

NYSARH POLICY WHITE PAPER

# The Rural Access Crisis: Bridging the Detection-Management Gap in New York State

An Evidence-Based Framework for Integrated Behavioral Health  
Collaborative Care Model · Community Paramedicine · CCBHCs · ED-Primary Care Integration

**New York State Association for Rural Health (NYSARH)**

*Building on the Statewide Aggregate Rural Health Needs Assessment (SARHNA) and NYSARH Implementation Guide*  
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## Overview

### Executive Summary

Rural New York faces a behavioral health crisis rooted not only in provider shortages, but in structural fragmentation. Patients are routinely screened for depression and anxiety in primary care settings yet face months or years-long waits to access treatment. Emergency departments stabilize patients in acute psychiatric crisis but discharge them into disconnected systems with phone numbers and hope. In many counties, the only 24/7 response to a behavioral health emergency is law enforcement.

The result is a system that reliably detects need but systematically fails to deliver care. This gap, between identifying a need and delivering intervention, is the defining failure of rural behavioral health infrastructure.

This paper argues that the central problem is not simply access, but continuity. Rural behavioral health systems are organized as a series of disconnected stages rather than a coordinated pathway, allowing patients to fall through gaps at every transition point.

To address this, the paper advances a unified framework: the Closed-Loop Behavioral Health System (CLBHS). The CLBHS is defined here as a scalable framework for transforming fragmented behavioral health services into a continuous, accountable system of care. In this model, detection, crisis response, treatment initiation, and long-term management are integrated into a single accountable care pathway. Each intervention point, including primary care, emergency departments, EMS, and community behavioral health providers, is connected through formalized handoffs, shared accountability, and outcome tracking.

This framework is operationalized through four complementary, evidence-based models:

- **The Collaborative Care Model (CoCM):** integrating behavioral health into primary care through team-based, measurement-driven care
- **Community Paramedicine Behavioral Health Programs:** extending care into the home and the critical post-crisis window using the existing EMS workforce
- **Certified Community Behavioral Health Clinics (CCBHCs):** establishing a 24/7, comprehensive hub for mental health services
- **Emergency Department-to-Community Care Integration:** converting acute psychiatric crisis encounters into structured entry points for coordinated ongoing care

These models are not parallel solutions. They are interdependent components of a single system designed to close the gap between detection and treatment. Each is supported by a robust evidence base and viable reimbursement pathways. The tools for transformation already exist. The challenge is not invention, but integration.

#### The Core Problem: The Detection-Management Gap

New York has built the infrastructure of detection. PHQ-9 and GAD-7 screening is now routine in primary care. What has not been built is the infrastructure of follow-through. For example, a positive screen in Chenango County sends a patient toward a six-month to two-year waitlist. This gap, between identifying a need and delivering the intervention, is the defining failure of rural behavioral health in New York State.

## Section I

### The Anatomy of Fragmentation

#### A System Built on Silos

The fundamental crisis of behavioral health in rural New York is not merely a shortage of providers; it is a structural failure driven by fragmentation. For decades, primary care, mental health, and specialty behavioral health have operated as separate systems, each with its own regulatory oversight, billing codes, electronic health records, and intake processes. In urban centers, provider density can sometimes mask these gaps. In rural New York, silos become canyons.

When a primary care provider in Hamilton or Chenango County identifies a patient with severe clinical depression through a routine PHQ-9 screen, the standard of care is a referral to a specialty behavioral health clinic. According to findings from the *Statewide Aggregate Rural Health Needs Assessment (SARHNA)*, rural New Yorkers face outpatient wait times ranging from six months to two years.<sup>1</sup> For a patient experiencing active suicidal ideation, a six-month wait is not delayed care. It is a denial of care.

#### The High Cost of Default Providers

When outpatient pathways fail, the default providers of rural mental health care become law enforcement and the emergency department, both of which are clinically inappropriate and fiscally unsustainable. In many rural counties, the only 24/7 mobile crisis resource is the local sheriff's department, forcing clinical emergencies into a carceral framework. Rural hospitals without on-site psychiatric beds board mental health patients in EDs for days while searching for distant transfer placements. This boarding crisis drains hospital resources and delivers no therapeutic value.<sup>2</sup>

#### Three Upstream Multipliers

Three structural realities transform an already fragmented system into an unreachable one:

- Transportation deserts, in counties spanning 800 or more square miles with no public transit, render a clinic forty miles away effectively nonexistent for patients without reliable vehicles.
- The digital divide limits telehealth deployment in the rural hollows and remote districts where broadband remains unavailable, preventing the deployment of the very technology meant to fix the system.
- Stigma in small communities, where privacy is scarce and walking into a standalone mental health facility is a public act, drives many residents to forgo care entirely. Integrated care, delivered inside the regular doctor's office, is the most effective way to bypass this barrier.

#### The Data Behind the Crisis

The SARHNA documents the depth of these failures across rural New York with specificity that resists abstraction.<sup>3</sup> In surveyed counties, a significant share of residents who needed behavioral health care reported not receiving it because the wait was simply too long. Psychiatric vacancies are widespread and persistent: most rural counties have few or no psychiatrists, critical shortages of licensed therapists and counselors, and virtually no child psychiatrists. In some counties, the psychiatrist-to-patient ratio reaches 1:1,690, a figure that makes the idea of timely access through traditional referral not just unlikely but mathematically impossible.

Youth are not spared: rural students report elevated rates of depression and suicidality, with transportation barriers and parental work schedules preventing many families from accessing outpatient care. Among older adults, several rural counties report elevated suicide rates linked to chronic illness, disability, and social isolation, a silent crisis that receives far less attention than youth mental health despite comparable urgency.<sup>4</sup>

Housing instability compounds all of it. Poverty, including the condition researchers term ALICE (Asset Limited, Income Constrained, Employed), is among the strongest predictors of unmet behavioral health need in rural communities.<sup>5</sup> Without stable housing, individuals cannot reliably engage in treatment, maintain medication regimens, or build the daily routines that support recovery. The behavioral health crisis and the economic crisis are not parallel problems. They are the same problem.

### Rural New York by the Numbers (1)

**6 months to 2 years:** typical outpatient wait time for behavioral health services in rural counties  
**1:1,690:** psychiatrist-to-patient ratio in some rural New York counties **3-5 days:** average ED boarding time for psychiatric patients in rural hospitals awaiting placement **40-60%:** share of rural pediatric specialty referrals that are never completed, primarily due to transportation and logistical barriers **Law enforcement:** the default 24/7 crisis response in the majority of rural New York counties.  
 Source: Grove & Coates (2025). Statewide Aggregate Rural Health Needs Assessment.

### The Fiscal Reality

The fragmented system is not only a clinical failure; it is an expensive one.<sup>6</sup> Every time a patient cycles through the emergency department for an untreated anxiety or depressive condition, the county and the hospital absorb costs that dwarf what outpatient care would have cost. ED boarding for psychiatric patients, which can last three to five days in rural hospitals, occupies beds, ties up nursing staff, and generates no therapeutic value. When law enforcement responds to a mental health call, it consumes officer hours, creates potential for trauma on both sides of the encounter, and produces no clinical outcome. These costs are real, recurring, and measurable. Yet they rarely appear in the same budget conversation as the cost of building integrated care infrastructure.

The business case for the models in this white paper rests not only on their clinical evidence but on this fiscal arithmetic. Investing in coordinated primary care, community-based crisis response, and comprehensive clinic infrastructure is not a social expenditure. It is a substitution: replacing high-cost, low-efficacy emergency and law enforcement encounters with lower-cost, high-efficacy clinical ones. The return on that substitution is documented, replicated, and available to any county willing to make the calculation.

### The Implementation Reality: Fragmentation Beyond Access

The fragmentation described above is not limited to patient pathways; it is embedded in the organizational and technological structure of the system itself. Primary care practices, hospitals, EMS agencies, and behavioral health providers frequently operate on incompatible electronic health record systems, limiting real-time information sharing. Financial incentives remain misaligned, with reimbursement structures often failing to support care coordination activities such as warm handoffs and follow-up. Organizational cultures, state policies, scope-of-practice limitations, and professional boundaries can impede service implementation and slow cross-system collaboration even when formal partnerships exist.<sup>7,8</sup>

The models presented in this white paper vary in the strength and type of evidence supporting them, ranging from randomized controlled trials to rural pilot evaluations and federal demonstration programs. They are designed to function within this fragmented environment while incrementally building the shared infrastructure, data pathways, and accountability mechanisms required for true system integration. A key coordination mechanism already available in New York, the Single Point of Access (SPOA), provides counties with a centralized triage and referral structure that can serve as an organizing scaffold for the broader system this paper proposes. Where SPOAs are not yet formalized, this white paper's action plan identifies their development as a near-term priority. These barriers are not incidental; they are the predictable result of a system that has never been designed to operate as an integrated whole, and addressing them requires policy alignment as well as programmatic innovation.

## Section II

### The Collaborative Care Model (CoCM)

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The Collaborative Care Model is the most rigorously studied approach to integrating behavioral health into primary care, supported by more than 80 randomized controlled trials.<sup>9,10</sup> Rather than referring patients out of primary care into a system they may never navigate, CoCM brings behavioral health into the setting where rural residents already have relationships and trust.

#### Understanding the Evidence Base

The models presented in this white paper vary in the strength and type of evidence supporting them. CoCM is supported by a large body of randomized controlled trials and represents the most rigorously tested approach to behavioral health integration.<sup>11,12</sup> Emergency department-based integration is supported by multi-site and quasi-experimental studies demonstrating strong improvements in treatment initiation and retention. Community paramedicine behavioral health programs, while highly promising, are supported primarily by rural pilot programs and emerging evaluation data.<sup>13</sup> CCBHCs are backed by federal demonstration projects and statewide implementation data.<sup>14</sup> Taken together, the evidence base is complementary: some models offer high internal validity, while others demonstrate strong real-world feasibility in rural contexts.

#### The Triangle of Care

CoCM is built around a three-part interdisciplinary team functioning as a single clinical unit:

##### The Primary Care Provider (PCP)

The PCP remains the patient's clinical home base and team lead. In rural settings, where patients may have decades-long relationships with their family physician but carry deep stigma toward psychiatric facilities, this is not merely a clinical convenience; it is a therapeutic strategy. The PCP identifies needs through universal screening, initiates treatment, and oversees the overall care plan.

##### The Behavioral Health Care Manager (BHCM)

The BHCM is the connective tissue of the model, typically a licensed social worker or registered nurse with specialized training in behavioral health care management. The BHCM provides brief evidence-based psychotherapy (Behavioral Activation, Problem-Solving Treatment), conducts proactive outreach to patients who miss appointments, and manages the patient registry, the operational core of the entire model. In rural settings where distance limits in-person contact, BHCMs increasingly deliver care management through secure video and telephone, allowing a single BHCM to serve patients across multiple counties without requiring travel.<sup>15</sup>

##### The Psychiatric Consultant

The consultant is the rural workforce multiplier. Rather than providing direct care, this specialist conducts systematic caseload reviews with the BHCM for one to two hours per week, reviewing every patient who is not improving and providing specific diagnostic and medication recommendations for the PCP to implement. One remote psychiatrist, operating via telehealth, can support 30 to 50 rural primary care practices simultaneously,<sup>16</sup> a scale of impact impossible through traditional direct-care referral. This virtual consultation model is particularly well-suited to rural New York, where academic medical centers such as SUNY Upstate, UR Medicine, and Columbia have established telepsychiatry programs specifically designed to support rural primary care networks.

## The Workforce Math

In some rural New York counties, the psychiatrist-to-patient ratio reaches 1:1,690. A traditional referral model means that a psychiatrist sees roughly 15 to 20 patients per week. Under CoCM, one remote psychiatric consultant provides systematic oversight for 30 to 50 practices simultaneously, multiplying specialist reach by a factor of 50 or more without a single new hire.

## Measurement-Based Care: The Treatment-to-Target Mandate

CoCM's most transformative feature is its shift from volume-based to outcome-based care. Every patient's symptom severity is tracked using validated tools: the PHQ-9 for depression and the GAD-7 for anxiety. If a patient's score has not improved by at least 50 percent within eight to twelve weeks, the registry flags the case as requiring a change in treatment. This treatment-to-target mandate means that stagnation is treated as a clinical emergency rather than accepted as a status quo.

This stands in direct contrast to the standard fee-for-service model, in which a provider can bill for 20 consecutive appointments with a patient who is not improving and face no system-level accountability for the lack of clinical progress.

## The Patient Registry in Practice

The patient registry is what separates CoCM from simple co-location of a therapist in a medical office. It is a population health tool, not an individual medical record. Every patient enrolled in CoCM appears in the registry with their current symptom scores, their treatment plan, their last contact date, and a flag indicating whether they are improving on schedule. The care manager reviews the registry daily. The psychiatric consultant reviews it weekly. No patient can quietly fall off the system's radar because inactivity itself triggers an alert.

In practical terms, this means a care manager in a rural FQHC might begin a Monday morning by scanning the registry for three things: patients whose PHQ-9 scores have not dropped by 50 percent after eight to twelve weeks (requiring a treatment change discussion with the PCP), patients who missed their last scheduled contact (requiring an outreach call), and patients newly flagged by the psychiatrist as needing a medication adjustment. This is proactive, systematic care, not reactive crisis management.

For rural communities where the "referral to nowhere" has long been the norm, the registry represents something genuinely new: a mechanism of accountability. When a patient is enrolled in CoCM, someone is responsible for knowing whether they are getting better. If they are not, someone is required to do something about it.

## What the Evidence Shows

Patients in CoCM are twice as likely to achieve remission from depression compared to those receiving usual care (50 percent vs. 25 percent remission rates).<sup>17,18</sup> Outcomes are consistent across settings, populations, and conditions including depression, anxiety, PTSD, and co-occurring conditions.

A landmark analysis found that for every dollar invested in Collaborative Care, health systems saved an average of six dollars in total medical costs.<sup>19</sup> These savings come primarily from three sources: reduced emergency department visits, fewer psychiatric hospitalizations, and better management of co-morbid physical conditions. Patients with well-managed depression show measurably better adherence to treatment for diabetes, heart disease, and hypertension, conditions that are expensive to manage and common in rural populations. CoCM does not just treat depression; it reduces the total cost of a patient's care.

In New York, Medicaid reimburses the Collaborative Care Model through CPT codes 99492, 99493, and 99494,<sup>20</sup> providing a predictable monthly case rate that supports care management, psychiatric consultation, and registry-based tracking. This reimbursement structure allows CoCM to operate as a sustainable clinical

model rather than a grant-funded program. Counties interested in detailed implementation steps, reimbursement structures, and technical assistance contacts may consult Evidence Based Best Practices for Rural Behavioral Health Access: A NYSARH Implementation Guide, which provides a full CoCM program profile.<sup>21</sup>

### **Implementation Pathway**

CoCM can be operational within six to twelve months. Implementation begins with identifying two to three primary care practices (FQHCs are ideal) willing to participate. A behavioral health care manager is hired or reassigned, a psychiatric consultation contract is established with an academic medical center or telepsychiatry vendor, primary care staff are trained on screening tools, and a patient registry is launched. Technical assistance is available through the AIMS Center at the University of Washington, which provides free implementation guides and training resources.

## **Section III**

### **Community Paramedicine as Behavioral Health Infrastructure**

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Rural New York cannot recruit its way out of the behavioral health workforce crisis. But it possesses an existing, geographically distributed workforce that already reaches every rural address: emergency medical services (EMS). Community paramedicine repurposes this resource, enabling EMS providers to conduct post-crisis follow-ups, suicide risk checks, behavioral health monitoring, and rapid treatment referrals during home visits.

#### **The Post-Crisis Window**

Research consistently identifies the 24-to-72-hour period after an acute behavioral health episode as the window of highest patient readiness for treatment engagement.<sup>22</sup> It is also the period of greatest system abandonment. When a patient is discharged from an ED after a psychiatric crisis, the standard of care in most rural counties is a sheet of referral numbers and a directive to call when ready. Most do not call. The system does not follow up. The crisis recurs.

Community paramedicine closes this gap. By protocol, an EMS-trained behavioral health responder makes a home visit within 24 to 72 hours of discharge.<sup>23</sup> Rural pilots show improved post-crisis treatment engagement, reduced hospitalization, and substantially higher connection rates to ongoing care. The model directly addresses what the SARHNA identifies as the most critical failure point in rural crisis response.

#### **A Distributed Workforce with Trusted Community Relationships**

Beyond their geographic reach, EMS providers bring a crucial cultural asset: they are trusted. In small rural communities where a standalone mental health clinic carries social stigma, a visit from a paramedic or EMT often feels familiar and non-threatening. Many rural EMS agencies have expressed strong interest in expanded behavioral health roles precisely because their providers already encounter these patients regularly, without the infrastructure to do anything meaningful.

Training extends EMS scope without requiring additional licensure. EMS providers complete coursework in Mental Health First Aid (an eight-hour standardized training offered by the National Council for Mental Wellbeing),<sup>24</sup> motivational interviewing, suicide risk assessment using validated tools, and crisis de-escalation. Protocols are established for follow-up within 24 to 72 hours post-crisis and for initiating warm handoffs, meaning personally supported, coordinated connections to the next provider, rather than passive referrals. The training provides both the clinical skills and the documentation framework needed to make post-crisis follow-up a reimbursable, accountable service rather than an informal act of goodwill.

## The Research on Post-Crisis Engagement

The 24-to-72-hour post-crisis follow-up window is not an arbitrary protocol choice. It reflects a well-documented pattern in behavioral health research.<sup>25</sup> Studies of individuals following suicide attempts, psychiatric hospitalizations, and acute anxiety or depressive episodes consistently find that readiness for treatment engagement peaks in the immediate aftermath of a crisis and declines rapidly without structured outreach. A patient who is willing to consider ongoing treatment on the night of a crisis may not be willing to make that call two weeks later. Community paramedicine captures that window; traditional referral systems do not.

Rural pilots of community paramedicine behavioral health programs report improved post-crisis treatment engagement rates, reduced emergency department readmissions within 30 days, and substantially higher connection rates to outpatient mental health services compared to discharge with a referral list.<sup>26</sup> The model is also associated with reduced law enforcement involvement in subsequent mental health calls for the same individuals, a meaningful secondary benefit in counties where every sheriff's deputy dispatched to a mental health call is unavailable for other work.

## Reducing the Law Enforcement Burden

In many rural New York counties, law enforcement currently functions as the de facto mental health system, not because officers are trained for this role, but because no other 24/7 resource exists. The SARHNA documents this pattern across surveyed counties,<sup>27</sup> where emergency dispatch routinely sends police to calls that are clinical rather than criminal in nature. This creates strain on law enforcement budgets, exposes officers to situations they are not equipped to resolve clinically, and often results in outcomes (involuntary transport, ED boarding) that are worse for the patient than a timely clinical response would have been.

Community paramedicine does not require replacing law enforcement as a crisis responder overnight. In many counties, the most realistic near-term model is co-response: a community paramedicine provider paired with a law enforcement officer for behavioral health calls, or a rapid follow-up protocol in which paramedicine visits within 24 hours of a police mental health response. Either approach reduces the frequency with which the same individuals cycle through law enforcement contacts, and it gives officers a clinical handoff partner they currently lack.

## Implementation and Funding

Implementation begins with EMS agency interest assessment and capacity review, followed by behavioral health training for EMS providers and protocol development for post-crisis follow-up. Warm handoff relationships are established with local mental health providers and CoCM practices. Funding currently flows primarily through SAMHSA rural EMS training grants, state crisis infrastructure funding, and hospital community benefit programs. New York is actively exploring Medicaid reimbursement pathways for community paramedicine behavioral health services. For detailed implementation guidance, funding pathways, and technical assistance contacts, see *Evidence-Based Best Practices for Rural Behavioral Health Access: A NYSARH Implementation Guide*.<sup>28</sup>

## Section IV

### The Emergency Department as a Gateway to Care

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Every day across rural New York, patients arrive at emergency departments in acute psychiatric crisis: suicidal ideation, severe panic and anxiety, depressive episodes with acute functional impairment, and psychiatric emergencies of every severity. In the absence of a coordinated system, the standard outcome is evaluation, stabilization, a safety plan, and discharge with a list of outpatient providers. The next available appointment is often months away. Most patients do not call. The crisis recurs, often with greater severity.

This is not a clinical failure. It is a systems failure. The emergency department has the clinical infrastructure to evaluate and stabilize a behavioral health crisis. What it lacks is the integrated community infrastructure to convert that moment into the beginning of sustained care. The CLBHS addresses this directly by positioning the ED not as a treatment endpoint but as an entry point into the coordinated behavioral health system.

### **The Psychiatric Crisis Presentation: A Missed Opportunity**

Research on patients presenting to emergency departments with suicidal ideation consistently shows that this moment, despite its acuity, represents one of the highest windows of treatment readiness in a patient's clinical trajectory.<sup>29</sup> The presentation itself reflects an implicit request for intervention. What happens in the hours and days following discharge determines whether that readiness translates into sustained engagement or evaporates into a long wait and a phone that never gets answered.

Studies of ED patients presenting with suicidal ideation who leave without a confirmed follow-up appointment find substantially elevated risk of subsequent attempt compared to those connected to a clinician before discharge.<sup>30</sup> The appointment itself, confirmed before the patient leaves, is a clinical intervention. The phone number on a discharge sheet is not.

### **The Warm Handoff Protocol**

The CLBHS replaces the discharge sheet with a protocol. Under a formal warm handoff agreement between an ED and a local CoCM practice or CCBHC, the following occurs before any behavioral health patient is discharged:

- A social worker or care manager liaison confirms a scheduled appointment at the CoCM practice or CCBHC, ideally within 24 to 72 hours of discharge.
- If the appointment cannot be confirmed before discharge, the CCBHC's 24/7 crisis line is documented in the discharge plan as an active bridge resource, not a backup option.
- Community paramedicine is notified for a home visit within 24 to 72 hours to confirm that the appointment was attended and assess stability.
- If the patient is not already enrolled in a CoCM practice, enrollment is initiated before discharge, with the BHCM making first contact within 48 hours.

This sequence requires no new clinical infrastructure. It requires a documented agreement between the ED and the receiving system, a designated staff role responsible for the handoff, and a shared communication protocol that functions reliably across shifts and leadership transitions. The protocol converts the ED from a silo into a gateway.

### **The Role of CCBHCs in Crisis Response**

CCBHCs, with their requirement to provide 24/7 crisis services including mobile crisis teams and crisis stabilization,<sup>31</sup> are the natural crisis infrastructure partner for rural emergency departments. In counties with an established CCBHC, the ED warm handoff agreement routes patients directly to the CCBHC for crisis stabilization, same-day assessment, and enrollment in ongoing services without requiring the patient to wait for a traditional intake appointment.

The CCBHC's open-access model, which requires that anyone seeking services be seen regardless of insurance status or ability to pay,<sup>32</sup> eliminates two of the most common barriers to post-ED follow-through in rural communities: the cost barrier and the wait barrier. A patient discharged from a rural ED on a Thursday evening can walk into the CCBHC on Friday morning. This is the documented operating standard of the CCBHC model, currently functioning in certified clinics across New York State.

### **988 and the Crisis Continuum**

The 988 Suicide and Crisis Lifeline represents a complementary layer of the behavioral health gateway. When a patient leaves the ED after a psychiatric crisis, the 988 number functions as a real-time bridge resource during the hours and days before an outpatient appointment is reached. In the integrated CLBHS, 988 is not positioned as an alternative to clinical follow-up but as a structured component of the post-ED care sequence, specifically the overnight and weekend coverage that CoCM practices and most outpatient providers cannot provide.

ED discharge protocols in the CLBHS include a structured 988 orientation, in which the patient and family member are walked through how to use the line, what to expect when they call, and how the line connects to local crisis services. This orientation takes approximately five minutes and substantially increases the likelihood that the number is actually used. It is a clinical step, not an afterthought.

### **Building the Agreements That Make It Work**

The warm handoff protocol requires a formal collaboration agreement between the ED and its receiving partners. This agreement specifies: which staff role owns the handoff, the timeline for appointment confirmation, the communication pathway to the BHCM or CCBHC intake team, the trigger for community paramedicine notification, and the escalation protocol when a patient declines follow-up. It is reviewed and updated annually, signed by clinical and administrative leadership on both sides, and does not depend on a personal relationship between two individuals who may leave their positions.

This administrative infrastructure is the single most underinvested element of rural behavioral health integration. Clinical models can be evidence-based, reimbursement pathways can be established, and providers can be trained, but without the documented institutional commitment that a collaboration agreement represents, the system defaults to fragmentation the moment a key individual is unavailable. The agreement is the infrastructure.

## **Section V**

### **Certified Community Behavioral Health Clinics (CCBHCs)**

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While CoCM addresses integration at the individual practice level and community paramedicine extends the system's reach into the home and post-crisis moment, CCBHCs represent a redesign of the entire safety net system. The CCBHC is not a single program; it is a singular, accountable hub for comprehensive behavioral health care, designed to eliminate the fragmentation that defines the current system.

Under Governor Hochul's \$1 billion mental health plan, New York is in the midst of significant multi-year effort to expand CCBHC clinics statewide.<sup>33</sup> For rural counties, the CCBHC is the gold standard for system-level accountability.

### **The Nine-Service Mandate: A "No Wrong Door" System**

CCBHC certification requires clinics to provide nine core service categories, either directly or through formal agreements with Designated Collaborating Organizations.<sup>34</sup> This mandate collapses the traditional silos between mental health and crisis services:

- 24-hour crisis behavioral health services including mobile crisis teams and crisis stabilization
- Screening, assessment, and diagnosis for any community member regardless of insurance status or ability to pay
- Patient-centered, holistic treatment planning
- Integrated outpatient mental health services for all ages
- Primary care screening and monitoring to address the shortened life expectancy common among people with serious mental illness
- Targeted case management during high-risk transitions such as discharge from a hospital or residential treatment program
- Psychiatric rehabilitation and community re-integration support
- Peer support and family services that leverage lived experience to engage hard-to-reach populations
- Specialized services for veterans and military families

For rural counties where residents have historically faced a maze of separate intake processes, disconnected records, and siloed waiting lists, the CCBHC offers a single point of accountable, comprehensive care. When someone arrives at a CCBHC, there is no wrong door.

### **What the Nine Services Mean in a Rural Context**

The CCBHC's nine required service categories are more than a regulatory checklist. They represent the specific gaps that have historically made rural behavioral health care fail. The 24-hour crisis services requirement directly addresses the single most common structural failure identified in the SARHNA: the absence of any clinical crisis resource outside of law enforcement. The requirement that screening and assessment be available to anyone, regardless of insurance status or ability to pay, addresses the access barrier most acutely felt in high-poverty rural counties. The primary care screening and monitoring requirement addresses a sobering reality: people living with serious mental illness in rural areas have dramatically shortened life expectancies,<sup>35</sup> driven in part by undertreated physical conditions that go unmonitored when behavioral health and primary care operate in separate silos.

The peer support requirement is equally significant in the rural context. In communities where stigma is a powerful deterrent to care-seeking, a Certified Recovery Peer Advocate with lived experience of mental illness can open doors that a licensed clinician cannot. Peers speak a different language, hold different credibility, and build different trust. CCBHCs are required to employ them not as supplemental extras but as a core component of the care model.

### **Implementation Pathway for Rural Counties**

CCBHC development is a 12-to-24-month process requiring significant organizational transformation. For smaller counties where standalone CCBHC development is not feasible, the preferred pathway is regional collaboration: two to four neighboring counties pooling resources to establish a shared CCBHC hub with satellite access points. Implementation begins with identifying an existing community mental health center willing to pursue certification, conducting a gap analysis against CCBHC requirements, applying to the New York State Office of Mental Health (OMH) for designation, and establishing the PPS reimbursement rate with Medicaid. SAMHSA planning grants of up to \$75,000 are available to support the gap analysis and pre-application work. For full implementation guidance, technical assistance contacts, and funding pathways, consult *Evidence-Based Best Practices for Rural Behavioral Health Access: A NYSARH Implementation Guide*.<sup>36</sup>

For counties not yet positioned to pursue full certification, designating an existing provider as a Designated Collaborating Organization with a nearby CCBHC creates a formal partnership that extends comprehensive services into the county.<sup>37</sup> This hub-and-spoke approach is particularly well-suited to the small, geographically dispersed counties that make up much of rural New York.

### **Fiscal Architecture: The Prospective Payment System**

The primary reason rural behavioral health clinics have historically failed is the sustainability gap: dependence on low-reimbursement fee-for-service models or short-term grants that eventually sunset.<sup>38</sup> The CCBHC model solves this through the Prospective Payment System (PPS),<sup>39</sup> which reimburses clinics at a clinic-specific rate covering the actual cost of delivering these intensive, coordinated services, rather than a flat per-visit fee that never approaches the real cost of care.

Under fee-for-service, a clinic is paid a fixed amount per visit, an amount that typically does not reflect the actual cost of delivering care to complex patients with co-occurring conditions, housing instability, and limited transportation. Under PPS, New York Medicaid pays a clinic-specific rate calculated on the basis of the clinic's actual costs: its staffing, its service mix, its infrastructure. The rate is set prospectively, meaning the clinic knows what it will be paid before the year begins, enabling genuine financial planning. New York's CCBHC Demonstration Program uses the PPS-1 rate structure, a daily rate covering all services on a given day.<sup>40</sup>

As of January 1, 2025, New York law requires commercial insurers to reimburse CCBHCs at no less than the published Medicaid PPS rate,<sup>41</sup> creating a stable revenue floor that allows rural clinics to hire full-time staff and invest in long-term infrastructure. The FY 2024 state budget included \$14.7 million<sup>42</sup> specifically to support CCBHCs in providing care to the uninsured, ensuring that ability to pay is never a barrier in high-poverty rural communities.

### **The Rural Return on Investment**

For rural policymakers who have watched county budgets strained by repeated ED boarding episodes and law enforcement mental health calls, the CCBHC offers not just a better system of care, but a fiscally defensible one. Federal demonstration data from Pennsylvania and Oklahoma shows 11 to 13 percent reductions in behavioral health-related ED visits following CCBHC implementation.<sup>43</sup> New York financial analysis suggests that if CCBHCs reach even 3.8 percent of the mental health population, the state's share of Medicaid remains budget-neutral due to the corresponding drop in expensive inpatient and ED spending.<sup>44</sup>

The CCBHC is also the natural downstream anchor for both CoCM and community paramedicine. CoCM warm handoffs for high-acuity patients go to the CCBHC. Community paramedicine's home visit connections go to the CCBHC. ED warm handoffs for patients with complex needs go to the CCBHC. It is, by design, the system's accountable hub.

### **Why Warm Handoffs Are Not Referrals**

A referral is a phone number. A warm handoff is a personally supported, coordinated connection in which a staff member stays with the patient until the next appointment is confirmed, the care manager is notified, and the transition is documented. The difference in treatment engagement rates between the two approaches is substantial. In rural communities where transportation and follow-through barriers are highest, that difference is the difference between care and abandonment.

### **New York's Expansion and What It Means for Rural Counties**

New York's commitment to expanding the number of CCBHCs statewide represents a meaningful policy investment, but the geography of that expansion matters.<sup>45</sup> A CCBHC in a metropolitan area serves a different population and faces different access challenges than one anchored in a rural county. Ensuring that the expansion reaches rural New York requires deliberate attention from OMH to the regional distribution of new certifications, support for the regional collaboration models that make rural CCBHC development feasible, and recognition that rural clinics may need longer timelines and more intensive technical assistance to meet certification requirements than their urban counterparts.

## Section VI

### The Closed-Loop Behavioral Health System in Action

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The four models in this white paper are most powerful not as alternatives, but as stages of a single integrated system. Understanding what the Closed-Loop Behavioral Health System looks like in practice requires more than a conceptual diagram. It requires tracing the pathway a patient travels from the moment a need is identified to the point at which that need is in active, accountable management, and understanding what happens at every transition point when the system is working as designed.

The loop is not a metaphor. It is a sequence of accountable handoffs, each triggered by a defined condition, each owned by a named role, each documented in a formal agreement between institutions. It does not close through clinical goodwill or informal coordination. It closes through the administrative infrastructure, shared registries, warm handoff protocols, and cross-system case conferences that transform good programs into a functioning system.

#### The Four Stages of the Loop

##### Stage 1-A: Detection and Primary Care Activation

The loop begins at the primary care level, where universal screening with the PHQ-9 and GAD-7 has become standard practice across rural New York. When a screen is positive, the critical difference between the current fragmented system and the CLBHS is what happens next.

In the current system, a positive screen generates a referral. The referral goes to a behavioral health clinic with a six-to-twelve-month waitlist. The patient receives paperwork. The primary care provider has no way of knowing whether the patient ever followed through. In most cases, they do not.

In the CLBHS, a positive screen generates an enrollment. The behavioral health care manager (BHCM) is notified the same day. Within 48 to 72 hours, the BCHM contacts the patient, completes an initial assessment, and adds them to the patient registry. The PCP receives a notification that the patient has been enrolled. The patient does not disappear into the weeks of silence between a diagnosis and an intake appointment. They are in the system from the moment the screen is positive.

This difference, between a referral and an enrollment, is the foundational structural shift of the CLBHS. It repositions the patient not as the navigator of their own fragmented care, but as the subject of active, proactive management by a team that is accountable for their outcomes.

##### Stage 1-B: The Emergency Department as Entry Point

Not every patient enters the loop through primary care. Many encounter the behavioral health system for the first time during an acute crisis, arriving at a rural emergency department with suicidal ideation, a severe depressive episode, or a panic disorder that has reached the point of acute impairment. For these patients, the ED is the detection point, and the entry to the loop, if the loop is functioning.

In the CLBHS, the ED has a standing warm handoff agreement with at least one CoCM practice and the regional CCBHC. When a behavioral health patient is evaluated and determined to be appropriate for outpatient follow-up, the discharge process includes a mandatory warm handoff step: a designated staff member contacts the CoCM practice or CCBHC before the patient leaves and confirms a scheduled appointment within 24 to 72 hours.

This step is not optional and is not dependent on which social worker happens to be working that shift. It is documented in the collaboration agreement between organizations. If the appointment cannot be confirmed before discharge, the patient is not discharged with a phone number. They are discharged with a follow-up call scheduled for the following morning, and the CCBHC's 24/7 crisis line documented as an active overnight bridge. Community paramedicine is notified for a home visit within 24 hours.

### **Stage 2: Community Paramedicine as the Redundancy Mechanism**

Every system has failure modes. Patients miss appointments. The transition from acute crisis to first outpatient contact is the most vulnerable moment in the behavioral health care sequence, the point at which motivation is highest but logistical barriers are also at their peak. Transportation falls through. Anxiety about entering a new clinical system leads to avoidance. The acuity of the crisis fades faster than the structural problems that caused it.

Community paramedicine is the CLBHS's designed response to this vulnerability. The home visit within 24 to 72 hours after any acute crisis serves three simultaneous functions. It is a clinical check: the paramedicine provider assesses safety, screens for deterioration, and documents the patient's current status. It is a logistical confirmation: the appointment has been scheduled, the patient knows how to reach the appointment in-person or virtually, and transportation has been arranged if needed. And it is a motivational bridge: a trusted community member, in the patient's home, reinforcing the value of the follow-through appointment at the precise moment when follow-through is most at risk.

If the appointment has not been made, the paramedicine provider completes the warm handoff on the spot, using a direct contact protocol with the receiving practice. The patient does not leave the home visit without a confirmed appointment. This is documented, tracked, and reported back to the care manager. For patients already enrolled in a CoCM practice, the paramedicine visit feeds directly back to the registry. If the patient is in crisis, the escalation pathway to the CCBHC is activated. If stable, the visit closes the post-crisis loop, and the registry resumes active monitoring.

### **Stage 3: The Registry as the Engine of Accountability**

Once a patient is enrolled in CoCM, the registry becomes the operational core of their care. Unlike an electronic health record, which documents what has happened, the registry is forward-facing: it tracks what needs to happen next, by when, and by whom. It is reviewed daily by the BHCM and weekly by the psychiatric consultant.<sup>46</sup> It flags patients who are not improving. It generates alerts when patients miss contacts. It provides the psychiatric consultant with a systematic view of the entire enrolled population, not a caseload of direct patients, but a population for which the consultant carries clinical responsibility through the team.

The treatment-to-target mandate, the requirement that any patient whose PHQ-9 or GAD-7 score has not improved by 50 percent within eight to twelve weeks must have their treatment plan changed,<sup>47</sup> is enforced at the registry level. Not changed at the discretion of the individual provider. Changed as a required protocol response to a documented clinical indicator. This is the shift from reactive to proactive care: the system identifies failure before the patient presents in crisis again.

When a patient disengages, the registry does not simply note their absence. It generates a required outreach sequence: BHCM contact attempt within 48 hours, second attempt within 72 hours, community paramedicine notification if both attempts fail. The patient does not fall off the map. The map comes to them.

For patients whose complexity exceeds the CoCM model's scope, including those with serious mental illness, housing instability, or need for intensive case management, the registry flags them for step-up referral to the CCBHC. The CCBHC collaboration agreement is already in place. The BHCM contacts the CCBHC care coordinator directly, shares the relevant registry data with patient consent, and confirms enrollment. The patient transfers from one accountable system to another. The loop does not break.

#### Stage 4: The CCBHC as Anchor and Step-Down Partner

The CCBHC occupies a dual role in the CLBHS. It is the anchor for the highest-acuity patients in the system, those who need 24/7 crisis backup, intensive case management, peer support, and psychiatric rehabilitation. And it is the step-down partner for patients who have been stabilized through the CCBHC's intensive services and are ready to transition to the lower-intensity management that CoCM provides.

This bidirectionality is essential to the loop's function. A system that can only escalate patients from CoCM to CCBHC, without a pathway back, will fill the CCBHC with patients who no longer need intensive services and leave no capacity for those who do. The formal step-down protocol, in which the CCBHC care coordinator, the CoCM BHCM, and the patient collaboratively agree on a transition date and plan, ensures that CCBHC capacity is preserved for the patients who need it most and that stable patients continue in active management rather than being discharged into an unmonitored gap.

#### Two Patient Journeys Through the Closed-Loop System

The following scenarios are fictional composites created for illustrative purposes only. They are intended to show how the CLBHS functions from two different entry points. Any resemblance to real individuals is coincidental.

##### Thomas, 52 | Depression Detected Through Primary Care | Delaware County

Thomas comes in for a routine physical at his county FQHC. His PCP administers the PHQ-9 as part of the standard adult wellness protocol. Thomas scores a 16: moderate-to-severe depression. He has not sought mental health care before. He lives alone, 35 miles from the nearest outpatient clinic. In today's fragmented system: Thomas receives a referral slip with two clinic names. The first has a seven-month wait. The second does not call back. In three months, Thomas is in the ED following a self-harm incident. In the CLBHS: The positive PHQ-9 triggers enrollment, not a referral. The BHCM calls Thomas that afternoon. Within the week, she completes his initial assessment, administers the GAD-7 (score: 11, moderate anxiety), and begins a brief Behavioral Activation protocol by telephone. The PCP initiates a low-dose antidepressant with the psychiatric consultant's guidance. At eight weeks, Thomas's PHQ-9 score is 14. Not improving sufficiently. The registry flags the case. During the weekly caseload review, the psychiatric consultant recommends a medication adjustment and a shift from Behavioral Activation to Problem-Solving Treatment. Thomas and his BHCM begin meeting by secure video. At sixteen weeks, Thomas's PHQ-9 score is 7 and his GAD-7 is 5, both at or near remission thresholds. Thomas continues in the registry for a six-month maintenance phase, with his PCP receiving a summary at each quarterly review. No seven-month wait. No ED visit. No self-harm incident. A positive screen became an enrollment. An enrollment became a system. A system produced a clinical outcome.

##### Sarah, 29 | Acute Anxiety and Suicidal Ideation Presenting to the ED | St. Lawrence County

Sarah arrives at a rural ED at 11pm, brought by her mother after disclosing thoughts of self-harm. She has a history of generalized anxiety disorder and major depression but has not been in treatment for two years. Her last provider's waitlist was over a year long. She stopped calling. In today's fragmented system: Sarah is evaluated, a safety plan is completed, and she is discharged at 1am with a list of outpatient providers. The nearest available psychiatric appointment is four months out. Sarah does not follow up. Six weeks later, she returns to the ED. In the CLBHS: Before Sarah is discharged, the ED social worker contacts the county FQHC's CoCM program using the standing warm handoff protocol. An appointment with the BHCM is confirmed for 9am the following morning. The CCBHC's 24/7 crisis line is documented and explained to Sarah and her mother. Community paramedicine is notified for a home visit the following afternoon. The next morning: Sarah attends the BHCM appointment. Her GAD-7 is 18 (severe anxiety). Her PHQ-9 is 17 (moderate-to-severe depression). She is enrolled in the registry. A brief CBT protocol begins. The BHCM notes Sarah's housing instability and flags the CCBHC for potential targeted case management referral.

That afternoon: Community paramedicine visits Sarah at her mother's home. She attended her appointment and is stable. The paramedicine provider documents the visit and reports back to the BHCM. Week 2: PCP consultation. Medication initiated with psychiatric consultant guidance. Week 4: Sarah's housing situation has not resolved. The BHCM and CCBHC care coordinator complete a warm step-up handoff. Sarah begins targeted case management through the CCBHC alongside continued CoCM monitoring. Week 12: GAD-7 is 8. PHQ-9 is 7. Both represent more than 50 percent improvement. Sarah has been connected to transitional housing through the CCBHC's services network. The step-down conversation begins. No four-month wait. No second ED visit. A crisis became the beginning of coordinated care. The loop closed.

### The Infrastructure That Closes the Loop

The patient journeys above are not the product of exceptional clinical skill or unusual provider dedication. They are the product of documented infrastructure operating as designed. That infrastructure consists of six components, none of which is expensive, and all of which require organizational commitment rather than new funding:

- **Formal collaboration agreements** between EDs, CoCM practices, CCBHCs, and EMS agencies specifying warm handoff procedures, communication protocols, and escalation pathways in writing, signed by clinical and administrative leadership, reviewed annually.
- **A shared or interoperable patient registry** that makes each enrolled patient's status, scores, and recent contacts visible to all members of the care team, regardless of which organization employs them.
- **Defined warm handoff procedures** that specify who is responsible for confirming the next appointment before the patient leaves any care setting. The confirmation is the intervention.
- **Monthly cross-system case conferences** at which ED staff, BHCs, CCBHC coordinators, and community paramedicine providers review shared patients, identify gaps, and resolve system friction in real time.
- **A bidirectional escalation and step-down ladder** that moves patients from CoCM to CCBHC for step-up and from CCBHC back to CoCM for step-down, with each transition documented and communicated to the patient.
- **Shared accountability metrics** reported across all partner organizations: what percentage of positive PHQ-9 screens are enrolled in CoCM within two weeks? What percentage of ED psychiatric discharges have a confirmed appointment before leaving the department? What percentage of enrolled patients reach treatment target within 16 weeks?

These components do not require new legislation. They do not require a budget appropriation. They require the decision, made at the leadership level of each participating organization, to treat behavioral health integration as a structural commitment rather than a programmatic experiment. The counties that make that decision, and formalize it in writing, are the counties where the loop closes.

## Section VII

### Strategic Action Plan

The transition from a fragmented, crisis-driven behavioral health system to an integrated, accountable one requires action at every level of governance. The recommendations below are organized by stakeholder role. They are not aspirational; each is grounded in existing policy levers, funding mechanisms, and implementation models already operating in New York State. What is required is the political and organizational will to deploy them at scale.

## For State Legislators and Policymakers

State-level policy is the foundation on which sustainable rural behavioral health integration is built or abandoned. Historically, New York has invested in innovation without investing in durability: funding promising pilots that collapse when grants expire; expanding access through programs that lack billing infrastructure; and deploying technology without the broadband to carry it. The recommendations below address this pattern directly.

- **Mandate and expand Medicaid reimbursement for Collaborative Care Model (CoCM)**, including expansion of eligible providers to psychiatric nurse practitioners and licensed mental health counselors. The current reimbursable provider list does not reflect the workforce actually available in rural New York. Broadening eligibility is not a policy concession; it is a recognition of rural practice reality.<sup>48,49</sup>
- **Authorize infrastructure stipends for rural practices** to adopt patient registries, care management tools, and the digital infrastructure required for population-level outcome tracking. Fee-for-service billing cannot cover the upfront cost of registry systems. Without a bridge investment, the most underserved practices, those serving the highest-need populations, will be the last to implement CoCM.<sup>50,51</sup>
- **Modernize scope-of-practice regulations to reflect rural workforce realities.** Scope-of-practice limitations are a recurring barrier to integrated behavioral health care across the models in this white paper. Psychiatric nurse practitioners, licensed mental health counselors, and licensed clinical social workers remain excluded from reimbursable roles that their training and competency would support. Updating these regulations is not a workforce expansion for its own sake; it is a prerequisite for making integrated care models function in counties where the ideal provider simply does not exist.<sup>52</sup>
- **Establish a dedicated Medicaid reimbursement code for community paramedicine behavioral health services.** New York EMS agencies have the workforce and the geographic reach to function as the system's post-crisis bridge. Without a reimbursement pathway, this capacity will remain a grant-funded experiment rather than a durable clinical infrastructure. Other states have moved; New York should lead.<sup>53,54</sup>
- **Treat broadband expansion initiatives as a clinical infrastructure investment, not merely a utility project.** Behavioral health provider sites, school-based health centers, and rural library telehealth hubs should be explicitly identified as priority deployment locations in state planning documents. A telehealth dead zone is a care dead zone. Reimbursement policy must keep pace: school-based health centers may not be reimbursed when a provider delivers care remotely rather than on-site, and audio-only telehealth currently lacks payment parity in New York, limiting access for patients who lack broadband or video-capable devices. Broadband investment without corresponding reimbursement reform will not close the access gap.<sup>55</sup>
- **Protect and expand Certified Community Behavioral Health Clinic (CCBHC) expansion funding** with explicit attention to rural geographic equity. A proportionate share must be anchored in rural counties or connected to rural communities through Designated Collaborating Organization agreements. Certification timelines and technical assistance resources should be scaled to account for the additional complexity of rural implementation.<sup>56,57</sup> Where a CCBHC is affiliated with or operated by a hospital that has been absorbed by a larger health system, the state should require that integration into the acquiring system's clinical and data infrastructure be a condition of ongoing certification. All CCBHCs and their Designated Collaborating Organizations should also be required to establish formal data-sharing agreements to support coordinated care and population-level outcome tracking across partner organizations.
- **Require warm handoff compliance as a condition of state behavioral health funding for hospitals.** Every hospital receiving state funds for behavioral health services should be required to demonstrate a documented, signed collaboration agreement with at least one outpatient behavioral health partner specifying warm handoff procedures. This transforms a best practice into a funding condition.<sup>58</sup> The state should also explore establishing a reimbursable billing pathway for warm handoff activities, so that the staff time required for these transitions can be sustainably funded rather than absorbed as an unfunded mandate by already-strained hospital and clinic budgets.

- **Commission a statewide audit of Single Point of Access (SPOA)** implementation and effectiveness across rural counties and counties adjacent to metropolitan areas, which may fall outside rural-specific programs despite facing comparable access gaps. While Adult and Children's SPOA coordinators are already required under Article 41 of the Mental Hygiene Law and embedded in the authority of every LGU, the existence of a coordinator position does not guarantee a functional, adequately resourced triage system. Implementation varies significantly across counties — in some, SPOA functions as a robust clinical intake infrastructure; in others, it exists largely on paper. A statewide scope is more appropriate than a rural-only lens; OMH should be designated as the lead agency responsible for implementing and reporting on audit findings. A clear picture of where SPOAs are operational, what populations and services they cover, and where gaps persist is a prerequisite for the regional integration this white paper recommends.<sup>59,60</sup>

### For Counties and Community Leaders

County-level leadership is where the CLBHS either takes hold or stalls. State policy creates the conditions; county governments and community leaders build the relationships, sign the agreements, and hold the system accountable when it fails. In rural New York, where counties are small and resources are thin, the path to integration runs through regional collaboration rather than standalone county systems.

- **Form Regional Behavioral Health Networks** by convening three to four neighboring counties around a shared implementation agenda. No rural county in New York should be attempting to independently build all components of the Closed-Loop Behavioral Health System (CLBHS). Shared CCBHC hubs, jointly contracted psychiatric consultation, and pooled community paramedicine programs are not compromises; they are the only fiscally sustainable model for counties under 30,000 residents.
- **Formalize the SPOA** as the county's central behavioral health triage function, with a single phone number (a dedicated county-level clinical intake line, distinct from 988, which provides crisis support and emotional counseling but does not perform local triage or facilitate direct referral into county treatment slots), a trained clinical triage staff, and real-time visibility into all available treatment slots across the region. Where a SPOA does not yet exist or functions primarily on paper, building one – whether through an existing community-based organization with centralized capacity, a county mental health department, or a newly formalized coordination structure, without necessarily requiring new brick-and-mortar infrastructure – should be treated as a prerequisite for the integration work described in this white paper. A system without a front door is not a system.
- **Establish a county-level behavioral health integration coordinator position**, a single staff member (such as a trained Community Health Worker (CHW) or other professional) whose explicit responsibility is managing the collaboration agreements, tracking warm handoff compliance, convening monthly cross-system case conferences, and reporting shared accountability metrics to county leadership. This role does not require a clinical license. It requires organizational capacity and the authority to hold partner organizations accountable.
- **Direct opioid settlement funds and other one-time capital toward durable infrastructure**, including telehealth equipment, shared registry systems, library telehealth suites, and warm handoff coordination staffing. The temptation to use settlement funds for temporary program positions is understandable but counterproductive. A telehealth booth in a public library that serves patients for twenty years is a better investment than a staff position that disappears in three.
- **Establish and sign formal collaboration agreements** between Emergency Departments, CoCM practices, community paramedicine programs, and CCBHCs before the end of the current fiscal year. Treat the signing of these agreements as a public, measurable milestone, reported to county boards of supervisors and included in annual public health reporting. Integration that is not formalized is not integration; it is cooperation that will dissolve under the pressure of the next leadership transition. Memoranda of understanding alone are insufficient: they are rarely enforced and carry no binding consequences when hospitals fail to follow through. Agreements should be structured as binding contracts with defined accountability mechanisms, annual compliance review, and consequences for non-performance tied to any state or county funding relationships.

- **Develop a county- or region-specific behavioral health dashboard** tracking the six accountability metrics outlined in Section VI: PHQ-9 enrollment rates, ED psychiatric discharge follow-up rates, CoCM treatment target attainment, community paramedicine post-crisis contact rates, CCBHC same-day access rates, and SPOA referral completion rates. Data drives accountability. Accountability drives improvement.

### For Hospital Administrators and Clinical Leaders

Rural hospitals are at the center of the behavioral health crisis in a way that is both visible and costly. They board psychiatric patients for days. They discharge individuals in crisis with referral lists that lead nowhere. They absorb the cost of repeated ED visits by the same patients cycling through an unmanaged system. The recommendations below do not ask hospitals to become behavioral health providers. They ask hospitals to become the gateway they already functionally are, with the infrastructure to make that gateway lead somewhere.

- **Establish a formal warm handoff protocol as standard operating procedure** for all behavioral health discharges, with a designated staff role – a function that structured as a reimbursable activity through existing care management billing codes wherever possible, to create a sustainable funding mechanism rather than an unfunded staff mandate – explicitly responsible for confirming the next appointment before the patient leaves the department. Audit compliance quarterly: what percentage of behavioral health discharges left with a confirmed follow-up? Report this metric to the board alongside readmission rates.
- **Sign collaboration agreements** with at least one CoCM practice and the regional CCBHC within the next six months. These agreements do not require lengthy negotiation. They require a conversation, a template, and leadership signatures. The obstacle is not complexity; it is prioritization.
- **Implement a 988-orientation protocol** for every behavioral health discharge. A five-minute structured walkthrough of the 988 Suicide and Crisis Lifeline: how it works, what to expect, and how it connects to local services, substantially increases utilization. This requires no new staffing and no new funding. It requires a protocol change and staff training that can be completed in a half-day session. A designated clinical lead (typically the ED social work supervisor or charge nurse) is trained and then certifies all relevant staff internally. No standardized off-the-shelf curriculum currently exists for this specific use case – existing 988 training is designed for crisis center counselors, not discharging clinical staff – so OMH should develop and disseminate a brief, replicable 988 orientation training module that hospitals can adopt directly. This builds lasting institutional capacity and does not require repeated external training costs as staff turns over.
- **Invest in community paramedicine behavioral health programs** through the hospital's community benefit budget. Community benefit spending is a legal requirement for nonprofit hospitals. Behavioral health post-crisis follow-up is among the highest-ROI community benefit investments available: it reduces readmission rates, decreases ED utilization by the same patients, and addresses the community health needs documented in the hospital's own Community Health Needs Assessment. Allocating 3 to 5 percent of annual community benefit spending to community paramedicine behavioral health programs is a reasonable benchmark for hospitals serving rural populations with documented unmet need. Implementation requires engagement with municipal partners: municipalities are not legally required to fund community paramedicine, and not all nonprofit hospitals own or directly operate local EMS agencies. The model is most feasible where hospitals contract directly with existing EMS providers and where state law is updated to authorize and reimburse behavioral health services delivered by EMS personnel, a legislative priority that should be included in any county legislative agenda.
- **Mandate measurement-based care** across all hospital-affiliated behavioral health services and evaluate clinical leadership performance accordingly. Volume metrics (appointments billed, patients seen) measure activity. Remission rates, treatment target attainment, and 30-day follow-up rates measure outcomes. If hospital leadership cannot answer the question 'what percentage of our depressed patients got better this year,' the system is not accountable.

- **Partner with county Local Government Units (LGUs)** to identify the highest-frequency behavioral health ED utilizers and develop individualized care plans for this population in coordination with CoCM practices and CCBHCs. A small number of patients account for a disproportionate share of behavioral health ED costs. Targeted case management for this population, supported by the CCBHC's intensive care infrastructure, produces measurable cost reductions within 12 to 18 months.

### **Implementation Barriers and Political Realities**

While the models outlined in this paper are operationally feasible, their implementation is not without challenges. Rural health systems are characterized by fragmented governance, with hospitals, county health departments, local government units (LGUs), EMS agencies, and outpatient providers operating under separate funding streams and leadership structures. Competition between organizations can further limit willingness to share care pathways or referral systems. Workforce constraints extend beyond shortages to include scope-of-practice limitations, which can slow role expansion and delivery of care, particularly in community paramedicine, and limit program implementation. Research examining behavioral health care delivery barriers in rural New York further identifies state policies on service quotas, low reimbursement levels, funding algorithms, and budget cuts, and difficulties in securing grant funds, as additional challenges for rural behavioral health systems.<sup>61</sup>

Upfront infrastructure investments, including patient registries, telehealth systems, and care coordination staffing, require short-term funding before long-term reimbursement mechanisms stabilize. Political leadership at the county and state level is therefore critical, not only for funding but for convening stakeholders and formalizing collaboration agreements.

These barriers do not negate the feasibility of the proposed system. They define the work required to build it. Counties that succeed will be those that treat integration not as a programmatic add-on, but as a structural redesign requiring sustained administrative coordination and policy alignment.

## **CONCLUSION**

### **From Crisis to Continuity**

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The behavioral health crisis in rural New York is not an inevitable consequence of geography; it is the predictable result of an outdated, fragmented architecture. For too long, rural residents have been expected to navigate a maze of silos while in the midst of their most vulnerable moments. This paper has outlined the Closed-Loop Behavioral Health System as a practical framework for achieving that transformation.

The tools for transformation are already in our hands. The Collaborative Care Model creates coordinated, outcome-accountable primary care infrastructure. Community paramedicine deploys the existing rural workforce to extend that infrastructure into the home and the critical post-crisis window. Emergency department integration ensures that moments of acute psychiatric crisis become doorways into sustained care rather than dead ends. And CCBHCs anchor the entire system with a singular, 24/7, no-wrong-door hub that makes comprehensive care available regardless of ability to pay or place of residence.

None of these models requires waiting for a recruitment solution that may never arrive or a budget appropriation that may never be sufficient. They require organizational will, formalized collaboration agreements, and the commitment to measure success by outcomes rather than by the volume of referrals that disappear into silence.

The SARHNA provides the evidence of need. This white paper provides the framework for response. It is now the responsibility of New York's rural stakeholders, including legislators, county health departments, hospital administrators, and community leaders, to close the gap.

This white paper draws on content from the **Evidence-Based Best Practices for Rural Behavioral Health Access: A NYSARH Implementation Guide** (Grove & Horner, 2026) and the **Statewide Aggregate Rural Health Needs Assessment: Mental Health and Wellbeing** (Grove & Coates, 2025), available at [nysarh.org/sarhna-mental-health](https://nysarh.org/sarhna-mental-health).

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- 27.** See note 1.
- 28.** See note 21.
- 29.** Substance Abuse and Mental Health Services Administration. (2020). National guidelines for behavioral health crisis care: A best practice toolkit. Bureau of Justice Assistance. <https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/samsha-national-guidelines.pdf>. Source for evidence base on post-crisis follow-up effectiveness; elevated risk of subsequent attempt among ED psychiatric patients discharged without confirmed outpatient follow-up; treatment readiness in the immediate post-crisis window.
- 30.** See note 29.
- 31.** See note 14.
- 32.** See note 14.
- 33.** New York State Office of Mental Health. (2024, December 27). New York State announces awards for 13 Certified Community Behavioral Health Clinics. <https://apps.cio.ny.gov/apps/mediacontact/public/view.cfm?parm=5BBD31B4-DBDE-54E5-8002C3C36431AA9C>. Source for Governor Hochul's \$1 billion mental health plan; CCBHC statewide expansion.
- 34.** See note 14.
- 35.** Parks, J., Svendsen, D., Singer, P., & Foti, M.E. (2006). Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Program Directors (NASMHPD). <https://www.nasmhpd.org/content/morbidity-and-mortality-people-serious-mental-illness>. Source for substantially shortened life expectancy among individuals with serious mental illness compared to the general population, driven in part by undertreated co-occurring physical health conditions.
- 36.** See note 21.
- 37.** See note 14.
- 38.** See note 1.
- 39.** See note 14.
- 40.** New York State Office of Mental Health. (n.d.). CCBHC Prospective Payment System (PPS). <https://omh.ny.gov/omhweb/bho/ccbhc-pps.pdf>. Source for PPS-1 rate for CCBHC Demonstration Program.

**41.** New York State Department of Financial Services, New York State Office of Mental Health, & New York State Office of Addiction Services and Support. (2025). Commercial insurance reimbursement mandate for OMH & OASAS behavioral health outpatient services beginning on and after January 1, 2025. <https://omh.ny.gov/omhweb/bho/commercial-rate-mandate-faqs.pdf> Source for commercial parity mandate requiring insurers to reimburse CCBHCs at no less than the published Medicaid PPS rate.

**42.** Governor Kathy Hochul. (2023, December 6). Governor Hochul announces doubling of Community Behavioral Health Clinics, funding 13 new clinics across New York. New York State Governor's Office. <https://www.governor.ny.gov/news/governor-hochul-announces-doubling-community-behavioral-health-clinics-funding-13-new-clinics>. Source for \$14.7 million FY 2024 budget expansion for CCBHCs, including funding from the state's newly created uncompensated care pool .

**43.** See note 14.

**44.** Dickerson, C., Rosenzweig, C., & Rubin, J. (2022). An Analysis of the Financial Impact of New York State's Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program. NYS Council for Community Behavioral Healthcare. <https://nyscouncil.org/wp-content/uploads/2023/01/NYS-CCBH-CCBHC-financial-analysis-for-distribution-20221219-1.pdf>. Source for financial analysis of CCBHCs in NYS.

**45.** See note 33.

**46.** See note 9.

**47.** See note 9.

**48.** See note 20.

**49.** LePoire, E., Joseph, M., Heald, A., et al. (2024). Barriers and facilitators to collaborative care implementation within the New York State Collaborative Care Medicaid Program. *BMC Health Services Research*, 24, 505. <https://doi.org/10.1186/s12913-024-10909-0>. Source for CoCM billing requirements and reimbursement rates as barriers to implementation, particularly within NYS Medicaid; supports the case for expanding the eligible provider list to reflect actual rural workforce composition.

**50.** See note 1.

**51.** See note 9.

**52.** See note 8.

**53.** See note 13.

**54.** National Rural Health Association. (2024). Bridging the Gap: A Policy Framework for Sustainable Community Paramedicine in Rural America. <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/policy%20brief/nrha-policy-brief-community-paramedicine-final.pdf>. Source for state-level variation in community paramedicine Medicaid reimbursement; barriers to sustainable reimbursement for EMS-delivered behavioral health services; calls for national and state-level reimbursement reform.

**55.** New York Health Foundation & Manatt Health. (2024, July). Ensuring Long-Term Equitable Access to Telehealth in New York State. [https://nyhealthfoundation.org/wp-content/uploads/2024/07/NYHealth\\_Manatt\\_Telehealth\\_Access.pdf](https://nyhealthfoundation.org/wp-content/uploads/2024/07/NYHealth_Manatt_Telehealth_Access.pdf). Source for unresolved payment parity gaps for audio-only telehealth and Article 28 FQHC off-site telehealth reimbursement inequities in New York State; payment parity currently extended only through April 1, 2026.

**56.** See note 14.

**57.** See note 33.

**58.** See note 29.

**59.** See note 1.

**60.** New York State Conference of Local Mental Hygiene Directors. (n.d.). County/New York City Directory. [https://www.clmhd.org/contact\\_local\\_mental\\_hygiene\\_departments/](https://www.clmhd.org/contact_local_mental_hygiene_departments/). Source for SPOA as a county administered structure operated by Local Government Units (LGUs).

**61.** See note 8.