CHCF

# Beyond Clinical Care: Closing California's Data Exchange Gap

## Appendices

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## About the Authors

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**Manatt Health** provides legal and consulting services to health care organizations and includes more than 200 attorneys and consultants. It is part of Manatt, Phelps & Phillips, and Manatt Health Strategies. Learn more at www.manatt.com/health.

## 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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# Appendix A. Relevant Publications from CHCF

CHCF has funded a range of projects and reports in recent years to help describe the data exchange landscape and define the need for more robust exchange in California (Table A1). This body of work spotlights what still needs to be done and informs ongoing efforts and new strategies that can support cross-sector data exchange.

**Table A1. Relevant Publications from CHCF**

| PROJECT OR REPORT TITLE | PUBLICATION DATE | DESCRIPTION |
|---|---|---|
| Health Data Exchange Drives Efficiency and Cuts Costs | July 2025 | Expert interviews and literature review to identify real-world use cases, research findings, and early return-on-investment signals that show where health information exchange is delivering value and where untapped potential remains. |
| California Health Information Technology Landscape Assessment | November 2024 | Project commissioned by the California Department of Health Care Services (DHCS) to assess the readiness of mental health, substance use disorder (SUD), and social service organizations to participate in data exchange. Findings indicate that there are widely varying levels of health information technology adoption, structured data capture, and cross-sector data exchange capability. |
| How to Share Data: Practical Guide for Health and Homeless Systems of Care | May 2022 | Guide for agencies and organizations in the health and homeless systems of care on how to break down silos and share data to better serve patients and clients. Includes guidance on data sharing agreements, client consent and release of information, and technology considerations. |
| Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness | July 2021 | Report that outlines ways in which California's housing and health care sectors are sharing data to better coordinate and to support mutual clients. Highlights challenges and barriers experienced in this cross-sector care collaboration and identifies potential opportunities to overcome them. |
| CalAIM and Health Data Sharing: A Road Map for Effective Implementation of Enhanced Care Management and In Lieu of Services | May 2021 | Implementation road map that identifies data, data exchange, and information system barriers to implementing Enhanced Care Management (ECM) and In Lieu of Services program functions under California Advancing and Innovating Medi-Cal (CalAIM). Offers a set of recommendations and actions that policymakers, government agencies, managed care plans (MCPs), and providers can take to resolve these barriers. |
| Why California Needs Better Data Exchange: Challenges, Impacts, and Policy Options for a 21st Century Health System | March 2021 | Illustration of four real-life scenarios that highlight the shortcomings of California's health information exchange ecosystem and the challenges and impacts on Californians. Provides direction on specific actions that policymakers may consider to address these issues. |

| PROJECT OR REPORT TITLE | PUBLICATION DATE | DESCRIPTION |
|---|---|---|
| Expanding Payer and Provider Participation in Data Exchange: Options for California | November 2019 | Report that outlines the policy, contracting, and financing levers available to states that are working to advance interoperability among health care entities to seamlessly exchange patient data. |

Sources: Katy Haynes, *Health Data Exchange Drives Efficiency and Cuts Costs*, CHCF, July 9, 2025; *California Health Information Technology Landscape Assessment: Summary of Findings* (PDF), UCSF Department of Medicine, Center for Clinical Informatics and Improvement Research, and CHCF Innovation Fund, November 4, 2024; Lauren Larin and Julie Silas, *How to Share Data: Practical Guide for Health and Homeless Systems of Care* (PDF), CHCF, May 2022; Erika Siao and Julie Silas, *Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness* (PDF), CHCF, July 2021; Jonah Frohlich et al., *CalAIM and Health Data Sharing: A Road Map for Effective Implementation of Enhanced Care Management and In Lieu of Services* (PDF), CHCF, May 2021; Jonah Frohlich et al., *Why California Needs Better Data Exchange: Challenges, Impacts, and Policy Options for a 21st Century Health System* (PDF), CHCF, March 2021; and *Expanding Payer and Provider Participation in Data Exchange: Options for California* (PDF), Manatt Health and CHCF, November 2019.

# Appendix B. Current State Programs, Initiatives, and Levers to Advance Data Exchange Recommendations

In recent years, California Governor Newsom's administration has launched several initiatives to advance cross-sector data exchange and to realize coordinated care across the state. The state also has several policy levers through which it can identify funding for and implement the policy recommendations that are put forth in this report; relevant legislation is highlighted in Table B1.

**Table B1. Current State Programs, Initiatives, and Levers to Advance Data Exchange**

| AGENCY | INITIATIVE | TIMELINE | DESCRIPTION |
|---|---|---|---|
| **California Department of Health Care Services** | CalAIM Initiatives | 2022–2026 | A multiyear initiative to transform Medi-Cal into a more person-centered, coordinated, and equitable program. CalAIM initiatives that encourage or mandate cross-sector care coordination include:<br>▸ Behavioral Health Initiative<br>▸ ECM and Community Supports<br>▸ Justice-Involved Reentry Initiative<br>▸ Providing Access and Transforming Health (PATH) initiative |
| | Authorization to Share Confidential Member Information (ASCMI) Initiative | Since 2023 | A statewide effort under CalAIM to promote and standardize the exchange of certain physical health, behavioral health, and social service information among providers, health plans, county agencies, and social service organizations. ASCMI includes a standardized consent form for real-time data sharing between care partners. |
| | Data Sharing Authorization Guidance and accompanying toolkits | Guidance published 2023; toolkits published 2025 | Resources to provide guidance to Medi-Cal providers — including MCPs, Tribal Health Programs, community-based organizations, and correctional facility health care providers — on data privacy and data sharing consent regulations to support CalAIM implementation. The guidance:<br>▸ Clarifies when and how consent is required to share personal information<br>▸ Helps Medi-Cal providers navigate complex privacy laws across sectors<br>▸ Supports ECM and Community Supports services<br>▸ Aligns with California Assembly Bill (A.B.) 133 (2021), which expanded data sharing permissions for CalAIM. |
| | Behavioral Health Transformation | Since 2024 | Implementation of California's Proposition 1 (see the "Legislation and policy levers" information in this table) to modernize the behavioral health delivery system, to improve accountability and transparency, and to expand the capacity of behavioral health facilities. This effort includes up to $6.4 billion in bonds to build new supportive housing and community-based treatment settings. |

| AGENCY | INITIATIVE | TIMELINE | DESCRIPTION |
|---|---|---|---|
| **California Department of Health Care Services** (continued) | Equity and Practice Transformation Payments Program | 2024–2025 | One-time $140 million program for primary care practices to advance health equity and to reduce disparities by working on upstream care models, improving quality of care, value-based payment models, and practice transformation. These funds may support infrastructure investments in data exchange and analytics. |
| | Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative | 2024–2029 | Section 1115 Medicaid demonstration designed to strengthen behavioral health services for Medi-Cal members with serious behavioral health needs. BH-CONNECT aims to expand access to community-based services, strengthen the behavioral health workforce, and ensure that Medi-Cal members receive high-quality care. The initiative includes a particular focus on family-based services and children and youth who are involved in child welfare. It will also involve an effort to align the Child and Adolescent Needs and Strengths tool processes between DHCS and the California Department of Social Services (CDSS) to facilitate care coordination and to reduce redundancy between providers. |
| **California Health and Human Services Agency (CalHHS)** | State Health Information Guidance (SHIG) | Since 2017; latest edition updated January 2025 | Guidance to clarify federal and state laws related to the sharing of health and social services information (HSSI) to facilitate care coordination. Specific areas of focus include behavioral health information, HIV/AIDS information, information to address food and nutrition insecurity, information about people living with intellectual and developmental disabilities, and information about minors and foster youth. |
| **California Department of Health Care Access and Information (HCAI)** | Data Exchange Framework (DxF) | Since 2021 | A statewide initiative that requires the secure and real-time data exchange of HSSI across providers, with the goal of providing timely, safe, and person-centered care. DxF was enabled by A.B. 133, which mandated the creation of a statewide Data Sharing Agreement and a common set of policies and procedures.<br>The DxF Roadmap (2025) includes provisions highlighting public health and social service data exchange priorities over the next three years. |
| **California Department of Public Health (CDPH)** | Data Modernization Initiative (DMI) | Since 2019 | Federal initiative to transform public health data management by investing in state, tribal, local, and territorial data modernization efforts. Between 2023 and 2025, CDPH received $53.7 million under DMI. |
| | Future of Public Health | Since 2021 | Initiative to strengthen and transform California's public health system and to bring a new, innovative approach to equitably advancing the health of communities throughout the state. This initiative includes "IT, Data Science, and Informatics" as one of its six foundational governmental public health services. The goal is to expand data access and interoperability to enable data-driven decisionmaking and advanced analytics to explain, to predict, and to prevent disease spread. |

| AGENCY | INITIATIVE | TIMELINE | DESCRIPTION |
|---|---|---|---|
| **California Department of Social Services** | Child Welfare Universal Authorization for Release of Information (ROI) Pilot | Since 2024 | Pilot implementing a new universal ROI form for children and youth in the child welfare system to support care coordination and planning across providers in different sectors. |
| | Child Welfare Services–California Automated Response and Engagement System (CWS-CARES) | 2026 | New central repository being implemented for assessments, outcomes, and goals for each child and youth in the state's child welfare system. CWS-CARES may serve as the statewide system for sharing data between child welfare and specialty mental health services to facilitate timely care coordination. Goals include reducing the need for multiple assessments, minimizing traumatization, and reducing the administrative burden on providers. |
| **Legislation and policy levers** | Proposition 30 | Enacted 2012 | Funding source to support county behavioral health agencies in complying with federal interoperability requirements and participating in Medi-Cal data exchange. |
| | A.B. 133 | Enacted 2021 | A Medi-Cal transformation effort focused on improving care for managed care members by addressing social determinants of health and by streamlining processes. Data exchange is a core component of these efforts. Bill provisions include:<br>▸ Establishment of the DxF<br>▸ Establishment of CalAIM:<br>▸ One component of CalAIM is to explore opportunities for counties to pool resources through adoption of multicounty shared service models — such as joint contracts or third-party administrators — to improve compliance, access, and efficiency in behavioral health service delivery.<br>▸ Permission to limit the applicability of certain state privacy laws so that information can be more easily shared to promote service delivery and care coordination under CalAIM. This authority should make it easier to share data and alleviate the privacy barriers identified in the survey. |
| | Proposition 1 | Enacted 2024 | Mandate for state investments in the coordinated provision of behavioral health and housing supports, which require improvements in interoperability and connectivity between sectors. |
| | Senate Bill 660 | Enacted 2025 | Bill that expands and strengthens DxF by:<br>▸ Establishing board governance to oversee the DxF Data Sharing Agreement and the exchange of health and social information in the state<br>▸ Expanding the entities required to sign the DxF Data Sharing Agreement and authorizes the Department of Health Care Access and Information to determine other categories of entities required to sign the agreement (including counties, potentially) |

Sources: "CalAIM Initiatives," DHCS, accessed August 2025; "CalAIM ASCMI Initiative," DHCS, accessed August, 2025; "The Data Sharing Authorization Guidance 'Medi-Cal Housing Support Services' and 'Reentry Initiative' Toolkits," DHCS, accessed August, 2025; "Behavioral Health Transformation," DHCS, accessed August, 2025; "Equity and Practice Transformation Payments Program," DHCS, accessed August, 2025; "Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative," DHCS, accessed August, 2025; "State Health Information Guidance (SHIG)," California Center for Data Insights and Innovation, accessed August, 2025; "A Healthy California for All," Data Exchange Framework and CalHHS, accessed August, 2025; A.B. 133, 2021–22 Leg., Reg. Sess. (Cal. 2021); Data Exchange Framework Roadmap (PDF), CalHHS and Center for Data Insights and Innovation, February 2025; "Data Modernization Initiative (DMI)," US Centers for Disease Control and Prevention Archive, May 15, 2024; "State & Territory Funding Profiles," US Centers for Disease Control and Prevention Public Health Infrastructure Grant, September 3, 2024; "Future of Public Health," CDPH, updated October 21, 2025; "Universal Authorization for Release of Information Pilot," CalHHS, updated August 21, 2024; "CWS-CARES User Resources," State of California Child Welfare Digital Services, accessed August, 2025; "Proposition 30: Temporary Taxes to Fund Education, Guaranteed Local Public Safety Funding, Initiative Constitutional Amendment," California Legislative Analyst's Office, July 18, 2012; "Proposition 1 Authorizes $6.38 Billion in Bonds to Build Mental Health Treatment Facilities for Those with Mental Health and Substance Use Challenges, Provides Housing for the Homeless, Legislative Statute," California Legislative Analyst's Office, March 5, 2024; and S.B. 660, 2025–26 Leg., Reg. Sess. (Cal. 2025).

# Appendix C. Project Methodology

## Project Timeline

May 2023–September 2025

## Project Methodology

### Overview

The following sections outline the detailed methodology for this project:

- Stakeholder Engagement
  - Stakeholder Interviews
  - Advisory Group Convenings
  - State Engagement
- Use Cases and Focus Groups
- County Surveys
- Policy Recommendations

It should be noted that project findings represent data captured during the project time frame and survey distribution windows. The authors acknowledge that findings (e.g., feedback from focus and advisory group participants and survey responses) might differ slightly if the project was conducted in today's environment, given current federal administration priorities and the anticipated impacts of the 2025 H.R. 1 bill.

### Stakeholder Engagement

Manatt and CHCF conducted stakeholder engagement throughout the course of the project to solicit insights on the current landscape of cross-sector data exchange; to receive feedback on project strategy, findings, and recommendations; and to generate awareness about the project.

**Stakeholder Interviews.** Manatt conducted structured 30-minute interviews with subject-matter experts (SMEs) and state and county leaders to obtain insights on the current state of county-level cross-sector data exchange and what the ideal state might look like. The representatives who were interviewed are listed in Table C1.

**Table C1. Stakeholder Interviewees**

| NAME AND TITLE | ORGANIZATION |
|---|---|
| **Amie Miller,** Executive Director | California Mental Health Services Authority (CalMHSA) |
| **Amanda Clarke,** Vice President of Programs | California Association of Public Hospitals and Health Systems |
| **Ash Amarnath,** Chief Health Officer | California Association of Public Hospitals and Health Systems |
| **Elissa Feld,** Director of Policy and Regulatory Affairs | County Behavioral Health Directors Association of California |
| **Susan Fanelli,** Chief Deputy Director, Health Quality & Emergency Response | California Department of Public Health |
| **Caroline Kurtz,** Deputy Director, Regional Public Health Office | California Department of Public Health |

| NAME AND TITLE | ORGANIZATION |
|---|---|
| **Michelle Gibbons,** Executive Director | County Health Executives Association of California |
| **Christiana Smith,** Director of Information Technology Policy | County Welfare Directors Association of California |
| **Cathy Senderling-McDonald,** Previous Executive Director | County Welfare Directors Association of California |
| **Julie Silas,** Senior Directing Attorney | Homebase |
| **Alissa Weiss,** Directing Analyst | Homebase |

Source: Authors, 2025.

**Advisory Group Convenings.** CHCF and Manatt recruited an advisory group comprising state and county leaders and managed care plan representatives to advise on project methodology, to share insights, and to provide feedback on policy recommendations. The advisory group was convened twice to solicit input at different stages of the project. Additional sessions were hosted that gave advisory group members opportunities to share feedback on project findings. Advisory group members included the representatives listed in Table C2. (Note that titles and organizations represent each person's role at the time that they were initially engaged.)

**Table C2. Advisory Group Members**

| NAME | TITLE | ORGANIZATION |
|---|---|---|
| Elissa Feld | Senior Policy Analyst | County Behavioral Health Directors Association of California |
| Michelle Gibbons | Executive Director | County Health Executives Association of California |
| Eileen Cubanski | Deputy Executive Director | County Welfare Directors Association of California |
| Amie Miller | Executive Director | California Mental Health Services Authority |
| Ken Riomales | Senior Director of Interoperability | California Mental Health Services Authority |
| Julie Silas | Directing Attorney | Homebase |
| Cary Sanders | Senior Policy Director | California Pan-Ethnic Health Network |
| Eric Sergienko | Mariposa Health Officer | California Conference of Local Health Officers |
| Jolie Onodera | Senior Legislative Advocate | California State Association of Counties |
| Katherine Barresi | Chief Health Services Officer | Partnership HealthPlan of California |

| NAME | TITLE | ORGANIZATION |
|---|---|---|
| Gary Tsai | Director | Los Angeles County Substance Abuse Prevention and Control |
| Christopher O'Malley | Chief of Community Health Statistics | San Diego County Department of Public Health |
| Kim Saruwatari | Director | Riverside County Department of Public Health |
| Robert Ratner | Director | Santa Cruz County Housing for Health |
| Chevon Kothari | Deputy County Executive for Social Services | Sacramento County Department of Social Services |
| Steven Tong | Senior Management Analyst | Santa Clara County Office of Supportive Housing (Continuum of Care [CoC] Collaborative Applicant and Homeless Management Information System Lead) |
| Jegnaw Zeggeye | Chief Data Officer | San Diego Regional Task Force on Homelessness (CoC Collaborative Applicant) |
| Tamera Kohler | CEO | San Diego Regional Task Force on Homelessness (CoC Collaborative Applicant) |
| Lisa Mancini | Director of Aging and Adult Services, and Acting Deputy Chief | San Mateo County Health |
| Jill Nielsen | Deputy Director of Programs, Department of Disability and Aging Services | San Francisco Human Services Agency |
| Joe Cobery | Immediate Past President | Area Agency on Aging |
| Margarita Pereyda | Chief Medical Officer | Los Angeles County Department of Health Services Ambulatory Care Network |
| Aneeka Chaudhry | Assistant Agency Director | Alameda County Health Care Services Agency |
| Luke Anderson | Executive Director of Prevention Supports and Services | Placer County Office of Education |
| Allison Murphy | Director of Mental Health | Placer County Office of Education |
| Charis Baz | Senior Department Analyst | Marin County Behavioral Health and Recovery Services |

Source: Authors, 2025.

**State Engagement.** Manatt engaged representatives from state departments to share context and rationale for the project, to discuss intersections between the project and the state's programs and priorities, to seek assistance in encouraging survey responses, and to get input on project findings. Participants engaged in this process include representatives from DHCS, CalHHS, CDPH, CDSS, and the California Department of Corrections and Rehabilitation (CDCR).

### Use Cases and Focus Groups

In collaboration with expert stakeholders, Manatt developed six distinct use cases to illustrate the ideal state of cross-sector data exchange if data systems were in place and functioning as needed.

Use cases consist of a narrative story describing the actors (the players needed for optimal care coordination) and the steps needed to address a particular set of health challenges, as seen from the actors' point of view. These use cases also include a system flow map depicting the flow of information between systems, entities, and actors. Use cases reflect the following state priorities:

- Children and youth
- Housing and homelessness
- Reentry services
- Mental health and SUD
- Aging and disability
- Eligibility and enrollment

Use cases were reviewed with sector-specific focus groups comprising a subset of county leaders and data exchange SMEs from the advisory group. Participants were given the opportunity to provide feedback online as well as asynchronously via written feedback.

### County Surveys

Manatt and the University of California, San Francisco (UCSF), developed comprehensive sector-specific surveys, which were administered to all counties to capture the current state of the data exchange landscape. Surveys were distributed to county behavioral health agencies, county public health agencies, county social service agencies, and managed care plans across the state. Surveys were intended to be responded to by a representative or team familiar with the electronic systems in place and their current state, and the barriers to effective electronic system adoption or data exchange. Given the survey distribution 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.

Data on data exchange gaps and barriers were collected, and findings were quantified and analyzed.

## Methodology

**Survey Development**

Four tailored survey instruments were developed to collect information from key sectors: Behavioral Health, Public Health, Social Services, and MCPs. Each survey was informed by detailed use cases. The survey was designed collaboratively by UCSF, Manatt, and CHCF. To enable cross-sector comparisons, a standardized survey structure was designed with consistent sections. This common framework ensured comparability while allowing sector-specific customization by removing irrelevant content and by adjusting the lists of data exchange partners. The surveys were organized into the following sections:

- Client/Patient Intake Processes
- Client/Patient Assessment
- Sexual Orientation and Gender Identity Data Collection and Exchange

- Race, Ethnicity, Language, and Disability Data Collection and Exchange
- Client/Patient Consent to Share Data
- Eligibility and Enrollment Processes
- Service Authorization Requests
- Billing for Services
- Referrals for Additional Services
- Alerts and Notifications
- Health and Social Services Information Exchange
- Consumer Access/Control Over Data

The survey instruments underwent multiple rounds of review and revision prior to launch, incorporating feedback from advisory group members; pilot testers from each sector; and relevant representatives from various state entities, including the California Center for Data Insights and Innovation and DHCS. The surveys were programmed and administered by using Qualtrics, with extensive testing of branching logic conducted to ensure accurate routing and optimal response collection.

**Survey Distribution**

Distribution of the surveys was facilitated through collaboration with partner organizations, who supported survey dissemination. Each distribution included a brief overview of the survey and project, a direct link to the Qualtrics survey, a Word document version of the survey, and a survey glossary. To enhance response rates, direct reminder emails and follow-up communications were sent by both the UCSF research team and distribution partners throughout the data collection period. See Table C3 for additional details on the distribution partners and dates of data collection.

During the distribution of the social service survey, initial response rates were low, and feedback from social service organization representatives indicated that the survey was perceived as too long and burdensome. In response, the research team significantly streamlined the survey to improve completion rates. These revisions focused on retaining the most essential questions to ensure cross-sector comparability of top-level findings.

**Table C3. Summary of Survey Distribution**

| SECTOR | DISTRIBUTION PARTNER | DATES OF DATA COLLECTION |
|---|---|---|
| Behavioral Health | County Behavioral Health Directors Association of California | October 2024–January 2025 |
| Public Health | County Health Executives Association of California | October 2024–February 2025 |
| MCP | California Association of Health Plans and Local Health Plans of California | November 2024–March 2025 |
| Social Services | County Welfare Directors Association of California | May–June 2025* |

* Original distribution took place in October 2024. Dates represent redistribution of streamlined survey.

Sources: CHCF, Manatt, *UCSF California County Data Exchange Survey* (October 2024 to June 2025).

The original survey distribution took place in October 2024. The dates in Table C3 represent redistribution of the streamlined survey.

**Survey Analysis**

Survey response data were exported from Qualtrics into Excel for analysis. Descriptive statistics and visualizations were generated for each question. To assess overall levels of data exchange, responses from key questions across survey sections were combined and analyzed by using weighted averages. A data exchange index was also developed, assigning a score of three points for responses indicating "All/Most," two points for "Some," and one point for "Few/None," allowing a quantifiable comparison of exchange levels across exchange partners and sectors. Additionally, responses to key questions were stratified by county classification (urban, suburban, and rural) to identify geographic variations. Qualitative responses were analyzed thematically to identify the common barriers to electronic system adoption, the challenges related to data exchange, and the most frequently cited enabling factors. For full survey results, please reference the accompanying chart packs: CHCF, Manatt, UCSF California County Data Exchange Survey (October 2024 to June 2025).

***Survey Response Rates: Statewide Reach***

The maps in Figures C1 through C4 provide a visual representation of the counties with respondents to the sector-specific surveys. Not all county representatives submitted responses for all sectors. These maps illustrate the statewide geographic reach of responses by sector.

Response rates and respondents for each sector-specific survey are outlined in this section.

**Figure C1. Behavioral Health County Survey Respondents**


**Blue:** Urban counties
**Purple:** Suburban counties
**Green:** Rural counties
**Gray:** Did not respond

**Behavioral Health Survey**

28 responses,
48% response rate:

Alameda
Amador
Colusa
Contra Costa
Del Norte
Fresno
Glenn
Imperial
Kern
Lake
Lassen
Los Angeles
Madera
Mariposa
Mono
Monterey
Placer
Sacramento
San Bernardino
San Diego
San Luis Obispo
San Mateo
Santa Clara
Santa Cruz
Shasta
Solano
Tulare
Ventura

Sources: Sector-specific surveys conducted by the authors for the *2025 California County Data Exchange Survey.*

## Figure C2. Public Health County Survey Respondents


**Blue:** Urban counties
**Purple:** Suburban counties
**Green:** Rural counties
**Gray:** Did not respond

**Public Health Survey**

22 responses,
38% response rate:

Alameda
Amador
Butte
Calaveras
Glenn
Imperial
Los Angeles
Madera
Merced
Monterey
Napa
Nevada
Orange
Sacramento
San Luis Obispo
San Mateo
Santa Clara
Sierra
Solano
Sutter
Ventura
Yuba

Sources: Sector-specific surveys conducted by the authors for the *2025 California County Data Exchange Survey*.

## Figure C3. Social Service County Survey Respondents


**Blue:** Urban counties
**Purple:** Suburban counties
**Green:** Rural counties
**Gray:** Did not respond

**Social Service Survey**

24 responses,
41% response rate:

Alameda
Amador
Butte
Calaveras
Del Norte
El Dorado
Fresno
Los Angeles
Mendocino
Merced
Monterey
Napa
Orange
Placer
Sacramento
San Bernardino
San Diego
San Luis Obispo
San Mateo
Santa Cruz
Siskiyou
Sonoma
Stanislaus
Yuba

Sources: Sector-specific surveys conducted by the authors for the *2025 California County Data Exchange Survey*.

**Figure C4. MCP Survey Respondent County Coverage**


**Blue:** Urban counties
**Purple:** Suburban counties
**Green:** Rural counties
**Gray:** Did not respond

**Managed Care Plan Survey**

11 responses, 48% response rate:

Blue Shield of California Promise Health Plan

Central California Alliance for Health

Community Health Group Partnership Plan

Contra Costa Health Plan

Gold Coast Health Plan

Health Net Community Solutions Inc.

Health Plan of San Mateo

Kaiser Permanente

L.A. Care Health Plan

Partnership HealthPlan of California

San Francisco Health Plan

Note: The only county not covered by MCP respondents is Alpine.

Sources: Sector-specific surveys conducted by the authors for the *2025 California County Data Exchange Survey*.

## Policy Recommendations

Manatt developed policy recommendations to advance California toward the ideal state. Recommendations were informed by the following elements:

- Insights on the ideal state of cross-sector data exchange as envisioned in the use cases
- Analysis of the current state gaps and barriers reported in the surveys
- Insights from stakeholder interviews
- Insights from focus and advisory group convenings
- Insights from state engagement

# Appendix D. Detailed Policy Recommendations

## 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 (e.g., standardized data elements) to support interoperability. Build on the DxF and associated policies, standards, and oversight mechanisms to facilitate secure and efficient data exchange while protecting client privacy. Consider using the data elements proposed in the United States Core Data for Interoperability (USCDI) initiative, USCDI+, as a starting place for behavioral health and public health data governance.[1]

- **Build standardized architecture and operational capacity for data exchange functions,** including for admission, discharge, and transfer (ADT) event notifications and service authorizations. This could help counties facilitate cross-sector data exchange in compliance with federal regulations (e.g., the Centers for Medicare & Medicaid Services Interoperability and Prior Authorization Final Rule).[2] Providing these tools for optional use by counties could also support state reporting needs by giving the state direct access to relevant data.

- **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. The state should consider a variety of funding options to expand the DxF QHIO Onboarding Grants program to achieve this goal.[3] The program was launched in 2023 and supported Data Sharing Agreement signatories in the process to onboard with a QHIO and to exchange data with other DxF participants. The grant program could be designed to support behavioral health, public health, and social service entities and to require new or existing QHIOs and other intermediaries to meet the data exchange needs of these entities.

- **Support counties in pursuing multicounty or statewide procurement processes.** Pooling resources allows counties to streamline administrative functions (e.g., claims processing, financial and accounting services, and electronic documentation system adoption) and to drive innovation, thereby expanding access to services and freeing up more resources to invest in data infrastructure. Examples include the following:

  - Counties that have implemented third-party administrative service organizations such as Optum San Diego.

  - The relatively unique Joint Powers Authority implemented through CalMHSA for county behavioral health agencies and the Semi-Statewide Electronic Health Record (EHR), which brought together 25 counties to implement a standardized EHR to improve billing, data collection, data aggregation, and interoperability.[4]

  - The CalMHSA Multi-County Full Service Partnership Innovation Project, which brought together multiple counties to improve their

ability to collect, use, and share data to address administrative and programmatic challenges while improving service delivery.[5]

## 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. Providers frequently must take on additional tasks in the absence of adequate administrative and technical staff, reducing the time that they could otherwise spend with clients and on providing care. The state could model this effort on prior approaches with demonstrated success, such as the HITECH University-Based Training Program and the Community College Consortia Program, which together provided health IT training to over 20,000 students across the country.[6]
- **Request that state agencies, particularly the California Department of Human Resources, develop and share best practices, guidelines, and frameworks for counties to conduct classification and compensation studies.** This would support counties in reclassifying roles related to IT systems management and data exchange to improve compensation 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 (e.g., utilizing third-party administrators and establishing multicounty community care hubs). Another benefit of the CalMHSA Semi-Statewide EHR project is the technical support that it offers, including systems that contract oversight and vendor and technical staff management to support participating behavioral health departments. Sharing these services offers efficiency and reduces costs.

## 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. 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. Together, these programs are akin to the Health Information Technology for Economic and Clinical Health (HITECH) Act 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. These forums could support building infrastructure for secure data sharing between Health Insurance Portability and Accountability Act (HIPAA)–covered and non-HIPAA-covered entities.[7] Learning Collaboratives could be modeled after the partnership between HC2 Strategies and the Institute for Healthcare Improvement to convene counties and Indian Health communities across the state. These collaboratives would work to advance CalAIM implementation and successful practices under the CalAIM Providing Access and Transforming Health Initiative.[8]
- **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 and

All Plan Letters) that is currently communicated via various channels. Consolidated guidance could expand upon and leverage existing CalAIM Data Sharing Authorization Guidance Toolkits and State Health Information Guidance and provide targeted, on-the-ground support for counties.[9]

- **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. The state could build off the Authorization to Share Confidential Member Information Initiative and also develop consent solutions that support populations with different legal and fundamental needs (e.g., foster youth).[10] This would facilitate the sharing of client consent between providers, minimize the administrative burden on providers, reduce duplication and the burden for the client from having to sign multiple forms for each provider, and ensure that clients receive care coordination when and where they need it.
- **Develop standardized Memorandum of Understanding templates and other data sharing agreements** to simplify and clarify the real-time data sharing requirements between sectors. Build upon existing templates for managed care plans published by the California Department of Health Care Services to facilitate data sharing between the behavioral health, public health, and social service sectors.[11]
- **Ensure that clients are informed, educated, and aware of their rights** in providing consent to share their data. The state can continue this work with partners and leverage existing client feedback channels (e.g., Medicaid beneficiary advisory committees).

## Endnotes


1. "USCDI+," Assistant Secretary for Technology Policy, accessed September 8, 2025.
2. 42 C.F.R. parts 422, 431, 435, 438, 440, and 457, and 45 C.F.R. part 156, 2024.
3. *DSA Signatory Grants: Guidance Document* (PDF), Center for Data Insights and Innovation, 2025.
4. "Electronic Health Record," California Mental Health Services Authority, accessed August 18, 2025.
5. Nicole Eberhart et al., *Evaluation of the California Multi-County Full Service Partnership Innovation Project*, RAND Corporation, April 4, 2024.
6. "HITECH Workforce Development Programs," Assistant Secretary for Technology Policy, accessed August 18, 2025.
7. For more information about HIPAA-covered entities, see "Covered Entities and Business Associates," US Department of Health and Human Services.
8. "Collaborative Planning and Implementation," California Department of Health Care Services: PATH, accessed August 18, 2025.
9. "The Data Sharing Authorization Guidance 'Medi-Cal Housing Support Services' and 'Reentry Initiative' Toolkits," DHCS, accessed August 18, 2025; and "State Health Information Guidance (SHIG)," Center for Data Insights and Innovation, accessed August 18, 2025.
10. "CalAIM ASCMI Initiative," DHCS, accessed August 18, 2025.
11. "Memoranda of Understanding Between Medi-Cal Managed Care Plans and Third-Party Entities," DHCS, accessed August 18, 2025.