The Emperor’s New Clothes?  
A $12 Million Tale

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Computerized prescriber (also called “physician” or “provider”) order entry (CPOE) is currently a hot topic in the field of medicine. CPOE is offered as a cure for many of the ills in health care delivery organizations, offering not only increased patient safety but also improved efficiency and quality of care. If they haven’t already done so, P&T committees should become familiar with CPOE issues.

A January 2003 report by the First Consulting Group estimates average CPOE startup costs to be approximately $12 million, depending on a system’s complexity and existing infrastructure, for new expenditures on hardware, software, implementation, and staff training. Annual maintenance costs thereafter are estimated at 12% of the initial investment.

Most health care organizations are eager to get some kind of system up and running, because self-appointed quality experts have said that doing without one is almost criminal. The lack of CPOE leads to errors, some resulting in death, and to other unsavory consequences. A national coalition of major health services purchasers, the Leapfrog Group, has mandated that hospitals acquire CPOE systems or risk losing their business.

CPOE is a journey with no apparent end

The Leapfrog Group was started in 2000, but despite its impressive list of members, the actual clinical expertise of the staff is not readily apparent. I have proposed the following theories on why health care interest organizations such as this one can tell us what to do and why we are listening:

1. They are right, and we know it. Having survived two recent crises de jour—Y2K (correcting the date and time of the new century for computers) and HIPPA (the new health privacy act), we are now ready to take on another complex information technology (IT) task. Our greatest challenge is to spend dollars wisely in tough economic times.

2. They are right, but we are not really sure—hence the delays in implementing systems, the protracted timelines, and even the occasional revolt back to the (bad) old ways. In many places, there is a strong desire to get almost anything set up quickly and perfectly (two mutually exclusive desires) to keep up with the competition. Wouldn’t it be nice if payers gave CPOE-active providers an extra 12%?

3. They are not right, and we know it. Health care is struggling with huge staffing, financing, and access issues, and spending millions of dollars in one IT area will only make these matters worse. Just imagine the safety, quality, and efficiency gains that could be bought for $2 to $3 million each year by adding extra staff in those focused areas in the organization. Unfortunately, it is difficult to tell the emperor that he is naked.

4. They are not right, and we don’t know it. This scenario is similar to Number 2 above.

I know one thing for sure: CPOE is a journey with no apparent end. Hardware and software will get better, and training will always be required for new staff. The greatest challenge will be to develop new systems to quickly translate the latest scientific evidence into routine clinical practice. The biomedical literature is full of examples of unexplained practice variations to the detriment of the outcomes for patients. Successful organizations will have to navigate beyond the usual excuses of “we can’t afford it,” “medical staff culture incompatibility,” and “resistance.” CPOE is a fundamental, eternal process change.

Or perhaps the emperor is not fully clothed?

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