Background

A. Description of Service Area and CCBHC Sites

Provide information on the defined service area of the CCBHC. Include information on where CCBHC sites and satellites are. Include information on any DCO site the CCBHC partners with.

Consider including a map.

B. Demographics of Service Area

Provide information on county-level demographic data around race/ethnicity, age, gender, veteran status. Include additional information on sexual orientation.

Data Sources:
United States Census Bureau County Profile

As there is not yet a good county-level view of LGBTQIA+ individuals, clinics may use information from the Williams Institute and EHR data to write a narrative around the demographics of LGBTQIA+ individuals within their community.

C. Special Populations in Service Area

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

To gain a better understanding of the health inequities within your community, provide information on underserved populations in your service area. These should be populations with demonstrated health disparities and/or populations experiencing barriers to treatment. Examples include but are not limited to: people experiencing houselessness, veterans, LGBTQIA+ youth, older adults, etc.)

This section should be supported by county specific data. In identifying communities experiencing health disparities, data considerations are prevalence data provided by the Oregon Health Authority, social drivers of health data, census data, and qualitative data from individuals and families with lived experience and community partners.

D. Summary

Based on the information gathered and reviewed, what are the key takeaways?

Prevalence Data

A. Mental Health Prevalence

Use the county level data to demonstrate the prevalence of mild/moderate and severe mental illness by age and race/ethnicity.

Include additional qualitative information from families and individuals with lived experience and community partners to demonstrate the mental health needs within the community. This may include information on barriers to treatment, county specific considerations explaining mental health prevalence, etc.

The goal of this section is to demonstrate the MH need within the county.

B. Substance Use Disorder Prevalence Data and Co-Occurring Prevalence Data

Use the county level data to determine the prevalence of substance use disorder and co-occurring prevalence by age and race/ethnicity.

Include qualitative information from families and individuals with lived experience and community partners to demonstrate substance use disorder needs within the community. This may include information in barriers to treatment, most commonly used substances, county specific considerations explaining substance use prevalence, etc.

The goal of this section is to demonstrate the SUD need within the county.

C. Physical Health and Behavioral Health Prevalence Data

Use the county level data to determine the prevalence of behavioral health and physical health comorbidities by age and race/ethnicity. Identify specific physical health disorders that are most common and most in need of additional consideration.

Include qualitative information from individuals and families with lived experience and community partners to demonstrate substance use disorder needs within the community. This may include information in barriers to treatment, most commonly used substances, county specific considerations explaining substance use prevalence, etc.

The goal of this section is to demonstrate the SUD need within the county

D. Intellectual and Developmental Disabilities

Use county level data to demonstrate the prevalence of intellectual and developmental disabilities within the community.

Include qualitative information from local IDD department, families and individuals with lived experience, and community partners.

Data Sources:
US Census Data

E. Suicide and Overdose Rates

Use county level data to demonstrate the rates of suicide and overdose within community.

Data Sources:

County Level Suicide Rates
2025 Suicide Numbers
Oregon Overdose Dashboard

F. Unmet Needs and Health Disparities

Compare prevalence data to census data to identify health disparities.

Interview individuals and families with lived experience and community partners on what are perceived as unmet needs and health disparities within the community.

Review any county specific reports on unmet needs, treatment barriers, and disparities.

The goal of this section is to articulate to the best of the clinic's ability what the unmet needs and health disparities of their community are.

G. Summary

Based on the information gathered and reviewed, what are the key takeaways?

Social Drivers of Health

A. Poverty and Employment

Provide an overview of the financial barriers to treatment and/or drivers of health. This should include information on poverty rates within the county, income averages, etc.

In recognition that the federal poverty level may not accurately or fully capture the financial barriers many face, include qualitative information from the community to demonstrate the financial barriers related to treatment and/or behavioral health.

Data Sources:
Stratified County Level Poverty Rates : View county-level poverty data by race/ethnicity.

United States Census Bureau County Profile: View income data and poverty rates by age.
Oregon Poverty Levels by Race/Ethnicity: View state poverty data by race/ethnicity

B. Food Insecurity

Provide an overview of food insecurity and food needs within the community. This should include data on access to food benefits, food insecurity data, and other information relating to access to nutritional food.

Include qualitative data from community food banks, individuals and families with lived experience, and community partners to demonstrate the food insecurity needs of the community.

Data sources:
WIC Data by Local Agency: View number of families served and some additional data
County Level Hunger Task Force Data: View SNAP data and food insecurity data

C. Interpersonal Safety and Community Violence

Provide an overview of interpersonal safety and community violence. This includes rates of intimate partner violence, and community crime that may impact the safety of individuals and families being served.

Include qualitative data from law enforcement, individuals and families with lived experience, shelters (particularly from shelters for victims of domestic abuse) and other relevant partners to demonstration the safety considerations of the community.

Data Sources:
Crime Reporting Data by County: View offenses committed against persons and other crime data
Oregon Domestic Violence Data: Mostly state-level findings
Child Welfare Data: View Oregon Child Welfare Data
County Level Systems of Care Data: View county level data on youth services, including child welfare and juvenile justice.

D. Housing Insecurity and Houselessness

Provide an overview of housing insecurity and houselessness within the community, including information on houseless populations. Identify potential need for housing assistance within community, such as supported housing services, rental assistance, home modifications, case management, or other services.

Include qualitative information from local housing supports, individuals and families with lived experience, shelters, and community partners.

Data Sources:
Oregon Housing Data by County

E. Transportation Barriers

Provide an overview of the transportation barriers experienced within community. Include information on public transit, if applicable, transportation vouchers, and other transportation considerations. Include qualitative information from community partners and individuals and families with lived experience.

As telehealth is a common approach to helping those with transportation barriers to access services, provide information on internet access and computer/device use within your county. This can include clinic observations, feedback from families and individuals with lived experience, and input from community partners.

Data Sources:
There is limited public information on transportation barriers within Oregon. Clinics are encouraged to work with their Coordinated Care Organization and local hospital/health system to gather information on transportation barriers within your community. Many community health needs assessments or community health improvement plans within Oregon have some information on transportation.
Broadband Mapping Tool: View county grants to expand internet access

F. Utility Need and Climate Supports

Provide an overview of the utility and climate support needs within the community. Include qualitative data from local utility payment assistance agencies, individuals and families with lived experience and other community partners.

Data Sources:
Local Utility Assistance Programs: View programs in area who provide utility assistance
County Level Data on Utility Assistance: View information provided utility assistance
County Level Data on Energy Cost: View average cost of electricity etc. by county
Climate Support Report

G. Insurance Status

Provide an overview of insurance coverage within your community and compare with coverage status among individuals seen at your clinic. Include qualitative information from individuals and families with lived experience (particularly those with insurance and still experiencing barriers to services) and community partners.

Data Sources:
Health Coverage Data: View state and county level data on health coverage
EHR data on the insurance status of individuals reflective of metric report out

H. Additional Information

Space to provide any additional information the clinic views as important in understanding the social drivers of health needs within their community. This may include education and other social/community contexts that impact an individual's health.

I. Summary

Based on the information gathered and reviewed, what are the key takeaways?

Culture and Language

A. Language Needs in Community

Describe the different languages spoken within community, information on deaf and hard of hearing services needed within community, and literacy needs. Provide clinic specific information in comparison to county-level data. List the different languages the clinic offers information in.

Include qualitative information from individuals and families with lived experience, particularly as it relates to readability of the information they receive from the clinic (brochures, individual rights, intake packets, etc).

Data Sources:
Common Languages by County
Deaf and Hard of Hearing Prevalence 2018-2022

B. Cultural Considerations of the Community

Provide an overview of the cultural context of the community you serve. Include information on demographics; status as urban, rural, or remote; special populations such as refugees, migrant workers, Veterans, older adults, etc.; information on local tribes; information on common religious beliefs and practices; and other information important to understanding the community served.

This section is primarily qualitative. Be sure to include input from individuals and families with lived experience, community partners, staff members, and others.

C. Summary

Based on information gathered and reviewed, what are the key takeaways?

Service Provision

A. Outreach, Engagement, and Retention Needs

Provide an overview of the outreach, engagement, and retention service needs within your community. Information to consider in determining need include but are not limited to, individuals discharged before completing treatment, average number of visits before discontinuing services, health disparities identified, special populations and their unique needs for engagement in treatment, and current outreach programs.

Include qualitative information from individuals and families served, community partners, and staff.

B. Promising, Cultural, and Evidenced Practices

Based on the needs of the community, provide information on promising practice, culturally specific practices, and/or evidence-based practices the clinic uses or would like to include. These may be specific practices or categories based on prevalence within community, for example a clinic may note there is a high percentage of individuals with intellectual and developmental disabilities and thus need for specific practices to address their unique needs.

Include qualitative data from individuals and families with lived experience (particularly those within specific cultural contexts), community partners, and advocacy groups that may be in the area.

C. Service Hours and Locations within the Community

Include information on service hours and locations outside of the CCBHC as well as walk-in crisis hours. Provide information from community partners, individuals and families with lived experience, and other relevant information that informs service hours and locations. Information that may inform service locations and hours include but are not limited to, where individuals are within the community (shelters, schools, streets, etc.), employment information that may impact availability between standard working hours, and crisis services.

Current Strengths Challenges

A. Strengths

a. *Addressing Community Needs and Barriers*

Provide summary of what the clinic does well in addressing the needs of the community and removing barriers to treatment.

b. *Community-Responsive Staffing and Services*

Provide summary of what the clinic does well in ensuring staff are appropriately trained, qualified, and supported to address the service needs of the community. Include information on strengths of ensuring the services provided are culturally responsive and address the needs of the individuals and families the clinic serves.

c. *Effective Partnerships and Care Coordination*

Provide summary of what the clinic does well in coordinating care across the continuum. Include information on who the clinic currently partners with and the strengths of those partnerships.

B. Challenges

a. *Addressing Community Needs and Barriers*

Provide summary of what the challenges the clinic experiences in addressing the needs of the community and removing barriers to treatment.

b. *Community-Responsive Staffing and Services*

Provide summary of challenges clinic experiences in ensuring staff are appropriately trained, qualified, and supported to address the service needs of the community. Include information on challenges around ensuring the services provided are culturally responsive and address the needs of the individuals and families the clinic serves

c. *Effective Partnerships and Care Coordination*

Provide summary of challenges the clinic experiences in coordinating care across the continuum. Include information on who the clinic currently partners with and the challenges of those relationships and/or partnerships clinic would like to include based on the community needs assessment.

C. Summary

Based on the provided information, what are the key takeaways on strengths and challenges? Are there way the clinic can build on their strengths to address some of the challenges?

Action Plan

Based on the findings of the community needs assessment, what are 2-3 priorities for the next 3 years? What considerations and decision-making went into identifying the priorities? What impact does your clinic hope to have in addressing these 2-3 areas? What steps will the clinic take to address these areas? What supports does the clinic need from community partners, their CCO, the Oregon Health Authority, and others?

Priority 1:

A. Steps Already Taken:
B. Steps/Considerations for Future Steps:
C. Additional Supports Needed:
D. KPI to include in continuous quality improvement plan:

Priority 2:

A. Steps Already Taken:
B. Steps/Considerations for Future Steps:
C. Additional Supports Needed:
D. KPI to include in continuous quality improvement plan:

Priority 3:

A. Steps Already Taken:
B. Steps/Considerations for Future Steps:
C. Additional Supports Needed:
D. KPI to include in continuous quality improvement plan:

Additional Priorities: