NATIONAL COUNCIL *for* Mental Wellbeing

Strategies for Improving Access to Care in CCBHCs

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CCBHC-E National Training and Technical Assistance Center

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Contents

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Introduction

In 1993, the Institute of Medicine defined access to care as "having the timely use of personal health services to achieve the best health outcomes." The Agency for Healthcare Research and Quality has identified four factors that comprise access to care: 1) insurance coverage, 2) a usual source of healthcare services, 3) timeliness, and 4) capable, qualified, and culturally competent providers. Through requirements for timely access to comprehensive, high-quality behavioral health services, Certified Community Behavioral Health Clinics (CCBHCs) are improving access to healthcare across the country by assessing risk during an initial request for services and providing a timely response based on whether the need is routine, urgent, or emergent. The Health Resources and Services Administration's (HRSA) State of the Behavioral Health Workforce December 2025 report found that the United States is experiencing a "mental health crisis," with increased levels of unmet behavioral health needs. In addition, workforce shortages are affecting behavioral health providers' ability to meet demand.

CCBHC Community Needs Assessment and Access Requirements

CCBHCs are required to conduct a Community Needs Assessment (CNA) at least every three years. A CNA is a systematic approach to identifying program needs and understanding program capacity to meet the needs of the populations within the CCBHC's service area. CCBHCs collaborate with key community stakeholders to understand the current healthcare landscape and related mental health and substance use needs. Key stakeholders include individuals receiving services, staff providing services, primary care and specialty providers, hospitals, emergency departments, urgent care providers, justice-involved agencies, youth- and family-focused agencies, faith-based leaders, social health needs providers, and other behavioral health providers.

To understand access to and availability of services in a community, the CNA is required to:

- Assess whether the CCBHC services are being provided during times that facilitate accessibility and meet the needs of the populations being served by the CCBHC, including evening and weekend hours.
- Determine whether the services provided at locations are accessible and meet the needs of the populations being served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.
- Conduct outreach, engagement, and retention activities to support inclusion and access for all populations in the service area.

A comprehensive CNA provides valuable insights into how, where, and by whom behavioral healthcare services are accessed across the continuum of care in the community. To learn more about how to conduct a CNA, visit the National Council's CCBHC Community Needs Assessment Toolkit. Through the CNA, CCBHCs can assess how closely their current practices align with CCBHC standards for access to and availability of services. This document highlights requirements for access to and availability of services in a CCBHC. The full list of CCBHC requirements can be found here. The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines requirements for timely access to services and completion of initial and comprehensive evaluations. If triage identifies an emergency or crisis need, appropriate action must be taken immediately, including steps to reduce or remove risk of harm and facilitate any necessary outpatient follow-up. To support timely access to services, CCBHCs require:

- Initial evaluations for non-emergent presentations to be completed within 10 business days.
- Urgent needs, including an initial evaluation, to be addressed within one business day of the request.
- For new or established clients, urgent, non-emergency clinical needs are generally addressed within one business day of the request, or at a later time if preferred by the person receiving services.

Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, mental health and substance use disorder social workers, adult psychiatrists, child and adolescent psychiatrists, and school counselors are projected in 2038.

- As of December 2, 2025, 40% (137 million) of the U.S. population lives in a Mental Health Professional Shortage Area (Mental Health HPSA).
- Rural counties are more likely than urban counties to lack behavioral health providers. Residents of rural counties are also more likely to receive behavioral health services from primary care providers.
- The lack of uniformity in behavioral health providers' scope of practice, reimbursement challenges, and increased burnout hinder the accessibility of the behavioral health workforce.
- Expanding integrated care, leveraging health support workers, and using tele-behavioral health may help alleviate behavioral health workforce shortages and maldistribution.

https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf

Access to Crisis Services

CCBHCs are required to either directly provide or coordinate access to crisis services, which must be available and accessible 24 hours a day, seven days a week. To support individuals in accessing the right services, at the right time, and in the right location, CCBHCs must make publicly available policies and procedures for accessing the continuum of crisis prevention, response, and post-intervention services. In addition, CCBHCs are expected to educate community members about crisis service offerings, including crisis planning, psychiatric advance directives, and how to access crisis services, including 988 Suicide & Crisis Lifeline services. CCBHCs should also maintain working relationships with local emergency departments, emergency medical services, and law enforcement.

CCBHCs provide services regardless of an individual's ability to pay or residency status. Each CCBHC must publish its sliding fee scale on its website and in its waiting rooms. The sliding fee discount schedule must be communicated in languages and formats that are accessible to individuals seeking services who have limited English proficiency or whose primary language is not English.

CCBHCs are expanding the availability of services across the crisis continuum directly and through partnerships with 988 call centers, mobile crisis response providers and state-sanctioned crisis systems.

More than 80% of CCBHCs were already working in partnership with 988 Suicide and Crisis Lifeline call centers as of March 2024, well ahead of their July 2024 deadline.

29% of CCBHCs were able to add mobile crisis response as a result of certification, an indication of the expansion of mobile crisis availability in their communities.

The greatest gains in mobile crisis availability were found among Medicaid CCBHCs and rural CCBHCs.

What Good Access to Care Looks Like

To facilitate access to services, CCBHCs provide direct transportation support, partner with organizations that provide medical transport, and/or transportation vouchers to/from service appointments. In addition, CCBHCs are expected to leverage telehealth, telemedicine, video conferencing, asynchronous interventions, remote patient monitoring, and other technologies in alignment with the preferences and needs (e.g., translation services) of the individual receiving services.

Building a comprehensive, efficient, and effective approach to access requires CCBHCs to develop staffing models that meet demand, supported by protocols and metrics to monitor access. Leadership must review and respond to key performance indicators tied to access. Through active tracking and response to community needs, the CCBHC model can reduce unnecessary emergency room visits and provide immediate, community-based care regardless of an individual's ability to pay for services. CCBHCs work closely with Federally Qualified Health Centers (FQHCs), schools, justice-involved organizations, and other community providers and partners. They may also embed staff in the community, thereby increasing access and bringing care directly to people where it is needed. For CCBHCs evaluating their access-to-care approaches, the following checklist provides a curated list of effective strategies aligned with corresponding CCBHC requirements. If an organization is state certified or plans to pursue state certification, it is important that the CCBHC also align with any state-specific certification access requirements.

Expanding timely access to care CCBHCs continue to close the treatment gap that leaves millions of people in the US unable to access lifesaving mental health and substance use care.

Today, CCBHCs serve an estimated **3 million** people, representing continued yearly growth since the inception of the model.

Access gains were particularly pronounced among Medicaid CCBHCs, which expanded their number of people served by an average of **33%.**

The most commonly reported access expansions were among children/youth, uninsured people and those without a prior source of outpatient care.

87% of Medicaid CCBHCs and established grantees offer one or more forms of MAT for opioid use disorder, compared to 64% of substance use treatment facilities nationwide.

Access to Care Clinic Ten-Point Checklist

1. **Timeliness and Risk Triage Standards:** Does the clinic consistently execute clinical triage that meets SAMHSA response timelines? This requires immediate action and risk mitigation for emergency or crisis presentations, clinical services within one business day for urgent needs (for both new and established clients), and completion of initial evaluations for non-emergent presentations within 10 business days.

   CCBHC Criteria: Criteria 2.a (Availability and Accessibility of Services – Time-Response Standards)

2. **Leadership Monitoring and Access Governance:** Is there an established access governance plan where executive and middle managers actively review operational trend reports weekly? Management must track shifting trends in demand, clinic capacity, no-show rates, financials, and referral flows, supported by daily and weekly standard work protocols for site and team leaders.

   CCBHC Criteria: Criteria 5.b (Quality and Other Reporting – Continuous Quality Improvement) & Criterion 1.a.2 (Staffing – Management Team)

3. **Community Needs Assessment (CNA) Integration:** Is the mandatory three-year CNA directly driving clinic operations? The assessment must actively dictate accessible service hours (including evening and weekend hours) and responsive care settings in the community, such as schools, social service agencies, partner organizations, and in-home care.

   CCBHC Criteria: Criterion 1.a.1 (Staffing – Needs Assessment) & Criterion 2.a.2 (Availability – Hours of Operation)

CCBHCs work closely with primary care partners, using multiple strategies to coordinate and integrate care — with the result that access to primary care is increasing among individuals served.

Half of CCBHCs exceed minimum requirements by making comprehensive primary care available on-site.

76% of CCBHCs reported that referrals to primary care have increased since becoming a CCBHC, including 30% reporting that referrals have increased by 20% or more.

4. **Low-Barrier Scheduling Models:** Has the clinic integrated an open access framework to capture individuals at the exact moment they seek help? Clinics should actively leverage open access scheduling or evidence-based frameworks like, Just In Time Prescriber Scheduling and Same Day Access (SDA) model which allows individuals to call and schedule an appointment within a few days for routine needs. SDA eliminates wait lists and provides services on the same day an individual contacts the CCBHC.

   CCBHC Criteria: Criterion 2.a.3 (Availability and Accessibility of Services – Access to Services)

5. **Community Care Coordination and Closed-Loop Referrals:** Are formal coordination agreements actively maintained with key community stakeholders (including FQHCs, schools, emergency departments, and justice-involved agencies)? Each agreement must have a designated staff owner responsible for managing the provider relationship and utilizing data-driven tracking to ensure closed-loop referrals.

   CCBHC Criteria: Criteria 3.c (Care Coordination – Care Coordination Agreements)

6. **Business Intelligence and Demand Forecasting:** Does the agency's data infrastructure allow teams to capture, analyze, and report real-time access data? Access, clinical, and executive teams should utilize dashboard reports to monitor utilization patterns, track team caseloads, and forecast demand at daily, weekly, and monthly intervals.

   CCBHC Criteria: Criteria 5.a (Quality and Other Reporting – Data Collection and Reporting Capacity)

Meeting children, youth and families where they are CCBHCs are increasing access for children and youth through an expanded workforce, targeted services and community partnerships.

68% of Medicaid CCBHCs and established grantees reported the number of children/youth they serve has increased, including 24% that indicated the increases to their number of child/youth clients were substantial.

The vast majority of CCBHCs **(83%)** provide services on-site in one or more schools, childcare or other youth-serving settings.

7. **Capacity and Backlog Management:** Are there well-defined backlog thresholds paired with data-informed assignment algorithms? When capacity targets are exceeded, clear protocols must trigger immediate operational relief, such as utilizing cross-team backup, adjusting staff workflow requirements, or safely transitioning stabilized clients to lower levels of intensive care.

   CCBHC Criteria: Criterion 1.a.3 (Staffing – Staffing Plan) & Criteria 2.a (Availability)

8. **Centralized Scheduling Optimization:** Is scheduling centralized and integrated with human resources platforms to align with employee work hours? Implementing standardized templates, clear scheduling windows, and restricted scheduling software access, such as read-only access for clinical staff, minimizes errors and maximizes client-facing time.

   CCBHC Criteria: Criteria 2.a (Availability and Accessibility) & Criteria 1.a (Staffing Plan & Operations)

9. **Trauma-Informed Front Desk and Call Management:** Is the first point of contact designed to scale efficiently with call volume while remaining accessible? Call center and front desk workflows must utilize standardized, trauma-informed booking guidelines and booking flags, alongside dedicated bilingual staff or robust, immediate workflows for interpreter services.

   CCBHC Criteria: Criteria 1.d (Staffing – Cultural and Linguistic Competence) & Criteria 1.c (Staffing – Training Plan)

True SDA is different than the "fast access" programs that some organizations implement to meet CCBHC intake guidelines.

Fast access is an assessment within 7-10 days.

Same Day Access is just that – same day assessment. There's no scheduling – all assessments are available on an unscheduled basis so there are never any no-shows.

10. **Accessible, Client-Centered Policies and Training:** Are organizational policies nonpunitive and explicitly designed to address access gaps? This includes enforcing trauma-informed no-show and token payment policies, ensuring the sliding fee scale is prominently displayed and translated, and providing ongoing staff training in motivational interviewing, health literacy, and person-centered practices to effectively engage people in need of care. Examples include service materials in the languages of known community populations, translation services, and assistance for individuals with hearing or vision impairments.

    CCBHC Criteria: Criteria 2.e (Availability – No Refusal of Services Due to Inability to Pay / Residence) & Criteria 1.c (Staffing – Training Plan)

Recommendations

CCBHCs seeking to improve access to care should begin with a comprehensive Community Needs Assessment that directly informs service hours, locations, staffing, outreach, and partnership strategies. Access efforts should include ongoing education and coordination with community partners, so referral sources understand available services, eligibility expectations, care pathways, and how to successfully connect individuals to care. Clinics should also assess the operational dependencies needed to strengthen access, including change management, business intelligence tools and reporting, staff training, leadership accountability, and routine performance monitoring at all levels of the organization. Where Prospective Payment System (PPS) funding is available, CCBHCs should use anticipated cost and utilization data to support hiring, onboarding, and training qualified staff who can meet community demand. Workforce development strategies, may also help address staffing shortages and expand timely access to behavioral health services.

Conclusion

Improving access to care in CCBHCs requires more than meeting minimum response timelines; it requires a coordinated, data-informed, and community-centered approach that removes challenges at every point of entry. By using the Community Needs Assessment to guide service design, strengthening crisis and referral pathways, monitoring capacity and demand, and investing in a workforce that reflects community needs, CCBHCs can deliver timely and comprehensive behavioral health services. As clinics continue to refine their access strategies, sustained leadership attention, partner collaboration, and performance monitoring will be essential to ensuring that individuals and families receive the right care, at the right time, in the right setting.

Resources

Use the following resources to support CCBHC access planning, implementation, evaluation, and continuous improvement.

CCBHC Guidance and Implementation Tools

- CCBHC Community Needs Assessment Toolkit
- CCBHC Federal Criteria, March 2023

Access Models and Behavioral Health System Research

- A Model for Compassionate and Accessible Mental Health and Substance Use Care: Certified Community Behavioral Health Clinics
- Behavioral Health Care in the United States: How It Works and Where It Falls Short

CCBHC Impact Reports

- 2026 CCBHC Impact Report
- 2024 CCBHC Impact Report
- 2022 CCBHC Impact Report

Rural Access Considerations

Rural Health Information Hub: Healthcare Access in Rural Communities

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