

Computerized physician order entry final

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The use of a COPE system is proven to reduce medical errors related to poor handwriting or transcription of medication orders. The adoption and implementation of the COPE will not only help this facility comply with a government mandate, but it will be a future investment that will pay off by the receipt of monetary incentives in the form of Medicare reimbursement. If as providers we can show "meaningful use". By 2015 health care facilities with no HIT in place will see a reduction in Medicare reimbursement as a penalty (Patella, 2012).

Keywords: HIT, COPE, EMIR and HIT. COPE procedure The Implementation of COPE systems at North Bronx Cardiology and Associates will allow along Like many as other facilities that have adopted Health Information Technology systems to improve the quality of health care, enhance the patients' safety, reduce the costs, improved efficiency, prevent medical records errors and increase health care accuracy and procedural correctness (Hander, 2012).

As a medical practice serving the North Bronx community we strive on good customer service and the facility has a need to improve our practice standards for the good of our patients well being. Our staff is comprised of twelve cardiologist, four nurses, five two receptionist/billed and one filling clerk.

We acknowledge that our practices needs to be in compliance with 1996 Health Insurance Portability and Accountability Act (HIPPO) and its new Omnibus Rule that extends the HIPPO regulations to business associates and subcontractor , and HIT; transition from paper patient medical

prescriptions to electronic ones and training all our medical and administrative staff to this new technology will be mandatory as well as having a evaluation tool to recognize drug to drug interactions, allergy to medications , and ordering tool for vibratory tests, and radiology orders.

As general manger of this facility I did the research and sent ten Request for Proposal (RAP) to ten HIT vendors specialized in COPE software and implementation. All vendor proposals were reviewed and as manager in charge for COPE clinics implementation, I chose quotes from Clinician Into with their Eccentrics COPE software products and approved of their presentations, because they covered all our facility needs and are able to customize the program to fit our order selection, order specification and cardiology specialty.

Acquisition The need for acquisition of a Computerized Physician Order Entry which will improve medication prescribing, reduce medication errors , better patients safety and promote standard medical practice made the Board of Directors consider and allot a budget for HIT implementation. The budget allocated and approved by the Board of Directors for the COPE purchase will cover the Sentries COPE software, IT infrastructure, IT contractor, training, implementation expenses and maintenance contract.

Contracting The contract offered by Clinician Into for the implementation of COPE will include he Eccentric software, IT infrastructure, IT contractor, training, implementation, and maintenance and optimization contract. The contract will cover everything described above with specifications that include three months of training, a two years' maintenance and service, and

a one year optimization contract which will include unlimited service calls and new hire training in site. Implementation a.

Initiating phase This first phase is of importance for the COPE implementation project, the commitment from leadership is very influential for all the other staff members to actively participate. The selection of an implementation team is one of my priorities in this project. This team will collaborate with me to implement a plan to motivate and choose member of our staff that are IT knowledgeable or are willing to learn and train others. As a team, we will put in place a project charter that will summarize the project goal, requirements, and participants. B.

Planning phase The charter will provide the project structure and a plan; with the assistant of the Clinicians Ninth vendor, he will explain the required infrastructure and software. The implementation team and myself will develop a physician adoption strategy and directly recruit willing physician to be part of COPE system project. The current care plans, nursing orders, policies, and procedures will need to be reviewed before the In this phase, we will determine what clinical content we want in the Essentials software and will make sure to include the order set strategy.

This is important to plan, the workflow, and mapping of the implementation to avoid complete shut down during implementation; it will be done in phases. Here, we will also establish COPE tries to ensure the proper benchmarks that will help control and maintain all computerize physician order entries, make sure the program software is interoperable, and that there is data exchange with our clinic and affiliate hospitals ERR. We will

make sure the implementation team gathers input or suggestions from physicians/clinicians for the customization of the order and order set templates. . Building phase This phase is a content management phase; paper order sets are gathered for the creation of customized order set templates, final metrics, measurements, monitoring, ND reporting. E. Testing phase Unit, integration, parallel, and acceptance testing will take place in this phase as it will make our system interoperable and a pilot testing of the system will also be performed to assure it works properly to begin training. The testing of all these component lets us identify the different aspects to be address in training and to customize the training. . Training phase The first step in this phase is to identify the students and divide the training session accordingly into levels. The training content will be identified, educational material reared, and different classes devised specifically for trainers, nurses, administrative staff and physicians. Training will be both real time and in formats to an accommodating schedule; the training will be in group sessions and 1: 1 sessions. The session will provide enough test patients for order entry practice and training user ID's with respective security right.

At the end of the training sessions, competency test will be administer to assess for further training. G. Activation phase In this phase of the implementation project all alternative plans must be in place to sure the COPE system activation, identification of proficient users are essential to take the lead when the system " goes live". We will confirm that all staff has completed their training and are ready to start using the HIT system.

System activation reminder will be posted, and e-mailed to all staff member weeks and then days before COPE activation. Once the COPE system has been activated feedback meetings will help find if further maintenance is needed. H. Maintenance and Optimization of the COPE Review of the various part of the COPE system will be conducted periodically for glitches that can cause further problems. We will check that all the COPE medical facility formula synchronizes with all other HIT system and this way update patient records (orders, laboratory results, etc. . We will make sure to follow up on new advances on the newly implemented technology and update according to the agreed contract. As part of the optimization process, we will have the vendor help the North Bronx Cardiology Associates standardization of orders and order set and, if needed, re-organize our order module to include new services orders to fit the facility needs. The implementation of Sentries COPE software for North Bronx Cardiology and

Associates will be a milestone for this cardiology facility that wants to adopt another health information technology that will help secure patients information, provide confidential treatment, and use updated technology that will improve order quality and communication speed . It was understood from the beginning that the adoption for this project was a financial investment, which will need the cooperation and commitment of senior management, medical staff, and practitioners for a positive outcome.

In further research on the medical facilities experiences with COPE adoption and implementation, I found several cases regarding slow communication speed, and one interesting case study discussion by Josses Donahue from

the HCl group " physicians at smaller hospital venue in the Silicone Valley of California, part of a larger healthcare system had recently undergone an EMIR implementation with a well- established and dependable vendor. There were the usual training opportunities in place, with lots of time to get the staff and physicians up to speed with the product.

However physician training was not mandatory, and ultimately use of the EMIR wasn't squired of them. Essentially the hospital administration didn't provide any tangible expectations for the physicians. As imagined, without training or commitment with the expectation to move from paper to electronic charting the process of implementation deteriorated rapidly. Right away during implementation bright and technically sax. N. Y physicians found fault with the software.

Reportedly it couldn't do what they expected and they felt it was too time consuming. In spite of every effort to bring in developers, software engineers, and additional trainers the physicians would mind little they could appreciate about the product and quickly lost interest. Despite efforts by the Hospital Administration to rally the physicians back into its use, the physicians eventually mounted such intense resistance that the Medical Board members of the hospital deemed the vendor's product " unsafe".

Overwhelmingly, the board voted to prevent it use until the vendor could meet certain demands to prove there was no risk in using the product, which by the way, had been proven multiple times with multiple clients over multiple years. Nevertheless, no amount reassurance would help bring them back. Ultimately physicians at that particular hospital still charted in

whatever way they pleased paper or electronic, or sometimes both. Through this example we see hospital administrators made great attempts to bring the process back into focus, but eventually couldn't hold its ground.

Lesson learned: In a conversion from paper to electronic charting it is proper to establish a commitment from the end users by encouraging a contract, and by mandating the training and use with the physicians ensuring expert and effective support from the vendor. Hospital leadership must stand firm, within reason, alongside the vendor, in purport of the process during this kind of changed" (Donahue, 2013). ERR can prove to be a complex part in the field of electronic health; it may have its benefits but may have potential barriers as well.

In an article titled, 'Electronic Health Records: What are the Most Important Barriers' by Hale Ayatollah', the author expresses how they systems, lack of efficient planning, and limitations in training courses for health professionals can cause delays in implementation as well as technical issues likes the one described above regarding slow communication speed. In this same article, individual barriers that were less important had to do with technical, financial, and ethical legal barriers.

A recommendation for improvement on the quality of healthcare data that is accessible through ERR implementation is better strategic planning for national infrastructure and to recruit a team of experts to lead implementation projects.