NATIONAL COUNCIL
for Mental Wellbeing

Health Information Technology for CCBHCs Toolkit

Part 3: CCBHC Requirements and Needed HIT Capacity

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.

This publication was made possible by Grant Number 1H79SM085856 from the SAMHSA. Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions or policies of SAMHSA or the U.S. Department of Health and Human Services.

Acknowledgments

This toolkit was developed in 2024 by Bowling Business Strategies in partnership with the National Council for Mental Wellbeing's CCBHC-E National Training and Technical Assistance Center. It reflects the requirements outlined in SAMHSA's updated CCBHC Certification Criteria.

We are especially grateful to the following people who provided input, feedback and support on the development of this toolkit.

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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.

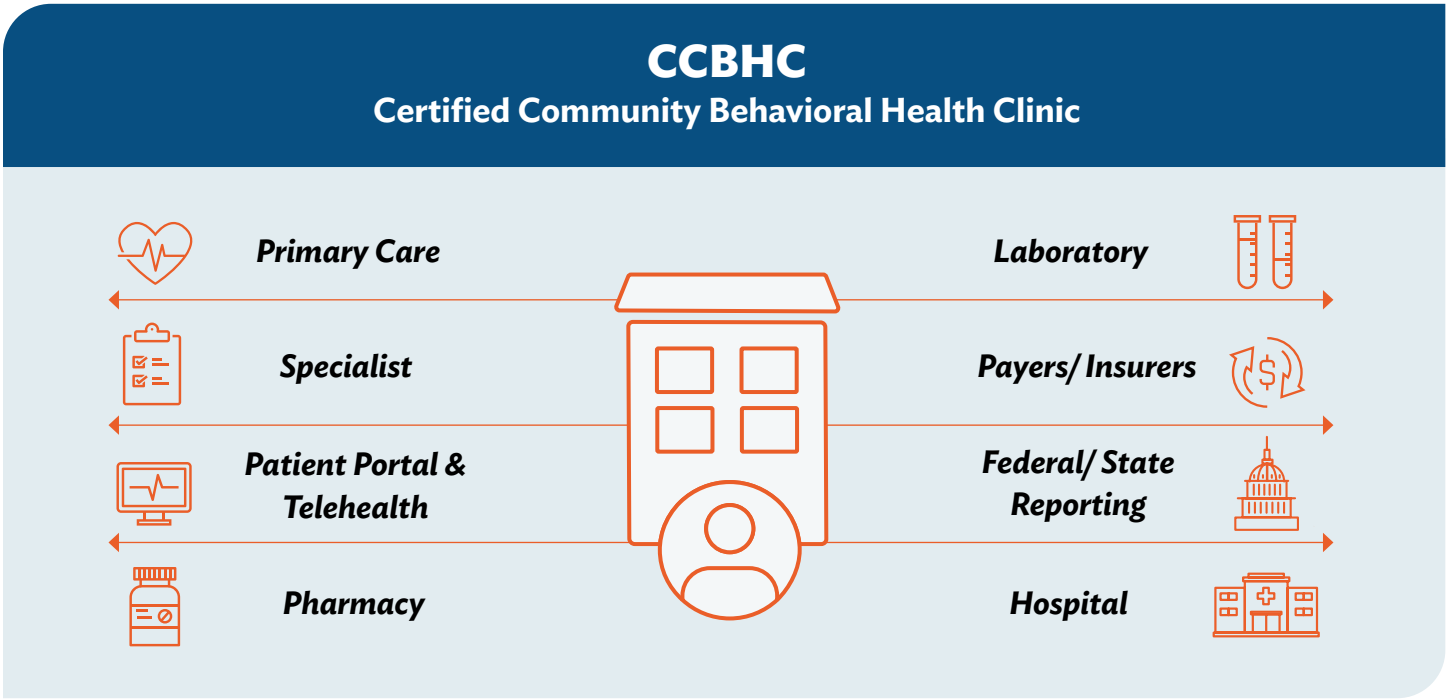
Electronic health records (EHRs) support care that is coordinated across a full range of settings and tailored to the health needs of people receiving services, by documenting the services and activities within clinic walls and with external providers, including referrals and their follow-up. EHRs document 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.

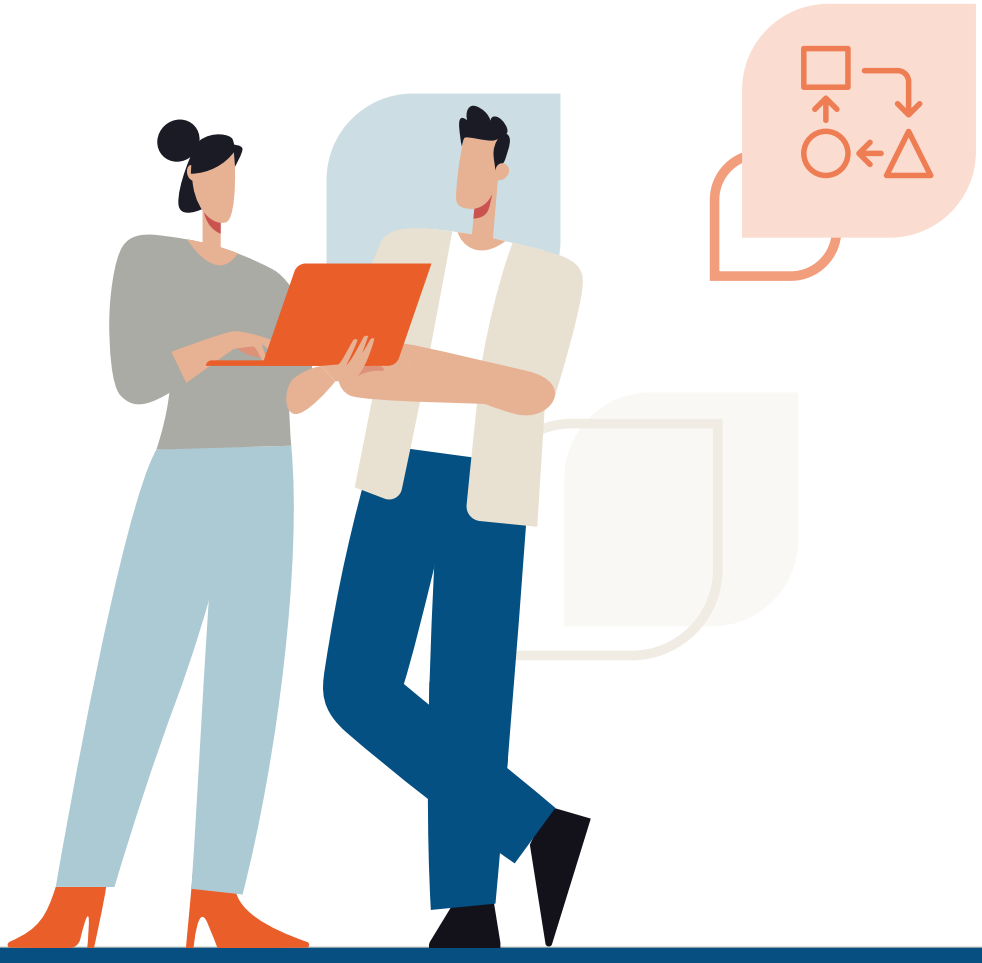
What is health information exchange?

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).*

Figure 1: Health information technology data flow





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 glosary 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.

Part 3. CCBHC Requirements and Needed HIT Capacity

Part 3, CCBHC Requirements and Needed HIT Capacity, is intended for Certified Community Behavioral Health Clinic (CCBHC) leaders with an active electronic health record (EHR) and an understanding of HIT fundamentals who are seeking to optimize their health information technology (HIT). The following tables identify the Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Certification Criteria by HIT-related requirement (left column) and provide associated guidance for building HIT capacity for CCBHCs (right column). In some cases, the SAMHSA requirement listed may be an excerpt of the full requirement that has implications specifically for HIT capacity. When reviewing these tables, document areas of strength and gaps in your current technology to guide your internal discussion.

Table 1. Availability and Accessibility of Services

Requirement (SAMHSA, 2023)	Guidance for HIT Capacity
2.a.5 The CCBHC uses telehealth/telemedicine, video conferencing, remote client monitoring, asynchronous interventions and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services.	When assessing telehealth systems, look for: - Seamless integration with the practice management system (PMS)/EHR that supports documenting consent to treatment via telehealth. - Integration of appointment types with the provider's schedule. - Tools that make it easy for CCBHC staff to support and/or start telehealth meetings. - Seamless collection of data entered by the person receiving services in screening tools (e.g., depression, anxiety, tobacco use, social determinants of health [SDOH]). - Listings of individual preferences (e.g., method of communication, pronouns) that are easily viewable and applicable. - Capacity, capabilities and needs of the person receiving services. - Ability to enable ADA-compliant, robust and accurate closed captioning. - A system that allows for multiple attendees (e.g., family member, translator) to join a session, from different locations. - A "separate rooms" functionality for private conversation, which allows the person receiving services to share data from remote monitoring devices (e.g., glucometer, blood pressure cuff).

2.a.8 The CCBHC has a continuity of operations/ disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses HIT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of	SAMHSA requires CCBHCs to have plans in place to continue operations in the event of a natural disaster, human-caused emergency or cyberattack. The plan must address securing HIT systems and ensuring that the essential health information of people receiving services is accessible during a disaster. This requirement refers to having a plan for securing systems to prevent a breach or ransom situation.
2.b.1 All people new to receiving services will, at the time of first contact, receive preliminary triage, including a risk assessment. Preliminary triage may occur telephonically. The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.	Look for PMS features and functionality that include: - Scheduling reporting that allows the CCBHC to monitor time from first contact to preliminary triage, and time from preliminary triage to initial and final comprehensive evaluation. - Registration fields that display family relationships and supports for the person served. Look for EHR features that include standardized templates that lead the user through the elements of preliminary triage, initial evaluation, comprehensive evaluation and, ultimately, a treatment plan. Look for EHR capacity to document the preferences of people receiving services, including both recovery and life goals, wishes for behavioral health and health care, and advance directives. Optimally, the EHR will have the capacity to document individual strengths and capture preferences in the person's words. Optimized templates: - Are organized in a workflow that makes sense to the clinical team. - Display information gained during registration (e.g., individual preferences, family/friend support relationships, contact information, preferred pharmacy). - Draw from previous visits, allowing providers and staff to build a person-directed treatment plan that includes needs, strengths, abilities, preferences and goals. (See additional information in Table 3, Scope of Services, on page 19.)

	■ Draw from data that has been entered into the person's chart out-side the context of an episodic visit (e.g., data captured through SDOH screening). ■ Translate the information gathered using click boxes and dropdown menus to a useful, readable note. ■ Allow all members of the care team to view and update as indicated and needed. ■ Support navigation to other parts of the system (e.g., registration to confirm or update contact information as needed). ■ Allow for sending data to and receiving data from outside organizations. Optimally, the system can: ■ Reconcile information like diagnoses, medications, allergies, vital signs and lab information as structured data in your EHR. ■ Send a query from your EHR to a state health information exchange (HIE) database on demand. ■ Allow you to send information electronically to outside organizations. It is helpful if the HIE information can be integrated into and viewable from within the EHR and does not require logging into a separate system.
2.b.2 The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal or applicable accreditation standards are more stringent.	Look for PMS features that collect vital demographic information, including family and friend relationships that constitute the support system of the person receiving services. Look for EHR features that can: ■ Make vital relationships visible within treatment plan templates. ■ Allow for all members of the care team to view and update treatment plans. ■ Set an alert and reminder to ensure treatment plans are regularly reviewed and updated. ■ Allow for electronic signature functionality for people receiving services to endorse the treatment plan.

2.b.3 People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.	Look for PMS features with flexible scheduling options that can: - Set up schedule searches to allow the staff to quickly find the next available appointment based on appointment type and number of business days. - Set up scheduling templates with open access scheduling slots for same-day or next-day scheduling options.
2.c.1 The CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.	Strongly consider a hosted or cloud-based system that is easily deployed and accessible to partner organizations. Explore how well the system documents staff work in the community (outside of the clinic). Determine if staff in the community will have timely access to information and whether the system can enable extended access (without lag or timing out). Be sure to consider partners when budgeting for access to the EHR. Ask the EHR vendor the best way to provide your partner with access to your system.
2.c.4 The CCBHC maintains a working relationship with local hospital emergency departments.	Explore your local HIE and inquire about encounter notification, which allows the CCBHC to see admission, discharge and transfer (ADT) information in real time and notifies the care team of the ADT status of the person receiving services. Organizations use this information to communicate with hospitals and emergency departments, which enhances the working relationship.
2.c.6 Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains and follows a crisis plan to prevent and deescalate future crisis situations, with the goal of preventing future crises.	Look for EHR functionality that includes templates for creating, maintaining and regularly updating crisis plans that are created in collaboration with the person served. Alerts and reminders to regularly review the crisis plan are helpful.

2.d.1

The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)); and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).

2.d.2

The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have limited English proficiency (LEP), literacy barriers or disabilities.

Look for PMS features that include the ability to:

- Set up self-paying people receiving services on a sliding fee scale that is based on income, family size and percentage of federal poverty guidelines.
- Configure the sliding fee scale based on a schedule of fees and payments defined by the CCBHC.
- Calculate the person's responsibility based on income.
- Store income documentation.
- Alert and remind staff when eligibility needs to be updated.
- Provide the person receiving services with a written good-faith estimate of fees.
- Provide for the fee schedule to be printed or published in multiple languages and formats.

Table 2. Care Coordination

Requirement (SAMHSA, 2023)	Guidance for HIT Capacity
3.a.1 The CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare.	Acquire the HIT tools needed to coordinate care across a spectrum of services including: ■ Referral management that supports efficient tracking of internal and external referrals. Look for this functionality either in a specialized module from the EHR vendor or from a population health management (PHM) system. Specific needs include reporting that allows for tracking of referrals (e.g., in process, scheduled, prior authorization, completed) and a view of the number of referrals and status issued to each person receiving services. Another helpful report is the number of referrals issued by providers. ■ Embedded access to a database of community-based services to address SDOH. ■ E-prescribing functionality: » Basic e-prescribing with easy workflow for refills, including the ability to identify nurse delegates to complete refills, perform drug-to-drug interaction checking and find medications that are on the person's drug formulary. It is also helpful if the system can suggest alternatives that are in the formulary. » Prescribing for scheduled medications, with integrated access to the prescription drug monitoring program (PDMP) database — with access to multistate information, if applicable. » Prescription history, so staff can see medications prescribed by other providers and add those medications to the medication list. This allows providers to check drug-to-drug interactions even if a medication was not prescribed by a CCBHC provider.
3.a.4 Crisis plans may support the development of a Psychiatric Advanced [sic] Directive (PAD), if desired by the person receiving services.11 Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.	**If you want the EHR to store and retrieve PADs, ask the vendor about:** ■ Functionality that reminds the care team to support, store, and retrieve these documents currently reflecting the wishes of the person receiving services. ■ Alerts and reminders to address PADs initially, and to review and update them per any updates from the person receiving services. ■ Education tools to help people receiving services guide and direct the development of PADs.

3.b.2 The CCBHC uses its secure HIT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.	SAMHSA stipulates that the CCBHC should use electronic or digital tools that are up to date with current industry standards. For HIT, this means including: ▪ PHM tools either as a separate system or as a module embedded in the EHR. ▪ Tools for easy and flexible reporting. ▪ Systems that are accessible to all people, including staff and people receiving services. ▪ Systems that support generating lists of people receiving services for outreach, asynchronous two-way communication between people receiving services and their families and the care team, and ways to document outreach activities that can be viewed by all members of the care team. ▪ Systems that allow for access to individual-level data that can be deidentified for research purposes.
3.b.3 The CCBHC uses technology that has been certified to current criteria 13 under the ONC Health IT Certification Program for the following required core set of certified HIT capabilities … that align with key clinical practice and care delivery requirements for CCBHCs. Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).	See certification criteria from HealthIT.gov (ONC, 2024). For a list of ONC-certified EHRs, review the Certified Health IT Product List (ONC, n.d.). This describes functionality that is typically found in a PMS. Look for this functionality to be fully integrated with the EHR, not in a separate system.
At a minimum, support care coordination by sending and receiving summary of care records.	This refers to the ability to curate a summary of care from the encounters documented in the EHR that can be shared.
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[2] using a personal health app of their choice.	This refers to patient portal functionality. Configure, activate and maintain a patient portal. **Develop a process for offering enrollment in the patient portal for people receiving services:**

[2] *An Application Programming Interface (API) is software with a distinct function that communicates between two systems with requests and responses (ONC, 2017). For example, staff puts in a member's information, and the API communicates with an insurance system to determine coverage for a specific procedure.*

	■ Provide the people receiving services with instructions for enrolling in the portal. ■ Assist the people receiving services with enrollment as needed. ■ Ensure the people receiving services understand how their data will be secured and remain private. ■ Ensure the people receiving services know the benefits of using the portal. The CCBHC needs to also be prepared to work with other applications the person receiving services may be using to access their health information.
Provide evidence-based clinical decision support.	This refers to functionality within the EHR that guides and directs the care team at the point of care. Examples include calling out missing lab values such as a HbA1c.
Conduct electronic prescribing.	E-prescribing, including prescribing narcotics and other scheduled medications (which requires two-factor authentication), is a necessity.
3.b.4 The CCBHC will work with designated collaborating organizations (DCOs) to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements.	Electronic signature functionality enables obtaining consent from people receiving services remotely. Look for this functionality to be included as a part of either the telehealth functionality or the patient portal.
3.b.5 The CCBHC develops and implements a plan within two years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a HIT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the HIT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.	The EHR will need functionality for exchanging electronic health information between the CCBHC and DCO to support communication, documenting and sharing informed consents, evaluation planning, care coordination and treatment. Ensure the system can integrate clinically relevant treatment records generated by the DCO into the CCBHC health record. SAMHSA does not expect that all these requirements will be met on day one. However, the CCBHC must have a plan to have the functionality in place within two years of certification. This document describes a process for data or technology governance that can be used to develop a plan for the transition to a more advanced use of technology.

Table 3. Scope of Services

Requirement (SAMHSA, 2023)	Guidance for HIT Capacity
4.c.1 The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified or licensed system or network for the provision of crisis behavioral health services.	This certification criteria specifically mentions three crisis behavioral health services — emergency crisis intervention services, 24-hour mobile crisis teams and crisis receiving/stabilization (including suicide prevention and intervention and crises relating to substance use). For the CCBHC or DCO, needed HIT functionality includes: ▪ Telehealth ▪ Access to PMS/EHR for community partners and 24-hour crisis teams ▪ Failsafe or redundancy of systems ▪ Standardized templates for documenting crisis evaluations that include standardized and validated screening tools for suicide risk and substance use, including risk of overdose Consider broadband access for people receiving services in the catchment area and the need to provide assistance with technology. Based on broadband access, will there be a need to collect and store information that can be forwarded and imported when internet access is established? (This is often referred to as "store-and-forward" functionality.)
4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed) includes at a minimum: 1. Preliminary diagnoses 2. The source of referral 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services 5. A list of all current prescriptions and over-the-counter medications, herbal remedies and dietary supplements, and the indication for any medications	Look for EHR functionality that includes: ▪ Standardized templates for initial evaluation that address each of the listed components. ▪ Automatic population of information already gathered during triage, crisis assessment or other risk assessments. The goal is to reuse all data collected during a visit and/or entered outside the context of a visit (e.g., by a care coordinator updating the chart between visits). ▪ Structured information as much as possible, to improve information accuracy and efficiency for the staff and allow them to focus on the person served rather than the computer for documentation. ▪ Templates that provide adequate space for the use of free text to document the words of the person served. ▪ Access to data collections and reports on medications, previous treatments, etc.

6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful 7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications 8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors 9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence 10. Assessment of need for medical care (with referral and follow-up as required) 11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services 12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice)	
4.d.5 Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix B of these criteria. **4.d.6** The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement. **4.d.7** The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.	Program Requirement 5 describes data collection, reporting, and tracking, as well as continuous project management. Appendix B lists required measures, including depression remission, preventive care and screening, clinical depression (and follow-up plan) and SDOH. Look for: - Systems that come with common assessment tools embedded or the ability to add assessment tools as needed. Evaluate what is included by verifying that the system includes the screening and assessment tools you are currently using or wish to use. - Standardized, validated and culturally, linguistically and developmentally appropriate screening tools. Ask the vendor which of the standardized tools you wish to use are included. In some cases, vendors may not include the exact assessment tool to avoid copyright costs. - Screening tools that can be adapted for literacy levels and disabilities.

4.e.1 The CCBHC directly, or through a DCO, provides person-centered and family-centered treatment planning, including but not limited to, risk assessment and crisis planning (CCBHCs may work collaboratively with DCOs to complete these activities).	Determine if third-party integration is possible. Review functionality for interoperability with other organizations for sharing clinically relevant treatment records between the CCBHC and DCO. Look for EHR functionality that displays family relationships and supports in the context of the templates used to develop the treatment plan.
4.e.2 The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.	Look for EHR functionality with templates that help guide treatment planning by: - Populating templates with information gathered during the triage, crisis evaluation, initial evaluation and outside of the context of a visit. - Supporting documentation regarding health promotion, disease prevention activities and medical and behavioral health needs. - Permitting viewing and updating by all members of the care team (e.g., care coordinators, peer support). - Clearly documenting the person- and family-centered treatment goals. - Gathering the necessary consents for release of information to and from community partners.
4.e.4 Treatment planning includes needs, strengths, abilities, preferences and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.	Evaluate all clinical information from assessments, other providers, discussion with the person served around their care needs and reasons for seeking care, and other relevant input (e.g., caregivers, guardians), to ensure any areas of concern can be captured in the treatment plan as both structured data and in free text using the words of the person served. Free text is captured in labeled fields so that it can be pulled into future encounters, where it can be reviewed and updated. Free-text fields can accommodate a large number of characters. Some vendors truncate free-text fields, forcing users to adapt the text to the size of the field.
4.e.7 The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services.	Look for EHR functionality that: - Includes documentation that (a) advance directives and/or crisis plans are on file, or (b) the person served declines to share advance directives. - Allows these documents to be viewed and updated during a clinical encounter. - Allows user-defined alerts and reminders to ensure advance directives are regularly reviewed and updated.

4.f.2 Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth-guided and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes.	Measurement-informed care is driven by individual-reported data that informs clinical care and individualizes ongoing treatment plans. The person served completes standard assessment tools, and the EHR then produces results viewable as structured data. Identify the library of screening tools you in-tend to use through the EHR and match it to screening tools available in the core set the EHR offers. Look for EHR functionality that: - Allows access to data from standard assessment tools you distribute through the patient portal or tablet technology. - Documents the goals and shared decisions of the person receiving services. - Incorporates the goals and shared decisions of the person receiving services in the treatment plan. - Allows automating a schedule in the system for distributing the assessment tools based on the type of person receiving services (e.g., diagnosis) and their age.
4.g.1 The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions: - HIV and viral hepatitis - Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix B - Other clinically indicated primary care key health indicators of children, adults and older adults receiving services, as determined by the CCBHC Medical Director and based on environmental factors, social determinants of health and common physical health conditions experienced by the CCBHC person receiving services population.	Current guidelines do not explicitly state what screening and monitoring will be required and leave it up to the medical director to establish protocols. CCBHCs will want to be prepared to ensure that the people receiving services are getting routine primary care screening and monitoring of health risk as the model develops and matures. Essential EHR functionality includes the ability to: - Document important health promotion activities as structured data. - Receive health information as structured data in the CCBHC's EHR (e.g., vital signs, lab values, diagnoses, medications, allergies, immunizations). - Document HIV and viral hepatitis status. - Document HbA1c values for people receiving services with or at risk for diabetes. CCBHCs need to develop protocols that specify who will be responsible (i.e., CCBHC or DCO) for screening. Developing these protocols prior to choosing an EHR and other reporting systems such as the PHM system or module, is beneficial.

4.g.2 The Medical Director will develop organizational protocols to ensure screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols will include: - Identifying people receiving services with chronic diseases; - Ensuring that people receiving services are asked about physical health symptoms; - Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g. The CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization.	Based on decisions about collecting biological samples for lab analysis, consider implementing a lab interface. If you plan on ordering labs, you will want a bidirectional interface with the lab — orders outbound from your EHR to the lab(s), results inbound (as structured data) to your EHR from the lab(s). You will also want the inbound interface to automatically complete the lab order. Alternatively, if the DCO will be responsible for labs, you will want to be sure that lab information can be shared with you as structured data, keeping in mind that structured data is reportable and the ability to report will become important for program and funding purposes, as well as evaluating performance internally.
4.g.3 The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following: 1. ensuring individuals have access to primary care services; 2. ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions; 3. coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and 4. promoting a healthy behavior lifestyle.	Look for PHM functionality that: - Enables care coordinators to identify people receiving services who need access to primary care services. - Embeds access to referral to primary care. - Includes pre-visit planning tools that identify gaps in care (e.g., completed or missing lab tests, risk calculations, and/or diagnostic testing). - Gives care coordinators the information they need to collaborate with primary care providers and care teams to encourage engagement of the person receiving services. - Makes education materials for the people receiving services readily available to be shared with them in person or through the patient portal.
4.h.1 The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC.	To meet this requirement, look for PHM functionality that: - Identifies the group of people receiving services who need targeted case management services. - Embeds access to a database of community agencies that provide relevant services, and the ability to seamlessly refer people receiving services to these agencies and track referrals. - Allows the CCBHC to create panels of people receiving services, assign them to care coordinators and manage workload. - Includes reporting capabilities to monitor quality indicators and staff performance.

4.k.1

The CCBHC is responsible for providing directly, or through a DCO, intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law.

4.k.7

There is a behavioral health treatment plan for all veterans receiving behavioral health services.

1. The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and the plan itself.
3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning and prevent relapses or recurrences of episodes of illness.
4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
5. The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

To meet this requirement, the CCBHC will first need to evaluate the volume of active military members and veterans they will be supporting.

The EHR requirements will be primarily related to:

- Reviewing the specific requirements for the treatment plan (see Requirement 4.k.7).
- Ensuring that substance use is considered in the context of behavioral health diagnoses.
- Allowing for advanced privacy and security that protects the identity of the person receiving services when necessary.

Ask the vendor about "break-the-glass" functionality. This alerts staff opening an encounter or chart that they must (a) have security clearance to "break the glass," and (b) state their reason for opening the encounter or chart. All this information is reportable, and an organization can take action if a staff member is accessing information without authorization.

Table 4. Quality and Other Reporting

Requirement (SAMHSA, 2023)	Guidance for HIT Capacity
5.a.1 The CCBHC has the capacity to collect, report and track encounter, outcome and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards.	Collecting and reporting on comprehensive data is important for fulfilling program and funding requirements. The data is also critical for facilitating organizational decisions about people, processes and technology. Note the phrase "but not limited to" in the CCBHC requirements. Ask vendors about: - The system's ability to report on all structured data in the EHR. - Additional reporting modules that will help you meet reporting requirements. - Sample reports that illustrate how the system can meet your needs. Strongly consider PHM options (third-party or extra module in the EHR). Among their core functions, PHM systems report on clinical quality measures and contain other tools that help CCBHCs improve quality. Functions include: - Identifying lists of people receiving services based on various criteria, which can be used for outreach and monitoring. - Providing pre-visit planning tools that can be used during an encounter (e.g., a reminder that a person needs to complete a HbA1c lab). - Enabling reporting on performance indicators by location, provider, etc.
5.a.2 [CCBHCs] must collect and report the Clinic-Collected quality measures identified as required in Appendix B. Reporting is annual and, for Clinic-Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA.	Appendix B on page 58 of the SAMHSA Certification Criteria specifies the required clinic-collected measures. These include: - Time to services - Depression remission at six months - Preventive care and screening: unhealthy alcohol use: screening and brief counseling - Screening for clinical depression and follow-up plan - Screening for SDOH Note that, for Medicaid demonstration sites, there will also be some state-required reporting that may include additional measures. It is also critical to consider that, if collaborating with a DCO, the CCBHC is responsible for arranging access to quality measure data for individuals receiving CCBHC-related services by the DCO when the relationship with the DCO is created.

5.a.3

In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC-identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to the Centers for Medicare and Medicaid Services (CMS) through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred.

In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually.

To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and, as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.

Your CCBHC is not required to offer the same program to all people receiving services in your population, although you will need to identify the people participating in this program. You can use claims information to meet this requirement and will need to ask your vendor (PMS/EHR, PHM) how you will be able to identify the people receiving services engaged in the CCBHC model, including:

- Date of service
- CCBHC covered services
- Units of services provided
- Diagnoses addressed

Ask the vendor to demonstrate this functionality.

5.b.2 The continuous quality improvement (CQI) plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.	To include these events in the CQI plan, you will need a way to identify that they occurred and have a process for documenting them. HIT can help with either of these approaches: If available, use encounter notifications through the HIE that include ADT information. It is important to identify how you will get encounter notification information directly into your EHR, particularly as structured data. Some HIEs offer a clinical portal where this information can be viewed and sorted, and then manually entered into the EHR for documenting and reporting purposes. Create a direct feed from the HIE to the PHM system. Typically, this information can be pulled in as structured data. It then becomes a data element in the PHM system and can be used to report on these significant events. Either approach will require that you adopt a process to document and code these events in the EHR.
5.b.3 The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC-collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.	For the focus on populations, use a PHM system or, at minimum, a PHM module embedded in the EHR. The PHM system is a more reliable option because the CCBHC will be able to see clearly how data in the EHR is mapped in the PHM system and will be able to adapt the mapping to how the EHR is used. For example, if an SDOH screening tool has been integrated into the EHR, the mapping of the SDOH criteria can be customized to the screening tool being used to gather the data. In an embedded system, the organization will need to adapt to accommodate the vendor-provided SDOH screening tool to view and report SDOH data from a population level.

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

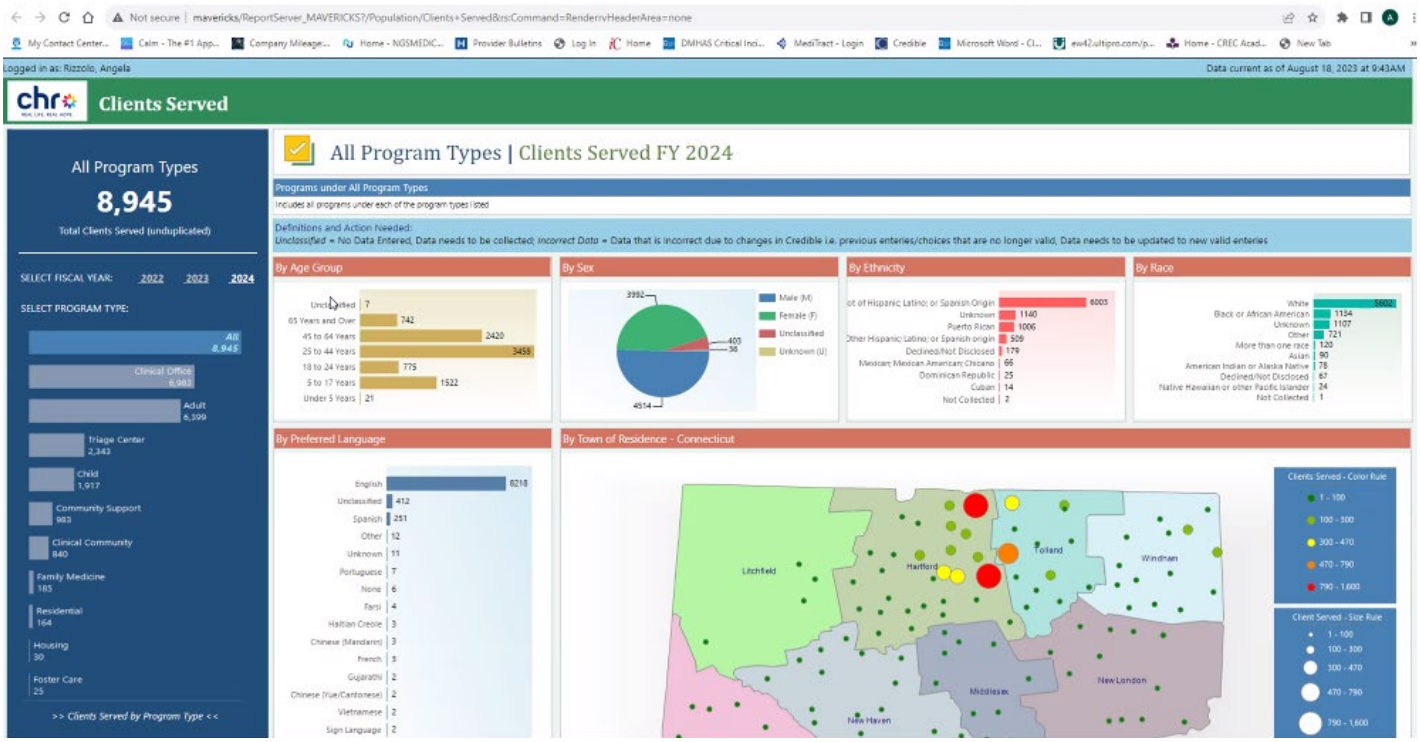
During times of change and HIT system transitions, it is important to seek input from interested stakeholders and proactively communicate with them about new requirements and processes. This tool can help you plan your engagement strategies, grounded in an understanding of what is important to each stakeholder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

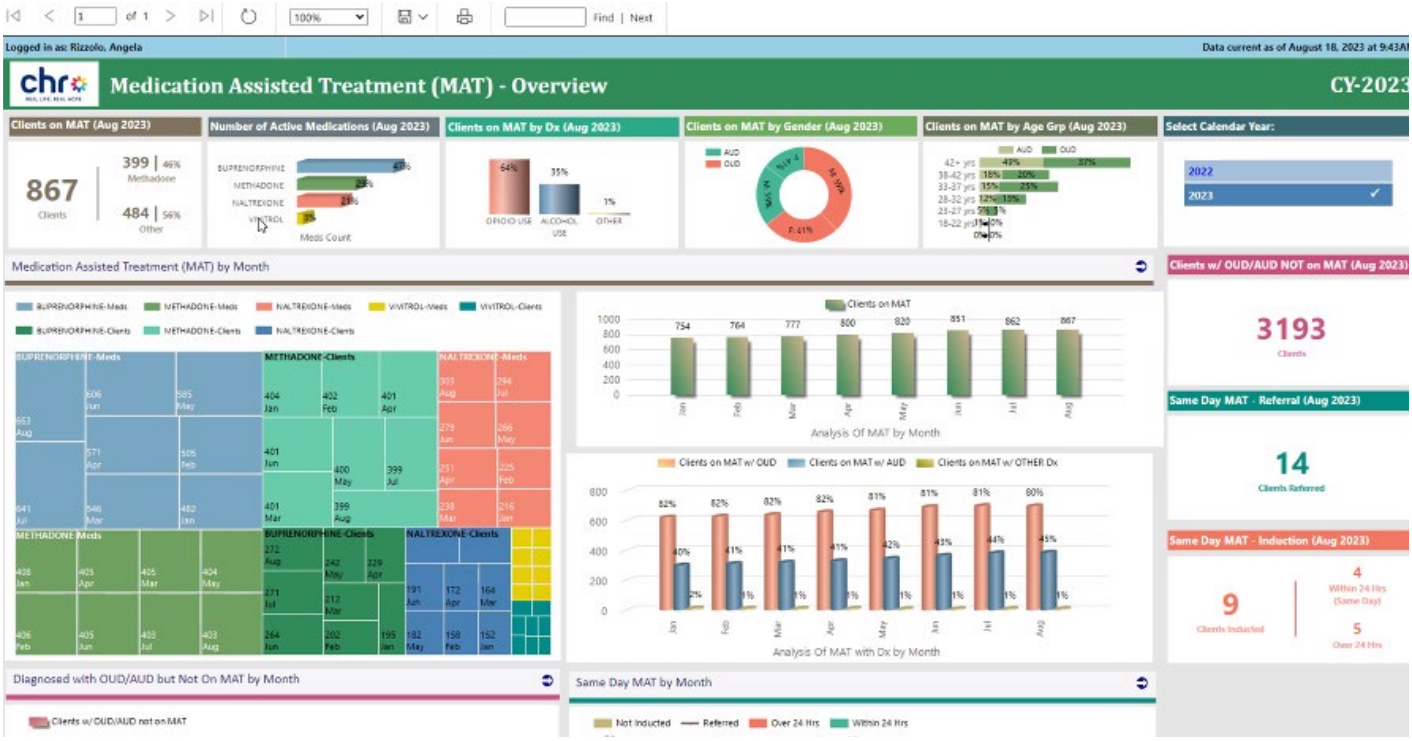
Stakeholder Group	Areas of Interest and/or Concern	Stakeholder Manager	Engagement Approach	Engagement Tools
Front desk staff	Communication with clients; Documentation burden	Operations Director	Face-to-face; Staff training	Email; Handouts at quarterly all-staff meeting; HIT vendor-created tutorials
Current 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				