EVIDENCE-BASED BEST PRACTICES FOR RURAL BEHAVIORAL HEALTH ACCESS

A NYSARH Implementation Guide

NYS ASSOCIATION FOR
RURAL HEALTH

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1. Executive Summary

Rural communities across New York State face significant barriers to accessing mental health and substance use disorder (SUD) services, including workforce shortages, geographic isolation, fragmented systems of care, long wait times, and limited access to sustainable funding. These challenges are well documented in the *Statewide Aggregate Rural Health Needs Assessment: Mental Health and Wellbeing* (SARHNA) and related local needs assessments.

This guide is designed for rural county health departments, nonprofit organizations, healthcare providers, schools, hospitals, and community partners working to strengthen behavioral health access and outcomes. It compiles evidence-based and promising practices shown to be effective in rural and underserved settings, drawing on peer-reviewed research, federal and state resources, and implementation experience in comparable communities. This guide contains 34 programs, organized to support prioritization across a range of barriers and local conditions.

This guide functions as a decision and implementation tool, helping communities identify a small number of high-impact strategies aligned with their most pressing needs, available capacity, and organizational readiness. It is not intended to prescribe a single model or require comprehensive adoption. Instead, it provides a structured set of options that can be adapted to local context.

Programs are organized by the primary barriers they address and include evidence strength ratings (Highest, High, Moderate) to support informed prioritization. Each program profile includes implementation steps, estimated costs, funding pathways, and technical assistance resources to support planning and execution. A program selection tool further supports decision-making based on priority barriers, implementation capacity, and county size.

The guide is structured to move from assessment to action. It begins with a quick-start framework for selecting strategies, followed by detailed program profiles, cross-cutting implementation considerations, funding and sustainability guidance, common implementation pitfalls, and example timelines for phased rollout.

Strategies vary in complexity and resource requirements. Some can be implemented within existing infrastructure in a matter of months, while others require multi-year planning and regional collaboration.

By presenting a clear and evidence-informed set of options, this guide supports locally driven decision-making and incremental system improvement.

Ultimately, the goal is to help rural communities translate identified needs into practical, sustainable action that improves access to care and behavioral health outcomes.

Key Features

- Programs organized by the primary barriers they address, cross-referenced to reflect that many address multiple challenges simultaneously

- Evidence strength ratings (Highest / High / Moderate) to support informed prioritization
- Each program profile includes implementation steps, estimated costs, and potential funding sources; everything needed to begin planning in one place
- Funding sources, technical assistance contacts, and sustainability pathways for each program type, with emphasis on Medicaid reimbursement and other ongoing public funding mechanisms rather than short-term grants alone
- A program selection decision tool to support prioritization by barrier, implementation capacity, and county size
- Guidance on common implementation pitfalls and how to avoid them
- Example implementation timelines illustrating phased approaches for counties of different sizes

How This Guide Is Organized

The guide opens with a decision-support framework to help users identify priority barriers and match them to appropriate programs. Detailed implementation guidance, funding resources, and practical tools follow, organized so that users can engage with the sections most relevant to their context without reading the document in full.

Strategies vary in complexity, resource requirements, and implementation timelines. Some can be initiated using existing infrastructure within months, while others require phased development and multi-sector partnerships over one to three years. By presenting a menu of credible options rather than a prescriptive model, this guide supports locally driven decision-making and incremental system improvement.

Ultimately, this guide aims to help communities move from assessment to action, providing clear, evidence-informed choices that fit rural capacity and existing systems.

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2. How to Use This Guide

This section outlines how to select and prioritize a small number of strategies based on local barriers, available capacity, and existing resources. The guide is intended to support focused, feasible action rather than broad or simultaneous implementation.

Step 1: Identify Priority Barriers
Use SARHNA findings, county planning documents, and local data to identify the most pressing behavioral health challenges in your community. Common priority barriers include workforce shortages, long wait times, geographic isolation, crisis response gaps, youth mental health needs, overdose risk, co-occurring conditions, housing instability, stigma, and older adult isolation.

Step 2: Match Programs to Barriers
Use Section II (Programs Organized by Primary Barrier) to identify programs that directly address your highest-priority challenges. Programs are cross-referenced where relevant, but each includes a primary placement to support navigation.

Step 3: Assess Local Capacity and Readiness
For each program, assess:

- Evidence strength (Highest, High, Moderate)
- Resource requirements (staffing, funding, infrastructure)
- Partnership needs (healthcare, schools, law enforcement, community organizations)
- Implementation timeline (3–6 months vs. 1–3 years)

Step 4: Select a Small Number of Strategies
Select up to 2 to 5 strategies aligned with identified barriers and available capacity. Limiting initial selection improves feasibility, sustainability, and the ability to measure progress.

Step 5: Identify Funding and Technical Assistance
Use Section III (Cross-Cutting Implementation Considerations) to identify funding sources, reimbursement pathways, and technical assistance resources to support implementation.

Step 6: Plan for Phased Implementation
Distinguish between near-term actions that can be implemented quickly and longer-term system investments that require additional planning, partnerships, and resources.

Step 7: Revisit and Expand Over Time
Reassess priorities as capacity, partnerships, and funding evolve. Additional strategies may become feasible as initial programs are implemented and sustained.

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3. Purpose and Scope

Purpose

This document provides a practical resource for counties, nonprofit organizations, healthcare providers, schools, hospitals, and community partners working to improve access to mental health and substance use disorder (SUD) services in rural and underserved communities.

Building on findings from the *Statewide Aggregate Rural Health Needs Assessment: Mental Health and Wellbeing* (SARHNA), it moves beyond identifying needs to focus on actionable strategies. The guide translates local assessment findings into a curated set of evidence-based and rural-tested programs that address persistent challenges such as workforce shortages, long wait times, youth mental health needs, overdose risk, transportation barriers, and gaps in crisis services.

This guide includes 34 programs, each selected for relevance to rural settings, feasibility of implementation, and potential for sustainable impact. Programs are organized to support rapid decision-making, allowing counties to quickly identify:

- What each program does
- Which barriers it addresses
- Why it is effective in rural contexts
- Typical implementation timelines
- Required partnerships
- Available pathways for sustainable funding, including Medicaid reimbursement

Alignment with SARHNA Findings

The programs and strategies in this guide directly respond to barriers identified through SARHNA (Grove & Coates, 2025) and related local needs assessments across rural New York counties. These include:

- Severe shortages of psychiatrists, therapists, and SUD treatment providers
- Extended wait times for outpatient care
- Geographic isolation and transportation barriers
- Limited crisis infrastructure, with law enforcement often serving as default responders
- A youth mental health crisis with insufficient school-based supports
- Rising overdose mortality driven by fentanyl and limited harm reduction capacity
- Fragmented systems requiring individuals to navigate multiple disconnected providers
- Housing instability and poverty contributing to unmet behavioral health need
- Stigma and engagement challenges that limit service utilization
- Elevated suicide risk among older adults linked to isolation and limited access to care

Each program is matched to one or more of these barriers, with cross-references reflecting the interconnected nature of these challenges.

Focus on Rural Mental Health and Substance Use Systems

Rural communities face structural constraints that require different solutions than those used in urban or suburban settings. This guide prioritizes models that have demonstrated effectiveness in rural contexts, including:

- Telehealth and technology-enabled care that extends specialist access across large geographic areas
- Mobile and community-based services that bring care directly to individuals

- Integrated care models that embed behavioral health within primary care, schools, and other trusted settings
- Peer and recovery-oriented supports that improve engagement among underserved populations
- Regional and multi-county approaches that allow smaller counties to share resources and sustain services

The guide is intended to support coordinated, cross-sector efforts to strengthen behavioral health access and outcomes across rural New York.

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4. Methodology and Evidence Sources

This guide is based on a systematic review of evidence-based and promising practices in behavioral health and substance use disorder (SUD) care, with a focus on effectiveness in rural and underserved settings. Programs were identified, evaluated, and selected using established federal, state, and research-based sources, along with documented implementation experience in rural communities.

AI-assisted tools were used to support literature review and program verification; all content was reviewed and approved by the authors.

Evidence-Based and Promising Practices
Programs included in this guide fall into two categories:

- **Evidence-based practices** are supported by rigorous research, including randomized controlled trials (RCTs), meta-analyses, and multi-site evaluations demonstrating consistent positive outcomes across populations and settings. These programs have established implementation infrastructure, including training resources, fidelity measures, and sustainable funding pathways.
- **Promising practices** have a growing evidence base, including observational studies, pilot evaluations, or strong theoretical support. These programs are included when they address gaps not fully covered by established evidence-based models or when rural implementation experience indicates meaningful impact.

Evidence strength reflects how rigorously a program has been evaluated:

- **Highest:** Multiple randomized controlled trials (RCTs), meta-analyses, or Cochrane reviews with consistent positive outcomes across populations and settings
- **High:** Strong research base with documented rural effectiveness; published evaluations; recognized by federal evidence clearinghouses
- **Moderate:** Promising practices with strong early evidence; pilot data or program evaluations with positive outcomes in rural or comparable settings

Evidence strength ratings included herein were assigned during the development of this implementation guide and may differ from ratings assigned using different methodology, such as in *County Health Rankings & Roadmaps* (CHR).

Complexity Ratings

Each program is assigned a complexity rating (Low, Low to Medium, Medium, Medium to High, or High) based on five factors:

1. Resource requirements (staffing, funding, infrastructure)
2. Number and type of partners required
3. Implementation timeline
4. Degree of organizational change required
5. Funding complexity and sustainability pathways

These ratings reflect implementation demands, not program importance. Higher-complexity programs may require greater investment and longer timelines but can offer substantial long-term impact. Lower-complexity programs can often be implemented more quickly and serve as entry points for system development.

Data Sources and Clearinghouses

Programs were identified and vetted using multiple established sources, including:

- Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices Resource Center
- Campbell and Cochrane systematic reviews and meta-analyses
- County Health Rankings and Roadmaps (CHR): What Works for Health
- HRSA Office of Rural Health Policy program evaluations
- Rural Health Information Hub (RHIhub)
- HD Pulse Interventions Portal
- New York State Office of Addiction Services and Supports (OASAS) and Office of Mental Health (OMH) resources
- Peer-reviewed literature in behavioral health, rural health, and health services research
- Federal agency program evaluations (SAMHSA, HRSA, CDC, NIH, CMS)
- Documented implementation experience from rural New York counties

Criteria for Inclusion

Programs were selected based on the following criteria:

1. Demonstrated effectiveness in rural or underserved settings
2. Direct relevance to SARHNA-identified barriers
3. Feasibility within typical rural capacity constraints
4. Potential for sustainable funding, particularly through Medicaid or ongoing public programs
5. Availability of implementation support, including training, technical assistance, or established networks

Development of Program Profiles

Program profiles were developed through synthesis of implementation guides, toolkits, and technical assistance resources from federal agencies, rural health clearinghouses, and program-specific materials. Implementation steps, cost estimates, and partnership requirements were adapted to reflect the capacity constraints and service environments typical of rural New York counties.

Section I: Quick-Start Guide: Selecting and Prioritizing Programs

This section is designed to help counties move quickly from identifying needs to selecting a manageable set of programs to implement. It combines a priority barrier reference table, a program overview by complexity, and a step-by-step decision tool.

For full program profiles, implementation steps, and funding details, see Section II (Programs Organized by Primary Barrier) and Section III (Cross-Cutting Implementation Considerations).

Note on County Health Rankings and Roadmaps (CHR)

County Health Rankings and Roadmaps (CHR), including the Model of Health and What Works for Health database, provides evidence on upstream social and structural factors that influence behavioral health outcomes. CHR strategies are intended to complement the programs in this guide by strengthening conditions that support access, engagement, and long-term outcomes.

Part A1: Priority Barrier Reference Table

Use this table to quickly locate programs aligned with your highest-priority challenges.

Priority Barrier	Go To Section
Co-occurring mental health and substance use	II-G Co-Occurring Disorders

Priority Barrier	Go To Section
Crisis infrastructure gaps	II-D Crisis Infrastructure Gaps
Fragmentation and coordination gaps	II-I Fragmentation and Coordination Gaps
Geographic isolation and transportation barriers	II-B Geographic Isolation and Transportation Barriers
Housing instability and poverty	II-H Housing Instability and Poverty
Long wait times	II-C Long Wait Times
Older adult suicide and isolation	II-K Older Adult Suicide and Isolation
Overdose deaths	II-F Opioid/Overdose Deaths
Stigma and engagement failure	II-J Stigma and Engagement Failure
Workforce shortages	II-A Workforce Shortages
Youth mental health crisis	II-E Youth Mental Health Crisis

Part A2: Program Reference Table by Level of Complexity

The table below summarizes all programs included in this guide, organized by implementation complexity to help communities identify realistic starting points.

How to use this table:

- Start with your top priority barriers, identified through SARHNA or local data
- Filter by complexity and capacity: lower-complexity programs are good starting points for communities with limited resources
- Use the timeline column to distinguish quick wins from longer-term investments

LOW COMPLEXITY

Good starting points for most communities

Program	Barriers Addressed	Estimated Timeline	Key Partners
CA Bridge Program	Primary: Long Wait Times Secondary: Opioid/Overdose Deaths	3–6 months	Hospitals, emergency departments
NAMI Family-to-Family	Primary: Stigma & Engagement Failure	3–6 months	NAMI affiliates

Program	Barriers Addressed	Estimated Timeline	Key Partners
Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)	Primary: Workforce Shortages Secondary: Stigma & Engagement Failure	3–6 months	OASAS-certified providers, recovery community organizations
Prevention Resource Centers (OASAS)	Primary: Youth Mental Health Crisis	3–6 months	OASAS, schools
SBIRT (Screening, Brief Intervention, and Referral to Treatment)	Primary: Youth Mental Health Crisis Secondary: Workforce Shortages	3–6 months	Primary care, FQHCs, school-based health centers
Social Support Programs for Isolated Older Adults	Primary: Older Adult Suicide & Isolation	3–6 months	Senior centers, aging services, Area Agencies on Aging
Telehealth and Telepsychiatry (suite of models – Section II-A, Program 4)	Primary: Workforce Shortages Secondary: Geographic Isolation & Transportation, Long Wait Times, Youth Mental Health Crisis, Older Adult Suicide & Isolation	3-6 months	Academic medical centers, telepsychiatry vendors, hospitals, public libraries, nursing homes, schools

LOW TO MEDIUM COMPLEXITY

Program	Barriers Addressed	Estimated Timeline	Key Partners
Data-Driven Overdose Surveillance with Public Dashboards	Primary: Opioid/Overdose Deaths Secondary: Fragmentation & Coordination Gaps	3–6 months	Public health departments, hospitals, EMS, county data teams
Harm Reduction Programs & Syringe Services Programs	Primary: Opioid/Overdose Deaths	3-6 months	OASAS, recovery community organizations, EMS, health department
MATTERS Network	Primary: Long Wait Times	3–6 months (if joining existing network)	Statewide network, local MOUD providers, hospitals

Program	Barriers Addressed	Estimated Timeline	Key Partners
Collaborative Care Model (CoCM)	Primary: Workforce Shortages Secondary: Long Wait Times, Fragmentation & Coordination Gaps	6–12 months	Primary care, psychiatric consultant, care manager
Family Support Navigators	Primary: Stigma & Engagement Failure	6–12 months	Behavioral health providers, OASAS
Recovery Community Centers & Recovery Community and Outreach Centers	Primary: Stigma & Engagement Failure	6–12 months	Recovery organizations, OASAS
School-Based Health and Mental Health Centers	Primary: Youth Mental Health Crisis Secondary: Geographic Isolation & Transportation, Stigma & Engagement Failure	6–12 months	Schools, local mental health providers, FQHCs

MEDIUM COMPLEXITY

Program	Barriers Addressed	Timeline	Key Partners
Centers of Treatment Innovation (COTIs) and Mobile Treatment Vans	Primary: Geographic Isolation & Transportation Secondary: Opioid/Overdose Deaths	6–12 months	OASAS-licensed providers, peer specialists, transportation services
Community Paramedicine Behavioral Health Programs	Primary: Geographic Isolation & Transportation Secondary: Crisis Infrastructure Gaps, Stigma & Engagement Failure, Older Adult Suicide & Isolation, Fragmentation & Coordination Gaps	6–12 months	EMS agencies, hospitals, OASAS providers
Cross-Walk Program (Integrated Care in Primary Care)	Primary: Co-Occurring Mental Health & Substance Use Disorders	6–12 months	Primary care practices, FQHCs

Program	Barriers Addressed	Timeline	Key Partners
Mobile Medication Units (MMUs)	Primary: Geographic Isolation & Transportation Secondary: Opioid/Overdose Deaths	6–12 months	Licensed OTP providers, OASAS, municipalities
Recovery Residences (Certified Sober Living)	Primary: Housing Instability & Poverty	6–12 months	NYSARR, OASAS, recovery community organizations
Rural Outreach Center (ROC) Model	Primary: Housing Instability & Poverty Secondary: Fragmentation & Coordination Gaps	6–12 months	Faith communities, social services agencies, nonprofits
Youth Clubhouses	Primary: Youth Mental Health Crisis Secondary: Stigma & Engagement Failure	6–12 months	Schools, nonprofits, OASAS
24/7 Open Access Centers	Primary: Long Wait Times Secondary: Crisis Infrastructure Gaps	12–18 months	OASAS, local SUD providers, hospitals

MEDIUM TO HIGH COMPLEXITY

Program	Barriers Addressed	Timeline	Key Partners
AmericaServes and NYServes Coordinated Referral Networks	Primary: Fragmentation & Coordination Gaps	6–12 months	Multi-sector coalitions, IVMF at Syracuse University
Crisis Now Model (988 + Mobile Crisis + Stabilization Centers)	Primary: Crisis Infrastructure Gaps	12–24 months	OMH, OASAS, EMS, hospitals, 988 centers
Recovery-Oriented System of Care (ROSOC) and Whole-Person Care	Primary: Housing Instability & Poverty Secondary: Fragmentation & Coordination Gaps	12–24 months	Hospitals, correctional facilities, counties
Rural Mental Health Workforce Pipeline Programs	Primary: Workforce Shortages	12–24 months	Universities, AHECs, rural clinics

HIGH COMPLEXITY

Requires significant resources, multi-agency partnerships, and lead time

Program	Barriers Addressed	Timeline	Key Partners
Assertive Community Treatment (ACT) and Flexible ACT	Primary: Geographic Isolation & Transportation	12–18 months	OMH, multidisciplinary clinical team
Certified Community Behavioral Health Clinics (CCBHCs)	Primary: Co-Occurring Mental Health & Substance Use Disorders Secondary: Long Wait Times, Housing Instability & Poverty, Fragmentation & Coordination Gaps	12–24 months	State certification (OMH), Medicaid, local providers
HEALing Communities Study Model & Healing Cayuga	Primary: Opioid/Overdose Deaths Secondary: Fragmentation & Coordination Gaps	12–24 months	Public health departments, community coalitions, health systems, university partner
Permanent Supportive Housing (PSH) for SUD	Primary: Housing Instability & Poverty	12–24 months	Housing authorities, HUD, OASAS
RCORP Consortiums (Rural Communities Opioid Response Program)	Primary: Long Wait Times Secondary: Workforce Shortages, Opioid/Overdose Deaths, Fragmentation & Coordination Gaps	12–24 months	HRSA grant, hospitals, multiple counties
Regional Behavioral Health Networks	Primary: Fragmentation & Coordination Gaps	12–24 months	Regional partnerships, hospitals, health departments
SPOA and Regional Crisis and Step-Down Capacity	Primary: Crisis Infrastructure Gaps Secondary: Fragmentation & Coordination Gaps	12–24 months	Counties, OMH, all intensive service providers
Vermont Hub and Spoke Model	Primary: Long Wait Times Secondary: Geographic Isolation & Transportation, Opioid/Overdose Deaths, Co-Occurring Mental Health & Substance Use Disorders	12–24 months	Regional specialty center, primary care network, OASAS

Part B: Rapid Selection Guide

Use this section as a quick reference to identify high-fit strategies based on your primary barrier, implementation capacity, and available funding. This is intended as a shortcut to support decision-making, not a replacement for the step-by-step process above.

Step 1: Start with your highest-priority barrier

Focus on one priority barrier to start. Select programs with the strongest evidence and most direct impact.

Examples of how you might begin exploring different options starting with a priority barrier (*subset of barriers shown below; other program options not listed here may also be appropriate within your context*):

- **Workforce Shortages**
    - Start with: Collaborative Care Model (CoCM)
    - Also consider: Telehealth & Telepsychiatry Suite, Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)
- **Long Wait Times**
    - Start with: MATTERS Network and CA Bridge Program
    - Also consider: 24/7 Open Access Centers, Vermont Hub and Spoke Model
- **Youth Mental Health Crisis**
    - Start with: School-Based Health & Mental Health Centers and SBIRT
    - Also consider: Telehealth & Telepsychiatry Suite, programs listed under Prevention & Early Intervention
- **Opioid/Overdose Deaths**
    - Start with: Harm Reduction Programs & Syringe Services Programs and Data-Driven Overdose Surveillance with Public Dashboards
    - Also consider: Mobile Medication Units (MMUs), HEALing Communities Study Model & Healing Cayuga
- **Crisis Infrastructure Gaps**
    - Start with: mobile crisis teams (within Crisis Now model)
    - Also consider: stabilization centers (within Crisis Now model), Community Paramedicine Behavioral Health Programs
- **Geographic Isolation & Transportation**
    - Start with: Telehealth & Telepsychiatry Suite and programs listed under Bring Services to People
    - Also consider: programs listed under Create Coordination Infrastructure

- **Housing Instability & Poverty**
  - Start with: Recovery Residences (Certified Sober Living)
  - Also consider: Permanent Supportive Housing (PSH) for SUD
- **Fragmentation & Coordination Gaps**
  - Start with: AmericaServes and NYServes Coordinated Referral Networks
  - Also consider: Single Point of Access (SPOA) & Regional Crisis and Step-Down Capacity, Regional Behavioral Health Networks

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Step 2: Match to your current implementation capacity

Examples of how you might begin exploring different options based on implementation capacity (*other program options not listed below may also be appropriate within your context*):

- **Low capacity (limited staff and funding)**
  - SBIRT
  - Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)
  - Join existing networks (MATTERS Network, Prevention Resource Centers)
  - Telehealth & Telepsychiatry Suite using existing infrastructure
- **Moderate capacity**
  - Collaborative Care Model (CoCM)
  - School-Based Health & Mental Health Centers
  - Harm Reduction Programs & Syringe Services Programs
  - Mobile crisis teams (within Crisis Now model)
- **High capacity**
  - Certified Community Behavioral Health Clinics (CCBHCs) development
  - Vermont Hub and Spoke Model systems
  - RCORP Consortiums
  - Crisis stabilization centers (within Crisis Now model)

Step 3: Confirm sustainable funding options

Prioritize programs with clear reimbursement or ongoing funding. (Note: funding options may change over time. Verify current funding options as part of the planning process.)

Examples of how you might begin exploring different program options based on funding sustainability (*other program options not listed below may also be appropriate within your context*):

- **Medicaid-reimbursable services**
    - Collaborative Care Model (CoCM)
    - School-Based Health & Mental Health Centers
    - Telehealth & Telepsychiatry Suite
    - Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)
    - Certified Community Behavioral Health Clinics (CCBHCs)
- **Federal funding (multi-year)**
    - RCORP Consortiums
    - SAMHSA grants
    - HRSA grants
- **State-supported programs**
    - OMH and OASAS initiatives
    - Prevention Resource Centers (OASAS)

Avoid launching programs dependent solely on short-term grants without a sustainability plan.

Step 4: Adjust based on county size and structure

Examples of how you might begin exploring different options or combinations of options based on county size and structure (*other program options not listed below may also be appropriate within your context*):

- **Very small counties (<30,000)**
    - Prioritize regional partnerships
    - Use an option within the Telehealth & Telepsychiatry Suite and integrated primary care
    - Implement Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)
- **Small to medium counties (30,000 to 100,000)**
    - Combine Collaborative Care Model (CoCM), School-Based Health & Mental Health Centers, and SBIRT
    - Add mobile crisis (within the Crisis Now model) or Harm Reduction Programs & Syringe Services Programs

- **Larger counties (>100,000)**
    - Consider system-level approaches such as Certified Community Behavioral Health Clinics (CCBHCs), Crisis Now, and Vermont Hub and Spoke Model

Part C: Integrating Upstream Strategies

Programs in this guide focus on service delivery. Upstream strategies addressing broader community conditions, detailed by frameworks such as the University of Wisconsin Population Health Institute Model of Health, can strengthen the effectiveness of these programs.

Key domains to support rural behavioral health include:

- **Housing stability**
  Supports ACT, crisis response, and recovery systems
- **Transportation access**
  Improves treatment engagement and retention
- **Broadband and digital access**
  Enables telehealth and remote care
- **Economic supports for families**
  Reduces risk and improves long-term outcomes

Rural communities may pursue these strategies alongside program implementation to improve utilization, equity, and sustainability.

Section II: Programs Organized by Primary Barrier

This section presents evidence-based and promising programs organized by the primary barriers they address. Each subsection begins with a summary of the relevant challenge, based on findings from the *Statewide Aggregate Rural Health Needs Assessment: Mental Health and Wellbeing* (SARHNA) and related local data.

Programs are designed to be used individually or in combination. Many address multiple barriers and are cross-referenced accordingly. Where a program appears more than once, the full description is provided at its first occurrence.

Each program profile includes:

- A brief description of the model
- Rationale for effectiveness in rural settings

- Evidence strength (Highest, High, Moderate)
- Implementation complexity
- Step-by-step implementation guidance
- Estimated costs and funding pathways
    - *Note*: cost estimates and funding pathways may vary over time and by program type, region, available resources, etc.
- Key partners
    - *Note*: References to specific agencies or organizations in program profiles, including under "Key partners," are for illustrative purposes only and do not imply the availability of active partnership opportunities.

Programs are grouped into immediate-term and medium- to long-term strategies to support phased implementation.

A. Workforce Shortages (Psychiatrists, Therapists, SUD Specialists)

SARHNA Challenge: Most rural counties have few or no psychiatrists, critical vacancies for therapists and licensed counselors, little to no access to child psychiatrists, and insufficient substance use disorder treatment providers. This shortage is not simply a matter of recruitment. It reflects decades of underinvestment in rural training pipelines, limited loan repayment incentives, and working conditions that make rural practice difficult to sustain. The result is that primary care providers are often the only point of contact for residents with behavioral health needs, frequently without the training, time, or backup support to address those needs effectively (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) SBIRT and RCORP Consortiums.

Increasing Access to Peer & Professional Support

1. Collaborative Care Model (CoCM)

What it is: Embeds a behavioral health care manager and psychiatric consultant into primary care settings.

Why it works: One remote psychiatrist can support 30 to 50 rural primary care practices, expanding the reach of limited psychiatric resources.

Evidence: Highest. Supported by 80 or more randomized controlled trials (RCTs); meta-analyses show twice the remission rates (50% vs. 25%) for depression compared to usual care.

Complexity: Low to Medium

Implementation:

1. Identify 2 to 3 primary care practices willing to participate (FQHCs are ideal).
2. Hire or reassign one behavioral health care manager (can be a Licensed Master Social Worker, Licensed Clinical Social Worker, or Registered Nurse with specialized training in behavioral health care management, including measurement-based care and registry management).
3. Contract with an academic medical center or telepsychiatry vendor for psychiatric consultation (1 to 2 hours per week per practice).
4. Train primary care staff on screening tools (Patient Health Questionnaire-9, or PHQ-9, and Generalized Anxiety Disorder-7, or GAD-7).
5. Implement a registry system for tracking patients.
6. Bill using CPT codes 99492 to 99494 (covered by Medicare and Medicaid since 2017).

Estimated cost: $60,000 to $80,000 per year for care manager; $100 to $150 per hour for psychiatric consultation.

Key partners: Academic medical centers (such as SUNY Upstate, Columbia, and UR Medicine) and telepsychiatry vendors (such as Iris Telehealth and InSight).

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2. Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)

What it is: People with lived experience of substance use disorder (SUD) or mental health recovery provide outreach, navigation, coaching, and harm reduction.

Why it works: Bypasses clinician shortages. Peers excel at engagement with populations that avoid traditional services, building trust where clinical staff often cannot.

Evidence: High. Meta-analyses show increased treatment engagement, reduced relapse, and improved social supports among individuals served by peer recovery programs.

Complexity: Low

Implementation:

1. Partner with an OASAS-certified peer training program.
2. Recruit individuals with one or more years of recovery and willingness to be trained.
3. Complete the 46-hour CRPA certification training.
4. Embed peers in emergency departments, correctional facilities, outreach teams, treatment programs, and recovery centers.
5. Bill Medicaid for peer services under Peer Engagement and Retention Services.

Estimated cost: $35,000 to $45,000 per year per peer advocate; approximately $1,500 per person for training.

Key partners: OASAS, local recovery community organizations, treatment providers.

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3. Rural Mental Health Workforce Pipeline Programs

What it is: Partnerships with universities to create supervised training placements in rural schools and clinics, with pathways to convert interns and residents into permanent staff. Programs can include social work, counseling, psychology, as well as nursing, physician assistant training, and other health professions given the important role of primary care in rural behavioral health.

Why it works: Clinicians trained in rural settings are significantly more likely to remain in rural practice. Exposure during training is one of the strongest predictors of rural career choice.

Evidence: High. HRSA workforce evaluations document improved retention when training occurs in underserved settings.

Complexity: Medium to High

Implementation:

1. Approach social work, counseling, psychology, nursing, primary care, and/or other health professions training programs at regional universities (such as SUNY schools and Syracuse University) as well as Area Health Education Centers (AHECs) engaged in healthcare workforce training focused on medically underserved areas (including rural communities).
2. Offer robust field placements with strong supervision. Where a rural clinic or school does not have an on-site licensed professional available to supervise, remote supervision options should be explored and arranged through the university partner.
3. Provide stipends or tuition assistance in exchange for a 2- to 3-year rural practice commitment.
4. Create a clear transition pathway from intern to employed clinician.
5. Apply for National Health Service Corps (NHSC) or New York State loan repayment for recruited clinicians.

Estimated cost: $10,000 to $20,000 per year per student stipend, plus supervisor time.

Funding sources: HRSA Behavioral Health Workforce Education and Training (BHWET) grants; New York State OMH and OASAS workforce initiatives.

Key partners: University social work, counseling, psychology, primary care, and/or other health professions training programs; school districts; rural clinics as placement sites; AHECs.

4. Telehealth and Telepsychiatry: A Suite of Access Models

What it is: A set of technology-enabled approaches that extend psychiatric, behavioral health, and substance use expertise across rural geographies. Rather than a single program, telehealth and telepsychiatry represent a range of implementation models that share an evidence base and can be tailored to different settings, partners, and target populations.

Why it works: Telehealth fundamentally addresses the core rural behavioral health access problem: there are not enough specialists in rural areas, but technology allows one specialist to reach many patients and providers across a large geography. Different models address different access gaps — from specialist shortages at the provider level, to direct patient care, to institutional integration in schools, hospitals, and nursing homes.

Evidence: High to Highest across models. The telehealth evidence base is robust and consistently demonstrates improved access, reduced wait times, and outcomes comparable to in-person care for most behavioral health conditions.

Overview of models:

a. Project ECHO (Extension for Community Healthcare Outcomes)

Regular video case conferences linking specialists with rural providers for mentoring and case-based learning. Multiplies expertise without requiring recruitment. Rural providers gain skills to treat conditions they previously had to refer out. The federal ECHO Act was passed in 2016 in recognition of the model's effectiveness.

- Partners: Academic hubs such as SUNY Upstate, UR Medicine, Columbia, Bassett Healthcare
- Costs: Hub participation is often free through HRSA or state grants
- Technical assistance: Project ECHO Institute (projectecho.unm.edu)

b. Direct Telepsychiatry (Clinical Care)

Psychiatrists provide direct diagnostic evaluations, medication management, and follow-up to patients via video, without requiring travel. One psychiatrist can serve patients across multiple counties.

- Partners: Telepsychiatry vendors (such as Iris Telehealth, InSight Telepsychiatry), academic medical centers, hospitals
- Costs: Billed to Medicaid and commercial insurance; typically $150 to $250 per appointment

c. Academic-Rural Telepsychiatry Partnerships

Formal partnerships in which university psychiatry departments provide telepsychiatry, consultation, and training to rural provider networks. Universities have psychiatrists and residents seeking practice experience; rural areas gain stable psychiatric access without needing to recruit and retain full-time on-site staff. Multi-year New York partnerships show reduced wait lists, increased provider confidence, and stable utilization over time.

- Partners: Academic medical centers such as SUNY Upstate, UR Medicine, NYU, Columbia. An example of an existing partnership is the Finger Lakes Rural Telepsychiatry program through UR Medicine.
- Implementation: Negotiate an MOU covering telepsychiatry services, consultation, and resident rotations; ensure a Medicaid reimbursement pathway; create a regional hub-and-spoke structure if multiple counties are participating
- Costs: Typically billed to insurance; universities may provide discounted rates for training sites

d. Academic-Rural School Telepsychiatry Partnerships

University-based child psychiatrists provide telepsychiatry services to school-based programs and pediatric primary care practices. Addresses the near-complete absence of child psychiatry in rural areas. One child psychiatrist providing services via telehealth can serve students across multiple school districts. New York partnerships show reduced wait lists and high satisfaction among students, families, and school staff.

- Partners: Child psychiatry departments at SUNY Upstate, UR Medicine, Columbia; school districts; school-based health centers; telehealth training providers
- Implementation: Negotiate services covering medication management, diagnostic evaluations, and consultation to school-based therapists; ensure schools have appropriate telehealth space, adequate technology, and that school staff have received training on telehealth workflows and processes.
- Costs: Typically $150 to $250 per appointment, billed to Medicaid and commercial insurance

e. Rural Hospital Telehealth Behavioral Health Integration

Small rural hospitals contract with psychiatric teleconsultants for emergency department evaluations, inpatient consultations, and outpatient therapy. Turns rural hospitals into behavioral health hubs without requiring on-site psychiatrists and reduces costly transfers to distant hospitals. Multi-hospital evaluations show reduced wait times, reduced transfers, and increased outpatient access.

- Partners: Telepsychiatry vendors, academic medical centers, hospital administration
- Costs: Billed to insurance; infrastructure investment of $20,000 to $50,000 may be required
- Funding: Hospital operating budget; Critical Access Hospital programs; telehealth infrastructure grants

f. Rural Library Telehealth Hubs

Public libraries provide private space, connectivity, devices, and support staff to enable telehealth visits for residents who lack adequate home broadband, computer devices, or privacy. Eliminates the broadband and device access barrier for rural residents. Pilot implementations in New York and other states suggest that public libraries can effectively host telehealth visits and reduce broadband and device-related access barriers.

- Partners: Public library systems, telehealth providers, FQHCs, digital equity coalitions

- Costs: Minimal; uses existing library infrastructure. Possible device purchases of $1,000 to $3,000.
- Funding: Library construction grants; county health department; New York State ConnectALL Office broadband and digital equity grants

g. Nursing Home Telepsychiatry

Psychiatrists provide virtual consultations to nursing home residents via video, including psychiatric evaluations, medication reviews, and medication adjustments. Nursing homes in rural areas lack on-site psychiatric access, and travel to specialty care may not be feasible for residents. Telepsychiatry brings psychiatric expertise directly to residents, treating the late-life depression that is strongly linked to suicide risk in older adults.

- Partners: Academic medical centers and telepsychiatry vendors. An example of an existing program is UVM Medical Center, which provides telepsychiatry to nursing homes in rural New York and Vermont including Alice Hyde Medical Center in Malone, New York.
- Costs: Typically $150 to $250 per appointment, billed to Medicare or Medicaid
- Implementation note: Train nursing home staff on telepsychiatry workflows and processes. Staff may also need foundational digital skills training as a prerequisite, depending on their familiarity with video technology.

General implementation steps (applicable across models):

1. Assess broadband capacity at all sites before selecting a model.
2. Ensure a HIPAA-compliant video platform is in place.
3. Create private, quiet spaces for telehealth visits.
4. Train staff on telehealth workflows and technology troubleshooting.
5. Develop backup plans for technology failures (e.g., switching to a phone appointment if video fails).
6. Verify credentialing and licensure requirements for out-of-state providers.
7. Confirm Medicaid and insurance reimbursement pathways before launch.
8. Partner with public libraries for patients who lack adequate home broadband or devices.

B. Geographic Isolation and Transportation Barriers

SARHNA Challenge: Rural counties cover large geographic areas, and residents may need to travel significant distances to reach the nearest mental health or SUD treatment provider. Transportation is a leading cause of missed appointments, treatment dropout, and delayed care. Counties cover hundreds of square miles, and public transit is largely absent (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Telehealth & Telepsychiatry Suite, School-Based Health & Mental Health Centers, and Vermont Hub and Spoke Model.

Bring Services to People (Rather Than Transport People to Services)

5. Mobile Medication Units (MMUs)

What it is: State-licensed mobile extensions of opioid treatment programs providing methadone, buprenorphine, and counseling from vehicles traveling regular routes to underserved communities.

Why it works: Eliminates lengthy daily round trips required for methadone dosing, which is one of the most significant transportation barriers faced by individuals in treatment for opioid use disorder (Grove & Coates, 2025).

Evidence: High. Federal evaluations show increased treatment continuity, improved retention, and reduced missed doses in rural regions served by mobile units.

Complexity: Medium

Implementation:

1. Identify a licensed opioid treatment program (OTP) willing to sponsor a mobile unit.
2. Acquire and equip a vehicle with medication storage and a private counseling space.
3. Apply for OASAS mobile licensure.
4. Hire and onboard MMU clinical and support staff.
5. Map routes to underserved towns, scheduling 2 to 3 days per week at each location.
6. Partner with local venues such as libraries, community centers, and fire stations for parking locations.

Estimated cost: $200,000 to $300,000 for vehicle acquisition; $150,000 to $200,000 in annual operating costs including staff, fuel, and maintenance.

Funding sources: OASAS mobile medication unit expansion grants; SAMHSA; local hospitals.

Key partners: Licensed OTPs, OASAS, municipalities for parking locations.

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6. Centers of Treatment Innovation (COTIs) and Mobile Treatment Vans

What it is: Mobile vans equipped with telehealth technology, exam space, and peer support that bring medication for opioid use disorder (MOUD), counseling, and connections to care directly to communities.

Why it works: Broader than mobile medication units. Provides counseling, peer support, outreach, transportation assistance, and insurance navigation in addition to medication, reaching populations not accessing brick-and-mortar clinics.

Evidence: High. More than 13,000 New Yorkers have been engaged through COTIs, including populations not reached by traditional clinic-based services.

Complexity: Medium

Implementation:

1. Apply for OASAS COTI designation (if expanding an existing provider) or contract with an existing COTI.
2. Equip the van with telehealth technology and a private counseling space.
3. Embed a peer engagement specialist.
4. Create a regular schedule visiting underserved areas including parks, libraries, and community events.
5. Offer transportation vouchers for appointments that must be in-person.

Estimated cost: Similar to mobile medication units. OASAS COTIs receive dedicated state funding.

Funding sources: OASAS COTI program; initial federal investment totaling more than $30 million supported COTI expansion in New York State. Ongoing funding availability varies by fiscal year and region.

Key partners: OASAS-licensed providers, peer specialists, transportation services, telehealth platform vendors, IT support providers, broadband or connectivity partners.

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7. Assertive Community Treatment (ACT) and Flexible ACT

What it is: Multidisciplinary teams including psychiatrists, nurses, peers, and vocational staff who provide intensive mental health and SUD services directly in clients' homes and communities.

Why it works: Goes to people who cannot reliably travel to clinics, preventing hospitalizations and keeping individuals with serious mental illness connected to care.

Evidence: Highest. Decades of RCTs and Cochrane reviews confirm effectiveness; consistent reductions of 50% or more in hospitalization rates.

Complexity: High

Implementation:

1. Apply for OMH ACT licensing (standard ACT, or Flexible ACT, which is designed specifically for rural areas with smaller required team sizes).
2. Assemble a multidisciplinary team.

3. Enroll individuals with serious mental illness and high rates of hospitalization or emergency department use.
4. Provide intensive community-based services including psychiatry, nursing, peer support, vocational assistance, and housing support.
5. Use fidelity scales to ensure model integrity.

Estimated cost: $800,000 to $1,200,000 annually for a full ACT team of 10 to 15 staff. Flexible ACT teams are smaller and less costly, making them more feasible for rural counties with lower population density and smaller caseloads.

Funding sources: Medicaid Home and Community-Based Services waiver; OMH grants; county mental health funding.

Key partners: OMH, hospitals, community mental health centers.

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8. Community Paramedicine Behavioral Health Programs

What it is: Emergency medical services (EMS) providers conduct home follow-ups for post-overdose outreach, suicide risk checks, mental health and SUD monitoring, and rapid treatment referral.

Why it works: Uses an existing geographically distributed workforce that already reaches every rural address. Dramatically improves post-crisis engagement at a time when individuals are often most open to connecting with services.

Note: Rural EMS agencies often face service gaps in behavioral health triage, post-crisis follow-up, and long-distance psychiatric transport, contributing to system strain and repeat utilization.

Evidence: Moderate to High. Rural pilots show improved post-overdose engagement, reduced hospitalization, and higher treatment connection rates.

Complexity: Medium

Implementation:

1. Assess EMS agency interest and capacity (many rural agencies are eager for an expanded role).
2. Provide behavioral health training to EMS providers, including Mental Health First Aid (a standardized training program offered by the National Council for Mental Wellbeing), motivational interviewing, suicide risk assessment, and naloxone administration. Identify appropriate training providers as part of planning; note that some trainings require certified instructors.
3. Create protocols for post-overdose and post-crisis follow-up within 24 to 72 hours.
4. Partner with MOUD and mental health providers for rapid warm handoffs (direct, supported connections to the next provider rather than a referral to call a phone number).

5. Explore sustainable funding pathways. While some states have established Medicaid reimbursement for community paramedicine services, New York State currently relies on grant funding, settlement funds, or local partnerships for most behavioral health–focused community paramedicine models.

Estimated cost: Training costs $5,000 to $10,000; additional EMS compensation may be needed if expanding beyond traditional scope.

Funding sources: SAMHSA rural EMS training grants; state EMS offices; hospital community benefit funding.

Key partners: EMS agencies, OASAS providers, hospitals, mobile crisis teams, behavioral health training providers.

C. Long Wait Times (6 Months to 2 Years for Treatment)

SARHNA Challenge: Rural counties across New York report wait times of 6 months or more for outpatient mental health and SUD treatment, with some areas reporting waits approaching 2 years. A significant share of residents who needed care did not receive it because the wait was too long (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Telehealth & Telepsychiatry Suite, Collaborative Care Model (CoCM), and Certified Certified Community Behavioral Health Clinics (CCBHCs).

Eliminate Waits Through Immediate Access Models

9. 24/7 Open Access Centers

What it is: Round-the-clock walk-in assessment and referral centers with no appointment needed, providing immediate connection to available treatment slots.

Why it works: Eliminates the intake appointment bottleneck that delays treatment for months. When someone is ready to seek help, they can access it immediately rather than waiting weeks for a first appointment.

Evidence: High. New York program data shows increased treatment initiation, reduced time from decision to seek help to treatment start, and improved crisis response.

Complexity: Medium

Implementation:

1. Identify an OASAS-licensed provider willing to operate an open access center.
2. Secure 24/7 staffing including assessment counselors and peer specialists.
3. Develop relationships with all area treatment programs to maintain awareness of available slots.

4. Create no-wrong-door referral protocols so anyone can be connected regardless of their presenting need.
5. Offer crisis support while arranging treatment connection.
6. Engage families during the intake process.

Estimated cost: $400,000 to $600,000 annually for 24/7 staffing.

Funding sources: OASAS open access center grants; hospital community benefit funding; county SUD services funding.

Key partners: OASAS, all local treatment providers, hospitals, crisis services.

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10. MATTERS Network (Medication for Addiction Treatment and Electronic Referrals)

What it is: A rapid referral network guaranteeing next-day MOUD appointments from emergency departments, urgent care centers, correctional facilities, and law enforcement.

Why it works: Closed-loop tracking ensures attendance. Eliminates the weeks or months between an emergency room overdose visit and treatment start, converting a critical moment of readiness into immediate action.

Evidence: High. Program data shows significantly higher connection rates compared to traditional referral lists; thousands of statewide referrals have been completed.

Complexity: Low to Medium

Implementation:

1. Join the existing statewide MATTERS Network by contacting OASAS.
2. Ensure local MOUD providers participate and commit to next-day appointment capacity.
3. Train emergency department, urgent care, correctional facility, and law enforcement staff on the MATTERS referral process. Training providers should be identified as key partners in this step.
4. Use closed-loop referral technology to track whether appointments are attended.
5. Provide transportation vouchers or arrange transportation assistance if needed, partnering with non-emergency medical transportation programs or other community transportation services.

Estimated cost: Network participation may be free; requires provider capacity commitment. Costs may range widely.

Funding sources: OASAS supports the network; local implementation is through provider operating budgets.

Key partners: OASAS, hospitals, correctional facilities, MOUD providers, non-emergency medical transportation programs, and organizations providing services or advocacy for justice-involved individuals.

11. CA Bridge Program (Hospital-Based MOUD Access)

What it is: A training and protocol model for hospitals to start buprenorphine in the emergency department and link patients to outpatient follow-up within 24 to 72 hours through warm handoffs (direct, supported connections to the next provider rather than a referral to call a phone number).

Why it works: Converts a missed opportunity, specifically overdose patients discharged with only a phone number, into immediate treatment engagement at the moment a patient may be most ready for help.

Evidence: High. Multi-hospital studies show large increases in MOUD initiation and substantial improvements in treatment retention.

Complexity: Low

Implementation:

1. Identify a champion physician willing to complete buprenorphine training (a federal waiver is no longer required as of 2023, but training remains beneficial).
2. Complete buprenorphine training.
3. Establish emergency department protocols: offer buprenorphine, provide initial doses, and schedule follow-up within 48 hours.
4. Create warm handoff relationships with outpatient MOUD providers.
5. Track metrics including the percentage of overdose patients offered buprenorphine and the percentage connected to outpatient care.

Estimated cost: Minimal, as the model uses existing emergency department staff. Buprenorphine medication costs approximately $100 to $200 per month.

Funding sources: Hospital operating budget; billed to insurance; SAMHSA grants for training and implementation support.

Key partners: Emergency departments, outpatient MOUD providers, OASAS.

Expand Treatment Capacity

12. Vermont Hub and Spoke Model

What it is: Regional specialty addiction centers (hubs) provide intensive treatment and consultation for office-based opioid treatment in community settings (spokes) such as primary care practices, obstetrics and gynecology clinics, and pain clinics.

Why it works: Distributes MOUD capacity across many sites instead of concentrating it in a few specialty programs, allowing patients to be treated closer to home.

Evidence: Highest. Vermont achieved the highest treatment capacity in the United States; patient outcomes show a 96% reduction in opioid use.

Complexity: High

Implementation:

1. Designate 1 to 2 regional specialty centers as hubs using existing OASAS programs.
2. Recruit multiple spoke sites including primary care practices, obstetrics and gynecology clinics, and pain clinics.
3. Hubs provide buprenorphine induction for complex patients, psychiatric consultation, and ongoing training and mentoring for spokes.
4. Spokes provide office-based buprenorphine, counseling referral, and ongoing medication management.
5. Create bidirectional referral protocols so spokes can refer complex cases to hubs and hubs can step down stable patients to spokes.
6. Use data sharing to track patient flow and outcomes.

Estimated cost: Hub capacity expansion $200,000 to $400,000; spoke training and support $50,000 to $100,000 per practice.

Funding sources: OASAS hub and spoke initiative; RCORP medication-assisted treatment grants; Medicaid.

Key partners: OASAS, specialty treatment programs, primary care practices, obstetrics and gynecology clinics.

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13. RCORP Consortiums (Rural Communities Opioid Response Program)

What it is: HRSA-funded multi-county consortia that strengthen prevention, treatment, and recovery for SUD and opioid use disorder (OUD) through cross-sector coalitions.

Why it works: Pools resources that no single county could sustain independently. Includes built-in workforce development, telehealth, evaluation, and sustainability planning components.

Evidence: High. HRSA evaluations show RCORP grantees consistently meet benchmarks for expanded MOUD access, naloxone distribution, and care coordination.

Complexity: High

Implementation:

1. Convene a multi-county coalition including hospitals, health departments, OASAS providers, law enforcement, and recovery community organizations.

2. Conduct a needs assessment identifying treatment gaps, workforce needs, and coordination barriers.
3. Apply for an HRSA RCORP Planning or Implementation grant.
4. Use funds to expand MOUD capacity, train the workforce, implement telehealth, develop care coordination, distribute naloxone, and build recovery housing.
5. Participate in RCORP technical assistance and evaluation.

Estimated cost: RCORP Planning grants are approximately $200,000; Implementation grants are up to $1,000,000 per year for 3 years.

Funding sources: HRSA RCORP grants (federal); requires a local match, which can often be provided in-kind.

Key partners: Multiple counties, hospitals, OASAS, health departments, law enforcement, organizations providing services or advocacy for justice-involved individuals.

D. Crisis Infrastructure Gaps

SARHNA Challenge: Many rural counties have extremely limited crisis services. Emergency department boarding for psychiatric patients can last 3 to 5 days or more while patients await placement. Most areas lack a 24/7 crisis response system, and law enforcement serves as the default responder for mental health emergencies even when a clinical response would be more appropriate and effective (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) 24/7 Open Access Centers and Community Paramedicine Behavioral Health Programs.

Build a Comprehensive Crisis System

14. Crisis Now Model (988 + Mobile Crisis + Stabilization Centers)

What it is: A standardized three-component crisis system consisting of a regional call hub connected to the 988 Suicide and Crisis Lifeline, 24/7 mobile crisis teams, and short-term crisis stabilization facilities.

Why it works: Provides an appropriate crisis response without relying on psychiatric inpatient beds or law enforcement, keeping people in the community and connecting them to the right level of care. The model integrates 988 crisis line coordination, mobile crisis response, and short-term stabilization capacity as a unified system; references to 988 elsewhere in this document are contextual descriptions of this integrated model rather than separate program listings.

Evidence: High. Implementations in Arizona and Georgia show major reductions in emergency department use, jail involvement, and cost per crisis episode.

Complexity: Medium to High

Implementation:

1. Join the New York 988 system, coordinated statewide by the Office of Mental Health (OMH).
2. Establish or expand mobile crisis teams with OMH funding, staffing them with mental health clinicians, peer specialists, and in some cases nurses. Teams should provide 24/7 response within one hour, offer field stabilization and safety planning, and make referrals to appropriate services.
3. Develop a crisis stabilization center, which can be regional and shared across counties. These centers operate 24/7 as voluntary walk-in facilities offering psychiatric assessment, SUD stabilization, and peer support. They can hold individuals for up to 23 hours for observation and stabilization, or longer if subacute beds are available, before connecting them to outpatient or residential services.
4. Create protocols so that 988 dispatches mobile crisis teams directly rather than only providing referrals.

Estimated cost: Mobile crisis team $300,000 to $500,000 per year; crisis stabilization center $1,000,000 to $2,000,000 per year in capital and operating costs.

Funding sources: OMH mobile crisis expansion grants; OMH and OASAS crisis stabilization center initiative; Medicaid.

Key partners: OMH, OASAS, 988 centers, hospitals, EMS, law enforcement, organizations providing services or advocacy for justice-involved individuals.

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15. Single Point of Access (SPOA) and Regional Crisis and Step-Down Capacity

What it is: A centralized referral and triage system for serious mental health and SUD services, combined with regional crisis and short-term treatment facilities shared across rural counties.

Why it works: A single phone number for all intensive services eliminates the experience of making dozens of calls to find an open program. Shared regional beds provide high-acuity services that no single rural county could sustain independently.

Evidence: Moderate to High. County evaluations show reduced fragmentation and improved matching of individuals to appropriate service levels.

Complexity: High

Implementation:

1. Designate a lead agency to operate the SPOA, such as a health department, community mental health center, or hospital.
2. Create a centralized intake line staffed by triage clinicians.
3. Build relationships with all intensive service providers including Assertive Community Treatment (ACT) teams, residential programs, crisis services, and inpatient facilities.

4. Develop regional crisis and step-down beds shared across 3 to 5 counties. OMH supports regional models for this purpose.
5. Implement a real-time bed registry so SPOA staff always know current availability.
6. Train all potential referral sources, including hospitals, clinics, schools, and law enforcement, on the SPOA number and process.

Estimated cost: SPOA operation $200,000 to $300,000 per year; regional bed costs vary by model.

Funding sources: OMH, county mental health funding, Medicaid.

Key partners: OMH, multiple counties, all intensive service providers, organizations providing services or advocacy for justice-involved individuals.

E. Youth Mental Health Crisis

SARHNA Challenge: Rural youth face elevated rates of depression, suicidality, vaping, and binge drinking. Transportation barriers and parental work schedules prevent many families from accessing outpatient care. Child psychiatrists are virtually absent from rural areas. Schools are critical access points for struggling youth, yet most rural schools lack on-site mental health clinicians (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Telehealth & Telepsychiatry Suite.

Bring Mental Health Services into Schools

16. School-Based Health and Mental Health Centers

What it is: Behavioral health clinicians provide counseling and therapy directly inside schools, often integrated with primary care services.

Why it works: Therapy is delivered where students already are, eliminating all youth transportation barriers, reducing stigma, and addressing the SARHNA finding that schools are critical access points for youth mental health (Grove & Coates, 2025).

Evidence: Highest. HRSA reviews show improved attendance, increased mental health service utilization, and reduced emergency department use. Extensive research base across multiple states and settings.

Complexity: Low to Medium

Implementation:

1. Partner with school districts, starting with high-need districts or those with existing school-based health centers.

2. Determine a staffing model. The most common and sustainable approach is for an FQHC, hospital, or mental health agency to employ the clinician and locate them within the school building, which allows for Medicaid billing. School districts may also directly employ clinicians, though this makes billing more complex.
3. Ensure the clinician holds appropriate licensure and credentials for a school setting.
4. Secure a private counseling space within the school building.
5. Implement screening, with school counselors typically screening students and referring to the clinician.
6. Obtain parent consent and establish clear confidentiality protocols.
7. Bill Medicaid and commercial insurance for services. For students who are uninsured, sliding scale or charity care options through the employing FQHC or hospital may help fill the gap.

Estimated cost: $70,000 to $90,000 per full-time clinician; space is typically provided by the school.

Funding sources: Medicaid (primary payer); HRSA School-Based Health Center grants; hospital community benefit funding; school district contributions; federal Mental Health Services for Students Act funds.

Key partners: School districts, FQHCs, hospitals, mental health clinics. Examples of existing models include Bassett Healthcare School-Based Health in Otsego and Northern Catskills counties and the Upstate Medical school-based program in Central New York.

Prevention and Early Intervention

17. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

What it is: Universal substance use screening using validated tools (e.g., the CRAFFT tool for youth; AUDIT-C or a single-item drug use screen for adults); a 5- to 15-minute motivational interviewing conversation for risky use; and referral to treatment for those who screen positive for a substance use disorder.

Note: Adult SBIRT is especially relevant in primary care and emergency department settings and complements strategies described in the Workforce Shortages and Long Wait Times sections by identifying substance use early and reducing escalation to specialty care.

Why it works: Addresses the SARHNA finding that substance use often goes undetected until a crisis occurs (Grove & Coates, 2025). Enables early intervention before use escalates to disorder and is feasible within existing staff and visit structures.

Evidence: Highest. SAMHSA evidence-based practice. The American Academy of Pediatrics recommends SBIRT for all adolescents. RCTs show reduced risky use.

Complexity: Low

Implementation:

1. Implement universal screening in school-based health centers, pediatric primary care practices, and school physicals.
2. Train nurses, medical assistants, and health aides on the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screening tool, a validated 6-question tool in which 2 or more positive responses indicate risky use.
3. Train clinicians on brief motivational interviewing (5 to 15 minutes).
4. Create referral pathways to SUD treatment for those who screen positive for a disorder.
5. Bill Medicaid and insurance using SBIRT billing codes.
6. Track screening rates and outcomes.

Estimated cost: OASAS provides free SBIRT training statewide; minimal incremental cost as the model uses existing staff.

Funding sources: Medicaid and insurance reimbursement; SAMHSA SBIRT grants.

Key partners: OASAS, school-based health centers, pediatric practices, primary care providers, and regional technical assistance organizations.

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18. Prevention Resource Centers (OASAS)

What it is: Regional centers funded by OASAS that implement evidence-based prevention curricula in schools, including LifeSkills® Training and Too Good for Drugs. Centers provide technical assistance to schools and support local data collection.

Why it works: Builds upstream prevention infrastructure and provides evidence-based curricula and training to rural schools that lack internal prevention expertise or staffing.

Evidence: High. Evidence-based prevention curricula including LifeSkills® Training have RCT support.

Complexity: Low

Implementation:

1. Contact the OASAS Prevention Resource Center for your region.
2. Arrange training for school staff on evidence-based curricula.
3. Implement curricula with fidelity, typically in middle school settings.
4. Use data collection tools provided by the Prevention Resource Center.
5. Build a local coalition to sustain prevention programming beyond initial implementation.

Estimated cost: Free to schools. OASAS funds Prevention Resource Centers statewide.

Funding sources: OASAS operates Prevention Resource Centers statewide as an ongoing program.

Key partners: OASAS Prevention Resource Centers, school districts.

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19. Youth Clubhouses (OASAS)

What it is: Non-clinical drop-in centers for adolescents offering peer support, recreation, skill-building, and a substance-free social environment. Prevention-focused rather than treatment-focused.

Why it works: Provides age-appropriate, stigma-free, non-clinical support. Fills the gap between school-based clinical services and formal treatment. Offers a safe alternative to environments where substance use is common, particularly during after-school and weekend hours.

Evidence: Moderate. The youth clubhouse model is adapted from the mental health clubhouse model, which has a stronger evidence base. Prevention recreation programs show reduced substance use among participants.

Complexity: Medium

Implementation:

1. Identify a location accessible to youth such as a community center, YMCA, or library.
2. Secure funding for youth peer specialists and recreation staff.
3. Create programming including recreation, skill-building workshops, employment readiness, and arts activities.
4. Establish a substance-free environment with clear expectations.
5. Create connections to clinical treatment when clinical needs are identified.
6. Operate during after-school and weekend hours, which are higher-risk times for youth substance use.

Estimated cost: $150,000 to $250,000 per year for staffing and operations.

Funding sources: OASAS youth services expansion funding; community foundations; county youth services funding.

Key partners: OASAS, youth-serving organizations, recovery community organizations.

F. Opioid/Overdose Deaths (Including the Fentanyl Crisis)

SARHNA Challenge: Overdose mortality rates in many rural New York counties significantly exceed state and national averages. Fentanyl is now present in most opioid-related fatalities. Research suggests that

comprehensive interventions can achieve meaningful reductions in both fatal and non-fatal overdoses (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) CA Bridge Program, Centers of Treatment Innovation (COTIs) & Mobile Treatment Vans, Mobile Medication Units (MMUs), RCORP Consortiums, and Vermont Hub and Spoke Model.

Immediate Harm Reduction

20. Harm Reduction Programs and Syringe Services Programs

What it is: Syringe exchange, fentanyl test strips, safer use education, naloxone distribution, peer outreach to active users, and linkage to treatment when individuals are ready.

Why it works: Meets people who are not ready for abstinence-based treatment where they are. Prevents overdose deaths, HIV, and hepatitis C virus (HCV) transmission. Builds the trust that often leads to treatment engagement over time.

Evidence: Highest. Extensive harm reduction research base. Cochrane reviews confirm that syringe programs reduce HIV and HCV transmission. Naloxone distribution saves lives. Fentanyl test strips prevent overdoses by allowing individuals to detect fentanyl in the drug supply before use.

Complexity: Low to Medium

Implementation:

1. Apply for OASAS Outreach and Engagement Services (OES) funding, which supports harm reduction programs.
2. Hire peer outreach workers with lived experience of substance use.
3. Establish syringe exchange sites, which can be fixed or mobile.
4. Distribute naloxone widely.
5. Provide fentanyl test strips, which have been legal in New York State since 2022.
6. Offer safer use education covering wound care, overdose prevention, and vein health.
7. Create pathways to treatment that are on-demand and low-pressure.
8. Partner with EMS to geographically target areas with high overdose rates.

Estimated cost: $150,000 to $300,000 per year for staff and supplies.

Funding sources: OASAS OES funding; SAMHSA harm reduction grants; CDC overdose prevention funding.

Key partners: OASAS, recovery community organizations, EMS, health department, existing syringe programs. Educational materials including overdose prevention cards, safer use guides, and treatment resource lists may be available through OASAS and the National Harm Reduction Coalition or may need to be developed locally.

Data-Informed Decision-Making

21. Data-Driven Overdose Surveillance with Public Dashboards

What it is: Real-time or near-real-time dashboards tracking overdoses and related indicators, used by community coalitions to focus naloxone placement, treatment outreach, and policy decisions.

Why it works: Not a treatment intervention itself, but proven infrastructure that underpins effective priority identification. Enables strategic naloxone placement, outreach, and coalition consensus around priorities.

Evidence: Moderate to High. Research from rural New York shows that overdose dashboards are acceptable and useful to stakeholders and support data-driven decision-making at the local level.

Complexity: Low to Medium

Note on data suppression: In small rural geographies with small populations, data suppression concerns may affect the granularity of dashboard data. This should be considered during design to avoid inadvertently identifying individuals while still producing actionable geographic and trend information.

CDC's Overdose Data to Action (OD2A) program and the HEALing Communities Study both demonstrate how community-level overdose surveillance and cross-sector data integration can inform targeted prevention strategies and drive implementation of evidence-based practices.

Implementation:

1. Partner with a university or health information technology vendor.
2. Obtain data feeds from EMS overdose calls, emergency department visits, medical examiner and coroner data, naloxone distribution records, and treatment admission data.
3. Build a dashboard with geographic mapping and trend analysis, taking data suppression considerations into account for small geographies.
4. Share the dashboard with stakeholders such as community coalitions, treatment providers, and EMS.
5. Use data to focus interventions such as naloxone vending machines in high-overdose ZIP codes and outreach to underserved areas.
6. Track outcomes including overdose rates and treatment connections over time.

Estimated cost: $50,000 to $100,000 for dashboard development; $20,000 to $40,000 per year for maintenance.

Funding sources: SAMHSA Data-Driven Prevention Initiative; CDC overdose surveillance funding; university partnerships.

Key partners: Universities, health department, EMS, hospitals, community coalitions. Columbia University provides data dashboard support to New York counties participating in HEALing Communities initiatives.

Comprehensive Community Response

22. HEALing Communities Study Model and Healing Cayuga

What it is: A structured county-level initiative in which county government, a university partner, and local providers coordinate evidence-based strategies for opioid use disorder and mental health through a community coalition. Core components include a shared overdose dashboard, expanded MOUD access, naloxone distribution, jail-based treatment, and harm reduction access points.

Why it works: Multi-sector partnership improves access to treatment, harm reduction, and coordination across systems. The data dashboard guides targeting. The comprehensive approach addresses multiple failure points simultaneously rather than relying on any single intervention.

Evidence: Highest. Supported by a National Institutes of Health (NIH) randomized controlled trial. Cayuga County documented a 41% reduction in non-fatal overdoses and a 61% reduction in fatal overdoses between 2021 and 2023 using this approach. Note that these outcomes reflect the combined effect of the full HEALing Communities model and should not be attributed to any single component intervention.

Complexity: High

Implementation:

1. Form a coalition with representation from county government, law enforcement, correctional facilities, hospitals, treatment providers, EMS, recovery community organizations, faith communities, and others.
2. Partner with a university for technical assistance and data support. Columbia University supports New York counties implementing this model.
3. Implement an overdose data dashboard (see Program 21 above for full implementation guidance).
4. Use a coalition consensus process to select evidence-based interventions from a menu that includes expanded MOUD capacity, wide naloxone distribution through pharmacies, libraries, community locations, and vending machines, jail-based MOUD, harm reduction access points, school-based prevention, and recovery housing.
5. Track outcomes using the dashboard.

Estimated cost: Coalition coordination $100,000 to $150,000 per year. Intervention costs vary: dashboard approximately $75,000; MOUD expansion $200,000 or more; naloxone distribution approximately $50,000 per year.

Funding sources: SAMHSA Opioid Response Grants; RCORP; state opioid settlement funds; county budgets.

Key partners: County government, Columbia University Social Intervention Group, all coalition sectors. Cayuga County's comprehensive approach serves as a replicable model.

G. Co-Occurring Mental Health and Substance Use Disorders

SARHNA Challenge: Treatment programs in rural areas are often siloed, with mental health and substance use services operating separately and without coordination. Depression, anxiety, and trauma frequently intersect with substance use, yet integrated treatment models that address both conditions simultaneously are rare. Individuals with co-occurring disorders are often too complex for standard outpatient mental health programs but do not meet criteria for inpatient admission, leaving them without appropriate care (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Vermont Hub & Spoke Model.

Integrated Treatment Models

23. Certified Community Behavioral Health Clinics (CCBHCs)

What it is: Clinics certified by states to provide comprehensive, 24/7 behavioral health services including crisis response, mental health treatment, SUD treatment, and primary care screening, for anyone regardless of ability to pay.

Why it works: CCBHC certification requires integrated care across mental health and SUD. Same-day access is required by the model. Services are available to anyone regardless of insurance status or ability to pay, removing a major access barrier in high-poverty rural communities.

Evidence: Highest. Federal demonstration with rigorous multi-site evaluation. Studies show 13% to 33% increases in patients served, improved access, and reduced emergency department use.

Complexity: High

Implementation:

1. Identify an existing community mental health center or multi-service provider willing to pursue CCBHC certification.
2. Conduct a gap analysis against CCBHC requirements, which include nine required service types and 24/7 crisis response.
3. Apply to OMH for CCBHC designation.
4. Implement required services: diagnostic assessment, outpatient mental health treatment, outpatient SUD treatment, 24/7 crisis services, primary care screening and monitoring, patient-centered treatment planning, psychiatric rehabilitation, peer support and counseling, and family support services.
5. Establish a Prospective Payment System (PPS) rate with Medicaid, which provides a sustainable per-encounter reimbursement rate.

Estimated cost: Significant organizational transformation required. Expect an 18- to 24-month implementation timeline. Costs vary depending on existing capacity and gaps.

Funding sources: Medicaid PPS reimbursement (financially sustainable ongoing); SAMHSA CCBHC planning and implementation grants; OMH.

Key partners: OMH (state CCBHC lead), existing mental health and SUD providers, hospitals, FQHCs. Syracuse Community Health Center is an example of a certified CCBHC in New York.

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24. Cross-Walk Program (Integrated Care in Primary Care)

What it is: A model that embeds a behavioral health specialist directly within a primary care practice to treat co-occurring SUD and depression, with patients referred within the same facility.

Why it works: Treats co-occurring conditions in one setting, removing the specialty referral barrier. Leverages primary care as the most accessible entry point in rural communities. Particularly useful for patients who would not engage with a separate mental health or SUD specialty program.

Evidence: Moderate. Documented rural implementation with promising outcomes in the Upper Great Lakes region. Aligns with the broader integrated care evidence base.

Complexity: Medium

Implementation:

1. Similar to the Collaborative Care Model, but the behavioral health specialist is directly employed by the primary care practice rather than working in a care management role.
2. The specialist provides both counseling and coordinates with the primary care provider on medication decisions.
3. This model is particularly useful for patients with co-occurring depression and substance use who need integrated support in a single, trusted setting.

Estimated cost: $70,000 to $90,000 per year per embedded behavioral health specialist.

Funding sources: Medicaid integrated care billing; HRSA; practice operating budget.

Key partners: Primary care practices, FQHCs. An example of this model in a rural setting is Marquette County, Michigan in the Upper Great Lakes region.

H. Housing Instability and Poverty

SARHNA Challenge: Housing instability reinforces cycles of behavioral health crises. Without stable housing, individuals cannot reliably engage in treatment, maintain medication regimens, or build the routines that support recovery. Poverty, including deep poverty and the condition of being asset-limited, income-constrained, and employed (ALICE), is among the strongest predictors of unmet behavioral health need in rural New York communities. Unstable housing intensifies distress and increases the risk of relapse (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Certified Community Behavioral Health Clinics (CCBHCs).

Housing and Wraparound Services

25. Permanent Supportive Housing (PSH) for SUD Populations

What it is: Rental subsidies combined with intensive case management and employment counseling for homeless or housing-unstable individuals with a history of SUD. Uses a scatter-site model in which participants live in regular apartments throughout the community rather than in congregate facilities.

Why it works: Directly addresses the SARHNA finding that housing instability undermines treatment engagement and recovery (Grove & Coates, 2025). Provides a stable foundation that makes treatment success possible. Housing First principles mean that housing is not contingent on sobriety, but support is consistently offered.

Evidence: Highest. Extensive research shows PSH improves housing stability (90% or higher retention rates), treatment retention, and employment, while reducing hospitalizations, emergency department use, and justice system involvement. Cost-effective compared to the ongoing costs of homelessness.

Complexity: High

Implementation:

1. Partner with a housing authority and community development corporation.
2. Secure rental subsidies through HUD, state, or local sources.
3. Hire case managers with SUD expertise.
4. Use a scatter-site model with regular apartments rather than congregate housing.
5. Implement Housing First principles so that housing is not contingent on sobriety, while consistently offering support and treatment connection.
6. Provide housing location assistance, rental assistance, case management, employment counseling, benefits navigation, and linkage to SUD and mental health treatment.
7. Track housing retention and health outcomes.

Estimated cost: Rental subsidy approximately $800 to $1,200 per month per person; case management $60,000 to $80,000 per year per case manager carrying a caseload of 15 to 20 individuals.

Funding sources: HUD Continuum of Care (CoC) program, which is a federal program coordinating housing and services funding at the local level; HUD Housing Choice Vouchers; Medicaid Home and Community-Based Services; state housing funds; OASAS recovery housing funding.

Key partners: Housing authority, community development corporations, OASAS, hospitals, local Continuum of Care (CoC) organizations.

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26. Recovery Residences (Certified Sober Living)

What it is: Peer-run shared living environments for individuals in recovery. Structured environments with house rules and peer accountability. Not clinical treatment, but voluntary recovery support housing that fills the gap between residential treatment completion and independent living.

Why it works: Provides a stable, supportive housing environment with peer accountability during the vulnerable transition out of residential treatment. Fills a critical step-down gap that is particularly acute in rural areas where independent housing options are limited.

Evidence: High. Recovery housing research shows improved treatment retention, reduced relapse, stable housing outcomes, and employment gains. Homes certified by the National Alliance for Recovery Residences (NARR) meet established quality standards.

Complexity: High

Implementation:

1. Connect with the New York State Alliance of Recovery Residences (NYSARR) for the NARR certification process.
2. Identify a property, which can be rented or owned, and can be a single-family home or apartment.
3. Complete NARR quality standards certification.
4. Establish house agreements covering expectations, rules, and peer governance.
5. Apply for an OASAS Recovery Residence Grant of up to $75,000 for property improvements.
6. Set reasonable fees to sustain operations, typically $400 to $700 per month.

Estimated cost: Property costs vary. OASAS grant up to $75,000. Ongoing operating costs are largely covered by resident fees.

Funding sources: OASAS Recovery Residence Grant; resident fees; private fundraising.

Key partners: NYSARR, OASAS, recovery community organizations, housing organizations.

Address Poverty and Social Drivers Holistically

27. Rural Outreach Center (ROC) Model

What it is: A holistic support model addressing the root causes of poverty through care coordination, therapy, budgeting assistance, employment support, housing help, and food assistance. Multi-generational poverty is a core focus. This model was developed by The Rural Outreach Center (ROC), a nonprofit in Western New York, which has worked to create materials to support replication of this model in other regions.

Why it works: Addresses the SARHNA finding that poverty is among the strongest predictors of unmet behavioral health need (Grove & Coates, 2025). The holistic approach addresses the social determinants that compound behavioral health crises and prevent individuals from sustaining recovery.

Evidence: Moderate to High. Using this model, The ROC serves approximately 250 individuals annually. Participants achieve sustained housing stability, savings, and employment goals.

Complexity: Medium

Implementation:

1. Identify a community organization or faith-based initiative to lead.
2. Secure funding for wraparound services including a care coordinator, benefits counselor, employment specialist, therapist, and other roles as needed.
3. Create a welcoming community hub that feels accessible and non-clinical.
4. Provide care coordination, therapy and counseling, financial literacy and budgeting support, employment readiness, housing assistance, food assistance, and life skills programming.
5. Use an empowerment approach focused on building long-term capacity rather than only providing crisis relief.

Track participant outcomes across multiple domains including housing, employment, income, and behavioral health.

Estimated cost: $200,000 to $400,000 per year for staff and programming.

Funding sources: Community foundations; faith-based networks; hospital community benefit funding; United Way; county social services.

Key partners: Faith communities, social services agencies, workforce development organizations, food banks, housing organizations. The Rural Outreach Center, serving a multi-county region in southern Western New York, is the originating organization for this model.

28. Recovery-Oriented System of Care (ROSOC) and Whole Person Care

What it is: Intensive care coordination for high-need adults with chronic SUD, mental health conditions, and medical complexity who are frequent users of emergency departments and correctional facilities. Cross-system referrals come from emergency departments, mental health providers, and correctional facility medical staff.

Why it works: Wraparound coordination addresses housing and income barriers simultaneously. Moves people from crisis cycling to ongoing stable care. The super-utilizer approach is cost-effective because the individuals served account for a disproportionate share of emergency department, crisis, and correctional facility costs.

Evidence: High. Rural California data shows 77% of participants receiving therapy or psychiatric medications, 76% receiving alcohol and other drug treatment, and 96% reducing emergency department and correctional facility use to zero or one incident per period.

Complexity: Medium to High

Implementation:

1. Identify high utilizers through data on frequent emergency department visits, correctional facility involvement, and crisis service use.
2. Hire intensive care coordinators with low caseloads of 10 to 15 individuals.
3. Create cross-system case conferences involving health, behavioral health, correctional, housing, and social services partners.
4. Address multiple domains simultaneously including housing, income and benefits, food, healthcare, and behavioral health.
5. Use flexible funds for immediate needs such as first month's rent, transportation, and a phone.
6. Track cost savings from reduced emergency department, correctional, and crisis service use alongside participant outcomes.

Estimated cost: $80,000 to $100,000 per care coordinator with small caseloads; flexible funds of $50,000 to $100,000 per year.

Funding sources: Medicaid Health Homes; delivery system reform incentive payments; county savings from reduced correctional and emergency department costs.

Key partners: Hospitals, correctional facilities, social services agencies, housing authorities, managed care organizations, organizations providing services or advocacy for justice-involved individuals.

I. Fragmentation and Coordination Gaps

SARHNA Challenge: Treatment programs in rural areas are often siloed, with residents forced to make dozens of calls trying to find programs with available slots. Families are left stranded between agencies with no clear pathway to care. Counties frequently operate in isolation from one another, missing opportunities for regional collaboration. A lack of defined expectations for collaboration across sectors compounds these challenges (Grove & Coates, 2025).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Collaborative Care Model (CoCM), Community Paramedicine Behavioral Health Programs, Data-Driven Overdose Surveillance with Public Dashboards, Rural Outreach Center (ROC) Model, Recovery-Oriented System of Care (ROSOC) and Whole-Person Care, Certified Community Behavioral Health Clinics (CCBHCs), HEALing Communities Study Model & Healing Cayuga, RCORP Consortiums, and Single Point of Access (SPOA) & Regional Crisis and Step-Down Capacity.

Create Coordination Infrastructure

29. AmericaServes and NYServes Coordinated Referral Networks

What it is: A centralized coordination center and shared technology platform (Unite Us) that routes referrals among many providers across domains including housing, employment, legal services, and behavioral health, with closed-loop tracking to confirm whether needs were actually met.

Why it works: Directly addresses the SARHNA finding that people are stranded between agencies (Grove & Coates, 2025). Closed-loop tracking ensures that referrals result in services rather than being lost. Coordinates across housing, employment, SUD, and mental health in a single system.

Note: The AmericaServes model was originally developed for veterans and military families through the Institute for Veterans and Military Families (IVMF) at Syracuse University, but the platform and coordination model are applicable to broader community populations as well. Communities interested in this model should clarify with IVMF how the network can be structured to serve all residents.

Evidence: Moderate to High. Early network evaluations show improved access for individuals with complex needs. Network performance data identifies service gaps and informs capacity planning.

Complexity: Medium to High

Implementation:

1. Contact the Institute for Veterans and Military Families (IVMF) at Syracuse University (ivmf.syracuse.edu) about joining an existing local network or creating a new one.
2. Convene multi-sector partners across behavioral health, housing, employment, legal services, veterans services, and healthcare.

3. Implement the Unite Us platform for closed-loop referrals.
4. Train all participating organizations on the referral process.
5. Designate care coordinators to track referrals and follow up on unmet needs.
6. Use network data to identify service gaps and adjust capacity.
7. Hold regular network meetings to review performance and address barriers.

Estimated cost: Platform fees approximately $50,000 to $75,000 per year; coordination center approximately $150,000 to $200,000 per year.

Funding sources: Community foundations; hospital community benefit funding; United Way; county funding; federal grants.

Key partners: IVMF at Syracuse University, multi-sector service providers across behavioral health, housing, employment, and legal services.

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30. Regional Behavioral Health Networks

What it is: Regional coordination entities that convene behavioral health providers, facilitate partnerships, and coordinate planning across multiple counties to address shared behavioral health challenges. In New York State, these networks most closely resemble Behavioral Health Independent Practice Associations (BH IPAs), which are organized around provider coordination, value-based payment arrangements, and data sharing, and are supported through OMH's Behavioral Health Value Based Payment Readiness Program. These are distinct from Rural Health Networks funded by the NYS Department of Health, which address broader rural health issues such as transportation, chronic disease, and workforce.

Why it works: Addresses the SARHNA finding that counties are operating in isolation (Grove & Coates, 2025). Creates a coordination backbone that facilitates telepsychiatry contracting, workforce development, and cross-provider collaboration at a scale no single county could achieve alone.

Evidence: Moderate to High. Network reports show improved access, reduced wait times, and expanded telehealth penetration in regions with active coordination networks**.**

Complexity: High

Implementation:

1. Designate a lead organization such as a regional health planning organization, hospital system, or health department.
2. Convene a multi-county behavioral health network including hospitals, FQHCs, mental health centers, OASAS providers, EMS, correctional facilities, and schools.
3. Conduct a regional needs assessment and capacity inventory.

4. Identify shared priorities such as telepsychiatry, mobile crisis, and youth services.
5. Create regional solutions including shared telepsychiatry contracts, joint workforce recruitment, and coordinated crisis response.
6. Meet quarterly to coordinate and problem-solve.
7. Track regional performance metrics over time.

Estimated cost: Network coordination approximately $100,000 to $150,000 per year.

Funding sources: County contributions; hospital community benefit funding; HRSA Rural Health Network Development grants; regional planning grants.

Key partners: Multiple counties, hospitals, providers across sectors. Examples of existing networks in New York State include the North Country Behavioral Healthcare Network serving Jefferson, Lewis, and St. Lawrence counties through the Fort Drum Regional Health Planning Organization, and Integrity Partners for Behavioral Health IPA, which serves 34 rural counties across Western, Finger Lakes, Central, and South Central New York.

J. Stigma and Engagement Failure

SARHNA Challenge: Stigma around seeking care for mental health and substance use conditions prevents many rural residents from accessing services. In small communities where anonymity is limited and social networks are tight, the fear of being identified as someone with a mental health or substance use condition is a significant deterrent. Engagement failures leave some of the most vulnerable community members entirely outside the reach of traditional services (Grove & Coates, 2026).

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs), School-Based Health & Mental Health Centers, Community Paramedicine Behavioral Health Programs, and Youth Clubhouses.

Peer-Driven Models

31. Recovery Community Centers and Recovery Community and Outreach Centers

What it is: Recovery Community Centers (RCCs) are peer-led, non-clinical spaces that provide recovery support services, mutual aid opportunities, workforce development assistance, and linkage to treatment and social services. RCCs are designed to reduce isolation, strengthen recovery capital, and create community-based support networks for individuals in or seeking recovery.

Why it works: RCCs expand access to peer support and recovery navigation in rural areas where formal treatment infrastructure may be limited. They reduce stigma, increase engagement in care, and provide

structured pathways to employment, housing, and long-term recovery support. Peer-led environments can improve retention in recovery services and strengthen local recovery ecosystems.

Evidence: Moderate. Research indicates that peer-led recovery support services are associated with improved engagement, increased treatment retention, and enhanced recovery capital. Recovery Community Centers have demonstrated feasibility and positive outcomes across diverse community settings.

Complexity: Low to Medium

Implementation:

1. Partner with OASAS and local recovery community organizations.
2. Identify accessible, community-based space for peer-led programming.
3. Recruit and train Certified Recovery Peer Advocates (CRPAs) or equivalent peer staff.
4. Develop structured programming including support groups, navigation services, and workforce support.
5. Establish referral pathways with treatment providers, courts, and primary care.
6. Promote the center as a stigma-free recovery support hub.

Estimated cost: Costs include staffing (peer personnel), facility expenses, and operational support. Dollar estimates vary by staffing model and facility costs.

Funding sources: OASAS funding streams, opioid settlement funds, Medicaid-reimbursable peer services where applicable, and local or philanthropic support.

Key partners: OASAS, recovery community organizations, peer-led organizations, workforce development agencies, treatment providers, and local social service agencies.

Family Support

32. NAMI Family-to-Family (Rural Delivery Model)

What it is: A free, eight-session education program for family members supporting a loved one with mental illness. Peer-delivered by trained family members with their own lived experience. Reduces stigma and improves care engagement.

Why it works: Addresses the SARHNA finding that families face isolation and heartbreaking choices when trying to support a loved one with mental illness (Grove & Coates, 2025). Low-resource and easy to scale in rural areas that lack sufficient clinicians.

Evidence: High. Research shows reduced caregiver distress, improved knowledge about mental illness, increased problem-solving capacity, and increased treatment engagement among family members who complete the program.

Complexity: Low

Implementation:

1. Contact the National Alliance on Mental Illness (NAMI) affiliate in your region.
2. Recruit family members with lived experience supporting a loved one with mental illness who are willing to be trained as facilitators.
3. Complete NAMI Family-to-Family teacher training.
4. Schedule the eight-week program in an accessible community location such as a library or community center.
5. Promote to families through providers, schools, and faith communities.
6. Provide dinner and childcare if possible to reduce participation barriers.

Estimated cost: Minimal. NAMI provides the curriculum free of charge. Facilitators typically volunteer their time. Venue and food costs are approximately $500 to $1,000 per cohort. Note that staff time for coordinating volunteers, scheduling, and logistics should be factored into planning even if not a direct budget line.

Funding sources: NAMI; community foundations; hospital community benefit funding; county mental health funding.

Key partners: NAMI affiliates, family organizations, mental health providers.

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33. Family Support Navigators (OASAS)

What it is: Specialized navigators who help families understand addiction, navigate the treatment and insurance systems, support families through a loved one's treatment journey, and address insurance coverage denials.

Why it works: More specialized than general care navigation. Focuses specifically on family members of people with SUD. Addresses the SARHNA finding that families are stranded trying to help loved ones, and that insurance navigation is a critical gap given the frequency of coverage denials for SUD treatment (Grove & Coates, 2025).

Evidence: Moderate to High. Patient navigation research shows improved outcomes. Family engagement in SUD treatment is associated with better treatment retention.

Complexity: Low to Medium

Implementation:

1. Embed a family support navigator in an OASAS provider agency or health department.

2. Recruit a person with a combination of family lived experience, understanding of SUD, and knowledge of insurance and Medicaid systems.
3. Provide training on family support approaches, the SUD treatment system, insurance and Medicaid navigation, and the Community Health Access to Addiction and Mental Healthcare Project (CHAMP) model.
4. Offer services to families including education about addiction, system navigation, insurance appeals, and family therapy referrals.
5. Track family satisfaction and outcomes including loved one treatment engagement and reduction in family burden.

Estimated cost: $50,000 to $65,000 per year per family support navigator.

Funding sources: OASAS; hospital community benefit funding; insurance care management funding.

Key partners: OASAS, treatment providers, insurers.

K. Older Adult Suicide and Isolation

SARHNA Challenge: Several rural New York counties report elevated suicide rates among adults aged 65 and older, linked to chronic illness, disability, and social isolation. Older adults represent a silent crisis that is often less visible than youth mental health challenges but equally urgent. Mobility limitations, lack of transportation, and the absence of geriatric mental health resources compound the challenge (Grove & Coates, 2025). Older adults may also experience co-occurring chronic medical conditions that complicate behavioral health treatment. Programs such as tele-mental health for older adults, integrated primary care models, peer and community engagement initiatives, and outreach-based models can help address these gaps.

Other Program Options: In addition to the programs listed below, other options to consider may include (but are not limited to) Telehealth & Telepsychiatry Suite and Community Paramedicine Behavioral Health Programs.

Integrated Social Support Strategies

34. Social Support Programs for Isolated Older Adults

What it is: A set of integrated strategies that embed mental health outreach, screening, and support into existing programs and services that already reach isolated older adults in rural communities.

Why it works: Isolated older adults are unlikely to seek out mental health services on their own. Embedding outreach and screening into programs they already use, such as Meals on Wheels and senior centers, brings support to them rather than requiring them to navigate unfamiliar systems.

Evidence: Moderate. Individual components such as community paramedicine wellness checks, Meals on Wheels, and senior center programming have established evidence bases. The integrated outreach model specifically targeting rural older adult isolation is a promising practice with growing implementation experience.

Complexity: Low to Medium

What this program does:

- Uses community paramedicine programs to conduct wellness checks on isolated older adults, particularly following a health crisis or hospitalization. For additional details on community paramedicine, see Section II-B, Program 8, Community Paramedicine Behavioral Health Programs.
- Trains Senior Services staff in Mental Health First Aid for Older Adults (a standardized training program offered by the National Council for Mental Wellbeing) and suicide risk assessment.
- Partners with Meals on Wheels programs to incorporate brief depression screening during regular delivery visits, using validated tools such as the Patient Health Questionnaire-2 (PHQ-2). Screening should be conducted by trained Meals on Wheels staff rather than untrained volunteers. Organizations implementing this component must establish clear protocols for positive screens, including referral to a primary care provider, mental health clinician, or care coordinator. Protocols should also address suicidal ideation, which research indicates appears at elevated rates among homebound older adults who screen positive for depression.
- Creates volunteer friendly visitor programs specifically targeting isolated older adults who have no regular social contact.
- Ensures senior centers have on-site or telehealth-accessible mental health services.
- Uses telehealth to bring geriatric psychiatry services to homebound older adults who cannot travel.

Estimated cost: Mental Health First Aid training costs vary. Some classes are subsidized by grant funds to the training organization, allowing participants to attend for free; others may charge registration fees. These participant-facing costs do not include event costs for the training provider or host organization. Volunteer programs have low direct costs but require coordination staff time. Telehealth services are billed to Medicare and Medicaid.

Funding sources: Area Agency on Aging funding; county senior services budgets; hospital community benefit funding; OMH; telehealth infrastructure grants.

Key partners: Area Agencies on Aging, Senior Services departments, Meals on Wheels programs, senior centers, volunteer organizations, community paramedicine programs, telehealth providers, and organizations offering Mental Health First Aid training.

Section III: Cross-Cutting Implementation Considerations

The following considerations apply across all programs described in this guide. Regardless of which interventions a county selects, attending to these cross-cutting factors will significantly improve the likelihood of successful and sustainable implementation. These considerations were synthesized from the evidence base and implementation guidance underlying the Section II program profiles, as well as from technical assistance resources including the Rural Health Information Hub (RHIhub), SAMHSA, HRSA, and the AIMS Center, which consistently identify workforce, technology, funding, coalition building, data, and equity as critical factors in successful rural behavioral health implementation.

A. Staffing and Workforce Development

Key Principles:

1. **Use existing staff creatively before hiring new positions.** Consider expanding roles such as EMS providers doing post-overdose follow-up, library staff supporting telehealth, and school nurses conducting SBIRT screening.
2. **Prioritize the peer workforce.** Peer specialists bypass clinician shortages and excel at engaging populations that avoid traditional services.
3. **Leverage telehealth.** One remote specialist can support many rural sites, expanding limited workforce capacity.
4. **Build training infrastructure.** Pipeline programs, Project ECHO, and clinical supervision structures create a sustainable workforce over time rather than depending on individual recruitment.

Common Staffing Challenges and Solutions:

Challenge	Solution Options
Cannot recruit psychiatrists	Telepsychiatry, Collaborative Care Model, Project ECHO
Cannot recruit therapists	School-based placements, pipeline programs, telehealth
High turnover	Competitive salaries, loan repayment through the National Health Service Corps (NHSC), peer support for staff, reasonable caseloads
Insufficient clinical supervision	Partner with academic medical centers for remote supervision; use Project ECHO for ongoing mentoring
Need 24/7 coverage	Regional shared staffing, mobile crisis teams covering multiple counties, on-call rotation shared across providers

Loan Repayment Programs:

- **National Health Service Corps (NHSC):** Up to $50,000 in loan repayment for a two-year rural practice commitment. Application at nhsc.hrsa.gov.
- **New York State loan repayment:** Additional funds may be available for mental health providers practicing in underserved areas. Contact OMH for current program details.

B. Technology Infrastructure

Essential Technology Investments:

1. **Broadband access:** Work with county planning offices and the NYS ConnectALL Office to prioritize behavioral health sites in broadband expansion planning.
2. **Telehealth equipment:** Approximately $5,000 to $10,000 per site for camera, monitor, secure software, and sound dampening.
3. **Electronic health records:** Interoperable electronic health records (EHRs) enable care coordination and data sharing across providers.
4. **Data systems:** Dashboards, patient registries, and closed-loop referral platforms are foundational infrastructure for coordinated care.

Telehealth Implementation Checklist:

- Assess broadband capacity at all sites.
- Ensure a HIPAA-compliant video platform is in place.
- Create private, quiet spaces for telehealth visits.
- Train staff on technology troubleshooting.
- Develop backup plans for technology failures, such as switching to a phone appointment if video fails.
- Address patient digital literacy through public library partnerships, health navigators, or digital navigator programs. Organizations including nonprofits and community-based organizations may offer digital skills training and/or digital navigation services.
- Verify credentialing and licensure requirements for out-of-state providers.
- Confirm Medicaid and insurance reimbursement for telehealth services before launch.

C. Funding Strategies

Note: Federal, state, and local funding programs and their availability may change over time. Communities should verify current program status and funding levels directly with the relevant federal, state, or local agency before planning or applying. This section is not intended as an exhaustive list of funding opportunities.

Federal Funding Opportunities:

Grant Program	Purpose	Typical Award	Application Cycle	Agency
RCORP (Rural Communities Opioid Response Program)	SUD prevention, treatment, recovery	Planning: $200,000; Implementation: $1,000,000/year for 3 years	Spring	HRSA
SAMHSA Opioid Response Grants	State and county opioid crisis response	$300,000–$2,000,000/ year	Fall	SAMHSA
CCBHC Planning and Implementation	Develop Certified Community Behavioral Health Clinics	Planning: $75,000; Implementation: $2,000,000/year	Rolling	SAMHSA
HRSA Behavioral Health Workforce	Training, loan repayment, workforce development	$200,000–$1,000,000/ year	Spring	HRSA
SAMHSA Mental Health Block Grant	State allocations for community mental health	Formula-based	State-administered	SAMHSA
CDC Overdose Prevention	Surveillance, prevention, harm reduction	$300,000–$800,000/ year	Fall	CDC
School-Based Health Center	Capital and operations for school-based health	$300,000–$600,000	Spring	HRSA
Rural Health Network Development	Multi-county coordination	$250,000/year for 3 years	Spring	HRSA

State Funding (New York):

- **OASAS Provider Grants:** SUD treatment, recovery, prevention, and harm reduction. Contact your OASAS regional office for current opportunities.
- **OMH Community Mental Health Services:** ACT, mobile crisis, CCBHC, and supported housing. Contact your OMH regional field office for current opportunities.

- **Opioid Settlement Funds:** New York counties may receive opioid litigation settlement funds through 2038. Allowable uses include treatment, prevention, harm reduction, recovery support, and criminal justice interventions. Funds cannot be used for law enforcement or prosecution and must supplement rather than supplant existing services. Contact your county's opioid settlement advisory committee for allocation processes. For statewide coordination, see the NYS Opioid Settlement Fund Advisory Board.
- **Medicaid:** The primary ongoing funding source for most clinical services. Ensuring Medicaid billing is in place from the start is essential to sustainability. Note that Medicaid reimbursement policies, covered services, and rates are subject to change based on federal and state budget decisions. Communities should verify current coverage and reimbursement rates with their state Medicaid agency before designing programs around specific billing assumptions and monitor for policy changes that could affect long-term sustainability.
- **Private Foundations:** Statewide private foundations with grant-making priorities relevant to rural behavioral health. These are independently endowed organizations distinct from community foundations. Review each foundation's website for current priorities and application processes.

Local Funding:

- **Hospital Community Benefit:** Nonprofit hospitals must invest in community health to maintain tax-exempt status. Behavioral health access is a high priority in most hospitals' Community Health Needs Assessments (CHNAs). Contact the hospital's VP of Community Health or hospital foundation with a proposal aligned to their most recent CHNA.
- **Community Foundations:** Place-based organizations that pool donations from local donors and distribute grants in their region. Use the Council on Foundations directory (cof.org) to find foundations in your region.
- **United Way:** Local United Way chapters fund coordination, navigation, and prevention programming.
- **County Budgets:** Health department and mental health authority allocations.

Sustainability Planning:

- **Medicaid reimbursement** is the top priority for long-term sustainability. Ensure all clinical services are billable from day one.
- **Value-based payment:** Document cost savings such as reduced emergency department use and reduced incarceration to make the case for ongoing funding from payers and county government.
- **Diversify funding:** Combine federal grants, state funding, Medicaid, and local sources to reduce dependence on any single stream.
- **Build into existing infrastructure:** Programs embedded in schools, primary care practices, and hospitals with ongoing funding are more likely to survive than standalone grant-funded projects.
- **Document outcomes rigorously:** Data drives continued funding and demonstrates value to funders and community stakeholders.

D. Coalition Building and Community Engagement

Why Coalitions Matter:

The SARHNA documents isolation and fragmentation as major barriers to behavioral health access in rural communities (Grove & Coates, 2025). Evidence-based models such as HEALing Communities and RCORP require active multi-sector coalitions to function. Coalitions also create shared ownership and sustainability that extends beyond any single organization.

Essential Coalition Members:

1. **County government:** Health department, mental health authority, social services
2. **Healthcare:** Hospitals, FQHCs, primary care practices, EMS
3. **Behavioral health providers:** Mental health centers, OASAS programs
4. **Schools:** Superintendents, school nurses, counselors
5. **Justice system:** Police, sheriff, correctional facilities, district attorney, and organizations providing services or advocacy for justice-involved individuals
6. **Recovery community:** Peer specialists, family organizations, recovery centers
7. **Faith community:** Trusted community messengers with broad reach
8. **Libraries:** Increasingly important as community hubs and telehealth sites. Interventions involving digital technology may also benefit from partnering with stakeholders such as computer device distributors, digital skills training providers, digital navigation programs, and/or community computer labs.
9. **Workforce development:** Employment services for people in recovery
10. **Housing:** Housing authority, community development corporations

Coalition Best Practices:

1. **Use data to guide decisions:** Overdose dashboards, needs assessments, and outcomes tracking keep coalitions focused on evidence rather than anecdote.
2. **Start with quick wins:** Build momentum with achievable early successes before tackling more complex system changes.
3. **Share credit broadly:** Recognize the contributions of all partners to sustain engagement over time.
4. **Meet regularly but efficiently:** Monthly or bimonthly meetings of 90 minutes with clear agendas work well for most coalitions.
5. **Create workgroups:** Break into smaller groups organized around topics such as youth, opioids, and crisis response to maintain focus and depth.

6. **Include people with lived experience:** Peers, family members, and youth should be at the table, not just professionals.
7. **Communicate progress:** Regular updates through newsletters, social media, and presentations to county leadership sustain community investment.

Example Models for Coalition Structure:

- **HEALing Communities:** University-supported, data-driven, structured consensus process
- **Communities That Care:** Five-phase model with a risk and protective factors framework
- **RCORP Consortiums:** HRSA-funded with required multi-sector coalition
- **Regional Planning Organizations:** Multi-county structure such as the North Country Behavioral Healthcare Network

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E. Data and Evaluation

Essential Data Systems:

1. **Overdose surveillance dashboard:** Near-real-time tracking of overdoses, naloxone use, and treatment connections. See Section II-F, Program 21 for full implementation guidance.
2. **Treatment capacity inventory:** Always know available slots, current wait times, and services at all local providers.
3. **Closed-loop referral tracking:** Know whether referrals resulted in services being received. The AmericaServes/Unite Us model (Section II-I, Program 29) provides one approach to this.
4. **Population health metrics:** Track overall county and regional trends in overdoses, suicides, emergency department use, and treatment admissions over time.

Example Metrics to Track by Program Type:

Program Type	Key Metrics
Workforce and Telehealth	Wait time for appointments (average days), number of patients served (monthly count), provider satisfaction (survey), patient outcomes (standardized measures)
MOUD and SUD Treatment	Treatment capacity (number of slots), time from referral to treatment start (average days), retention at 30, 90, and 180 days (percentage), overdose deaths (rate per 100,000)

Program Type	Key Metrics
Crisis Services	Response time (average minutes), emergency department diversions (monthly count), correctional facility diversions (monthly count), follow-up connection to care (percentage)
School-Based	Students screened (count), students served (count), school attendance rate, grades, percent change in disciplinary incidents
Prevention	Youth substance use rates (annual survey), program reach (number of students), curricula implemented with fidelity (percentage of sites)
Housing	Housing retention rate (percentage at 6 and 12 months), treatment retention rate, employment rate, percent change emergency department and correctional facility use
Harm Reduction	Naloxone distributed (count), overdoses reversed (reported count), syringes exchanged (count), treatment connections made (count)

Note: Metrics in this table draw from program-specific evidence bases, SAMHSA, HRSA, and OMH program reporting frameworks, and standard behavioral health evaluation practice. Communities might adapt these measures to their local context and available data systems.

Evaluation Support:

- University partnerships with institutions such as Columbia University and SUNY Upstate often provide evaluation support at low or no cost in exchange for access to practice-based research.
- HRSA and SAMHSA grants typically include evaluation funding and technical assistance as part of the award.
- Consider forming a regional evaluation collaborative to share costs across multiple counties.

F. Addressing Health Equity

Rural Health Equity Considerations:

While all rural residents face geographic barriers, some populations experience compounded disadvantages that require tailored attention. High-priority equity populations in rural New York include:

1. People experiencing extreme poverty, including deep poverty and ALICE households
2. Black, Indigenous, and People of Color (BIPOC) communities, including Native American communities which often experience the highest rates of substance use and suicide

3. Migrant and seasonal agricultural workers, who face language barriers, mobility, and fear of authorities
4. LGBTQ+ youth, who experience higher rates of suicidality and may face hostility in small rural communities
5. Veterans, who have distinct behavioral health needs and may be served by specialized programs
6. Justice-involved individuals, who need continuity of care between correctional facilities and the community
7. People with disabilities, who face transportation and accessibility challenges
8. Older adults, who face isolation and mobility limitations

Equity Strategies:

- **Tailored community outreach:** Peer workers from priority populations are most effective at reaching those communities.
- **Eliminate cost barriers:** Sliding scale fees, charity care, and assistance with copays keep services accessible regardless of income.
- **Address transportation:** Mobile services, telehealth, and transportation vouchers remove geographic barriers.
- **Cultural competence:** Staff training, materials made available in multiple languages, and integration of traditional healing practices where appropriate; see the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as an example framework for healthcare organizations.
- **Reduce stigma:** Peer-delivered services, anonymous drop-in options, and harm reduction approaches lower the threshold for engagement.
- **Justice coordination:** Correctional facility-based MOUD, warm handoffs upon release, and specialized probation support continuity of care.
- **School-based services for youth:** Eliminates transportation barriers and reduces stigma for young people.
- **Accessibility:** Ensure facilities and services are Americans with Disabilities Act (ADA) compliant, including telehealth services. Provide American Sign Language (ASL) interpretation and live captioning for virtual services. Apply web accessibility standards and universal design principles to all materials and environments.

G. Information, Training, & Technical Assistance Resources

This section provides a comprehensive but not exhaustive reference for information, training, and technical assistance resources relevant to the programs and topics described in this guide.

Note that federal, state, or local funding programs and resources and their availability may change over time. Communities should verify current program status and funding levels directly with the relevant agency before planning or applying.

Reference to specific agencies or organizations in this section does not imply the availability of active partnership opportunities.

National Agencies & Organizations

1. **AIMS Center, University of Washington (Collaborative Care Model)**, https://aims.uw.edu/
2. **CA Bridge**, https://bridgetotreatment.org/
3. **CDC Overdose Data to Action (OD2A) Program**, https://www.cdc.gov/overdose-prevention/php/od2a/index.html
4. **Crisis Now**, https://crisisnow.com/
5. **HRSA Behavioral Health Workforce Education and Training (BHWET) Program**, https://bhw.hrsa.gov/programs/bhwet-program-professionals
6. **HRSA Bureau of Primary Care**, https://bphc.hrsa.gov/
7. **HRSA Federal Office of Rural Health Policy (FORHP)**, https://www.hrsa.gov/rural-health
8. **HUD Exchange**, https://www.hudexchange.info/
9. **National Alliance for Recovery Residences (NARR)**, https://narronline.org/
10. **National Alliance on Mental Illness (NAMI)**, https://www.nami.org/
11. **National Council for Mental Wellbeing**, https://www.thenationalcouncil.org/
12. **National Harm Reduction Coalition**, https://harmreduction.org/
13. **NORC SBIRT Education and Training**, https://www.sbirteducation.com/
14. **Project ECHO Institute**, https://projectecho.unm.edu/
15. **RCORP Technical Assistance Center**, https://www.rcorp-ta.org/
16. **Rural Health Information Hub**, https://www.ruralhealthinfo.org/
17. **Rural Minds**, https://www.ruralminds.org/
18. **SAMHSA CCBHC Technical Assistance Center**, https://www.samhsa.gov/technical-assistance/ccbhc-s-tac
19. **School-Based Health Alliance**, https://www.sbh4all.org/
20. **Substance Abuse and Mental Health Services Administration (SAMHSA),** www.samhsa.gov

New York State

1. **Center for Practice Innovations (CPI) at Columbia Psychiatry**, https://www.practiceinnovations.org/
2. **Charles D. Cook Office for Rural Health**, orh@health.ny.gov
3. **Columbia University Social Intervention Group - HEALing Communities Study**, https://sig.columbia.edu/research-projects/healing-communities-study
4. **Conference of Local Mental Hygiene Directors**, https://www.clmhd.org/
5. **ConnectALL Office**, https://broadband.ny.gov/
6. **Department of Health (DOH)**, https://www.health.ny.gov/
7. **Mental Health Association in New York State (MHANYS) School Mental Health Resource & Training Center**, https://www.mentalhealthednys.org/
8. **NAMI New York State**, https://naminys.org/
9. **New York Certification Board [peer recovery support certification]**, https://www.asapnys.org/ny-certification-board/
10. **New York State Alliance of Recovery Residences (NYSARR)**, https://www.nysarr.org/
11. **New York State Area Health Education Center (AHEC) System**, https://nysahec.org/
12. **New York State Association of County Health Officials (NYSACHO)**, https://nysacho.org/
13. **New York State Trauma-Informed Network & Resource Center (NYS TINRC)**, https://www.traumainformedny.org/
14. **Northeast Telehealth Resource Center (NETRC)**, https://netrc.org/
15. **Office of Addiction Services and Supports (OASAS)**, https://oasas.ny.gov/
16. **Office of Mental Health (OMH)**, https://omh.ny.gov/

Academic Partners

University partnerships may offer free or low-cost evaluation support, access to evidence-based practices, student interns and trainees, and enhanced credibility for grant applications. Contact universities directly for more information.

Examples of academic institutions in New York State:

1. SUNY Upstate Medical University (Syracuse) Department of Psychiatry: Telepsychiatry, Project ECHO, and school-based mental health
2. University of Rochester Medical Center Department of Psychiatry: Finger Lakes Rural Telepsychiatry Program and Collaborative Care Model

3. Columbia University Social Intervention Group: HEALing Communities Study
4. Bassett Healthcare (Bassett Research Institute) and Columbia University: School-based health in Otsego and Northern Catskills counties
5. Syracuse University Institute for Veterans and Military Families (IVMF): AmericaServes and NYServes coordinated referral networks

How to initiate a university partnership:

- Email department chairs or research centers expressing interest
- Emphasize mutual benefit: the community gains technical assistance and evaluation support; the university gains access to practice-based research
- Consider formalizing the relationship through a Memorandum of Understanding (MOU) or affiliation agreement

Consumer Access and Insurance Navigation Resources

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

CHAMP is a statewide New York State ombudsman and navigation program that assists individuals in accessing mental health and substance use disorder services by helping them understand insurance benefits, enroll in coverage, resolve denials, and locate providers. A joint program of OASAS and OMH, CHAMP provides free, confidential assistance through a statewide helpline and regional community-based partners.

- Website: https://champny.org/

Section IV: Common Implementation Pitfalls and How to Avoid Them

Even well-designed programs with strong evidence and adequate funding can fail in implementation. The pitfalls described below are the most common barriers to successful and sustainable program launch in rural communities. Reviewing this section before beginning implementation can help communities anticipate and prevent these challenges.

Pitfall 1: Pilot Project Syndrome

What it is: A program launches successfully with grant funding but collapses when the grant ends, leaving the community without the service and partners feeling burned out.

How to avoid it:

- Build Medicaid billing into the program design from day one, before launch.
- Embed the program in existing infrastructure such as schools, primary care practices, and hospitals that have ongoing funding streams.
- Diversify funding from the start by combining three or more sources.
- Build community ownership through a coalition or advisory structure rather than housing the program in a single organization.
- Document cost savings from reduced emergency department use, correctional facility costs, and crisis services to justify ongoing local investment when grants end.

Pitfall 2: Build It and They Will Come

What it is: A new service is created but the target population does not know about it, does not trust it, or faces barriers that prevent access.

How to avoid it:

- Develop a proactive outreach strategy using peer outreach workers rather than relying on flyers and passive promotion.
- Partner with trusted community messengers including faith communities, schools, recovery community organizations, and libraries.
- Reduce access barriers including transportation, childcare, inflexible hours, and required appointments.
- Design services with direct input from the target population.
- Sustain promotion and awareness efforts beyond the initial launch period.

Pitfall 3: Hero Clinician Burnout

What it is: The program depends entirely on one passionate clinician who eventually burns out and leaves, causing the program to collapse.

How to avoid it:

- Use a team model with at least two staff members so the program is never dependent on a single person.
- Follow evidence-based caseload ratios such as 50 to 75 patients per care manager in the Collaborative Care Model and a 1:10 staff-to-patient ratio in Assertive Community Treatment.

- Provide regular clinical supervision, peer consultation, and structured self-care support.
- Cross-train staff and document protocols so that no single person holds all the institutional knowledge.
- Offer competitive compensation and use National Health Service Corps loan repayment and other incentives to improve retention.

Pitfall 4: Technology Failure

What it is: Telehealth or data systems do not work reliably, eroding trust among providers and patients and stalling program operations.

How to avoid it:

- Test all technology thoroughly with a small pilot group before full launch.
- Develop clear backup plans for common failures, such as switching to a phone appointment if video fails.
- Designate IT support staff rather than expecting clinical staff to troubleshoot technology issues.
- Partner with public libraries to serve participants who lack adequate home broadband and/or device access.
- Select platforms designed for users with limited technology experience and provide orientation before the first appointment.

Pitfall 5: Silo Service

What it is: A new program operates in isolation from existing services, duplicates effort, and fails to connect participants to the broader care system.

How to avoid it:

- Embed programs in existing systems such as primary care, schools, and emergency departments rather than building standalone programs.
- Formalize partnerships through Memoranda of Understanding (MOUs) that define roles, referral processes, and data sharing.
- Hold regular case conferences, weekly or monthly, between partnering organizations.
- Implement shared data systems including closed-loop referral tracking and coordinated care plans.
- Use a coalition structure such as the HEALing Communities or RCORP model with regular cross-sector meetings.

Pitfall 6: Mission Creep

What it is: A program gradually takes on too many functions, loses its focus, overburdens staff, and becomes unsustainable.

How to avoid it:

- Define clearly in writing what the program does and, equally importantly, what it does not do.
- Build strong referral relationships with other providers for services outside the program's scope.
- Resist pressure to become everything for everyone, and communicate the program's boundaries consistently to referral sources and community partners.
- Measure fidelity regularly to track whether the program is being implemented as designed.
- Use a coalition or advisory board to hold the program accountable to its original mission.

Pitfall 7: Evaluation Afterthought

What it is: A program operates for years without tracking whether it is working, making it impossible to demonstrate value when funding is threatened or to improve based on experience.

How to avoid it:

- Determine which outcomes to track before launching, not after.
- Start with simple metrics that are easy to collect consistently, such as number of people served, wait times, and patient outcomes using standardized tools.
- Implement a database or registry from day one to track participants and outcomes.
- Review and share data at least annually with funders, partners, and the community.
- Partner with a university for free or low-cost evaluation support and to strengthen credibility with funders.

Section V: Example Implementation Timelines

The following examples are fictional and provided for illustrative purposes only. They are intended to help counties and organizations visualize what phased implementation might look like in practice, including realistic timelines, budget structures, and sustainability considerations. They are not intended to represent actual county experiences or to prescribe a single correct approach.

Example 1: Small Rural County Implementing Collaborative Care in Two Primary Care Practices

County profile: 40,000 residents; no psychiatrists; 6-month wait for outpatient mental health; two FQHCs

Lead organization: County health department in partnership with FQHCs

Timeline:

- Month 1: Meet with FQHC leadership to propose Collaborative Care Model; secure commitment from both practices
- Month 2: Apply for HRSA Behavioral Health Workforce Education and Training grant; negotiate psychiatric consultation contract with academic medical center. *Note: Identify bridge funding to cover startup costs in advance of grant award, as hiring and contracting will begin before grant funds are available.*
- Month 3: Post position and begin hiring process for behavioral health care manager (shared across both practices). *Note: Hiring timelines may extend beyond one month; activities in Month 4 can begin in parallel.*
- Month 4: Complete AIMS Center training; set up patient registry; develop workflows and billing processes
- Month 5: Pilot launch with first 20 patients; hold weekly huddles with care manager, primary care providers, and psychiatric consultant to troubleshoot
- Month 6: Expand to full operations with a goal of 50 to 75 active patients
- Month 12: Review outcomes including PHQ-9 change scores, remission rates, and billing revenue; expand to additional practices if results are strong

Budget:

Item	Annual Cost
Behavioral health care manager salary and benefits	$80,000
Psychiatric consultation ($150/hour, 2 hours/week, 50 weeks)	$15,000
Total	**$95,000/year**

Revenue: Collaborative Care Model billing generates approximately $120 to $150 per patient per year. At 50 patients, this produces approximately $6,000 to $7,500 in year one. At full capacity of 75 patients, annual revenue reaches approximately $9,000 to $11,000. Additional revenue comes from reduced emergency department visits and improved chronic disease management.

Sustainability: HRSA grant supports years 1 through 3. Transition to Medicaid reimbursement as primary funding source. Demonstrate value to FQHCs through improved patient outcomes and reduced inappropriate emergency department use to secure their ongoing commitment.

Example 2: Medium County Implementing School-Based Mental Health in a High School

County profile: 75,000 residents; elevated youth suicide rate; one school district with a 1,200-student high school

Lead organization: Local hospital employs the clinician and bills Medicaid; school provides space

Timeline:

- Month 1: Meet with superintendent and principal; present data on youth mental health from the SARHNA (Grove & Coates, 2025) and relevant county sources; propose school-based mental health program
- Month 2: Negotiate Memorandum of Understanding between school and hospital covering services, space, billing, confidentiality, and emergency protocols
- Month 3: Post position and begin hiring process for LCSW with adolescent experience. *Note: Hiring timelines may extend beyond one month; space setup in Month 4 can begin in parallel.*
- Month 4: Set up counseling office in school; train clinician on school protocols including mandated reporting and IEP process; develop referral process with school counselors
- Month 5: Launch services; begin accepting referrals from school counselors, parents, and student self-referrals
- Month 6: Reach 30 active students; add a weekly anxiety management group
- Month 12: Review outcomes including attendance, PHQ-A scores, and disciplinary incidents; present data to superintendent; expand to middle school if results support it

Budget:

Item	Annual Cost
LCSW clinician salary and benefits	$100,000
Total	**~$100,000/year**

Revenue: Medicaid reimbursement at approximately $90 per session. At 25 students with one session per week over 36 school weeks, annual revenue is approximately $81,000. Additional revenue from commercial insurance billing for students with coverage.

Sustainability: Medicaid reimbursement covers most costs. Hospital community benefit funding supplements the gap. Demonstrate value through improved student outcomes including attendance, grades, and reduced crisis incidents to secure ongoing school district and hospital commitment.

Example 3: Multi-County RCORP Consortium for Opioid Response

County profile: Three rural counties with a combined population of 120,000; high overdose rates; limited MOUD capacity; workforce shortages

Lead organization: Regional health planning organization serving all three counties

Timeline:

Year 1: Planning Phase

- Months 1–3: Form consortium with representation from three county health departments, two hospitals, OASAS providers, law enforcement, correctional facilities, and recovery community organizations
- Months 4–6: Conduct regional needs assessment; identify treatment gaps, workforce needs, and coordination barriers across all three counties
- Months 7–9: Apply for HRSA RCORP Implementation grant ($1,000,000 per year for 3 years)
- Months 10–12: Develop detailed implementation plan covering MOUD expansion at two sites, a mobile medication unit, harm reduction programming, peer navigation, overdose surveillance dashboard, and coalition coordination

Year 2: Implementation, Grant Year 1

- Q1: Hire consortium coordinator; establish mobile medication unit routes; hire peer navigators
- Q2: Expand MOUD capacity at two sites by training providers and increasing available slots; launch harm reduction program
- Q3: Implement overdose surveillance dashboard; coordinate naloxone distribution across all three counties
- Q4: Review data; adjust implementation based on early outcomes and coalition input

Year 3: Implementation, Grant Year 2 Continue expanding services. Focus on sustainability by ensuring Medicaid billing is in place for all clinical services, diversifying funding, and building community ownership through the coalition structure.

Year 4: Implementation, Grant Year 3 and Sustainability Planning Transition services to ongoing funding through Medicaid, OASAS program funding, and county budgets. Document outcomes including overdose deaths, treatment capacity, naloxone distribution, and cost savings to make the case for continued investment.

Budget:

Item	Annual Cost
MOUD expansion at two sites	$250,000
Mobile medication unit (capital and operations)	$200,000
Harm reduction program	$150,000
Peer navigators	$150,000
Overdose surveillance dashboard	$100,000
Consortium coordination	$150,000
Total	**$1,000,000/year (RCORP grant)**

Sustainability: As grant years conclude, services transition to Medicaid reimbursement, OASAS program funding, county opioid settlement funds, and demonstrated value for ongoing county investment. The consortium structure itself becomes a permanent regional coordination infrastructure.

Section VI: References and Evidence Sources

This guide draws on peer-reviewed research, federal and state program evaluations, and established evidence clearinghouses. Sources are organized by how they inform each section of the guide, with additional key evidence provided by program area.

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1. Decision-Making Frameworks and Priority Setting

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Cross-Sector and Upstream Strategies

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2. Evidence-Based and Promising Practices

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New York State Office of Mental Health (OMH). https://omh.ny.gov

New York State Office of Mental Health (OMH). Regional Field Offices. https://omh.ny.gov/omhweb/aboutomh/fieldoffices.html

NY State Charles D. Cook Office of Rural Health. orh@health.ny.gov

Federal Agencies

Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. https://bphc.hrsa.gov

Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth. https://www.hrsa.gov/telehealth

Health Resources and Services Administration (HRSA). Office of Rural Health Policy. https://www.hrsa.gov/rural-health

Evidence-Based Practice Databases & Clearinghouses

Campbell Collaboration. Systematic Reviews Database. https://www.campbellcollaboration.org/evidence/

Cochrane Collaboration. Cochrane Reviews Database. https://www.cochranelibrary.com

County Health Rankings and Roadmaps. *What Works for Health.* University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health

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Key Evidence by Topic

Selected foundational studies, evaluations, and resources supporting major topics addressed in this guide.

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Certified Community Behavioral Health Clinics (CCBHCs)

National Council for Mental Wellbeing. CCBHC Success Center. https://www.thenationalcouncil.org/program/ccbhc-success-center/

Substance Abuse and Mental Health Services Administration (SAMHSA). CCBHC State Technical Assistance Center. https://www.samhsa.gov/technical-assistance/ccbhc-s-tac

Community Paramedicine

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