CHCF

Beyond Clinical Care:
Closing California's Data Exchange Gap

Addressing Barriers in Behavioral Health, Public Health, and Social Services

FEBRUARY 2026

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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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Executive Summary

California has invested heavily in clinical health information exchange (HIE), but behavioral health, public health, and social services have largely been left behind. This has led to fragmented systems of care that negatively affect quality and outcomes for people with complex needs.

Past federal programs like the Health Information Technology for Economic and Clinical Health (HITECH) Act show what is possible when resources support data exchange. Similar investments could transform how behavioral health, public health, and social services share information.

From May 2023 to June 2025, researchers at Manatt, with support from the California Health Care Foundation (CHCF), engaged key stakeholders to understand barriers to cross-sector data exchange and to identify solutions for overcoming these barriers. This research can help guide California in advancing how behavioral health, public health, and social services share information.

In 2009, clinical data exchange was nascent. Today, in part because of the HITECH Act, nearly all acute care hospitals can share data electronically with other hospitals. But data sharing across sectors has not advanced at all. Just as clinical data sharing started with small steps and developed over time, so, too, can cross-sector data sharing. This paper offers clear recommendations for launching and advancing this critical work.

Key Takeaways

Research findings reveal significant gaps in data exchange:

➤ About half of county behavioral health, public health, and social service agency representatives report that they exchange data electronically *with few or no partners.*

➤ 71% of county behavioral health agencies do not receive electronic notifications for major events, such as someone entering the hospital for a mental health emergency.

➤ Only 7% of county public health agencies can receive electronic alerts from hospitals.

County agency respondents attribute the inability to share data to entrenched barriers in four key areas — technology, workforce, financing, and policy:

➤ 71% of public health respondents cite the lack of even basic electronic systems.

➤ 70% of social service respondents do not have funds to purchase and configure electronic systems.

➤ 77% of behavioral health respondents report that unclear privacy laws and regulations impede data sharing.

What California Can Do

To provide timely, coordinated care, organizations must address barriers to cross-sector electronic data exchange in four critical areas.

Technology
➤ **Support the development of standardized data exchange governance and policies that address the specific needs of the behavioral health, public health, and social service sectors**, including the development and implementation of data standards to support interoperability.

Workforce
➤ **Support workforce development** to recruit, train, and retain technical and administrative staff who can support data exchange workflows, manage technical infrastructure, and minimize the administrative burden on providers.

Financing

➤ **Identify strategies to leverage and to creatively braid federal, state, local, and philanthropic funds** to secure the necessary financing to build statewide data infrastructure and to incentivize sectors in developing the capacity to support cross-sector exchange.

Policy, Guidance, and Technical Assistance

➤ **Provide targeted technical assistance** through Communities of Practice and Learning Collaboratives facilitated by subject-matter experts to share insights and to support counties in dispelling and overcoming perceived data sharing privacy barriers.[1]

Why It Matters

Robust cross-sector data exchange supports timely access to equitable care. It reduces administrative burden and allows public dollars to go further. And the urgency is rising. To meet its goals under the California Advancing and Innovating Medi-Cal (CalAIM) and Behavioral Health Transformation efforts and to manage anticipated H.R. 1 (2025)–related fiscal constraints, California needs scalable solutions to maximize efficiency in access to and delivery of care. Cross-sector data sharing is an essential step in realizing these goals.

Research Objective

CHCF commissioned this report to identify current gaps in cross-sector data sharing, informed by stakeholder interviews with county- and state-level subject-matter experts. Additional input was provided by sector-specific focus groups and an advisory group comprising county, managed care plan (MCP), and state representatives. (For more information about data exchange reports commissioned by CHCF, see Appendix A.) County behavioral health, public health, and social service agency representatives were also surveyed to better understand the current landscape of data exchange and barriers to progress, and to identify targeted, scalable strategies to support modernization efforts.

For more information about existing state modernization efforts related to cross-sector data exchange and care coordination, see Appendix B. For a more detailed overview of the project methodology, including a list of respondents to county surveys, see Appendix C.

Background and Context: HITECH and the Data Exchange Framework

The 2009 HITECH Act was designed to modernize the US health care system by incentivizing the adoption of electronic health records (EHRs) and by improving health information exchange (HIE).[2] Nationally, an estimated $36 billion was invested in data exchange infrastructure development, with hospital EHR adoption going from 10% prior to HITECH to 96% by 2024.[3] In California, virtually all acute care hospitals adopted at least a basic EHR system by 2024.[4] The percentage of hospitals able to electronically send and receive data increased from 66% to 89% (send) and from 38% to 82% (receive) between 2014 and 2018.[5]

Behavioral health, public health, and social service sectors were left out of HITECH's funding and modernization initiatives, however. This exclusion has perpetuated the following:

➤ **Fragmented systems** that frequently rely on manual processes.

➤ **Poor outcomes for clients**, especially those with complex needs that require care across sectors.

▶ **A burden on providers** who lack access to real-time data to support care delivery and coordination. (*Real time* is the sharing of client information with other care partners in a timely manner, meaning as soon as the information becomes available and without intentional or programmatic delay, to support important care decisions that benefit all Californians.)

▶ **Barriers to cross-sector statewide initiatives** that support California Advancing and Innovating Medi-Cal (CalAIM) and Behavioral Health Transformation efforts, which depend on integrated and coordinated care.[6]

▶ **Emergency response limitations** for wildfires and pandemics, where data sharing is essential to support timely, coordinated response.

With growing recognition of the need for cross-sector information exchange, California passed Assembly Bill (A.B.) 133 in 2021.[7] This bill required the establishment of the Data Exchange Framework (DxF) to facilitate secure, real-time sharing of health and social service information, which includes behavioral health, housing, public health, and criminal and legal data. The DxF establishes standard "rules of the road" by requiring hospitals, providers, health plans, and other mandated signatories to sign a statewide Data Sharing Agreement and comply with its policies and procedures.[8] While the DxF facilitates standardized cross-sector data exchange, the behavioral health, public health, and social service sectors — none of whom are required signatories — face significant challenges with their data infrastructure and capacity to opt in and to meaningfully participate. Real and perceived barriers, including lack of electronic documentation systems and misunderstanding of when data can be shared, further complicate efforts to help these sectors build capacity.

Compounding these issues is that H.R. 1, passed in 2025, requires the state to do more with less.[9] By reducing federal matching for emergency Medi-Cal and capping both provider assessments and state-directed payments, H.R. 1 (2025) will significantly reduce California's ability to draw down federal Medicaid funds. Consequently, there is renewed urgency to prioritize data exchange infrastructure development to improve efficiency and minimize the impact of Medicaid policy changes. These policy changes include Medicaid work reporting requirements and increased frequency of eligibility redeterminations for expansion populations, which are anticipated to take effect in January 2027. To maintain Californians' access to care, the state must be laser focused on maximizing efficiency and deploying available resources as strategically as possible.

With HITECH as a precedent and with the DxF offering a practical pathway to support behavioral health, public health, and social service data exchange, California can fast-track progress to address current care coordination challenges and the anticipated consequences of the 2025 H.R. 1. To maximize this opportunity, the state must implement strategies to improve cross-sector exchange by developing a clear vision for progress and by analyzing where existing capabilities fall short.

Essential Activities for Data Exchange to Support

Stakeholders who have been engaged for this project agree that robust cross-sector data exchange should support the timely completion of the activities listed in Table 1.

Table 1. Essential Activities Involving Data Exchange

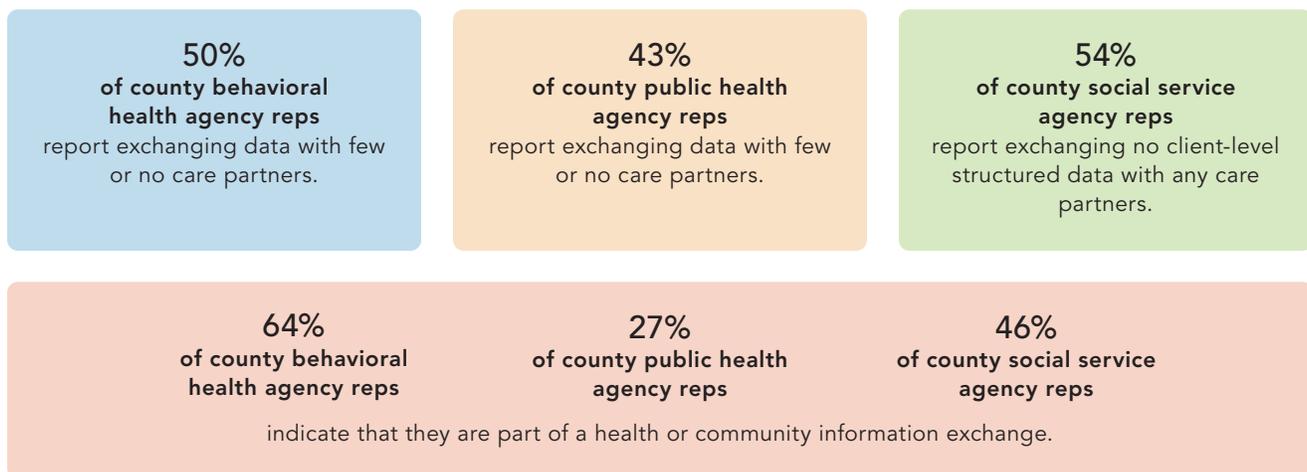| ACTIVITY	DESCRIPTION
Intake	Collecting demographic data (including sexual orientation and gender identity; and race, ethnicity, language, and disability) and capturing consent to treat, to provide services, and to share data
Assessment	Determining service needs (e.g., behavioral health or substance use disorder [SUD] and social needs assessments)
Referral	Sending, receiving, and confirming referrals; closing the loop with providers, county agencies, and community-based organizations (CBOs)
Service authorization	Verifying eligibility and coverage and obtaining approvals from payers for necessary services and procedures
Service provision and alerts	Delivering services and generating critical event notifications (e.g., hospital discharge) to support care coordination
Eligibility and enrollment	Sharing data for clients to apply for and maintain benefits (e.g., Medi-Cal; CalFresh; and the Women, Infants, and Children [WIC] program)
Payment and billing	Submitting claims and receiving payment; reusing data for population health, quality improvement, and other research

Source: Authors' analysis based on stakeholder engagement, 2025.

Current Capability Gaps

Survey respondents report difficulty in carrying out the essential activities outlined in Table 1 by using their existing data exchange capabilities. As reflected in their responses, cross-sector behavioral health, public health, and social service data exchange is nascent, similar to the state of clinical data exchange when HITECH was initiated in 2009. Figure 1 presents some key responses.

Figure 1. High-Level Survey Responses

50%
of county behavioral health agency reps
report exchanging data with few or no care partners.

43%
of county public health agency reps
report exchanging data with few or no care partners.

54%
of county social service agency reps
report exchanging no client-level structured data with any care partners.

64%
of county behavioral health agency reps

27%
of county public health agency reps

46%
of county social service agency reps

indicate that they are part of a health or community information exchange.

Source: Sector-specific surveys in behavioral health, social services, and public health conducted by authors for this report, 2025.

Given that the survey was distributed to county agencies, responses may or may not include provider perspectives, depending on (1) whether the county engages in any direct service provision and (2) whether the county contacted any service providers for input.

Survey results illustrate the gap between stakeholders' aspirations for leveraging data exchange to accomplish essential work activities and the limitations of their current systems. For examples, see Table 2.

Table 2. Example Data Exchange Gaps in Current County Landscape

ESSENTIAL ACTIVITY	ASPIRATIONAL CAPABILITY	CURRENT CAPABILITIES
Intake	Care partners can access a client's previously collected information through a health information exchange or a community information exchange (HIE/CIE) that connects electronic documentation systems across sectors.	The percentage of counties surveyed that are part of an HIE/CIE: ▶ 64% of county behavioral health agencies. ▶ 27% of county public health agencies. ▶ 46% of county social service agencies. When asked whether each sector can receive or query data from other systems or entities, regardless of an HIE/CIE, county representatives reported the following:* ▶ 12% of county behavioral health agencies can receive or query **intake** data from other systems or entities. ▶ 8% of county public health agencies can receive or query **intake** data from other systems or entities. ▶ 30% of county social service agencies can receive or query **any** data from other systems or entities.
Referral	Care partners can electronically send and receive referrals with hospital EHRs, including information necessary for clients' needs assessment, and the status of these referrals is tracked (known as a *closed-loop referral*).	The percentage of surveyed county respondents indicating that they can receive electronic referrals from hospitals: ▶ 26% of county behavioral health agencies. ▶ 43% of county public health agencies. ▶ 10% of county social service agencies.
Service authorization	Care partners can request approval of services through their EHR or other electronic system to the appropriate payer and receive a response via the same electronic pathway.	Of the MCP representatives surveyed: ▶ 18% report sending electronic service authorizations to county behavioral health agencies. ▶ 27% report sending electronic service authorizations to county public health agencies. ▶ 0% report sending electronic service authorizations to county social service agencies.

ESSENTIAL ACTIVITY	ASPIRATIONAL CAPABILITY	CURRENT CAPABILITIES
Service provision and alerts	Care partners can exchange alerts and notifications on shared clients to coordinate care across providers and share real-time information when needed.	The percentage of surveyed county agencies that receive electronic alerts and notifications from hospitals: ▶ 16% of county behavioral health agencies. ▶ 7% of county public health agencies. ▶ Only 10% of county social service agencies receive **any** electronic data from hospitals.

Notes: The authors note that access to data is essential at all phases of the client service life cycle and have identified the gaps in this table as just a few examples from survey findings. Responses that indicated "N/A" or "don't know" were excluded from analysis.

* For this and all subsequent statistics in this table, percentages capture "all/most" or "some" responses from survey respondents. For example, in this row, the "12%" of county behavioral health agencies captures those representatives who indicated that they can receive or query intake data from "all/most" or "some" systems or entities. It does not capture responses indicating that they receive or query intake data from "few/none" systems or entities, which was the other response option in the survey.

Source: Sector-specific surveys conducted by the authors for this report as part of the 2025 California County Data Exchange Survey.

Overall findings illustrate the substantial size and nature of data sharing gaps at the county level and the pressing need for strategies that initiate and that will continue to advance real-time cross-sector data sharing.

Critical Barriers

To enable data exchange that helps deliver whole-person care, counties need interoperable technology systems and common data standards, well-trained workers, funding for investment and operations, and clear federal and state policies. Survey respondents report barriers in each of these areas, as described in Table 3.

Table 3. Barriers to Cross-Sector Data Exchange: County Self-Reported Challenges

BARRIER CATEGORY	DESCRIPTION	% OF COUNTY REPS REPORTING BARRIER TO CROSS-SECTOR DATA EXCHANGE		
		BEHAVIORAL HEALTH	PUBLIC HEALTH	SOCIAL SERVICES
Technology	Misalignment of data fields and elements	65%	81%	60%
	Lack of electronic systems among partners	55%	71%	20%
	Interoperability issues with partner electronic systems	68%	85%	38%
Workforce	Dearth of qualified technical staff with necessary skills to hire at existing salary scales	57%	62%	55%
	Existing staff who are not adequately trained in necessary skills	51%	60%	27%
Financing	Insufficient funding to purchase or configure electronic systems	50%	71%	70%
	Limited funding to operate and maintain electronic systems	48%	70%	73%
Policy	Unclear privacy laws and regulations	77%	68%	64%

Source: Sector-specific surveys, conducted by authors for this report, 2025.

Recommendations for Advancing Cross-Sector Data Exchange

California can build on what is already working — such as the DxF and a 2025 state law that strengthens governance — and apply lessons from past federal programs to help counties share data across different sectors more easily. (See Appendix B for a list of existing policies and legislation that could be leveraged to address barriers.) To achieve this goal, the state needs to find and commit to long-term funding that helps organizations set up and maintain strong, real-time data sharing systems. Following are specific steps that the state can take to address the gaps and barriers identified in this report. The IT or service procurements and state agency contracts that are recommended in this section should incorporate interoperability requirements that meet DxF policies and procedures.

For more details on each recommendation, including the existing policies and programs that can serve as models, see Appendix D.

Technology

➤ **Support the development of standardized data exchange governance and policies that address the specific needs of the behavioral health, public health, and social service sectors**, including data standards to support interoperability.

➤ **Build standardized architecture and operational capacity for data exchange functions,** including admission, discharge, and transfer (ADT) event notifications and service authorizations.

➤ **Strengthen the DxF Qualified Health Information Organization (QHIO) program** by aligning standards with county and state priorities and by expanding participation among intermediaries who can meet behavioral health, public health, and social service data sharing needs. Provide sustained funding to support QHIOs — both existing and new intermediaries — in meeting programmatic requirements and expanding their networks.

➤ **Support onboarding with QHIOs and other data exchange intermediaries** to facilitate real-time data exchange processes across sectors.

➤ **Support counties in pursuing multicounty or statewide procurement processes** to streamline administrative functions (e.g., claims processing, financial and accounting services, electronic documentation system adoption) and to drive innovation. This effort would expand access to services and free up more resources to invest in data infrastructure.

Workforce

➤ **Prioritize workforce development efforts** to recruit, train, and retain technical and administrative staff who can support data exchange workflows, manage technical infrastructure, and minimize the administrative burden on providers.

➤ **Request that state agencies, particularly the California Department of Human Resources, develop and share best practices, guidelines, and frameworks. Counties could use them to conduct classification and compensation studies**, to improve compensation for IT roles, and to incentivize the development of a more robust county data exchange workforce.

➤ **Support multicounty service models** to help smaller and under-resourced counties leverage shared resources.

Financing

➤ **Identify strategies to leverage and braid federal, state, local, and philanthropic funds** to build statewide data infrastructure and to

incentivize counties to invest in cross-sector exchange. Follow New Jersey's lead in leveraging a Section 1115 waiver to support two new Promoting Interoperability Programs (PIPs), the Substance Use Disorder PIP and the Behavioral Health PIP.[10] Together, these programs are akin to HITECH for SUD and behavioral health providers to incentivize EHR adoption and data sharing.

Policy, Guidance, and Technical Assistance

➤ **Provide targeted technical assistance** through Communities of Practice and Learning Collaboratives facilitated by subject-matter experts to share insights and to support counties in dispelling and overcoming perceived data sharing privacy barriers.[11]

➤ **Consolidate existing data exchange guidance across sectors** to support standardized, clear, and accessible communications for all parties involved. This includes subregulatory guidance (e.g., Behavioral Health Information Notices, All Plan Letters, and All County Letters) that is currently communicated via various channels.

➤ **Establish a statewide standardized consent form and consent management platform** that aligns with federal (e.g., 42 C.F.R. part 2) and state (e.g., A.B. 133) privacy regulations.

➤ **Develop standardized Memorandum of Understanding templates and other data sharing agreements** to simplify and clarify the real-time data sharing requirements between sectors.

➤ **Ensure that clients are informed, educated, and aware of their rights** in providing consent to share their data.

Endnotes

1. *Communities of Practice: A Toolkit*, UC Davis Health, University of California Davis School of Medicine, accessed August 18, 2025.

2. Health Information Technology Act, 42 US Code § 17901 et seq., Title XIII of the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong. (2009).

3. Robert O'Harrow, "The Machinery Behind Health-Care Reform," *Washington Post*, May 16, 2009; and *National Trends in Hospital and Physician Adoption of Electronic Health Records*, Assistant Secretary for Technology Policy, accessed August 18, 2025.

4. *California Health Information Technology Landscape Assessment: Summary of Findings* (PDF), UCSF Department of Medicine, Center for Clinical Informatics and Improvement Research, California Health Care Foundation, November 4, 2024.

5. Walter Sujansky, *An Assessment of the California Health Information Technology Landscape in 2022: Summary of Key Findings* (PDF), California Health Care Foundation, June 2022.

6. "DHCS Is Transforming Medi-Cal to Ensure That Californians Get the Care They Need to Live Healthier Lives," California Department of Health Care Services (DHCS), accessed August 18, 2025; and *Behavioral Health Services Act*, DHCS, accessed August 18, 2025.

7. A.B. 133, 2021–22 Leg., Reg. Sess. (Cal. 2021).

8. "Data Exchange Framework (DxF)," Center for Data Insights and Innovation, accessed August 18, 2025.

9. One Big Beautiful Bill Act of 2025, H.R. 1, 119th Cong. (2025).

10. *New Jersey FamilyCare Comprehensive Demonstration*, Centers for Medicare & Medicaid Services, accessed October 15, 2025.

11. *Communities of Practice*, UC Davis Health.