Updated Jan. 2026

2026 CCBHC Community Needs Assessment

DUE With Submission of Full/Renewal Application

Certification Process

- **1.a.2: the community needs assessment must be completed and submitted with the application for certification**

- For providers applying for initial certification:
  - At time of preliminary application, notify OHA of intent to either complete a CCBHC Community Needs Assessment or submit a Regional Needs Assessment with accompanying CCBHC requirements
  - Community Needs Assessment or Regional Needs Assessment is due with the submission of your full application

- For renewing providers:
  - Submit updated community needs assessment or regional needs assessment with submission of certification application

Community & Regional Assessments Reqs.

1.a.1: The community needs assessment (or regional needs assessment) must inform the CCBHC's service delivery and operations:

- Size and composition of staff needed to serve the community (1.b.1),
  - The number of staff should allow for manageable caseloads across all staff types,
  - Make up of provider types should reflect the needs of the community- an appropriate number of staff to children and family services, housing services, substance use services, etc.
  - To extent possible, staff should reflect the diversity of the community.
- Language services and needs to serve the community (2.b.4),
- Walk-in hours and evening hours (4.c.2),
- Key performance indicator(s) on identified priorities areas (5.c.6),
- Evidence-based practices needed to meet the needs of the community, locations of services provided, community partners, and other relevant service delivery needs of the community.

Community & Regional Assessments Reqs.

1.a.5: The community needs assessment or submitted regional assessment must include input regarding:

1. Cultural, linguistic, physical health, and behavioral health treatment needs,
2. Developmentally appropriate evidence-based and promising practices and behavioral health crisis services,
3. Access and availability of CCBHC services including days, times, and locations, and telehealth options, and
4. Potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages

Community & Regional Assessments Reqs.

1.a.6: Clinics must attempt to obtain input from the following entities in the service area to incorporate within the community needs assessment and action plan:

1. People with lived experience of mental and substance use conditions, parents/caregivers of children, youth, and young adults with serious social and emotional needs, and persons who have received/are receiving services from the clinic,
2. Crisis response providers or systems,
3. Health centers (including FQHCs),
4. Local health departments (Note: these departments also develop community needs assessments that may be helpful),
5. Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics,
6. One or more Department of Veterans Affairs facilities,
7. Jails, courts, and juvenile justice systems,
8. Representatives from local K-12 school systems,
9. Early Learning Hubs,
10. Local System of Care,
11. Other community partners

Community Needs Assessment Requirements

1.a.4: Required components of the CCBHC community needs assessment:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs,
2. Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose,
3. Economic factors and social drivers of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing

Community Needs Assessment Requirements

1.a.4 continued…

4. Cultures and languages of populations residing in service area,
5. Identification of underserved population(s),
6. A description of how the staffing plan does and/or will address findings, and
7. Current strengths and challenges, and
8. Plan of action

Regional Needs Assessment Requirements

1.a.3. The CCBHC is permitted to use regional assessments completed within 3 years of the required CCBHC community needs assessment to fulfill the community needs assessment requirement. CCBHCs who submit regional needs assessments must also submit the following:

1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCHC, including through DCOs,
2. Identification of health disparities if not identified within regional needs assessment or if those identified are outside scope of CCBHC,
3. Current strengths and challenges, and
4. A plan of action

OHA Provided Materials

1. Community Needs Assessment Guidance
    - Guidance document providing county-level data links and guidance on how to address each section of the community needs assessment.
2. Regional Needs Assessment Guidance
    - Guidance on how to address each section of the community needs assessment.
3. Community Needs Assessment/Regional Needs Assessment Blank Template
    - Blank template clinics may use to input information.
    - Providers are not required to use the template to complete their own community needs assessment; however, every section of the template needs to be easily identified within the provider's community needs assessment.
4. National Council Interview Scripts and Guidance
    - Guidance on engaging community partners and service users in identifying community needs.
5. 2026 Staffing Plan Template
    - Template to demonstrate current staffing, including vacancies, and services provided.
    - The staffing template should be informed by the community needs assessment or regional needs assessment.

How to Use Following Information:

- The following information covers each section of the CCBHC Community Needs Assessment Guidance/Template.
  - Clinics completing their own community needs assessment will need to complete each outlined section,
  - Clinics submitting a regional needs assessment only need to complete the below sections. They will be highlighted in yellow in the slides.
    1. A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCHC, including through DCOs
    2. Identification of health disparities if not identified within regional needs assessment or if those identified are outside scope of CCBHC
    3. Current strengths and challenges
    4. A plan of action

General Information

- Clinics are NOT limited to the data links provided within the CCBHC Community Needs Assessment Guidance. These links are data vetted by OHA that is sufficient to answer the questions; however, clinics may use other resources available to them, including county-specific assessments conducted since 2022 providing the same information.

  ** If a clinic has any questions about a resource they would like to use and if it meets the needs, you may always contact the CCBHC team and/or bring up in 1:1 meetings.

- Data must be specific to the CCBHC's service area. In instances where such data is not readily available, clinics must articulate how data used translates to the needs of the service area.
- Clinics may include additional information that is not covered in the community needs assessment as they see fitting and appropriate for demonstrating the needs of their community.
- Clinics may use their own letterhead and formatting; however, each section of the CCBHC Community Needs Assessment Template must be present and clear within the submitted needs assessment.

CCBHC Template

1. Description of Service Area and CCBHC Sites
   - CCBHC catchment area is the county in which their site(s) reside.
   - Clinics with a DCO must show where there DCO partners are
2. Demographics of Service Area
   - Use United States Census Bureau County Profile Data
   - For populations of interest not addressed in the Census data such as veteran populations, religious affiliation, refugee and immigrant populations, LGBTQIA+ populations, etc., counties are encouraged to leverage county-specific data where available or articulate expected prevalence based on Oregon specific or other higher-level data .

     Example, if data suggests 2% of the population of Oregon fall into “X” demographic do you expect your county to be the same, higher, or lower and why.
3. Special Populations in Service Area
   - To the degree possible, this section should be supported by county specific data and emphasis populations who experience health disparities.

CCBHC Template: Prevalence Data

Goal:

Demonstrate the behavioral health needs within the community. This informs staffing and services offered.

1. Mental Health, Substance Use Disorder Prevalence and Co-Occurring, and Physical Health and Behavioral Health Co-Morbidity Prevalence
   - Clinics may use as many visualizations as they choose. Clinics should note any findings of interest in narrative.
2. Intellectual and Developmental Disabilities
   - Clinics should use US Census Data available on disabilities to address this section.
     Disability data is the “Health” section of the county profile
3. Suicide and Overdose Rates
   - County Level Suicide Rates
   - 2024 Preliminary Suicide Numbers
   - Oregon Overdose Dashboard
   - Oregon Overdose October 2024 Report

CCBHC Template: Identifying Unmet Need

Goal:

Demonstrate county-specific unmet needs and health disparities. This informs best practices, staffing needs, services offered, and community partners needed.

Strategies for Identifying Unmet Needs and Health Disparities

1. Comparisons between prevalence data and demographic data
2. Comparisons between county prevalence data and data pulled from EHR
3. Comparisons between prevalence data and available services
4. Literature review with specific examples of how findings specifically translate to the community's needs

Clinics may use other strategies and resources to identify health disparities and unmet needs in their community. The goal is to demonstrate county-specific disparities and unmet needs. If using general data on health disparities, please articulate what that specifically looks like in your community.

CCBHC Template: Social Drivers of Health

Goal:

Identify the SDoH that may impact access to treatment, ability to meet basic needs, and/or impact ability to successfully engage in treatment. SDoH informs case management needs, care coordination needs, telehealth and community service needs, and best practice needs.

1. Poverty and Employment
2. Food Insecurity
3. Interpersonal Safety and Community Violence
4. Housing Insecurity and Houselessness
5. Transportation Barriers
6. Utility Need and Climate Supports
7. Insurance Status
8. Additional Information
   - Clinics may include additional information on SDoH unique to their county.

CCBHC Template: Culture and Languages

Goal:

Identify the cultural and language considerations for the community served. This should inform language service needs, best practices, community partners, community engagement, and trainings.

1. Language Needs in Community
   - Commonly spoken languages, literacy rates, intellectual disabilities, hearing services, and other information that impact an individual and families' ability to engage in services because of language barriers.
2. Cultural Considerations
   - This may include demographic data but may also contain information on the overall culture of the county. Examples include but are not limited to types of work (agriculture, ranching, technology, service industry, etc.), migration information (growing county or shrinking county), largest age group (older or younger), significant historical context that impact how people in the county view themselves, explore the cultural events in the area and what that means to the community.

CCBHC Template: Service Provision

Goal:

Identify the types of services needed, best practices, trainings needed, service locations and hours, and other information around services to offer and how to offer them.

1. Outreach, Engagement, and Retention Needs
   - Which populations are underrepresented? Which populations are most likely to drop out of treatment? At what point are individuals or families most likely to drop out of treatment?
2. Promising, Cultural, and Evidence Practices
   - What evidence-based practices may be needed within your community? What are culturally specific or responsive services available in your area and in what ways can you partner with them? What are culturally responsive assessments that may be needed? What are the service types most needed in your community and for whom.
3. Service Hours and Locations
   - What are your service hours and in what way do they meet the needs of the community? What informed that decisions? Where do your provide services within the community and what informed that decision? Are there locations and/or hours needed based on feedback?

CCBHC Template: Challenges and Strengths

Goal:

Identify the things your clinic is doing well within each area and identify where your clinic would like to improve.

1. Addressing Community Needs and Barriers
   - What needs are you addressing? What barriers are you addressing? How can you further improve? What needs and barriers are you not addressing? Are there populations who are underserved within your clinic? Are there prevalence categories underrepresented within your clinic? Are there services needed not provided?
2. Community-Responsive Staffing and Services
   - In what ways are the services provided culturally responsive? What best practices do you implement to address the unique needs of the people your clinic serves? How does your staffing meet the needs? What trainings are offered? In what ways can your clinic improve? What additional trainings could you explore? What additional best practices may your clinic explore?

CCBHC Template: Challenges and Strengths

Goal:

Identify the things your clinic is doing well within each area and identify where your clinic would like to improve.

3. Effective Partnerships and Care Coordination
   - Who are your current partners and in what ways are these partnerships ensuring treatment needs are met? What partners do you regularly meet with and routinely update policy/procedures with? Are there partners in your community you would like to engage? Are there culturally specific or grassroots organizations that could help further your services? Are there transitions in care or points of coordination where service users fall through the gaps?

CCBHC Template: Action Plan

Goal:

Articulate key 2-3 findings from community needs assessment and plan to address the needs.

1. Steps Already Taken
   - Leveraging existing strengths, what are you already doing that address the need?
2. Steps/Considerations for Future Steps
   - What are steps you can take to further improve and better address the need?
3. Supports Already in Place
   - What partnerships, programs, and resources do you already have that can be used to develop and implement a plan and/or address the need?
4. Additional Supports Needed
   - What are partnerships you can explore? What resources do you need? What supports can OHA provide? What supports can community partners or other organizations provide?

CCBHC Template: Action Plan

Goal:

Articulate key 2-3 findings from community needs assessment and plan to address the needs.

5. Key Performance Indicator
   - What can you track to indicate progress is being made? This does not have to be an existing metric or an established BH metric. It can simply be something trackable that would indicate improvement. **This KPI should be included in the continuous quality improvement plan.**

Prevalence Data

- Mental Health Data
  - Mild/Moderate Mental Illness (MMMI)
  - Severe Mental Illness (SMI)
  - Any Mental Illness (SMI + MMMI)
- Substance Use and Co-Occurring Data
  - Any substance use disorder
  - Substance use disorder (SUD) and mild/moderate mental illness
  - SUD and severe mental illness

Prevalence Data

- Behavioral Health and Physical Health Co-Morbidity
  - Any mental health condition and one of the below physical health conditions
  - Mild/Moderate mental illness and physical health
  - Severe mental illness and physical health
- Specific physical health conditions
  - Chronic Obstructive Pulmonary Disease (COPD) and Asthma
  - Diabetes, including pre-diabetes
  - All Cardiovascular diseases
  - Chronic pain illnesses
  - Human Immunodeficiency Virus (HIV)
- All provided data includes stratifications by race and ethnicity, sex, and age.

Staffing Plan

1. Service Provision
   - CCBHCs must input number of services provided in each service category to the best of their abilities with the data they have.
2. Staffing Plan
   - Clinics must enter the total FTE for each provider and staff type within the CCBHC.
   - Clinics must include vacancies.
   - Clinics must include additional staff anticipated to meet the needs of the community.
3. Staff Training
   - Indicate the name of the training and the number of staff who have received that training
4. Anticipated Addition Narrative
   - Explain briefly how anticipated increase in staffing was calculated and how it address community needs.

OHA Review

DUE With Submission of Full/Renewal Application

- Compliance Review
  - Review that the community needs assessment/regional needs assessment was completed and submitted.
  - Review that each required component was addressed.
  - Will allow a period of correction in the event there are missing sections.
- Program/Quality Review
  - Program may provide feedback on the strengths and areas of growth of each community needs assessment. If such feedback is provided, it does not impact compliance review findings but is intended as part of continuous quality improvement.