Center for Health Care Strategies

Increasing Access to Rural Behavioral Health Care Through a Community-Based Workforce

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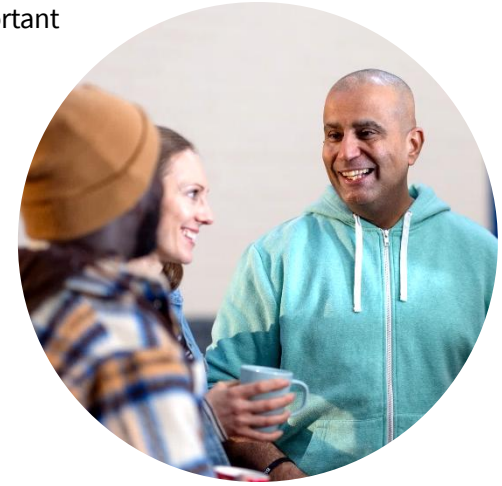
KEY TAKEAWAYS

- Rural communities face persistent barriers to behavioral health care access, including workforce shortages, transportation challenges, and limited service availability, contributing to unmet need.
- Expanding the community-based workforce — including peer support specialists, community health workers, and other trusted community-based professionals — can extend care team capacity, improve engagement, and increase access to behavioral health services.
- These models align with federal rural health priorities, including the Rural Health Transformation Program's focus on improving workforce development and health care access.
- This brief outlines five key considerations for providers and health systems seeking to expand community-based workforce models to address behavioral health needs in rural areas, with additional recommendations for state agencies to support implementation and sustainability.

Rural communities are at a pivotal moment for improving access to behavioral health care. The Rural Health Transformation Program (RHTP) creates a time-limited opportunity to strengthen access and build upon innovative, community-driven approaches already emerging across rural settings. One key strategy is expanding the non-clinical community-based workforce — including peer support specialists (peers), community health workers (CHWs), community paramedics, and care coordinators — to complement clinical teams and extend support beyond traditional health care settings. This approach is especially important given persistent access barriers to behavioral health care in rural communities, including workforce shortages, transportation challenges, and limited availability of local services, alongside significant behavioral health needs and ongoing challenges related to substance use disorder (SUD), suicide, and social isolation. By leveraging trusted individuals with deep community ties, the community-based workforce can extend provider capacity, improve engagement, and connect residents to care and supports where they live.



Maximizing the impact of federal investments such as RHTP will depend on provider innovation alongside state policies and financing strategies that support the long-term sustainability of these workforce approaches. To better understand how rural communities are using community-based workforce roles to address behavioral health needs, the Center for Health Care Strategies (CHCS) interviewed 14 rural health care providers and community-based organizations (CBOs) across 10 states that are implementing a range of innovative approaches.

Drawing on the interviews and additional research, this brief outlines five considerations for providers seeking to expand community-based workforce approaches to address behavioral health needs in rural areas:

1. **Design workforce roles around community needs and assets**;
2. **Put relationship-building skills on par with formal training**;
3. **Create the conditions for peers to thrive**;
4. **Integrate community-based roles into clinical teams and community settings**; and
5. **Leverage time-limited funds to build toward long-term sustainability**.

Each consideration includes key action steps and examples from the field. The brief also outlines **state opportunities** to support these approaches through supportive workforce, reimbursement, and financing policies. An **appendix** highlights key features of the community-based workforce approaches described in this brief. It can help states, rural health providers, and community organizations identify and adapt promising models for improving behavioral health care access in rural areas.

How a Community-Based Workforce Strengthens Behavioral Health Care

A growing body of evidence demonstrates the effectiveness of community-based workforce roles in supporting behavioral health care delivery and improving outcomes for the individuals they serve. Roles such as peers, CHWs, and community paramedics can improve engagement in care, strengthen connections to treatment and support services, and increase ongoing participation in care. Collectively, these roles can support access to care by helping individuals navigate services and connect with behavioral health and community-based resources.

In rural communities facing persistent shortages of licensed behavioral health providers, community-based staff can help extend the reach and capacity of clinical teams. When integrated into multidisciplinary care teams, these community-based workers help fill critical gaps in care by supporting outreach, engagement, navigation, and care coordination activities, complementing — rather than replacing — the work of

licensed clinicians. This allows licensed providers to focus on delivering more complex behavioral health services. Community-based staff also play an important role in facilitating referrals to other health care and social services. In addition, this workforce can support access to telehealth services by helping rural residents navigate technology, overcome digital access barriers, and connect to a broader range of clinical and specialty providers.

These roles may also support workforce sustainability. Burnout is common among health care professionals, particularly in resource-constrained environments. Team-based care models that include community-based staff can help distribute responsibilities across care teams, expand capacity, improve job quality, and allow providers to practice at the top of their license.

Community-Based Workforce Roles

Through interviews and research, CHCS identified community-based workforce roles commonly used to expand behavioral health care access in rural communities. The definitions below are intended as general descriptions of these roles and are not exhaustive. Titles, responsibilities, and training requirements may vary across organizations and states.

- **Peer Support Specialists (Peers)**: Individuals with lived experience of recovery from mental health or substance use challenges who use that experience to provide support, mentoring, advocacy, and connections to treatment and recovery resources.
- **Community Health Workers (CHWs)**: Trusted community members who help individuals navigate health and social services, address barriers to care, provide health education, and connect people to community resources.
- **Community Paramedics**: Specially trained paramedics who provide preventive, follow-up, and care coordination services in homes and community settings, helping address unmet physical and behavioral health needs and reduce avoidable emergency department use.
- **Care Coordinators**: Staff who help individuals access and navigate health care, behavioral health, and social service systems by coordinating services, facilitating referrals, and supporting continuity of care across settings.

Considerations for Implementing Community-Based Workforce Approaches to Improve Behavioral Health Access in Rural Communities

This section outlines five practical considerations for providers seeking to integrate community-based workforce roles into behavioral health care delivery in rural communities. Each consideration includes key action steps and examples from across the country.

1. Design workforce roles around community needs and assets.

Each rural community has unique strengths, needs, and workforce assets. Successful organizations begin by identifying local behavioral health needs, including barriers such as clinical workforce shortages. Organizations can also identify assets they can leverage, such as strong social networks, trusted CBOs, and community members with interpersonal skills needed for community-based workforce roles. Organizations can then design workforce roles that align with local priorities and resources.

Community members, frontline staff, and individuals with lived experience of behavioral health needs can provide valuable perspectives and help ensure workforce roles meet the needs of the populations they serve. External partners, such as technical assistance organizations, nonprofits, community foundations, and other local funders, can also support the design and implementation of workforce approaches that address local needs. Additionally, communities can explore partnerships beyond traditional health care settings, such as libraries and other trusted spaces where people may already seek support.

There is no "one-size-fits-all" approach to building and deploying a community-based workforce. While local needs and assets should shape workforce roles, providers should also consider long-term financial sustainability, as financing and reimbursement opportunities vary by state and role. For example, providers in states that allow Medicaid reimbursement for CHWs or peer support services through state plan amendments or 1115 waivers may be better positioned to implement those roles than community-based roles that are not eligible for reimbursement. Aligning workforce design to ensure Medicaid coverage can help sustain and expand these roles over time.

Key Actions

- **Identify existing assets and unmet needs**. Conduct a needs assessment, gap analysis, or asset mapping exercise to identify behavioral health service gaps, existing workforce resources, and community assets. Use findings to determine which workforce strategies are best suited for local needs.
- **Engage frontline staff and community members**. Involve providers, community partners, and people with lived experience in planning and decision-making. Their perspectives can help identify service gaps and ensure workforce roles respond to local needs.
- **Adapt roles as community needs change**. Regularly assess whether workforce roles are meeting intended goals. Stay responsive to changing needs and modify roles and responsibilities over time.
- **Evaluate sustainability alongside workforce design**. Consider how to finance roles over time. Reimbursement policies, certification requirements, and funding opportunities vary by state and may influence which approaches are most feasible.

Examples from the Field

- **River Valley Health**, **Tennessee** (Federally qualified health center (FQHC), community mental health center (CMHC), and licensed alcohol and drug treatment facility).
  As behavioral health needs increased during and after the COVID-19 pandemic, River Valley Health leaders recognized that psychiatric prescribers, including psychiatrists and psychiatric nurse practitioners, needed more support. In response, they developed a behavioral health assistant role that functions like a medical assistant in psychiatry, supporting treatment plans, gathering records, troubleshooting pharmacy issues, and checking in with patients. River Valley has since expanded its community-based workforce roles to address staffing shortages and strengthen patient engagement in behavioral health care, adding peer wellness coaches, CHWs, community health coordinators, and individual placement and support specialists (IPS). These roles were created to meet identified needs rather than as part of a predetermined workforce model.

> **If the position hasn't been established yet, ask your community what they would like out of the role. Maybe the role you think you need is different than the role your community needs most.**
>
> - Tessa Leindecker, Business Development Advisor, Southcentral Foundation

- **The Meadowlark Initiative**, **Montana** (integrated behavioral health model for pregnant and postpartum people). After providers identified a growing number of infants with prenatal substance exposure and gaps in their capacity to respond, the Montana Healthcare Foundation funded a national scan of promising practices and supported development of the Meadowlark Initiative. The initiative integrates obstetric providers, behavioral health providers, and care coordinators to better support pregnant and postpartum people with behavioral health needs, including SUDs, across rural and tribal communities. The National Council for Mental Wellbeing provided technical assistance to help Meadowlark care teams better serve their patients. Care coordinators connect patients to treatment and community supports, helping providers feel more comfortable screening for substance use. To meet local workforce needs, the care coordinator role was designed with flexible qualification requirements, allowing individuals from a range of backgrounds, including nurses, peers, doulas, lactation consultants, and CHWs, to serve in the position.
- **Libraries for Health Initiative**, **Texas** (rural library-based peer program). After a community health needs assessment identified significant gaps in mental health care access in rural areas, follow-up conversations revealed that public library staff regularly encountered patrons with mental health concerns but lacked the resources to support them. In response, St. David's Foundation funded the Libraries for Health initiative, which embeds peers in rural libraries to provide support and connect individuals to care. St. David's considered both peers and CHWs for the role, but ultimately chose peers based on local needs and an implementation partner, Via Hope, which had experience training peers and embedding them in non-traditional settings.

2. Put relationship-building skills on par with formal training.

Interpersonal skills are critical to the success of community-based workforce roles. Skills and qualities such as trust-building, compassion, cultural humility, patience, adaptability, and a non-judgmental approach enable individuals in these roles to engage people, build credibility, navigate stigma, advocate, and build partnerships across organizations and systems. As a result, many organizations prioritize these qualities and "soft skills" alongside, or even above, formal education or credentials, while providing additional training upon hire.

This is particularly important in rural communities, where individuals with lived experience of behavioral health needs, or a history and connection with the area, often bring a level of trust and credibility that credentials alone cannot provide. Community-based staff often

serve as a trusted first point of contact, helping individuals engage in care and obtain needed services. Community-based staff are well positioned to build relationships with community partners, which is especially important given the limited resources in rural areas.

Key Actions

- **Prioritize relationship-building skills in hiring**. Develop job descriptions and recruitment processes that value trust-building, communication skills, cultural responsiveness, and community connections alongside formal education and credentials.
- **Provide training and ongoing support**. Offer on-the-job training in motivational interviewing, behavioral health activation, and boundary setting. Regular supervision by licensed clinicians, experienced peers, or other community-based staff can reinforce skill development and provide opportunities for coaching, including on the challenges of working in close-knit rural communities where staff may encounter individuals they serve outside of work.
- **Invest in career growth and advancement**. Support staff in pursuing professional development and career advancement opportunities, including peer certification, additional training, degree programs, and leadership roles. This may include providing supervision hours needed for credentials or degrees, mentorship, scheduling flexibility, or letters of recommendation.

Examples from the Field

- **Blacktail Health**, **Montana** (FQHC). Recognizing that trust and patient engagement are foundational to effective care management, Blacktail Health prioritizes interpersonal skills such as compassion, kindness, and adaptability over specific educational credentials when hiring care managers. These skills enable care managers to build trusting relationships with patients who, for example, may be reluctant to engage in therapy. As trust develops, patients are often more willing to discuss challenges and accept support. Blacktail Health's behavioral health director described their care managers as "expert problem solvers" who often uncover challenges that patients may not share with clinicians, such as being unable to afford medications. The care managers draw on relationships they have built with CBOs to connect patients with resources to address identified barriers.

- **Southcentral Foundation**, **Alaska** (nonprofit Tribal health care provider). Southcentral Foundation's relationship-based "customer-owner" model shapes how it hires and supports Behavioral Health Aides (BHAs), who are part of Alaska's statewide Behavioral Health Aide Program. The organization prioritizes candidates with strong community engagement and local knowledge. In many remote communities, distance and travel barriers make it difficult for patients to access services and for providers to travel between locations. BHAs serve as advocates, educators, and connectors, facilitating access to services, supporting visiting clinicians, and providing cultural and community context that informs care delivery. One employee described BHAs as the program's "eyes and ears — and teachers," helping clinicians understand community needs while building trust and engagement.
- **River Valley Health**, **Tennessee** (FQHC, CMHC, and licensed alcohol and drug treatment facility). Recognizing the importance of interpersonal skills and the challenges of rural recruitment, River Valley often recruits from within its existing workforce. Staff who demonstrate strong relational skills, such as patient service representatives in frontline positions, are encouraged to pursue community-based workforce roles, creating pathways for career advancement while helping fill workforce gaps.

3. Create the conditions for peers to thrive.

Peers with lived experience of recovery from SUD are uniquely positioned to build trust, reduce stigma, and engage individuals in treatment. Organizations that have integrated peers into care teams reported that patients often share information with peers that they would not disclose to licensed providers. These insights can help care teams better understand an individual's circumstances and recovery needs. Peers can also help clinical teams and community partners better understand SUD and recovery.

In many rural communities, providers and first responders primarily encounter individuals with SUD during a crisis, overdose, or period of active use. The visibility of peers in recovery can challenge stereotypes, demonstrate that recovery is possible, and reduce stigma within communities and care systems.

Realizing these benefits requires investments in recruiting, supporting, and retaining peers. While peers face many of the same workforce challenges seen across rural health care, interviewees also highlighted barriers unique to peer roles. Past involvement with the criminal legal system, background check requirements, and challenges related to workforce reentry can make it more difficult for peers to obtain employment, even when they are well qualified for these roles. Organizations also stressed the importance of ongoing supervision, training, and mentorship from experienced peers to help newer staff navigate professional boundaries, strengthen their skills, and support long-term retention.

Key Actions

- **Support candidates with lived experience through the peer certification process**. Help individuals with lived experience navigate certification requirements through training, mentorship, mock interviews, volunteer opportunities, and on-the-job learning opportunities. Connect individuals pursuing peer certification with experienced peers who can provide guidance, share lessons learned, and support professional development.
- **Leverage statewide recovery networks**. Partner with statewide peer-led organizations such as recovery community organizations (RCOs) and other recovery advocacy organizations to recruit candidates, support certification, and connect peers to training and professional development opportunities.
- **Support peer well-being and retention**. Provide ongoing supervision, training, peer support, and clear role expectations to help peers navigate professional responsibilities and maintain healthy boundaries. As demand for services grows, ensure staffing and administrative support keep pace to prevent burnout and support retention.
- **Review hiring and background check policies**. Where appropriate, identify opportunities to reduce unnecessary barriers to employment that may exclude otherwise qualified candidates with lived experience from peer roles.
- **Create opportunities for career advancement**. Develop pathways into senior and supervisory roles to improve retention and recognize the expertise peers gain through lived experience and professional practice.

Examples from the Field

- **Walton Empowers**, **Georgia** (RCO). Walton Empowers supports individuals with lived experience obtain peer certifications through several Georgia certification pathways. The organization supports prospective peers throughout the process, including with applications, essays, reference letters, interview preparation, and other certification requirements. Walton Empowers also offers volunteer opportunities that help prospective peers gain practical experience, strengthen peer-support skills, and prepare for future employment and leadership roles.
- **Chestnut Health Systems**, **Illinois and Missouri** (Certified Community Behavioral Health Clinic (CCBHC)). Chestnut supports its peer workforce by creating opportunities for advancement. Its Recovery Support Development Coordinator role trains and supervises peer staff and supports peers pursuing certification. A supervisor with lived experience can provide valuable guidance grounded in an understanding of recovery and the challenges of professional peer work.

- **Rural Health Redesign Center's Peer Recovery Expansion Project (PREP)**, **Pennsylvania** (hospital emergency department peer program). PREP convenes a monthly support group for its peers that combines group support with structured learning. PREP's technical advisor, the Addiction Recovery Mobile Outreach Team, facilitates discussions on challenges unique to the peer role in emergency departments, including professional boundaries, confidentiality, self-care, and supporting individuals from their own communities.
- **Arukah Institute's Living Room Program**, **Illinois** (peer-led behavioral health crisis diversion program in a CCBHC). The Living Room model is a welcoming, low-barrier alternative to the emergency department that provides peer support, crisis de-escalation, and connections to services. Peers receive crisis intervention training, regular supervision, and support to pursue advanced credentials. The program fosters a supportive, non-clinical environment, enabling peers to build trust, engage people in crisis, and connect them to behavioral health and social services.

4. Integrate community-based roles into clinical teams and community settings.

Integrating community-based staff into care teams can expand clinical capacity, improve continuity of care, and strengthen patient engagement. Successful approaches clearly define the roles of community-based staff and clinicians while creating opportunities for collaboration through team huddles, case conferences, and shared workflows. Community-based staff often support key touchpoints, such as intake and follow-up, helping address social needs, connect individuals to local resources, and reinforce care plans. Their knowledge of the community can also help clinicians navigate sensitive issues and connect patients to support beyond traditional clinical care.

Successful integration requires an organizational culture that values community-based staff as essential members of the care team. Leadership plays an important role in communicating the value of these roles and addressing confusion or resistance among clinical staff.

Rural communities are also integrating these roles beyond traditional health care settings. For example, some organizations partner with criminal legal systems, child welfare agencies, or other community organizations to reach individuals where they already seek services. Others embed community-based staff in libraries, community centers, and other trusted settings, bringing support directly to places where people already live and interact and building local capacity to address behavioral health needs. These approaches reflect a broader movement toward community-initiated care, which seeks to make behavioral health services more accessible outside of traditional clinical settings.

Community-Initiated Care

Community-initiated care (CIC) trains trusted community members to recognize behavioral health needs and engage in supportive conversations in everyday settings such as restaurants, hair salons, and libraries. CIC equips trusted community members with practical helping skills to provide low-intensity support, respond to signs of distress, and promote well-being. When additional support is needed, CIC can help connect individuals to appropriate resources, including peers, CHWs, clinicians, and psychiatrists.

Following are resources that provide more information on CIC:

- Community Initiated Care: A Blue-print for the Practical Realization of Contextual Behavioral Science
- Expanding the Mental Health Care Continuum: A Framework for Philanthropic Investment in the Mental Health Workforce
- Community-Initiated Care in Behavioral Health: Exploring Funding Mechanisms for Substance Use Disorders

> ***"Community-initiated care should be the foundation and first response for people who need support."***
>
> *- Benjamin Miller, Adjunct Faculty, Stanford University School of Medicine; Principal, Revolution Desk*

Key Actions

- **Create workflows that support community-based workforce integration**. Include this workforce in daily workflows including team huddles and case conferences with clinical staff, and other routine staff activities to support communication, coordination, and team-based care.
- **Design roles to fill specific gaps in care**. Identify functions that are difficult for clinical staff to carry out, such as patient engagement, care coordination, addressing social needs, and connecting individuals to community resources. Community-based roles may have more success meeting these needs, which also frees up clinical staff to focus on providing care.
- **Invest in onboarding, training, and supervision**. Provide training for both community-based staff and clinicians on topics such as role clarity, confidentiality, professional boundaries, and stigma reduction to support effective collaboration.
- **Develop an organizational culture that values community-based roles**. Reinforce the importance of these roles through leadership support, inclusive team practices, and clear expectations that all members of the care team contribute valuable expertise.
- **Build strong partnerships across community settings**. Develop clear workflows when engaging community-based staff in other settings such as hospitals, or the criminal legal and child welfare systems. Whenever possible, formalize these relationships through referral agreements, memoranda of understanding, or other partnership structures to support seamless care across settings.

Examples from the Field

- **Blacktail Health**, **Montana** (FQHC). Blacktail Health fully integrates community-based care managers into its clinical teams, where they collaborate closely with physicians and other clinical staff. As trusted care team members, they help provide patient-centered care by addressing communication or culture gaps. The organization also supports professional development, with several care managers advancing into social work roles, demonstrating pathways for career growth.
- **Walton Empowers**, **Georgia** (RCO). Walton Empowers integrates peer recovery support across courts, community supervision, child welfare, and health care settings. Peers work alongside accountability court teams and the Georgia Department of Community Supervision, collaborate with child welfare staff, and provide support in the local hospital emergency department. These partnerships create opportunities for individuals and families to connect with recovery support at key points along their recovery journey.
- **McDowell County Community Care Paramedic Program**, **North Carolina**. McDowell County integrated a peer and care navigator into its community paramedicine team. Together, they assess community members' needs and coordinate responses, often conducting joint visits to address overlapping social, behavioral health, and medical challenges.

> **The [community-based workforce] is fully integrated into the care team. People who've observed our huddles and team meetings have remarked that they can't tell who the licensed provider is and who the community-based staff member is.**
>
> - Tessa Leindecker, Business Development Advisor, Southcentral Foundation

5. Leverage time-limited funds to build toward long-term sustainability.

Sustaining community-based workforce roles remains a significant challenge in rural communities. Interviewees often rely on grants, opioid settlement funds, state start-up funding, and other time-limited funding sources to support these roles. The RHTP is one recent example, providing time-limited funding to hire new staff, build partnerships, and establish the workflows and infrastructure needed to implement new workforce models.

Long-term sustainability, however, often depends on demonstrating impact and securing ongoing funding. Many rural providers have limited capacity to track outcomes or demonstrate return on investment, making it difficult to justify continued investment even when these roles are meeting critical community needs. Community paramedicine programs were a notable exception, in part because they are designed to address measurable and costly outcomes such as ambulance transports, emergency department visits, and law enforcement responses.

While Medicaid and other reimbursement pathways can support some community-based workforce roles, opportunities vary considerably across states, settings, and provider types. Interviewees noted that activities such as care coordination and relationship-building are not always directly billable to Medicaid or other insurance. Even when reimbursement is available, organizations may face challenges related to reimbursement rates, billing requirements, and administrative burden. Some organizations, such as RCOs, may not qualify as Medicaid-authorized providers and cannot bill Medicaid directly.

Without a long-term financing pathway, providers may not be able to sustain community-based workforce roles when grant funding ends, disrupting care coordination, reducing patient engagement, and weakening connections to needed services. Early planning can help communities maintain successful programs and preserve improvements in behavioral health access and outcomes. RHTP funding presents a critical opportunity to build the partnerships, evidence, and financing pathways needed to support effective community-based workforce models over time.

Key Actions

- **Create workflows that support community-based workforce integration**. Include this workforce in daily workflows, including team huddles and case conferences with clinical staff, and other routine staff activities to support communication, coordination, and team-based care.
- **Braid multiple funding sources**. Layer grants like RHTP funds, opioid settlement funds, local government support, health system investments, philanthropic funding, and health care reimbursement opportunities to reduce reliance on any single funding stream.
- **Explore reimbursement opportunities and billing partnerships**. Work with health systems, FQHCs, Medicaid-authorized providers, and technical assistance organizations, to identify pathways for Medicaid and Medicare reimbursement and develop billing capacity. For example, resources such as CHW Financial Sustainability Toolkit, Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Peer Workforce, and New Ways to Finance Community Health Worker Services in Medicare can help organizations understand available Medicaid, Medicare, and other financing opportunities.
- **Monitor emerging funding opportunities**. Stay informed about state and local initiatives such as RHTP and opioid settlement funding opportunities, or other state workforce investments that can support community-based roles.

- **Engage payers and policymakers early**. Collaborate with Medicaid agencies, managed care organizations, and other payers, as well as state behavioral health agencies, legislators, governors' offices, and other policymakers, to identify ways to support sustainable financing.
- **Build the case for sustainability**. Collect and share data, patient stories, and cost or utilization outcomes that demonstrate the value of community-based workforce roles and support discussions with potential financing partners about long-term sustainability.
- **Use time-limited funding to build lasting infrastructure**. Invest grant and other time-limited funds in workforce development, partnership building, training, workflow development, data systems, and other capabilities that support long-term sustainability. Time-limited funding can help communities build the foundational infrastructure, partnerships, and workforce to sustain these roles beyond the grant period.

Examples from the Field

- **McDowell County Community Care Paramedic Program**, **North Carolina**. The Community Care Paramedic program was initially funded through the Kate B. Reynolds Charitable Trust. Program leaders tracked reductions in emergency medical services (EMS) utilization, emergency department visits, and hospital readmissions linked to community paramedicine interventions, resulting in $1.66 million in cost savings in the four years following implementation. By demonstrating value to county leaders, the program secured county funding through the EMS budget, transitioning from a grant-funded pilot to a sustained, publicly supported community service.
- **Olmsted County Crisis Response Team**, **Minnesota** (county behavioral health crisis response program). Olmsted County used a blended financing strategy to support its behavioral health response programs. The program braided municipal and county opioid settlement funds to launch peer recovery and post-overdose outreach services, while supporting mobile crisis services through a combination of state grant funding and Medicaid reimbursement. This layered approach allowed the county to expand services while reducing reliance on any single funding source.
- **Walton Empowers**, **Georgia** (RCO). Walton Empowers implemented a reentry text message line connecting individuals leaving the local jail with peer recovery support. After demonstrating its value and securing funding from the sheriff's office, it evolved into Bridge to Community, a broader program linking people leaving incarceration to peer support and community resources.
- **Butterfield Park Medical Center**, **Missouri** (Rural Health Clinic). Butterfield Park Medical Center, a rural health clinic within Citizens Memorial Healthcare, houses the

CMH Addiction Recovery Program, which provides medication-assisted treatment (MAT) and recovery support for people with substance use disorders. Because the original peer role was not directly reimbursable, program leadership developed an alternative sustainability strategy by training peers to help eligible patients enroll in Medicaid. Program leaders calculated that enrolling approximately 25 eligible but uninsured individuals annually would generate enough reimbursement to support the position. The peer also meets with hospitalized patients identified as potential candidates for SUD treatment and helps connect them to outpatient care before discharge. About half of these patients attend an outpatient appointment, creating a sustainable referral pathway that supports ongoing program engagement.

- **Caldwell County Post-Overdose Response Team, North Carolina** (paramedic team). Caldwell County used time-limited funding sources to build its behavioral health workforce and services. The program initially received grant funding to support justice-involved individuals during reentry by connecting them to substance use treatment and MAT. It later used opioid settlement funds to expand peer support, post-overdose outreach, recovery court activities, and treatment linkage.

How States Can Support This Work

Providers, CBOs, and funders are driving innovation to improve behavioral health access in rural communities. State policymakers and agencies can help sustain and scale these efforts through supportive workforce, reimbursement, and financing policies. While state Medicaid agencies are often central to this work, behavioral health agencies, rural health offices, public health departments, county government, legislatures, and governors' offices can also support these approaches. The following strategies highlight opportunities for state leaders to support community-based workforce approaches that address behavioral health needs in rural communities.

- **Use RHTP and other temporary funding to build long-term sustainability.** Many states are already using RHTP and other time-limited funding sources to address behavioral health workforce shortages and improve access to care. These investments can be used to test and refine community-based workforce models, gather evidence of their impact, and build the case for long-term financing. States can support sustainability by using RHTP or other temporary funding to help providers and CBOs overcome Medicaid billing and implementation barriers.

- **Create sustainable financing and reimbursement pathways for community-based workforce roles**. States can support the long-term sustainability of a community-based workforce by strengthening reimbursement opportunities, advancing payment models that support team-based care, and investing in community-based workforce roles, particularly in rural areas with limited workforce capacity. For example, through Tennessee's Health Link behavioral health coordination program, River Valley Health supports community health coordinators using a value-based payment model. By improving quality and utilization metrics, including emergency department use, the organization has earned significant performance-based incentive payments from Medicaid managed care plans.
- **Reduce administrative barriers to participation**. Several organizations interviewed highlighted the challenges of navigating Medicaid billing, credentialing, and reimbursement requirements, particularly when payment rates do not always justify the administrative effort required. States can help make community-based workforce models more viable by streamlining billing and credentialing processes, ensuring reimbursement rates adequately support community-based services, providing targeted technical assistance, and creating pathways for RCOs and other community-based entities to become Medicaid-authorized providers, where appropriate.
- **Invest in workforce development and support for community-based workers**. Recruitment and retention challenges often limit the availability of community-based workers. States can support these roles by funding training, certification, supervision, and career development opportunities; partnering with community colleges, universities, and workforce development boards to strengthen workforce pipelines; reviewing policies that may create unnecessary barriers to employment, such as certain background check requirements; and supporting learning collaboratives that help rural providers recruit, train, and retain staff.
- **Highlight and share successful models**. States can help accelerate adoption of effective community-based workforce approaches by identifying and promoting successful rural programs, disseminating implementation lessons and resources, creating opportunities for peer learning across communities, and sharing evidence with providers, payers, and policymakers to support broader adoption and investment.

Conclusion

Rural behavioral health care providers, CBOs, funders, and state and county partners are finding innovative ways to address behavioral health access gaps in rural settings through community-based workforce roles. While there is no one-size-fits-all model, the examples highlighted in this brief demonstrate the potential of community-based approaches to expand access, strengthen connections to care, and better meet the behavioral health needs of rural residents. As states and providers implement RHTP funding and other rural health investments, there is a unique and timely opportunity to test, strengthen, and sustain these approaches. For rural communities facing persistent behavioral health workforce shortages, a community-based workforce model offers a practical, community-driven strategy for expanding access to care.

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Appendix: Community-Based Workforce Approaches Featured in this Brief

Program	Location	Setting	Workforce Roles	Program Description and Community-Based Workforce Role
Arukah Institute's Living Room Program	Princeton, Illinois	CCBHC	• Peer support specialists (peers)	• Provides crisis de-escalation, resource navigation, and connections to care through peers with lived experience. • Creates a welcoming, non-clinical space with couches, blankets, and kitchenettes that allows peers to build trust more naturally.
Blacktail Health	Butte and Dillon, Montana	FQHC	• Non-clinical care managers	• Uses non-clinical care managers as problem solvers, behavioral health extenders, and trusted contacts for patients not ready for therapy. • Trains care managers in motivational interviewing and suicide safety planning to address gaps in access to behavioral health services.
Butterfield Park Medical Center	Bolivar, Missouri	Rural Health Clinic	• Peers	• Deploys peers as recovery coaches, patient navigators, and resource connectors within a medication-assisted treatment and recovery support program. • Uses peers to connect individuals to benefits, employment, and other supports across health care, justice, and community settings. • Involves peers in Medicaid enrollment assistance as a sustainability strategy.
Caldwell County Community Paramedic Program	Caldwell County, North Carolina	Rural county emergency services agency	• Community paramedics • Peers	• Combines community paramedics and peers to reduce unnecessary emergency service use, conduct post-overdose outreach, and connect residents to treatment and social services. • Deploys on-call peers outside business hours, including hospital-based response when EMS encounters an individual seeking recovery support.
Chestnut Health Systems	Bloomington, Belleville, Granite City, and Maryville, Illinois (serving rural counties in Illinois and Missouri)	FQHC and CCBHC	• Peers	• Embeds peers across crisis services, residential treatment, housing programs, jails, public transit outreach, and community settings. • Supports peer career advancement through certification assistance, structured training, peer supervision, and leadership pathways. • Creates psychologically safe spaces for discussing recovery-related workplace challenges. • Uses peers to conduct proactive outreach in community spaces, including public transit, to engage individuals experiencing behavioral health challenges.

Program	Location	Setting	Workforce Roles	Program Description and Community-Based Workforce Role
Libraries for Health Initiative	Libraries in Central Texas	Public libraries	• Peers	• Embeds trained peers in rural public libraries to provide support, facilitate groups, conduct outreach, and connect patrons to resources. • Builds library staff capacity to support patrons with mental health-related needs.
McDowell County Emergency Services' Community Care Paramedics	McDowell County, North Carolina	Rural county emergency services agency	• Community paramedics • Peers • Care navigators	• Uses a multidisciplinary team of community paramedics, a peer, and a care navigator to provide in-home patient support, resource navigation, benefits coordination, services, and connections to care. • Serves as a community resource hub, leveraging partnerships across health care, social services, law enforcement, housing, and local nonprofits to resolve issues before they become emergencies.
The Meadowlark Initiative	Montana (multiple sites statewide)	Hospital, tribal, and community-based maternal health settings	• Care coordinators	• Embeds care coordinators within obstetric (OB) care teams across rural and tribal communities to support pregnant and postpartum people affected by behavioral health conditions. • Prioritizes trust, relationship-building, and community connection skills over specific credentials, with sites using peers, CHWs, doulas, nurses, lactation consultants, and other community-based staff. • Bridges OB providers, behavioral health services, child and family services, and community resources to support timely referrals, warm handoffs, and family needs.
Olmsted County's Community Outreach Specialist Team	Olmsted County, Minnesota and surrounding rural communities	Community-based behavioral health crisis response program	• Peers	• Provides co-response with a social worker and law enforcement, mobile crisis response, and post-overdose outreach and support. • Deploys peers to support post-overdose response, respond to referrals from community-based agencies, assess readiness to receive services, and provide ongoing support.
River Valley Health	Multiple sites across Tennessee, primarily serving rural and Appalachian communities	Integrated community health organization (FQHC, CMHC, and licensed alcohol and drug treatment facility)	• Peers • CHWs • Community health coordinators/case managers • IPS • Behavioral health assistants	• Uses a broad community-based workforce to deliver integrated primary care and behavioral health services. • Addresses workforce shortages through care coordination, recovery support, health education, social needs navigation, and treatment plan support. • Integrates community-based staff into care teams and organizational culture, with staff working alongside licensed clinicians in a non-hierarchical, team-based model.

Program	Location	Setting	Workforce Roles	Program Description and Community-Based Workforce Role
Peer Recovery Expansion Project (PREP)	Five rural counties in Pennsylvania	Hospital emergency departments	• Peers	• Embeds peers in seven hospital emergency departments, under the Rural Health Redesign Center, to support patients with SUD through resource navigation and referrals to relevant treatment services.
Behavioral Health Aides at Southcentral Foundation	Remote Alaska Native communities	Tribal health clinics integrated with primary care	• Behavioral Health Aides (BHAs)	• Employs BHAs in remote Alaska Native communities as part of Alaska's broader Behavioral Health Aide Program. • Uses BHAs to act as cultural bridges, community advocates, and care team members, who help tailor services to local priorities, strengthen trust, and reduce stigma. • Supports traveling clinicians by helping them navigate local communities and build connections with residents. • Provides a four-level certification framework through which BHAs can advance their skills — with BHAs at the highest-level conducting assessments and providing a limited scope of treatment services.
Walton Empowers Addiction Recovery Support Center	Walton County, Georgia	RCO	• Peers	• Provides recovery coaching, support groups, transportation, resource navigation, and individualized recovery supports through a peer-led RCO. • Integrates peer recovery support across health care, child welfare and justice systems, and community supervision settings through partnerships with courts, child welfare agencies, and hospital emergency departments. • Supports individuals with lived experience in obtaining peer certifications through mentorship, certification preparation, volunteer opportunities, and pathways to employment and leadership roles.