

Healthcare Data Pooling: Coming Soon to a Community Near You?

Brian H. Studebaker, Paul M. Leonardo

It is clear that healthcare will be an issue important to the electorate in the upcoming U.S. presidential election. With nearly 50 million uninsured Americans, climbing from 40 million in 2000 (Aizenman & Lee, 2007), presidential candidates in both parties have already begun to formulate detailed policy statements with federal policy approaches and initiatives. Once again, the problem arises of trying to provide high-quality healthcare to children and families while also controlling ever-inflating costs.

Perhaps if politicians looked a little closer to home, they would find some of the best solutions in their own backyards. In Massachusetts, Minnesota, Washington, and Wisconsin, the most significant steps now being taken are the product of local reform efforts aimed at finding ways to pool data for better understanding of local healthcare landscapes (Davis, 2007).

These reform efforts appear to be another part of an ongoing evolution in healthcare delivery—seeking smart, effective, and cost-efficient data-driven strategies within the context of localized regions. The underlying intention, in parallel with most consumer-driven healthcare initiatives, is that an informed constituency makes wiser long-term healthcare decisions (Burke & Pipich, 2007; Sturm, 2006). Extensive public reporting of healthcare data informs not only payers but also providers, employer groups, and consumers (Walker et al., 2005).

Promoting Cooperation Among Competitors

The first and most difficult issue is cooperation. As in any other field, in healthcare, complications in data sharing are endless. After all, information is the single most valuable asset for most payers (Milliman, 2003). The unique challenges of sharing it are not taken lightly.

“The more organizations you have at the table, the more legal departments you have,

Abstract: A main topic in the upcoming U.S. presidential election is the issue of providing high-quality healthcare and simultaneously controlling costs. However, in Massachusetts, Minnesota, Washington, and Wisconsin, local reform efforts are already focusing on data pooling as a way to better understand the healthcare environment. Data pooling can help fuel quality and efficiency measures and provide real knowledge about local healthcare trends. Widespread public reporting of healthcare data can also boost the level of information available to payers, providers, employers, and consumers alike. It is in the interest of all these parties to participate in data pooling initiatives.

and they all have to get in synch before you can move forward,” said Julie Bartels, executive director of the Wisconsin Health Information Organization (WHIO) (personal communication, June 8, 2007).

But the necessity of data sharing is growing clearer all the time. Things like tiered networks and provider performance evaluations appear to be here to stay. Establishing a data reporting system is cost prohibitive for any one health plan to take on individually, and it is counterproductive to publish results that differ markedly from one payer to the next. Further, few local insurers have the depth of data to make performance evaluations meaningful.

Cooperation can quickly become the order of the day. Apply a little public pressure, and the necessity becomes even more compelling. In Massachusetts, the catalyst was provided by a mid-1990s series of investigative articles by the *Boston Globe* that identified the Massachusetts hospitals with the highest mortality rates (Kong, 1994). The series put hospitals and doctors on the defensive. The late Richard Nesson, then chair of the Massachusetts Hospital Association Board, responded to the *Globe* article by concluding, “Hospitals and physicians will always be on the defensive if someone else

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is measuring their quality. It looks really bad to the public. Hospitals and physicians should measure themselves and be accountable to the public" (B. Rabson, personal communication, May 16, 2007).

This public scrutiny led to the formation of the Massachusetts Health Quality Partners (MHQP), a consortium of physicians, hospitals, health plans, employer groups, consumers, and government agencies dedicated to collaboratively measuring and reporting healthcare performance data (MHQP, 2007). MHQP's goals are to provide trusted information to physicians to improve the care they provide to their patients and to give consumers better information so that they can make better decisions. The group's first public efforts came with a 1998 report that looked at Massachusetts's hospitals. That was followed by efforts to expand the state's universe of measures and to develop an infrastructure that can report at more granular levels, including physician networks, physician medical groups, and practice sites. By 2002, MHQP was reporting evaluations based on 16 different measures (B. Rabson, personal communication, May 16, 2007).

Given concerns about the accuracy of claims data, MHQP extrapolates the differential between rates based on claims versus rates based on chart reviews to create an adjustment factor. MHQP then incorporates that factor for each plan by measure. MHQP also reports to physician groups before publicizing the data so that if anomalous results turn up, MHQP has time to resolve discrepancies by consulting with health plans and physician groups before releasing the information publicly. The results are publicly available on the group's Web site at www.mhqp.org/quality/clinical/cqSearch.asp?nav=032400.

In Minnesota, the group Minnesota Community Measurement (MNCM) was not far behind its Massachusetts counterpart (A. M. Snowden, personal communication, April 27, 2007). Since 2001, MNCM, a clearinghouse that enabled large health plans in Minnesota to pool data, has taken the data and aggregated it, attributed it to provider groups, and publicly reported it.

MNCM started a few years after MHQP but has pursued a far more incremental approach. In 2001 and 2002, the group calculated only a diabetes measure, called the Optimal Diabetes Care measure. The measure

can be hard to attain because it is multifaceted and complex. But MNCM developed a series of nuanced findings from it, which have produced steady and tangible public health improvements.

MNCM is now tracking 13 evidence-based measures (EBMs) but continues to emphasize the importance of the first EBM. According to MNCM, the Optimal Diabetes Care measure tracks a significant and very high-profile issue. "We saw the diabetes measure as having the most potential for truly engaging providers, on an issue that could have tremendous impact," said Anne McGeary Snowden, director of quality reporting at MNCM (personal communication, April 27, 2007). MNCM's diabetes measure is available on the group's Web site at <http://mnhealthcare.org>.

Harnessing the Power of Evidence-Based Measures

Most of the EBMs used by both Massachusetts and Minnesota were based on standards established by the National Committee for Quality Assurance (NCQA), or more often, on specific measures already created and vetted by the NCQA's Health Plan Employer Data and Information Set (HEDIS). These measures, carefully created and administered, enable "apples-to-apples" comparisons of health plans across various medical domains, including comprehensive diabetes care, breast cancer screening, childhood immunizations, and high blood pressure control.

The task appears simple enough: line up data-holding partners, get buy-in from providers, aggregate the data, and analyze it. But that approach can prove more difficult because of the number of moving parts and the potential for conflicting motivations across disparate organizations (eHealth Initiative, 2007).

Take WHIO, for example, which was established in 2005. "One of the most difficult things to deal with is when there are changing faces in a multistakeholder situation," said Bartels. "These stakeholders have no real reason to work with one another on a daily basis and certainly not to trust each other. Many are competitors in the marketplace. That makes it very difficult to move forward with any kind of speed" (personal communication, June 8, 2007).

Thus, the imposing difficulty of the situation is the challenge of looking for mutually beneficial

angles in practically every incremental decision. “We can’t move in favor of one of the groups at the expense of the others. Finding the points of compromise across all of these disparate organizations has been by far the most challenging piece,” Bartels said (personal communication, June 8, 2007).

The good news is that, as with Massachusetts and Minnesota, it seems likely that a compromise in Wisconsin is possible. WHIO has been able to continue moving forward, producing agreements that everyone can buy into. What’s more, it has managed to keep all of the initial participants at the table and has even added additional providers to ensure that the representation is fair and acceptable to the market when it starts to produce public data in mid-2008.

“The next 6 months will be very instructive for us,” said Bartels. “If we can put together a robust database, there’s no end to the exciting possibilities for it, especially 5 or 10 years out. But first we have to go through this process of reaching that point. We have to figure out a lot of details before we can know if we can really produce what we think we can produce” (personal communication, June 8, 2007).

Fostering an Attractive Situation for Providers

Again and again, data poolers bring up the importance of maintaining good relations with providers.

WHIO defines its primary focus as supporting quality improvement on the part of the provider. It expects that this information will be shared publicly; however, the main goal is to improve healthcare. The provider is the primary beneficiary of the information WHIO compiles.

Getting support from the Minnesota Medical Association (MMA) was an early priority for MNMCM in order to make the measures viable with providers. MNMCM has made it a point to involve MMA by establishing a role on its board of directors. As a result, MMA decided not to fight the new approach but instead got on board to figure out how to make it work. “Once they get to know us and realize that we’re just trying to provide quality information to the public, and that we’re the only organization who can provide it in a comparative way, they see the importance and the value of it and also that it’s information they can use,” said Snowden (personal communication, April 27, 2007).

MHQP faced similar skepticism; many questioned whether the group could get everyone at the table and cooperating. Nearly 14 years later, MHQP is still going strong. “We’ve tried very hard to listen and respond to concerns of our physician leaders,” said Barbra Rabson, executive director of MHQP. “When somebody comes to us with a lot of concerns, we invite them to examine what we’re doing. This tends to make them less negative and more interested in taking ownership for what is happening in their community. We have developed a terrific group of MHQP physician ambassadors who are supportive of the work MHQP does” (personal communication, May 16, 2007).

Promoting Diligent and Conscientious Reporting

In Massachusetts, MHQP requires each measure to meet certain criteria before it publicizes the results. If results appear unstable and require further investigation, MHQP first works with health plans and providers to examine the data more closely before disclosing it publicly.

MHQP also makes a point of reaching out to physician groups to confirm data in its Master Physician Directory, a compendium of individual physicians tied across multiple health plans. With hundreds of clinical sites and even more physicians, it’s a huge task that requires multiple iterations of outreach, follow-up, and verification.

Although MHQP knows that consumers want to see data about individual physicians, methodological and cost issues have prevented them from reporting data at the individual physician level. “Given the current measures we are working with, we felt strongly that we didn’t want to start reporting at the individual physician level, in part because these were process measures and because it’s really practice systems (or lack thereof) that make a difference in performance,” said Rabson (personal communication, May 16, 2007).

Drawing on the Experience of Others

The Seattle-based Puget Sound Health Alliance (PSHA) in Washington State was created in 2004 as the result of a commitment by metropolitan Seattle’s King County executive Ron Sims to improve the delivery of healthcare in western Washington (M. Stanley, personal communication, September 10, 2007). The vision is familiar: bring together disparate

elements of the regional healthcare industry (payers, public and private employers, unions, consumer groups, physicians, hospitals, and other providers) to examine states of regional diseases such as diabetes or cardiac conditions; build EBMs around them; and report on healthcare delivery performance using a unique combination of data analytics, actuarial analysis, and clinical indicators.

PSHA's approach is ambitious. Currently, PSHA is drawing its data from 14 sources, based on 21 EBMs; more of both will be added in the future. A future source could include Medicare data—a practice that the Minnesota and Massachusetts groups followed. PSHA plans to release its first report in early 2008. The aggressive timeline is apparent when compared to Massachusetts's nearly decade-long work with six primary sources of data and Minnesota's current work with 13 EBMs, developed during a period of 3–5 years.

PSHA “has been fortunate to be able to build on the lessons learned from other efforts to produce performance reports and from community coalitions that are further along,” said Margaret Stanley, executive director of PSHA (personal communication, September 10, 2007). Progress made thus far in the state of Washington has been promising enough that interest in expanding PSHA's original mandate beyond western Washington continues. For example, the Washington State Department of Health and Social Services has submitted a grant request to the Centers for Medicare and Medicaid Services to expand PSHA's reporting statewide and fully incorporate Medicaid as a participant in the effort.

Defining Success

Defining the success of healthcare data pooling and reporting may not be as easy as it first appears. High-quality and more affordable healthcare delivery is the goal, but determining progress toward that objective is difficult. In the end, both quality and value are highly qualitative measures and need to be considered from a number of different angles (Lavizzo-Moury, 2007).

The potential for wide-ranging population-centric analysis is emerging, now that the Massachusetts and Minnesota groups are looking beyond physician and clinic report cards. In time, these groups will be able to drill into the details of less prevalent conditions and help

analysts get a better read on efficiency and cost-effectiveness throughout the system.

One simple example: the gap between the highest- and lowest-performing medical groups in Massachusetts on some new measures (e.g., screening for colon cancer) is 60 points. But in recent years, on measures that MHQP has reported to the physicians and the public (e.g., HbA_{1c} testing for diabetics), the gap between high and low performers is now only 20 points.

Healthcare data may vary widely by region, but in the end that's exactly the point. The reports produced by the Massachusetts and Minnesota groups are based not on extrapolated federal averages applied across the board but rather on solid, relevant data sensitive to regional variations, issues, and priorities. Payers, providers, employer groups, and consumers who are focused on specific conditions in their areas are better positioned and empowered to make the best healthcare decisions for their regions and for their families (American Health Quality Foundation, 2006).

As these organizations continue to gain experience and expertise, they will provide increasingly sophisticated analyses that can correctly assess health trends and help providers respond quickly and effectively. Along the way, the implementation of the various efficiencies revealed that best practices or more tightly targeted vaccination strategies can contribute to controlling costs.

The result should be a win-win-win-win situation for payers, providers, purchasers, and consumers and their families.

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Authors' Biographies

Brian H. Stuebaker, MS, is a healthcare technology consultant for Milliman, Inc., Milwaukee, WI. He implements healthcare data warehousing systems, including Milliman's MedInsight Data Warehouse, and designs data analysis and performance measurement systems for clients.

Paul M. Leonardo is a healthcare management consultant for Milliman, Inc., Seattle, WA. He has more than 15 years of experience in healthcare account management, including provider network management, provider contracting, and financial and risk management.

For more information on this article, contact Brian Stuebaker at brian.stuebaker@milliman.com or 262/784-2250 or Paul Leonardo at paul.leonardo@milliman.com or 206/504-5886.