Access to actionable, real-time data can create opportunities for physicians to improve the health of their patients, but the current environment often prevents physicians from being able to access and use that data. Find out what three experts think the future holds for data usage and what they say needs to change first.

How health data can—and does—save lives

Experts recently spoke to the health IT community about current and future uses of data at Health Datapalooza in Washington, D.C. Though there are issues in the current health system that cause problems for data usage in practice, the panelists were first and foremost optimistic about the future.

“We are using data to save people’s lives,” said David T. Feinberg, MD, president and CEO of Geisinger Health Systems. For example, his practice saw a 16-year-old girl, who came to the emergency department for dehydration but volunteered for Geisinger’s population health-based genetics program.

“We take a look … and it turns out that she has two of the genes associate with fatal cardiac arrhythmias in young athletes,” he said. “She wasn’t dehydrated; it was the beginning of her cardiac symptoms.”

“Our data shows that 30 people in her extended family are treated by us,” he said. Geisinger then brought in her family members and set up monitoring for those at risk.

“To me, it’s the first time we looked at this kind of information and [could] anticipate what’s going to happen in people’s lives,” he said, “and completely change the trajectory.”
Barriers standing in the way of progress

There are many practices already using data to coordinate care, create better outcomes and focus on population health, but three barriers are still slowing progress and impeding practices' abilities to use data in a helpful way.

Time and technology

“We ask people who are driven to spend time with their patients to complete complex cognitive tasks,” said James L. Madara, MD, AMA executive vice president and CEO. “[A lot of] of physicians’ time during the day is on the keyboard [not] face to face with patients, which is why they went into that field. Added onto that … hours in the evening finishing up their keyboard work.”

“One of the issues is the failure to recognize the variation that occurs regionally and in terms of practice type,” Dr. Madara said. “We often get tools that have this monolithic kind of feel to them. A good place to start is a really well-defined problem, and then the ideas stem from that.”

For example, electronic health records (EHRs),” he said. “The idea is that we have lots of data—we have to organize it in some digital way. If you would have said that was the problem initially, and the problem is actionable, organized data at the point of care, easy entry, protecting the interface between patient and physician and recognizing that … continuity and interoperability are really important, we would have had a digital approach with a very different set of products than we have today.”

Chet Burrell, president and CEO of CareFirst BlueCross BlueShield, gave an example of how physicians have worked together to make improvements based on access to meaningful data outside of a handed-down mandate.

“We have tended to organize primary care physicians into small teams,” he said. “One of the things we have learned [is that] when they see each other’s data, they see things, do things, act on things in a way no government or regulator or payer ever could cause them to do.”

The wrong incentives

The rapid growth of high-deductible plans has made many patients reluctant to seek the care that they need, Burrell said. “We see people who need care coordination and need certain services but say, ‘I know I need it, but I can’t afford all the out-of-pocket expense.’ I’m worried about the long-term
implications of those designs.”

On the physician side, Burrell said, putting financial risks on physicians doesn’t foster improvements. It’s the current movement toward incentives that has been more effective, he said.

But perhaps the real incentives U.S. health care needs aren’t financially based.

“I think we have the incentive systems all wrong,” Dr. Madara said. A nationwide study the AMA conducted with the RAND Corporation found that “the primary driver of physicians was time face to face with patients,” he said, “and everything that got in the way of that was a disincentive.”

“There have been studies that show that if you ask a physician what [they] need to improve [their] practice, they say actionable data in real-time,” he said. “[If] you give it to them, they produce higher quality care than one does with small economic incentives.”

The incentive isn’t the payment—it’s the patient’s health and the physician’s relationship with him or her.

“The more we shift toward paying for value, the better,” Dr. Feinberg said. “It will play out differently in different communities and at different levels, but the concept of paying for outcomes, paying for quality, for functionality … however it plays will be better.”

“The biggest barrier is that we’re completely worried about our own turf,” Dr. Feinberg said. “This is a crisis in America—the type of health care we deliver, who gets it, the quality, who doesn’t get it and the cost.” Industry stakeholders are all worried about what’s happening to them, Dr. Feinberg said. “It’s never really been the year of the patient.”

“Then something happens in your family, and you interact with this system, even as an insider,” he said. “It’s totally a pain. I think if we’re going to fix this, it’s going to take a huge dose of selflessness, and I don’t see the industry talking about that.”

Gaps in education

“We’re focused on connecting the data to missing gaps in the health system,” Dr. Madara said. One example is the AMA’s Accelerating Change in Medical Education Consortium, which consists of 32 medical schools. “We are now populating the consortium with a learning EHR … which [will] allow students to get the rhythm of what an EHR can do and get them ready for the next generation of EHRs.”

“In terms of the flow of work in physician offices,” Dr. Madara said, “we have created a set of interactive modules—STEPS Forward™—that allow one to use data in a more effective way in
practice.”

It is important that the next generation of physicians is prepared and has the knowledge to make sure the system continues to shift in the right direction, he said. “And that requires changing the structure of medical school.”

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