Making the Most of California's Health Databases



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News earlier in 2019 about the launch of the Symphony Provider Directory, an online repository of California provider data, had to be music to the ears of provider and health plan administrators. Funded by a $50 million grant from Blue Shield of California and spearheaded by the non-profit Integrated Healthcare Association (IHA), Symphony promises to improve the accuracy and timeliness of provider directory data and reduce the cost and hassle of traditional directory updates.

As California providers and health plans have long known, updating traditional provider directories – as mandated by state law – is administratively burdensome and costly. Worse, provider directories are typically out-of-date as soon as they're published, frustrating consumers who rely on them for accuracy.

With Symphony offering an online resource for providers and plans to exchange and reconcile provider data, the efficiency of directory updates should significantly improve over prior, manual compilation methods. IHA estimates that by 2023, at least 80 percent of California's plans and physician providers will be listed within Symphony. Symphony's success in gaining increasing marketplace interest shows the opportunities available when introducing a statewide health-related database. Yet there can also be significant stumbling blocks. As one of the nation's leaders in offering statewide health-related databases, California offers ample examples of the

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possibilities – and challenges – common with such initiatives.

Database Rewards and Challenges

Health policymakers, professionals, purchasers and even consumers have for years considered the potential benefits of statewide databases for:

- Improving the quality, consistency and cost-effectiveness of provider care across all health settings
- Documenting positive and negative patterns of health care expenditures
- Assessing public health trends and patterns of illness and injury
- Identifying unmet regional or local health care needs
- Leveraging technology to create operational efficiencies and support ease of doing business

A state as populous and diverse as California has many opportunities to build broad-based databases to help improve the quality and effectiveness of health care. Over the past decade, there have been several statewide databases introduced in the Golden State.

For example, in 2014, the California Department of Public Health began a pilot project sending pathology cancer data directly and immediately to a central database, the California Cancer Registry (CCR). Before this, the CCR often had to wait up to two years to receive such information. The mission of the CCR is to help further understanding about the prevalence, prevention, treatment and control of cancer. Since 1988, the CCR has gathered information on 7 million cases of cancer among Californians, and adds more than 175,000 new cases annually. It's considered one of the largest cancer data registries in the world.

Yet no matter how well-intentioned the CCR's registry efforts, transmitting diagnostic data in real time raises questions about the rigor of patient privacy protection, according to a recent article in the American Journal of Managed Care. As the article's authors noted, "de-identified" data, of the type collected by the CCR, may still be identifiable. Data Privacy Lab researchers linked more than 80 percent of names and contact information to publicly available data profiles in the Public Genome Project.

Another potential issue with a statewide health database is the pervasiveness of eligible user participation. The quality and usefulness of a state-level database typically depends on having a high participation rate, but that can vary. Prompting higher database participation sometimes requires greater government and technical intervention.

That was the case with California's online prescription drug monitoring program (PDMP), which debuted in 2009 as a searchable, user-facing database within the state's Controlled Substance Utilization Review and Evaluation System (CURES). Initially, there was no requirement for California physicians and prescribers to interact with CURES, which in original form proved to be cumbersome and time-consuming to use. Predictably, by 2012, less than 10 percent of providers were using CURES. California provider compliance improved rapidly after the 2018

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introduction of a vastly improved PDMP, dubbed CURES 2.0, and a new statewide law requiring providers to query it before prescribing Schedule II, III or IV controlled substances. Critical to the introduction and success of CURES 2.0 was engaging the California Medical Association, representing 43,000 California physicians, which advocated for improving PDMP usability and efficiency.

Conclusion

With any state health database initiative, early engagement is the key to success for both database organizers and participants. The earlier that health plans and providers are involved with creating and contributing to health databases, the greater the say they'll have in ensuring it meets their specific needs and interests. When asked about your interest in a new database initiative, get involved early. Be proactive and lend your time, expertise and input to the effort, and you'll more likely be satisfied with the end result.

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