Addressing Barriers to Data Sharing: Experience from Pennsylvania

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Context of PA Integration Initiative

- Goal: Improve integration of PH/BH care for adults with SMI
  - Increase data sharing across systems
  - Establish integrated care "homes"
  - Create financial alignment
- Delivery System:
  - PH through full-risk MCOs
  - BH through full-risk, county-administered BH-MCOs
- Two pilots: Southeast and Southwest

Data Sharing Activities

- Performance incentives tied to:
  - Joint risk stratification
  - Integrated health profiles or care plans
  - Real-time hospital notifications
  - Pharmacy management
- Involves plan-to-plan and plan-to-provider data sharing

Crux of the Issue: When is Consent Required?

- Relevant regulations:
  - HIPAA
  - 42 CFR Part 2
  - State law – PA viewed as highly restrictive
- Guidance provided by PA DPW:
  - No consent required to share mental health info
  - No consent required to share HIV info among health care providers and their agents
  - Consent needed in almost all cases to share drug and alcohol info

PA Pilot Approaches to Data Sharing

- Southeast:
  - Required consent to share information as condition of enrollment in voluntary program
  - Pros: full beneficiary protection, more complete clinical picture
  - Cons: limited subset of total eligible population
- Southwest:
  - Stripped out drug and alcohol information from all systematic data sharing
  - Pros: full beneficiary protection, reduced risk of breach of information
  - Cons: less complete clinical picture

Lessons from PA

- Data sharing is invaluable
- 42 CFR Part II is a critical barrier
  - Consent/disclosure requirements are very specific
  - Data redaction challenge is significant
- Consent was easier to obtain than expected
- Plans approached data sharing more conservatively than required by state