NATIONAL COUNCIL for Mental Wellbeing

Health Information Technology for CCBHCs Toolkit

Part 2: CCBHC Priority Areas

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.

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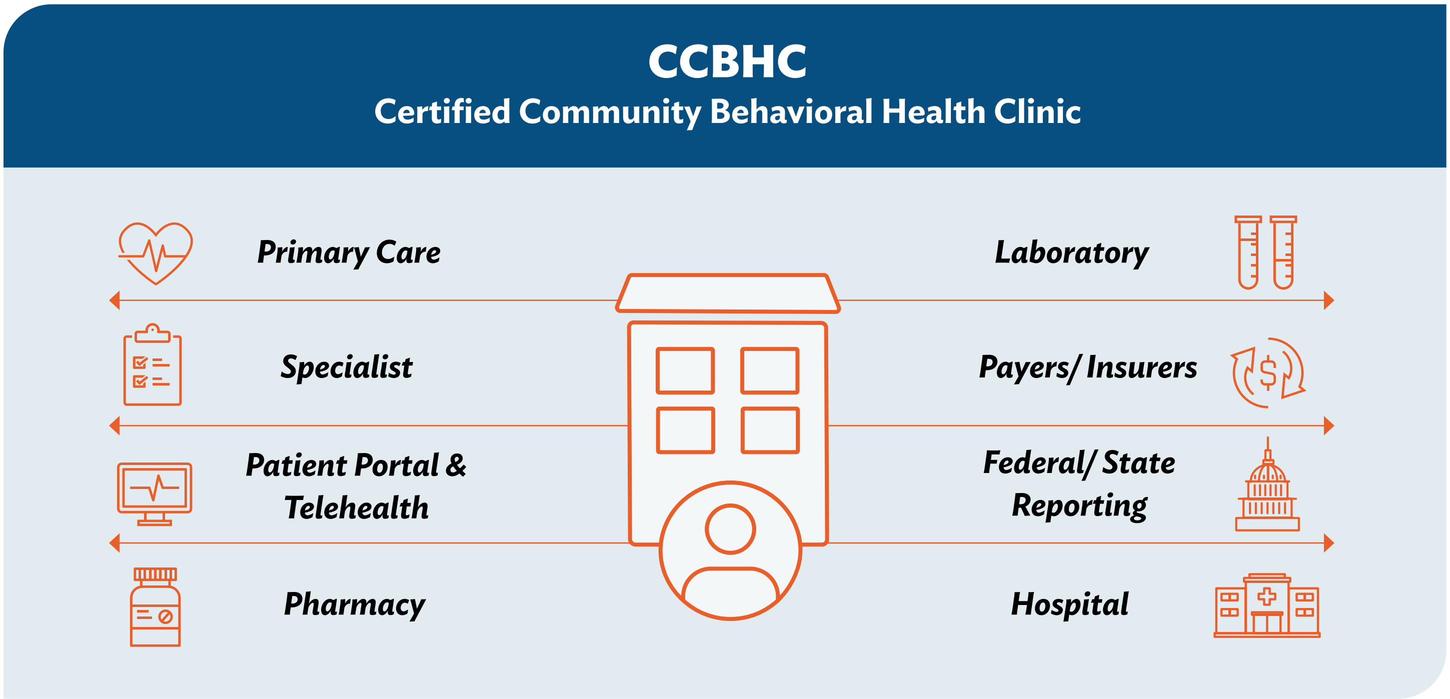
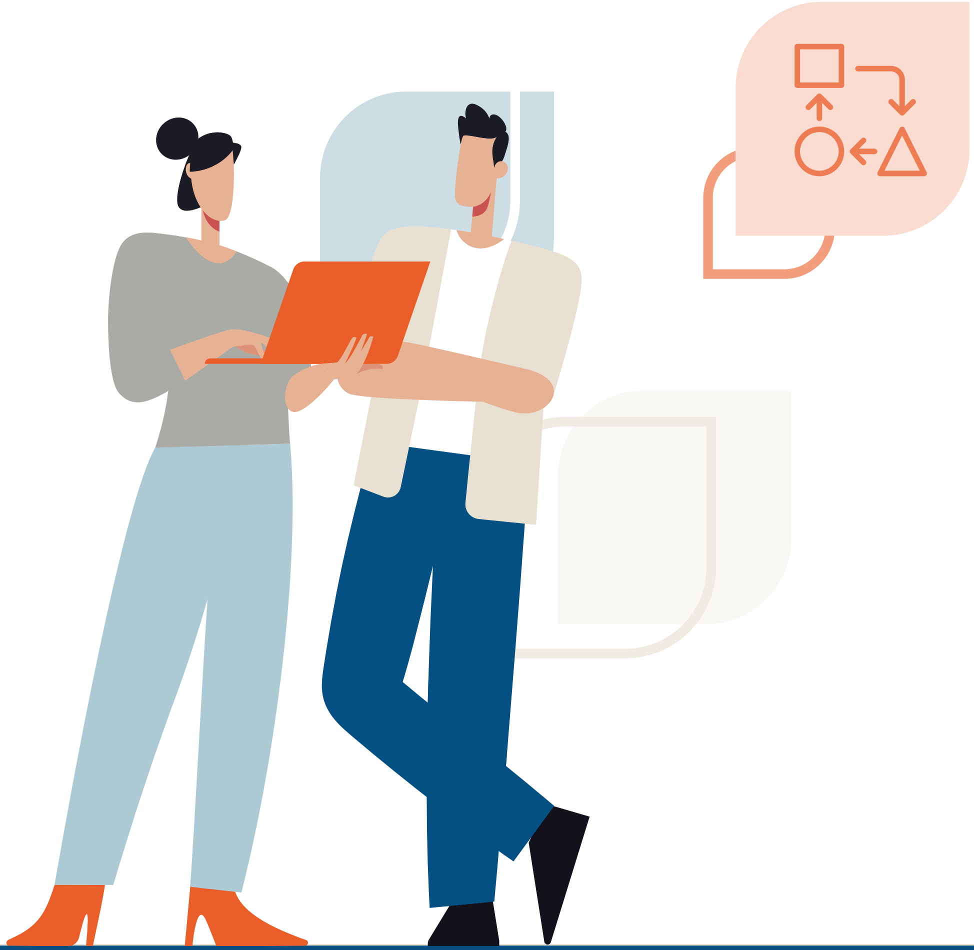
[1] *The Health Information Technology, Evaluation and Quality Center (hiteqcenter.org) has many helpful resources related to data and reporting, including Growing and Sustaining a Data-driven Culture (vimeo.com/397988837).*

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 2. CCBHC HIT Priority Areas

Part 2, CCBHC Priority Areas, identifies important considerations for the use of Certified Community Behavioral Health Clinic (CCBHC) health information technology (HIT), including care delivery, care coordination, health information exchange (HIE), person- and family-centered treatment planning, population health management and quality and funder reporting.

Care Delivery

Ultimately, the goal of HIT is to deliver high-quality, timely care to people receiving services from your CCBHC.

With ever-expanding clinical knowledge and best practices, HIT can support clinicians, staff, people receiving services and others by providing the best available guidance in the context of each person's needs and goals, to enhance their health and care via clinical decision support (CDS). The Office of the National Coordinator for Health IT (ONC) (2018) describes a range of CDS tools to enhance decision-making in the clinical workflow, including:

- Computerized alerts and reminders to care providers and people receiving services
- Clinical guidelines
- Condition-specific order sets (i.e., diagnostic or symptom-based)
- Focused data reports and summaries on people receiving services
- Documentation templates
- Diagnostic support
- Contextually relevant reference information

CDS is beneficial because it increases the quality of care and enhances health outcomes, helps avoid errors and adverse events and leads to improved efficiency, cost savings in relation to benefits, and provider and satisfaction of the person receiving services.

Another use of HIT that has been shown to improve the quality of care and improve treatment outcomes is measurement-informed care (MIC). MIC is a clinical model of person-centered care that enhances an individual's experience and engagement in care. A 2022 Substance Abuse and Mental Health Services Administration (SAMHSA) workgroup defined measurement-based care (another term for MIC) as "a clinical process that uses standardized, valid, repeated measurements to track an individual's progress over time and to inform treatment, utilizing a shared patient-provider treatment planning and treatment decision-making process" (Barber et al., 2022).

Measures (often referred to as instruments or tools) may be focused on a population (e.g., children), a diagnostic category (e.g., schizophrenia), a specific problem (e.g., pain, social isolation) or factors such as engagement between the therapist and the person receiving services. The measures selected are specific to the different populations served, settings, services and needs. MIC is tailored to the CCBHC's HIT and existing workflows and workforce capacity.

Lastly, when HIT brings data into decision-making in a user-friendly way, it can lead to better approaches to care. The CCBHC representatives interviewed found that data visualization is a valuable tool for sharing progress and impacting care decisions.

> **We worked in tandem with our EHR to create an outcomes-based treatment plan. So as someone is providing a service, we wrap that up into an encounter. As part of that encounter, we provide feedback on how that individual is meeting their objectives on their treatment plan. So it is a living, breathing treatment plan, using data visualization, where you have the data on how they are doing at any point, not just during a formal review at 90 days or six months. You can review progress and make adjustments for the individual based on what's working or not working before you get to those checkpoints."**
>
> *—Matthew Spencer, MA, LPC, CPRSS, Chief Clinical Officer, Grand Mental Health*

Care Coordination

Early in your HIT planning process, starting with completing the Community Needs Assessment, consider how you will use HIT for care coordination, which is a core consideration for establishing your CCBHC. The specific criteria are listed under Program Requirement 3: Care Coordination in the CCBHC Certification Criteria (SAMHSA, 2023a).

Care coordination is an approach to care focused on aligning care within the CCBHC and across settings and supports to address the full range of care. It is a core activity rather than a service, one that you may need to add or expand so that the care activities of the person receiving services are intentionally organized, with a specific focus on their preferences and ensuring that everyone involved in their care is properly engaged and aware of preferences.

According to the Agency for Healthcare Research and Quality (2018), care coordination activities include:

- Establishing accountability and agreeing on responsibility
- Assessing the needs and goals of the person receiving services
- Creating a proactive care plan
- Communicating/sharing information
- Helping with transitions of care
- Monitoring and follow up, including responding to changes in the person's needs
- Supporting the person's goals and decisions
- Linking to community resources
- Aligning resources with individual and population needs

Implementation considerations

Be sure you have done a full assessment of your technology needs to support your care coordination program. This assessment, which can be part of your Community Needs Assessment, will be a critical part of your requirements-driven technology procurement and implementation process.

1. Meet with care coordination staff to assess how HIT can help your care coordination program. List all the requirements you expect your electronic health record (EHR) vendor to provide based on available modules, templates or add-ons.

2. Determine any gaps between your technology requirements and what is available through the EHR, to assess whether additional hardware or software would be beneficial to your program. Focus on how technology can help your care coordination staff be more efficient and effective in improving health outcomes for the people receiving services. Don't be fooled by bells and whistles that may negatively impact workflows, create staff burden or make accomplishing a task more complicated or expensive.

3. Create a prioritized list for procurement and implementation based on your stated requirements, any additional wish-list items and available resources.

4. Work with your HIT vendor(s) to implement any new HIT using a phased approach, including any data migration efforts.

5. Train all staff are trained to use all new technology using best practices, such as a train-the-trainer model with supplemental support (e.g., video tutorials and FAQs) for each new application, module or tool.

6. Educate and onboard all people receiving services and their caregivers to any patient- or caregiver-facing applications using tip sheets and web tutorials as needed.

7. Follow up with care coordination staff frequently in the early stages of implementation of any new tools, and then at regular intervals once tools have been in use, to solicit feedback about how the tools are being used, any barriers to use, and any new requests or suggestions for improvements.

HIT tools to improve care coordination capacity and workflows

HIT can be used to improve care coordination across many of the areas noted above, including:

- Providing structured assessments.
- Developing a person-driven treatment plan, centering the goals and preferences of the person receiving services.
- Accessing and sharing patient information between members of the care team and between providers, people receiving services and caregivers.
- Documenting advance directives for health care, including psychiatric advance directives, living wills and durable power of attorney.
- Providing referrals to community resources.
- Improving engagement in treatment.

HIT is especially valuable when the people receiving services are transitioning to different levels of care, such as emergency departments, acute care and psychiatric hospitals, residential facilities and skilled nursing facilities. In addition, recent studies have shown that implementing technology to coordinate care enables the people receiving services to be more involved in their care decisions and maintain control of their treatment and progress (Samal et al., 2016).

HIT tools to support care coordination, and the corresponding care coordination goal or activity, are detailed in the table below.

HIT Tool	Purpose	Care Coordination Value
EHR template for assessments and treatment plans	Provides an efficient way to access and record clinical and social determinants of health (SDOH) assessments and per-son-centered treatment plans.	Assess the needs and goals of the person receiving services Create a comprehensive care plan Support the person's preferences and decisions Respond to changes in the person's needs
EHR-embedded CDS tool	Provides specific alerts or suggestions accessed in the clinical or care coordination workflow that is based on the person's recent medical history, new prescription, or care transition.	Support transitions of care Enable monitoring and follow-up Communicate information
EHR/PMS-embedded care coordination worklist and dashboard	Helps staff prioritize the people they serve for outreach and follow-up and enables staff to record their activities and track their progress.	Support transitions of care Enable monitoring and follow-up Communicate information Respond to changes in people receiving services' needs Capture care coordination activities in billing and reporting
Secure messaging application	Allows providers to communicate directly with another provider or with a member of the care team via a secure email or text message. This tool may be embedded in the EHR or may be a separate application.	Enable communication between members of care team, including person receiving services/caregiver Support individual preferences Enable monitoring and follow-up
Telehealth technology	Facilitates the provision of long-distance/remote health care.	Support individual preferences Enable monitoring and follow-up Communicate information
Community resource directory and referral tool	May include an SDOH assessment, resource directory and referral capability to address the person's needs outside the health care system.	Link to community resources Support person's goals and decisions Communicate information Assess and respond to person's needs

HIE	Facilitates electronic data-sharing among authorized organizations and individuals.	Facilitate communication and coordination between clinical providers, care coordinators and people receiving services Support transitions of care Enable monitoring and follow-up
Personal health record (PHR) and portals	Provides the people receiving services with secure, 24-hour access to their health information from any location with an internet connection. People receiving services may schedule appointments, refill prescriptions, email their providers and access their discharge instructions and medication information.	Facilitate communication and coordination between clinical providers, care coordinators and people receiving services Support individual goals, decisions and preferences Establish responsibility and accountability Support transitions of care
Remote monitoring and client-facing mobile applications	Allows people receiving services to access educational and behavioral support mate-rials specific to their health conditions and needs; in addition, these apps may provide mobile access to PHRs and the ability for people to submit health information to their care team.	Facilitate communication and coordination between clinical providers, care coordinators and people receiving services Support individual goals, decisions and preferences Establish responsibility and accountability

Care coordinator information and communication needs

Efficient, effective care coordination includes sharing information electronically among all the participants supporting patient care, including providers within the CCBHC and external partners (e.g., primary care providers [PCPs]), and with the person receiving services and their caregiver.

To provide efficient and effective care coordination, the care coordination team needs the following:

1. **A specialized view of the health information stored in the PMS/EHR, including:**
    - **A high-level or dashboard view of all assigned people receiving services** with supporting, individual-level information, to help the care coordinator plan coordination activities and measure their effectiveness.
    - **A prioritized worklist of all assigned people receiving services** that allows staff to work through the list and document their care coordination activities. This list can be driven by alerts related to

transition-of-care support needs or alerts related to preventive or chronic care management needs (e.g., “A1c test needed”). The worklist could also be generated from the population health management (PHM) system, where people receiving services are prioritized based on specific criteria or where a specific population is prioritized for outreach activities.

- **Access to individual-level information to support their outreach activities and understand the preferences of people receiving services.** This will include information collected in the patient registration fields (e.g., family relationships, preferences for language and communication, pronouns), their treatment plan and, if available, a crisis plan. It should also include necessary information from the EHR that notes any behavioral health and physical health conditions.

- **A display of the members of the person’s care team,** internal and external to the CCBHC, (e.g., behavioral health providers, physical health providers, care coordinators, social workers, peer support team members, community service providers), noting who among the external members has primary responsibility for care coordination.

2. **The ability to view and incorporate health information shared electronically from organizations outside the CCBHC.**

   - As the CCBHC grows, care coordinators may need to **routinely identify gaps** in care and make reasonable attempts to fill these gaps and document when gaps have been closed. Identifying these gaps may require information shared from another health care provider, such as primary care. For example, if a person with diabetes is receiving primary care from another provider, the care coordinator checks with the PCP to ensure that the person has an updated A1c test or an updated diabetic eye exam. Other examples may include preventive screenings such as mammograms or immunizations such as flu or shingles vaccines for people over a certain age. In all of these scenarios, the care coordinator may need to document that the identified test or vaccine is needed, and then document again once the person has received the test or immunization.

   - **Information from social service providers via an SDOH platform** or from other communication methods will enable the care coordinator to monitor and follow up with the person about their ability to access community resources to address their SDOH needs, such as access to reliable transportation to travel to and from health care appointments or access to healthy foods, especially for people with certain chronic conditions like diabetes or heart disease.

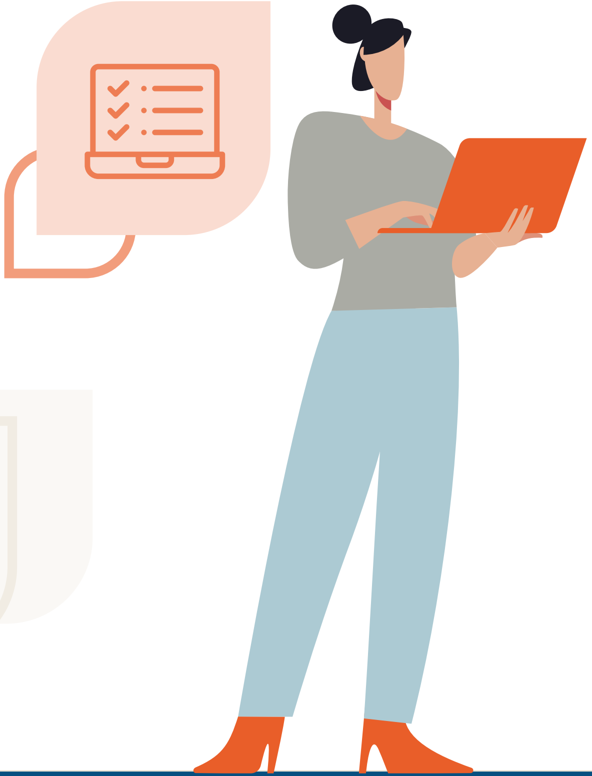
   - To support successful transitions of care for the person receiving services, the care coordinator will need **access to real-time admission, discharge and transfer (ADT) alerts** to provide timely follow-up with the person when they are discharged from a hospital or have an emergency department visit. These alerts may be available from a state or regional HIE or via a direct ADT feed with a partner hospital.

   - The care coordinator will also need a **method to communicate with internal and external members of the health care team,** to ensure that the person’s preferences and goals are communicated to all team members.

Scenario: Care coordinator use of HIT

As a care coordinator for Great Treatment CCBHC, Cathy is responsible for coordinating care and community resources for a group of 35 people who receive behavioral health care at Great Treatment. Cathy begins each day by logging into the care coordination module of Great Treatment's comprehensive EHR. Cathy reviews the list of her assigned people receiving services in the dashboard, where she can see if any new people have been added to her list. She is also able to see at a glance which people she needs to prioritize for outreach or follow-up that day. The dashboard view uses a color-coding system to prioritize the people receiving services, so she can quickly create a worklist of those who have a red or yellow indicator. Cathy knows that the people in these two highlighted groups need to be contacted because they have had a recent hospital visit or other care transition, or because they have experienced a gap in care, missed an appointment or haven't been able to be contacted recently.

Prior to contacting each person in the red category, Cathy checks her encounter notification tool, which is fed by the state HIE. This tool provides real-time notification of any hospital ADT information for a person receiving services. Cathy has already established a filter, so she is only reviewing alerts for the people on her list. Cathy sees in the tool that one of the people prioritized for the day has had a recent emergency department visit, and another person was just admitted to a local hospital. She decides to prioritize the person who was just at the emergency department, but she wants to get a little more information before contacting him, so she logs into the EHR, which is connected to the state HIE. Cathy can see his emergency department discharge instructions and makes a note in her worklist that his medications were changed and that he is supposed to exercise more and adopt a low-salt diet. With this information in hand, Cathy turns to her care coordination module, where she can find the person's contact information, treatment plans, noted preferences for contact time and any notes from previous contacts that will help her connect to her people receiving services.



When Cathy reaches her first person receiving services, she reminds him about his discharge instructions and asks if he has any questions or needs any support with his new dietary restrictions and exercise recommendations. Cathy schedules him for an appointment with his PCP at Great Treatment, reminds him that he has an appointment with his psychiatrist there in two weeks, and tells him that he can always contact his care team through the patient portal if has any questions or concerns. She also reminds him about the mindfulness meditations and visualization techniques in the patient mobile application that might help him reduce his stress, as recommended by his PCP.

As Cathy continues her day, reaching out to people receiving services, she makes notes in the care coordination module and sends any necessary messages to other members of the person's care team, alerting them of any concerns or requested changes in the treatment plan. As her day winds down, Cathy makes her second attempt of the week to contact a person who has been identified as high priority due to his recent hospital admission and two recently missed appointments. She is excited when he answers the phone and agrees to talk to her about his current situation. He mentions that he missed the appointments because his car broke down; he also tells her that he has been feeling more depressed recently because he thinks he might get evicted soon. Cathy quickly opens the community resource platform to connect him to needed resources. He consents to answering a few screening questions and, upon hearing that she can electronically refer him to a new, Medicaid-supported transportation service provider, he excitedly accepts the referral. She closes the call by rescheduling his missed appointments and making a note in his record that he might soon need housing support.

Health Information Exchange

For CCBHCs, partnering with one or more HIEs enables them to meet key CCBHC requirements and measures, such as “Follow-up after hospitalization for mental illness” for adults, adolescents and children.

Primary goals of this exchange of information include:

- Reducing hospital readmissions
- Avoiding medication errors and improving safety for people receiving services
- Improving health outcomes
- Decreasing duplicate testing
- Improving care coordination

HIEs provide hospital encounter notifications as a core service. HIEs receive ADT messages from hospitals and then use this to provide notifications to a user who has subscribed to receive these notifications for their people receiving services. Some states, including West Virginia, provide prescription drug monitoring program (PDMP) access through their state HIE.

Clinical data is the primary health information exchanged in an HIE. The clinical data available through the HIE often originates within a hospital as a discharge summary or lab result, and it could also originate from an ambulatory provider such as a primary care, behavioral health or specialty physician. Ambulatory sites such as skilled nursing facilities, urgent care offices, labs, radiology or surgery centers may share information through the HIE, as well.

In addition to data generated at the point of care, some HIEs may have access to claims data from public and private payers, including Medicaid and Medicare. HIEs may use and display this data differently, depending on the agreements and policies for use of the data. For example, CRISP, the state designated HIE in Maryland, makes data from Medicaid available to HIE participants for query. This data is divided into encounters, medications and procedures. Depending on what the querying participant is looking for, they can verify procedures and medication dispensed and then follow up with the person receiving services or review additional clinical data when available to get more information. Claims data may also be available for population and quality improvement reports in some states.

For public health data on immunizations or outbreaks (e.g., hepatitis C), the HIE often has a relationship with public health authorities that enables the HIE to provide public health data reports or alerts at the point of care. This information is also available to participating public health agencies providing overdose response follow-up and helping people access substance use disorder (SUD) treatment.

For HIPAA-protected health information, including SUD data protected by 42 CFR Part 2, most HIEs operate using an opt-out model. In this model, the data of the person receiving services is automatically shared through the HIE for any purpose allowed by HIPAA, state law and the HIE policies, unless the person has taken an action to opt out of HIE data sharing. A person may have multiple ways to opt-out, depending on the HIE.

For data the provider identifies as sensitive, including data protected by 42 CFR Part 2, people receiving services must submit a written consent for the data to be shared with or from the HIE.

Benefits of HIE participation

Overall, the benefits to CCBHCs from participating in HIE include:

- Providing more comprehensive care.
- Improving care coordination.
- Providing continuity of care, particularly during times of transition between levels of care.
- Demonstrating quality improvement and evaluation.

Best practice guidance for HIE participation

To successfully work with HIEs, be sure to:

- Prior to accessing or sharing any information, review all HIE legal agreements, including policies and procedures, to ensure an understanding of what will be required of your organization. These agreements serve as the underlying data governance documents and contain the policies and procedures you will be expected to adhere to as you use the HIE. In addition, these documents outline all security procedures and the HIE and CCBHC requirements, in case of a security incident or data breach.
- Assign a staff person to serve as the HIE administrator/point of contact.
- Review and reference the HIE user guide provided.
- Request training for all users.
- Collaborate with the HIE to help them understand how best to work with CCBHCs.

HIT requirements

The requirements for a CCBHC and other providers include:

- Paying HIE fees, where applicable — these costs may be included in the CCBHC cost report for eligible CCBHCs that are participating in the Medicaid demonstration program.
- Maintaining and regularly submitting active rosters of people receiving services to the HIE, in accordance with the HIE policies. The HIE could require an updated roster as frequently as every 60-180 days.
- Establishing workflows for using HIE information.
- Integrating HIE date into the EHR.
- Following 42 CFR Part 2 regulations.

Navigating 42 CFR Part 2

The federal regulation, 42 CFR Part 2, requires that a person receiving services submit affirmative consent before their SUD treatment information can be viewed by a member of their health care team, protecting the confidentiality of their SUD treatment data. SAMHSA and the ONC have offered . SAMHSA has offered guidance and regulatory updates to help HIEs work with providers and participants to share Part 2 data using Qualified Service Organization Agreements and capturing patient consent through the HIE. Several HIEs have been working with Part 2 programs and people receiving services to enable this data sharing, including employing a consent registration tool and process to enable Part 2 data sharing. In addition, recently finalized updates to 42 CFR Part 2 regulations will people receiving services to provide consent for their SUD treatment data to be shared with members of their health care team in accordance with HIPAA (U.S. Department of Health and Human Services [HHS], 2024). Updates to 42 CFR Part 2 took effect in April 2024, and SUD treatment providers will have two years to comply with all requirements. The updated requirements include the following (HHS, 2024):

- "Allows a single consent for all future uses and disclosures for treatment, payment and health care operations."
- "Allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations," with limited exceptions including that the Part 2 information "may not be used in legal proceedings against the patient."
- "Permits disclosure of records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule."
- "Restricts the use of records and testimony in civil, criminal, administrative and legislative proceedings against patients, absent patient consent or a court order."

- "Aligns Part 2 penalties with HIPAA by replacing criminal penalties currently in Part 2 with civil and criminal enforcement authorities that also apply to HIPAA violations."
- "Applies the same requirements of the HIPAA Breach Notification Rule to breaches of records under Part 2."
- "Aligns Part 2 Patient Notice requirements with the requirements of the HIPAA Notice of Privacy Practices."

> **Criterion 4.b.1: "The CCBHC ensures all CCBHC services, including those supplied by its DCOs ... reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided and developmentally appropriate. A shared decision-making model for engagement is the recommended approach"**
>
> — (SAMHSA, 2023a).

Person- and Family-centered Treatment Planning

Effective HIT and workflow processes support person- and family-centered treatment planning, one of the nine required CCBHC services. Treatment planning is the process for capturing all factors impacting a person's functioning and wellbeing, their unique background and circumstances and their input, to plan, monitor and update critical interventions and care to address their needs. Ultimately, person- and family-centered treatment planning supports a person's right to self-determination and incorporates their day-to-day realities.

As noted in Criteria 4.E, care teams can use HIT to strengthen person- and family-centered treatment planning in both the CCBHC and DCOs by first documenting:

- Comprehensive information at intake, including race, ethnicity, sexual orientation and gender identity of each person receiving services, along with cultural and other needs.
- Results of screening and assessments.

Then they can engage in a treatment planning process that:

- Denotes the care team, which includes the person receiving services.
- Documents the person's stated goals, strengths, needs, preferences, supports and any services or care they are currently receiving.
- Includes a comprehensive assessment and evaluation of the person's current functioning, symptoms, needs, strengths and goals.
- Lays out a plan that reflects the person's preferences and readiness for change and identifies critical care needs, services and processes.
- Records the evidence-based strategies used to support recovery.
- Captures and reflects progress toward goals.

The treatment team — with the input of the person receiving services, family members and other supports, and existing service providers — establishes goals as the foundation of the plan. The plan is regularly updated, based on input from the person receiving services, the team and other providers on progress, challenges and emergent needs. The plan identifies treatment team members, their responsibilities regarding the person's care and the overall goals and shared treatment aims.

HIT will need to support CCBHCs and DCOs to engage in a coordinated intake process and treatment planning, so that information can be shared and direct communication established to inform care and support the person receiving services across both entities.

Implementation planning

In your HIT planning process, consider the range of ways staff will use the treatment plan, including for responding to crises, capturing tasks and progress in team huddles and collaborating with other agencies and community providers for care coordination.

Several HIT tools, as noted in the table on page 15, are important in supporting a person's needs as part of treatment planning, such as:

- **EHR template for assessments and treatment plans**
- **EHR-embedded CDS tool**
- **EHR/PMS-embedded care coordination worklist and dashboard**
- **Secure messaging application**
- **Telehealth technology**
- **Community resource directory and referral tool**
- **HIE**
- **Personal health record (PHR) and portals**
- **Remote monitoring and client-facing mobile applications**

Each tool enhances communication among and between providers and is critical for monitoring and follow-up. When designing your HIT, consider the workflow for using these tools and how to ensure treatment planning is person- and family-centered. Treatment progress dashboards can be valuable for sharing updates and new developments with the whole team, as well as for conveying progress to the person receiving services. Consider whether your EHR has the capacity for creating dashboards (and any changes necessary for design) or if you will need to acquire additional technology.

To support design, consider these care-planning steps and their related considerations:

Person- and Family-centered Treatment Planning

Care Planning Step	Considerations
Summarize assessment findings and discuss them with the person receiving services. **Seek stakeholder input.**	Which team members are involved in this process? Who drafts the treatment plan? What is the workflow for obtaining psychiatric/medical input and signature, if required? How are the person's expressed needs and the priorities captured and reflected in the plan?
Identify target treatment goals.	How is meaningful input obtained from family, caregivers and other care providers, as well as the associated consents? What is the process for ensuring that goals address prevention, medical and behavioral health needs? Are prompts built into the treatment plan to support this? What is the process for obtaining the person's signature/endorsement of the plan?
Identify the urgency of the person's need for intervention and assign them to the appropriate level of care/intervention	What is the workflow for assignment to various levels of intervention/care pathways? What is the process for internal warm handoff from assessment to intake? What SDOH needs are identified during the assessment? Who is responsible for coordination of SDOH services?
Review and reassess the person's functioning; revise the treatment plan.	What is the interval for reassessment of need and revision of the treatment plan required by the most stringent regulatory requirement? What flag exists in clinic workflows to highlight when reassessment is required, based on emergent need/changes in symptomatology? What psychometric and other data is considered in determining the current status of the person receiving services and their response to intervention? What workflows allow for leveraging the interdisciplinary planning team in emergent circumstances?

Population Health Management

PHM is an approach for understanding the care needs of your people receiving services and proactively tailoring care and interventions based on level of need. In PHM, the CCBHC looks at defined populations or subpopulations that may have the same health risk or have shared characteristics, such as age, gender, race, insurance or a specific health condition. In the subpopulation or group, staff can set criteria that define risk factors, such as a particular diagnosis, a recent emergency department or urgent care visit, body mass index and blood pressure. Staff can then connect these factors to level of risk — no/low, moderate, high — and forecast who is likely to be in significant need of services, and who may need less. This arranging — or stratifying — by risk level enables the CCBHC to direct staff and other resources in a tailored and efficient way. For those who have no or low risk, staff can focus on health promotion. For people who are at moderate risk, staff focus on managing health risks and coordinating care. For those at high risk, disease management interventions are needed.

For example, a subgroup of the CCBHC may have psychiatric disorders such as schizophrenia, bipolar disorder and major depressive disorder. Since the medications for these conditions can trigger metabolic syndrome, the CCBHC could take a PHM approach and assess the level of cardiovascular and diabetes risk in this group of people. This could include considering other health indicators (e.g., A1c results, blood pressure measures), other chronic illness diagnosis or other health factors or behaviors (e.g., tobacco use, alcohol use). The providers can design care coordination for those at moderate risk while focusing more intensive resources on those at greatest risk for poor health outcomes.

HIT tools for population health management

HIT plays a central role in managing population health. Staff can work with technology vendors to develop reports on specific populations or subgroups or use PHM software to perform more complex tasks. Specific PHM software further automates the process of analyzing and understanding groups. PHM software interfaces with the EHR to pull individual-level data that allows CCBHC staff to organize people receiving services into groups based on the shared characteristics they choose (e.g., people diagnosed with depression or diabetes). Staff can run reports on each group for use in identifying care gaps, outreach, pre-visit planning, individual treatment planning, case review, care coordination, team huddles, and quality improvement. PHM systems can be used to:

- Develop a complete view of the populations served by using all available data to measure and visualize the health of the population.
- Segment populations by risk to support timely interventions.
- Improve analytics and develop more efficient protocols through reports that can be used by care coordination staff.

- Measure the effectiveness of targeted interventions, enabling programs to adapt and adopt new interventions quickly and efficiently.
- Create data visualizations (e.g., dashboards) to show statistics for selected indicators and provide a snapshot of the population. The dashboard information can be filtered or manipulated to identify subpopulations or indicators of interest.

Developing a data-driven strategy for managing a population allows the CCBHC to identify patterns and potential disparities and address care and SDOH needs. With PHM systems, the CCBHC is able to track and report on population activity and measure improvements. Building this capacity also better positions the CCBHC to enhance quality reporting, meet funder reporting requirements, and participate in value-based payment programs, where providers receive incentives for achieving population-based outcomes (Centers for Medicare and Medicaid Services, 2024).

Using HIT to identify and address health disparities

A successful population health management (PHM) program improves the health of a group or population, including the reduction of health disparities in that population. It enables the CCBHC to develop a better understanding of the overall health of its population and requires the CCBHC to identify and address potential disparities associated with a specific subpopulation. This could include a specific racial, ethnic, or linguistic minority or a group with a specific SDOH need. It is well known that, at the individual and population level, factors such as social circumstances, environmental exposures, and behavioral patterns can be major contributors to poor health outcomes. HIT can help to stratify populations for planned interventions by risk, and it can help identify potential health disparities in a CCBHC population. The CCBHC can use PHM to measure the health of the overall population or of specific subgroups and then to identify disparities within those groups. PHM can also help measure the effectiveness of disparity reduction interventions.

Implementation considerations

As CCBHCs assess and implement HIT for PHM, they must work with members of their clinical, care coordination, PHM, and IT staff to:

- Use the PHM system or EHR modules to **develop a full picture of the population's health**. This data could include demographics, identified SDOH needs, co-occurring somatic conditions, and use of the health care system by people receiving services.
- **Identify any potential health disparities** readily apparent in specific groups, using available PHM analytics and report capabilities. For example, disparities may include people receiving services of a specific race, ethnicity or gender identity having worse health outcomes or having less access to and/or use of a specific service.

- Identify specific subpopulation(s) to target. This could mean **identifying a group that is at risk of poor health outcomes due to specific characteristics and developing an intervention** to address a specific problem or need (e.g., identifying that people with comorbid depression and heart disease are at higher risk of stroke and developing a specific clinical or case management strategy to address this); or it could mean **identifying a group that could be most impacted by a service or activity**, such as comprehensive case management. For example, people with two or more SDOH needs and an SUD may be in greater need of case management than those without any SDOH needs.

- Choose **a few subpopulations or health disparities to address** initially with the targeted intervention, determine what will be most impactful to the health of that group, and **develop measures to track the progress of those specific interventions**. Identifying targets can support an organization's Disparity Impact Statement, which is required for SAMHSA grantees to identify disparities in care for population groups most at risk of poor outcomes. Furthermore, honing the target to a few groups is helpful, as CCBHC staff can easily become overwhelmed if they implement too many interventions or try to track too many measures initially.

- Train and onboard staff to use the PHM tools as needed, ensuring that **staff have access to the tools and understand how to use them to improve workflows**.

- **Integrate the PHM system and the care coordination system or module**. Population health risk stratification and analytic dashboards and reports must feed into the care coordination program. This will enable the CCBHC to tier its care coordination activities, providing the most intensive services to people who are most at risk of poor health outcomes.

- Implement a continuous improvement cycle, **monitoring evaluation metrics to assess the effectiveness** of the interventions and modifying interventions as necessary. This also includes working with the HIT vendor to **understand all the PHM functions available** and whether the CCBHC can improve the configurations or update the system to improve its functionality and ease of use.

- **Celebrate successes of the PHM program** and ensure that staff understand its impact on the health and wellness of their people receiving services. This will help achieve greater staff buy-in and adoption.

These strategies will position the CCBHC to make significant progress for the targeted populations. Some agencies may assign PHM tasks to a case manager who has already been triaging people receiving services. If the organization is establishing a new, large-scale PHM program, it may be beneficial to hire staff with a PHM skill set.

Example: Use panels and reports to improve outcomes and close care gaps

One PHM strategy that many CCBHCs may want to consider is using an EHR-based report to create a registry or panel of people receiving services who have one or more care gaps to be addressed. Many EHRs have a health maintenance screen with a list of routine preventive and chronic care tests, such as blood pressure readings, immunizations and HbA1c tests. Your PHM team can select a few of the most pivotal measures to be addressed and then develop a report of all individuals in your population who haven't yet received an immunization, diabetic eye exam or HbA1c test. You could also select an assessment, such as a SDOH needs screening that you want everyone in a specific group to complete and generate a panel of those people who haven't yet been screened.

This process involves the following steps:

1. Select a specific care gap or assessment your team wants to focus on. If you aren't already tracking the completion of the assessment or test, you will need to work with your EHR vendor to enable this function and train staff to record the assessment in the record of the person receiving services.
2. Determine if you want to focus on one or more subpopulations. Consider filtering the report by specific categories to determine if a disparity exists, if this functionality is available in your PHM system or EHR.
3. Use your EHR or PHM module to generate a report or list of all the active people receiving services who have not yet closed that care gap or been assessed.
4. Via an integration between the care coordination and PHM systems, provide the panel of people receiving services to the care coordination team to begin outreach to close the gap or complete the assessment.
5. If your EHR has the capability, generate prompts or alerts for physicians and other care team members in the workflow for people noted on the report.
6. Monitor and evaluate progress and make any modifications to the reports and the PHM plan. This could also include developing a dashboard if this is a measure you wish to track and improve in the long term.

The CCBHC can use a similar plan to develop a report for other important disparities or a risk-stratification report for people receiving services who may be at higher risk of hospital admission. The steps are the same, but the factors being used to develop the list of people receiving services and stratify them into priority groups would change.

Quality and Funder Reporting

Quality improvement reporting

The National Association of County and City Health Officials defines quality improvement as "a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes that achieve fairness and improve the health of the community." It requires an organization to develop and implement various activities and program modifications in response to monitoring and tracking specific metrics identified as relevant to quality improvement.

Some measures used to assess quality include the effectiveness of current processes, individual health outcomes, the experience of the person receiving, and cost. Identifying and tracking specific quality improvement measures will enable the CCBHC to assess the quality and results of their current processes and prioritize improvements. In addition, implementing clinical quality measures (CQMs) will allow the CCBHC to specifically measure the quality of clinical services to identify areas for improvement (SAMHSA, 2023b). A CQM result is usually expressed as a ratio with a numerator and a denominator. For example, a CQM focusing on diabetes management might have a denominator of "all people receiving services with diabetes" and a numerator of "patients at target HbA1c." It is important to note that federal and private payers expect health care providers to measure and address quality metrics. A variety of quality improvement and public reporting requirements, including those of the Centers for Medicare and Medicaid Services, use an electronic format, or eCQMs.

Use of HIT for quality reporting

The ONC certifies the capability of HIT, including EHRs, to accurately calculate and report specified eCQMs. Certified EHRs are able to extract and transmit data that is collected during normal care and documentation. This succinct capturing of CQM data in the workflow can help CCBHCs implement or accelerate quality improvement activities by:

- Reducing manual data entry
- Reducing potential data entry and transcription errors
- Improving ability to calculate quality measures, such as CQMs
- Facilitating data extraction and analysis
- Enabling direct submission of measures for quality reporting requirements to payers or other programs
- Lessening reporting burden

It is important to note that CCBHCs will need to identify and remain focused on activities that yield the highest value, such as improved patient outcomes, cost reductions and staff work satisfaction, not on activities that are easiest to measure or track. To reduce burden, it is also critical to develop workflows and trainings that enable CQM capture within the clinical process, rather than as a separate add-on task for staff. One recommendation is to align eCQMs with conditions and processes being monitored as part of the CCBHC's PHM, to avoid duplicating efforts.

Funding reporting requirements

Value-based payments

Implementing a quality improvement program with specific metrics and eCQMs will prepare the CCBHC to participate in alternative payment models (APMs), such as value-based payments. In models like these, payment is linked to quality and the health outcomes of the people receiving services. The goal for these programs is to deliver quality care that improves health outcomes for people receiving services while decreasing the overall cost of delivering care. APMs align with quality reporting in that they are often focused on prevention or management of chronic conditions and reduction in emergency department use or hospital inpatient days. Recently, some APMs are also considering the impact of SDOH on health outcomes and have incorporated strategies to address these needs as a way to reduce health care costs.

The HIT tools used for quality improvement or APM reporting often are the same as what the CCBHC can use for its PHM program. Similar dashboards, analytics and reports can be used to track and report progress and drive care coordination activities. Aligning tools, workflows and staff across these activities will reduce staff burden and overall cost of implementing the programs, as well as demonstrate how CCBHCs are improving health outcomes for the people they serve.

Grant reporting

The use of a certified EHR not only accelerates a quality improvement program but also can drastically reduce the burden of grant reporting requirements on a CCBHC. A certified EHR can filter, analyze and extract data into reportable formats — a game-changer in easing the reporting burden, including federal and state agency or private grant reporting. Best practice is to develop a team composed of those responsible for reporting requirements, IT staff, quality and PHM staff, clinicians and care coordination staff to:

- Identify all reporting requirements that can be captured via the EHR
- Evaluate quality, PHM and reporting requirements to find alignment
- Prioritize and develop metrics to be tracked across all programs
- Assign responsibility for monitoring metrics and extracting reports
- Train all staff to ensure that critical data is being captured by staff during clinical care and other interventions
- Monitor progress and implement necessary modifications

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

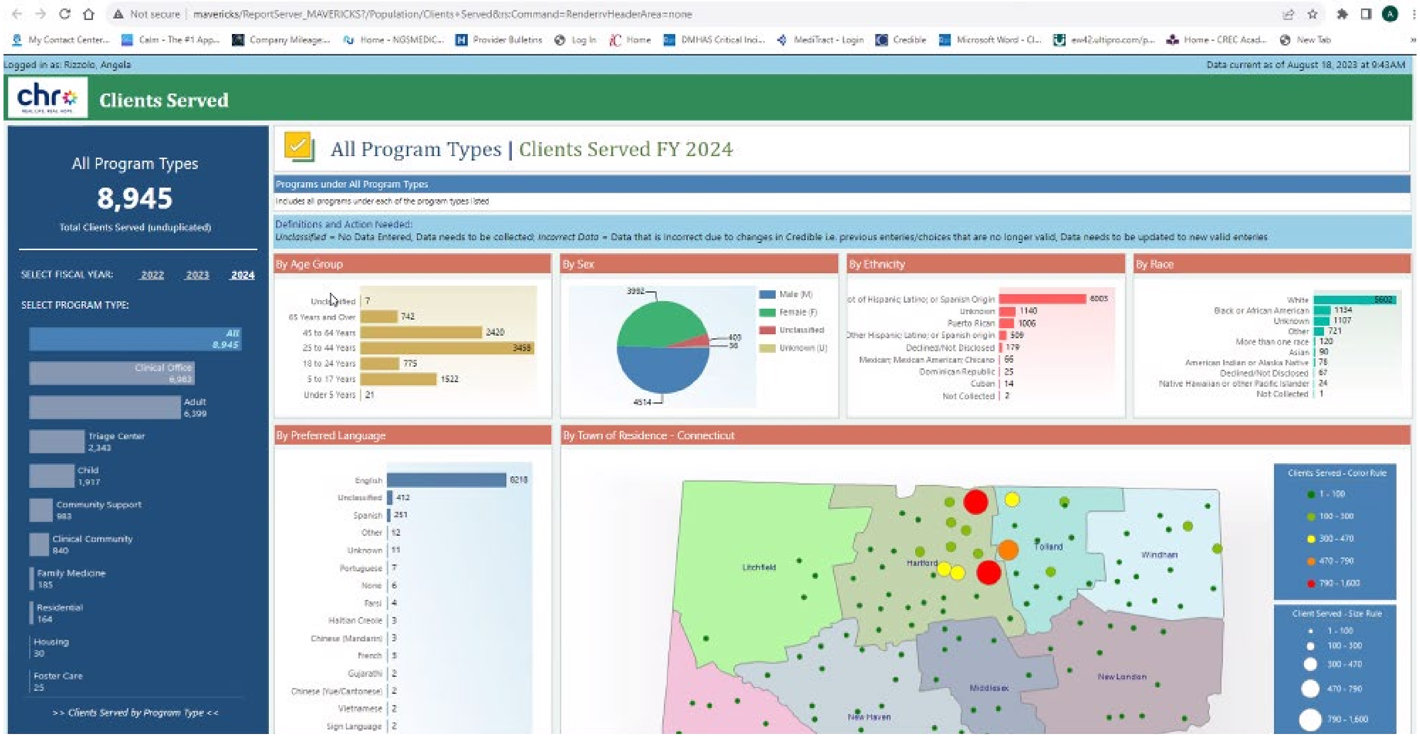
During times of change and HIT system transitions, it is important to seek input from interested stakeholders and proactively communicate with them about new requirements and processes. This tool can help you plan your engagement strategies, grounded in an understanding of what is important to each stakeholder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

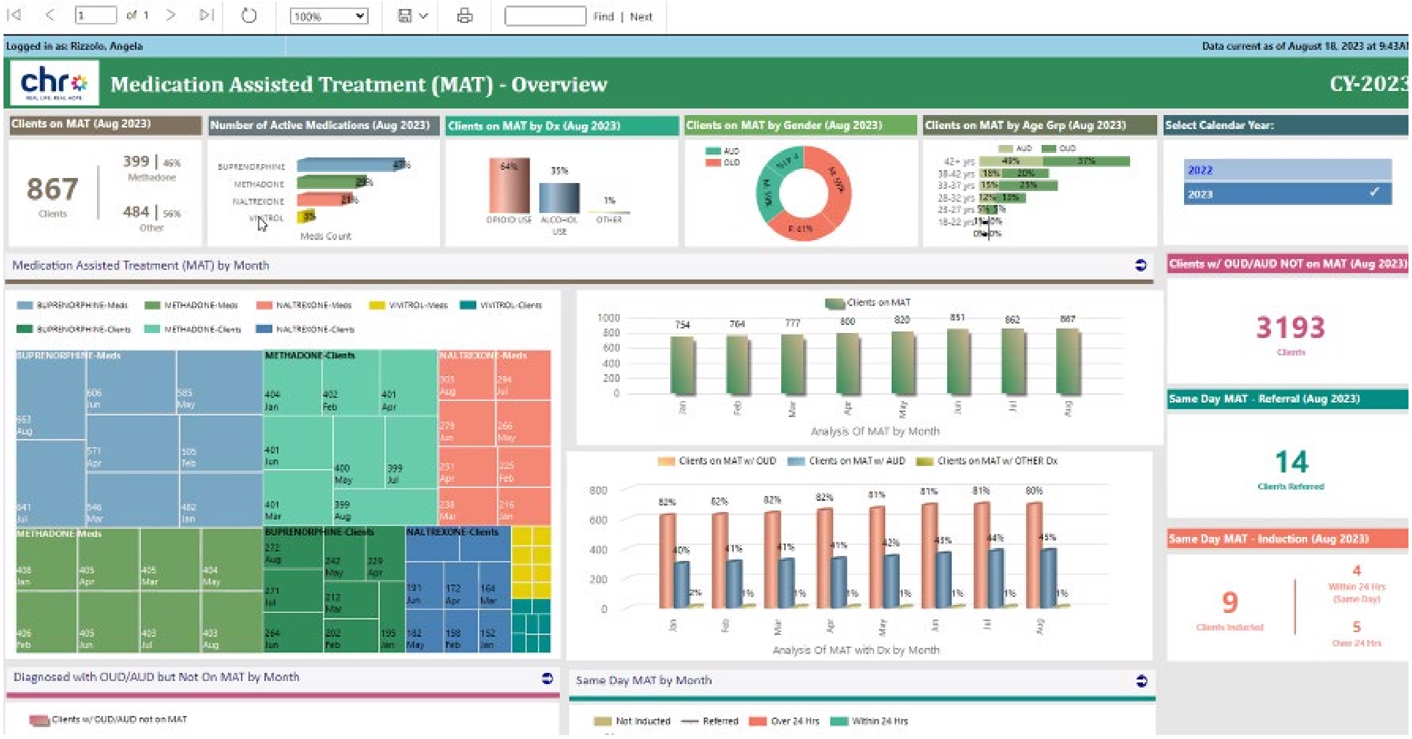
Stakeholder Group	Areas of Interest and/or Concern	Stakeholder Manager	Engagement Approach	Engagement Tools
Front desk staff	Communication with clients; Documentation burden	Operations Director	Face-to-face; Staff training	Email; Handouts at quarterly all-staff meeting; HIT vendor-created tutorials
Current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