CHCF

Beyond Clinical Care: Closing California's Data Exchange Gap

Use Cases

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AUTHORS
Manatt Health:
Jonah P. B. Frohlich, *MPH*
Claudia Page
Kaitlyn Motley, *MPA, MA*
Catherine Dong, *MBA, MPH*

About the Authors

Jonah P. B. Frohlich is senior managing director, Claudia Page is senior advisor, Kaitlyn Motley is senior manager, and Catherine Dong is manager at Manatt Health.

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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Introduction

From May 2023 to June 2025, researchers at Manatt, with support from the California Health Care Foundation, engaged key stakeholders to understand the barriers to cross-sector data exchange and to identify solutions for overcoming these barriers. As part of this project, Manatt developed six use cases that describe how behavioral health, public health, and social service providers could exchange information electronically on behalf of their clients, but for important gaps in their current systems and processes. The use cases, provided here, highlight state priority populations or areas of focus, and they center on the stories of clients with complex needs who require cross-sector care coordination. Each use case comprises a person-centered narrative accompanied by a system map illustrating the ideal workflow and capabilities that would support addressing the person's needs in a timely manner.

The six use cases have been vetted with focus groups to confirm existing gaps and to ensure that the idealized data exchange workflows make sense and have true potential to be realized in the future. Manatt leveraged this material and collaborated with researchers at UCSF to design a statewide survey of counties to quantify the gaps and challenges across the behavioral health, public health, and social service sectors. Findings in *Beyond Clinical Care: Closing California's Data Exchange Gap* highlight the most critical challenges and recommendations related to data exchange for state and county leadership action.

Use Case Terminology and Definitions

Each use case description includes the following elements:

- **Narrative.** Description of a hypothetical person with a specific set of complex needs, and how county service providers could interact to address those needs if robust data exchange systems and processes were in place to enable those interactions.
- **System maps.** A visual representation of the workflow and capabilities needed to support addressing a hypothetical person's needs across sectors as outlined in the narrative.
- **Goals.** Specific behavioral health, public health, or social service programs and the outcomes intended for the use case character to receive and to achieve, respectively.
- **Assumptions.** Conditions and circumstances required to make the use case workflows and outcomes possible.
- **State priorities.** State priorities are highlighted by the use case.
- **Populations.** Category of people with complex needs highlighted by the use case.
- **Programs.** Federal, state, and local programs are highlighted by the use case.
- **Process steps.** Specific processes and data exchange activities enabling behavioral health, public health, and social service providers to coordinate and to achieve use case goals on behalf of their client.

Key: Use Case System Maps

→ System-to-system data exchange (e.g., via Application Program Interface, health information exchange) or person-to-system interaction

- - → Person-to-person interaction or nonelectronic data exchange (e.g., mail, phone call, assessment)

Blue icons: Electronic systems involved in data exchange

Black icons: People, organizations, or entities implicated in data exchange

Juan: Mental Health and Criminal/Legal Involvement

Narrative

Juan is 36 years old and is serving time in the county jail. While in jail, he was diagnosed with co-occurring substance use disorder and bipolar disorder, and he has been on medication to manage both conditions. After he is released from jail, Juan will need to continue to see a psychiatrist in his community and to take his medications, but he does not know how he can get this care. Because Juan has a qualifying mental health and substance use condition, he is eligible for and will enroll in the 90-day prerelease Medi-Cal services under the California Advancing and Innovating Medi-Cal (CalAIM) Justice-Involved Reentry Initiative. He will receive services before he is released from jail. After he has been released, Juan will also be eligible to receive Enhanced Care Management (ECM) through an ECM provider who will coordinate all his care postrelease.

During intake at the county jail, the jail intake coordinator (JIC) screens Juan to determine eligibility for prerelease services. The JIC completes the prerelease services eligibility information in the Justice-Involved Screening Portal (JI Portal) within 24 hours after the screening, including entering the prerelease services eligibility date, which is automatically sent to the California Statewide Automated Welfare System (CalSAWS). This information is then transmitted to the Medi-Cal Eligibility Data System (MEDS), which allows him to be assigned to a managed care plan (MCP). The MCP assigns a prerelease care manager (PRCM), who is staffed at the county jail, to provide prerelease services to Juan while he remains in jail. The MCP also assigns Juan an ECM provider to coordinate Juan's care postrelease. The PRCM and ECM provider review the prerelease screening and meet with Juan to conduct a new MCP enrollee screening. They also conduct an assessment as part of CalAIM's Population Health Management (PHM) Program because Juan is newly entering ECM.[1] Additionally, they work with Juan to develop a reentry care plan to support Juan's transition back into the community after he has been released.

Prior to his release, the PRCM conducts a behavioral health warm handoff that connects Juan to county behavioral health services (BHS). This warm handoff also includes Juan's ECM provider. During the warm handoff, Juan informs the BHS social worker, the PRCM, and the ECM provider that he does not have a place to stay after his release. Because of this situation and Juan's substance use, the BHS social worker, along with the ECM provider, determines that Juan could be eligible for substance use services (SUS) transitional housing, and they work to coordinate that placement for him.

Through coordination and access to data across his providers, Juan is connected to prerelease and postrelease services that allow him to integrate effectively back into the community. The ECM provider coordinating Juan's care can ensure that he is receiving all the services in his community. Juan is placed in SUS transitional housing, where he receives SUS, continued reentry planning, and transportation assistance through a community-based organization (CBO) contracted with the county behavioral health agency. From the jail's on-site pharmacy, through the Controlled Substance Utilization Review and Evaluation System, Juan will receive a 90-day supply of his medication to take with him upon release. He will continue to receive psychiatric, mental health, and SUS at the SUS transitional housing where he will be placed. Through this placement and the care that Juan receives, Juan can recover and stabilize in the community.

Goals

- Enroll Juan in health coverage 90 days prior to release.
- Connect Juan with ECM and postrelease services.
- Reduce recidivism and help Juan remain in the community.
- Connect Juan to SUS transitional housing.
- Help Juan manage his substance use and bipolar disorder conditions.

Assumptions

- The county has access to a universal consent form and a consent management service.
- The consent management service includes 42 C.F.R. part 2 data.
- The JI Portal is able to transmit data to the California Department of Health Care Services (DHCS), and DHCS is then able to transmit data back to jail staff.
- The JI Portal can share data with the BHS electronic health record (EHR) and the CBO EHR systems.
- The BHS EHR and CBO EHR have an application programming interface (API) to share data about Juan's ongoing care plan.

State Priorities

- Mental health
- CalAIM

Populations

- Mental health
- Substance use disorder
- Criminal/legal
- Housing and homelessness
- Eligibility and enrollment

Programs

- ECM
- Jail mental health
- Community mental health
- County behavioral health
- SUS transitional housing
- CalAIM Justice-Involved Reentry Initiative
- Medi-Cal eligibility and enrollment

Process Steps

1. Juan arrives at county jail and meets with the JIC.
2. During jail intake, the JIC screens Juan for Medi-Cal enrollment and eligibility for Medi-Cal prerelease services. The JIC enters the information into the JI Portal and walks Juan through the universal consent form, which Juan signs. The consent form is uploaded to the JI Portal, which transmits the completed form to a consent management service.
3. Juan's information is entered into the JI Portal and then is automatically transmitted to CalSAWS.
4. Juan's demographic information, eligibility determination, and aid code are uploaded from CalSAWS to MEDS.

5. MEDS triggers auto-assignment of an MCP and transmits the member eligibility file to the MCP portal.

6. DHCS mails Juan a notice of action confirming his Medi-Cal eligibility and alerts the JIC about the notice in the JI Portal.

7. Via transmission to the JI Portal, the MCP assigns a PRCM, who is staffed at the county jail.

8. The MCP assigns an ECM provider at a CBO and sends an alert to the CBO EHR. The MCP also requests that the ECM provider conduct a new enrollee screening and PHM assessment for Juan.

9. The PRCM and ECM provider meet with Juan in jail to conduct the new enrollee screening and assessment, to coordinate a care plan, and to link Juan to county BHS. The screening and assessment results are shared via the CBO EHR with the MCP.

10. The ECM provider sends a referral via the CBO EHR to the county BHS EHR.

11. The county BHS social worker uses the consent management service to confirm that Juan has authorized the sharing of his data and reviews Juan's behavioral health services received at the county jail and other records.

12. The BHS social worker conducts an assessment in jail and enters information into the county BHS EHR. The county BHS staff submit a prior authorization (PA) for BHS to the MCP.

13. The MCP approves. An automated alert is sent to notify the BHS EHR.

14. The BHS staff refer Juan to SUS within the BHS EHR.

15. The PRCM enters Juan's release date into the JI Portal, which sends an electronic notification to the MCP and the Department of Social Services (DSS) about Juan's release date.

16. The SUS provider uses the consent management service to confirm authorization to share data and reviews Juan's records in the BHS EHR.

17. Juan is released from jail and enters SUS transitional housing, and he continues to receive care coordination from the ECM provider.

Figure 1. Bridging Behavioral Health and Criminal Justice: A Coordinated Care Model

→ System-to-system data exchange or person-to-system interaction
- - → Person-to-person interaction or nonelectronic data exchange (e.g., mail, phone call, assessment)
Blue icons: Electronic systems involved in data exchange
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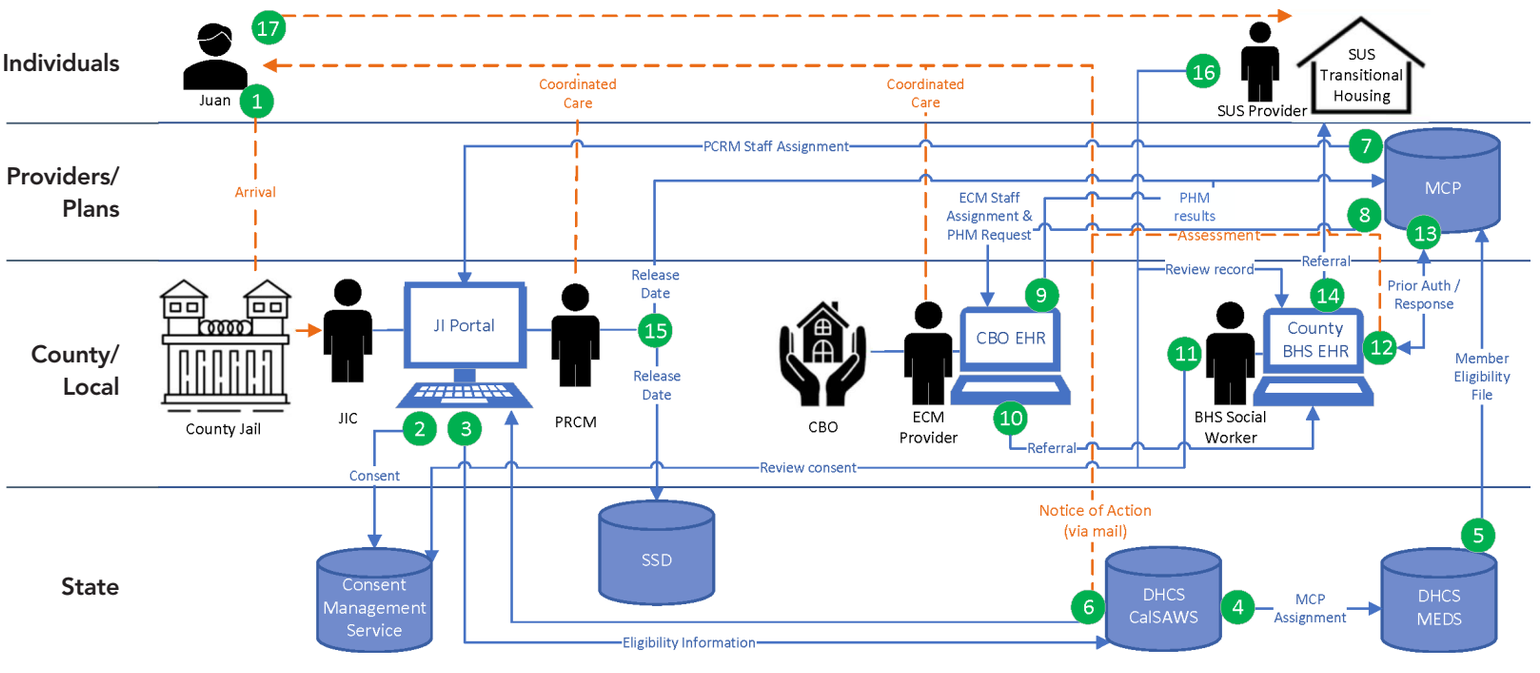
Juan: Mental Health and Criminal/Legal Involvement

Juan is a 36-year-old man serving time in county jail. He has co-occurring substance use disorder and bipolar disorder. He qualifies for prerelease services and will need to transition his care once released back into the community.



1. Juan arrives at county jail and meets with jail intake coordinator (JIC).

2. JIC screens Juan for Medi-Cal prerelease services within JI Portal. JIC walks Juan through the universal consent form in the JI portal, which is transmitted to the state consent management service after Juan signs.

3. Juan's information in the JI portal is automatically transmitted to CalSAWS for Medi-Cal enrollment.

4. Juan's demographic information, eligibility determination and aid code are uploaded from CalSAWS to MEDS.

5. MEDS triggers auto-assignment of MCP and transmits a member eligibility file to the MCP Portal.

6. DHCS mails notice of action confirming Medi-Cal eligibility to Juan and alerts JIC of the notice in the JI portal.

7. MCP assigns a prerelease care manager (PRCM) staffed at the county jail via a transmission to the JI Portal.

8. MCP assigns CBO-based Enhanced Care Management (ECM) provider via CBO EHR and requests a new enrollee screening and Population Health Management (PHM) assessment.

9. PRCM & ECM provider meet with Juan in jail to conduct the new enrollee screening and PHM assessment, coordinate a care plan, and link Juan to community supports and county BHS. Results are shared via the CBO EHR with the MCP.

10. County BHS receives referral from ECM provider via API between CBO EHR and County BHS EHR.

11. County BHS social worker reviews consent management system to confirm Juan has authorized the sharing of his data and reviews Juan's behavioral health services received at county jail.

12. County BHS social worker conducts assessment in Jail using County BHS EHR and submits prior authorization for BHS services to MCP.

13. MCP approves. An automated notification alert is sent to BHS EHR.

14. BHS social worker refers Juan to substance use services (SUS) within the BHS EHR.

15. PRCM enters Juan's release data into the JI portal, which sends an electronic notification to the MCP and Social Services Department of Juan's release date.

16. SUS provider reviews consent management service to confirm authorization to share data and reviews Juan's records in the BHS EHR.

17. Juan is released from jail and enters SUS transitional housing and receives care coordination from ECM provider.

Source: Developed by the authors and HLN consulting to depict the ideal state of data exchange based on focus group and advisory group feedback, August 22, 2025.

Win: Youth Mental Health

Narrative

Win is a 16-year-old nonbinary person who has experienced a suicide attempt. Win's mother takes them to the children's hospital psychiatric emergency department (ED), where Win spends the night and is assessed for ongoing risk of self-harm. Win's provider team has authorization to access Win's medical record and therefore knows that Win has been receiving gender-affirming support; the team can also see Win's preferred pronouns.

The hospital licensed clinical social worker (LCSW) obtains data sharing consent from Win's mother as they are a minor, and the hospital's third-party contracted Qualified Health Information Organization (QHIO) vendor platform receives real-time notification of Win's admission to the ED.[2] The QHIO sends notification of admission to Win's managed care plan (MCP), primary care provider (PCP), and gender-affirming care provider.

Based on Win's change in risk and level of care, the LCSW administers a Population Health Management (PHM) assessment on behalf of Win's MCP. Results from the assessment are uploaded via the QHIO to the MCP portal.

The LCSW contacts the county mental health plan (MHP) access point to request an in-person screening at the ED to determine an appropriate care plan for Win upon discharge.

A county LCSW administers behavioral health and suicidality screenings in person in the ED by using online assessment tools. Win's scores on the behavioral health and suicidality screenings are uploaded automatically to the county EHR and the QHIO. The scores indicate that it is safe for Win to return home with their mother and that they require psychiatric care from county specialty mental health services (SMHS). Win is referred to the youth system of care within the MHP to receive peer/group support and psychiatric services. Win is automatically assigned to a care manager (CM), who inputs a care plan into the county EHR. This action triggers the QHIO to share it with the MCP, the children's hospital, Win's PCP, and their gender-affirming care provider. Win is discharged from the ED, and the QHIO sends another admission, discharge, and transfer (ADT) alert to the parties above.

After Win begins to receive SMHS, their CM obtains permission (in compliance with Family Educational Rights and Privacy Act [FERPA] regulations) to alert the school-based mental health provider at Win's high school about the psychiatric event. The school-based mental health provider is added to Win's care team, and Win continues receiving services through the MHP. The school-based mental health provider invites the county CM and Win's gender-affirming care provider to be on Win's Individualized Education Plan (IEP) team to support Win's return to school.

Goals

- Ensure immediate and effective response to Win's acute psychiatric episode.
- Provide seamless and timely care coordination across mental and physical health systems, as well as between MCPs and county MHPs, schools, and other relevant parties.
- Provide culturally affirming care by using affirming and respectful terminology.
- Ensure that care providers in all settings are informed about transitions.
- Maintain and improve Win's health status and prevent exacerbation of Win's mental health condition.
- Support Win's return to school.

Assumptions

- A contracted QHIO provides data exchange on behalf of the children's hospital — executing data sharing agreements and conducting specific transactions with approved parties, including the MCP, MHP, PCP, gender-affirming care provider, and school-based mental health provider.
- The hospital ED has authority to view Win's medical record at the time of their admission to the ED.
- As Win is a minor, their mother has consented to data sharing between the parties (including FERPA consent to share data with the school).
- Relevant mental health data can be automatically uploaded to appropriate parties via the QHIO.
- Win already has an IEP at their high school.

State Priorities

- Youth mental health
- School-based mental health
- Data sharing via QHIOs

Populations

- Youth at risk
- Mental health

Programs

- SMHS
- School-based mental health

Process Steps

1. Win is admitted to the hospital ED by an LCSW, who uses the EHR to check Win's medical record.

2. The LCSW obtains permission (from Win's mother, because Win is a minor) from the hospital Release of Information (ROI) and from the consent management service (also in the EHR) for data to be shared with Win's PCP, MCP, gender-affirming care provider, and other providers as needed. The EHR automatically sends the admission alert and data sharing permission authorization to the contracted Qualifying Health Information Organization (QHIO) platform.

3. The QHIO electronically sends an ADT notification from its platform to Win's MCP, PCP, and gender-affirming care provider. The QHIO also facilitates authorized data sharing regarding Win's mental health episode, gender-related pronouns, and care considerations with Win's other providers.

4. Upon receipt of Win's ADT notification, the MCP sends a request to the hospital EHR via the QHIO for a provider to conduct a PHM assessment for Win.

5. The LCSW administers the PHM assessment and uploads the results to the QHIO platform.

6. The LCSW sends an electronic referral with relevant medical and mental health data from the hospital EHR to the county mental health plan (MHP) EHR via the QHIO platform. The referral requests that Win be assessed for specialty mental health services (SMHS) on-site in the ED.

7. The county MHP EHR returns confirmation of the referral request and assignment of a county LCSW to conduct an assessment at the ED.

8. The county LCSW administers mental health and suicidality screening assessments while Win is in the hospital ED by using online assessment tools in the county MHP EHR. The county LCSW enters a psychiatric diagnosis into the county MHP EHR, which triggers auto-assignment of Win's case to a county CM. The assessment results and diagnosis are uploaded to the QHIO platform.

9. The county care manager reviews Win's medical history in the MHP EHR and develops a care plan, which is uploaded to the QHIO and is sent to Win's other providers.

10. Win is discharged from the ED. The QHIO sends an ADT notification to Win's MCP, PCP, gender-affirming care provider, and county MHP.

11. In adherence with FERPA, the county care manager obtains Win's mother's consent in the county EHR for data related to Win's treatment and care coordination to be exchanged with the school-based mental health care provider (who contracts with a local CBO). Consent is automatically uploaded via an API from the county EHR to the QHIO.

12. The school-based mental health provider accesses relevant data from the QHIO via the CBO EHR.

13. The school-based mental health provider invites the county care manager and Win's gender-affirming care provider to be on Win's IEP team to support Win's return to school. All participants have access to the data that they require.

Figure 2. Connecting Systems for Youth Mental Health: From Crisis to Community Care

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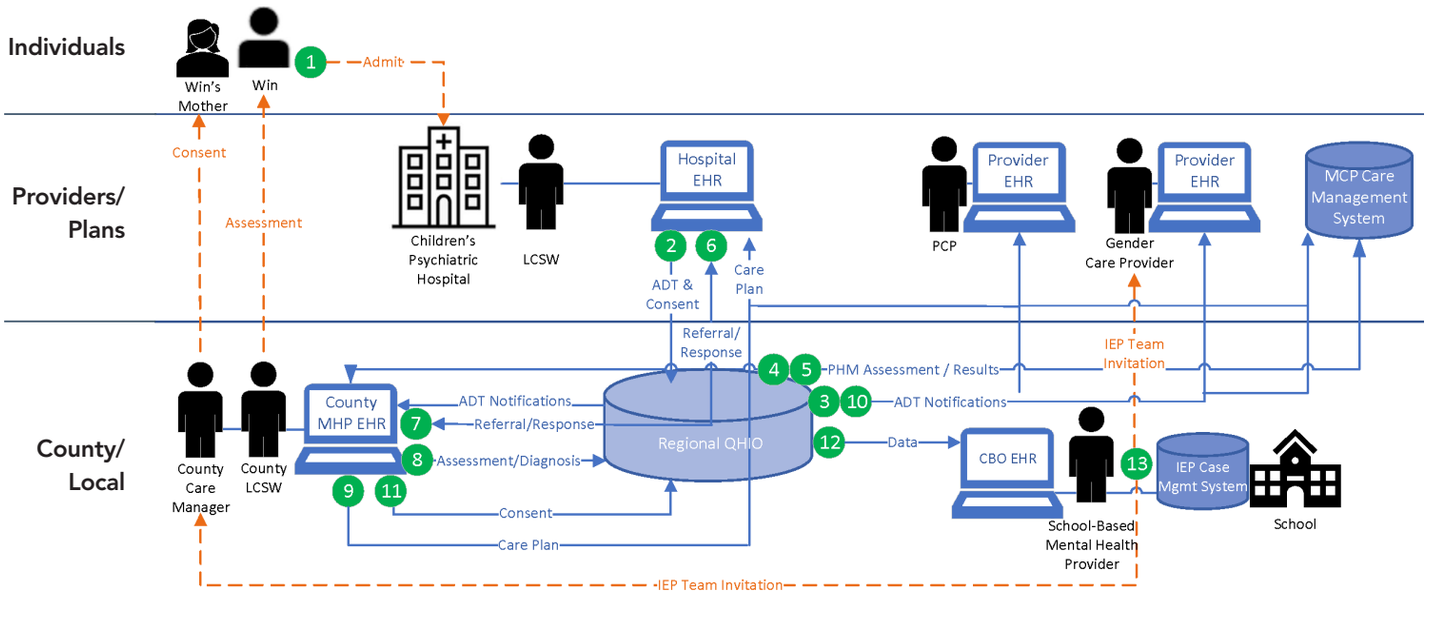
Win: Youth Mental Health

Win is a 16-year-old non-binary individual who experiences a suicide attempt. They are taken to the children's psychiatric emergency department for evaluation.



1. Win is admitted to Children's Psychiatric Emergency Department and meets with an LCSW, who uses the hospital EHR to check Win's medical record.

2. Hospital LCSW obtains consent for data to be shared with Win's PCP, MCP, and gender care provider. Hospital EHR sends admission alert and consent to regional QHIO.

3. QHIO sends an ADT notification of Win's encounter to Win's providers. The QHIO also facilitates authorized data sharing regarding Win's mental health episode and gender-related pronouns and care considerations to Win's providers.

4. MCP sends a request to the hospital EHR via the QHIO for a provider to conduct a PHM assessment for Win.

5. LCSW administers PHM assessment and uploads results to QHIO.

6. Hospital LCSW sends referral requesting Specialty Mental Health Service assessment from hospital EHR to county MHP EHR via QHIO.

7. County MHP EHR returns referral confirmation and assignment of County LCSW.

8. County LCSW administers assessments and enters psychiatric diagnosis into County MHP EHR, which assigns a county care manager (CM). Assessment results and diagnoses are sent to the QHIO.

9. County CM reviews Win's medical history and develops care plan in County MHP EHR, which is sent to the hospital EHR via the QHIO.

10. Win is discharged. QHIO sends event notification to Win's providers.

11. County CM obtains consent (per FERPA regs) from Win's mother to exchange data with School-Based Mental Health provider in the County MHP EHR, which is uploaded to the QHIO.

12. The school-based mental health provider accesses data from QHIO via the CBO EHR.

13. The school-based mental health provider invites county CM and Win's gender affirming care provider to be on Win's Individualized Education Plan (IEP) team.

Source: Developed by the authors and HLN consulting to depict the ideal state of data exchange based on focus group and advisory group feedback, August 22, 2025.

Eddy: Aging and Disability

Narrative

Eddy is a 62-year-old man with asthma and diabetes who is covered by a Medi-Cal MCP. He was diagnosed with autism spectrum disorder as a child. He lives with his daughter, Miranda, and has become increasingly fragile. A month ago, Eddy began using a wheelchair, and his care needs have become more complicated. He has also become anxious and increasingly depressed about his functional limitations.

At an appointment with his primary care provider (PCP) at Clinic XYZ, Eddy asks about the possibility of getting help at home. During the visit, the PCP recognizes that Eddy may have a qualifying condition (autism spectrum disorder) per the Lanterman Act that entitles him to services for intellectual and developmental disabilities. The PCP makes a referral to the local regional center (RC), transferring relevant clinical documentation from the clinic EHR to the RC eligibility and intake system (EIS). Eddy is approved for in-home respite services, and he and Miranda secure a respite provider.

After his appointment, Eddy and Miranda meet with the clinic's caseworker, who sends a real-time request to Eddy's MCP asking for approval for enrollment in Enhanced Care Management (ECM) under the Adults Living in the Community and At Risk for LTC Institutionalization Population of Focus. Eddy also meets the criteria for certain Community Supports (CS), and the caseworker submits authorization for those services at the same time. Because Clinic XYZ is a contracted ECM provider, the caseworker begins to assess Eddy's options for support while he is there in person and while they wait for MCP approvals.

Two days later, Clinic XYZ receives approval from the MCP for Eddy to receive 12 months of ECM and to receive specific CS. Because Eddy is newly entering ECM, Eddy's MCP requests that the case worker, who is appointed as the ECM Lead Care Manager (LCM), conduct a Population Health Management (PHM) assessment for Eddy. The LCM calls Eddy to conduct the assessment and, using a closed-loop referral (CLR) system, completes by phone the process that they had started in person.

The following referrals are made to various entities:

- **Local Area Agency on Aging (AAA)** for Eddy to receive Options Counseling, a service offered through the Aging and Disability Resource Connection to identify goals and needs and to coordinate counseling and emotional support services in the community.
- **A Community Supports (CS) subcontractor** for Eddy to receive services for home modifications to add a wheelchair ramp and shower grips to his home.
- **County Department of Social Services (DSS) In-Home Supportive Services (IHSS)** for authorization for Eddy to receive assistance with housecleaning and with personal care services to assist with showering.

A week later, Eddy's LCM is alerted by the CLR system that Eddy has met with the AAA options counselor and is connected with a social support group to address anxiety.

The LCM assigns Eddy to a home-modification subcontractor, who schedules the ramp and shower-grip installation. Two weeks later, the LCM receives an alert that the ramp and grips have been successfully installed.

The LCM helps Eddy to complete an online IHSS application and then contacts Miranda to help her

remotely complete an online IHSS program provider enrollment application. Miranda later completes the required fingerprinting to become an IHSS certified provider and responds to a text query from the LCM about the status of her application.

Goals

- Support Eddy's medical and social needs.
- Provide Eddy with group counseling and social-emotional support to address the anxiety that he is feeling about his new functional status.
- Provide timely in-home assistance and the services needed to manage Eddy's chronic care, social needs, and activities of daily living.
- Provide supports to allow Eddy to remain safely in his home.
- Prevent adverse outcomes, including falls and a worsening of his anxiety and depression.
- Keep Eddy and his daughter apprised of steps and outcomes via access to the member portal of the closed-loop referral system.

Assumptions

- MCPs are not required to obtain member (or parent, guardian, or caretaker) authorization (in writing or otherwise) for data sharing as a condition of initiating delivery of ECM (from the ECM Policy Guide).
- The clinic is a contracted ECM provider.
- A statewide standardized ECM-CS referral form exists.
- The caseworker has access to a fully enabled CLR platform with bidirectional data sharing capability.
- Closed-loop referrals (CLRs) entail evidence of delivery of service notifications to the referring entity.
- A CLR system is a comprehensive database of programs and services that are available to clients.
- Other providers (AAA) and vendors (county-based Community Support vendors) have permission-based access to the CLR via a web-based portal to view and to enter specific data.
- There is an API between the clinic EHR and the MCP ECM authorization portal.
- There is an API between the clinic EHR and the Regional Center Eligibility and Intake System.
- The CLR platform has a member/patient portal for Eddy to track referrals himself.
- The CLR platform has an interface to the clinic EHR to share data on the status of a referral for inclusion in the patient's medical record.
- A local AAA provides Aging and Disability Resource Connection services.
- It is possible to apply online for all the necessary services and programs.
- Eddy has reliable internet bandwidth at home.
- Eddy is not receiving Section 1915(c) waiver services, and he is therefore eligible to receive both ECM and Regional Center services.

State Priorities

- Aging and disability

Populations

- Aging and disability

Programs

- ECM
- RC services
- IHSS
- Aging and Disability Resource Connection services
- CalAIM Community Supports

Process Steps

1. Eddy visits his PCP and inquires about getting help at home.

2. The PCP refers Eddy to the local Regional Center (RC) for respite services, transferring relevant clinical documentation from the clinic EHR to the RC Eligibility and Intake System (EIS).

3. RC staff conduct an intake; an RC service coordinator contacts Eddy to conduct a needs assessment (in the EIS).

4. The RC EIS sends approval for RC respite services to the clinic EHR.

5. The clinic EHR automatically notifies the MCP ECM-CS system about the RC respite services approval.

6. Miranda searches the RC provider directory and finds a respite provider who works for a CBO contracted with the RC.

7. The PCP refers Eddy to an internal clinic caseworker (CCW).

8. The clinic case worker (CCW) uses the clinic EHR to send an electronic authorization request for ECM and CS to the MCP ECM-CS portal.

9. The MCP returns the Member Information File (MIF) with a utilization history, authorizing Eddy's enrollment in ECM and assigning him to the clinic ECM LCM.

10. The MCP returns member authorization to the clinic EHR for the installation of shower grips and a wheelchair ramp at Eddy's home.

11. The MCP requests that the LCM conduct a PHM assessment for Eddy. Results from the assessment are sent to the MCP via the clinic EHR.

12. The LCM uses the EHR to submit a referral request via the closed-loop referral (CLR) platform to the Area Agency on Aging (AAA) for counseling support.

13. The AAA case manager uses the CLR portal to send the LCM a referral receipt and closure notification (assignment to a social-emotional support group). Disposition is automatically uploaded from the CLR portal to the clinic EHR and the MCP portal via an API.

14. The LCM uses the CLR portal to connect Eddy with a CS subcontractor for installation of shower grips and a wheelchair ramp.

15. The CS subcontractor uses the CLR portal to notify the LCM of referral receipt and, after the work is complete, sends a closure notification to the LCM. Disposition is automatically uploaded from the CLR portal to the clinic EHR and the MCP portal.

16. The LCM uses the clinic EHR to directly submit data to the county department of social services (CDSS) IHSS application portal.

17. The LCM assists Miranda via Zoom in completing the online IHSS provider application for Miranda to become an IHSS provider:

18. Miranda creates her own account in the online application and successfully submits the required information to the DSS IHSS eligibility system.

19. The LCM follows up with Miranda by text to inquire about the outcome.

20. Miranda texts that she has been approved. The LCM notes it in the EHR.

21. Notification of approval for 65 hours of services per month is sent to the clinic EHR and MCP portal from the DSS IHSS system.

Global step (G). Eddy has access to a member-facing CLR portal to check the status of the referrals made on his behalf and to confirm scheduling with the CS subcontractor about installation of shower grips and a wheelchair ramp.

Figure 3. Bridging Medical and Community Services for Aging Populations

→ System-to-system data exchange or person-to-system interaction
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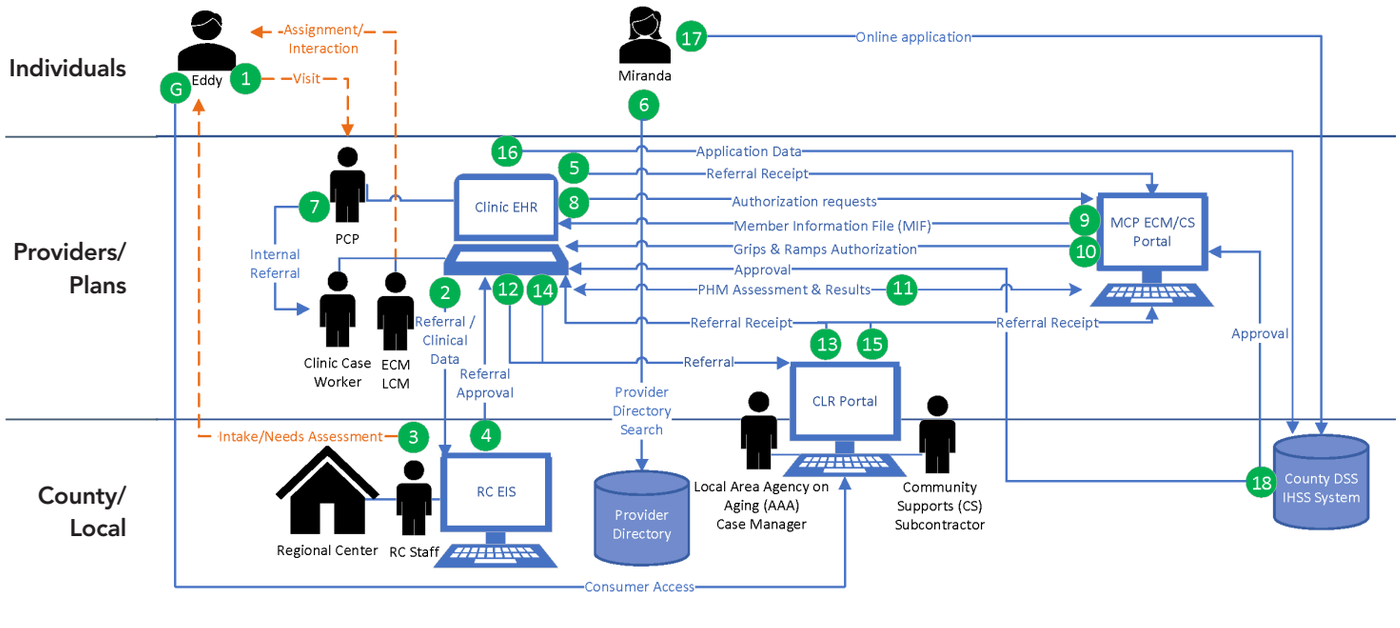
Eddy: Aging and Disability

Eddy is a 62-year-old man with several chronic conditions, including autism. He needs support services to live a quality life independently. His daughter, Miranda, helps him.



1. Eddy visits PCP and inquires about getting help at home.

2. PCP uses EHR to refer Eddy to a local Regional Center (RC) for respite services and share clinical documentation to the RC Eligibility and Intake System (EIS).

3. RC staff conduct intake. RC service coordinator conducts needs assessment in EIS.

4. RC EIS sends approval for RC respite service referral to clinic EHR.

5. Clinic EHR automatically notifies the MCP ECM/Community Supports (CS) Portal of the respite service referral approval.

6. Miranda searches RC provider directory and finds respite provider who works for a CBO contracted with the RC.

7. PCP refers Eddy to an internal clinic case worker (CCW).

8. CCW uses EHR to send authorization requests for ECM and CS to the MCP portal.

9. MCP returns member information file (MIF) with utilization history authorizing enrollment and assigning Eddy to clinic ECM Lead Care Manager (LCM).

10. MCP returns authorization for installation of grips & ramps.

11. MCP requests LCM conducts PHM assessment for Eddy. Results from assessment are sent to the MCP via the clinic EHR.

12. LCM uses EHR to submit referral to AAA for counseling support via CLR.

13. AAA case manager uses CLR portal to 1) send referral receipt and 2) closure upon assignment of Eddy to a social emotional support group to the EHR and MCP.

14. LCM uses EHR to submit referral to CS subcontractor to install grips & ramps via CLR.

15. CS subcontractor uses CLR Portal to 1) send referral receipt and 2) closure upon completion to the EHR and MCP.

16. LCM sends application data to County DSS In Home Support Services (IHSS) System via an API from the EHR.

17. LCM helps Miranda (Eddy's daughter) complete online IHSS provider application.

18. Notification of approval for 65 hours of services per month is sent from County DSS IHSS System to the EHR and MCP.

G. Eddy has access to a member-facing CLR portal to check the status of referrals made on his behalf and confirm scheduling with the CS subcontractor installing grips and ramps.

Source: Developed by the authors and HLN consulting to depict the ideal state of data exchange based on focus group and advisory group feedback, August 22, 2025.

Imani: Aging and Disability and Housing

Narrative

Imani is a 68-year-old woman who is currently experiencing homelessness. Previously, she shared a home with two other housemates and worked part-time; however, a recent chronic illness and associated injury meant that she could not hold on to her employment and could no longer afford rent. For the past three years, Imani has been in and out of shelters and programs but has had no consistent housing. Without stable housing, she has had difficulty keeping up with her medication and getting adequate health care. As her illness progresses, Imani is in need of more supportive care, including housing and health care.

Imani goes to her local Coordinated Entry (CE) Access Point, operated by a CBO that is contracted with the county social service department, to be assessed for eligibility for housing services. The CE social worker conducts a housing assessment to determine the type of support and housing intervention that may be most beneficial to improve Imani's long-term housing outcome. The housing assessment is integrated into the Homeless Management Information System (HMIS). Based on Imani's responses to the housing assessment, Imani is determined to be eligible for senior Permanent Supportive Housing (PSH). The social worker refers Imani to the county housing program that oversees the PSH portfolio and shares the outcome of Imani's assessment via the HMIS.

The CE social worker also learns that Imani does not have health coverage and knows that Imani is likely eligible for both Medicare and Medi-Cal coverage. The CE social worker uses a closed-loop referral (CLR) portal to refer Imani to the local Area Agency on Aging (AAA) at the DSS to receive assistance in applying for Medicare via the Health Insurance Counseling and Advocacy Program (HICAP). Imani is also referred internally to an out-stationed county eligibility worker to obtain assistance with enrollment in Medi-Cal.

The county eligibility worker transmits Imani's information through the CA Statewide Automated Welfare System (CalSAWS) to the Medi-Cal Eligibility System (MEDS), which allows Imani to be assigned to a managed care plan (MCP). After Imani's enrollment, the CE social worker conducts a new MCP enrollee screening and assessment for Imani as part of the Population Health Management (PHM) program. Results from the screening and assessment are shared via the HMIS to the MCP portal.

Imani is placed into PSH with on-site medical staff from the county public health department. Her condition is improving, and her PSH case manager is hoping that Imani will eventually be able to step down from her current level of care and begin to receive health care and other services in the community. Imani is beginning to receive much of her health care through the local Federally Qualified Health Center (FQHC). The PSH medical care team is able to provide the FQHC with access to Imani's health records through their EHR and via the consent form that Imani completed.

Goals

- Place Imani into senior PSH with health care on-site.
- Get Imani enrolled in Medicare and Medi-Cal coverage.
- Stabilize Imani's health condition.

Assumptions

- There is immediate availability for a placement in senior PSH that includes on-site medical staff from the county public health department.
- The county has access to an electronic universal ROI form that is accessible and shared with other county eligibility and public health offices as needed to provide services.
- The county has access to a consent management service to confirm ROI access rights.
- The housing placement manager and Coordinated Entry social worker work for the same social services–housing department.
- A county eligibility worker is staffed at Coordinated Entry to assist with benefits.
- An API exists between the PSH EHR and the MCP eligibility system.
- An API exists between the HMIS and the PSH EHR.
- A closed-loop referral system is available to refer Imani to an Area Agency on Aging for assistance with enrolling in Medicare.
- Social services and noncovered entities have a business associate agreement with the covered entity and are therefore complying with HIPAA (Health Insurance Portability and Accountability Act) when they receive health information.
- Closed-loop referrals (CLRs) entail evidence of delivery of service notifications to the referring entity.
- A CLR system is a comprehensive database of programs and services that are available to clients.

State Priorities

- Housing and homelessness
- Aging and disability

Populations

- Housing and homelessness
- Aging and disability
- Eligibility and enrollment

Programs

- Coordinated Entry Access Points
- Permanent Supportive Housing
- Medi-Cal and Medicare (dually eligible)
- PSH public health medical team

Process Steps

1. Imani goes to a community-based Coordinated Entry (CE) Access Point seeking housing assistance.
2. The CE social worker conducts a housing assessment in the HMIS and walks Imani through completing a universal consent form. Imani then signs the consent form, and it is uploaded to the HMIS.
3. The CE social worker refers Imani to a housing placement manager (HPM) via the HMIS.
4. The CE social worker refers Imani to an out-stationed county eligibility worker (CEW) via a warm handoff on-site. The CEW submits Imani's Medi-Cal application to CalSAWS.
5. Imani's demographic information, eligibility determination, and aid code are transmitted from CalSAWS to MEDS.

6. MEDS notifies Imani's chosen MCP about her new member enrollment.

7. The MCP sends the CE social worker a request for a new MCP enrollee screening and PHM assessment. Results from the screening and assessment are sent from the HMIS to the MCP.

8. The CE social worker sends a referral, by using a closed-loop referral (CLR) portal to the Health Insurance Counseling and Advocacy Program (HICAP) at the county department of social services (DSS) for Imani to get assistance in applying for Medicare.

9. DSS Area Agency on Aging (AAA) staff use the CLR to notify the CE social worker about receipt of the referral. AAA staff contact Imani and send a referral closure notification in the CLR to the CE social worker.

10. The HPM receives an alert in the HMIS about the referral (step 3). The HPM (a) reviews Imani's HMIS record, (b) calls Imani to establish an appointment, then (c) discusses housing options at her appointment.

11. The HPM submits a Permanent Supportive Housing (PSH) referral by using the HMIS.

12. The CBO operating the PSH reviews the referral in the HMIS and assigns a CBO PSH case manager in the HMIS.

13. The CBO PSH case manager contacts Imani to perform intake and develops a care plan.

14. The CBO PSH case manager refers Imani to a CBO PSH on-site medical care team, who conduct intake and document her information in the CBO PSH EHR.

15. The CBO PSH medical care team submits a prior authorization (PA) request to the MCP for ongoing services.

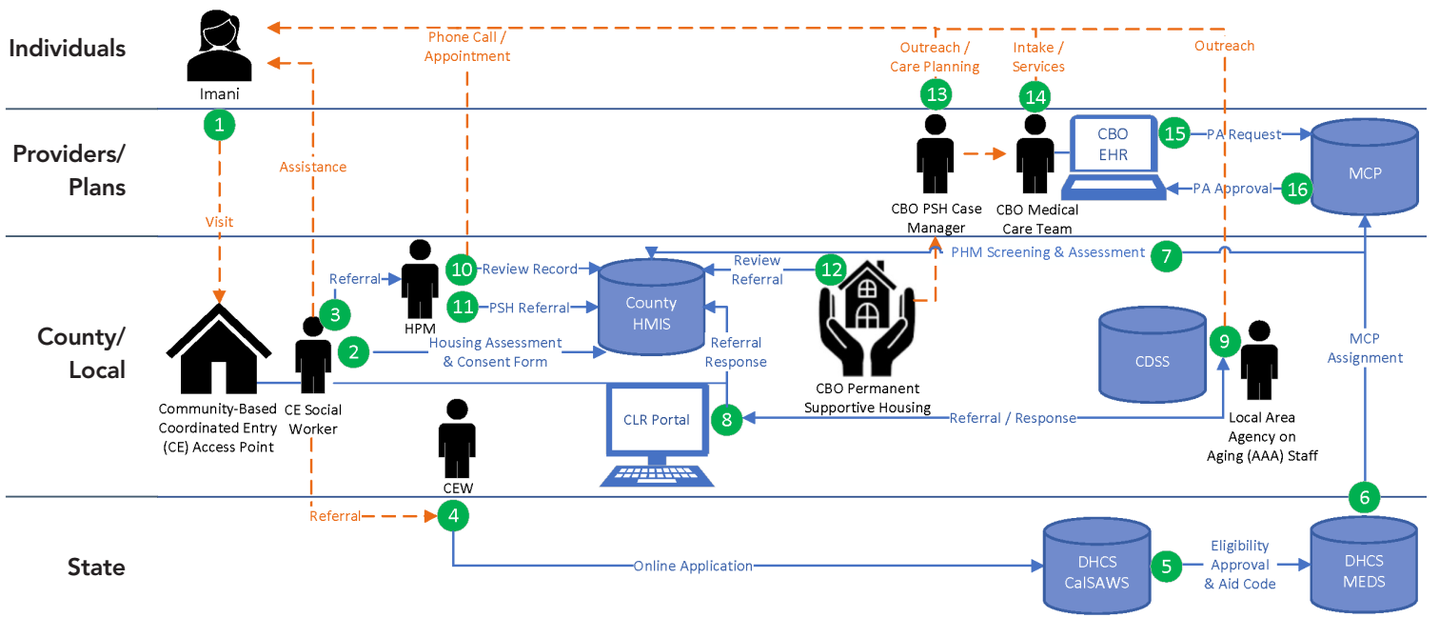
16. The MCP reviews and approves the PA, and sends a Member Information File (MIF) to the CBO EHR, allowing the CBO PSH case manager and the CBO PSH medical care team to provide tailored services to Imani on-site.

Figure 4. Connecting Health, Disability, and Housing Services for Vulnerable Populations

→ System-to-system data exchange or person-to-system interaction
- - → Person-to-person interaction or nonelectronic data exchange (e.g., mail, phone call, assessment)
Blue icons: Electronic systems involved in data exchange
Black icons: People, organizations, or entities implicated in data exchange

Imani: Aging and Disability and Housing

Imani is a 68-year-old woman currently experiencing homelessness. She has a recent chronic illness and associated injury. As her illness progresses, Imani is in need of more supportive care, including housing and healthcare.



1. Imani visits community-based Coordinated Entry (CE) Access Point seeking housing assistance.

2. CE social worker conducts housing eligibility assessment in County HMIS system and walks Imani through completing a universal consent form, which is then signed and uploaded into the HMIS.

3. CE social worker refers Imani to housing placement manager (HPM) via the HMIS.

4. CE social worker refers Imani to out-stationed county eligibility worker (CEW) via warm handoff onsite. The CEW submits Imani's Medi-Cal application into CalSAWS.

5. CalSAWS transmits eligibility approval and aid code to MEDS.

6. MEDS notifies Imani's chosen MCP of new member enrollment.

7. MCP sends request for new MCP enrollee screening and PHM assessment to CE social worker. Results from screening and assessment are sent from HMIS to MCP.

8. CE social worker sends referral using CLR portal to the Health Insurance Counseling and Advocacy Program (HICAP) at the CDSS for assistance with applying for Medicare.

9. AAA staff use CLR to notify CE social worker of receipt of referral. AAA staff reach out to Imani and send referral closure notification in CLR to CE social worker.

10. HPM receives alert in HMIS of the referral and a) reviews Imani's HMIS record, b) calls Imani to establish appointment, then c) discusses housing options at her appointment.

11. HPM submits Permanent Supportive Housing (PSH) referral using HMIS system.

12. CBO reviews referral in HMIS and assigns CBO PSH case manager.

13. CBO PSH case manager outreaches to Imani to perform intake and develop care plan.

14. CBO PSH case manager refers Imani to CBO PSH onsite medical care team, who conducts intake and documents in CBO EHR.

15. CBO PSH medical care team submits prior authorization request for ongoing services to MCP.

16. MCP reviews, approves prior authorization, and sends member information file (MIF) to CBO EHR, allowing the CBO PSH case manager and CBO PSH medical care team to provide tailored services to Imani onsite.

Source: Developed by the authors and HLN consulting to depict the ideal state of data exchange based on focus group and advisory group feedback, August 22, 2025.

Kayla: Maternal and Child Health and Housing Support

Narrative

Kayla is a 29-year-old Black woman in her fourth month of pregnancy. She is covered by Medi-Cal, receives CalFresh, and is currently housed but at risk of experiencing homelessness. At her first prenatal care appointment at Clinic A, Kayla signs a universal consent form that is submitted to a consent management service. Her ob/gyn provider refers her for the ECM Birth Equity Population of Focus, which will provide comprehensive, whole-person care management. The clinic staff submit a universal ECM referral form from the clinic EHR to the local managed care plan (MCP) portal for review and approval. The MCP reviews the form and assigns the clinic of origin as the ECM provider, which then assigns an ECM Lead Care Manager (LCM) to coordinate supports and services for Kayla. The MCP sends the ECM provider a notice via a Member Information File (MIF) to the clinic EHR within five days of assignment, with confirmation of Kayla's eligibility and enrollment into the program throughout the duration of her pregnancy and up to 12 months postpartum. Because Kayla is entering ECM, the MCP requests a Population Health Management (PHM) assessment for Kayla.

The LCM meets with Kayla to conduct the PHM assessment and to identify available supports for Kayla based on her needs. The LCM learns that Kayla is at risk of eviction due to late rent payments. The LCM makes an immediate referral to the local Coordinated Entry (CE) office to see whether Kayla qualifies for housing supports, such as rental assistance. A social worker at CE receives the referral, and the LCM and CE staff meet with Kayla to review what she is eligible for. After completing the steps in a local housing assessment tool, the CE staff determine that Kayla is eligible for rental assistance and submit the application for approval.

The LCM also shares Kayla's contact information with the local WIC agency for enrollment in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The LCM also helps Kayla enroll in the Black Infant Health Program at the clinic. The BIH Program will provide prenatal group sessions, case management, and skills-based interventions.

Kayla is able to receive rental supports through CE, which enable her to pay only one-third of her monthly income toward rent, while the local housing agency pays the difference.

The LCM continues to meet with Kayla to coordinate her care. Through these supports and data sharing between her care providers, Kayla is able to stay in her apartment without fear of eviction, and she can receive the prenatal care and supports that she needs to have a safe and healthy pregnancy.

Goals

- Prevent Kayla from losing her housing.
- Provide Kayla with all the necessary prenatal and postpartum support services that are available to her.
- Help ensure that Kayla delivers a healthy baby and has supports in place for the early months as a new parent.

Assumptions

- Real-time electronic referrals can be made from a clinic EHR to a housing and homeless program.
- A statewide standardized ECM-CS referral form exists.
- There are a universal consent form and a consent management service that all providers have access to.
- Data can be shared electronically with the local WIC agency from the community clinic.
- It is possible to apply for the Black Infant Health Program online, and personally identifiable information from the community clinic EHR can be shared with this program's database.
- There is a Maternal, Child, and Adolescent Health (MCAH) system that can serve as a referral and enrollment portal for all MCAH services.
- Social services and noncovered entities have a business associate agreement with the covered entity and are therefore complying with HIPAA when they receive health information.

State Priorities

- Housing and homelessness

Populations

- Maternal and child health
- Housing and homelessness

Programs

- Women, Infants, and Children
- Black Infant Health Program
- CalAIM Enhanced Care Management (ECM) Birth Equity Population of Focus
- Coordinated Entry

Process Steps

1. Kayla has her first prenatal care appointment with an ob/gyn.
2. The ob/gyn staff help Kayla with a universal ROI and submit it to the consent management service.
3. The ob/gyn staff send an ECM referral for Kayla from the clinic EHR to the MCP portal.
4. The MCP reviews and approves the referral for ECM and assigns the clinic of origin as the ECM provider by sending Member Information File to the clinic EHR. The MCP also requests a PHM assessment for Kayla.
5. The ECM provider assigns the Lead Care Manager (LCM), who is alerted about the referral in the clinic EHR.
6. The LCM meets with Kayla to conduct the PHM assessment and to assess Kayla's needs. The LCM notifies the MCP via the MCP portal about the assessment results and that Kayla is receiving ECM services.
7. The LCM sends a referral to Coordinated Entry (CE) for housing supports via an API between the clinic EHR and the CE HMIS.
8. A CE staff member contacts Kayla and completes the eligibility screening and application for rental assistance in the HMIS.
9. The status of the CE rental assistance referral is shared back to the LCM via the clinic EHR from the HMIS and to the MCP via the MCP portal.
10. The LCM informs WIC staff about Kayla's ROI, and the WIC staff use the consent management service to receive Kayla's ROI and contact information into the WIC Web Information System Exchange via an API.

11. The CE staff send an email to Kayla confirming that she will receive rental assistance.

12. WIC staff contact Kayla and complete her virtual intake over a videoconferencing platform.

13. The WIC Web Information System Exchange sends a confirmation that Kayla received WIC services to the clinic EHR and notifies the MCP.

14. The LCM sends data from the EHR to the Maternal, Child, and Adolescent Health system.

15. The MCAH system sends confirmation of enrollment to the EHR and notifies the MCP.

16. MCAH staff provide services to Kayla.

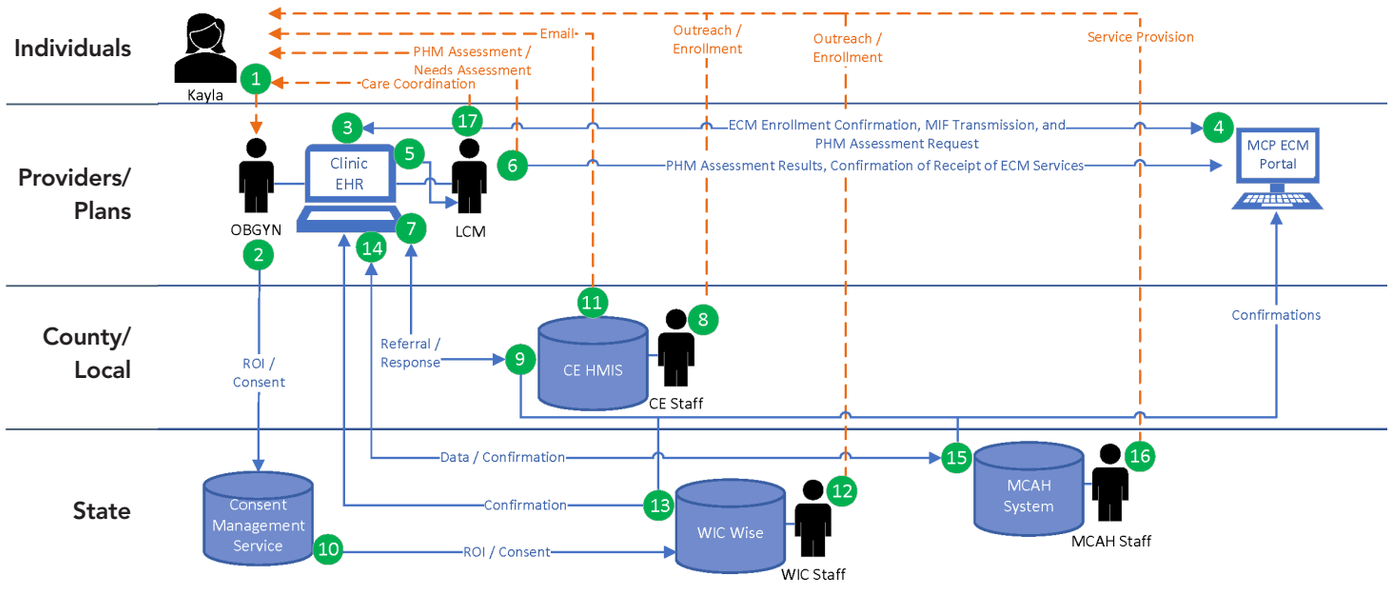
17. The LCM continues to coordinate care for Kayla, and Kayla is able to remain in her apartment.

Figure 5. Bridging Clinical, Social, and Housing Supports for Expectant Parents

→ System-to-system data exchange or person-to-system interaction
- - → Person-to-person interaction or nonelectronic data exchange (e.g., mail, phone call, assessment)
Blue icons: Electronic systems involved in data exchange
Black icons: People, organizations, or entities implicated in data exchange

Kayla: Maternal/Child Health and Housing Support

Kayla is a 29-year-old Black woman in her fourth month of pregnancy. She is covered by Medi-Cal, receives CalFresh, and is currently housed but at risk of experiencing homelessness.



1. Kayla has first prenatal care appointment with OBGYN.

2. OBGYN staff helps Kayla with a universal Release of Information (ROI) and submits it to the consent management service.

3. OBGYN sends an ECM referral for Kayla from the clinic EHR to the MCP portal.

4. MCP reviews and approves referral for ECM and assigns the clinic of origin as the ECM provider by sending MIF to clinic EHR. MCP also requests a PHM assessment.

5. ECM provider assigns a lead care manager (LCM) who is alerted of referral in the clinic EHR.

6. LCM meets with Kayla to conduct the PHM assessment and assess her needs. LCM notifies MCP via the MCP portal that Kayla is receiving ECM services.

7. LCM sends referral using EHR to CE Homeless Management Information System (HMIS) for housing supports.

8. CE staff reaches out to Kayla to complete eligibility screening and application for rental assistance in the HMIS.

9. Status of CE rental assistance referral is shared back to LCM via clinic EHR from HMIS and to the MCP via the MCP portal.

10. LCM informs WIC staff of Kayla's ROI and WIC staff uses consent management service to receive Kayla's ROI and contact information into WIC Wise via an API.

11. CE staff sends email to Kayla confirming she will receive rental assistance.

12. WIC staff contact Kayla and completes virtual intake via video conferencing.

13. WIC Wise sends a confirmation that Kayla received WIC services to the clinic EHR and notifies the MCP.

14. LCM sends data from EHR to Maternal, Child, and Adolescent Health (MCAH) system.

15. MCAH system sends confirmation of enrollment to EHR and notifies the MCP.

16. MCAH staff provide services to Kayla.

17. LCM continues to coordinate care for Kayla and Kayla is able to remain in her apartment.

Source: Developed by the authors and HLN consulting to depict the ideal state of data exchange based on focus group and advisory group feedback, August 22, 2025.

Ben: Infectious Disease

Narrative

Ben, a 54-year-old man who is unhoused, arrives at Hospital A with a high fever, abdominal pain, and nausea. He is tested at the lab at Hospital A. The lab processes the test for Ben and determines a positive result for HepA. Because HepA is a reportable condition, the positive result is sent to the county public health agency as an electronic laboratory report (ELR). Based on the positive result, the EHR at the hospital sends an electronic initial case report (eICR), with additional information from the patient's visit, to the county public health agency.

As the county and state public health agencies receive more data about additional cases, as well as data from other sources (such as wastewater, environmental data, and point-of-care testing), they discover an unusual increase of HepA cases in the county. By combining the information from ELR and eICR data, they determine that many of the cases have arisen in the unhoused population. By using the California Health Alert Network (CAHAN), the state public health agency sends a health alert message to health care providers in the area, recommending that people who are unhoused be vaccinated for HepA. The county public health agency alerts the local homelessness response system (HRS) about the HepA outbreak and requests that outreach be made in the community by HRS and Coordinated Entry (CE). HRS outreach workers and a CE Access Partner go into the community to provide support and to conduct assessments and potential referrals for any people who are unhoused. Assessments and eligibility determinations are entered into the county Homelessness Management Information System (HMIS). At the same time, the county public health agency initiates contact tracing activities.

When it is discovered that a staff member at a local shelter is also infected, HRS collaborates with the county public health agency to inform medical providers that the point of transmission likely occurred in one of the local shelters. By using the HMIS, the county public health agency and the Continuum of Care are able to identify all the people who were at the shelter during the potential transmission time period. The system also helps the county public health agency provide outreach to those people based on the contact information in the HMIS, assign them to vaccination or clinical sites, and arrange for isolation and quarantine when applicable. Medical providers query their EHR to generate and download from the HMIS a list of targeted people who need vaccinations. In addition, adhering to protocol, shelter staff are vaccinated by their own provider(s) as a means of preventing further outbreak in the homeless facilities.

As patients are treated and case investigations are conducted by public health, public health staff query the California Immunization Registry (CAIR2) to determine whether the patients are up-to-date on their HepA immunizations; if not, they are offered vaccinations, and the dose provided is reported to CAIR2. The county public health agency partners with the local Continuum of Care to set up vaccination clinics at the shelter where the outbreak is occurring. As the investigations continue, a query is sent from public health to the hospital EHR to look for updates to the case (e.g., hospitalization of a patient or death), and the disease surveillance system is updated with the information. When vaccines are administered, immunization information is sent by the vaccination clinic to CAIR2, allowing them to monitor the immunization coverage, to identify pockets of need for HepA immunizations, and to monitor the progress of the vaccination campaign.

In addition to contact tracing and immunization efforts, CAHAN is used to notify other departments (such as Public Works) to put mitigation efforts in place (such as sanitation) in the homeless community to stop further spread.

Goals

- Achieve timely detection and reporting of cases.
- Link data from multiple sources to estimate the prevalence of disease among a vulnerable population.
- Continue monitoring to identify new cases.
- Prevent further spread of a preventable disease among a vulnerable population, including isolation of infectious cases.
- Maintain an updated vaccine registry to assist in mass vaccination and prophylaxis efforts.

Assumptions

- Public health receives ELRs regularly.
- Clinics and hospitals regularly send electronic case reports on HepA to public health.
- Public health receives electronic initial case reports (eICRs) in its disease surveillance system.
- Public health has the capacity (policy-wise and technically) to query for additional information from an EHR on patients for whom they have received ELRs or eICRs.
- Identity matching between the HMIS, CAIR2, EHRs, and state disease surveillance data are possible.
- Outreach workers have (read-only) authorization to see a person's immunization history.
- Immunization administrators enter immunization records into their EHR.
- All administered vaccinations are required to be reported to the state (CAIR2).
- The HMIS is capable of responding to bulk Fast Healthcare Interoperability Resources queries from the EHR.
- Shelter staff demographic and health data are maintained in their providers' EHRs, and vaccination event information is reported to CAIR2.
- The HRS can be trained on HepA disease spread mitigation and how to assess risk to self and others in a timely fashion.
- Recuperative care is a service that is available in the jurisdiction.

State Priorities

- Housing and homelessness
- Vaccination coverage

Populations

- Infectious disease
- Housing and homelessness

Programs

- California Health Alert Network (CAHAN)
- Public health disease surveillance programs
- Homelessness Response System
- Coordinated Entry

Process Steps

1. Ben arrives at the hospital and tests positive for HepA.

2. The result triggers transmission of an electronic lab report (ELR) from the laboratory to county public health.

3. The lab result is received in the hospital's EHR, which triggers an automatic electronic initial case report (eICR) to the county public health disease surveillance system.

4. County public health sends case information to the state disease surveillance system. County and state public health agencies monitor data from multiple facilities and for multiple patients, as well as from other data sources (such as wastewater), and detect a trend.

5. State public health uses CAHAN to message providers about vaccinating people who are unhoused for HepA.

6. The county disease surveillance system receives additional data from the EHR about infected people.

7. County public health alerts the homelessness response system (HRS) about the HepA outbreak.

8. HRS goes into the community and enters assessments and eligibility determinations into the county Homeless Management Information System (HMIS).

9. The provider EHR queries the HMIS for a list of people who are targeted for vaccination.

10. County public health conducts contact tracing on people who are at risk for HepA.

11. The provider EHR queries CAIR2 for vaccination history and people who need the HepA vaccine are offered vaccination.

12. The provider EHR sends vaccine administration information to CAIR2.

13. CAIR2 is used to identify pockets of need for the HepA vaccine.

14. CAHAN sends alerts to other systems (e.g., Public Works).

15. Ben is treated by the hospital provider and is discharged to recuperative care after he is no longer infectious.

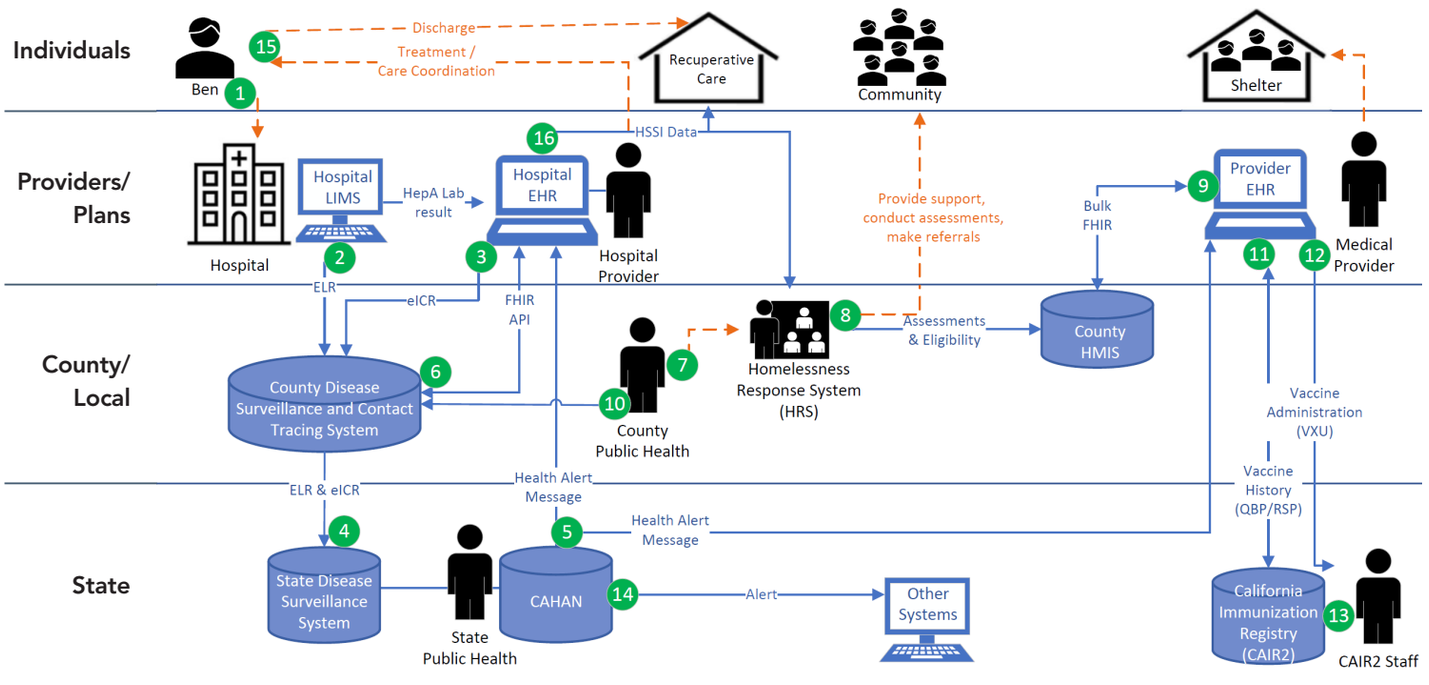
16. The hospital EHR sends Ben's data to recuperative care and HRS. HRS dispatches staff to visit Ben in recuperative care to begin coordinating housing supports.

Figure 6. Coordinating Care for People Who Are Unhoused and Have Infectious Disease

→ System-to-system data exchange or person-to-system interaction
- - → Person-to-person interaction or nonelectronic data exchange (e.g., mail, phone call, assessment)
Blue icons: Electronic systems involved in data exchange
Black icons: People, organizations, or entities implicated in data exchange

Ben: Infectious

Ben is a 54-year-old unhoused man who arrives at Hospital A with symptoms and is subsequently diagnosed with HepA.



1. Ben arrives at hospital and tests positive for HepA.

2. Hospital Laboratory Information Management System (LIMS) sends electronic lab report (ELR) to county public health.

3. Hospital receives positive result from hospital lab. Hospital EHR sends eICR to county public health disease surveillance system.

4. County disease surveillance system sends case information to state disease surveillance system. County and state monitor data and detect a trend.

5. State public health uses California Health Alert Network (CAHAN) to message providers about vaccinating unhoused individuals for HepA.

6. County disease surveillance system receives additional data from hospital EHR about infected individuals.

7. County public health alerts homelessness response system (HRS) about HepA outbreak.

8. HRS goes into community and enters assessments and eligibility determinations into county HMIS.

9. Provider queries HMIS for list of individuals targeted for vaccination using provider EHR.

10. County public health conducts contact tracing on individuals at risk of HepA in county disease surveillance system.

11. Provider uses EHR to query CAIR2 for vaccine history and vaccinates individuals needing HepA vaccine.

12. Provider EHR sends vaccine administrations to CAIR2.

13. CAIR2 staff uses CAIR2 to identify pockets of need for HepA vaccine.

14. CAHAN sends alerts to other systems (e.g. public works).

15. Ben is treated by the hospital provider and discharged to recuperative care once he is no longer infectious.

16. Hospital EHR sends Ben's health and social services information (HSSI) data to recuperative care and HRS. HRS dispatches staff to visit Ben in recuperative care to begin coordinating housing supports.

Source: Developed by the authors and HLN consulting to depict the ideal state of data exchange based on focus group and advisory group feedback, August 22, 2025.

Use Case Glossary of Abbreviations

AAA: Area Agency on Aging

ADT: admission, discharge, and transfer

API: application programming interface

BHS: behavioral health services

BIH: Black Infant Health Program

CAHAN: California Health Alert Network

CAIR2: California Immunization Registry

CalAIM: California Advancing and Innovating Medi-Cal

CalAIM PHM: CalAIM Population Health Management

CalSAWS: California Statewide Automated Welfare System

CBO: community-based organization

CCW: clinic caseworker

CE: Coordinated Entry

CEW: county eligibility worker

CLR: closed-loop referral

CM: care manager

CS: CalAIM Community Supports

DHCS: California Department of Health Care Services

DSS: County Department of Social Services

ECM: CalAIM Enhanced Care Management

ED: emergency department

EHR: electronic health record

eICR: electronic initial case report

EIS: eligibility and intake system

ELR: electronic laboratory report

FERPA: Family Educational Rights and Privacy Act

HepA: hepatitis A infection

HICAP: Health Insurance Counseling and Advocacy Program

HMIS: Homeless Management Information System

HPM: housing placement manager

HRS: Homelessness Response System

IEP: Individualized Education Plan

IHSS: In-Home Supportive Services

JIC: jail intake coordinator

JI Portal: Justice-Involved Screening Portal

LCM: lead care manager

LCSW: licensed clinical social worker

LIMS: laboratory information management system

MCAH: Maternal, Child, and Adolescent Health Program

MCP: managed care plan

MEDS: Medi-Cal Eligibility Data System

MHP: mental health plan

MIF: Member Information File

PA: prior authorization/service authorization

PCP: primary care provider

PRCM: prerelease care manager

PSH: Permanent Supportive Housing

QBP/RSP: Query by Parameter/Response to Query by Parameter

QHIO: Qualified Health Information Organization

RC: regional center

ROI: Release of Information

SMHS: Specialty Mental Health Services

SUS: substance use services

WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

Endnotes

1. For more information about PHM, see CalAIM: Population Health Management (PHM) Policy Guide (PDF), DHCS, July 2025.
2. "California Announces Designation of Nine Qualified Health Information Organizations to Support Secure Statewide Data Exchange Ahead of January 2024 Deadline," Data Exchange Framework and California Health and Human Services Agency, accessed August 2025.