NATIONAL COUNCIL
for Mental Wellbeing

Health Information Technology for CCBHCs Toolkit

Part 1: Important Considerations for Establishing HIT to Fulfill the CCBHC Model

Revised January 2025

CCBHC-E National Training and Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

BBS strategy + heart

Overview

This three-part toolkit is a planning resource for Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic-Expansion (CCBHC-E) grantees, including Planning, Development and Implementation (PDI) and Improvement and Advancement (IA). It will help them build and/or expand health information technology (HIT) to support CCBHC requirements. It provides an overview of HIT fundamentals and includes foundational considerations, priority areas, and specific requirement-focused guidance for establishing HIT that supports the CCBHC.

Goals

The goals of the toolkit are to:

- Support organizations in meeting the SAMHSA CCBHC requirements through HIT.
- Support organizations in planning for and expanding HIT capacity to effectively implement care coordination.
- Describe priority areas for using and benefiting from HIT as a CCBHC.

How to Use This Toolkit

The intended audience includes staff members working for and with CCBHC PDI and IA grantee organizations, including executive, quality improvement, clinical, administrative, and IT staff. The toolkit is divided into three parts, all three of which include an introduction to HIT support for CCBHCs. Part 1 shares important considerations for establishing HIT to fulfill the CCBHC model. Part 2 provides a deeper dive into priority areas for HIT for CCBHCs. Part 3 delineates the needed HIT capacity to meet the Updated (March 2023) SAMHSA CCBHC Criteria within four program requirement areas.

For Additional Resources and Support:

The National Council for Mental Wellbeing's CCBHC-E National Training and Technical Assistance Center is committed to advancing the CCBHC model by providing SAMHSA CCBHC-E programs training and technical assistance related to certification, sustainability and implementation of processes that support access to care and evidence-based practices. For additional information, to learn about upcoming events and to request technical assistance, visit the CCBHC-E National Training and Technical Assistance Center.

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List of Abbreviations

ADT	Admission, Discharge, and Transfer
AI	Artificial Intelligence
API	Application Programming Interface
APM	Alternative Payment Model
BH	Behavioral Health
CCBHC	Certified Community Behavioral Health Clinic
CDS	Clinical Decision Support
COOP	Continuity of Operations plan
CQM	Clinical Quality Measure
DCO	Designated collaborating organization
eCQM	electronic Clinical Quality Measure
EHR	Electronic Health Record
HIE	Health Information Exchange
HHS	U.S. Department of Health and Human Services
HIT	Health Information Technology
MIC	Measurement-Informed Care
ONC	Office of the National Coordinator for Health IT
PAD	Psychiatric Advance Directive
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Program
PHM	Population Health Management
PHR	Personal Health Record
PG	Patient-Generated data
PMS	Practice Management System
QI	Quality Improvement
QM	Quality Management
RFP	Request For Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SUD	Substance Use Disorder

Introduction: HIT Support for CCBHCs

Introduction

A strong plan for using health information, together with a robust health information technology (HIT) system, has many benefits for people receiving services, health care providers/clinicians and organizations. Health information has much to offer person-centered care and, at the same time, requires careful stewardship and planning. Accurate and reliable data — describing which individuals and populations are being served and the services they are receiving — enables providers to deliver high-quality care that is safe, effective, timely, person-centered, efficient and equitable. HIT refers to how health information is stored, shared and analyzed and to the electronic systems used by health care professionals and the people they serve. HIT supports health information management across different computer systems and organizations. Effective HIT enables Certified Community Behavioral Health Clinics (CCBHCs) to better understand the people they are serving, promote person-centered care and regularly review and refine processes for delivering care and determining its impact.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines requirements and criteria for the use of HIT in the CCBHC Certification Criteria (SAMHSA, 2023): "The CCBHC establishes or maintains a health information technology (HIT) system that includes, but is not limited to, electronic health records." Meeting the requirements for the use of HIT will likely require an in-depth review of the current technology, identification of gaps and strategic decisions regarding how gaps will be filled.

Certified Community Behavioral Health Clinics

CCBHCs comprise a community behavioral health model designed to improve service quality and ensure access to high-quality, comprehensive care.

The CCBHC model aims to:

- Provide integrated, evidence-based, trauma-informed, recovery-oriented, person- and family-centered care.
- Offer the full array of CCBHC-required mental health, substance use disorder and primary care screening services.
- Serve anyone who walks through the door, regardless of their diagnosis and ability to pay.
- Offer access to 24-hour crisis care.
- Include established collaborative relationships with other providers and health care systems to ensure coordination of care.

HIT can help a CCBHC to:

Support a person- and family-centered approach to care by, for example, providing care responsive to the identity and cultural needs of each person receiving services and documenting their input in treatment planning, goals, objectives, strengths, preferences and natural supports.

Screen and track individual progress of the person receiving services.

Provide people receiving services with timely electronic access to view, download or transmit their health information or to access it via an application programming interface (API) using a personal health app of their choice.

Implement, share and revise treatment plans across providers with updates on referrals made and individual progress to support care coordination.

Coordinate care by sharing data from assessments, referrals and follow-ups and by collecting data on care transitions.

Support population health approaches for groups of people with shared characteristics for care planning and reporting.

Identify health disparities.

Identify who is not being served or is underusing services.

Track and evaluate CCBHC outcomes.

Extract and report quality measures.

Monitor staff-related measures (e.g., quality, caseloads).

Protect the data of the person receiving services and the organization.

Work with designated collaborating organizations (DCOs) through electronic health information exchange that improves transitions of care and supports integrated evaluation planning, treatment and care coordination.

Designated collaborating organizations

DCOs are entities with which the CCBHC establishes a formal relationship to ensure all required services are provided to the CCBHC population. If the CCBHC is able to provide all nine required services on its own, it does not need a DCO. However, a DCO provides a mechanism for making available one or more services (or elements of them) that the CCBHC does not provide directly. DCOs must follow the same criteria for person-centered, recovery-oriented care as the CCBHC, as specifically noted in the criteria: "The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services across providers under the umbrella of a CCBHC" (SAMHSA, 2023). This relationship is supported by a legal arrangement (e.g., contract, memorandum of agreement, memorandum of understanding) that describes mutual expectations — including data sharing — and establishes accountability for services to be provided.

HIT plays a critical role in the relationship between CCBHCs and DCOs. While not under the CCBHC's direct supervision, the criteria state that a DCO must meet the same quality standards as those provided by the CCBHC and in a manner consistent with applicable CCBHC criteria. The HIT structures and processes for collecting and sharing data help CCBHCs and DCOs engage in a coordinated intake process and treatment planning, share information and establish direct communication so a person receiving services or their family members don't have to relay information between the DCO and CCBHC. This toolkit will refer to DCO-specific criteria throughout, as appropriate.

Electronic health records (EHRs) support care that is coordinated across a full range of settings and tailored to the health needs of people receiving services, by documenting the services and activities within clinic walls and with external providers, including referrals and their follow-up. EHRs document encounters for providers to use in planning and providing care and tracking quality improvement, and for the people receiving services to access their health records. Well-designed EHRs support the goal of providing people with meaningful choices and self-determination and reflect their goals, actions, preferences and natural supports. CCBHCs can use data to prioritize populations who experience disparities in care, and to develop quality improvement activities that enable participation in programs that provide enhanced funding or value-based payments. High-quality data and HIT also can support the evaluation of the CCBHC's work, using metrics from EHR data, other HIT systems and/or Medicaid claims data.[1] Health information exchange (HIE) is a critical data source that can support connections between the CCBHC and other physical health and behavioral health providers.

What is health information exchange?

The Office of the National Coordinator for Health IT (ONC), the government agency responsible for coordinating nationwide efforts to implement and use HIT, defines HIE as the appropriate and confidential **electronic exchange of clinical information among authorized organizations that "allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a person's vital medical information electronically** — improving the speed, quality, safety and cost of patient care" (ONC, 2020). The focus has expanded to other members of the physical health and behavioral health care team, including payers, care coordinators and population health and public health staff. HIE can provide critical support for care coordination by tracking and sharing changes in levels of care using hospitals' admission, discharge and transfer (ADT) systems.

1 *The Health Information Technology, Evaluation and Quality Center (hiteqcenter.org) has many helpful resources related to data and reporting, including Growing and Sustaining a Data-driven Culture (vimeo.com/397988837).*

Navigating the Toolkit

This toolkit, grounded in SAMHSA's CCBHC Certification Criteria, lays out the core considerations related to HIT for a CCBHC. It begins with a definition and overview of HIT. Following the overview, the toolkit is divided into three parts, described below. Each part concludes with a glossary of key terms and a list of references and HIT resources.

Part 1. Important Considerations for Establishing HIT to Fulfill the CCBHC Model is recommended for providers seeking a foundation for establishing their health information strategy and guidance in identifying and selecting core HIT components such as an EHR. This section includes taking an organizational approach to data, establishing HIT leadership, evaluating and purchasing HIT and core considerations in building HIT for a CCBHC.

Part 2. CCBHC Priority Areas identify important considerations for the use of HIT in a CCBHC. These include care delivery, care coordination, HIE, person-centered and family-centered treatment planning, population health management and quality and funder reporting.

Part 3. CCBHC Requirements and Needed HIT Capacity is intended for leaders with an active EHR and an understanding of HIT fundamentals who are seeking to optimize their HIT for their CCBHC. This section includes tables that delineate each SAMHSA requirement pertaining to HIT and provides guidance on the HIT capacity and functions needed to meet the requirement.

CCBHC program requirements areas

Organizations seeking CCBHC certification address the needs of people receiving services and those who are not currently served, staff, processes (what the staff does and how it will be done), and technology (the HIT needed to support staff and facilitate processes), as well as reporting, analysis and quality improvement.

Ideally, HIT informs and enhances all six CCBHC program requirements areas, which include:

01

Staffing: Staffing plan driven by local needs assessment, licensing and training to support service delivery.

02

Availability and Accessibility of Services: Standards for timely and meaningful access to services, outreach and engagement, 24/7 crisis services, treatment planning and acceptance of all people regardless of ability to pay or place of residence.

03

Care Coordination: Care coordination agreements across services and providers, defining the accountable treatment team, HIT and care transitions.

04

Scope of Services: Nine required services, as well as person-centered, family-centered and recovery-oriented care.

05

Quality and Other Reporting: Required quality measures, a plan for quality improvement and tracking of other program requirements.

06

Organizational Authority and Governance: Consumer representation in governance, appropriate state accreditation.

To support high-quality, efficient delivery of the nine required services, CCBHCs need specific features and functionality in their HIT systems that allow for:

- 24/7 access for people in crisis needing immediate assistance, regardless of living arrangements or the ability to pay
- Person- and family-centered screening, assessment, diagnosis and treatment planning
- Primary care screening and monitoring
- Psychiatric rehabilitation, outpatient mental health and substance use services
- Care coordination and targeted case management
- Peer support and family/caregiver support
- Community care for active military and veterans

Health Information Technology Overview

HIT refers to how health information is stored, shared and analyzed and to the electronic systems used by health care professionals and the people they serve. For this tool, HIT includes the EHR, practice management systems (PMS), population health management systems, patient portals, electronic prescriptions, telehealth (Matulis, 2022), cybersecurity, data security and privacy and related systems, as well as artificial intelligence (AI) text generation. Often, the PMS, patient portal and electronic prescribing functionality are fully integrated within the EHR. Regardless of whether you have, or are adopting, a fully integrated EHR, you will need to determine if the features and functions of your systems meet the needs of the CCBHC model. (See Figure 1 on page 13.)

Although these components are the technological drivers of your health information system, your health information strategy is the compass that directs their use. A health information strategy lays out your organization's vision for collecting, processing, reporting and using health information. The strategy supports a clear understanding of your goals in providing care, supporting clinical decision-making, sharing progress and outcomes for care provided and improving the health of those you serve.

SAMHSA has described minimum standards for the use of HIT in CCBHCs (SAMHSA, 2023). This toolkit assumes the CCBHC is seeking to use or already has technology (either a single system or a combination of tools) that has met current ONC criteria for the required core set of HIT capabilities (see text box, "CCBHC Certification Criteria 3.b.3"), which are aligned with key clinical practices and care delivery requirements for CCBHCs. The EHR must be ONC-certified and meet these minimum SAMHSA standards. If a CCBHC's EHR does not initially have all the functionality needed, a strong health information strategy will guide the process of acquiring, implementing and activating HIT tools and systems to improve CCBHC efficiency and sustainability.

CCBHC Certification Criteria 3.b.3:

Required core set of certified HIT capabilities

- Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity and disability status (as feasible).
- At a minimum, support care coordination by sending and receiving summary of care records.
- Provide people receiving services with timely electronic access to view, download or transmit their health information or to access their health information via an API using a personal health app of their choice.
- Provide evidence-based clinical decision support.
- Conduct electronic prescribing.

Electronic health record

An EHR is a person-centered digital repository of a person's health information and can include:

- Demographic information
- Medical, behavioral and surgical history
- Family medical history
- Diagnoses and medical conditions
- Lists of active and inactive medication
- Treatment plans
- Immunization records
- Allergies
- Diagnostic imaging and X-ray reports
- Laboratory data
- Consult reports
- Screening information (e.g., anxiety, depression, substance use disorder, social determinants of health)

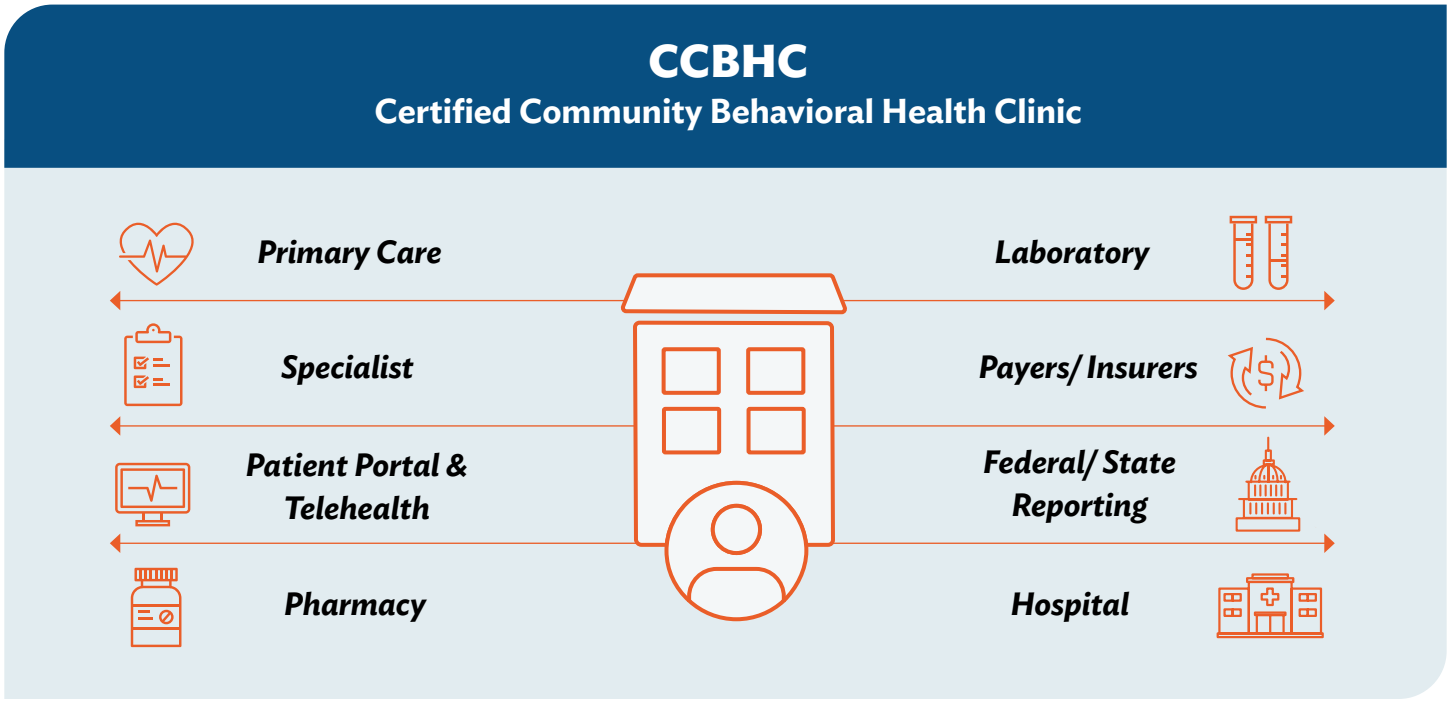
In addition, EHRs provide access to essential tools such as electronic prescribing for all medications (including medication for opioid use disorder), clinical decision support tools to guide and direct standards of care, sharing information electronically (as allowed by HIPAA and as useful for documenting consent where feasible and responsive to the needs of the person receiving services), and sharing information with the person receiving services in a format that allows for viewing, downloading and transmitting. As stated in criterion 3.a.2, "CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services" (SAMHSA, 2023).

Practice management system

A PMS automates and streamlines administrative and billing functions and typically offers the following functionality:

- Capturing and storing the demographic information of the person receiving services, including name, date of birth, address, phone number, emergency contacts, race, ethnicity, sexual orientation, gender identity, preferences as to method of contact (phone, text, email), pharmacy and language
- Appointment scheduling templates
- Preregistration or "mini" registration for new people receiving services
- Capturing and storing insurance information and maintaining insurance payer files (e.g., fee schedules)
- Eligibility and benefit checking
- Billing functions (e.g., submitting claims electronically, posting payments electronically)
- Generating revenue and operations reports on such metrics as time from initial contact to first appointment or appointments completed, scheduled, canceled or marked "no show"

Figure 1: Health information technology data flow



Part 1. Important Considerations for Establishing HIT to Fulfill the CCBHC Model

Laying the Groundwork for HIT in a CCBHC

Adopting or expanding health information technology (HIT) involves managing both adaptive (incremental) changes and transformational change (major shifts in strategy, structure, performance and processes) for the organization (Miller, 2020). These changes impact organizational culture, workflows, policies and practices, affecting clinicians, people receiving services, administrators and vendors. Engaging all impacted stakeholders throughout the process is time well spent, and it is critical for gaining trust and buy-in. Focus on understanding stakeholders' needs and preferences, addressing their concerns and questions, and soliciting their feedback and input. Tools and frameworks such as stakeholder analysis, stakeholder mapping and stakeholder communication plans can help you with this process. (See Appendix A for a Stakeholder Engagement Form.) Engagement can increase awareness and understanding, enhance participation and collaboration, and improve satisfaction and loyalty.

5 Steps in the Change Management Process

(Miller, 2020)

- Prepare the organization for change
- Craft a vision and plan for change
- Implement the changes
- Embed changes within [organizational] culture and practices
- Review progress and analyze results

In preparation, management can help all staff understand the Certified Community Behavioral Health Clinic (CCBHC) model and how implementing it will improve individual and population care, support clinicians with the data necessary to make informed care decisions and eliminate duplicative or ineffective practices. Taking a clinician-centric approach, where clinicians are empowered to do their work better, will go a long way toward getting their buy-in and effective collaboration in using HIT.

The sections below share how you can engage stakeholders, craft a vision and plan for change and select systems appropriate for your CCBHC. It includes considerations for implementing and embedding HIT into your organization. It is broken into three key steps:

1. ***Create an HIT review and implementation team***
2. ***Adopt a data strategy and governance process***
3. ***Select HIT***

Step 1: Create an HIT Review and Implementation Team

Although not a Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC requirement, establishing an HIT review and implementation team can help you evaluate how your HIT meets your organization's needs plan for changing or expanding HIT. Be as inclusive as possible when evaluating and selecting the HIT that will support your organization. In addition to technology staff, include perspectives from CCBHC leadership, front desk staff, direct care staff and operations, among others. Your staff are experts on how the people receiving services flow through your practice and how new CCBHC processes will be accommodated. People with lived and living experience with mental health and substance use conditions are critical voices in your HIT planning. They can contribute valuable input on workflows for gathering data and processes that could reduce the burden for people receiving services. Including many voices will also create buy-in and improve adoption. This step can help you avoid purchasing technology that is never adopted and activated. The HIT Governance Committee, a subset of this team, is described in **Step 2: Adopt a Data Strategy and Governance Process.**

Ideally, the HIT review team will represent a wide variety of stakeholders, providing a comprehensive view across the organization and from all groups impacted by the system, particularly people receiving services. These stakeholders will identify which care team members will need access and how they will be using the HIT. For example, a psychiatrist may need access to all aspects of the system. A member of the front desk or billing staff may need to view the chart, but they will not be adding data or content to a progress note. The HIT review team should include the CCBHC program director and be composed of:

- **Senior leadership,** to set the vision and process for the review.
- **Operations leadership and staff,** including compliance officers, to bring a clear understanding of data privacy/HIPAA compliance, registration of people receiving services, scheduling and workflow.
- **Clinical staff** (e.g., nurses, care coordinators, providers, peer-recovery specialists), to convey how to adapt current clinical workflows and processes to new requirements of the CCBHC model and an improved use of technology.
- **IT staff and electronic health record (HER) analysts,** to evaluate current technology use and articulate how technology could be optimized — they understand what is possible in the EHR and can steer the team toward improved use and greater efficiency.
- **Finance staff,** to ensure that costs, value, and budget implications are considered.
- **Quality improvement (QI) staff,** to review, analyze and report on data and population health.

Although not technically part of the HIT review team, the following stakeholders should be considered in the discussion when your organization considers adopting a new system or new functionality:

People receiving services and their families, who are extensively impacted by the system, can provide valuable feedback for planning or expanding HIT, including feedback about the workflow of information requests (e.g. when questions are asked, to avoid repeat questions). This person-centered approach — in which goals, strengths, needs, and preferences are documented in their words — allows them to process experiences, such as how easy it is to schedule an appointment, request a refill, send and receive messages to and from the care team through the patient portal, get access to their health records, complete informed consent or generate and provide their data before a visit. As an added benefit, this type of engagement could eventually lead to deeper involvement and help support your organization in meeting Option 1 of the CCBHC governance requirement (criterion 6.b.1): "At least 51% of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families" (SAMHSA, 2023).

Partner organizations, such as health information exchanges (HIEs) (see page 34) that receive and provide data on people receiving services, billing systems, hospitals, state agencies, payers, and the designated collaborating organizations (DCOs) that fulfill a CCBHC-required service, can inform your decision-making regarding how technology is or could be used to support communication between the organizations. What do their data-sharing processes and systems look like now? Do they have direct referral systems? Develop relationships with your state or regional HIE(s) and engage in future-state planning for HIT/HIE integration to:

- Ensure that necessary interfaces are developed
- Understand the connectivity criteria and formats for submission
- Ensure that EHR vendors are capable of sending the required data
- Promote a stronger understanding of how data is used (e.g., for state or federal reporting and analysis, for integrated care delivery, or both?)
- Establish proper consent processes and procedures both within the HIE and the CCBHC, to comply with federal guidance
- Ensure that the user's voice is represented

Whether or not your state requires an interface to the HIE, you can use this opportunity to determine if these costs can be included in your CCBHC cost report.

Embedding HIT Changes into Culture and Practice

Invest in HIT staff and cross-agency collaboration

CCBHCs benefit from having an analyst or application manager on staff who is tasked with developing a deep understanding of all HIT systems including the practice management system (PMS)/EHR and population health management (PHM) systems. At the same time, it is critical that IT staff also understand the clinical side. One role repeatedly emphasized by CCBHC interviewees is an HIT staff member who can work collaboratively with clinicians to create a range of reports, such as data visualizations that show care progress and gaps. At MiSide, the leadership team developed a Data Taskforce and established a full-time data evaluator role. This has allowed them to create CCBHC-specific dashboards, using various data trends to evaluate the effectiveness and impact of care. (See dashboard examples in Appendix B.) This role has helped the agency create tools for educating staff about changes in data-input needs, such as National Outcome Measures, as well as meeting with team members who struggle with workflows.

Cross-agency collaboration connects staff with different expertise to define a more effective product.

> **We held working meetings where we brought the clinical staff, the IT staff and a 'translator' staff member who understands both the clinical and technology aspects together to figure out the rollout for the reports we needed. The tech person brought a high level of skills in data, databases, importing and exporting and implementations. His skills together with clinical people — boots on the ground — who knew what to share on how it impacts them, [and] how it impacts clients, works. Together they define the language, the specifications, produce a report, review, discuss and revise."**
>
> *—Michelle Ruby, Vice President, Information Systems, CHR*

Staff orientation and training

CCBHC interviewees emphasized the need to thoroughly train all staff in using data and HIT and inform and include staff in the continual changes and improvements. At Grand Mental Health in Oklahoma, staff noted that a well-built HIT approach is only effective if it is comprehensible to the staff using it. Their Learning and Development and Technology team integrates staff training and education into their process. With each new innovation, a representative from the learning team is involved, and changes are introduced incrementally. Each week, Grand educates staff about these ongoing changes and innovations through "What's New Wednesdays."

In CHR in Connecticut, another CCBHC, orientation includes a full day of training on HIT, as well as training on data-driven decision-making. To support ongoing learning, CHR shares a monthly video episode called "The Ponderer: Why the Why," where they focus on a pain point or innovation and explain why the change was made and how it helps.

Incorporate HIT into the culture

When staff across the agency effectively use HIT and associated data on a daily basis, it becomes part of the culture. CCBHC interviewees shared how they incorporate HIT into their work to benefit the people they serve and could serve, their staff and the organization.

> **We review data everywhere. In our staff meetings, subcommittee workgroup meetings, in our multidisciplinary team meetings, in our EHR meetings. We were already data driven, but becoming a CCBHC elevated it more."**
>
> *—Angela Rizzolo, MBA, Senior Vice President, Operations and Compliance, CHR*

At Grand, automation has been applied to clinician processes that historically were manual. For example, Grand has partnered with an AI company to support summarizing session notes in compliance with data privacy and with the consent of people receiving services.

The chief information officer explained that some people receiving services are provided with an iPad loaded with proprietary software that is integrated with the EHR. They may use the iPad to call clinicians for scheduled sessions and to access crisis services. In each instance, AI assesses the conversation and creates augmented notes. It allows clinicians to be more focused on engaging the person during the session, with the awareness that they can determine which aspects of the summary notes they want to use. The summaries can be corrected/clarified and quotes added, as needed.

When people receiving services use the technology to connect with the crisis team, a log is generated that shows when they made a call for crisis services, who responded, and a summary of the discussion and disposition. This allows clinicians to be better prepared going into their sessions, as they can view individual encounters between scheduled sessions.

Note: One consistent caution from interviewees is to build incrementally, when possible, to avoid overwhelming staff and the system.

> **One approach to consider is to be mindful, maintaining balance of what is enough data needed to guide implementation, inspire innovation and meet regulations and requirements. And in times of tension, keep the clinical outcomes as the primary guidepost."**
>
> *—Courtney Sheehan, LPC, Senior Program Director/CCBHC Program Director, CHR*

Step 2: Adopt a Data Strategy and Governance Process

In crafting your plan for HIT, three foundational elements include determining your organization's data strategy, how your data will be managed (i.e., data governance), and how it will be kept secure.

Data strategy

An organization's approach to data: How it is collected and by whom; how it is organized; where and how it is stored; how and by whom it is accessed and analyzed; and how it is used for person- and family-centered decision-making, population health improvement, meeting grant reporting requirements and organizational decision-making.

Data governance

The process by which data is managed. The American Health Information Management Association (2022) defines data governance as "the overall administration, through clearly defined procedures and plans, that assures the availability, integrity, security, and usability of the structured and unstructured data available to an organization."

Together, data strategy and data governance guide and direct IT decisions related to which systems are used and how — and how those systems are continuously improved and developed to support the organization's mission and goals. Effective organizations often establish a HIT governance committee, which can serve as a subset of the HIT Review and Implementation Team to work out governance details, share decisions, and request feedback from the larger team. The HIT governance committee is charged with:

- Developing, maintaining, and updating policies and procedures that govern how the EHR and other systems will be used, including:[2]
  - Who is responsible for gathering information?
  - How it is documented, and how to use the EHR to optimize the use of data from people receiving services.
  - How to address data breaches.

  The CCBHC's legal counsel and privacy officer must stay abreast of all legal and regulatory requirements and ensure that staff are properly trained and adequate systems are in place to protect individual privacy, as required.

2 Note: These policies and procedures include protecting the privacy and security of protected health information. Because CCBHCs treat substance use disorder, it is essential that policies and procedures reflect updated federal guidance regarding the confidentiality of substance use disorder treatment data of a person receiving services (Confidentiality of Substance Use Disorder Patient Records, 2017), as well as comply with all HIPAA privacy and security requirements. Strategies include protective screen covers, password policies, encryption, policies and trainings, which should cover at a minimum proper access, viewing, downloading and sharing of protected health information and substance use disorder treatment data. Some states may have additional regulations above HIPAA to protect specific types of protected health information that may be considered sensitive, such as HIV status.

- Providing input on continuous QI plans, including what data will be gathered and analyzed; how data will be shared with and used by staff; how the EHR and other systems will be used to gather, store, retrieve and share data from people receiving services; and what is the source system (i.e., software program, platform or database) for reports needed to support the continuous QI plan.
- Making decisions related to developing and adopting systems, forms and templates used for gathering information on people receiving services.
- Ensuring that adequate initial and ongoing training is offered to existing staff members and incorporated into the onboarding process for new staff.
- Determining how data will be curated and reported from various sources, including the PMS and EHR systems, HIE from hospitals and community organizations, claims data from insurers and registry data from health departments.
- Monitoring the impact on workflows and staff satisfaction as new data collection is required or new data is available to staff. This includes gathering feedback from all those who record, use or share data to determine what is working and what needs to be improved.
- Determining responsibility for identifying new and additional skill sets needed for data-related positions.

Data Security

A wide range of electronic and print data is handled within CCBHCs, including data on people receiving services, personnel, management, processes, billing, and partners. Maintaining the security of this data involves staff training, clear data governance, policies and procedures that prioritize confidentiality and privacy, and managed system access. The CCBHC must focus on protecting digital data from unauthorized access, corruption, or theft. For digital data and digital systems, cybersecurity means protecting the network (i.e., operating systems and network architecture), cloud, and physical security. The U.S. Cybersecurity and Infrastructure Security Agency provides best practices for maintaining safety, including:

- Implement multifactor authentication
- Maintain updated software
- Avoid clicking on suspicious links
- Use strong passwords

In addition, the CCBHC must perform the HIPAA-required annual risk assessment, which according to the Department of Health and Human Services should consider all the administrative, physical, and technological risks your organization faces. The governance committee may recommend that the CCBHC use a third party to conduct an audit or risk assessment, as a best practice. Experts in the field of data security will serve as a neutral party, which may enable them to spot issues not easily recognized by internal staff. If the CCBHC chooses to conduct the assessment internally, a tool offered by the Office of the National Coordinator (ONC) and the Agency for Healthcare Research and Quality may be helpful (Dimitropoulos, 2007).

In working with partners, a number of best practices can support data security, as noted in this example.

> **We follow a 'business need to know' process, trying to limit data sharing to only what they need. We have business agreements with our partners to ensure they are complying with HIPAA regulations. We're also selective: Due diligence in picking our partners is important because after you shed the data, it's too late to take it back. So, if there is any protected health information involved, we require that they have third-party cybersecurity certification (often two kinds)."**
>
> *— Rony Gadiwalla, Chief Information Officer, Grand Mental Health*

Structured vs. Unstructured Data

Structured data includes discrete data types such as numbers, short text and dates that can be quantified in tables and reports, which is critical for looking at individual progress, population status and trends. Unstructured data does not fit a schematic due to its size or nature (e.g., a large number of words, phrases and sentences, scanned documents, or audio or video files that do not translate directly to discrete data). Unstructured data is qualitative in nature and can add shape and depth to quantitative data or fill gaps where quantitative data does not exist.

Structured data

To enhance standardization and ensure that each person receiving services has a similar experience and all members of a care team can easily access reliable documentation, HIT uses standardized templates and forms, commonly referred to as **clinical content**; these templates use data entry methods such as click boxes that translate to readable text, for ease of use and efficiency. Standardized templates support core components of the CCBHC program, for example:

- Preliminary triage
- Initial intake
- Screening and assessments
- Crisis plans
- Psychiatric Advance (and other health) Directives
- Treatment plans

Components, such as Psychiatric Advance Directives, can be designated in the EHR for easy access in the case of an emergency or inpatient admission, to follow the wishes of the person receiving services. Also, structured data can be pulled from previous encounters and incorporated into population health management systems and used in analytic tools such as reports. This improves efficiency, which unstructured or free text cannot. It is best to use structured data in the following instances:

- Structured processes such as intake, crisis plans, initial evaluations and treatment plans
- Risk assessment (e.g., substance use including tobacco, alcohol, drugs)
- Screening (e.g., social determinants of health, anxiety, depression, suicide)
- Diagnoses or conditions
- Allergies
- Medications and immunizations
- Problem list
- Most lab data
- Orders for disease prevention and health promotion activities (e.g., lifestyle modification, diet, exercise)
- Care coordination activities, including referrals

For optimal use, templates should include adequate space for free text to augment the documentation and ensure the voice of the person receiving services is represented.

Unstructured data

Free text is often used when:

- Telling the story of the person receiving services, such as when taking a history
- Describing the person's reaction
- Using the person's words

Using a Requirements-driven Process to Select Systems

Evaluating and selecting software systems can be a challenging process. Using a requirements-driven process makes evaluation less stressful and ensures objectivity. Requirements encompass the CCBHC Certification Criteria, the user experience, organizational considerations (e.g., budget) and vendor expectations. Treat the requirements as a compass to help you get what your CCBHC needs. Use the following two steps as you define the requirements for your HIT:

1. **Consider what you want the software and the system to do. This includes identifying any gaps in your current HIT systems.**

What problems must it solve? What is the value you want the software to bring to your practice? Will it create cost savings, time savings, improved staff satisfaction, improved outcomes or satisfaction for the people receiving services?

2. **Begin listing the requirements.**

This will be an iterative process. Take your time, review, revise and enlist as many stakeholders as possible in the process. Consider functional requirements (what does the system need to do?), usability requirements (is the system user friendly and easy to learn?) and technology preferences (will the system be cloud-based or housed on the premises or in a data center?). What is your budget? What are your reporting requirements? What are the vendor requirements? Must the vendor have CCBHC or behavioral health experience, for example? See Sections III and IV for more specifics in defining requirements.

CCBHC interviewees reflected that, in hindsight, building the EHR to mimic the needs of a demonstration site would have been beneficial.

> **On the clinical side too … when we were just going through a lot of the standards we were like, 'Oh that doesn't apply. We're not a demonstration site. We don't need to do that.' When we look back, it would have just been so helpful to go ahead and start implementing some of those things. We had the tools in place in our EMR, and it would have just been a really easy transition for staff if we had started getting them ready years ago."**
>
> *— Tanisha Black, Senior Director, Quality and Corporate Compliance, MiSide*

Step 3: Select HIT

Choose a Vendor

Choosing, and then managing, the vendor is an important process for successfully adopting and activating EHRs and other HIT tools. Using a requirements-driven, structured process when evaluating HIT (whether new or currently in place) sets the tone for vendor management in the future. Ask vendors to show you each required capability step by step to make sure the functionality meets your expectations. For example, if a system has e-prescribing but the process has too many steps or vital information is not accessible during the prescribing process, the system does not meet your functionality requirements.

If your CCBHC is clear on its expectations, it will be easier to convey those expectations to the vendor. The following tips for the vetting process can be applied to the process of evaluating existing technology.

Vendor Selection and Management Tips

Use a structured process for evaluation

Assemble an internal team (see discussion of HIT review and implementation team on page 15) and develop a set of project goals and objectives or guiding principles. This document, specifically the tables in Part 3, CCBHC Requirements and Needed HIT Capacity, can be used as a framework. This process will be useful as you evaluate your current HIT and consider what you need to change or add.

Define the current and future needs of your practice

Using this document as a guide, develop a set of requirements to be shared with vendors. Think about the technology you need now and your ultimate goals for serving the community — e.g., will telehealth technology enable you to obtain consent remotely so you can be responsive to the needs and capabilities of people seeking or receiving services? — and for your organization — e.g., whether this technology will be useful across your organization. Look for opportunities for technology to support multiple programs.

The list of requirements should be detailed and practical. Start with the top 10 functions you must have and then move to desired or preferred functions. This valuable exercise will help you more explicitly set expectations with vendors, understand how technology can be used as an accelerator and optimally use the technology you acquire. Consider that you may wish to upgrade some systems and procure other new systems to ensure all your needs are met. For example, you may decide to add a new care coordination module to your existing EHR suite, while you also may need to purchase a new telehealth system because this will be a new offering for your organization.

Prepare for the product demonstration

The purpose of the demonstration is to identify a short list of preferred vendors for consideration. Most vendors are happy to provide multiple demonstrations of their products, especially if these can be conducted using remote video tools like Zoom. Schedule presentations to accommodate as many members of your HIT review team as possible and ensure representation from both administrative and clinical staff at a range of levels. Ask that the demonstrations be recorded and shared with you. Some vendors object to recording to protect their intellectual property and prevent you from sharing the recordings with competitors, but it's worth asking. Provide staff with a form to provide structured feedback.

Create tools to assist in decision-making

Using the top 10 requirements and list of vendor questions on page 27 of this document create a scorecard that can be used when evaluating current systems or during the demonstration of a new system. Consider developing a demonstration script, which might include:

- Documenting a preliminary triage, intake, and comprehensive assessment encounter.
- Stipulate that vendors must demonstrate how each encounter connects to and builds on previous encounters.
- Documenting and updating a treatment plan. Stipulate the need to demonstrate this functionality based on roles (e.g., signing in as a care coordinator, or as a provider).
- Electronic prescribing and medication history gathering.
- Extracting clinical and other data to produce a quality report, in particular extracting data to meet CCBHC reporting requirements.

Develop a request for proposals

Although time-consuming to develop, a request for proposals (RFP)[3] can be used to develop your service-level agreement and contract and to hold vendors accountable if or when systems do not perform as described or demonstrated. The RFP can be used and presented to your current vendor when upgrading current systems or adding new functionality, or if you make the decision to make a wholesale change. The easiest way to develop an RFP is to base it on the requirements document and add information specific to the vendor's experience and performance implementing similar programs with other organizations like yours.

3 See Tri-County Behavioral Healthcare Request for Proposals: Behavioral Health Electronic Health Record Platform (https://tcbhc.org/wp-content/uploads/2021/12/RFP_Packet.pdf).

Enable a testing sandbox

One of the best ways to get a true understanding of functionality and the pros and cons of technology is to ask the vendor to enable a "testing sandbox" where your staff representing the range of stakeholders identified by the HIT team can try out the product. From this process, you can create a list of questions and a risk log to gather more information from potential vendors. A risk log is used to identify and evaluate possible risks that could affect implementation.

Talk to your peers

An important step in the vetting process is to speak with CCBHCs already using the technology. Reach out through your regional or statewide behavioral health providers association or through this list from the National Council (2023). Visit sites and meet with key users to better understand the pros and cons of the functionality, customer service, hidden costs, security, and interoperability.

Develop internal capacity

A critical success factor for using HIT efficiently and effectively is understanding how your system works together, including all its capabilities and functionality. Staying current on new functionality and upgrades will help you understand what it means to accept an upgrade, including benefits, costs, and challenges. As noted, organizations benefit from a staff analyst or application manager with a deep understanding of their HIT systems. Such analysts are also responsible for requesting vendor support when needed, holding the vendor accountable for fixing issues, and ensuring the system performs as promised and designed.

Questions for Vetting HIT Vendors and Systems

- Has the HIT been successfully tested and certified by the ONC Health IT Certification Program? Ask about the latest certified version. (You can also check the Certified Health IT Product List.)
- Is the vendor familiar with SAMHSA requirements for CCBHCs? In what ways? Does the vendor have the capacity to collect CCBHC data for analytical and reporting purposes? How many behavioral health providers use their system(s)?
- What capabilities (e.g., structured templates, e-prescribing, integrated prescription drug monitoring programs [PDMPs], patient portal, telehealth, client interface solutions) come with the PMS/EHR, and what functionality can be added with optional modules? Does the EHR system have data extraction and reporting capabilities? Does it have a population health or QI module or functionality?
- Can the system be configured by the CCBHC staff, or can configuration be done only by the vendor? Can the system be customized, and what specialized training will be needed to customize it? If the system cannot be customized, how does the vendor stay current on CCBHC requirements for billing, documentation and reporting? What are the vendor's estimated costs for configuration and customization, from their experience with other customers? What would be the vendor's cost to perform these functions, and what would be the cost of training the internal staff?
- What is required of the CCBHC in terms of maintenance and deployment of the system? Is it cloud-based, or will the CCBHC have to maintain servers?
- If the system is cloud-based, does the vendor offer cloud hosting? If so, does the hosting include managed services for the help desk, asset management and application management? Does it include cybersecurity, intrusion management and active detection and response monitoring? Does the hosted model also include guaranteed "uptime" (i.e., the total amount of time the server hosting your website is up and running)?
- What integrations are available in the current version of the system? Does the EHR currently support integration with your state/regional HIE and/or prescription drug monitoring program (PDMP)? Are there charges for additional integrations requested by the CCBHC?
- How often does the vendor upgrade the system? What happens to the legacy components? Ask the vendor to describe how and when the CCBHC will be notified of coming upgrades so that CCBHC staff can be trained ahead of time. Will the practice have access to a test or demo version of the upgrade, allowing EHR analysts to evaluate the impact on CCBHC staff? What functionality is in the pipeline for an upgrade? Ask the vendor to describe the documentation that will be provided with an upgrade (e.g., detailed instructions for any workflow modifications in the upgrade).

- How is security within the system configured? Is access role-based through an active directory? Can the system use the organization's existing active directory, allowing security to be centralized for applications used across the organization?
- What experience does the vendor have managing 42 CFR Part 2 data?
- What is the process when the equipment is not functional, such as during maintenance, adjustments or technical failure? What happens when there is a security breach? What is the ransomware defense strategy? What are the company's mitigation strategies?
- What training and ongoing support is available to the CCBHC? Can the training be customized to the CCBHC's individual workflow?
- Does the vendor have user groups or a peer support group to allow users to share tips and tricks?
- What is the cost or licensing model? Is it per total number of users or per users of a specific type? What kind of payment structure does the vendor use (e.g., monthly subscriptions, yearly payment)?
- How well does the product work outside the walls of the clinic? Does it meet the need for community-based and/or remote workers?

Integration and Interoperability

Interfacing with third-party systems can be expensive and potentially problematic if the interface fails or an upgrade disrupts interface functionality. Many EHR vendors have a list of preferred third-party applications, which may minimize the challenges and potentially the cost of interfaces. In reviewing HIT, look for a vendor that can accommodate most of your functionality requirements. Ask vendors if third-party integration is possible, what an interface costs on average and if they have a list of preferred vendors. Vendors are likely to ask about the functionality you are seeking, as it may be available in the EHR.

Three of the most important integrations for a CCBHC to consider are:

- With a state or regional HIE to support coordination and continuity of care for the people receiving services
- With a designated collaborating organization (DCO)
- With the state PDMP

The CCBHC and DCO are required (see criterion 3.b.5) to develop and implement a plan for improving care transitions to and from the CCBHC through electronic exchange of health information. They need to work together to integrate clinically relevant treatment records generated by the DCO into the CCBHC health record and coordinate communication between systems for evaluation planning, treatment and care coordination.

Integration of the PDMP with an EHR makes it easy for clinicians to quickly check a person's PDMP report before prescribing or dispensing medications, to ensure that the people receiving services receive appropriate medications and avoid adverse or even life-threatening effects from drug interactions. The availability of PDMP and HIE information integrated seamlessly in the EHR, as opposed to having multiple user accounts and logins, results in minimal disruption to clinician workflows and reduces the time and resources used. Be sure to request a demo of all desired functionality, so you can see how the EHR works and assess whether it can be easily incorporated into your workflow.

Considerations in Evaluating the Cost of HIT

No matter the HIT system, cost is always a consideration. To better understand the full cost, be clear and specific on your requirements and let them drive the demonstrations and conversations about how that vendor will be able to meet them. Be sure to consider both immediate and future costs, including:

System licensing

Most systems are licensed based on a subscription model that includes access to all core features of the system plus support and maintenance — in some cases, these costs also include secure hosting of the data. Determine how the vendor licenses access to the system. The preferred licensing model is based on billable providers, with limited costs for the other members of the care team. Additional users with specific needs for care coordination, population health or quality reporting access may incur added costs. Clarify how the vendor manages adding access and/or training for new staff or staff from a collaborating practice; hosting data; coordinating access for additional third-party systems, like a PHM system; configuring or customizing data collection forms; and running data reports. A preferred approach is for the vendor to provide virtual training that can be assigned to new staff, with hosting and licensing costs bundled.

Integration costs

Integration allows seamless linking to PDMPs, HIEs, outside labs (e.g., LabCorp, Quest) or a hospital-based lab, and immunization or other registries. Contracting with HIEs typically incurs ongoing, annual costs.

Change management

The staff cost of managing the change involved in implementing and adopting HIT is an essential consideration. Contemplate the average amount of time staff spend planning, testing and incorporating HIT, particularly nonbillable time for clinical staff — for example, the amount of time HIT team members spend per week in meetings, reviewing data and determining report content. In addition, consider the time all staff spend in piloting and learning new processes.

Lost and delayed revenue

When implementing a new system, providers and staff will need to see fewer people as they become accustomed to the system. Time will be needed for training, go-live preparation, testing the system's reporting capability and implementing any associated technology. In addition, adjustments to how claims are sent to insurers may result in delayed revenue.

Transfer of the information of people receiving services

When moving from one system to another, you will want core data elements to transfer to the new system. These include registration information of the people receiving services and core clinical information, such as diagnoses, medications and allergies. Although this is a one-time cost incurred during implementation, there will be an ongoing need to maintain basic access to the old system for reference, to meet legal requirements for maintaining records for seven years, and to satisfy requests for information from people receiving services and others.

IT infrastructure

Various approaches to IT infrastructure (networks, servers and staff to maintain the system) beyond the software itself were discussed previously on pages 21 to 27. Consider both upfront and ongoing costs when evaluating options. IT staff are often the biggest cost in this area, as they have specialized skills, may be difficult to find and command high salaries; turnover tends to be high.

Staff training

Consider both initial and ongoing training. Although training is costly, developing a comprehensive, mandatory training curriculum during implementation is money and time well spent.

> **When you start to use the system, you realize, 'Wow, during the demo, it looked so easy!' However, you can't just walk in and expect someone to learn their tool and do the kinds of things we need to do with it. It takes expertise and training."**
>
> *— CCBHC information systems leader*

The most important consideration in choosing technology is that it fits into the overall HIT strategy, so that it is used and optimized to meet the overall goals, objectives and requirements of the CCBHC model. When evaluating cost versus value, consider how the technology might reduce administrative burden, allow your team to become more efficient and satisfied with its work, improve the experience of people receiving services, and contribute to quality and improved individual and population health outcomes. Also consider how the technology will enable reporting and monitoring, and how it will integrate into the broader health delivery system. For CCBHCs eligible to participate in the Medicaid demonstration, incorporating the cost of establishing or expanding HIT into your cost reporting for the prospective payment system can support these considerations.

Explore the rest of the toolkit

- **Part 2, CCBHC Priority Areas,** identifies important considerations for the use of CCBHC HIT. These include care delivery, care coordination, HIE, person-centered and family-centered treatment planning, population health management, and quality and funder reporting.
- **Part 3, CCBHC Requirements and Needed HIT Capacity,** is intended for leaders with an active EHR and an understanding of HIT fundamentals who are seeking to optimize their HIT for their CCBHC. This section includes tables that delineate each SAMHSA requirement on HIT and guides the HIT capacity and functions needed to meet the requirement.

Glossary

Client-server systems

These systems store the health information of people receiving services in a local data center, either on the organization's premises or in an outsourced data center. In general, client-server systems are becoming less common, in favor of cloud-based systems.

Advantages of client-server systems include:

- Control over when an upgrade will be accepted and applied.
- More opportunities to customize clinical forms and templates to suit individual workflow requirements.
- Adding database fields to accommodate customized structured data reporting.

If the EHR is on the premises, the main disadvantage is that IT staff is responsible for:

- Properly backing up the system.
- Ensuring the system is accessible 24/7 by all staff and partners.
- Ensuring the system has sufficient computing power and network/bandwidth capacity for optimal performance (e.g., minimal downtime, slowness, being kicked out of the system).
- Properly securing and protecting the system from intrusion or data breach.
- Predicting what storage and computing power upgrades will be needed.

Cloud-based systems

Cloud-based EHR systems use the internet and computer (workstation or laptop) to store, exchange, and protect medical information.

A cloud-based system has the following advantages:

- Reducing IT burden on the organization (e.g., server performance and maintenance, security, backup, disaster recovery).
- Storing protected health information in a HIPAA-compliant manner.
- Optimizing access to the EHR for staff and partners.
- Streamlining integration with labs, immunization registries, PHM systems, and PDMPs.
- Streamlining upgrades and maintenance.

Potential disadvantages of cloud-based systems include:

- Less robust customization.
- Forced upgrades (i.e., you will not be able to choose whether to upgrade and may need additional training for providers and staff).

Configuration

Configuration refers to areas of the system that the organization can set up to meet its needs. Examples include scheduling templates, making registration form fields required, creating order sets or dummy codes to meet the needs of a specific program for reporting or other purposes, and changing or adding to picklists. (A picklist is a configurable set of options from which a user can select, typically in a dropdown menu or smart search list.)

The EHR system should be usable "out of the box," with minimal configuration required to meet the basic requirements for the CCBHC model.

Customization

Customization refers to the ability to create new templates or forms within the system. Customization requires specialized knowledge of and skills using the specific EHR and is costly in both resource usage and time. Customized features may not continue to work after a system upgrade.

Designated collaborating organizations

DCOs are organizations with which the CCBHC establishes a formal relationship to ensure all required services are provided to the CCBHC population. The National Council published information on contracting with DCOs in the CCBHC Contracting Community Partnership Toolkit (National Council, 2024).

Electronic prescribing (e-prescribing)

This basic functionality is found in most EHR systems and includes:

- Creating prescriptions that are automatically sent to the pharmacy.
- The ability to check a medication being prescribed for medication-to-medication and drug-to-allergy interaction.
- The ability to query Surescripts for prescriptions prescribed to the person receiving services by providers outside of your organization — a great time saver, because the medication, dosage, and prescriber information is visible and can be selected to be added to the medication list in the CCBHC EHR.

- The ability to send a message to the pharmacy indicating that a medication is discontinued or dosage has changed.
- Two-factor authentication for electronic prescribing of narcotics and other scheduled medications.
- The ability to seamlessly integrate with PDMPs (including with multiple states, if needed).

Fully integrated systems

"Fully integrated" means that all features and functionality come from one vendor, form one system, and share the same database.

Advantages include:

- Seamless, streamlined communication between the PMS, EHR, patient portal, and telehealth systems.
- Information gathered at registration (e.g., preferred method of communication, preferred language, pronouns, family relationships) is visible and can be updated during clinical encounters.
- Patient portal can be used to distribute screening tools; information entered by the person receiving services is viewable and comes into the EHR as structured data.
- Integrated telehealth functionality makes compliance, supporting people receiving services through technology, and reporting more efficient and effective.
- All features and functionality are on the same upgrade schedule from the vendor (i.e., the organization can count on all features working reliably through an upgrade).

Health information exchanges

HIEs allow healthcare professionals and the people they serve to appropriately access and securely share medical information electronically (ONC, 2023). Exchanges can be at the local, regional, state, or national level. Many states have designated HIEs that connect to the national HIE.

HIEs typically share hospital and emergency department discharge information in the admission, discharge and transfer (ADT) and/or continuity of care document format, which, depending on the EHR, allows for the reconciliation of information across care delivery systems. Encounter notification is another valuable service offered by HIEs, providing real-time notification of ADT information for people receiving services. This service provides the CCBHC with information about established people receiving services if they are being cared for at a hospital or emergency department. This information supports proactive outreach and engagement as people transition from inpatient to outpatient care locations.

Interfaces

"Interfaces are tools and concepts that technology developers use as points of interaction between hardware and software components. They help all components within a system communicate via an input-output system and detailed protocols while also allowing them to function independently. Interfaces also help users interact with various types of devices through hardware like keyboards, mice and touch screens and software like operating systems or internet protocols" (Indeed Editorial Team, 2024).

Patient-generated data

Patient-generated (PG) data refers to data that is entered by the person receiving services and is reviewed by the clinic staff before it is absorbed into the EHR. PG data is best used for screening activities (e.g., SDOH, depression, anxiety, substance use). Screening tools must be nationally recognized, validated and standardized to qualify for the CCBHC program.

The value of PG data is multifaceted. Generally, data is more accurate when coming directly from the person receiving services, and it can be completed prior to a visit, which is more convenient for the individual and frees up valuable staff time. PG data can be gathered electronically through the patient portal or tablets in the office. This data can populate the EHR through integration, which is supported by most modern EHRs, portals and tablet applications. Challenges include the significant amount of configuration that CCBHC staff and the vendor must complete during initial implementation. Also, relying on the person receiving services to generate data will not work in all cases because of language restrictions, disabilities and individual preferences. If your system works for even 30% of the people you serve, however, it is valuable to the CCBHC.

Patient portals

According to the ONC (2017), "a patient portal is a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an internet connection." This information can include recent visits, discharge summaries, medications and immunizations, allergies and lab results. These portals provide a means for secure, asynchronous communication between the person receiving services and the care team. This functionality must be compliant with the United States Core Data for Interoperability.

The portal should allow people to:

- View, download and transmit health information (e.g., screening tools)
- Send and receive secure messages from the members of the care team
- Request refills and referrals
- Schedule or request appointments

- View and download educational materials
- Receive reminders for appointments and other health activities
- Update contact information
- Make payments

CCBHCs must comply with federal legislation (e.g., the 21st Century Cures Act) regarding types of information that must be shared with the people receiving services; there is also federal guidance regarding information blocking (ONC, 2024b). Psychotherapy notes, which providers create for themselves, do not need to be shared in an EHR (American Psychiatric Association, n.d.; U.S. Department of Health and Human Services, 2017). However, encounter notes do need to document the interaction with the person receiving services in their personal health record.

Privacy and security

Privacy refers to a person's ability to keep personal health information private and free from unauthorized access, while retaining the ability to access this information and share it as needed. Security is the control of access — who, how and under what circumstances the health information of a person receiving services can be accessed. CCBHCs need to balance securing and sharing this information with the person receiving services and among partners. As this is often challenging for behavioral health providers, readers are referred to Section 7 of the ONC Health IT Playbook (2020). Privacy and security policies and activities are multilayered, and everyone in the organization plays a role.

Telehealth

According to the Centers for Medicare and Medicaid Services (n.d.), "Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distances. At one time, telehealth in Medicaid had been referred to as telemedicine."

Telehealth seeks to improve a person's health by permitting two-way, real-time interactive communication between the person receiving services and the physician or practitioner at a distant site. This communication often requires interactive telecommunications equipment that can include audio and video components, but it can also be conducted via audio only, as states deem appropriate. Telehealth includes such technologies as telephones, email systems and remote client monitoring devices, which are used to collect and transmit the person's data for monitoring and interpretation.

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Appendix A: Sample Stakeholder Engagement Plan

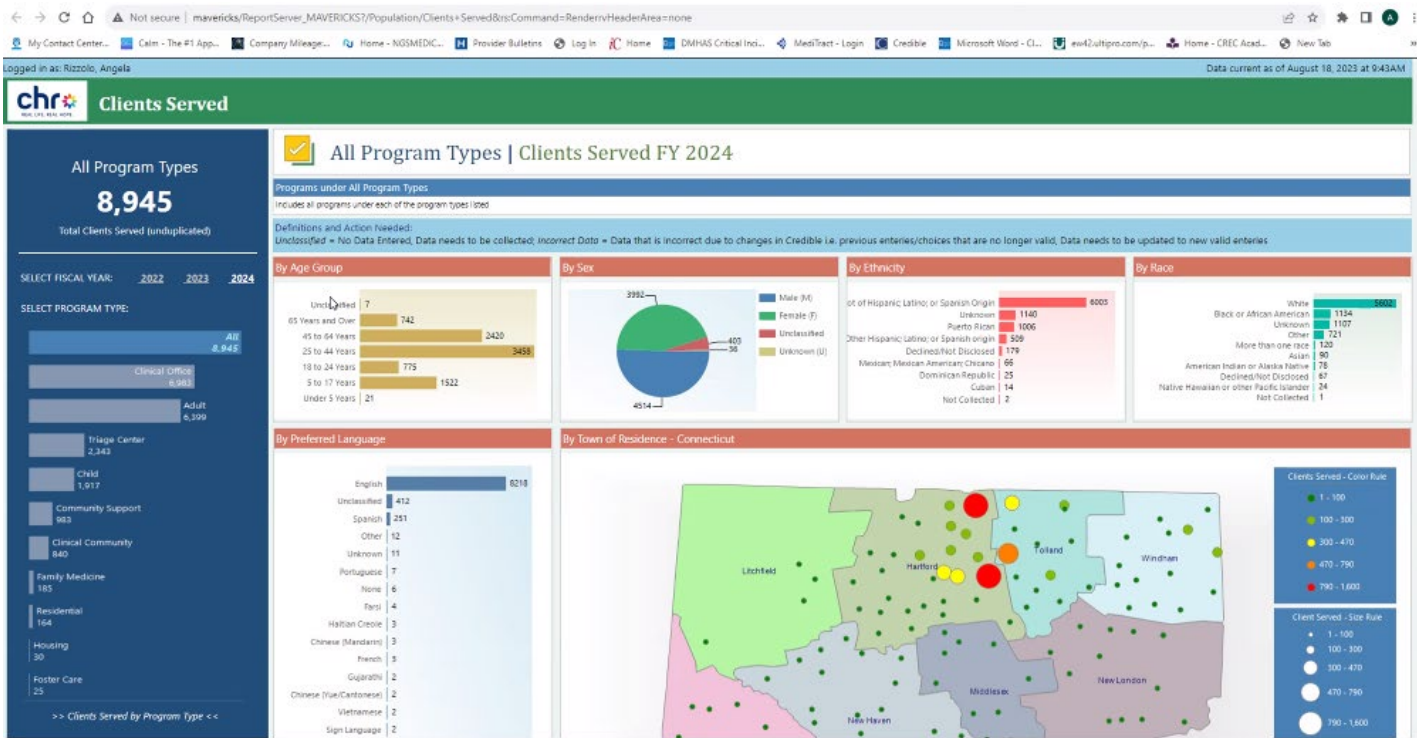
During times of change and HIT system transitions, it is important to seek input from interested stakeholders and proactively communicate with them about new requirements and processes. This tool can help you plan your engagement strategies, grounded in an understanding of what is important to each stakeholder group in the context of HIT. Examples are provided in the first two rows.

Additional stakeholder groups to consider for your CCBHC include: care coordination partners, designated collaborating organizations, clinical staff, government funders (especially those with their own data reporting requirements) and payers.

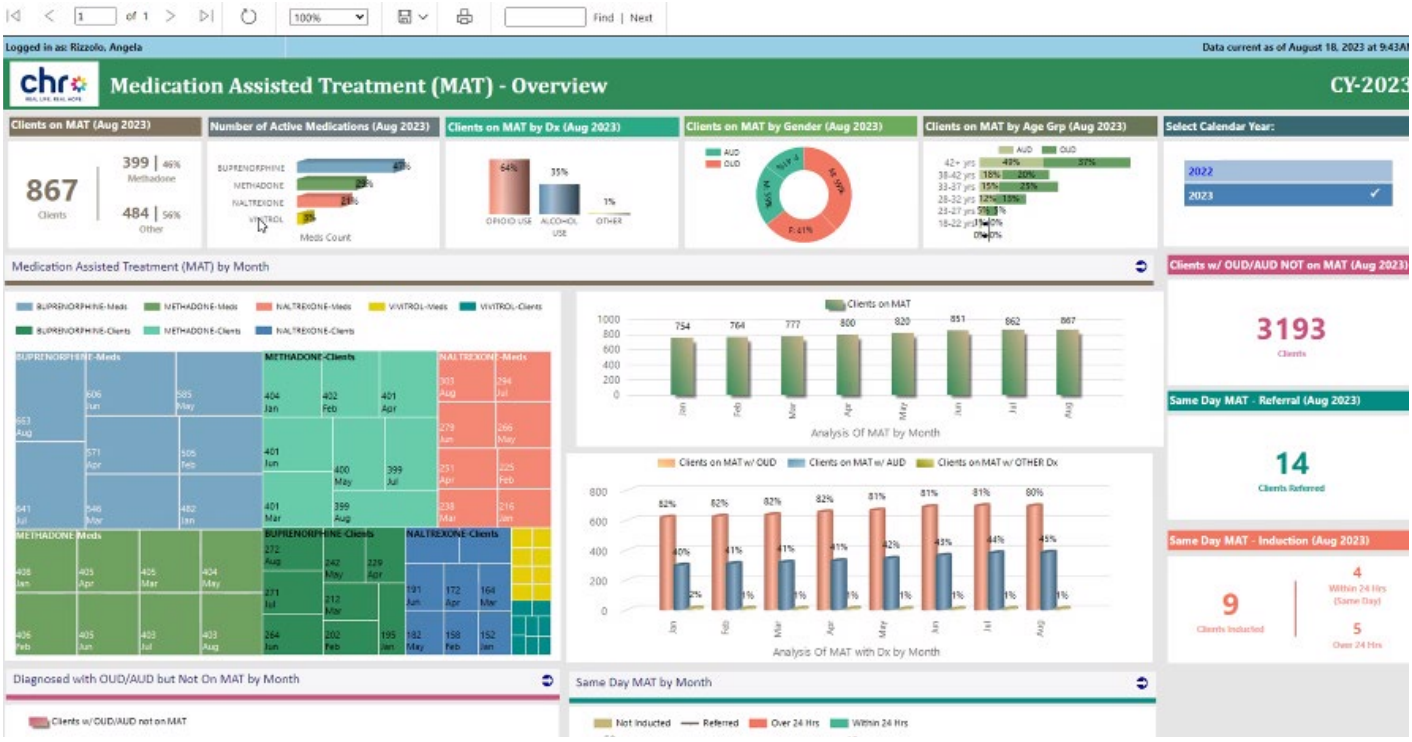
Stakeholder Group	Areas of Interest and/or Concern	Stakeholder Manager	Engagement Approach	Engagement Tools
Front desk staff	Communication with clients; Documentation burden	Operations Director	Face-to-face; Staff training	Email; Handouts at quarterly all-staff meeting; HIT vendor-created tutorials
Current clients	Patient portal functionality; Ease of intake	Client Experience Manager	Face-to-face; Materials shared in waiting room and during intake process	Face-to-face education from front desk staff; Posters and brochures in waiting room and clinical spaces

Appendix B: Dashboard Examples

Clients Served



Medication Assisted Treatment (MAT) — Overview



Appendix C: HIT Vendor Evaluation Form

For CCBHC staff

Vendor Name	
HIT System of Component	
Staff Member Name	
Evaluation Date	
Attended Vendor Product Demonstration YES/NO	

	Staff Completion			
List of 10 Priority Requirements for all vendors *[To be completed by the HIT Team Lead]*	***Meets***	***Partially Meets***	***Does not Meet***	***Notes***
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

CCBHC Requirements

AVAILABILITY AND ACCESSIBILITY [SEE HIT TOOLKIT PART 3, TABLE 1]					
Requirements #	***Focus***	***Meets***	***Partially Meets***	***Does not Meet***	***Notes***
2.a.5	**Telehealth**				
2.a.8	**COOP/disaster plan**				
2.b.1	**Preliminary triage and risk assessment**				
2.b.2	**Person- and family-centered treatment plan**				
2.b.3	**Appointment scheduling**				
2.c.1	**Crisis management services**				
2.c.4	**Relationships with emergency departments**				
2.c.6	**Crisis plans**				
2.d.1	**No denial of services regardless of ability to pay**				
2.d.2	**Sliding fee discount schedule**				
CARE COORDINATION [SEE HIT TOOLKIT PART 3, TABLE 2]					
3.a.1	**Coordination across the spectrum of health services**				
3.a.4	**Psychiatric Advance Directive**				
3.b.2	**Secure HIT to conduct PHM, QI, QM and reporting, reducing disparities, etc.**				
3.b.3	**ONC certified**				
	Captures health information				
	Supports care coordination				
	Provides people access to info				
	Evidence-based clinical decision support				
	Conduct e-prescribing				
3.b.4	**Working with DCOs**				
3.b.5	**Plan for improving care coordination**				
SCOPE OF SERVICES [SEE HIT TOOLKIT PART 3, TABLE 3]					
4.c.1	***Crisis services***				
4.d.3	***Initial evaluation includes:***				
	Preliminary diagnosis				
	Source of referral				
	Reason for seeking care				
	Identification of clinical care needs				
	All current prescriptions and OTC medications				

4.d.3	Previous mental health and SUD treatment				
	Alcohol and other drug use				
	Risk to self and others, including suicide risk				
	Other safety concerns, including Intimate Partner Violence				
	Need for medical care				
	Present/past member of armed services				
	System involvement for children/youth				
4.d.5	BH screening and assessment				
4.d.6	Standardized/validated screening and assessment tools				
4.d.7	Culturally and linguistically appropriate screening tools and approaches				
4.e.1	Person- and family-centered treatment planning				
4.e.2	Individualized treatment plan				
4.e.4	Treatment plan includes needs, strengths, abilities, preferences, goals				
4.e.7	Advance directives w/ client preferences				
4.f.2	Phase-appropriate treatment/MIC				
4.g.1	Outpatient primary care screening and monitoring				
4.g.2	Protocols to ensure screening				
4.g.3	Ongoing primary care monitoring				
4.h.1	Targeted case management services				
4.k.1	Intensive, community-based BH services for U.S. Armed Forces members and veterans				
4.k.7	Comprehensive BH treatment plan for all veterans				
QUALITY AND OTHER REPORTING [SEE HIT TOOLKIT PART 3, TABLE 4]					
5.a.1	Capacity to collect, report and track encounter, outcome and quality data				
5.a.2	Collect and report clinic-collected quality measures				
5.a.3	Medicaid claims or encounter data				
5.b.2	Continuous QI plan and significant events				
5.b.3	Data-driven continuous QI plan				