

Testimony to the Health Information Technology (HIT) Policy and Standards Committees

Clinical Quality Hearing

Panel 1: High Performing Healthcare Improvement Organizations and Analytics Systems to Support Them.

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My name is Michael Barbouche. I am the Founder and CEO of Forward Health Group, a health care measurement company based in Madison, Wisconsin. We transform fragmented clinical and administrative health care data, stored in multiple disparate systems into actionable information that can be used to drive population health improvement.

The arc of my career has given me a rich perspective on health care data. I've had the good fortune to work with providers, payors, purchasers, researchers, even patients. In every setting, I have witnessed firsthand how very rich, beautiful data are misused, misapplied, forgotten, or just plain disregarded.

Perhaps the greatest perspective I have on this subject, however, comes from my wife, an internal medicine physician. She manages a panel of about 1,300 patients. The arc of her career through medical school, residency, into practice, and the advent of Health IT has opened my eyes to what has worked, what hasn't worked, and the many important tasks left to be completed if we are to reap the benefits of Health IT's enormous potential. We're not there yet. Not even close.

What factors limit Health IT's ability to support quality measurement/improvement?

In 2004, I developed the infrastructure for the Wisconsin Collaborative for Healthcare Quality, a pioneering public reporting initiative. At the direction of employers and payors, we were charged with one very simple goal—apples to apples quality measurement, regardless of Health IT infrastructure, of both processes of care and outcomes. Oh, and if health systems didn't have any Health IT in place, we still needed to include these groups in the measurement effort.

What transpired over an 18-month period was remarkable. With unwavering support from administrative and clinical leadership, health systems rolled up their sleeves and dug into their very messy data. Each Monday, I would devise a fiendish list of new tasks to be completed in the next four business days. Some examples:

- Have ten PCPs manually chart review 500 (or even 1,000) patients to identify false positive diabetes' diagnoses; have the nurse and medical assistant look over their PCP's shoulder.
- Extract every unique CPT code used by the system in the past five years; sort by frequency and last date of use; distill all the custom codes that have been used more than two times; identify what those codes mean.
- Identify every physician that has worked in the system in the past three years; compile every permutation of ProviderID used for each physician.

A laboratory like this taught an entire state a very valuable lesson—the data was all there. It had always been there. Recall, this was 2004—while Health IT adoption was well underway in our state, the majority of systems did not have an installation in place (or even on the radar). We didn't need a standard, a protocol, an interface, or even a measure definition to produce accurate, patient-level outcomes for more than half of Wisconsin's residents. We simply needed a denominator.

As was clearly identified in the PCAST Report on Health Information Technology, health care has a metadata problem. It's clear that the next generation of standards that are being developed by your committees will address this very important issue. But, from the perspective of quality measurement, there is no question that the greatest factor limiting Health IT's contribution today is a lack of focus on the one thing needed to drive improvement—a good denominator.

How can Health IT better support quality measurement/improvement?

The turbulence of quality measure construction/revision/adoption is well documented. When I meet with a group of hesitant, skeptical physicians, I always tell them there is only certainty--the measures will continue to change.

Performance improvement, clearly the goal we all seek for the US health care system, is not easy stuff. Chaos in the measures space is not helping any of us meet our goal. When a Medical Director explains, "I need to track and monitor these 43 things immediately," one of our informaticists will gently suggest a slightly smaller scope—"You probably should start with two or three—this is going to be hard for you and for your doctors."

Health IT has focused on the measurement side of quality measurement/improvement. It is time to shift much of the energy to the improvement side. In simple terms, it is “Teach-a-man-to-fish” time for Health IT.

How can the quality lifecycle be accelerated?

Quality is stuck in the clinical setting for one very elementary reason--time. We need Health IT to support clinicians as they build and model, perhaps for the first time, workflows. These workflows, I can assure you, do not involve CPT Category II code capture. Nor should they. The clinical encounter must be focused on the communication, coordination, and collaboration of the patient and the provider—not a bunch of administrative data capture.

In order for the quality lifecycle to advance, we need to transform how we think about health care data. Today, a clinician like my wife enters endless amounts of data about her patients to meet billing, compliance, coding, and operations requirements. For every hour she sees patients, she spends 1.3 hours documenting. We need to give accurate, actionable data back to the people we expect to improve. Sadly, the accuracy and integrity of the data remains such a challenge because the people doing data entry get nothing back in return.

What is the role of Clinical Decision Support (CDS) in the quality lifecycle? How does CDS relate to quality measurement?

Unfortunately, the entire country has an extreme shortage of headphone-wearing, SQL-scripting data jockeys. If an analyst shows real depth at slinging data, she will invariably be hired away by the Chair of Cardiology or the health system CFO to maintain “control” over data within the health system. That will not advance quality.

In order for CDS to have a broad impact, we need to have data pre-positioned to answer questions. Sadly, we’re probably fifteen years away from having enough bodies supporting enough physician groups to make CDS a force for change on a large scale. In important, acute areas like oncology, CDS is a no-brainer. Answering questions like “this patient with this genetic mutation on this drug with these results” is the true “sweet spot” for CDS.

What is the Health IT vendor role in quality improvement programs?

Health IT’s role is to support quality improvement. Not to impede. Not to take away precious time. If the clinicians that need to improve look at their Health IT solutions as an impediment, there is a guaranteed outcome. Unfortunately, that’s not the outcome we need.

Are there viable business models in which vendors can/should share risk/reward with providers?

You bet. About a year ago, one of our informaticists asked a very simple question—how do we align our incentives as a vendor with the client? We are pleased to offer all of our clients a Performance Incentive Program—the client picks the measures, we harvest the data, we supply the measurement infrastructure. If the client moves the needle on quality, we reimburse a significant portion of their license fees.

Why do this? Again, a very simple answer—if the health system is able to improve, they will stay with our platform. More importantly, they'll tell others about their success. Incentives shouldn't be about making money; incentives are about fixing health care as quickly as we can. That should include the Health IT vendors.