—none of which was laid down in service for his or her country. This amounts to 7,000 deaths per year, more than double the lives lost in 9/11. This, too, deserves our outrage. It should summon our sympathy and prayers for loved ones and second victims, and it ought to fuel unflagging efforts to prevent these unintended tragedies.

Evidence reveals that by utilizing bar-coding medication administration (BCMA) technology at the point of care, we may have cut the number of patients harmed and lives lost by better than half in hospitals that have employed the systems. And while roughly 60 percent of U.S. hospitals have BCMA today, that number promises to move closer to 100 percent soon. One survey showed that of the remaining hospitals, 80 percent say they will implement the systems within two years. This could put BCMA hospitals near 90 percent in 2014.

Furthermore, on September 4, CMS published its Meaningful Use (MU) Stage 2 Final Rule, *2014 Edition EHR Certification Criterion 170.314(a)(16)*, expecting that inpatient hospitals "automatically track medications from order to administration using assistive technologies."
For all practical purposes, this translates into electronic medication- administration systems supported with bar-code scanning at the point of care. Net, net: Even more hospitals should commit sooner than planned, and those who have committed should be further incentivized to walk their BCMA talk.

The motivation for complying with MU involves rewards and penalties.
Hospitals are incentivized by the prospect of collecting handsome amounts of ARRA stimulus money for complying with MU now and fearful of losing CMS reimbursement down line if they don't.

Money may serve as the tipping point for full adoption. God knows how much hospitals need money to serve their communities. But money need not be the only motivation for bar coding or the greatest motivation for that matter.

There may be no more appropriate or popular hospital name in America than *Mercy*—a fascinating word.

The original Latin (*merces*) was used to recall the undeserved kindness of God. It also gave the French their word for thank you, *merci*. Sixth-century church Latin employed *merces* for the heavenly wage or reward of those who showed kindness to the helpless. Before long *merces* was also used for earned wages and morphed into *mercenary*, one who worked for a wage. Today we pejoratively use the word to label the "person primarily concerned with material reward often at the expense of ethics" (OED).

While hospitals are rightfully interested in gaining ARRA money and appropriately concerned about the risk of losing CMS reimbursement, I pray none will fail to see themselves as the hands of a merciful God for showing kindness to helpless patients and providing well-deserved wages to their employees. As the first century rabbi taught, "Blessed are the merciful, for they shall obtain mercy."

What do you think?

Mark Neuenschwander (a.k.a. Noosh)

mark@hospitalrx.com http://twitter.com/hospitalrx