Comment on Proposed Rule: Medicare and Medicaid Programs: Electronic Health Record Incentive Program-Stage 2 (Document ID CMS-2010-0022-001)

Early at his post, HHS's first National Coordinator for Health Information Technology, David Blumenthal, issued a memo to clarify the meaning of Meaningful Use.

> "By focusing on 'meaningful use,' we recognize that better health care does not come solely from the adoption of technology itself, but through the exchange and use of health information to best inform clinical decisions *at the point of care* (italics mine). "[1]

Though Blumenthal has moved on, the recently issued Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Stage 2 seems to demonstrates HHS's intent to stay Blumenthal's praiseworthy course.

We enthusiastically support your proposed rule that would require hospitals to "automatically track medications from order to administration using *assistive technologies* in conjunction with an electronic medication administration record (eMAR)" (italics mine). [2]

We also affirm the proposed redefining of eMAR "as technology that automatically documents the administration of medication into Certified EHR Technology *using electronic tracking sensors* (for example, radio frequency identification (RFID) or electronically readable tagging *such as bar coding*)" (italics mine). [3]

RFID, while promising, has a ways to go. Bar-code-enabled medication administration (BCMA) is not only ready it is also at work in thousands of hospitals across the country. When we triangulate market research, we estimate that over 46 percent of U.S. hospitals are using bar-code scanning to verify medication administrations, representing nearly 60 percent of total acute care beds.

Your proposed rule affirms the long-term experience the Hospital Corporation of America (HCA) and Brigham and Women's Hospital (BWH) who have adopted and studied the impact of barcoding on the safe dispensing and administration of medications.

Many other BCMA hospitals have done pre and post-implementation studies and demonstrated similar results to those published by BWH in the New England Journal of Medicine. BWH estimates they are intercepting 90,000 medication errors each year with BCMA.

Your proposed rule also supports the articulate BCMA position statements of the Institute for Safe Medication Practices (ISMP), University Hospitals Consortium (UHC), and American Society of Health-System Pharmacists (ASHP).

Your proposed rule also supports the expectations placed on member hospitals by The Joint Commission (TJC) [more below].

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[1] Paragraph 9

[2] Page 138

[3] Page 140

Coupling bar coding with eMAR helps achieve several critical objectives. First, because BCMA involves scanning patient wristbands, it forces the function of using eMARs at the point of care where Blumenthal insists, and we agree, they belong.

Second, BCMA facilitates achieving TJC's perennially number one Hospital National Patient Safety Goal: To improve positive patient identification.

TJC's rationale for their first goal is concise: "Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual." Exactly what we owe our patients—just what doctors order.

While TJC's first rule does not require bar coding, it does affirm its value: "Before initiating a blood or blood component transfusion, the goal calls for a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding."

We believe no process or technology shows greater efficacy for improving patient identification and matching services and treatments to the correct individual than bar-code enabled eMAR.

Third, using eMAR with bar coding at the point of care ensures accurate documentation of administration data, which impacts prescribing decisions making the quality of that data critically important to effective therapy. When ordering medications, physicians are presented with real-time, accurate documentation of medication administrations.

BCMA will never eliminate the need for caregiver eyes nor cognitive interaction with patients when possible. However, it powerfully augments the identification process with a safer method for triangulating electronic medication administration records and medications with the right patients. In the NEJM, thought-leader physicians, Gordon Schiff and David Bates note that diagnostic errors outnumber medication and surgical errors. They state: The diagnostic process must be made reliable, not heroic, and *electronic documentation will be key to this effort*" (italics mine).

We are grateful for your attentive ear, careful though, and wise decisions.

Sincerely,

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