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Improving Behavioral Health Through Data-Driven Collaboration

A Santa Cruz County Case Study

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About the Authors

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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California is the most populous state in the nation, with close to 40 million residents in its 58 counties. More than 15 million of these people, including 4 in 10 children, one in five working-age adults, and two million seniors and people with disabilities, are eligible for Medi-Cal, the state's Medicaid program for people with low incomes.[1]

Due to the scale and complexity of Medi-Cal, individual counties take on a large portion of the responsibility for administering the program and providing safety-net health care services to people in need. While this approach makes sense for a state where the geography, economics, and population patterns vary widely from region to region, it can also pose challenges for creating a coordinated, equitable, and seamless health care continuum.

To ensure a uniformly high-quality experience for Medi-Cal enrollees, the California Department of Health Care Services (DHCS) has introduced CalAIM (California Advancing and Innovating Medi-Cal): a long-term commitment to turning Medi-Cal into a person-centered, holistic health care delivery system. The overall CalAIM initiative is made up of a series of programs involving county Medi-Cal stakeholders, including the Behavioral Health Quality Improvement Program (BHQIP).

Robust, seamless, and compliant health information exchange (HIE) is at the heart of CalAIM's goals. From offering insight into population health risks to enabling timely follow-up on referrals for housing or other social needs, HIE is crucial for supporting appropriate allocations of resources, smooth transitions of care, and successful coordination between providers.

Santa Cruz County, just south of San Jose, is one of the state's leaders in leveraging HIE to improve care delivery for behavioral health clients. With a well-established HIE infrastructure, a clear roadmap for health system transformation, and a strong commitment to change, the county has become a case study in impactful innovation across its behavioral health services.

This paper explores how programs like BHQIP and other CalAIM initiatives can provide a framework for improving data-driven collaboration in county health care settings, using Santa Cruz's challenges and successes as a guide for addressing future reform efforts.

What is BHQIP?

BHQIP is a voluntary program that incentivizes county behavioral health agencies (BHAs) to implement service delivery and administrative reforms that will improve access to behavioral health services, simplify how these services are funded, and catalyze the administrative integration of mental health and substance use disorder (SUD) treatment. The program combines payment reforms and policy changes with a sharp focus on leveraging data exchange to better coordinate care for people with behavioral health needs.

Every participating county BHA will complete a series of milestones in three distinct goal areas: payment reform, behavioral health policy changes, and data exchange capacity building (see Table 1).

Table 1. Milestones for Participating in the Behavioral Health Quality Improvement Program

GOAL 1: PAYMENT REFORM
▸ Milestone 1a: Implement new Current Procedural Terminology or Healthcare Common Procedure Coding System codes, modifiers, place of service codes, and taxonomy codes.
▸ Milestone 1b: Update county reimbursement claims processing systems and successfully submit electronic claims for encounters, known as "837 transactions."
▸ Milestone 1c: Implement a new Intergovernmental Transfer agreement protocol with the Department of Health Care Services to pay for certain outpatient behavioral health services.
GOAL 2: BEHAVIORAL HEALTH POLICY CHANGES
▸ Milestone 2a: Implement new standardized screening tools for youth and adult enrollees.
▸ Milestone 2b: Implement a new standardized transition of care tool for enrollees who need more or fewer behavioral health services.
▸ Milestone 2c: For behavioral health agencies that participate in the Drug Medi-Cal Organization Delivery System, implement ASAM criteria to determine level of care.
▸ Milestone 2d: Implement revised documentation standards, including but not limited to assessment domains, problem lists, progress notes, and applicable timeliness standards.
▸ Milestone 2e: Provide guidance and training to county-operated and county-contracted providers on all new behavioral health policies.
GOAL 3: DATA EXCHANGE CAPACITY BUILDING
▸ Milestone 3a has two options: • Option 1: Demonstrate direct sharing of data with managed care plans. • Option 2: Demonstrate onboarding to a Health Information Exchange.
▸ Milestone 3b: Demonstrate an active Fast Healthcare Interoperability Resources application programming interface to comply with Centers for Medicare & Medicaid Services mandated interoperability rules.
▸ Milestone 3c: Demonstrate that the participating entity has mapped data elements to the United States Core Data for Interoperability standard set.
▸ Milestone 3d: Leverage improved data exchange capabilities to improve quality and coordination of care.

Sources: "CPT® overview and code approval," American Medical Association (AMA); "Healthcare Common Procedure Coding System (HCPCS)," AMA; *CalAIM Behavioral Health Payment Reform: Intergovernmental Transfer (IGT) Frequently Asked Questions (FAQs)* (PDF), Department of Health Care Services (DHCS), February 2023; *Youth Screening Tool for Medi-Cal Mental Health Services* (PDF), DHCS, January 2023; *Adult Screening Tool for Medi-Cal Mental Health Services* (PDF), DHCS, January 2023; "Drug Medi-Cal Overview," DHCS, Last modified March 23, 2023; "About the ASAM Criteria," American Society of Addiction Medicine (ASAM); Michelle Baass, DHCS, Behavioral Health Information Notice No: 22-019, April 22, 2022; The *FHIR® API* (PDF), Office of the National Coordinator for Health Information Technology (ONC); "Interoperability and Patient Access Fact Sheet," Centers for Medicare & Medicaid Services (CMS) Newsroom, March 9, 2020; "United States Core Data for Interoperability (USCDI)," ONC.

Santa Cruz County

Santa Cruz County lies at the northern end of Monterey Bay. While it is California's second-smallest county by land area, it is home to more than 264,000 residents and sees many more traverse the region on their way to and from Silicon Valley to the north and Monterey County directly to the south.

The Santa Cruz County Health Services Agency (HSA) has been actively involved in data-driven health system reform. The county launched its five-year Strategic Plan in 2020 and has developed a collaborative data strategy to align data governance and data management activities across county stakeholders.[2] Overall goals include expanding access to public health data for epidemiology and population health management, developing

formal data-sharing agreements with relevant parties, and preparing for upcoming statewide HIE projects, such as the Health and Human Services Data Exchange Framework (DxF).

Santa Cruz County participated in California's Whole Person Care (WPC) Pilots, which ran from 2016 to 2020. Santa Cruz's WPC Pilot focused mainly on connecting unhoused people with serious behavioral health or SUD treatment needs with resources to help them access housing and appropriate care. To do so, the County had to establish data sharing agreements and HIE pipelines with a variety of stakeholders, including public health entities, county public safety and criminal justice departments, the county housing authority, health system partners, payers, and community-based organizations providing social and non-medical services.

The county decided to participate in BHQIP to further augment its efforts to foster data-driven care across all its departments and health system partners.

Implementing BHQIP in Santa Cruz County

Launching BHQIP required Santa Cruz to assemble a team of subject matter experts across the three main goal areas to oversee the completion of each required milestone, including stakeholders from billing and quality improvement, leaders from Drug Medi-Cal Organized Delivery System (DMC-ODS) and managed care plans (MCPs) providing non-specialty mental health services, representatives from Santa Cruz Health Information Organization (SCHIO), as well as heavy users of Netsmart's myAvatar, the county HSA's behavioral health electronic health record (EHR).

With teams assembled, leaders could envision how BHQIP's goals would contribute to the larger data exchange ecosystem and begin to develop action plans for individual milestones.

Supporting Payment Reform

Under Goal 1 of the program, participating counties are required to upgrade their coding and claiming systems and modify their existing reimbursement structures for behavioral health services. These payment reforms are designed to standardize statewide reporting of behavioral health service utilization from DHCS to Centers for Medicare & Medicaid Services and move county BHAs to a fee-for-service model for reimbursement, which DHCS argues will simplify payments and incentivize providers to deliver value-based care.[3]

The milestones in this section include implementing new Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, updating county claiming systems and successfully submitting electronic 837 transactions, and implementing a new method for Intergovernmental Transfer (IGT) agreement protocols. These reforms are largely administrative and are not designed to directly address the exchange of patient information. However, they do indirectly support other CalAIM-related data sharing and quality improvement goals by modernizing a historically burdensome system.

Previously, many BHAs in California developed and used their own set of service codes to bill for behavioral health services. With the adoption of standardized CPT and HCPCS codes, BHAs can enhance data-driven decision making with a more detailed look at service utilization. Adopting standardized codes also aligns BHAs with other health systems and organizations that currently use the CPT and HCPCS code to bill for services.

Adapting to Align with Policy Reforms

Goal 2 of BHQIP centers on behavioral health policy changes that aim to improve access to personalized, timely care for enrollees. Key milestones include:

- Developing and implementing a standardized screening tool for clinician use to determine the correct delivery system and initial level of care for behavioral health services, as well as a standardized transition tool for transitioning enrollees to a lower or higher level of care
- Implementing revised documentation standards in a number of areas, including assessment domains, problem lists, progress notes, and applicable timeliness standards
- Providing guidance and training to county-operated and county-contracted provider organizations on all new behavioral health policies

In line with CalAIM's broader data sharing objectives, Santa Cruz needed to make several improvements to their behavioral health EHR to achieve Goal 2 milestones. The county's quality improvement team worked closely with providers and technical staff to develop draft templates for documentation standards (e.g., problem lists, progress notes).

The county repeated this process when DHCS released the final standardized templates for screening and transition tools in January 2023, establishing a workgroup to refine and then implement electronic versions of these tools within their EHR that integrated with an enrollee's record. These tools will help to streamline completion of the assessments and facilitate closed-loop communication with subcontracted providers and MCPs.

"This is an important effort for coordinating care. But what's not included in this goal is the creation of a step-down tool for people who no longer need the same intensity of care," said Subé Robertson, Director of Quality Improvement at Santa Cruz Behavioral Health Services. "In the future, I would like to see counties required to prove that they have a plan for stepping people down from treatment and the standardized tools for documenting those transitions in an organized way."

Enhancing Insight into Underserved Populations

Unlike many other counties, Santa Cruz has a unique partner that helps the county improve and deploy HIE activities. For the past 20 years, the Santa Cruz Health Information Organization (SCHIO) has worked to enable bidirectional data exchange for hundreds of providers, develop community-wide longitudinal health records, and connect to larger HIE networks such as eHealth Exchange.[4]

"We are firmly committed to being a health data utility and a single source of truth for the region while helping providers and county leaders navigate the tricky landscape of consent and privacy that governs data exchange," said SCHIO Executive Director Dan Chavez. "The rapport we have with the county, along with the trust and value we've built over the past twenty years, are incredibly important when embarking on improvement projects like these."

"We also have a very long lasting, strong relationship with the managed care plan in Santa Cruz County, which is the Central California Alliance for Health. Being a partner for both entities sets up the county to work effectively as a team and take advantage of what we want to do with WPC, BHQIP, and Cal-AIM in general," Chavez said.

Santa Cruz's established partnership with SCHIO gave the county a jumpstart on Goal 3, which

addresses data exchange infrastructure improvements. Because the behavioral health system was already connected to SCHIO, the County could easily check off Milestone 3a simply by demonstrating that the connection exists and is functional.

What's more, county leaders are working with SCHIO to use Health Level 7 International (HL7), which enables more a seamless exchange of Continuity of Care Documents (CCDs), ensuring critical clinical information is available when and where it is needed.[5]

"CCDs are standardized documents, but there can be different architecture for sending or receiving these documents on either end of a transaction," said Brian Dillon, Technology Strategy Consultant at Intrepid Ascent. "There has to be some sort of conversation around how these documents will be received - and more importantly, how both parties are going to identify the patient correctly and be sure that the right information is being associated with the right individual every time."

Patient matching is a perennial concern in data exchange and can be particularly challenging when coordinating care for populations that may not have standard demographic identifiers, such as a permanent address, social security number, or phone number. In addition, Medi-Cal members often enter and leave the program at unpredictable intervals, and may not consistently engage with providers.

"It's difficult to decide when to close out a patient, especially without a separate data field that indicates whether the person is active or not," said Dillon. "We are addressing this by exchanging a monthly patient roster that uses evidence of a recent encounter to indicate whether a person is currently active. That creates a monthly working population to manage, and makes it easier to add or drop records and update the information that needs updating."

"This is a big step forward in sharing behavioral health data because we are no longer limited to the standard admission, discharge, and transfer (ADT) feeds that only provide limited information on a person's activities. By enabling access to everything in a CCD, we can include important details that will help care teams make more informed decisions about what happens next with that person," Dillon continued.

Standardized connections are also the focus of Milestone 3b, which requires the implementation of an HL7 Fast Healthcare Interoperability Resources (FHIR) application programming interface into the EHR. This API isn't only a BHQIP bullet point: access to an HL7 FHIR API is a requirement for all 2015 Edition Certified EHRs as of December 2022.[6]

The capability is intended to enable the exchange of crucial health information "without special effort" on the part of either the sender or the recipient, according to the Office of the National Coordinator (ONC). As of August 2022, approximately two-thirds of inpatient users and 77 percent of ambulatory users nationwide had access to ONC-approved API functionality through their EHR vendors.[7]

But access to a function and active use of that tool are two different things. While a majority of EHR users nationally have the technical ability to use such an API to transmit data, thus meeting the basic mandate, very few have yet to make use of them. BHQIP goes one step beyond the national program by requiring that participants create active, workable connections through the API to send and receive real, meaningful data.

In Santa Cruz, the FHIR API became operational on March 1, 2023. While county agencies are not yet sending or receiving data through this pipeline, SCHIO is already an active user. By the fall of 2023, SCHIO plans to begin using the API to identify and close gaps in client data that is already being

exchanged across the county. Using the API will add flexibility to the County's technical infrastructure and ensure that important data is being exchanged appropriately to support care.

Milestone 3d, the final component of BHQIP, requires that counties leverage improved data exchange capabilities to improve quality and coordination of care across three use cases:

- Follow-up after an emergency department visit for alcohol and other drug abuse or dependence
- Follow-up after emergency department visit for mental illness
- Pharmacotherapy for opioid use disorder

As well, Santa Cruz created a performance improvement plan for each use case with the assistance of Praxis Associates to guide technical and workflow development activities in pursuit of these criteria. For example, the county recognized that most patients with SUD and mental illness-related visits to the ED were not getting appropriate follow-up care, with particularly significant disparities among Spanish-speaking people and those identifying as Latino/x.

To remedy the issue, the county assembled a weekly workgroup of stakeholders from senior management, IT, clinical care, and quality improvement. They also consulted with members of the Santa Cruz County Mental Health Advisory Board, which provides oversight and monitoring of local mental health and substance use services and is comprised largely of people who identify as consumers of behavioral health services themselves. The teams uncovered several root causes for the lack of appropriate follow-up, including confusion among providers as to the correct referral pathway; the use of "informal" referrals that are not actionable for tracking follow-up; and insufficient resources and knowledge to provide culturally-safe and responsive care to Latinos/x and primarily Spanish-speaking people.

Part of the solution lies in increasing the availability of Spanish-speaking translators, care navigators, and clinicians who can assist people who feel more comfortable communicating in Spanish. Meanwhile, the technical component of the solution centers on bidirectional data exchange. County behavioral health providers can already receive notifications that one of their clients has recently visited the emergency department. A new referral transmission and tracking system will enhance these insights by sending DMC-ODS referrals and discharge information to both the county behavioral health system and hospital substance use navigators (SUNs). Ideally, the system will also notify SUNs when an initial appointment has been made with the appropriate treatment provider.

The county is also working with SCHIO to produce daily reports on all enrollees admitted to the emergency department, which would include discharge information enabling the department to follow up on people when appropriate. These data will be compiled into detailed monthly and quarterly reports for data monitoring purposes to support continuous improvement in this area.

"This was a challenging area to solve for, because no solution is ever purely technical or purely administrative," said Jennifer Susskind, MCP, Lead Planner and Evaluator from Praxis Associates. "It will always take a combination of education and awareness for the front-line clinicians, improvements to the data we need to monitor performance, and upgrades to bidirectional data exchange capabilities to develop new workflows that have a direct impact on how clients receive care."

Lessons Learned from BHQIP as a Case Study in HIE Infrastructure Improvement

Coping with Ongoing Workforce Shortages

CalAIM is a years-long, multi-part initiative with plans to keep launching new improvement projects through 2027.[8] For county health leaders, this means a continuous series of challenges that will test their abilities to rally scarce resources, maintain motivation among stakeholders, and manage data efficiently and effectively to provide actionable insights for improved patient care.

Uneven guidance from state authorities on technical and administrative requirements paired with tight and shifting deadlines sometimes leads to guesswork and quick decisions that may or may not align with what CalAIM's architects envisioned. These circumstances can lead to dampened enthusiasm for programs like BHQIP.

"Everyone's plates are overflowing, which makes it tough to feel as if these initiatives are sustainable," acknowledged Robertson. "We're expected to make change upon change in a really short timeframe without the staff we need to make [those changes] happen, which doesn't feel great when we come into work every day bringing our best."

Robertson continued, "But on the other hand, sometimes you need pressure to shift perspectives. People are starting to realize that these activities don't just live in the quality improvement department. They affect everyone, and they could bring positive changes to everyone, if we all get involved. I'm seeing more understanding at the clinical team level that they have responsibility for these tasks, too, and that we can start to see results trickle down to our clients if we really work at it."

Taking a Broader View of Planning and Executing Data-Driven Projects

Widespread staffing shortages mean that Santa Cruz has been working with approximately 30% of its positions unfilled, leading to major gaps in the necessary skill sets to make headway on CalAIM goals.

"I don't have a health information management (HIM) manager at the Health Services Agency, and we don't have one in behavioral health," said Tiffany Cantrell-Warren, Santa Cruz County Director of Behavioral Health. "If we had people in those types of positions two years ago, we would have been able to develop a more comprehensive strategic vision for BHQIP and a plan to get there much more quickly. It's basically been different division directors, like myself, pulling these projects together amongst all our other responsibilities, and there's only so much we can do with our limited bandwidth."

Before the next round of quality improvement projects hit, Cantrell-Warren suggests counties try to secure an experienced data strategist who can take a bird's eye view of the problems at hand. Investing in this type of role could allow counties to work more effectively with limited staff and provide more clarity and certainty around what is expected of each contributor.

"There is so much duplication of systems and data sets in our county, and I'm sure in other counties, as well," she said. "The hardware people are thinking about hardware, and the software people are thinking about software, but no one is really overseeing both. We need someone who can understand what we have, envision how they should all work together, and direct the necessary changes so that we're meeting our objectives efficiently."

Navigating a Complicated Landscape of Consent and Privacy Regulations

Meeting the technical goals of BHQIP requires participants to first hash out answers to many long-standing questions about privacy and consent in the behavioral health space, such as how to appropriately share SUD data that is subject to federal confidentiality restrictions.[9]

"We have a network of federal and state regulations that are designed to empower behavioral health clients and prevent bias in their care and their daily lives, but they don't always align with each other in a way that allows clinicians to view their clients as whole people," explained Cantrell-Warren. "Many of these regulations come from a place of stigma and outdated thinking on SUD as a moral failing instead of a health condition, which needs to change."

"Voters and legislators are responsible for making that happen. As public servants, however, it's our job to find ways to treat people the best we can within the existing regulations and design our technical infrastructure to facilitate compliant data sharing wherever possible so that clinicians can make informed decisions," she said.

This lack of transparency can also be dangerous. "When you go to school as a clinician, you are very strictly told not to share information with pretty much anyone," said Robertson. "Many times, that's interpreted as not being able to share even with other members of the patient's care team, which isn't always true and can even bring harm to the patient when something like contraindicated medications are involved."

In Santa Cruz, BHQIP has shed light these concerns, as program participants continue to encounter legal hurdles as they work to exchange health information across entrenched barriers.

"At the start, we thought BHQIP would help us clear up some of the legal questions we had and give us a state-approved framework for sharing information. But that hasn't happened to the degree that we need," said Cantrell-Warren. "I'm still fielding questions about which federal laws supersede state laws and vice versa, and our stakeholders are struggling to come up with acceptable answers."

The result is unintentional data blocking, noted representatives from SCHIO, since certain highly restricted information doesn't flow through to the HIE at all. "We need to change the regulations and change how things are being done if we are truly going to achieve whole person care," said Becky Shoemaker, senior project manager. "The state could do a better job of relaying information and putting mandates in place that would allow participants to feel comfortable with sharing information appropriately."

"It would certainly help counties with these pilots because the attitude right now is that they cannot afford to take any risk, so they're erring on the side of not sharing at all. That's not going to work for the long term. We invite state leaders to take a more collaborative role in these improvement efforts on a granular level so that we can meet their expectations without preventable missteps."

Establishing a Neutral Convener

SCHIO has been an important asset to Santa Cruz's data transformation efforts, not just because of the technical infrastructure the organization has built and overseen, but also because it acts as a neutral party when county and state stakeholders come together to make decisions about workflows and business agreements.

"Everyone has their own interests to fight for. Whether we like it or not, access to data often becomes collateral in those conversations," said Cantrell-Warren. "If you have an HIE that isn't led by the county, and its driving mission is to facilitate data exchange to everyone equally, it offers the opportunity to have an objective opinion and a mediator when necessary."

"We've been fortunate to have SCHIO in that role. I would advise other counties to find an entity that can serve that purpose in their environment. It can make a significant difference in how difficult conversations play out and help everyone get to a shared solution quicker," she said.

Thinking Creatively to Ensure Health Equity

Medi-Cal covers more than a third of California's population, and almost none of those people spend their entire lives within the confines of a single county. Whether they have no fixed address, travel for work, seek care in multiple health systems, or visit family elsewhere in the state, patients don't respect arbitrary county borders the way administrators do.

"Our federated model has its strengths, but we also have to address the weaknesses and potential disparities that can occur when we only look internally all the time," said Chavez. "There isn't enough recognition that people will generally do what is convenient and gives them immediate satisfaction, and those things rarely align with our ideal vision of what the health system should look like."

"As hard as it is to develop HIE within a county, we have to do a much better job of creating cross-county data exchange so that we can support these individuals no matter where they are in California. That will require better patient matching infrastructure, timely eligibility checks for people going on

KEY TAKEAWAYS

- Workforce shortages aren't going away any time soon, meaning leaders have to be both proactive and realistic about what they can accomplish. To secure engagement and avoid burnout, be sure to educate staff about how programs like CalAIM and BHQIP will positively impact health care clients. Be clear about connecting the dots between specific workflow changes and their intended downstream effects.
- Coordination is key for success with a large, complex project like CalAIM. Think about creating a county-wide data strategy role that focuses on identifying how all the moving pieces should come together. This role doesn't have to be overly technical, but should act as a unifying, motivating force for understanding and executing on state objectives.
- Making sense of privacy rules can be extremely challenging, especially when state and federal regulations are both in play. While major policy changes may be out of a county's control, leaders should urge state-level officials to provide more guidance and meaningful resources to help clarify local and national laws.
- Counties are useful administrative units in a state as large as California, but clients don't always stay within a single county's borders when seeking care. Leaders need to work with their neighboring counties to understand how to share data appropriately across county lines and how to provide mutual aid in larger health system transformation goals.

and off Medi-Cal, and more robust intracounty data sharing agreements," he continued.

Chavez encouraged state and local leaders to apply lessons learned from Medi-Cal improvement initiatives to the broader health care environment in an effort to ensure equity in care delivery across population sectors.

"We don't want to reinforce inequities that we saw during the pandemic, and we certainly don't want to create new ones," he said. "Taking a close look at improving care for a focused population like Medi-Cal SUD and behavioral health clients is important, but we have to remember to roll up those learnings to other communities at risk so we can improve care and outcomes for everyone."

Conclusion

Santa Cruz County has been committed and successful in its pursuit of BHQIP's goals, in large part because leaders have made a point of treating the program as a jumping off point for HIE improvements that will have positive downstream impacts on patient care.

BHQIP is an ambitious and multifaceted program, but it offers a valuable opportunity for counties to address common gaps in their workflows and infrastructure. "BHQIP is helpful for providing structure, accountability, and financial support to focus our attention on tasks that we might not otherwise be able to prioritize," said Robertson. "It also helps us align our objectives and strategies across our various HSA agencies. It's prompted us to start looking at our strengths and weaknesses, such as where we need more resources or more learning to shore up our capabilities."

As well, BHQIP offers participating counties a way to meet defined targets in data exchange that have value far beyond the specifics of any single improvement program. And the results are already evident in qualitative ways.

"I've seen big changes in how teams are working together across different functions," said Cantrell-Warren. "I've seen a lot more engagement with the quality improvement team from people in administrative and EHR development, service delivery, psychiatry, children's behavioral health, and SUD. They want to get involved in what these workflows look like, because now they know that there's no such thing as a data question, or a QI question, or an EHR question. Everything is connected, and we're starting to acknowledge that much more clearly now."

However, there is still significant room to improve both the design of CalAIM's programs and the manner in which county-level stakeholders complete their objectives. Over the next several years, state leaders will need to work more closely with county officials to define the parameters for health information exchange and provide additional guidance on how to meet program goals within the unique context of each county's capabilities and priorities.

If participants can gain the necessary clarity and direction - and obtain the staffing resources to support continuous improvement - health information exchange will continue on the path to becoming a powerful tool for achieving CalAIM's vision of delivering high-quality, accessible, equitable health care to all Californians.

Endnotes

1. *Medi-Cal Monthly Eligible Fast Facts* (PDF), California Department of Health Care Services (DHCS), February 2023.
2. *Santa Cruz County Health Services Agency 2025 Strategic Plan* (PDF), Santa Cruz County Health Services Agency (HSA), September 2020; "County Strategic Plan," Data Share Santa Cruz County.
3. *California Advancing and Innovating Medi-Cal (CalAIM) Overview: Behavioral Health Payment Reform (PDF)*, DHCS, December 2022.
4. "What we do," eHealth Exchange.
5. "About HL7," HL7 International.
6. "Certification Criteria," ONC, last reviewed March 10, 2022.
7. Jennifer Bresnick, "Vendor alert: API deadline looms for Certified EHRs," DHI Insights, November 14, 2022.
8. *CalAIM Initiatives Launch Timeline as of February 2023* (PDF), DHCS, February 2023.
9. "Part 2 – Confidentiality of Substance Use Disorder Patient Records," Code of Federal Regulations, Title 42, January 18, 2017.