

BEST DEVICE, BEST DATA MANAGEMENT



Why point of care programs
shouldn't have to choose.

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Why point of care programs shouldn't have to choose.

A field perspective from TELCOR, informed by Becky Clarke, Co-Founder. Written for point of care directors, health system lab and quality leaders, and administrators at large physician practices evaluating point of care connectivity.

IN THIS PAPER

Why the device you buy and the software that manages it are separate decisions with different reversal costs, what is pulling point of care device inventories apart, the case for each approach, and a self-assessment to run before the next vendor call.

READING TIME

About 11 minutes.

01 / HOW THE DECISION GETS FRAMED

One purchase, three decisions

A hospital evaluating a new point of care device rarely experiences it as three separate choices. It experiences it as one purchase: pick the analyzer, sign the paperwork, get it on the unit. But the purchase bundles three decisions that behave nothing alike once the ink is dry. Which device to buy is a clinical and workflow question, and the most reversible of the three: a hospital can revisit it at the next refresh cycle. Which data management layer captures its results, tracks its operators and feeds the LIS and EMR is a second decision, usually made by default. How the contract for that software is structured, whether it renews on its own clock or on the device's, is the third, and it is rarely negotiated because few buyers realize it is on the table.

DECISION	WHAT IS DETERMINES	COST TO REVERSE
Which device to buy	Clinical fit at the bedside, ease of use for the operator, which tests are available where care happens.	Moderate to high. A device is a purchasing decision a hospital can revisit at the next refresh cycle.
Which data management layer runs on top of it	Result capture, operator training and certification records, QC, how (and whether) results reach the LIS and EMR without manual entry.	Moderate to high, depending on how the contract for it was structured.
What the data management contract's term is tied to	Whether a hospital can look at a calendar and know, without digging through paperwork, when each device's data management commitment is next up for renewal.	Extremely high if the term is tied to the device and staggered across years. Low if every device is co-terminous on one recurring date.

Vendor dependency is rarely about which device a hospital owns. It comes from what happens to the second and third decisions once the first one is made. Becky Clarke, TELCOR's co-founder, traces this back to a specific moment early in the company's history. TELCOR had been doing contract engineering work for early point of care device manufacturers, building a data management application for one instrument at a time. When other manufacturers started asking for the same treatment, one application per device brand, the company said no.

"This brand-by-brand model isn't going to work for the customer, because a customer will eventually have twenty to thirty different device types. They could end up with a lot of different data management systems or solutions, and that is untenable."

BECKY CLARKE, CO-FOUNDER, TELCOR

That decision, made decades before the industry had a term for this kind of dependency, set the course for everything that follows.

02 / WHAT IS FORCING THE QUESTION NOW

None of the pressure on this decision is new. What has changed is how many are landing at once, and a point of care program has limited capacity to handle that load, few dedicated specialists, and staff for whom testing is one part of a much bigger job.

Testing keeps moving out of the lab and the number of devices keeps growing

The global point of care diagnostics market was valued at roughly \$32.9 billion in 2025 and is projected to nearly double by 2034, a trajectory driven in large part by continued miniaturization of tests that used to require a central laboratory instrument.¹

Thousands of operators now run tests, and none of them are laboratorians

Every one of those newly miniaturized tests lands somewhere outside the lab, on a device, in the hands of an operator who is not a laboratorian. That changes the management problem. A central lab has a small, stable, credentialed staff, and keeping track of who is qualified to run which test is a manageable administrative task. Point of care runs on nurses, respiratory therapists, physicians, and OR staff, often numbering in the thousands across a single health system, and each has to be trained, certified, and re-certified on every device they touch.

Regulators tightened the documentation burden

In December 2025, CMS implemented the most significant overhaul of CLIA personnel and documentation requirements in more than two decades, updating what counts as an adequately qualified operator and what a facility has to be able to produce on demand about who tested what, when, and under whose supervision.² Clarke describes watching this tighten in real time: waived-complexity testing, once close to a formality, now demands meaningfully more documentation of who is doing the testing and what their certifications and quality records look like. A hospital juggling operator records across two or three disconnected point of care systems has to work out which system holds the answer while the surveyor waits.

Consolidation keeps adding device brands

As of early 2026, roughly 82 percent of practicing physicians in the United States were employed by a hospital or a corporate entity, a share that has climbed several percentage points in just two years, and hospitals and corporate owners now hold nearly two-thirds of all physician practices nationwide.³

Every acquired practice arrives with its own point of care equipment already installed, in whatever brand its prior owner happened to buy. Clarke is careful not to overstate what this changes: a health system that absorbs a smaller hospital or practice does not usually rip out its equipment on day one. It standardizes over time, on its own schedule, onto whatever platform it already runs. That shifts when the mixed-vendor problem arrives rather than removing it. Every acquisition adds, for some period, another device brand to a program that already had several.

Device manufacturers are building, and buying, their own data platforms

This is not a new instinct. Nearly a decade ago, one instrument manufacturer's own point of care division justified an acquisition of a connectivity company by pointing to exactly this dynamic: "as hospitals consolidate and acquire physician offices, there is a huge need by emerging healthcare networks for seamless integration of hundreds of decentralized devices" spread across dozens of sites.⁴ Manufacturers see the same fragmentation their customers do. Their answer is to become the platform a hospital standardizes on, built around their own instruments first.

03 / THE CASE FOR STAYING INSIDE ONE VENDOR'S SYSTEM

Staying on a single device manufacturer's own data management platform is not automatically the wrong call. The case for it is narrow, but it is real.

Small, single-device programs have little to gain from decoupling

A hospital under roughly a hundred beds that runs one device type from one manufacturer, glucose and nothing else, gains almost nothing from a vendor-neutral platform and has no multi-vendor problem to solve. Clarke is blunt about the limits of her own argument: “I would never go fight for someone who had Roche glucose, and that’s all they had to try, and get our system in there. That’s likely a losing battle,” she says.

The price is sometimes zero, on paper

Device manufacturers have at times bundled their data management software into the cost of the device or its consumables rather than charging for it as a separate line item. For a cost-conscious buyer with no cross-vendor connectivity need, that is a legitimate reason to stay put, at least in the short term. Whether that cost is truly zero or simply moved elsewhere in the relationship is taken up in Section 06.

Some instrument categories have a real technical ceiling a neutral platform cannot clear

In blood gas and respiratory testing specifically, a small number of manufacturers maintain proprietary two-way protocols that let their own software both read results from an instrument and actively manage it in real time, adjusting settings and configuration remotely. A vendor-neutral platform can connect to those instruments and capture their results, but it cannot manage the instrument itself the way the manufacturer’s own software can, because the protocol is not shared. For those instruments, bundled software offers something no one else can supply.

04 / THE CASE FOR VENDOR INDEPENDENCE

Outside that one respiratory exception, a single connectivity layer across every device, regardless of manufacturer, has a much stronger case, one that is easy to miss if a hospital compares vendors only on the software’s price tag, without weighing what shows up downstream in interfaces, operator management, and contract terms.

One interface instead of one per vendor

A hospital running three device manufacturers’ own data management systems needs, in practice, three separate connections into the EMR and three separate result interfaces, each one maintained, tested, and re-certified on its own schedule whenever that manufacturer pushes an update. A single vendor-neutral layer collapses all of that into one ADT interface and one result interface for the entire point of care program, no matter how many device brands sit underneath it, and it means one vendor, not three, is accountable when something breaks.

It protects the freedom to buy the right device next

The larger effect of this dependency falls on future purchases rather than current ones: it narrows what a hospital is willing to buy next. If a device cannot be connected, results must be charted manually, and most programs will not accept that trade-off. “It’s likely a customer would not be able to purchase an instrument if they can’t connect it,” Clarke says. A vendor-neutral connectivity layer means that constraint disappears from the buying decision entirely; if a new device, even from a smaller or newer manufacturer nobody else has bothered to integrate, is the right clinical fit, building the connection is routine work rather than a reason to pass. Handled this way, adding a device stops being the hospital’s problem and becomes the connectivity vendor’s.

It ends the duplication of managing the same person three times

The clearest cost Clarke points to has nothing to do with software fees. It is what happens to a single nurse’s certification record when her hospital runs point of care testing across systems that do not talk to each other.

A respiratory-focused platform built originally to manage blood gas operators gets extended, over time, to cover other device types the manufacturer has since acquired. But the nurse who draws a coagulation panel, a glucose check and a urine test in the same shift is not a respiratory operator, and she may already be managed correctly in a different system for everything else she does. Extend the respiratory platform to her too, and now the same person’s training record, certification date, and competency documentation exist in two or three places, entered by two or three different people, none of whom can see what the others recorded.

“You’ve got duplication of effort and the opportunity for huge errors,” Clarke says, “And you have the opportunity then, at inspection time, where you don’t have all the data for point of care testing in one place. I’ve got to go here for half of it, I have to go there for something else.” It is an audit finding waiting to happen, and it happens because two systems that never needed to be separate were never brought together.

05/ RED FLAGS IN EVALUATING A DEVICE AND ITS DATA MANAGEMENT SYSTEM

When a hospital is evaluating a new point of care device that comes bundled with its own data management software, four questions surface what the sales conversation leaves out.

How is the software being paid for.

- 01** If the answer is “it’s free,” ask where that cost is really sitting instead, whether it is built into the price of reagents and test strips or recovered some other way. Free usually means the cost has moved somewhere less visible.
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What does this company's software research and development look like.

- 02** A device manufacturer is a device company first. Ask how customer requests enter the release cycle, how often they ship, and whether the team building the product has ever had to build a connectivity platform rather than a single-vendor application.

Where is the development team physically located and what does that mean for support.

- 03** A request to fix or change something that has to be routed overseas, reviewed by people who may not know the U.S. market or its regulatory requirements, and answered on someone else's schedule, is a fundamentally different support relationship than one where the people building the software sit in the same market they're serving.

When something breaks and the device, the interface, and the host system each point to a different cause, who is actually responsible for solving it, and is that one call to make or three?

Does hospital data ever leave the United States for troubleshooting, and is that addressed in the contract.

- 04** TELCOR ran into this while trying to route a customer's data to an overseas development team for a support case: the necessary cross-border data agreements were never put in place, and the data simply could not be sent, delaying the fix. Any hospital evaluating a platform whose development sits overseas should ask, in writing, what happens the next time that same situation comes up with its own data.
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06 / THE COST OF VENDOR DEPENDENCY

A straight price comparison between "included" and "separately purchased" software misses most of what costs a hospital money over the life of a point of care program.

The lines items that belong in the model

The server and maintenance	This exists regardless of which platform a hospital chooses; it is not eliminated by consolidation, but it is not multiplied by it either.
The true cost of "free" software	If a manufacturer isn't charging for its data management platform directly, that cost is very likely recovered in the price of the reagents or test strips the hospital buys on a recurring basis. Model it as a cost, not as free.
Interface testing and re-certification	Every EMR and LIS interface gets updated on its own release cycle, and every update requires re-testing everything connected to it. Three vendor-specific systems mean three interfaces to re-test every year, and three vendors to coordinate when one of them breaks. Whether the testing is done in-house or outsourced, someone is paying for it.
Duplicated operator management	The same operator managed, trained, and certified in two or three disconnected systems means duplicated labor now and documentable audit exposure at survey time.

Invisible contract terms

A device-tied, staggered contract structure has a cost that never appears on an invoice: the inability to tell, at any given moment, whether the hospital is free to make a change. The next section takes it up in full.

“The longest-lived decision here belongs to the contract underneath the data management layer rather than to the device, and it is the one almost nobody thinks to negotiate.

Some device-tied data management contracts run on the device’s own term, set when that device was added, and every subsequent addition sets its own separate clock. A glucose device added in January might carry a five-year term. A coagulation device added the following June might carry a seven-year term. A cardiac marker device added the year after that starts its own clock again. None of those dates line up, and a hospital that has been adding devices for a decade this way can no longer say, without digging through several separate contracts, which is coming up for renewal and which is still obligated for years.

Clarke describes this as a deliberate structural pattern in how some vendors have built these contracts; tying the data management term to whichever device triggered it, so a hospital ends up piecing its renewal picture together across several separate agreements rather than reading it off one calendar.

The TELCOR model is built the opposite way on purpose: every device a customer adds, regardless of when it is added, gets folded into a single annual renewal date. Adding a device in year three doesn’t create a new multi-year obligation; it simply joins the existing one. Swapping a device out is a line-item change, not a contract renegotiation. That structure determines whether a hospital’s future device decisions stay reversible. Ask about it in writing before signing anything, whichever platform you choose.

08 / BEFORE ANY DEVICE OR VENDOR CALL: A SELF-ASSESSMENT

Seven questions to answer internally before the next point of care purchasing conversation.

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| 01 | How many different device brands are running across our point of care program today? |
| 02 | Do we know, right now, without looking anything up, when each of our point of care device contracts is up for renewal? |
| 03 | If we swapped one device next year, would that reset or extend a contract clock we didn’t realize we had? |
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| 04 | Are we managing the same operator's training and certification records in more than one system right now? |
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| 05 | If a surveyor asked for a complete operator competency file today, how many systems would we have to pull it from? |
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| 06 | Where does our current data management vendor's development team sit, and have we ever asked what happens to our data if support requires it to leave the country? |
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| 07 | If the right next device for a given test didn't already have a connectivity path built to our current system, would we still buy it, or shrink the shortlist to whatever already connects? |
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09 / WHERE THIS IS HEADED

Miniaturization is not slowing down. Clarke expects the pace of new point of care test introduction to keep climbing as sample sizes shrink and more testing becomes practical outside a hospital's walls entirely, in freestanding clinics, urgent care, and physician offices. FDA clearance still gates how fast any single device reaches the market, but the trend is clear.

At the same time, the ownership structure surrounding point of care programs keeps consolidating. Independent physician ownership of practices has fallen sharply over the past decade, with hospitals and corporate entities, increasingly private-equity-backed, now holding roughly two-thirds of all physician practices in the United States.⁵

Clarke expects that trend to continue until independent practices are, for practical purposes, absorbed entirely: "they can't survive on their own," as she puts it. Every one of those absorptions brings another set of device brands into a health system that already had its own.

A true industry-wide connectivity standard for point of care devices has existed on paper since 2001. More than two decades later, adoption remains uneven enough that one recent industry analysis still describes a persistent lack of clarity holding the interoperability effort back, even as the underlying testing market approaches ten times its size at the standard's introduction.⁶ In practice, hospitals have handled fragmentation with a connectivity layer maintained independently of any one device vendor rather than waiting for the standard to take hold.

10 / WHY THIS IS TELCOR'S PROBLEM TO SOLVE

Device independence was not a strategy TELCOR set out with; it was designed in from necessity. It came from the alternative, one custom application per device manufacturer, ceasing to make sense the first time a hospital showed up with more device types than any one vendor's software could cover. "Our intention was always vendor neutral," is how Clarke describes it. Asked whether the same bet would make sense if TELCOR were founded today: "We do not own meters, so we would still do this as vendor independence. We'd have to. Otherwise, there's no way you're getting in the market."

The questions this paper suggests asking any device or data management vendor, how they charge, where they build, whether hospital data ever must cross a border, and how their contract terms are structured, are the same questions worth putting to TELCOR. A hospital that runs the evaluation on every vendor, including this one, ends up with a clear view of whether next year's device decision is still open or was settled at signing.

ABOUT THE CONTRIBUTOR



BECKY CLARKE

CO-FOUNDER TELCOR

Becky Clarke co-founded TELCOR out of contract engineering work for early point of care device manufacturers, work that convinced her the market could not sustain a separate data management application for every instrument brand. That decision, to build one connectivity platform rather than a series of single-vendor tools, has shaped TELCOR's architecture and market position for more than three decades. She works directly with hospitals and health systems on point of care device and connectivity decisions.

SOURCES

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3. Physicians Advocacy Institute and Avalere Health, physician employment and practice ownership analysis, as reported by Becker's ASC Review and Medical Economics, early 2026.
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Quotations are drawn from a recorded conversation with Becky Clarke, 2026, lightly edited for length and readability.

