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Wellbeing

Overdose Safety Planning: Making it Operational in CCBHCs



Contents

Acknowledgments	3
Introduction Making Overdose Safety Planning Operational in CCBHCs.....	4
MODULE 1 The CCBHC Mandate for Overdose Prevention	6
MODULE 2 Workforce and Clinical Competencies— Leveraging the Strength of the CCBHC Model	15
MODULE 3 Implementation Infrastructure— Making Overdose Risk Reduction Operational in CCBHCs	27
MODULE 4 Sustainability—Billing & Reimbursement Strategy	40
MODULE 5 The Zero Overdose Clinical Core	53
Conclusion.....	64
Work Cited	65

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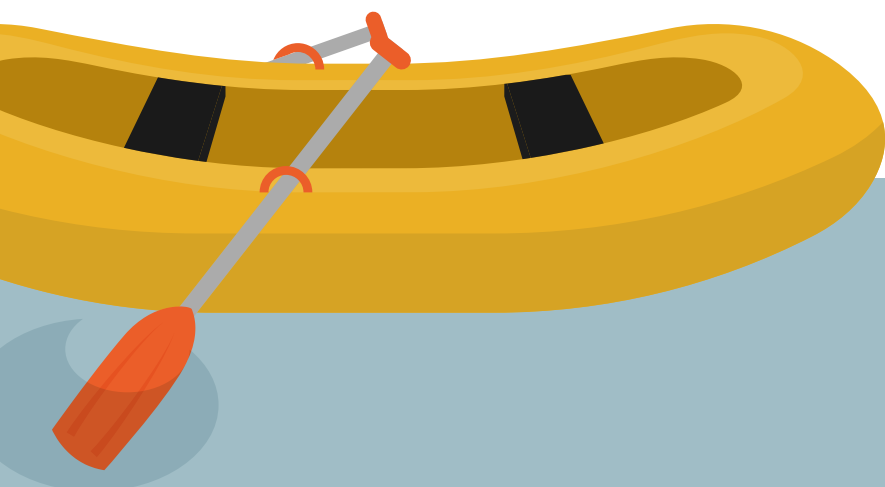
Introduction | Making Overdose Safety Planning Operational in CCBHCs

Certified Community Behavioral Health Clinics (CCBHCs) were created to deliver comprehensive, coordinated, and accountable behavioral health care in communities facing complex and evolving needs. They are uniquely positioned at the intersection of crisis response, out-patient treatment, medication management, care coordination, and quality oversight. Overdose risk lives in that intersection.

In many communities, people at elevated risk of overdose are not only seen in specialty substance use treatment. Overdose risk should be addressed during crisis stabilization, following discharge from in-patient or detox settings, during medication transitions, amid housing disruptions, and in moments of emotional distress. Because CCBHCs integrate these service lines under one model, they are uniquely positioned to anticipate risk rather than simply respond to adverse events.

Overdose Safety Planning (ODSP) provides a structured method for translating that “positioning” into reliable practice. It is not a standalone program. It is a framework that strengthens how CCBHCs assess vulnerability, coordinate transitions, reinforce protective factors, and sustain engagement over time.

This toolkit translates the Zero Overdose clinical model into CCBHC implementation strategy. It bridges clinical practice, Electronic Health Record (EHR) infrastructure, billing sustainability, interdisciplinary coordination, and quality measurement into a unified operational framework.



Each module serves a distinct but interconnected function:

Module 1 | The CCBHC Mandate for Overdose Prevention

Establishes federal alignment and demonstrates how ODSP strengthens compliance with certification criteria, crisis follow-up requirements, and quality measures.

Module 2 | Workforce and Clinical Competencies

Defines the competencies necessary for reliable overdose risk recognition, collaborative safety planning, and system follow-through across interdisciplinary teams.

Module 3 | Implementation Infrastructure

Operationalizes overdose risk reduction through EHR configuration, medication mitigation workflows, ADT (Admission, Discharge and Transfer) feed data integration, follow-up infrastructure, DCO (Designated Collaborating Organization) linkage, and quality oversight.

Module 4 | Sustainability—Billing & Reimbursement

Explains how ODSP integrates into CCBHC Prospective Payment Systems reimbursement models, aligns with qualifying encounters, supports value-based care positioning, and intersects with health-related social needs reimbursement pathways.

Module 5 | The Zero Overdose Clinical Core

Presents the Overdose Risk Formula and Seven-Step Overdose Safety Plan in depth, providing the structured clinical foundation that anchors all other modules.

These modules are mutually reinforcing. The clinical core informs workforce training. Workforce competency relies on infrastructure. Infrastructure supports billing integrity. Billing sustainability reinforces quality oversight. At the same time, each module may be used independently depending on audience and implementation stage.

Together, they form a coordinated approach to making overdose safety planning operational within the CCBHC model—strengthening patient safety, system reliability, and long-term sustainability.

MODULE 1 | The CCBHC Mandate for Overdose Prevention

CCBHCs were developed to do hard things well. They exist to expand access, respond to crisis, coordinate across fragmented systems, and deliver behavioral health care in moments when stability is fragile. The model was designed with complexity in mind. Overdose risk is part of that complexity.

In many communities, behavioral health teams are encountering individuals who are navigating co-occurring mental health conditions, changing substance use patterns, medication adjustments, housing disruptions, and transitions between care settings. These realities are not peripheral to CCBHC work—they are central to it.

Overdose safety planning fits naturally within this environment. It is not an add-on program. It is not a replacement for treatment. It is a structured way to make sure that when risk is present, we respond consistently, thoughtfully, and collaboratively.

This section explains how overdose safety planning aligns with existing CCBHC expectations and how it strengthens both clinical care and operational reliability.

The CCBHC Model Is Already Built for Safety

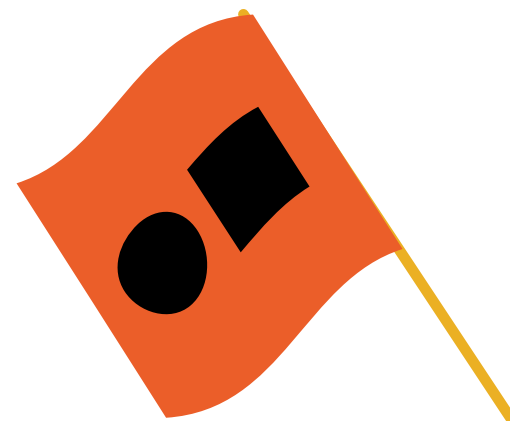
The CCBHC certification criteria established by SAMHSA outline expectations that go beyond service delivery. They define how care should be organized and supported.^{1,2}

CCBHCs are expected to:

- Provide 24/7 crisis services
- Conduct comprehensive assessments
- Coordinate care across systems
- Train staff in risk assessment and prevention
- Engage family and support systems
- Measure performance and improve quality

Taken together, these expectations reflect something important:

- CCBHCs are designed to anticipate risk, not just react to it.
- Overdose safety planning is one way to make that design operational.



Where the Mandate Lives in the CCBHC Criteria

The certification criteria do not contain a line that says, “implement overdose safety planning.” But when you look at the criteria holistically, the expectation becomes clear.

Workforce Training

The criteria require staff training in:

- Risk assessment
- Suicide and overdose prevention and response
- The role of family and support persons in safety planning³

This is a strong signal. If staff are expected to be competent in overdose prevention and response, then the organization must provide a reliable framework to support that competency. Training alone is not enough. Teams need shared tools and shared expectations. For example, imagine a clinic where staff are trained annually on overdose risk factors. Some clinicians conduct detailed assessments. Others rely on informal conversations. Documentation varies widely. The clinic has met the training requirement—but not necessarily the reliability expectation. A structured overdose safety planning framework gives staff something concrete to use. It turns knowledge into practice.

Crisis Services

Under Program Requirement 2 (Availability and Accessibility of Services), Criteria 2.c (Access to Crisis Management Services), CCBHCs must provide crisis services 24 hours a day, seven days a week.⁴ Crisis teams regularly encounter individuals at heightened risk—following an overdose reversal, during periods of emotional distress combined with substance use, or after discharge from higher levels of care. In these moments, stabilization matters. But so does what happens next.

Strengthening Alignment with SAMHSA Criterion 3.D.3

SAMHSA's CCBHC Certification Criteria include explicit requirements under Criterion 3.D.3 related to crisis plan development and timely follow-up after crisis encounters. This criterion requires that individuals receiving crisis services have a documented crisis plan and that follow-up contact occurs within 24 hours of a crisis episode. The intent is to ensure that stabilization is connected to ongoing care and coordinated response rather than episodic.

Overdose safety planning provides a structured method for fulfilling this requirement in a consistent and measurable way. When a crisis encounter involves substance use, overdose reversal, relapse, medication disruption, or destabilizing stressors, the safety plan can serve as the documented crisis plan referenced in Criterion 3.D.3. Embedding overdose safety planning into crisis workflows ensures that risk factors identified during stabilization are translated into protective strategies before discharge.

The 24-hour follow-up requirement further reinforces the need for structured systems rather than discretionary outreach. When overdose safety planning is integrated into crisis documentation and task routing, the follow-up contact becomes part of a closed-loop safety process. This alignment supports both regulatory compliance and continuity of care, strengthening the CCBHC model's emphasis on coordinated, accountable service delivery.

REAL-WORLD EXAMPLE

A mobile crisis team responds after an overdose reversal. The individual is medically stable and agrees to follow-up care. Without structured safety planning, the person returns home with the same environmental risks and few changes in protective supports.

With safety planning embedded into the crisis workflow, the team collaborates to identify:

- Warning signs that risk is increasing
- Safer behavioral strategies
- Trusted support contacts
- Steps to access help quickly

The crisis encounter becomes a preventive turning point rather than a temporary pause.

Care Coordination and Transitions

Care coordination is a cornerstone of the CCBHC model.⁵ Transitions between care settings are vulnerable moments. Research shows elevated overdose risk following discharge from hospitals, detoxification programs, or institutional settings.^{6,7,8} Operational excellence means planning for that vulnerability.

REAL-WORLD EXAMPLE

An individual completes detoxification and is discharged. But tolerance has decreased. Without education or planning, resuming prior use patterns carries significant overdose risk.

A CCBHC that integrates overdose safety planning into discharge workflows ensures that before discharge:

- Risk is reviewed
- Protective strategies are discussed
- Follow-up appointments are confirmed
- Support persons are included when appropriate

This is care coordination at its best—practical, proactive, and person-centered.



Scope of Services

CCBHCs are required to provide comprehensive substance-use disorder services.⁹ Treatment is central. But treatment works best when paired with strategies that reduce immediate risk between visits.

Overdose safety planning complements treatment by reinforcing:

- Awareness of high-risk situations
- Safer behavior strategies
- Medication considerations
- Early-warning-sign recognition
- Support system activation

It strengthens treatment; it does not compete with it.

QUALITY IMPROVEMENT

Aligning Overdose Safety Planning with Required Quality Measures

CCBHCs operate within a quality reporting framework that emphasizes screening, treatment initiation, engagement, and follow-up.^{10,11} Structured overdose safety planning strengthens performance across several commonly reported measures by converting risk identification into documented action.

Two measures are particularly relevant:

- SUD-AD (Substance Use Disorder Screening—Alcohol and other Drugs): Measures whether individuals are screened for substance use disorder using standardized tools.¹²
- IET-AD (Initiation and Engagement of Treatment—Alcohol and other Drugs): Measures whether individuals diagnosed with substance use disorder initiate and remain engaged in treatment within defined timeframes.¹³

Overdose safety planning does not replace these measures; it makes them operational.

How Overdose Safety Planning Supports Measuring Performance

1. Strengthens Screening Reliability (through SUD-AD)

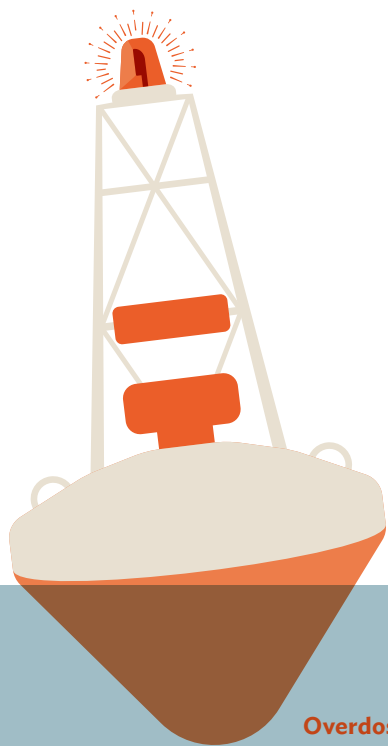
- Embedding overdose risk inquiry within intake workflows reinforces consistent screening practices.
- Structured safety planning prompts deeper assessment following positive screens.
- Discrete EHR fields improve documentation capture for reporting purposes.

2. Improves Initiation After Identification (through IET-AD)

- When overdose risk is identified, safety planning creates an immediate bridge to treatment planning.
- Defined follow-up scheduling during the same encounter increases likelihood of treatment initiation within the required timeframe.
- Crisis encounters that include structured safety planning are more likely to qualify as treatment engagement events.

3. Reinforces Engagement Beyond the First Visit (through IET-AD Engagement Phase)

- Safety plans provide practical next steps, reducing drop-off after initial diagnosis.
- Structured 24–72-hour follow-up contacts reinforce early engagement windows.
- Multidisciplinary reinforcement (peer, therapist, prescriber) strengthens continuity.



Conceptual Flow: Screening → Safety Planning → Engagement

Below is a simplified workflow illustrating how overdose safety planning integrates with quality metrics.

<i>Clinical Step</i>	<i>Operational Action</i>	<i>Quality-Measure Impact</i>
Standardized Screening	SUD screening tool administered and documented	Supports SUD-AD numerator
Risk Identified	Overdose safety planning initiated	Converts identification into documented intervention
Same-Day Scheduling	Follow-up visit scheduled before encounter closes	Supports IET-AD initiation window
Structured Follow-Up	24–72-hour outreach or next visit completed	Supports IET-AD engagement phase
Documentation Review	EHR fields completed and monitored	Strengthens reporting accuracy

When overdose safety planning is embedded into intake, crisis, and transition workflows, screening and engagement become coordinated rather than sequential. This alignment strengthens clinical reliability while also supporting measurable performance within the CCBHC quality framework.^{14,15}

CCBHCs are expected to collect data and engage in continuous quality improvement.¹⁶ When overdose safety planning is standardized, it becomes measurable. Leaders can ask:

- Are individuals being screened for overdose risk?
- Are safety plans documented?
- Are follow-ups occurring after high-risk events?
- Is staff competency being reinforced?

This moves safety planning from a well-intentioned conversation to a system process.

Overdose Safety Planning as Clinical Excellence

Clinical excellence is not just about expertise. It is about consistency. Overdose safety planning supports excellence by:

- Creating a shared approach across teams
- Encouraging collaboration rather than directive instruction
- Focusing on behaviors and situations instead of labels
- Recognizing that overdose risk may intersect with suicide risk without conflating the two

It respects autonomy while strengthening safety.

REAL-WORLD EXAMPLE: THE DUAL-RISK POPULATION

A person experiencing depression reports increased alcohol use and occasional use of opioids obtained from a friend. They deny suicidal intent but describe feeling overwhelmed.

A structured safety framework allows clinicians to address both emotional vulnerability and overdose risk within a unified, supportive plan—without forcing artificial categories. That is integrated care.

Overdose Safety Planning as Operational Excellence

Operational leaders often ask practical questions:

- When should screening occur?
- What triggers safety planning?
- How is documentation structured?
- Who reviews compliance?
- How are follow-ups tracked?
- How do we reinforce skills across teams?

Without a shared framework, answers vary. With a structured approach, safety becomes predictable.

Example: Consider two approaches that could be taken by CCBHCs

CCBHC A

Risk assessment depends on clinician preference. Safety planning is informal. Documentation is inconsistent.

CCBHC B

Risk screening occurs at intake, crisis, and discharge. Safety planning uses a shared template. Follow-up calls are tracked. Supervisors review documentation monthly. Both CCBHCs care deeply about their patients. Only one has operational reliability. That distinction can be consequential: when risk screening, safety planning, and follow-up are inconsistent, warning signs can be missed, people in crisis may go without needed intervention, and opportunities to prevent serious harm—including suicide—can be lost. The CCBHC model rewards the reliability needed to make these safeguards work consistently, not simply the intention to provide good care.

Criteria Crosswalk

<i>CCBHC Criterion</i>	<i>What It Requires</i>	<i>How Overdose Safety Planning Supports It</i>
Staffing & Training	Risk assessment & overdose prevention training	Provides shared protocol for staff to use
Crisis Services	24/7 crisis intervention	Embeds safety planning into crisis workflow
Care Coordination	Cross-setting coordination	Integrates risk review into transitions
Scope of Services	Comprehensive SUD services	Reinforces protective strategies during treatment
Quality Improvement	Data reporting & Continuous Quality Improvement (CQI)	Enables measurable safety processes

MODULE 2 | Workforce and Clinical Competencies—Leveraging the Strength of the CCBHC Model

CCBHCs are designed to deliver comprehensive behavioral health care among crisis services, out-patient treatment, medication management, peer support, and care coordination. Workforce competency allows a multi-component system to function reliably.

This section focuses on the competencies needed to make overdose safety planning operational throughout disciplines. It clarifies how risk recognition, collaborative safety planning, and system follow-through can be embedded into everyday workflows so that safety practices are consistent rather than variable.

The intention is not to introduce new regulatory requirements. Instead, this section translates existing CCBHC expectations into practical workforce capabilities that strengthen care quality, reinforce person-centered practice, and support operational reliability across service lines.

Structure as a Confidence Catalyst

One of the consistent challenges in overdose-risk conversations is hesitation. Clinicians may recognize vulnerability but feel uncertain about how to structure the conversation, how deeply to probe, or what to do next. Variability in approach often reflects ambiguity rather than lack of commitment. Structured frameworks reduce that ambiguity.

The Overdose-Risk Formula—which examines Amount, Route, Mindset, Tolerance, and Setting—provides clinicians a clear, repeatable way to assess vulnerability without relying solely on instinct. When staff have a defined structure to guide inquiry, conversations become more focused, documentation becomes more consistent, and next steps become clearer.

Confidence in this context is not about personal comfort. It is about predictability. A shared framework allows teams to approach overdose risk using the same conceptual map, which reduces avoidance, strengthens interdisciplinary communication, and increases the likelihood that risk identification leads to coordinated action.

Within the CCBHC model, structured frameworks such as the Overdose Risk Formula serve as practical tools that translate training requirements into reliable clinical behavior. They bridge the gap between knowing what to do and doing it consistently.

Why Workforce Competency Is Central to the CCBHC Model

CCBHCs are structured to deliver comprehensive behavioral health services in crisis response, out-patient care, medication management, peer services, and care coordination.¹⁷ This structure uniquely positions CCBHCs to identify and respond to overdose risk at multiple points in care.

CCBHCs are well-positioned to make overdose safety planning a shared clinical practice rather than a siloed intervention because they:

- Conduct structured intake assessments
- Provide 24/7 crisis services
- Maintain longitudinal out-patient relationships
- Integrate medication and behavioral health services
- Coordinate transitions across systems
- Engage family and support systems when appropriate

The federal requirement that staff receive training in risk assessment and overdose prevention and response reinforces this expectation.¹⁸ Workforce competency ensures that this training translates into consistent practice in varied roles and settings.

Defining Core Workforce Competencies Within a CCBHC

Overdose safety planning aligns with three interlocking competencies:

- 1.** Risk Recognition
- 2.** Collaborative Safety Planning
- 3.** System Follow-Through

These three reflect how CCBHCs are already designed to function—as coordinated, interdisciplinary systems of care.

COMPETENCY 1: RISK RECOGNITION

Risk recognition is the ability to identify patterns, transitions, and clinical indicators associated with increased overdose vulnerability and to initiate further assessment when indicated.

Why CCBHC Staff Are Positioned to Recognize Risk

Intake and Assessment Teams

Comprehensive intake assessments capture substance-use history, medication exposure, prior overdose events, recent transitions, and psycho-social stressors. Because intake is structured and occurs at the front door of care, it provides a consistent opportunity to identify risk early.

REAL-WORLD EXAMPLE: INTAKE SETTING

A person presents for therapy related to anxiety. During intake, they disclose recent completion of detoxification and occasional use of opioids obtained from acquaintances. The intake clinician recognizes the decreased-tolerance risk associated with recent abstinence and initiates safety planning during the same visit.^{19,20}

Crisis Services Teams

Crisis staff evaluate individuals at moments of acute distress, recent exposure, or post-emergency stabilization. These encounters often involve high-risk windows.

REAL-WORLD EXAMPLE: CRISIS SETTING

Mobile crisis responds to an individual following a non-fatal overdose reversal. The individual declines in-patient admission but agrees to out-patient follow-up. Crisis staff initiate a structured safety plan and ensure out-patient scheduling before discharge. Without this step, the encounter could end at stabilization. With it, the intervention becomes preventive.

Medication Providers

Prescribers review medication changes, sedating combinations, and tolerance shifts. The combined use of opioids with alcohol or benzodiazepines increases overdose risk due to respiratory suppression.^{21,22,23} Medication providers can identify and address these risks during routine visits.

Care Coordinators

Transitions across systems—hospital discharge, detox completion, incarceration release—are associated with elevated overdose mortality, particularly in early post-release periods.^{24,25} CCBHC care coordination infrastructure allows these transitions, and overdose risk identified in the course of care, to be tracked and proactively addressed.

Peer Support Specialists

Peers often learn about emerging stressors or changes in substance use patterns during informal conversations. Because of trust and shared experience, peers may hear early warning signs that warrant team communication. Peer support specialists can work with the team to update care plans to take these needs and risks into consideration. Care recipients are more likely to act on emerging concerns when they know what to do and have clear next steps, so teams should make those steps explicit and shared.

Evidence-Based Risk Patterns CCBHC Staff Should Recognize

Reduced Tolerance After Abstinence

After detoxification, hospitalization, incarceration, or other abstinence periods, tolerance decreases. Resuming previous levels of use during this period is associated with elevated overdose risk.^{26,27}

Poly-substance Exposure

Poly-substance involvement is increasingly present in overdose deaths nationally.²⁸ Consumption of opioids with other central nervous system depressants such as alcohol or benzodiazepines increases respiratory suppression risk.^{29,30}

Transition Vulnerability

The first weeks following release from institutional settings are associated with significantly increased overdose mortality.^{31,32} Structured follow-up during this period is protective.

Stress Escalation Combined with Increased Use

Periods of heightened stress, grief, or instability paired with heavier use, using alone, or decreased support contact may increase vulnerability. Recognition of behavioral shifts allows earlier safety intervention.

Common but Tricky Challenge: “This Is Not a Substance-Use Client”

In CCBHC settings, individuals may present for depression, trauma, or anxiety services. Substance-use patterns may be intermittent or secondary.

The challenge: overdose risk may not feel central to the presenting concern.

The opportunity: structured intake and longitudinal care allow subtle risk indicators to be identified early—before escalation. Risk recognition competency helps teams normalize safety planning even when substance use is not the primary treatment focus. Integrating co-occurring mental health and substance use care strengthens this approach, ensuring that substance use and behavioral health risks are recognized and addressed together rather than in isolation.

COMPETENCY 2: COLLABORATIVE SAFETY PLANNING

Collaborative safety planning translates risk recognition into actionable, person-centered strategies. Because CCBHCs operate interdisciplinary teams, safety planning can be reinforced across crisis services, out-patient therapy, medication management, peer support, and care coordination. Collaborative safety planning becomes reliable when staff understand how to approach each element clearly and consistently. Here are the core components.

- 1. Explain safety planning as a routine part of care.** Introduce safety planning as a standard and supportive practice used with many individuals, not as a response to wrongdoing or failure. Framing it as part of high-quality behavioral health care reduces stigma and normalizes open discussion about risk.
- 2. Identify personal warning signs of escalating vulnerability.** Help individuals recognize emotional, behavioral, or situational signals that risk may be increasing, such as isolation, increased stress, or changes in substance use patterns. Documenting individualized warning signs improves early detection and team awareness across service lines.
- 3. Discuss behavioral and environmental risk situations.** Explore contexts that may increase vulnerability, including using alone, mixing substances, major life transitions, or returning to prior patterns after abstinence. Using neutral, behavior-focused language supports honest discussion and avoids labeling.
- 4. Identify practical protective actions.** Collaboratively define realistic steps that can reduce risk during high-vulnerability moments, such as reaching out to a support person, adjusting routines, or scheduling earlier follow-up. Protective actions should be specific enough that other team members can reinforce them.

- 5. Clarify whom to contact and how to access urgent help.** Ensure the individual understands how to reach trusted supports, clinic staff, after-hours crisis services, or emergency services when needed. Clear instructions reduce uncertainty during high-stress moments and align with CCBHC crisis service infrastructure.³³
- 6. Document the plan for team continuity.** Record warning signs, protective steps, and contact information in a structured and easily accessible location in the EHR. Clear documentation allows crisis teams, out-patient clinicians, medication providers, and care coordinators to reinforce the plan consistently.

EXAMPLE: OUT-PATIENT THERAPY SETTING

A therapist notices a client's increased alcohol use following a recent relationship loss. The client denies suicidal thoughts and is not seeking substance use treatment.

The therapist says:

"I want to make sure we have a plan for moments when stress feels high and use feels more tempting. Would you be open to mapping that out together?"

The resulting safety plan includes:

- Recognizing high-risk events
- Scheduling supportive check-ins
- Identifying safer routines
- Clarifying emergency contact options

This approach reinforces autonomy and integrates safety without labeling.

Common but Tricky Challenge: Staff Discomfort

Some staff may feel unsure how to raise overdose risk without appearing accusatory. Others may worry that discussing risk "plants ideas." Evidence indicates that discussing risk does not increase risk; clear conversations often strengthen protective engagement.³⁴ When people know what to look for, how to ask about risk, and what steps to take next, they are more likely to act when concerns arise. Structured language and practice exercises during training help normalize these discussions and give staff clear, practical next steps for responding to identified risk.

Integrating Dual Risk Without Conflation

Overdose vulnerability and suicide risk can intersect but are clinically distinct. Competency includes:

- Conducting suicide risk assessment when indicated.
- Addressing overdose-related behaviors directly.
- Integrating both into a unified safety plan when appropriate.

This clarity protects both clinical integrity and person-centered care.

Adapting Safety Planning for Individuals with Co-Occurring Intellectual and Developmental Disabilities (IDD)

Overdose safety planning must be accessible to the person it is intended to support. Within the CCBHC model, individuals with Intellectual and Developmental Disabilities are served when IDD occurs together with a mental health and/or substance use disorder, and safety planning should be adapted accordingly. Individuals with Intellectual and Developmental Disabilities (IDD) may process information differently, benefit from simplified language, or respond more effectively to visual supports. A standardized, text-heavy safety plan may not be usable unless it is adapted to match communication and cognitive needs.

Adapting the plan does not mean reducing rigor. It means presenting the same core elements—warning signs, risk situations, protective actions, and support contacts—in formats that are easier to understand and recall. This may include:

- Using icons or images to represent warning signs such as “feeling overwhelmed,” and “being alone”
- Color-coded sections to distinguish “When I feel unsafe” from “What helps me stay safe”
- Short, plain-language statements rather than clinical terminology
- Including trusted caregivers or support staff in plan development and reinforcement

REAL-WORLD EXAMPLE

An individual with co-occurring IDD identifies that feeling “confused and frustrated” increases vulnerability. Instead of listing abstract triggers, the safety plan uses visual icons showing “crowded space,” “loud noise,” and “being alone.” Protective steps are illustrated with images of calling a support person, attending a day program, or taking a scheduled medication. The core safety elements remain intact; they are simply presented in a format that the individual can use independently.

Within the CCBHC model, adapting safety planning for individuals with IDD supports person-centered care, interdisciplinary coordination, and consistent reinforcement among caregivers and providers. It ensures that overdose risk reduction strategies are both clinically sound and practically accessible.

COMPETENCY 3: SYSTEM FOLLOW-THROUGH

System follow-through ensures that safety planning evolves as circumstances change. Because CCBHCs integrate multiple service lines, they are positioned to make follow-through standard practice.

When Safety Plans Should Be Updated

- **There is a crisis encounter or emergency department visit.** A crisis encounter signals a period of heightened instability or acute vulnerability. Even if the immediate situation resolves, the factors contributing to that crisis may persist after discharge. Reviewing and updating the safety plan ensures that new triggers, environmental factors, or stressors identified during the encounter are incorporated into ongoing care. It also reinforces continuity between crisis and out-patient teams.
- **An individual is discharged from hospital, detox, or residential care.** Discharge from structured settings often involves a shift from high supervision to greater independence. Tolerance levels, daily routines, and support access may change significantly during this transition. Without proactive review, individuals may return to environments associated with previous high-risk behaviors. Updating the safety plan at discharge strengthens continuity and reinforces protective strategies during a vulnerable re-entry period.
- **A person is released from incarceration or other institutional setting.**^{35,36} Research consistently shows elevated overdose mortality in the early period following release from incarceration, particularly within the first two weeks.^{37,38} Reduced tolerance, abrupt environmental change, and stressors related to reintegration contribute to increased risk. Reviewing the safety plan during this transition allows teams to address tolerance shifts, support access, and structured follow-up. CCBHC care coordination infrastructure is well-positioned to anticipate and provide support during this period of vulnerability.

- **Medication regimens change (new prescriptions, dosage adjustments, sedating combinations).**³⁹ Changes in medication can alter sedation levels, tolerance, or drug interaction risk.⁴⁰ Initiation of new prescriptions, dosage increases, discontinuation of medications, or combinations involving central nervous system depressants warrant careful review. Updating the safety plan during medication changes reinforces education, clarifies risk, and ensures coordinated messaging among prescribers and therapy teams. This supports both clinical and pharmacologic safety.
- **Substance use frequency or pattern changes.**⁴¹ Shifts in frequency, quantity, route, or substance combinations can meaningfully affect overdose risk.⁴² Poly-substance exposure has become increasingly common in overdose deaths nationally.⁴³ Reviewing the safety plan when use patterns change allows providers to reassess vulnerability and update protective steps accordingly. It also provides an opportunity to re-engage individuals in supportive services without stigma.
- **Major psycho-social stressors arise.** Life events such as housing disruptions, job loss, grief or the loss of a loved one, relationship changes, or legal stress can increase emotional distress and disrupt routines. Grief and loss can be particularly significant because people may turn to substances as a way to cope with these intense emotions, loneliness, or changes in their daily lives, disrupting recovery. These stressors may coincide with increased substance use or reduced engagement in care. Reviewing the safety plan during periods of significant stress allows teams to strengthen supports proactively. It also reinforces that safety planning adapts to life circumstances rather than remaining static.
- **Protective supports are lost or disrupted.** The loss of a trusted support person, peer group, stable housing, or community connection can reduce protective buffering. When supports shift, previously identified safety strategies may no longer be realistic. Updating the plan ensures that alternative contacts or supports are identified. This maintains continuity even when social conditions change.
- **Engagement in care changes (missed appointments, service gaps).** Missed visits or reduced contact may signal increasing instability or competing stressors. Gaps in care are also moments when risk may go unmonitored. Reviewing and refreshing the safety plan during re-engagement helps reestablish structure and clarify next steps. It reinforces that follow-up is part of a coordinated safety system rather than a stand-alone event.

EXAMPLE 4: TRANSITION AFTER RESIDENTIAL TREATMENT

An individual completes residential treatment and returns home. Tolerance has decreased, and community supports are limited. Care coordination schedules a 48-hour follow-up call. During that call, the safety plan is updated to reflect:

- New environmental triggers
- Reinforced protective behaviors
- Scheduled out-patient appointments

The plan evolves with the transition.

Common but Tricky Challenge: “We Already Did a Safety Plan”

Safety plans are sometimes treated as static documents. In reality, safety plans are dynamic. They should adapt to changing medication regimens, living situations, stressors, and treatment engagement. Operational reliability requires embedding updated triggers into workflow—not relying on memory alone.

Documentation and Communication

Because CCBHCs function as interdisciplinary teams, safety plans must be:

- Clearly documented in standardized formats
- Accessible across service lines
- Visible during handoffs
- Reinforced during supervision

Timely follow-up after high-risk events is associated with improved engagement and reduced adverse outcomes.⁴⁴ Systematic outreach after crisis encounters strengthens protective continuity.

Micro-Simulations: Building Skill Through Five-Minute Huddle Drills

Sustaining competency requires more than annual training. Brief, structured reinforcement exercises help translate knowledge into reliable behavior across disciplines. Micro-simulations are short (five-minute) huddle-based drills that allow teams to practice applying the Overdose Risk Formula in realistic scenarios without the burden of formal role-play sessions.

Unlike extended simulations, micro-simulations focus on rapid pattern recognition and structured inquiry. The goal is to strengthen comfort using the shared framework—Amount, Route, Mindset, Tolerance, and Setting—so that risk conversations become more natural during actual encounters. These drills can be conducted during existing team meetings or shift huddles, minimizing operational disruption.

Examples of five-minute micro-simulation prompts include:

- Intake Scenario: “A new client reports recent completion of detox, but continues to use opioids intermittently. Walk through the Risk Formula. What would you explore first?”
- Crisis Scenario: “Mobile crisis responds after a non-fatal overdose reversal. Which components of the Risk Formula guide immediate safety planning?”
- Medication Visit Scenario: “A patient is prescribed a benzodiazepine while reporting increased alcohol use. How does this affect Amount, Tolerance, and Setting considerations?”

Each drill ends with a brief reflection: What follow-up would be scheduled? What documentation fields would be completed? Who on the team reinforces the plan?

Micro-simulations normalize safety planning conversations, reduce hesitation, and build interdisciplinary consistency. Over time, they strengthen clinical confidence not through repetition of theory, but through repeated application of a shared structure.

Supervisor Observation Checklist: Reinforcing Safety Planning Fidelity

Sustained implementation depends on supervisory reinforcement. A structured observation checklist helps supervisors assess whether overdose safety planning is being applied consistently and collaboratively among clinicians and settings. The purpose of this tool is developmental—to support coaching, identify variability, and strengthen reliability—not to create punitive oversight.

Supervisors may use this checklist during direct observation (shadowing), chart review, or case consultation.

Risk Recognition

- Did the clinician explore recent transitions (e.g., discharge, detox, incarceration release)?
- Were patterns of use assessed using structured inquiry (Amount, Route, Mindset, Tolerance, Setting)?
- Were medication-related risks discussed when applicable?
- Did the clinician identify individualized warning signs rather than relying solely on general risk factors?

Collaborative Safety Planning

- Was safety planning introduced as a routine part of care?
- Did the clinician use neutral, behavior-focused language?
- Were warning signs clearly identified and documented?
- Were protective actions specific, realistic, and collaboratively defined?
- Were support contacts and urgent-access pathways clarified?

System Follow-Through

Was the safety plan documented in a structured and accessible format?

Were follow-up actions scheduled during the encounter (rather than deferred)?

- Were role-based responsibilities clear (e.g., outreach assigned to care coordinator)?
- Were update triggers identified if risk conditions change?

Supervisory observation reinforces shared standards and reduces variability among clinicians. When paired with micro-simulations and periodic documentation audits, it strengthens the integration of overdose safety planning as a system practice within the CCBHC model.

MODULE 3 | Implementation Infrastructure— Making Overdose Risk Reduction Operational in CCBHCs

Certified Community Behavioral Health Clinics (CCBHCs) are structured to deliver coordinated, interdisciplinary, and measurable care throughout out-patient services, crisis response, and medication treatment. Overdose risk reduction requires precisely this type of infrastructure. It depends on timely identification of vulnerability, standardized medication reassessment pathways, coordinated care transitions, reliable follow-up, and continuous performance monitoring.⁴⁵

The CCBHC model emphasizes care coordination, integration of health information technology, and accountability through quality measurement.⁴⁶ When overdose risk reduction is embedded within these structures, it becomes a reproducible system capability rather than a clinician-dependent practice. This section describes how CCBHCs can implement overdose risk reduction through certified EHR configuration, medication mitigation workflows, timely information exchange, structured follow-up infrastructure, quality oversight, and workforce reinforcement.

CERTIFIED EHR TECHNOLOGY (CEHRT) AND WORKFLOW INTEGRATION

Why EHR Infrastructure Matters in CCBHCs

CCBHCs are expected to provide coordinated and accountable care among disciplines and settings. Without structured EHR workflows, overdose risk response may vary by clinician and encounter. Properly configured Certified EHR Technology (CEHRT) allows clinics to standardize reassessment triggers, ensure documentation is actionable among teams, automate follow-up tasks, and generate measurable reporting—core elements of coordinated care.⁴⁷

What is a CEHRT?

Certified Electronic Health Record Technology (CEHRT) refers to EHR systems certified under the Office of the National Coordinator for Health IT (ONC) Certification Program and recognized by Center for Medicare and Medicaid Services (CMS) for meeting interoperability, structured data capture, and clinical decision support standards.⁴⁸ Certification can be verified through the ONC Certified Health IT Product List (CHPL).⁴⁹

CEHRT enables:

- Structured documentation fields
- Clinical decision support (CDS) triggers
- Interoperability (including ADT feeds)
- Registry and dashboard reporting

These capabilities allow overdose risk workflows to function as system processes rather than informal practices.

Key EHR Workflow Actions and Their Significance

<i>EHR Workflow Action</i>	<i>What It Does Operationally</i>	<i>Why It Is Significant</i>	<i>CCBHC Applicability</i>	<i>Example</i>
Risk-Triggered Clinical Decision Support (CDS)	Activates structured prompts when overdose risk indicators are documented	Converts risk recognition into required action; standardizes response	Supports coordinated, measurable care delivery	“Recent overdose” documentation opens reassessment module requiring medication review and follow-up scheduling
Structured Discrete Documentation Fields	Captures overdose risk and medication plan in searchable data fields	Enables dashboards, registries, and continuity among providers	Aligns with quality monitoring expectations	MOUD status and overdose history populate high-risk dashboard
Visit-Closure Controls	Requires completion of defined overdose risk elements before note sign-off	Prevents documentation gaps during high-risk visits	Reinforces reliability over discretion	Elevated risk requires documented follow-up timeframe
Role-Based Task Routing	Assigns reassessment or outreach tasks to defined team roles	Creates accountability within interdisciplinary care	Advances coordinated response expectations	Relapse routes MOUD reassessment task to prescriber
High-Risk Registries and Flags	Maintains visibility of elevated overdose vulnerability	Enables population management and oversight	Supports proactive panel monitoring	Patient remains flagged until follow-up complete
Automated Escalation Rules	Alerts supervisors when tasks are overdue	Prevents silent workflow failure	Supports timely access and accountability	Missed follow-up triggers supervisory alert

Together, these EHR mechanisms convert overdose risk detection into standardized clinical action.

MEDICATION MITIGATION WORKFLOWS

Why Medication Workflows Are Central to Overdose Risk Reduction

Medication-based stabilization is a core evidence-supported strategy for reducing overdose mortality. FDA-approved medications for opioid use disorder (MOUD)—buprenorphine, methadone, and extended-release naltrexone—are associated with improved survival and treatment continuity.⁵⁰ National clinical guidance from SAMHSA and ASAM outlines structured protocols for assessment and initiation.^{51,52} Overdose risk frequently escalates during identifiable transition points.

When Risk Escalates

- **Post-incarceration release:** Mortality risk from overdose is markedly elevated in the first two weeks following release.^{53,54}
- **Post-detoxification without continuity of care:** Loss of tolerance following detox increases overdose vulnerability if return-to-use occurs.^{55,56} Medically managed withdrawal without ongoing treatment is associated with increased mortality risk.⁵⁷
- **Concurrent benzodiazepine or sedative use:** CDC data indicate benzodiazepines were involved in 16.8% of overdose deaths in a multi-state analysis, with opioids present in over 90% of those cases.⁵⁸
- **Poly-substance exposure:** Contemporary overdose patterns frequently involve multiple drug classes, reinforcing the need for systematic reassessment.⁵⁹

Medication Mitigation Workflow Components

Medication mitigation workflows standardize response during these high-risk windows:

- Trigger-based identification within the EHR
- Structured reassessment for MOUD candidacy
- Defined timeframes for follow-up evaluation
- Scheduling guardrails
- Role-based task routing
- Escalation for missed reassessment visits

CDC describes outreach models initiating contact within 24–72 hours after nonfatal overdose events, underscoring the importance of rapid response intervals.⁶⁰

By embedding medication reassessment within structured workflows, CCBHCs reduce reliance on individual discretion and ensure timely stabilization planning.

TIMELY INFORMATION EXCHANGE AND ADT INTEGRATION

Why Timely Information Advances CCBHC Care Coordination Goals

Coordinated care across out-patient, crisis, and hospital settings is central to the CCBHC model.⁶¹ Timely awareness of destabilizing events strengthens transitions and reduces fragmentation during high-risk periods. When overdose treatment, detox admission/discharge, or psychiatric hospitalization occurs outside the clinic, rapid notification supports outreach, reassessment, and continuity.

What ADT Is

Admission, Discharge, and Transfer (ADT) notifications are electronic messages generated by hospital systems that signal care transitions, typically transmitted through health information exchanges using standardized messaging formats.⁶²

Pathways for Receiving ADT Notifications

CCBHCs commonly access ADT through regional or state Health Information Exchanges (HIE), direct hospital partnerships, or interoperability services. Each pathway serves the shared objective of ensuring timely notification of high-risk events.

Participation in an HIE often provides broader regional coverage. Direct hospital partnerships may be effective when a single system accounts for most transitions. Interoperability services may facilitate integration where internal technical capacity is limited.

Requests via these pathways—about care coordination, patient safety, and rapid follow-up—support collaborative engagement.

Integrating ADT into Clinical Workflow

The operational value of ADT depends on structured integration within the EHR. Effective integration ensures that notifications generate actions related to:

- High-risk chart indicators
- Time-bound outreach tasks
- Follow-up scheduling prompts
- Registry enrollment until follow-up completion

When timely information exchange is connected to structured workflow, ADT becomes a measurable care coordination tool rather than a passive alert.

Extending the Safety Plan to Care Coordination and Designated Collaborating Organizations

CCBHCs are allowed to maintain formal relationships with Designated Collaborating Organizations (DCOs) to ensure access to required services that may not be delivered directly by the clinic.⁶³ DCOs are formal partner entities that provide one or more designated CCBHC services through established agreements with the clinic. Depending on the structure of the CCBHC, DCOs may include specialty substance use disorder providers, mobile crisis partners, psychiatric rehabilitation providers, peer support organizations, or primary care partners delivering required services under formal arrangement.

Overdose safety planning also frequently extends across broader care coordination and transition sites that may not formally function as DCOs within the CCBHC model. These sites often play a critical role in stabilization, discharge planning, or transition management and may include hospitals, emergency departments, detoxification programs, residential treatment settings, correctional institutions, and reentry programs. Because overdose risk frequently emerges or escalates during transitions between care settings, safety planning cannot remain confined to out-patient encounters alone.

Operationally, the distinction is important: DCOs are formal service delivery partners within the CCBHC structure, while care coordination sites are external environments where information sharing, transition planning, and follow-up coordination remain essential to continuity of care.

Overdose safety planning becomes more effective when it functions as a transportable document across care environments. When appropriately documented within the EHR and supported by interoperability infrastructure, the safety plan can inform emergency physicians during crisis stabilization, discharge planners during hospital transitions, and reentry coordinators following institutional release. This ensures that risk recognition and protective strategies are not reset at each transition point.

Implementing care coordination via linkage involves aligning safety planning workflows with existing Health Information Exchange (HIE) and Admission, Discharge, and Transfer (ADT) notification systems described earlier in this module 3. When a CCBHC receives notification of a hospitalization or discharge event, outreach can be guided by the most current safety plan. Conversely, when an individual presents to a hospital or collaborating entity, the ability to view or transmit key safety planning elements strengthens coordinated response.

FOR EXAMPLE:

- **Hospital Discharge:** An emergency department notifies the CCBHC of an overdose-related visit through ADT. The CCBHC outreach team reviews the documented safety plan, confirms follow-up scheduling, and reinforces protective strategies during post-discharge contact.
- **Release from Incarceration:** A re-entry partner notifies the CCBHC of an upcoming release. The care coordinator schedules a same-week appointment, reviews tolerance considerations, and updates the safety plan to reflect new environmental risks and support pathways.^{64,65}

By positioning the Overdose Safety Plan as a shared care document rather than a clinic-specific note, CCBHCs strengthen continuity, reduce fragmentation during high-risk transitions, and fulfill the collaborative intent of the model within federal certification requirements.⁶⁶

The Warm Handoff Protocol: Using the Safety Plan as the Transfer Document

Within the CCBHC model, a warm handoff refers to a direct, coordinated transfer of care in which responsibility is actively and promptly communicated between providers rather than deferred through passive referral.⁶⁷ A warm handoff includes real-time contact, shared documentation, and defined follow-up steps. In the context of overdose risk reduction, the Overdose Safety Plan can function as the primary transfer document during these transitions.

Unlike a referral—which may involve providing contact information and instructing the individual to schedule an appointment—a warm handoff ensures that the receiving provider understands the individual’s current risk profile, warning signs, protective strategies, and follow-up plan. When the safety plan is accessible within the EHR and transportable through HIE or DCO pathways, it becomes the continuity bridge between settings.

Operationally, the safety plan supports structured communication during transitions such as:

- Crisis Stabilization Unit (CSU) to Out-patient Care
- Emergency Department discharge to CCBHC follow-up
- Detoxification or Residential Treatment discharge to medication evaluation
- Institutional release to community-based care^{68,69}

In each scenario, the safety plan provides immediate context: recent risk factors, tolerance considerations, identified triggers, protective supports, and agreed-upon next steps.

Operational Elements of a Warm Handoff Using the Safety Plan

- Confirm the safety plan is updated before transfer.
- Communicate directly (phone or secure messaging) with the receiving provider.
- Document the handoff in the EHR, including date, time, and receiving party.
- Schedule the follow-up appointment before discharge whenever possible.
- Assign responsibility for outreach if the appointment is missed.

When the safety plan travels with the individual and is actively reviewed during the transfer, the transition becomes a continuation of care rather than a restart. This approach reduces fragmentation during high-risk periods and reinforces the CCBHC model’s emphasis on coordinated, accountable service delivery.⁷⁰

The Safety Plan as a Living Interdisciplinary Document

Within a CCBHC, the Overdose Safety Plan should function as a living document rather than a one-time clinical note. Because CCBHCs operate as interdisciplinary systems, no single provider “owns” the safety plan. Instead, it evolves as different team members contribute updated information, reinforce protective strategies, and respond to changes in risk.

A static safety plan risks becoming outdated when medication regimens change, transitions occur, or new stressors emerge. A living document model ensures that the plan is reviewed and refined during therapy visits, medication appointments, peer check-ins, and care coordination outreach. Each encounter becomes an opportunity to confirm that warning signs, protective actions, and support contacts remain accurate and actionable.

Interdisciplinary contributions may come from:

- **Therapist:** Updates emotional triggers, stress-related warning signs, and coping strategies identified during sessions.
- **Prescriber:** Reviews medication interactions, tolerance considerations, and sedation risk factors; updates pharmacologic safety elements.⁷¹
- **Peer Specialist:** Reinforces protective behaviors in community settings and flags emerging instability.
- **Care Coordinator:** Reviews transition-related risks, confirms follow-up scheduling, and ensures support systems remain active.

REAL-WORLD EXAMPLE: RESUMED USE

An individual discloses resumed use during therapy following a recent housing disruption. The therapist updates the safety plan to reflect new environmental triggers. The prescriber reviews medication stabilization options during the next visit. The peer specialist reinforces daily check-ins during the first week after disclosure. The care coordinator confirms appointment adherence and support contacts. The safety plan remains consistent, but evolves through coordinated team action.

By treating the Overdose Safety Plan as a shared and dynamic document, CCBHCs reduce siloed care and strengthen continuity during high-risk periods. This approach aligns with the model’s emphasis on coordinated, accountable, and measurable interdisciplinary care delivery.⁷²

Joint Safety Planning When Overdose and Suicide Risk Co-Occur

Many individuals at elevated overdose risk also experience elevated suicide risk. The two remain clinically distinct, and each warrants appropriate assessment. Maintaining two separate safety plans, however, rarely serves the person in care or the supporting team. When both risks are present, teams should develop a joint safety plan integrating suicide-specific elements, such as warning signs of suicidal ideation and lethal-means counseling, with overdose-specific elements, such as tolerance changes, poly-substance exposure, and access to FDA-approved medication to reverse potential overdose.

A joint plan strengthens continuity throughout the CCBHC model. One document travels with the individual through crisis encounters, warm handoffs, and follow-up outreach; one set of warning signs, protective actions, and support contacts is reinforced by every discipline; and documentation remains clear during transitions and quality review. Suicide risk assessment should still be conducted whenever indicated, and the joint plan should record how each risk is being addressed so that neither is diluted. This approach aligns with the crisis plan expectations described in Criterion 3.D.3⁷³ and the dual-risk guidance presented in Modules 2 and 5.

FOLLOW-UP

Why Structured Follow-Up Is Essential

Overdose risk reduction is defined not only by detection but by closed-loop response. CCBHC goals emphasize timely access and coordinated intervention. Structured follow-up ensures high-risk events result in completed outreach, documented reassessment, and stabilization planning.

Core Follow-Up Components

- Time-bound outreach windows (e.g., 24–72 hours)⁷⁴
- Assigned task ownership
- Scheduling guardrails for timely follow-up visits
- Escalation protocols for missed appointments
- Registry persistence until mitigation criteria are met

EXAMPLES

Post-Detox Discharge Without MOUD

Tolerance reduction after detox increases overdose risk if substance use resumes.^{75,76} When discharge notification is received, outreach is initiated promptly and follow-up evaluation is scheduled within a defined window. Registry enrollment maintains visibility until reassessment is documented. Evidence indicates mortality risk is reduced when continuity of treatment follows detoxification.⁷⁷

Relapse Disclosure During Therapy

Relapse signals increased overdose vulnerability, particularly following abstinence. The EHR triggers medication reassessment and follow-up scheduling. If the patient misses the appointment, escalation rules prompt renewed outreach, treating missed visits as potential destabilization signals.

QUALITY OVERSIGHT AND PERFORMANCE MONITORING

Why These Measures Advance CCBHC Objectives

Quality monitoring transforms overdose risk workflows into measurable and accountable performance. CCBHC reporting expectations include structured quality measures, reinforcing that measurable follow-up and treatment engagement are integral to the model.⁷⁸

Selected Measures and Rationale

- Follow-Up After Emergency Department Visit for Substance Use (FUA): Measures timely out-patient follow-up after ED visits, including overdose diagnoses.⁷⁹
- Initiation and Engagement of Substance Use Disorder Treatment (IET): Assesses whether individuals initiate and engage in treatment promptly after diagnosis.⁸⁰
- Continuity of Pharmacotherapy for Opioid Use Disorder: Evaluates sustained medication treatment over defined periods.⁸¹

These measures reflect critical transition points between identification, engagement, and sustained stabilization.

Continuous Quality Improvement: Using PDSA to Sustain Overdose Safety Planning

Continuous Quality Improvement (CQI) ensures that overdose safety planning remains a living system process rather than a one-time implementation effort. The Plan-Do-Study-Act (PDSA) cycle provides a structured method for testing, refining, and sustaining workflow reliability within the CCBHC model.^{82,83}

In the context of overdose safety planning, CQI begins with clearly defined expectations: structured risk assessment, documented safety planning, timely follow-up, and interdisciplinary reinforcement. Once those expectations are embedded into EHR workflows and supervisory practices, performance can be monitored through periodic chart audits, dashboard reporting, and transition tracking.

Monthly safety plan audits can serve as the “Study” phase of a PDSA cycle. For example, a clinic may review a sample of charts to determine:

- Percentage of high-risk encounters with documented safety plans
- Timeliness of follow-up after crisis events
- Completion of update triggers during transitions
- Evidence of multidisciplinary reinforcement

If gaps are identified, the “Act” phase may include targeted interventions such as refresher training, revision of EHR prompts, clarification of role-based task routing, or supervisor coaching. The “Do” phase involves implementing these refinements in routine workflow, followed by continued monitoring in the next audit cycle.

Here is a simplified example of a PDSA cycle applied to overdose safety planning:

- **Plan:** Define expectation that all crisis encounters include documented safety plan review and scheduled follow-up.
- **Do:** Implement EHR visit-closure prompt requiring safety plan update before note completion.
- **Study:** Conduct monthly audit to assess compliance and timeliness of follow-up contacts.
- **Act:** Adjust training or modify task routing if documentation or outreach rates fall below target.

When applied consistently, PDSA cycles transform overdose safety planning from a documentation requirement into a monitored and improving system capability. This approach aligns with CCBHC expectations for measurable quality oversight and reinforces that safety planning is both a clinical priority and an operational discipline.^{84,85}

WORKFORCE REINFORCEMENT

Why Workforce Alignment Sustains Reliability

Overdose risk reduction depends on consistent application across roles and settings. Workforce reinforcement ensures workflows remain standardized despite turnover or variability in clinical background.

Workforce Elements

- Standardized onboarding on overdose risk workflows
- Role-specific competency development
- Supervision and documentation review
- Learning management system tracking
- Targeted retraining based on audit findings

National resources from SAMHSA, ASAM, and CDC provide guidance for clinical training and implementation support.^{86,87,88}

SYNTHESIS

CCBHCs are uniquely positioned to make overdose risk reduction standard practice because the model is structurally built around interdisciplinary care coordination, health information technology integration, crisis responsiveness, and measurable quality oversight. When overdose risk mitigation is embedded within CEHRT-enabled workflows, medication reassessment protocols, ADT-driven event notification, structured follow-up, and performance dashboards, it becomes a reliable system response rather than a discretionary clinical act. This integration is especially important during high-risk transition points—post-incarceration release, post-detoxification discharge, relapse episodes, and emergency department encounters—where evidence demonstrates that overdose vulnerability increases significantly.^{89,90,91,92}

Implementing this guidance requires alignment of governance, role clarity, training, and measurement systems alongside EHR build and interoperability infrastructure. CCBHCs that treat overdose risk reduction as both a clinical priority and an operational discipline are better positioned to ensure timely reassessment, medication-based stabilization, and closed-loop follow-up—advancing patient safety and meeting CCBHC quality reporting expectations.^{93,94,95}

EHR AND ORGANIZATIONAL READINESS CHECKLIST

Human Factors

- Clinical leadership and MOUD workflow ownership
- Defined role accountability for reassessment and outreach
- Written protocols for high-risk transitions
- Onboarding and refresher training
- Supervision and audit processes
- Quality dashboard governance

Technology Factors (EHR Configuration and Interoperability)

Verified CEHRT configuration and CDS capability⁹⁶

- Structured overdose risk documentation fields
- Task routing and escalation rules
- ADT connectivity through HIE or partnership⁹⁷
- Registry and dashboard reporting capability
- Access controls and audit logs



MODULE 4 | Sustainability—Billing & Reimbursement Strategy

CCBHCs were designed to deliver comprehensive, coordinated behavioral health services in a financially sustainable way. The Prospective Payment System (PPS) was intentionally structured to support integrated care rather than fragmented, procedure-based billing. Overdose safety planning fits within this model when it is embedded in qualifying encounters, crisis services, medication management, and care coordination—not when it is treated as a separate or supplemental activity.

Financial sustainability is not achieved by identifying new billing codes. It is achieved by ensuring that structured overdose risk assessment, safety planning, and follow-up are consistently delivered within reimbursable services and documented clearly. When aligned properly, safety planning strengthens encounter integrity, supports quality performance, reinforces crisis stabilization requirements, and enhances value-based positioning.

This module explains how overdose safety planning integrates with:

- PPS-1 and PPS-2 reimbursement models
- Qualifying encounter requirements
- Clinical-to-billing sequencing
- Crisis, psychotherapy, and medication coding
- Collaborative Care (CoCM) pathways where permitted
- Health-Related Social Needs (HRSN) reimbursement intersections
- Value-based care strategy

The objective is clarity and sustainability. Billing should follow care, not drive it.

Understanding the CCBHC Prospective Payment System (PPS)

CCBHCs operate under a state-approved Prospective Payment System authorized by CMS and SAMHSA.⁹⁸ Rather than using discrete procedural billing, PPS reimburses clinics using bundled payments intended to support comprehensive behavioral health services. States implement one of four models: PPS-1, PPS-2, PPS-3, or PPS-4.⁹⁹

PPS-1: Daily Bundled-Rate Model

Under PPS-1, the clinic receives a fixed daily rate for each day that a qualifying encounter occurs. Regardless of how many services are delivered during that encounter, one bundled rate applies.

Operational characteristics include:

- Payment is triggered by a qualifying face-to-face encounter
- Services delivered that day are bundled into one rate
- Revenue depends on encounter documentation integrity
- Splitting services into multiple same-day visits does not increase payment

This means overdose safety planning must occur within an already qualifying encounter. Its financial sustainability depends on strengthening the clinical substance of that encounter—through structured risk assessment, documented intervention, and defined follow-up.

Under PPS-1, the financial strategy focuses on:

- Ensuring safety planning is embedded in billable visits
- Avoiding fragmentation across non-qualifying encounters
- Strengthening documentation of medical necessity
- Using crisis codes appropriately when criteria are met

Documentation clarity, not code proliferation, contributes to sustainability.

PPS-2: Monthly Bundled Rate with Quality Incentive

Under PPS-2, clinics receive a fixed monthly payment per enrolled beneficiary regardless of visit frequency, provided service criteria are met. Many PPS-2 models include quality bonus payments tied to performance measures.¹⁰⁰ Because monthly rates are developed from cost reports and re-based using actual encounter data, overdose safety planning activities must still be captured in cost reports and documented as encounters. If this work is not reflected there, it will not be accounted for when rates are re-based, and the PPS rate may not cover the cost of delivering it.

Operational characteristics include:

- Revenue is less dependent on visit count
- Engagement continuity becomes financially significant
- Quality metrics influence financial performance
- Longitudinal management matters more than visit volume

Under PPS-2, overdose safety planning contributes financially by strengthening:

- Initiation and Engagement of Treatment (IET-AD)¹⁰¹
- Follow-Up After Emergency Department Visit (FUA)¹⁰²
- Continuity of MOUD
- Reduction of repeat crisis utilization

Here, the financial strategy emphasizes:

- Sustained follow-up
- Engagement reliability
- Registry tracking of high-risk individuals
- Structured transition management

PPS-3: Daily Bundled and Special Crisis Services

Under PPS-3, the clinic receives a fixed daily rate for each day that a qualifying encounter occurs, similar to PPS-1. However, PPS-3 also requires separate payment rates for Special Crisis Services (SCS). These rates are designed to reimburse qualifying crisis services outside the daily bundled rate.

Operational characteristics include:

- Payment is triggered by a qualifying daily encounter
- Services delivered during the qualifying encounter are bundled into the daily PPS rate
- Eligible SCS can generate a separate PPS payment
- Crisis services may include qualifying mobile crisis services and/or on-site stabilization, depending on state's approved methodology
- Revenue depends on documentation of both the qualifying encounter and the crisis service
- Splitting services into multiple same-day visits does not increase payment

This creates an important distinction for overdose safety planning. When safety planning is delivered as part of a routine encounter, it generally remains part of the daily bundled payment. However, when the patient requires SCS, the crisis response may fall under the separately reimbursable SCS rate rather than the standard PPS rate.

Under PPS-3, the financial strategy focuses on:

- Embedding overdose safety planning into qualifying daily encounters
- Clearly documenting the clinical risk, intervention, and follow-up plan
- Identifying encounters that meet the state's criteria for SCS
- Properly documenting and billing eligible mobile crisis and crisis stabilization services
- Avoiding fragmentation of routine services that does not create additional PPS payment
- Using crisis codes appropriately when criteria are met

The sustainability lever is twofold: strong documentation of routine encounters and appropriate identification of separately reimbursable crisis services.

PPS-4: Monthly Bundled Rate and Special Crisis Services

Under PPS-4, the clinic receives a fixed monthly rate for qualifying services rather than a daily rate. PPS-4 also requires a separate payment rate for SCS, but these crisis rates are structured on a monthly basis. PPS-4 additionally requires quality bonus payments and includes other features associated with the monthly PPS methodology.

Operational characteristics include:

- Payment is based on qualifying monthly unit rather than individual daily encounters
- Routine CCBHC services are incorporated into the monthly PPS payment
- Multiple services or encounters during the month generally do not create additional routine PPS payments
- Eligible SCS are reimbursed through separate SCS PPS rates
- Crisis services may include mobile crisis services and/or on-site crisis stabilization, depending on the state's approved methodology
- Quality Bonus Payments are required under PPS-4 when applicable performance requirements are met¹⁰³

For overdose safety planning, this means the financial strategy is somewhat different from PPS-3. A safety-planning intervention delivered during routine care is generally part of the monthly bundled payment. The greater financial opportunity comes from accurately identifying patients who require qualifying crisis services and documenting those services sufficiently to support the separate SCS payment.

Under PPS-4, the financial strategy focuses on:

- Embedding overdose safety planning throughout the patient's care rather than treating it as a separate billable routine service
- Maintaining strong documentation of risk assessment, intervention, medical necessity, and follow-up
- Identifying qualifying crisis episodes that may support an SCS payment
- Accurately documenting mobile crisis and/or crisis stabilization services
- Tracking quality measures because quality bonus payments are required under the PPS-4 methodology¹⁰⁴
- Avoiding fragmentation of routine services because additional encounters do not necessarily generate additional monthly PPS revenue

The sustainability lever is comprehensive care documentation combined with appropriate capture of qualifying services and quality performance—not increasing the number of routine billable encounters. As with PPS-2, all safety planning activity must be reflected in cost reports and captured as encounters so that CCBHC costs remain covered when monthly rates are developed and re-based.

IN SUMMARY:

PPS-1 rewards encounter integrity. PPS-2 rewards engagement durability and measurable performance. PPS-3 rewards encounter integrity plus appropriate capture of qualifying crisis services. PPS-4 rewards sustained engagement, qualifying crisis services, and measurable performance.

Coding Guidance: Why the Clinical-to-Billing Sequence Matters

Billing complexity often arises when documentation and clinical logic become disconnected. Overdose safety planning can feel administratively complicated when teams try to determine “what to bill” before clarifying what occurred clinically.

The proper sequence is:

Clinical need → Structured assessment → Collaborative intervention → Defined follow-up → Documentation → Code alignment.

PPS reimburses qualifying encounters, not isolated tasks.¹⁰⁵ When overdose safety planning strengthens assessment, intervention, and follow-up, it strengthens the qualification of the encounter itself.

Safety planning most commonly occurs within:

- Comprehensive diagnostic evaluation
- Ongoing psychotherapy
- Crisis stabilization
- Medication management
- Care coordination

The following scenarios illustrate why sequencing matters and how coding aligns.

Intake Following Non-Fatal Overdose or High-Risk Disclosure

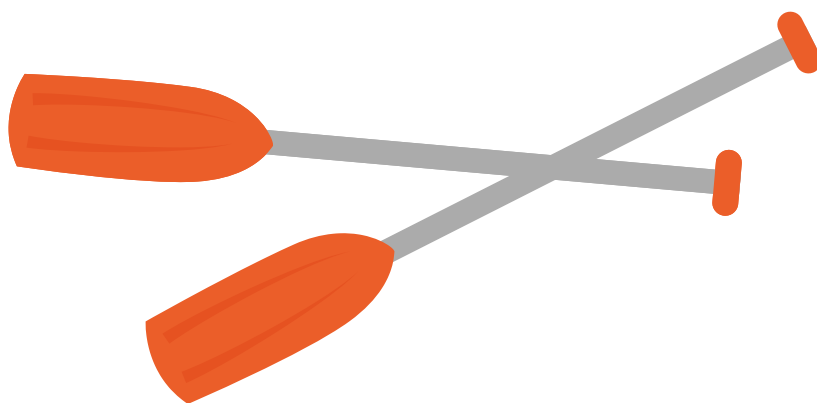
Clinical sequence:

1. Comprehensive diagnostic assessment
2. Substance use and tolerance review
3. Application of the Overdose Risk Formula
4. Collaborative safety planning
5. Scheduling of follow-up prior to visit closure

Coding:

- 90791—Psychiatric Diagnostic Evaluation
- 90792—Diagnostic Evaluation with Medical Services

Why this matters: Safety planning strengthens documentation of medical necessity by demonstrating active intervention in response to identified risk. Under PPS-1, this supports the daily bundled rate. Under PPS-2, it supports initiation and engagement metrics (IET-AD).¹⁰⁶ Under PPS-3, safety planning strengthens documentation supporting the daily bundled encounter and, when delivered as a part of qualifying crisis service, can support the capture of separately reimbursable SCS. Under PPS-4, it strengthens the clinical documentation supporting the monthly bundled payment and, when applicable, the documentation of qualifying SCS and performance measures. Without clear documentation of risk, intervention, medical necessity, and follow-up, the encounter or crisis episode may appear less clinically robust during audit or payment review.



Out-patient Psychotherapy with Escalating Risk

Clinical sequence:

1. Client reports increased stress or substance use
2. Risk reassessment conducted
3. Safety plan updated
4. Protective actions clarified
5. Next appointment scheduled

Coding:

- 90832—30-minute psychotherapy
- 90834—45-minute psychotherapy
- 90837—60-minute psychotherapy

Why this matters: Updating a safety plan during therapy reflects therapeutic intervention and clinical reasoning. Proper documentation supports both reimbursement integrity and engagement continuity.

Crisis Encounter After Overdose Reversal

Clinical sequence:

1. Acute crisis assessment
2. Immediate safety planning
3. Medication stabilization discussion
4. 24-hour follow-up scheduled in alignment with Criterion 3.D.32

Coding:

- 90839—Crisis Psychotherapy
- 90840—Add-on crisis time
- S9484—Community crisis intervention (state dependent)

Why this matters: Crisis billing requires documentation of acute assessment and intervention. Safety planning strengthens the clinical justification for crisis-level coding and reinforces compliance with follow-up requirements.

Medication Visit with Sedation or Poly-substance Risk

Clinical sequence:

1. Medication regimen reviewed
2. Sedating combination identified^{107,108}
3. Tolerance and environmental risks discussed
4. Safety plan updated
5. Follow-up clarified

Coding:

- 99213–99215—Evaluation & Management
- Psychiatric medication management codes

Why this matters: Safety planning supports pharmacologic risk mitigation and demonstrates clinical reasoning beyond routine medication refill.

COLLABORATIVE CARE MODEL (CoCM) INTEGRATION

The Collaborative Care Model supports structured, team-based management of behavioral health conditions over time. It emphasizes registry tracking, psychiatric consultation, systematic follow-up, and population-level monitoring.

In overdose risk management, these elements are often required—particularly during high-risk transitions such as post-discharge, post-incarceration release, or relapse.

Relevant codes include:

- 99492—Initial psychiatric collaborative care management
- 99493—Subsequent collaborative care management
- 99494—Additional time increments

CoCM reimburses structured coordination activities between visits, including:

- Registry monitoring
- Behavioral health manager outreach
- Psychiatric consultant review
- Ongoing stabilization planning

The importance of CoCM lies in supporting longitudinal risk management, not just visit-based intervention.

CCBHC leaders must confirm state Medicaid guidance, as concurrent billing under PPS may be restricted. Where permitted, CoCM strengthens sustainability by supporting structured follow-up infrastructure.

ALIGNING OVERDOSE SAFETY PLANNING WITH VALUE-BASED CARE

CCBHCs increasingly operate within performance-driven environments. Managed Care Organizations focus on:

- Reduced repeat emergency-department utilization
- Timely follow-up after crisis events
- Treatment initiation and engagement
- Continuity of pharmacotherapy

Overdose safety planning directly contributes to these outcomes.

By embedding safety planning into intake, crisis stabilization, and transitions, clinics strengthen:

- IET-AD performance¹⁰⁹
- FUA performance¹¹⁰
- MOUD continuity
- Reduction in repeat acute-care episodes

From a strategic perspective, overdose safety planning functions as a utilization stabilization protocol. When supported by registry tracking and EHR reporting, it becomes measurable evidence of coordinated care.



ADDRESSING OTHER FACTORS THAT MAY IMPACT OVERDOSE RISK

Overdose vulnerability often intersects with housing disruptions, transportation barriers, food insecurity, and legal stressors.

When safety planning identifies social drivers of risk, reimbursement pathways may include:

- ICD-10 Z-codes documenting health-related social needs
- CPT 96160 / 96161 for health-risk assessments
- Care coordination codes
- Community health integration services (payer dependent)
- Section 1115 waiver services where approved

Clinical sequence:

1. Social risk identified during safety planning
2. Structured screening conducted
3. Referral to community resources
4. Follow-up coordination documented

Even where direct reimbursement is limited, documenting HRSN helps to affirm medical necessity and supports value-based positioning.

Avoiding Common Billing and Sustainability Pitfalls

Sustainability is undermined when safety planning is informal or inconsistently documented for the following reasons:

- 1.** Failure to document structured assessment and intervention weakens audit protection. Clear documentation of risk, intervention, and follow-up is essential.
- 2.** Fragmentation across non-qualifying encounters reduces reimbursement integrity. Safety planning should occur during billable visits whenever possible.
- 3.** Misunderstanding billing for crisis rather than care coordination can create compliance risk. Clear sequencing protects both financial and clinical integrity.

Integration protects sustainability.

Leadership Takeaway

Financial sustainability is not about mastering every CPT nuance. It is about aligning structure with reimbursement logic.

- Under PPS-1 and 3, focus on encounter integrity and documentation completeness.
- Under PPS-2 and 4, focus on sustained engagement and measurable performance outcomes.

In each model, overdose safety planning is financially viable when embedded within structured clinical workflows, supported by strong documentation, and aligned with quality and transition management priorities.¹¹¹ When implemented thoughtfully, it advances patient safety, regulatory compliance, quality performance, and long-term financial stability.

MODULE 5 | The Zero Overdose Clinical Core

The preceding modules established the structural foundation for overdose safety planning within CCBHCs: federal alignment, workforce competency, infrastructure design, reimbursement sustainability, and quality oversight. These elements create the system architecture. The clinical core determines whether that architecture produces safety reliably.

The Zero Overdose model is grounded in two integrated components:

- The Overdose Risk Formula—organizes assessment
- The 7-Step Overdose Safety Plan—translates assessment into structured, collaborative action

Together, they provide clarity, consistency, and clinical depth within the CCBHC environment. This module provides detailed guidance on how each component should be understood, applied, documented, and reinforced within coordinated behavioral health systems.

The Overdose Risk Formula

The Overdose Risk Formula organizes clinical inquiry into five interacting categories:

1. Amount
2. Route
3. Mindset
4. Tolerance
5. Setting

These are not abstract constructs. They reflect observable, dynamic variables that influence overdose vulnerability. The value of the formula lies in its repeatability. It reduces variability among clinicians and helps transform what might feel like a sensitive or uncertain conversation into a structured clinical assessment.

Amount

Amount refers to the quantity and pattern of exposure within a defined period. This includes dose size, frequency, escalation patterns, binge episodes, and variability in potency.

Clinically, amount is rarely linear. Individuals may increase use during periods of stress, grief, or social disruption. Others may decrease use temporarily and then resume prior levels. A key clinical insight is that “returning to normal” may not reflect returning to previous tolerance conditions. What feels like a stable amount to the individual may represent a high-risk amount physiologically.

Assessment of amount should include:

- Recent increases in dose or frequency
- Variability in potency or unknown supply
- Changes in pattern (e.g., weekend binges vs. daily use)
- Use during periods of emotional escalation

Within CCBHC implementation, assessment of *amount* should be embedded in intake protocols, crisis stabilization workflows, and follow-up visits after relapse disclosure. Documentation should avoid vague phrasing such as “using more.” Instead, clinicians should capture concrete descriptions that can guide future review.

Amount assessment also supports medication management. For example, increasing amounts combined with sedating prescriptions requires additional clinical review.^{112,113} The *amount* category anchors the assessment in measurable behavior rather than subjective interpretation.

Route

Route refers to the method of substance administration. *Route* affects absorption rate, onset speed, intensity, and physiological stress.

Changes in *route* often occur during periods of experimentation, shifting access, or peer influence. Faster onset *routes* reduce the time available to recognize distress or escalating risk. Combining *routes* may introduce unpredictability.

Assessment should include:

- Whether *route* has changed recently
- Whether multiple *routes* are used
- Whether *route* differs by setting or emotional state

Within CCBHC systems, *route* should be documented in structured fields so that crisis teams, prescribers, and therapists share the same understanding. *Route* considerations may influence safety plan protective actions (e.g., avoiding high-risk methods during vulnerable periods). The *route* category reinforces that overdose risk is not only about how much is used, but how it is used.

Mindset

Mindset captures the emotional and cognitive state surrounding exposure. It includes distress, impulsivity, hopelessness, anger, social pressure, or fatigue.

Even when *amount* and *route* remain stable, vulnerability may increase when *mindset* shifts. Individuals may take greater risks when emotionally overwhelmed, grieving, or under social strain.

Assessment should explore:

- Emotional state prior to use
- Situational triggers
- Impulse-control changes
- Cognitive framing during vulnerable periods

Mindset is particularly important in dual-risk situations. While overdose safety planning does not substitute for suicide-risk assessment, emotional vulnerability may amplify exposure risk.

Within CCBHC implementation, *mindset* assessment should occur routinely in therapy and medication visits. Documentation of emotional context improves interdisciplinary communication and supports anticipatory follow-up. The *mindset* category ensures that overdose safety planning accounts for the psychological conditions that influence decision-making.

Tolerance

Tolerance refers to physiological adaptation to exposure. *Tolerance* increases with sustained use and decreases during abstinence.

Tolerance fluctuation is one of the most critical overdose risk factors. Periods of detoxification, hospitalization, incarceration, or medication interruption reduce tolerance. Resuming previous patterns during these periods significantly increases vulnerability.^{114,115}

Assessment should include:

- Recent abstinence periods
- Discharge from structured settings
- Gaps in medication-assisted treatment
- Length of time since last use

Within CCBHC workflows, tolerance must be assessed during transitions. ADT-triggered outreach, crisis follow-up, and discharge planning should explicitly include *tolerance* review. Documentation of *tolerance* considerations strengthens both clinical reasoning and care coordination integrity. *Tolerance* anchors overdose safety planning in physiological reality rather than behavioral intent.

Setting

Setting refers to environmental context. Isolation, unfamiliar environments, lack of support, or absence of emergency access may increase vulnerability.

Setting also includes transition points:

- Returning home after detoxification
- Housing disruptions
- Changes in peer group
- Periods of living alone

Assessment should include:

- Whether exposure occurs when the individual is alone
- Stability of living environment
- Access to emergency services
- Presence of trusted individuals

Within CCBHC implementation, *setting* should be incorporated into safety plan documentation and reinforced during care coordination. Peer specialists often provide critical reinforcement of environmental protective strategies. The *setting* category broadens overdose assessment beyond the individual to include contextual vulnerability.

THE 7-STEP OVERDOSE SAFETY PLAN

Clinical Application and CCBHC Implementation

The 7-Step Plan implements the Risk Formula. Each step must function as both a clinical intervention and a system-supported workflow element.

Step 1: Identify Personal Warning Signs

This step focuses on identifying early indicators that vulnerability may be increasing. Warning signs are individualized and should reflect the person's lived experience.

These may include:

- Emotional changes
- Increased stress
- Sleep disruption
- Escalating use
- Social withdrawal

Specificity improves clinical usability. “Feeling off” is less actionable than “feeling overwhelmed after conflict with partner.”

Within CCBHC implementation:

- Warning signs should be documented in discrete EHR fields
- Supervisors should review for specificity
- Peers and care coordinators should reinforce recognition

Early detection reduces reliance on crisis intervention.

Step 2: Recognize High-Risk Situations

High-risk situations are external contexts that amplify vulnerability. These may include anniversaries, discharge periods, housing disruptions, or relationship stress. Differentiating between warning signs (internal shifts) and high-risk situations (external contexts) aids anticipatory planning.

Within CCBHC workflows:

- Embed this step into discharge protocols
- Incorporate into ADT-triggered outreach
- Use registry tracking for recent transitions

Clear documentation supports team-wide awareness.

Step 3: Define Immediate Protective Actions

Protective actions are specific behaviors that reduce vulnerability during high-risk periods.

Examples may include:

- Avoiding isolation
- Contacting a trusted person
- Scheduling earlier appointments
- Adjusting routines
- Increasing structured activity

Protective actions must be realistic and specific. Vague guidance undermines effectiveness.

Within CCBHC implementation:

- Document clearly
- Reinforce during follow-up
- Assign role-based reinforcement

Specificity aids continuity.

Step 4: Strengthen Support Activation

Support activation clarifies who can assist during vulnerable moments. It may include family, peers, clinicians, or community partners. This step reinforces relational buffering and reduces isolation.

Within CCBHC implementation:

- Align with DCO linkage
- Integrate with warm handoff protocols
- Confirm consent and contact clarity

Peer specialists often play a key role in reinforcing this step.

Step 5: Discuss Lethal Means and Access to FDA-Approved Medication to Reverse Potential Overdose

This step addresses environmental safety and preparedness, including discussion of access to FDA-approved medication designed to reverse potential overdose.

The conversation should remain clinical and practical. It includes:

- Recognition of overdose warning signs
- Clarification of access
- Activation of emergency services

Within CCBHC implementation:

- Document access discussion clearly
- Reinforce during crisis stabilization
- Integrate into discharge workflows

Supervisory review should ensure respectful and consistent implementation.

Step 6: Define Professional Support Pathways

This step clarifies how to access professional support, including clinic services, after-hours crisis response, and emergency pathways. Clear instructions reduce hesitation during high-stress moments.

Within CCBHC implementation:

- Align with Criterion 3.D.3 requirements¹¹⁶
- Integrate into crisis documentation
- Ensure clarity in EHR documentation

Professional pathways anchor safety planning within system infrastructure.

Step 7: Identify the “Why”

The final step anchors safety planning in meaning. Individuals identify reasons they want to prioritize safety.

These may include:

- Family relationships
- Personal goals
- Responsibilities
- Long-term aspirations

This step strengthens intrinsic motivation and may reduce impulsivity during vulnerable periods.

Within CCBHC implementation:

- Document motivational anchors
- Reinforce during relapse or crisis
- Integrate into engagement strategies under PPS-2

Step 7 often strengthens engagement durability and therapeutic alliance.

Differentiation from Suicide Safety Planning

Overdose safety planning addresses exposure-based risk in relation to *amount, route, tolerance, and setting*. Suicide safety planning addresses intent and lethal-means restriction in a different clinical context. When both risks are present, both assessments should be applied appropriately and independently.

IDD Adaptations

For individuals with Intellectual and Developmental Disabilities, adaptations may include:

- Visual Risk Formula representations
- Simplified-step language
- Color-coded safety plans
- Caregiver inclusion

The structure of assessments remains intact; the presentation is adapted for acceptability.

System Integration

The Risk Formula and 7-Step Plan function as the clinical anchor for:

- Workforce training
- EHR structured documentation
- Crisis stabilization workflows
- PPS documentation integrity
- Quality metrics
- Care coordination

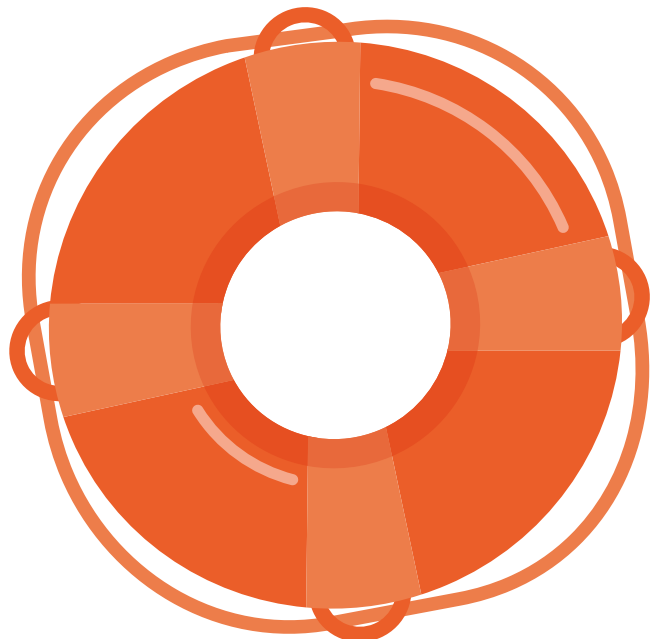
When applied consistently, the Zero Overdose clinical core transforms overdose safety planning from a conversation into a reproducible system capability.

Conclusion

Certified Community Behavioral Health Clinics were designed to bring operational structure, consistency, and clarity to complexity. The model's integrated approach to crisis response, care coordination, out-patient treatment, medication management, and quality oversight creates a uniquely strong foundation for implementing overdose safety planning throughout systems of care.

Overdose vulnerability represents one of the clearest tests of that design. When overdose safety planning is embedded into clinical assessment, interdisciplinary coordination, infrastructure workflows, reimbursement strategy, and quality oversight, it becomes more than a conversation—it becomes a system capability. The strengths already embedded in the CCBHC model—including longitudinal engagement, integrated service delivery, structured follow-up expectations, health information technology infrastructure, and measurable quality frameworks—position clinics to respond to overdose risk in coordinated, sustainable, and person-centered ways.

The Zero Overdose framework provides the structure; the CCBHC model provides the environment. Together, they create a coordinated approach to reducing preventable loss of life, strengthening continuity of care, and reinforcing operational reliability among different settings. Implemented consistently, this toolkit supports not only regulatory compliance and implementation sustainability, but the broader mission of CCBHCs: delivering accountable, integrated behavioral health care when it matters most.



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