



Alabama Department
of Mental Health
connecting mind and wellness

Certified Community Behavioral Health Clinics

Workflows For Centralized Intake, Triage & Staffing Patterns

TODAY'S AGENDA

Part 1

- Federal and AL Requirements on Staffing, Screening, Evaluation, Data
- Agency Transformation Tips

Part 2

- Quick Recap
- Staffing Scenarios
- Case Scenario



QUESTIONS AND ANSWERS

- Please use the CHAT feature to submit your questions throughout the session.
- We will answer as many as possible during the webinar and post a recording of the session on the ADMH website.
- Any unanswered questions will be documented, and responses will also be shared by ADMH following this orientation.
- Please only submit questions and comments that are relevant to today's topics. (Use the State's email address for additional questions.)

POLL

Take a moment and rank your understanding of the CCBHC requirements for **Screening, Assessment and Triage** on a scale of 1-5



FEDERAL AND AL CCBHC REQUIREMENTS

CCBHC CRITERIA 1A: GENERAL STAFFING REQUIREMENTS



Staffing plan **meets the requirements of the state behavioral health authority and any accreditation standards** required by the state.



The staffing plan is **informed by the community needs assessment** and includes clinical, peer, and other staff.



Must include a **medically trained behavioral health care provider**, who can **prescribe and manage medications** independently under state law, **including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders** (excluding methadone).



Must include staff with **expertise in addressing trauma and promoting the recovery** of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

ROLE OF THE MEDICAL DIRECTOR

Federal Requirements:

- Medical Director must oversee behavioral health services and care integration (role doesn't need to be full-time).
- If no psychiatrist, a licensed prescriber with psychiatric consultation is required.
- Responsible for screening protocols and contributing to the Continuous Quality Improvement (CQI) plan.

Alabama-Specific Requirements:

- CCBHCs must designate a Medical Director and report any vacancies to ADMH.
- Medical Director establishes written protocols for primary care screening and chronic disease monitoring.
- Co-chairs the CQI committee and oversees medical quality improvements.

CRITERIA 3.D INTERDISCIPLINARY TEAMS

Interdisciplinary Treatment Team

- The CCBHC designates a care team responsible for coordinating and managing services in collaboration with the person receiving care and, if desired, their family/caregivers or legal guardians.

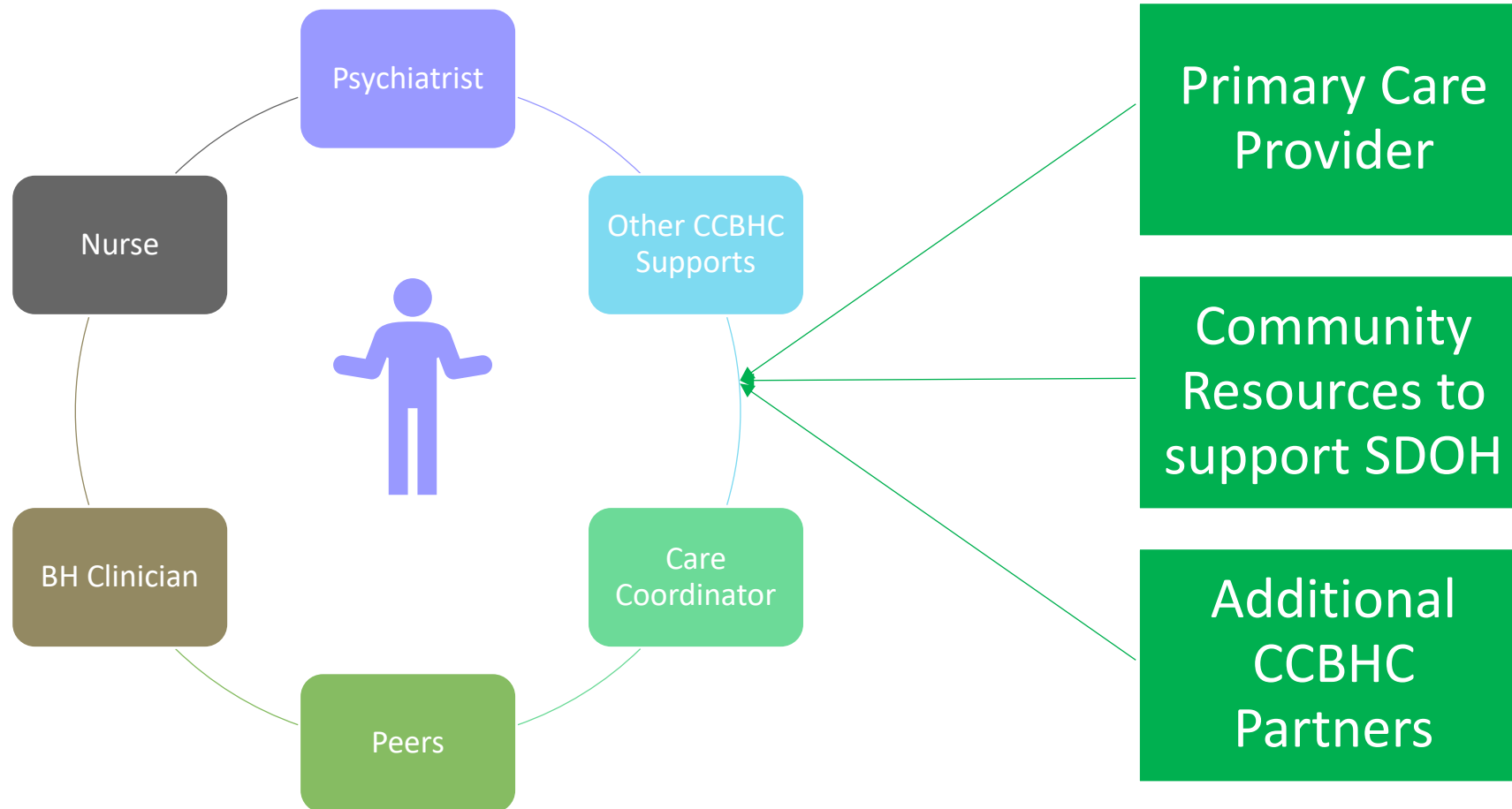
Person-Centered & Inclusive Care

- The treatment team includes the person receiving services, their family/caregivers (if they choose), and others they want involved in their care.

Coordinated DCO Services

- The CCBHC ensures that services provided by Designated Collaborating Organizations (DCOs) align with the individual's current treatment plan.

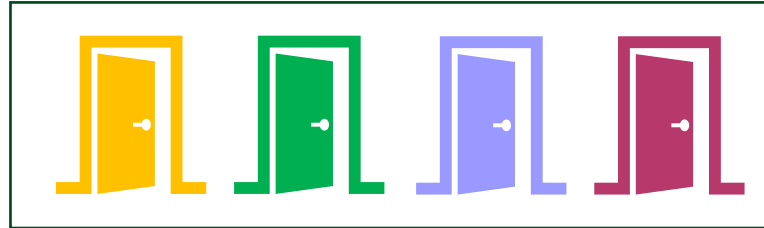
CONSIDERATION FOR INTERDISCIPLINARY TEAM MODEL



CCBHCs



No Wrong Door Approach to Accessing Services



Access supported via extended hours (evening and weekend)

Preliminary Triage &
&
BH Risk Assessment



Immediate service
Crisis Stabilization and
24/7 Mobile Crisis

Within 1 business day
often via Open Access;
includes evening hours

Within 10 business days
via clinic services;

Comprehensive evals within 60 days

9 core services and universal care coordination to connect other individualized services and supports as indicated

CCBHC CRITERIA 2B: TIMELY ACCESS TO SERVICES

Preliminary triage and risk assessment must be completed at the first point of contact (in-person, phone, or remote).

Emergency/crisis needs

- Addressed immediately with appropriate interventions.

Urgent needs

- Initial evaluation within **1 business day**.

Routine needs

- Addressed within **10 business days**

CCBHC CRITERIA 4C: CRISIS STABILIZATION SERVICES

- **Urgent care/walk-in** services should be available with evening hours **based on community needs**, aiming for **expanded hours** when possible.
- Services must include **suicide prevention, overdose response, and trauma-informed crisis care**, ensuring a safe, least-restrictive environment for stabilization.



SCREENING, ASSESSMENT & DIAGNOSIS

Federal Requirements

- Screening, assessment, and diagnosis, includes risk assessment for behavioral health conditions
 - » External referrals for services outside of CCBHC expertise
 - » Telehealth is an option
- Standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person
- Culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities
- Screening – Brief Intervention – Referral to Treatment (SBIRT)
- All must receive initial + comprehensive evaluation

AL Requirements

Written policies & procedures for brief screening prior to initial assessment/evaluation

- » Specific tools/ screening instruments
- » Risk assessment
- » Documentation and communication of results to recipients

REQUIRED COMPONENTS OF INITIAL AND COMPREHENSIVE EVALUATIONS

Initial Evaluation	Comprehensive Evaluations
<ul style="list-style-type: none">✓ Preliminary Diagnoses & reason for seeking care.✓ Referral Source & past treatment history✓ Current Medications✓ Mental Health & SUD Assessment✓ Risk & Safety Evaluation✓ Medical Needs Assessment✓ Military Status✓ Child/Youth System Involvement	<ul style="list-style-type: none">✓ Reason for Seeking Care✓ Social & Environmental Factors✓ Pregnancy/Parenting Status✓ Behavioral Health & Trauma History✓ Medical History & Medications✓ Mental Health & SUD Assessment✓ Risk & Safety Assessment✓ Treatment & Recovery Planning✓ Additional Service Needs✓ Physical Health Needs✓ Technology Preferences

AL REQUIREMENTS: BH SCREENING TOOLS

All Persons Served		
<i>Tool</i>	<i>Purpose</i>	<i>Age Range</i>
PHQ-9	Depression/Mental Health	12 years and older
Protocol for Responding to and Assessing Patient's Risks and Experiences (PRAPARE) (2016) or Standardized Health Related Social Needs Screening (HRSN)	Social Determinants of Health	All persons served should receive a HRSN screening. Children/youth may either complete the screening or have a parent/guardian complete the screening on behalf of the family. Note: the PRAPARE tool is for those 18 years or older
Columbia Suicide Severity Rating Scale (C-SSRS)	Suicidality	6 years and older
Adults		
<i>Tool</i>	<i>Purpose</i>	
UNCOPE	Substance Use	19 years and older
Audit-C	Alcohol Use	18 years and older
Adolescents		
<i>Tool</i>	<i>Purpose</i>	
CRAFFT	Substance Use	12-18 years

Referrals for treatment of conditions identified through screening should take place within seven (7) business days, with the follow-up appointment occurring promptly.



CRITERIA 5.B: CONTINUOUS QUALITY IMPROVEMENT

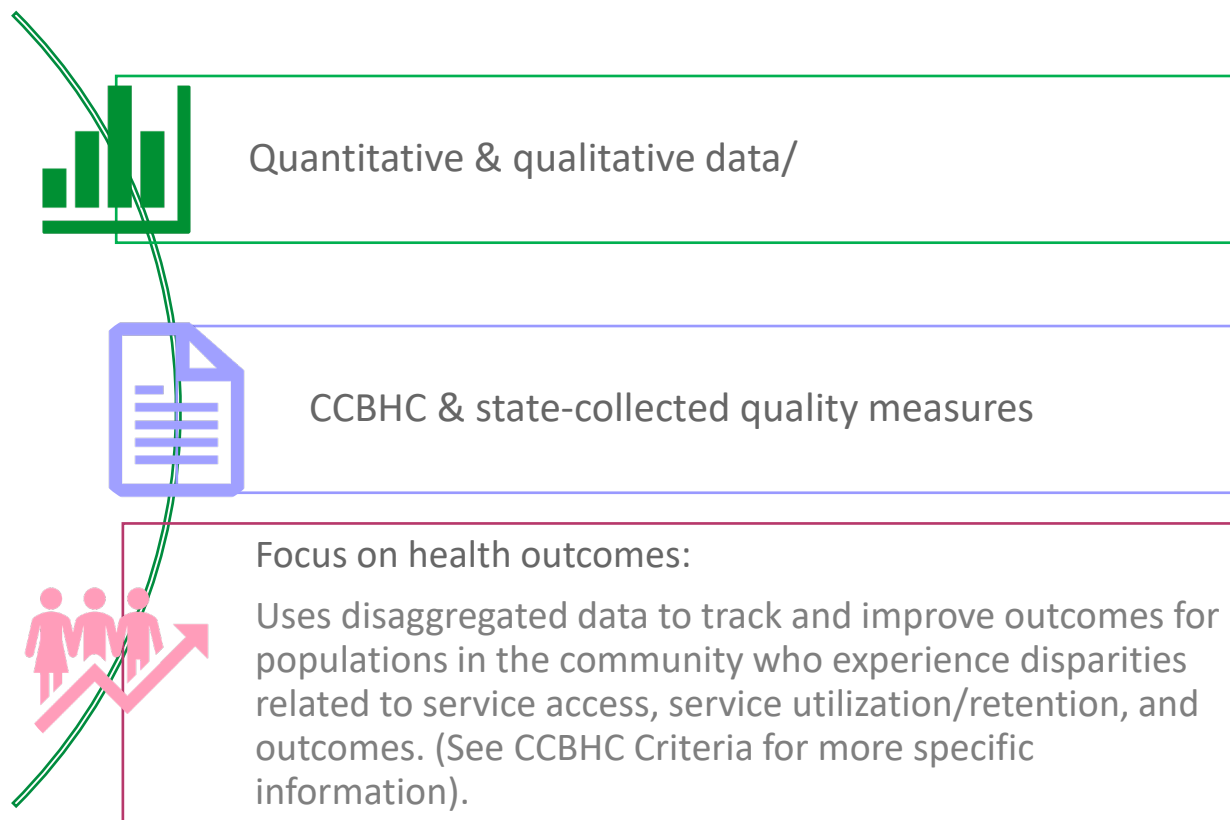
- CQI is required
- Key Focus Areas
 - Enhancing behavioral & physical health outcomes
 - Improving care patterns (reducing ER visits, rehospitalizations, and crisis episodes)
- Medical Director oversight and primary care integration

CRITERIA 5.B: CONTINUOUS QUALITY IMPROVEMENT







Significant Event Review

- Suicides or suicide attempts
- Fatal & non-fatal overdoses
- All-cause mortality among service recipients
- 30-day psychiatric/substance use readmissions
- Other critical events per state/accreditation guidelines

Data-Driven Approach



REQUIREMENTS: SUMMARY

					
Comply with state regulations	Screen for and offer the 9 core services to all persons served, as appropriate for their needs	Meet required timelines for care	Provide meaningful access	Complete required CNA* CQI QI/QA	Meet the needs identified in the CNA*

*CNA: Community Needs Assessment

AGENCY TRANSFORMATION TIPS

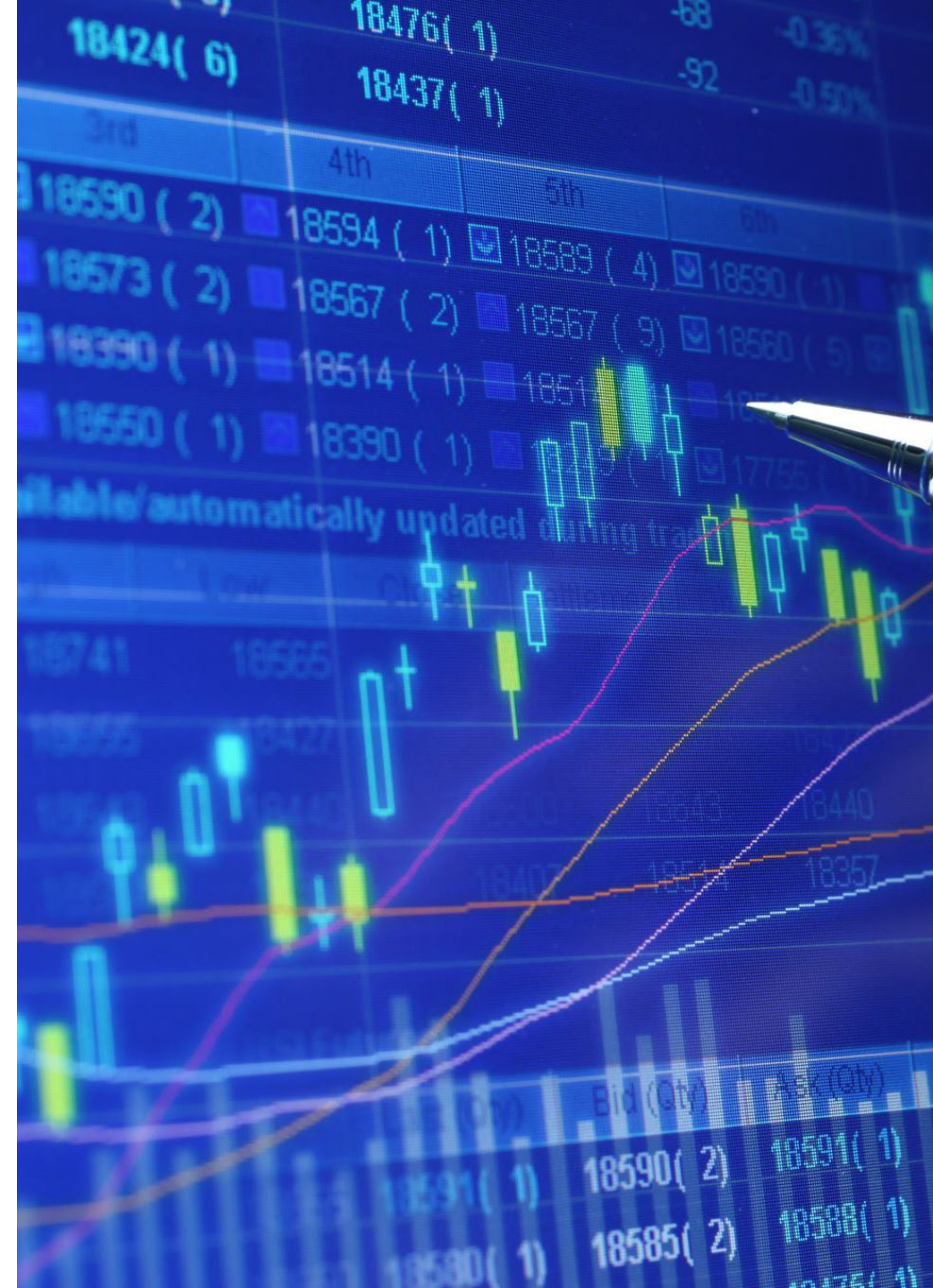
FEDERAL AND STATE COMPLIANCE

- All agencies must be delivering the 9 core services at the time of (1) certification, (2) CCBHC program launch
- This means, agencies must:
 - Have staffing models defined
 - Have policies and procedures defined
 - Ensure appropriate training is in place
 - Define internal QA/QI processes to ensure compliance with the model



TIP: CREATE A CCBHC-WIDE CROSSWALK FOR STAFFING

- List all of the 9 core services
 - » Identify which staff will be responsible for which services
 - » Make sure to split out separate tasks like screening, assessment, and diagnosis
 - » Consider who will be responsible for the centralized, community-focused service plan
- Ensure job descriptions are aligned with expectations
- Evaluate whether current FTEs are likely to meet the requirements of the model
- Identify any gaps



TIP: ENSURE POLICIES AND PROCEDURES ARE ALIGNED WITH STAFFING AND WORKFLOWS

- Create a visual workflow of the journey of a person served through care in your agency
 - From first contact (initial screening, walk-ins, triage) to completion
- Ensure that responsibilities for key tasks and associated communications are clearly defined
 - Ex: A person calls in for services and it's found that they have an OUD- how do we ensure they are connected with MAT, ideally same-day
 - Scheduling
 - Notification to prescriber
 - Prescription pick-up
 - Beginning the medication
- Ensure policies and procedures are aligned with workflows

TIP: REVAMP TRAINING TO ALIGN WITH THE MODEL



Create a crosswalk of current training requirements to evaluate current alignment with CCBHC training requirements



Ensure there is clear and regular training on workflows and position responsibilities that include:

EHR processes

Communication pathways and expectations

Documentation standards

TIP: ENSURE INTERNAL QUALITY ASSURANCE AND IMPROVEMENT



- Ensure that your agency has internal QA/QI processes in place to:
 - Evaluate that there is clear evidence that all of the required services are being regularly delivered
 - Monitor clear documentation of care coordination and centralized service plan management
 - Align documentation with state and federal regulations
 - Ensure high data quality and integrity

TIP: DEVELOP COMMUNITY NEEDS ASSESSMENT PLAN AND STRUCTURE EARLY



CNAs should be planned according to a schedule



CNAs should occur, at minimum, every three years



Agencies should have a plan re: CNAs that include:

Who will be included

How a representative population sample will be reflected

How CNAs will be tailored to federal and state goals/requirements

What will be included



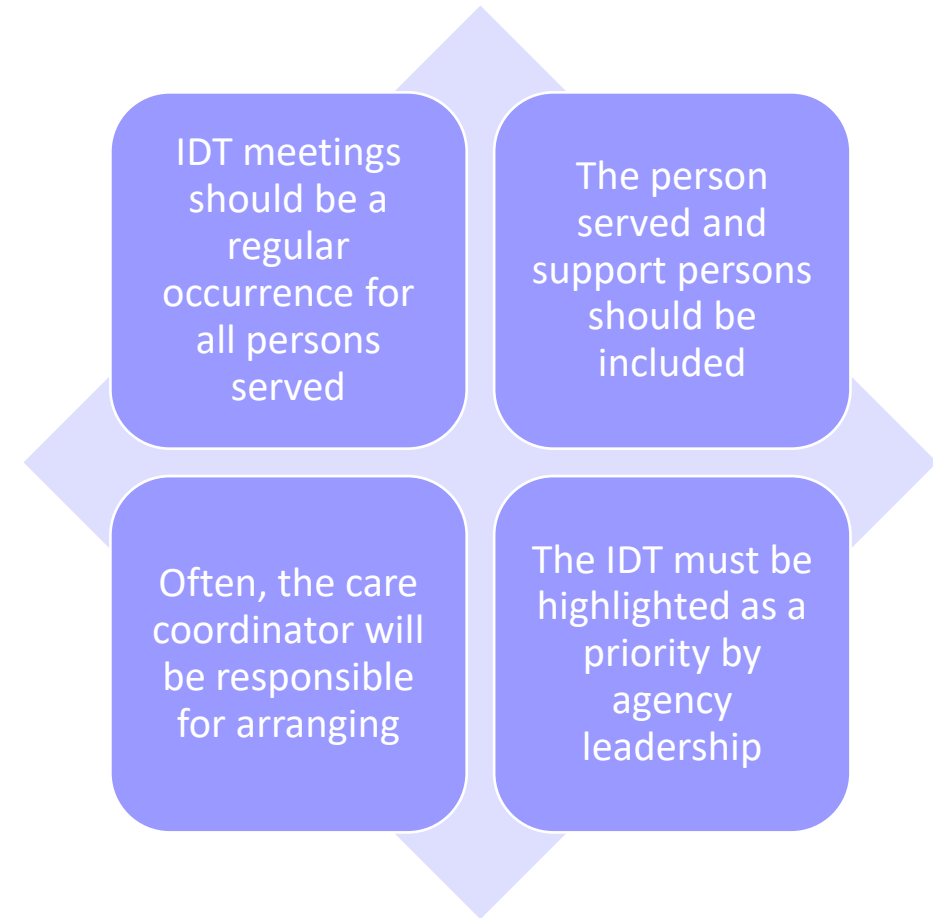
There should also be a clear plan for how information gathered from the CNA will be prioritized, incorporated into programming, and communicated to the community

TIP: ESTABLISH YOUR CQI TEAM EARLY

Establish	Establish your CQI team and data evaluation focus at the beginning of CCBHC operations
Evaluate	Ensure data is evaluated at least quarterly
Decide	Design the team so that decision-makers are part of the conversation and can approve associated program adjustments
Structure	Follow a true CQI structure <ul style="list-style-type: none">•Regular meetings•Data presentations•Associated intervention design•Evaluation of efficacy of interventions



TIP: ESTABLISH INTERDISCIPLINARY TEAM STRUCTURE EARLY



STAFFING AND INTAKE SCENARIOS

SCENARIO 1

Considerations: Cross-Trained staff, telehealth integration, Mobile Crisis Team Collaboration

Step	Front Desk / Admin	Licensed Clinician (LCSW, LPC, LMHC)	Peer Support Specialist	RN / Telehealth Provider/ Prescriber	Care Coordinator / Case Manager
Patient Arrival & Registration (5-10 min)	Collects intake forms, verifies insurance		Greets patient, offers engagement support		
Triage & Risk Screening (15-20 min)		Conducts risk screening, assigns priority level (Routine, Urgent, Crisis)	Provides emotional support		
Initial Intervention & Referral (10-15 min)		Provides psychoeducation, brief intervention	Assists with paperwork, ensures warm handoff	Telehealth provider consults for urgent med needs	Schedules follow-up, connects to external services
Follow-Up & Engagement	Sends reminders		Conducts outreach call within 24-48 hrs		Tracks engagement, follows up on missed appointments
Treatment Plan Management	Multidisciplinary Team Meetings				

SCENARIO 2

Considerations: Dedicated Triage Process, Enhanced Care Coordination, Community Partnerships

Step	Front Desk / Admin	Triage Clinician (LCSW, LPC, LMHC)	Peer Support Specialist	RN / Psychiatric NP	Case Manager / Care Coordinator
Patient Arrival & Registration (5-10 min)	Assists with kiosk-based check-in, insurance verification		Greets patient, helps with paperwork		
Triage & Risk Screening (15-20 min)		Conducts structured triage, assigns urgency level	Provides engagement, emotional support		
Medical & Behavioral Health Screening (20-30 min)				Conducts vitals, med reconciliation, brief psych eval	
Care Coordination & Referral (15 min)					Assesses social needs, schedules follow-ups
Follow-Up & Engagement	Sends reminders		Peer outreach within 48 hrs		Ensures warm handoff, tracks engagement

SCENARIO 3

Considerations: Specialized Roles, Integrated Crisis Response, Data-Driven Management

Step	Front Desk / Admin	Triage Clinician (LCSW, LPC, LMHC)	Peer Support Specialist	RN / Psychiatric Provider	Crisis Response Clinician	Care Coordinator / Case Manager
Patient Arrival & Registration (5 min)	Uses self-check-in kiosks, verifies insurance		Greets patient, assists with navigation			
Triage & Risk Screening (15-20 min)		Conducts structured risk assessment, assigns priority level (Routine, Urgent, Crisis)	Provides immediate emotional support			
Parallel Processing (Medical & Behavioral Health Screening) (30-45 min)				Conducts vitals, med reconciliation, psychiatric assessment	Provides crisis stabilization as needed	
Immediate Crisis Intervention (if needed)					Provides de-escalation, safety planning, CSU admission if necessary	
Care Coordination & Follow-Up Planning (15 min)						Assesses social needs, ensures follow-up care
Follow-Up & Engagement	Sends reminders		Peer outreach within 24 hours for high-risk patients			Intensive engagement for at-risk patients

CASE SCENARIO

MARIA

Maria is a **32-year-old** woman with a long **history of opioid use disorder (OUD)**. She has experienced multiple nonfatal overdoses and **intermittent engagement** with treatment. After a recent return to use, she realizes she needs immediate help. She arrives at Hope Community Services CCBHC seeking support, feeling overwhelmed but determined.



STEP 1: CENTRALIZED INTAKE & TRIAGE (SAME-DAY ACCESS MODEL)

Upon arriving at the CCBHC's walk-in clinic, Maria is greeted by a Peer Recovery Specialist—someone with lived experience who reassures her that she is in the right place.

Risk & Needs Assessment

A **licensed clinician** conducts a **real-time triage assessment** to determine Maria's medical and behavioral health needs.

Maria **screens positive for moderate withdrawal symptoms** (COWS score: 10) and reports recent fentanyl use.

She expresses a **strong desire for Medications for Addiction Treatment (MAT)**.

Immediate Crisis & Safety Plan

Since Maria is **not in immediate medical danger**, she does **not require hospitalization**.

A **crisis plan** is developed in case she experiences worsening withdrawal or cravings.

Warm Handoff to Care Team

Maria is introduced to a **Care Coordinator** who will guide her through the treatment process.

STEP 2: RAPID REFERRAL TO MAT & SAME-DAY INITIATION

Hope Community Services CCBHC has on-site MAT services, allowing for same-day Suboxone induction.

Medical Provider Evaluation

Maria meets with a **nurse practitioner (NP) specializing in addiction treatment** within an hour of her intake.

A **telehealth consultation** with an addiction medicine physician is available if needed.

Buprenorphine (Suboxone) Induction

Maria receives **Suboxone initiation** under medical supervision.

The provider **monitors her for withdrawal symptoms** over the next two hours to ensure she stabilizes.

Prescription & Follow-Up Plan

She is **prescribed Suboxone for home use** and scheduled for a **follow-up visit within 48 hours**.

She receives a full clinical evaluation within 7 days that identifies significant depression.

STEP 3: SUPPORT SERVICES & CARE COORDINATION

Before leaving, Maria is connected to supportive services that will help her stay engaged.

Peer Support & Recovery Coaching

A **Peer Support Specialist** checks in with Maria, sharing their own recovery journey and offering daily check-ins via text.

Case Management & Harm Reduction

Maria receives **Narcan** (naloxone) and **fentanyl test strips** to reduce overdose risk.

A care coordinator helps Maria apply for **Medicaid coverage** since she is uninsured. The care coordinator also helps connect her with transportation and childcare resources.

Next Steps & Transition to Comprehensive Treatment

Maria is enrolled in **outpatient behavioral therapy**, including group counseling and individual CBT counseling for co-occurring MH and SUD concerns.

A care coordinator schedules her an appointment with a **primary care provider** to address underlying medical conditions and ensures this care is documented in the CCBHC file.



OUTCOME

Maria Leaves with Hope & a Plan

After years of struggling to access treatment, Maria walks out the same day with:

- ✓ Suboxone initiation for OUD
- ✓ A follow-up appointment within 48 hours
- ✓ Connection to peer support & therapy for co-occurring needs
- ✓ Harm reduction tools and emergency contacts

CONSIDERATIONS

CENTRALIZED INTAKE & TRIAGE WORKFLOW

- How will you arrange your staffing to conduct initial triage and risk assessment at the first point of contact?
- What criteria will you use to identify and respond to immediate crises during intake?
- How will you ensure that individuals with urgent needs receive clinical services within one business day?
- What processes will you implement to guarantee that individuals with routine needs receive an initial evaluation within 10 business days?
- How can you leverage telehealth and digital intake processes to improve efficiency and access, particularly in high-demand or rural areas?

STAFFING & SCHEDULING MODELS FOR RAPID ACCESS

- How will you structure your intake team to ensure rapid access to care, including licensed clinicians, peer support specialists, and care navigators?
 - What components of the intake process can be handled by other roles, i.e., non-clinical staff?
- What strategies will you use to incorporate peer support specialists and care coordinators to improve engagement and follow-through?
- How will you design your scheduling system to allow for same-day access to initial assessments?
- What staffing model will you adopt to offer extended hours, including evenings and weekends, to increase access?
- How will you facilitate daily team-based huddles or case consultations to ensure effective coordination between intake staff, prescribers, and crisis response teams?

TECHNOLOGY & EFFICIENCY ENHANCEMENTS

- How will you integrate electronic health records (EHR) to streamline intake, including pre-visit forms and digital consents?
- What automated scheduling and reminder systems will you implement to reduce no-show rates and improve appointment adherence?

CRISIS SERVICE INTEGRATION

- How will you ensure mobile crisis response teams can reach individuals in crisis within one hour in urban areas and two hours in rural areas?
- Can you establish partnerships with hospitals and law enforcement to embed crisis staff in emergency departments and reduce unnecessary hospitalizations?



QUESTIONS

POLL

Take a moment and rank your understanding of the CCBHC requirements for **Screening, Assessment and Triage** on a scale of 1-5



WATCH
THIS
SPACE

ADDITIONAL TUESDAY TA SESSIONS

- Quality and Reporting
- Upcoming sessions TBD

CONTACT US

We're here to help! If you're interested in learning more about CCBHCs or have questions, contact us at ccbhc.dmh@mh.alabama.gov

Check out our CCBHC Implementation Bulletins here:

<https://mh.alabama.gov/ccbhc-implementation-bulletins/>