

NATIONAL COUNCIL *for* Mental Wellbeing

NTTAC Year 5: **Rural CCBHC Case Studies**

CCBHC-E National Training and Technical Assistance Center

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Introduction

Rural and frontier communities face behavioral health challenges shaped by geography, transportation issues, limited broadband and wireless infrastructure, long travel distances to care, and workforce shortages. These challenges can make it difficult for individuals to access timely mental health and substance use services, particularly when specialty providers are scarce or located far from where the individuals live. A 2020 report from the Rural Policy Research Institute identified elevated behavioral health risks in rural communities, including increased suicide risk, higher rates of alcohol use among people ages 12 to 20, and higher rates of opioid-related deaths (Rural Policy Research Institute, 2020).

The National Rural Health Association's "four **A**s" framework — Accessibility, Availability, Affordability, and Acceptability — offers a useful way to understand rural behavioral health needs (Rural Policy Research Institute, 2020). **Accessibility** refers to the ease of being able to access health care services and is affected by limited public transportation, long distances to care, and the time and cost required to travel. **Availability** is constrained by shortages of psychiatrists, licensed clinicians, and other behavioral health professionals, as well as reimbursement structures that may not fully support recruitment and retention. Certified Community Behavioral Health Clinics (CCBHCs) respond to access challenges through telehealth, transportation support, flexible scheduling, and community-based care. CCBHCs are required to ensure timely and accessible behavioral health care for all individuals seeking services, regardless of diagnosis, insurance status, or ability to pay. They provide prompt access to routine, urgent, and crisis services and maintain 24/7 crisis response capabilities. Federal criteria encourage the use of community-based, home-based, mobile, and telehealth services when appropriate, as well as care coordination and partnerships that help individuals access needed behavioral health, physical health, and social services (SAMHSA, 2026).

The CCBHC prospective payment system model helps address **affordability** by supporting services that reflect the actual cost of care, including community-based services in schools, shelters, mobile crisis settings, and other nontraditional locations. The model can also support wraparound services, care coordination, and social-emotional supports that may be difficult to sustain under narrower fee-for-service approaches. CCBHCs ensure that no individual is denied behavioral health care services because of inability to pay and are required to publish a sliding fee discount schedule that includes all services the CCBHC offers. Fee schedules must be available on the CCBHC website, posted in the waiting room, and readily accessible to individuals receiving services and their families. The sliding fee discount schedule is communicated in languages and formats appropriate for individuals seeking services who have limited English proficiency, literacy obstacles, or disabilities (SAMHSA, 2026).

Acceptability relates to how individuals and communities perceive the need for mental health and substance use services, as well as whether services feel context aware, trustworthy, and relevant. Stigma, mental health literacy, local identity, spiritual practices, age and life stage, justice involvement, and unmet needs can all shape whether people seek care and remain engaged. CCBHCs are required to use "culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities," including hearing disability and cognitive limitations (SAMHSA, 2026). Through community needs assessments, CCBHCs can better understand who lives in the community, who is being served, and where gaps remain; this information can then guide staff training, partnerships, outreach, and service adaptations (National Council for Mental Wellbeing, 2024), all of which foster access to care.

CCBHCs: A Solution for Rural Behavioral Health Challenges

A Certified Community Behavioral Health Clinic (CCBHC) is a specially designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs serve everyone who seeks care, regardless of diagnosis, insurance status, or place of residence. CCBHCs provide nine required services directly or through partnerships, including 24-hour crisis care, evidence-based practices, care coordination with primary care and hospital partners, and integration with physical health care (National Council for Mental Wellbeing, 2023A).

The CCBHC model is particularly relevant for rural and frontier communities because it combines comprehensive service requirements with a flexible payment structure that can support innovation. The prospective payment system (PPS) shifts CCBHCs from a traditional fee-for-service payment methodology to a payment structure that covers total cost of care, including care coordination and administrative support. In rural settings, this flexibility can help clinics expand services, hire and retain staff, embed providers in schools and justice-related settings, strengthen crisis response, and deliver care outside the four walls of the clinic. Mobile crisis teams, walk-in care, telehealth, care coordination, and community-based outreach can reduce reliance on emergency departments and law enforcement, while helping people receive support sooner. In farm and other geographically dispersed communities, CCBHCs can also bring services to trusted locations or use virtual platforms to reduce travel difficulties.

Recent national CCBHC data shows that the model is being used to expand access in rural communities. Rural CCBHCs are more likely to establish mobile crisis teams, unlike their urban counterparts who often have the option to partner with existing state-sanctioned crisis programs. CCBHCs are also increasingly delivering services in schools, childcare settings, mobile units, and other community-based locations. These trends align with the rural case study examples below, where clinics use flexible staffing, crisis response, transportation supports, technology, and partnerships to reach people who might otherwise face significant obstacles to care (National Council for Mental Wellbeing, 2023B; Smith & Talbert, 2025).

Case Studies

The case studies presented in this resource were developed to highlight how rural Certified Community Behavioral Health Clinics (CCBHCs) are implementing the model to address common behavioral health challenges in rural and frontier communities. Information was gathered through structured interviews with leadership and staff from five rural CCBHCs representing a range of geographic regions and organizational structures: Pines Behavioral Health Services (Michigan), Alluma (Minnesota), Citizen Advocates (New York), CREOKS (Oklahoma), and FCC (Missouri). Interviews explored strategies related to access, workforce development, crisis response, technology, partnerships, governance, and quality improvement. Themes were identified through a qualitative review of interview responses and supplemented with publicly available organizational and national CCBHC resources.

The National Council's National Training and Technical Assistance Center (NTTAC) extends its appreciation to the leadership teams and staff from Pines Behavioral Health Services, Alluma, Citizen Advocates, CREOKS, and FCC for sharing their experiences, lessons learned, and innovative practices. Their willingness to describe both successes and ongoing challenges made this resource possible and provides valuable insights for rural behavioral health providers, state leaders, and other organizations interested in strengthening behavioral health access through the CCBHC model.

The following examples highlight how the five rural CCBHCs are using the flexibility of the CCBHC model to respond to local needs. Common themes emerge: expanding access beyond clinic walls; strengthening rural workforce capacity; building cross-sector partnerships; enhancing crisis response; using technology to bridge distance; and leveraging data and governance structures to support continuous improvement.

PINES BEHAVIORAL HEALTH SERVICES, MICHIGAN

Organization Overview

Pines Behavioral Health Services is a Community Mental Health Services Program in southern Michigan, located about halfway between Detroit and Chicago. The organization serves individuals with mental health concerns, substance use disorders, intellectual and developmental disabilities, and veterans with intensive and complex needs. Pines is a state-certified CCBHC serving more than 2,500 people each year. Staff have used the flexibility of the CCBHC model to expand services, strengthen community partnerships, and build a more responsive behavioral health system in a rural setting (Michigan Department of Health and Human Services, n.d.).

Pines' rural CCBHC experience illustrates how flexible funding, local relationships, and a person-centered approach can turn common rural constraints into practical service design. A creative workforce makes mobile crisis care possible, and those services, in turn, strengthen trust with law enforcement and in the community. Strong community partnerships foster access to care beyond the four walls of the clinic, while all-embracing governance structures ensure that firsthand experience continues to inform financial, programmatic, and operational decisions.

Workforce

Pines' workforce strategy centers on adapting staffing models to the realities of rural labor markets. The organization describes difficulty recruiting psychiatrists, therapists, and high-acuity, master's-level clinicians, particularly for ACT and 24/7 mobile crisis roles. Rather than relying only on a traditional full-time staffing model, Pines pieces together capacity through contracted psychiatrists, partial FTEs, moonlighting arrangements, weekend and evening hours, licensed bachelor's-level staff, peers, interns, and team-based task distribution. This approach reflects a practical rural strategy: Define the work that must be done, then distribute it among credentials, schedules, and roles in ways that preserve quality while expanding coverage. Other workforce strategies include using flexible scheduling as a recruitment and retention tool, supporting staff to work at the top of their skill set, partnering with the local career center, and identifying local people with strong customer service, firsthand experience, technology, or business skills who can grow into future CCBHC roles. Healthy staff and a strong organizational culture are central to Pines' recruitment and retention efforts.

Crisis

Pines' mobile crisis model is one of its most visible rural innovations. Built on a commitment to "come to you," the team responds wherever a person is located, including homes, libraries, grocery stores, jails, and outdoor settings. This approach is especially important in a large rural county where transportation challenges, long travel distances, and limited crisis drop-in options can prevent people from reaching care. The model is clinically led and person-centered: Response teams generally include a licensed or master's-level clinician and a second responder, such as a paraprofessional or person with firsthand experience, while law enforcement is not positioned as the lead responder unless safety requires it. In Michigan, urban CCBHCs are expected to respond to crisis calls within one hour, while rural and frontier CCBHCs have up to two hours to respond given geographic distance and travel time (Michigan Department of Health and Human Services, n.d.).

The "we will come to you" model directly addresses rural access obstacles by bringing assessment, de-escalation, safety planning, and connection to services into the person's environment, while two-person crisis response balances clinical expertise with peer, paraprofessional, or firsthand-experience support, which can make interventions more relational and less institutional. This approach helps to divert behavioral health needs away from criminal justice or emergency-only responses when clinical care is more appropriate.

Pines is strengthening the crisis model by collecting data on response times, requests for law enforcement partners, and potential recidivism. This data could support quality improvement and future storytelling. The crisis program also functions as a 24-hour consultation resource for law enforcement and corrections staff who may need guidance even when a full mobile response is not required.

Partnerships

Partnerships are described as both a service strategy and a trust-building strategy. Pines' relationships with law enforcement, corrections, the Veterans Navigator outreach site at Hope Cafe (a local cafe), Tibbits Opera House, the Career Center, the food pantry, libraries, coffee shops, and other community settings extend the reach of behavioral health care beyond the clinic. These partnerships reduce obstacles by creating informal, familiar points of contact; they also help Pines learn from community members who may not otherwise complete surveys or attend formal meetings. The result is a rural access model that relies on showing up in places people already use and trust.

Pines' partnership with law enforcement encourages officers to request support early in calls, debrief after incidents, ask clinical questions, and publicly advocate for the value of mobile crisis service. Other partnerships extend that same trust-building approach into community spaces. The Hope Cafe outreach model gives veterans a low-stigma way to connect with a Veterans Navigator over coffee rather than through a formal clinic visit, while the Tibbits Opera House partnership turns theater into a behavioral health engagement strategy through talkbacks, resource tables, youth mental health messaging, and audience surveys. Feedback from these partnerships is not merely promotional; it has shaped service development, including parent support services and ideas for improving access. Hospital and primary care partnerships remain an area for future growth.

Firsthand experience in governance

At Pines, governance is not treated as a symbolic requirement. Pines describes firsthand experience as embedded across staffing, customer feedback, advisory structures, and the board. Board members with firsthand experience influence finance, program, and public relations decisions, including discussions about prospective payment system implications, service access, Medicaid application challenges, and family engagement. Pines says the connections to firsthand experience are authentic and specific to mental health and substance use, rather than a compliance checkbox (National Council for Mental Wellbeing, 2023B).

The governance structure creates clear pathways for practical knowledge and community feedback to shape operations. Board members contribute insight into how Medicaid applications actually work for people trying to maintain coverage, and that knowledge is being translated into staff training. The customer advisory committee strengthens accountability by sending reports directly to the board rather than allowing feedback to remain only at the program level. Pines also models openness internally through practices such as *Cookies and Conversation* gatherings, giving staff a regular, agenda-free opportunity to raise concerns, ask questions, and share successes with leadership. In this way, governance connects directly to workforce and service quality: When staff experience leadership open to feedback, they are better prepared to invite honest feedback themselves, and to respond in a solution-focused way.

ALLUMA, MINNESOTA

Organization Overview

Alluma is located in northwestern Minnesota, about 25 miles southeast of Grand Forks, North Dakota. The organization takes a community-based approach to integrating mental health and substance use care with supports that promote overall wellbeing. As a state-certified CCBHC, Alluma is positioned to serve its community by providing timely access to comprehensive behavioral health care, responding to crises, and building meaningful partnerships with local organizations.

Rural Implementation Strategies

Workforce

Alluma's rural CCBHC experience is grounded in a practical response to workforce scarcity: building and retaining talent from within the community rather than relying exclusively on external recruitment. The organization's "grow your own" approach links paid internships, flexible employment pathways, university partnerships, and loan repayment opportunities into a workforce pipeline that both addresses staffing shortages and improves access to care. This strategy also reflects a broader retention philosophy: Staff are more likely to stay when they can develop professionally at a manageable pace, move across roles or service lines, and see a future for themselves within the organization.

Crisis

Crisis services are central to the connection among Alluma's clinical programs, care coordination infrastructure, and community partners. Because Alluma operates mobile crisis-care services across its eight-county region in partnership with a larger health system, the organization can use crisis contacts for early signals for follow-up, coordination, and prevention. Care coordination staff review crisis logs daily and notify providers when individuals already receiving services have contacted crisis services, helping to close communication loops and reinforce a team-based approach to care. Crisis work also extends beyond immediate response. Community action efforts bring together law enforcement, hospitals, county partners, homeless service providers, and Alluma staff to identify recurring gaps, coordinate around shared individuals receiving services, and provide alternatives to emergency departments and incarceration.

Community Partnerships

Partnerships are both a necessity and an innovation strategy in Alluma's rural context. Some partnerships are formal and operational, such as the regional crisis partnership, jail-based reentry coordination, and the Community Action Team. Others are relational and developmental; these include connections with universities, public health, primary care leaders, schools, counties, law enforcement, hospitals, and community organizations. Alluma serves as a crisis response provider within a larger health system that responds to crisis calls across eight counties; Alluma directly provides crisis response in four counties, while partner providers respond in the other four. When Alluma responds to a crisis involving an individual receiving services from another provider, staff notify that provider about the crisis contact and the need for follow-up care.

These relationships help Alluma stretch limited rural resources, identify shared goals, and create more seamless pathways for individuals receiving services. At the same time, partnerships require ongoing attention; primary care integration remains uneven because of one-way information flow and limited health information exchange, while tribal engagement and context-aware workflows require being present, listening, and adapting standard processes to fit community realities.

Access

Access connects the workforce, crisis, and partnership. Alluma reframed access internally by reducing inappropriate or duplicative referrals, using a "single front door" mindset, and developing workflows that help individuals move through the system based on need rather than program protocols. Alluma's commitment to care coordination supports access by protecting time for interdisciplinary collaboration, allowing staff and partners to address complex needs before individuals fall through gaps. Transportation remains one of the most significant obstacles in rural and frontier service regions, and while telehealth helps bridge distance, Alluma has found that individuals receiving services often still want some in-person connection; Alluma supports delivering in-person services by coordinating medical transportation, providing bus tickets, and meeting with individuals outside the four walls of the clinic. Alluma is moving toward hybrid care models rather than assuming virtual care alone will solve rural access challenges.

Alluma is using the flexibility of the model to solve practical problems: growing its own workforce; embedding crisis response into broader care coordination; relying on trusted community partnerships; and redesigning access around the realities of distance, workforce capacity, and individual preference.

CITIZEN ADVOCATES, NEW YORK

Organization Overview

Citizen Advocates is located in upstate New York, about 10 miles from the Canadian border. The organization provides mental health treatment, addiction treatment, physical health support, and developmental disability services, along with housing and other essential supports that promote health and stability, including job training, food security, and transportation assistance. Serving more than 9,300 individuals and families each year across seven counties, Citizen Advocates has been a state-certified CCBHC since 2017. Through the prospective payment system funding model, the organization has been able to support important behavioral health activities that are not always otherwise funded, including outreach, education, collaboration, and care coordination with community partners.

Rural Implementation Strategies

Workforce

Citizen Advocates described workforce development as both a recruitment strategy and a retention strategy in a rural behavioral health environment. The organization has leaned into a "grow your own" approach by building formal and informal partnerships with local colleges, creating internship and practicum pathways, and exposing students in nursing, social work, counseling, and related fields to behavioral health early in their training. Retention efforts include internal continuing education opportunities, CEUs, loan repayment, tuition assistance, and support for existing staff to move into new roles, including paraprofessional and clinical pathways. The CCBHC model has also expanded the organization's ability to use targeted case managers, peer specialists, skill builders, and other paraprofessional staff in flexible ways that extend the reach of clinical teams across a geographically dispersed service area.

Access

Access challenges are shaped heavily by transportation, geography, broadband limitations, and technology impediments. Transportation remains a significant obstacle for individuals who lack reliable vehicles, cannot afford gas, encounter limitations with Medicaid transportation, or live far from services. Citizen Advocates addresses these challenges by using targeted case managers, peers, and skill builders to help individuals understand and navigate transportation options, while also providing more direct support, often outside of the four walls of the clinic, when safety, medical need, or crisis urgency requires it. Telehealth is another important access strategy, but the organization recognizes that broadband gaps, inconsistent cell service, and limited technology literacy can make virtual care difficult. To respond, Citizen Advocates has created telehealth rooms in its clinic locations for individuals who do not have access to broadband internet in their homes or who do not feel comfortable navigating technology. In-clinic staff are available to provide technical support in accessing the telehealth provider.

Crisis

Crisis services emerged as a major strength and defining feature of Citizen Advocates' rural CCBHC work. In some communities, particularly in northern Franklin County, the organization functions as a primary behavioral health and crisis care provider. Its 24/7/365 crisis campuses offer low-obstacle access, allowing individuals to walk in without an appointment and receive triage and connection to needed support. Citizen Advocates also provides mobile crisis response in Franklin and St. Lawrence Counties and can mobilize in other areas through its CCBHC program, meeting individuals where they are, regardless of whether they are already established in care. Crisis follow-up includes coordination with other providers within 24 hours when appropriate and efforts to connect individuals to care within 72 hours after hospitalization. Adult and children's crisis residences provide an additional stabilization option for individuals who do not require in-patient care but need more support than can safely be provided at home.

Data and Technology

Citizen Advocates has significantly strengthened its data and reporting infrastructure since becoming a CCBHC. Through the CCBHC model and its "grow your own" approach, Citizen Advocates has trained and supported staff to leverage its electronic health records, improve data integrity, and create a planning team for overall health among groups. The organization has invested in EHR optimization, data integrity, and alignment between its EHR team and the team that handles group-level health and planning, so that the system supports reporting and quality improvement rather than creating unnecessary burdens. Data analysts help build dashboards and analytics to monitor data such as days to intake, screening results, and other operational or clinical indicators. The organization also uses external data sources and benchmarks, including health information exchange and state or regional comparisons, to understand performance in context. In addition to quantitative reporting, Citizen Advocates values qualitative feedback from individuals receiving services and their families. Its Patient Advisory Committee and its review platform both inform continuous quality improvement, leadership reporting, and storytelling about results.

CREOKS, OKLAHOMA

Organization Overview

CREOKS Health Services is a nonprofit organization serving communities across eastern Oklahoma, with two additional locations in Arkansas. Through its integrated health, wellness, behavioral health, and social services, CREOKS works to strengthen individuals, families, and communities. The organization serves more than 30,000 people each year, operates 11 CCBHCs across eight counties, and offers a broad range of behavioral health services designed to expand access to care and reduce unnecessary mental health-related hospitalizations and incarceration. CREOKS also partners with schools, hospitals, law enforcement, and other community organizations to strengthen referral pathways, coordination, and community-based support.

Rural Implementation Strategies

Workforce

Workforce is a significant challenge for CREOKS, especially in psychiatry, nursing, therapy, and other specialized clinical roles. CREOKS emphasizes that workforce challenges are not specific to behavioral health and reflect broader rural and statewide shortages. CREOKS responds to these challenges by using a layered workforce strategy: recruiting nationally for high-need positions, highlighting Oklahoma's lower cost of living, using Advanced Practice Registered Nurses and other advanced-practice providers, and deploying telehealth to make provider time more efficient. In addition, CREOKS has built pathways with students, interns, peers, family support providers, and people early in their educational journeys.

Staff retention is tied to professional growth; supervisors, site directors, and internship coordinators help staff identify career goals, pursue practicum and internship opportunities, and build specialized skills in areas such as treatment courts, play therapy, domestic violence, human trafficking, and veteran services. In addition, CREOKS leadership uses both individual conversations and staff trends to anticipate training needs, determine internship capacity, and align workforce development with community needs.

Technology

Technology is used as a practical tool to expand clinical capacity and reduce the effects of distance and geography. Telehealth is central to outpatient medication management and psychiatry because it allows providers to serve multiple clinic locations without losing time to travel. This makes scheduling more flexible: If a provider is assigned to one community but has an opening, an individual in another location can be placed into that slot and seen more quickly.

At the same time, CREOKS is clear that technology only improves access when paired with support that addresses digital obstacles. CREOKS uses grant and contract funding to purchase devices, including iPads, that can be assigned to individuals receiving services for home use. When individuals lack broadband access, are uncomfortable with technology, or prefer in-person support, case managers and peer support staff can transport them to the clinic, where they can connect by telehealth while also receiving face-to-face support from nurses and other staff.

Access

For CREOKS, access to care is more than appointment availability; it means ensuring that individuals can receive the right service, at the right level of intensity, in a way that accounts for transportation, broadband, specialty needs, customs and beliefs, and family context. The CCBHC model enables broader access because it allows individuals to receive services based on need rather than narrow fee-for-service eligibility rules. Telehealth and clinic-based telehealth rooms expand access to psychiatry and medication management without requiring long-distance travel, while transportation support, coordinated scheduling, and same-day bundling of appointments reduce the number of trips individuals need to make to the clinic.

CREOKS also expands access through specialty programs designed for groups that may otherwise have unmet needs, including veterans, older adults with serious mental illness, children and families, people with intellectual and developmental disabilities or autism-related needs, and individuals involved with courts or child welfare systems. Dedicated pathways, such as veteran service teams, centralized referrals, trained front-desk staff, and clear outreach timelines, help ensure that individuals are not lost in general workflows and can be connected to the services and supports that best match their needs.

Partnerships

CREOKS views partnerships as the backbone of rural CCBHC work because strong local relationships help establish familiarity, trust, and collaboration across the communities it serves. In smaller communities, CREOKS staff often know local primary care providers, school personnel, law enforcement partners, DHS staff, court teams, dental providers, VA contacts, tribal and community partners, and family-serving organizations. These relationships support more effective and responsive referral and care coordination by creating practical pathways for communication, shared problem-solving, and whole-person support.

Several partnerships are especially important to CREOKS' rural service model. School partnerships support school-based crisis response teams that can respond to student needs in ways that reflect school culture and community expectations. Law enforcement partnerships allow behavioral health staff to assist with crisis response, de-escalation, and connection to higher levels of care when needed, while primary care and specialty care partnerships help individuals access nearby providers when local appointments are unavailable or booked far in advance. Dental, VA, DHS, court, foster care, and family network partnerships further broaden the care team beyond behavioral health and support a more comprehensive approach to individual needs.

CREOKS also uses structured tools and routines — including monthly staff meetings, multidisciplinary team meetings, care notebooks, referral forms, and shared data — to turn informal relationships into reliable systems of care. These tools help partners coordinate across settings, follow up on individual needs, and sustain collaboration over time.

FCC, MISSOURI

Organization Overview

FCC is a CCBHC serving 19 counties in southeast Missouri. The organization provides a broad range of recovery- and wellness-focused services, including mental health and substance use treatment, veterans' services, peer support, psychiatry, crisis intervention and stabilization, and therapy. To better meet community needs, FCC collaborates with schools, health care systems, and other local partners, and delivers services in clinics, homes, schools, and other community-based settings.

Rural Implementation Strategies

Access

FCC's access strategy reflects a shift from scarcity-based scheduling to a "meet people where they are" model. CCBHC implementation has enabled the organization to move from limited open access days to open access every day, reducing the likelihood that people in crisis or with urgent needs go without services. FCC repeatedly connects expanded access to expanded staffing, flexible funding, and the ability to provide services that may not be traditionally billable but are essential in rural communities.

Access is also broadened through community-based and mobile approaches. FCC reaches people in jails, schools, domestic violence shelters, libraries, recovery housing settings, and other community locations rather than relying only on clinic-based care. The mobile crisis unit, telehealth capacity, peer outreach in jails, and embedded school and shelter services all demonstrate an access model designed in relation to geography, transportation obstacles, and the realities of rural service delivery.

Workforce

Workforce development is a priority for FCC. FCC describes recruitment and retention challenges across roles and communities but responds with a "grow your own" approach that builds internal career pathways. Examples include supporting entry-level staff as they move into care coordination and supervisory roles, reimbursing credentialing and licensure costs, providing free supervision, paying for continuing education, offering leadership training, and creating scholarship opportunities. FCC also uses workforce design to enhance capacity by deploying team members in ways that expand support and allow clinicians to work to the top of their skill set. Peer specialists help increase contact with individuals receiving services and provide additional support where caseloads are high, while Health Liaisons take on non-billable coordination functions such as obtaining records, coordinating with primary care, and supporting follow-up. Coordinators of School Services (often retired school administrators) also strengthen partnerships with schools by bringing credibility, shared language, and system knowledge into the relationship.

Technology

Technology is also framed as a workforce support. Eleos, an AI documentation platform, reduces the clinical documentation burden and improves documentation accuracy, while IRIS telehealth helps address specialty staffing shortages. FCC believes that technology adoption requires training, supervisor involvement, peer encouragement, and attention to workplace culture change — particularly for staff who are accustomed to earlier workflows. In addition to documentation automation, Eleos also provides compliance and quality support as well as support in expanding care settings (virtual, home, or community).

Partnerships

Partnerships are both a necessity and a strength in rural communities. FCC staff describe close relationships with primary care providers, hospitals, schools, law enforcement, justice partners, residential care facilities, child welfare, juvenile justice, probation and parole, recovery housing, and community advisory groups. Rather than viewing these organizations as competitors, FCC describes an approach of shared responsibility to meet the needs of communities across a large, rural service area. Partnerships support FCC in responding quickly to emerging community needs. Examples include working with schools on vaping education, collaborating with libraries to reach people experiencing homelessness or isolation, and partnering with the VA and community committees to support veterans. FCC's approach to partnership functions like an ongoing community needs assessment; regular partner engagement reveals gaps and informs practical service adaptations, creating opportunities for continuous quality improvement.

FCC uses multiple strategies to sustain community partnerships, including interagency referral and care coordination workflows, daily reports that alert staff to hospitalizations and emergency department use, collaboration with local methadone providers, embedded crisis supports, FQHC co-location arrangements, and school partnerships across 22 districts. FCC also has a Designated Collaborating Organization (DCO) relationship with the crisis hotline/988 provider. Together, these partnerships help FCC meet service requirements, reduce fragmentation, and create multiple "no wrong door" pathways into care.

Data and reporting

FCC uses various types of data to guide services and demonstrate their effects. Quantitative examples include more than 10,000 Health Liaison services; daily hospitalization and emergency department reports; tracking of Eleos adoption through dashboards; and surveys such as stakeholder feedback, experience of individuals receiving services, and perception-of-care tools. These data sources support follow-up care, quality improvement, accountability, and documentation of the value of nontraditional roles.

FCC also emphasizes the importance of qualitative reporting. Stories and experiences of individuals receiving services, staff shoutouts, focus groups, advisory board input, suggestion boxes, and system-of-care meetings help capture what numbers alone may not show: whether services feel accessible, whether partnerships are working, and how coordinated, integrated care changes people's lives. Quantitative and qualitative data position FCC to tell a more complete story to funders, partners, staff, and community stakeholders.

Together these five case studies illustrate how rural CCBHCs are adapting the model to strengthen access, workforce capacity, partnerships, crisis response, technology, governance, and data practices. The following recommendations identify state- and clinic-level strategies to build on those innovations.

Clinic-Level Recommendations to Expand Access, Partnerships, and Rural Workforce Capacity

At the clinic level, rural CCBHCs can use the flexibility of the model to expand where and how services are delivered, strengthen cross-sector partnerships, and build local workforce capacity in ways that reflect community needs. Strong partnerships with law enforcement, jail staff, schools, faith communities, tribal health providers, FQHCs, and other local organizations can help strengthen referral pathways, crisis response, and care coordination. Clinics can also support these partnerships by offering training to law enforcement, jail staff, and other community partners on engaging, assessing, and assisting individuals experiencing a behavioral health crisis.

Rural CCBHCs can further expand capacity by training and certifying peer support specialists, community health workers, clergy, and other trusted community members to support outreach, engagement, and crisis response. Equipping mobile crisis teams and community-based staff with reliable technology can also support telehealth, care coordination, documentation, and connection to specialty consultation. In addition, clinics can broaden access by delivering services beyond the clinic walls — to homes, schools, partner organizations, mobile units, and other community-based settings where individuals are most likely to seek support.

Finally, rural CCBHCs can build stronger workforce pipelines by partnering with colleges, universities, training programs, and community organizations to recruit, train, and retain staff who understand local needs. Community feedback, data collection, and quality improvement processes can help clinics identify access gaps, assess whether services are reaching priority populations, and communicate results to the clinics' partners and state leaders. Creating regular opportunities for rural CCBHC staff and partners to share promising practices, troubleshoot implementation challenges, and learn from peer organizations can also support continuous improvement across rural service areas

Conclusion

These case studies of rural CCBHCs demonstrate that the model's value lies not only in expanding the scope of covered services, but also in giving clinics the flexibility to design care around local realities. Pines, Alluma, Citizen Advocates, CREOKS, and FCC each use the model to respond to common rural challenges — distance, transportation, limited broadband, workforce shortages, stigma, and fragmented service systems — while adapting their approaches to the specific strengths and needs of their communities. Their work shows that access to rural care is not through a single intervention; it requires braided strategies that combine telehealth, mobile services, crisis response, community-based care, peer and paraprofessional roles, transportation supports, and trusted local partnerships.

Resources

The following resources may support rural CCBHCs in best practices, implementation, communications, community assessment, care coordination, and governance (National Council for Mental Wellbeing, 2023, 2024).

- CCBHC Care Coordination Toolkit
- CCBHC Communications Toolkit
- CCBHC Community Needs Assessment Toolkit
- CCBHCs: A Vision for the Future of Community Behavioral Health Care

Any links to external websites and resources are provided for informational purposes only. The views, opinions and content expressed on those sites are solely those of the original authors or organizations and do not necessarily reflect the views or positions of the National Council. Including these links also does not imply endorsement, oversight or legal relationship with such authors or organizations.

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