

Thank you for inviting me to speak to the Meaningful Use Workgroup. I value the opportunity in part because it allows me to say thank you to the workgroup. Meaningful use has been a driver to accomplish the implementation of processes and programs that are beneficial to patients but which would have taken much longer to achieve without the incentives this program offers.

Lifespan is a four hospital, 1100 bed system in Providence RI that has achieved recognition as being at HIMSS Analytics level 6 for the three acute care hospitals (recognition for the pediatric psych hospital is pending); all three acute care hospitals have attested for meaningful use stage 1.

I will quote myself from the comments I made to the HIE workgroup: data is like salt water – “you can drown in it but you can’t drink it” – the issue we face is not that we lack data but that we can’t use it. The solution is standards. To the degree that Meaningful Use has specified standards this has been a tremendous help. We have coded all our laboratory orders and results in LOINC (with help from Dr. Clement MacDonald), all our Diagnostic Imaging orders and results in LOINC, and our problem list in SNOMED. We produce a CCD that contains this coded information, and can transmit it to an HIE that we have implemented for our hospitals and affiliated caregivers. Most of our affiliated physicians, all of the extended care facilities in the area, and all the other hospitals in the area cannot use this information, because they have not yet implemented these standards. And they cannot share information with us, although all have some electronic data that should be useful. We do successfully share this information with some practices that have implemented EMRs that use these standards.

As a result, quality measures are based on what data is available, not on what’s important. Co-ordination of care is poor, and is driven as much by administrative data as it is by clinical data, and consumers do not have truly comparable information to make a choice of healthcare provider, nor do they have full information about their own care that can be viewed across the continuum.

While I was preparing my written and oral remarks for this committee I was delayed for three days because we had a significant data issue: roughly 0.3% of our patients discharged over a 2 week period received erroneous medication instructions. The details are not worth discussing, but the root cause was that medications were coded in NDC numbers, and those with “obsolete” NDC numbers caused a minor flaw in the software to (rarely) change the name of a medication. If we had implemented a stable medication code (RxNorm) this would have been prevented; this implementation will likely not happen soon without an exterior driver such as meaningful use.

In brief, my three points are:

- 1) We don’t lack data, we just can’t share it or use it meaningfully
- 2) Implementing data standards and transmission standards will provide significant improvements in our ability to understand what we are doing, how we can do it better, and to share this information

- 3) An external driver such as the stimulus provided by Meaningful Use has been shown to be effective in accelerating this implementation and I would encourage this Workgroup to keep raising the bar.

Once again, thank you for the opportunity to present these comments.