Jan 8, 2025

2025 CCBHC Community Needs Assessment

DUE: 7/15/2025

CCBHC Criteria Requirements

1.a.1: Must be done every 3 years. Last community needs assessment was July 2022

1.a.2: Staff composition and size

The number of staff should allow for manageable caseloads across all staff types. You can engage staff in conversations around manageable caseload sizes and/or research current best practices available.

The make up of provider types should reflect the needs of the community, i.e. 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.

1.a.3: management team appropriate for the size and needs of clinic

1.b.2: includes clinical, peer, and other staff

** OHA does not have strict requirements around determining the appropriateness of staffing size and composition. Rather, the expectation is that clinics identify in what way the staff they have meets the needs of their community, gaps they note, and strategies to address gaps.

CCBHC Criteria Requirements

- Clinic uses community needs assessment to determine hours (2.a.2) and service locations (2.a.3)
  - Should see information in the assessment that justifies the office hours, such as feedback from individuals served and community partners.

- 2.a.6: Outreach and engagement services are informed by the community needs assessment
  - Should contain information that would inform the clinic on:
    Types of outreach and engagement needed in the community
    Locations of outreach and engagement needed in the community
    Potential partnerships needed to meet outreach and engagement needs

- 2.c.3: Community partners in addition to required partners are informed by the community needs assessment
  - Contain information that informs needed community partners, such as feedback from community partners and individuals and families serviced. Consider demographic data, social drivers of health data, cultural and language considerations of community, etc. to identify potential partners.

CCBHC Criteria Requirements

- 4.c.1: Walk-in hours are informed by the community needs assessment
  - Review crisis service data from EHR and crisis partners
- 4.f.1: Best Practices
  - Review diagnosis prevalence and demographic data to identify best practices and promising practices to offer clinics
  - In recognition of limitations of EBPs for culturally diverse populations, OHA encourages clinics to consider promising non-traditional practices that meet culturally specific needs of their community.
- 6.b.1: Clinics should engage their board members and/or advisory committee to identify community needs with understanding the intent is to involve the individuals with lived experience in better understanding the needs of the community.

Required Components (Appendix A)

- Description of physical boundaries and size of service area, including identification of sites where services are delivered by the CCBHC, including through DCOs
- Information abut the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose
- Economic factors and social determinants of health affecting the population's access to health services, such as percentage of population with income below the poverty level access to transportation, nutrition, and stable housing
- Cultures and languages of the populations residing in the service area
- The identification of the underserved population(s) within the service area
- A description of how the staffing plan does and/or will address findings

Input from Community and Service Users

Individuals and families with lived experience:

1. Surveys, can include information from MHSIP and YSS (state-led metrics)
2. Focus groups
3. Anonymous suggestion forms
4. Peer and family support specialists
5. Advisory committee and/or governance board
6. Review of complaints/grievances

Community Partners

1. Hospitals, emergency departments, residential services
2. Crisis providers and partners
3. FQHCs and primary care providers
4. Veteran Affairs offices and programs
5. Schools
6. Jails, juvenile justice agencies, courts, etc
7. MAT providers in community
8. Homeless shelters
9. Churches and other faith-based organizations offering services and support
10. Employment and housing services

*** These are suggestions and not requirements**

OHA Provided Materials

1. CCBHC 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. CCBHC Community Needs Assessment Blank Template
   - Blank template clinics may use to input information
3. CCBHC Community Needs Assessment Data Methods Overview
   - Review of the methodology used to calculate prevalence. Clinics may use this to pull similar data from their EHR for comparisons as appropriate and desired by clinic. (**Please note: it is not required for clinics to calculate clinic-specific prevalence data. Clinics may do so as is appropriate for identifying gaps and/or disparities**).
4. CCBHCC Needs Assessment County-Level Prevalence Data
   - County-level data or prevalence of mental health, substance use and co-occurring disorders, and behavioral health and physical health co-morbidity.
5. National Council Interview Scripts and Guidance
   - Guidance on engaging community partners and service users in identifying community needs.
6. 2025 Staffing Plan Template
   - Template to demonstrate current staffing, including vacancies, and services provided.

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 county-specific. In instances where such data is not readily available, clinics must articulate how data used translates to county-specific needs.
- 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: Background

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: Prevalence Data

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.

** Suggestions for consideration, not requirements to answer.

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?

** Suggestions for consideration, not requirements to answer.

CCBHC Template: Challenges and Strengths

Goal:

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

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?

** Suggestions for consideration, not requirements to answer.

CCBHC Template: Challenges and Strengths

Goal:

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

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?

**** Suggestions for consideration, not requirements to answer.**

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?

**** Suggestions for consideration, not requirements to answer.**

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 (Optional)
   - This section is optional. Clinics may calculate this for reference if they wish. Averages across CCBHCs can be found in the legislatively mandated evaluation to be released in the coming weeks. Clinics may run internal data for comparison if they wish.
2. Staffing Plan
   - This section is required. Clinics should enter the total FTE for each provider and staff type within the CCBHC. Clinics should indicate how much FTE for each provider type is for specific service types. **Please Note: clinics may determine best practice in calculating the FTE that is spent towards each service category based in information available and staff capacity. The total FTE for each provider type should reflect what is reported in cost reports.**
   - Please include vacancies.
   - Please include additional staff clinic feels is needed to address the needs of community.
3. Staff Training
   - Indicate what the training is 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 DATE: 7/15/2025

- Compliance Review
  - Review that the community needs assessment was completed and submitted.
  - Review that each required component was addressed.
  - Will allow a period of correction in the event the community needs assessment has missing sections.
  - Feedback: What are ways OHA can best support you in driving quality improvement through the community needs assessment and making meaningful use of the information you have gathered?
- **Feedback:** What are ways OHA can best support you in driving quality improvement through the community needs assessment and making meaningful use of the information you have gathered?
- Program/Quality Review
  - Program will provide feedback on the strengths and areas of growth of each community needs assessment. This feedback does not impact compliance review findings but is intended as part of continuous quality improvement.

Community Needs Assessment Office Hours

- OHA will offer open office hours; clinics can drop-in to ask questions, raise concerns, float ideas, or seek support.
- Please rank when you would prefer to have office hours. OHA will do their best to set office hours during times most clinics may be free to join if possible.

- Clinics may always reach out via e-mail:
  - Data Related Questions:

    Drew Docter: Drew.D.Docter@oha.oregon.gov

    Please include Katy Holmquist: Katy.Holmquist@oha.oregon.gov
  - Template/Guidance Questions:

    Katie Rosenthal: Katie.M.Rosenthal@oha.oregon.gov

    Please include CCBHC Inbox: CCBHC.Grant@odhsoha.oregon.gov

Questions??

Q & A