Request for Proposals: Community Needs Assessment Consultant Services
All proposals must include this completed cover page as the first page of the submission.
Proposal Submission Deadline: Friday, May 2, 2025

Organization Name
_____

Primary Contact Name
_____

Title
_____

Phone Number
_____

Email Address
_____

Mailing Address
_____

Website (if applicable)
_____

Federal Tax ID Number (EIN)
_____

Type of Entity (Check One): ☐ Nonprofit ☐ For-profit ☐ Academic Institution ☐ Government ☐ Other: _____
_____

Signature of Authorized Representative
_____

Printed Name
_____

Date
_____

Request for Proposal (RFP)

Community Needs Assessment Consultant Services

Hamilton Center, Inc.

I. Introduction

Hamilton Center, Inc. (HCI) is seeking proposals from qualified consulting firms or individuals to conduct a comprehensive Community Needs Assessment (CNA), aligned with the guidelines provided by the National Council, SAMHSA, Indiana Certification Criteria, and once finalized, the Indiana Division of Mental Health and Addiction's (DMHA) Community Needs Assessment Template. The selected consultant will lead the CNA process, gather and analyze data, engage stakeholders, and produce a final report that reflects the behavioral health needs of the communities served by HCI.

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Clay County	26,397	357.6	73.82
Greene County	30,924	542.5	57.00
Owen County	21,280	385.3	55.23
Parke County	16,316	444.7	36.69
Putnam County	36,838	480.5	76.67
Sullivan County	20,814	447.2	46.54
Vermillion County	15,477	256.9	60.25
Vigo County	106,523	403.6	263.93
Hamilton Center's Total Proposed RFP Service Area	274,569	3,318.3	82.74
Indiana	6,751,340	35817.0	188.50
United States	329,725,481	3,532,316	93.35

Report Area	White	Black or African American	American Indian / Alaska Native	Asian	Native Hawaiian / Other Pacific Islander	Two or More Races	Other Race	Hispanic or Latino	Not Hispanic or Latino
Clay County	96.0%	0.6%	0.0%	0.2%	0.0%	2.7%	0.4%	1.6%	98.4%
Greene County	99.0%	0.7%	0.9%	0.6%	0.0%	2.2%	1.0%	1.8%	98.2%
Owen County	99.3%	0.4%	1.7%	0.9%	0.0%	3.0%	1.0%	1.3%	98.7%
Parke County	98.3%	1.9%	2.4%	0.2%	0.1%	3.8%	1.0%	1.1%	98.9%
Putnam County	94.3%	3.1%	0.6%	2.9%	0.0%	1.8%	0.9%	2.1%	97.9%
Sullivan County	95.6%	5.1%	1.6%	0.2%	0.0%	4.0%	1.5%	1.8%	98.2%
Vermillion County	98.8%	0.7%	0.7%	0.9%	0.0%	2.2%	1.2%	1.4%	98.6%
Vigo County	89.4%	8.8%	0.9%	2.5%	0.1%	3.5%	2.1%	2.8%	97.2%
Indiana	81.2%	9.4%	0.2%	2.4%	0.0%	4.3%	2.5%	7.3%	92.7%
United States	68.2%	12.6%	0.8%	5.7%	0.2%	7.0%	5.6%	18.4%	81.6%

II. Background

Hamilton Center, Inc. is a regional behavioral health system serving multiple counties in Indiana. In keeping with federal, state, and accreditation requirements—as well as HCI's mission to support individuals and families in achieving their best mental health—HCI is undertaking a comprehensive Community Needs Assessment.

This CNA will help inform strategic planning, service development, and resource allocation by identifying unmet behavioral health needs and health disparities in the communities we serve.

III. Scope of Work

Division of Responsibilities

Hamilton Center, Inc. reserves the option to collaborate with the selected consultant to identify specific components of the Community Needs Assessment process that may be completed internally by Hamilton Center staff. The selected consultant and Hamilton Center will jointly determine which tasks—such as data collection, stakeholder engagement, or preliminary data analysis—will be the responsibility of the consultant versus Hamilton

Center. This approach is intended to maximize efficiency, leverage internal capabilities, and support capacity-building within HCI.

Review and Familiarization:

Review the National Council Community Needs Assessment Template (attached as Appendix C). Understand HCI's service areas, population demographics, and current programming.

- Data Collection & Analysis:

Collect and analyze both quantitative and qualitative data, including demographic and health indicators, substance use trends, social determinants of health, service utilization and gaps, community strengths and resources. Conduct stakeholder interviews, focus groups, and surveys.

- Community Engagement:

Engage diverse communities, especially underserved or marginalized populations. Ensure culturally and linguistically appropriate outreach methods.

- Report Development:

Draft and finalize a comprehensive CNA report that addresses all elements of the National Council CNA Template and once finalized, DMHA CNA Template. Provide visual data representations. Include recommendations for program improvement and expansion.

- Presentation & Technical Assistance:

Present findings to HCI leadership and stakeholders. Provide up to two virtual technical assistance sessions.

IV. Timeline

- RFP Release Date: Friday, April 11, 2025
- Proposal Submission Deadline: Friday, May 2, 2025
- Zoom Interview Window: Week of May 5–9, 2025
- Consultant Selection: By May 9, 2025
- Project Start Date: Monday, May 12, 2025
- Fieldwork Completion Deadline: Friday, September 5, 2025
- Final Report Due: On or before Tuesday, September 30, 2025

V. Proposal Requirements

- Cover Letter
- Organizational Overview – history, mission, relevant experience, project team overview
- Experience and Qualifications – CNAs or similar evaluations, behavioral health or community-based experience, Indiana knowledge
- Work Plan and Timeline – detailed methodology and project phases, estimated timeline

- Budget and Cost Proposal – line-item budget, total estimated cost
- References – at least three for similar projects

VI. Evaluation Criteria

- Responsiveness to the RFP and understanding of project scope
- Relevant experience and expertise
- Quality of proposed methodology
- Timeline and capacity to complete project
- Cost-effectiveness
- References and past performance

VII. Submission Instructions

Submit your complete proposal as a single PDF via email to:

Art Fuller
Hamilton Center, Inc.
620 8th Avenue
Terre Haute, IN 47804
Phone: 812-231-8363
Email: Afuller@hamiltoncenter.org

Deadline for submission: Friday, May 2, 2025

VIII. Attachments

Appendix A – Proposal Evaluation Rubric (included below)

Appendix B- Overview of Hamilton Center, Inc.

Appendix C– National Council Community Needs Assessment Template

- Prioritize pages 9, 26 – 28, and 35

Appendix A – Proposal Evaluation Rubric

Each proposal will be evaluated based on the following rubric:

Section	Criteria	Maximum Rating
Cover Letter	Clear, concise, and relevant to project goals	5
Organizational Overview	Demonstrates relevant organizational capacity and team structure	5
Experience and Qualifications	Proven track record in CNAs, behavioral health, Indiana familiarity	5
Work Plan and Timeline	Methodological rigor, realistic and detailed timeline	5
Budget and Cost Proposal	Reasonable and justified costs	5
References	Strong endorsements from similar projects	5
Interview	Clarity, alignment, and team dynamics during interview	5

Detailed Proposal Evaluation Rubric

Cover Letter (5 points)

5 – Excellent: Clear, concise, personalized, shows strong understanding of HCI and project goals.

4 – Good: Clear and relevant but lacks a personal touch or full alignment with project goals.

3 – Satisfactory: Generally clear, may be too generic or slightly off-focus.

2 – Weak: Unclear, too brief, or misses key goals.

1 – Poor: Missing or completely off-topic.

Organizational Overview (10 points)

5 – Excellent (10 pts): Shows strong capacity, detailed structure, relevant mission and experience.

4 – Good (8 pts): Solid background, some team or experience details missing.

3 – Satisfactory (6 pts): Basic overview, lacks detail on team or relevance to project.

2 – Weak (4 pts): Vague or limited info about organization or team.

1 – Poor (2 pts): Unclear or missing.

Experience and Qualifications (25 points)

5 – Excellent (25 pts): Strong history with CNAs, behavioral health, and Indiana-specific work.

4 – Good (20 pts): Strong in 2 of the 3 areas (e.g., CNA and behavioral health).

3 – Satisfactory (15 pts): General experience but limited in CNA or state-specific work.

2 – Weak (10 pts): Some relevant work but lacks direct alignment.

1 – Poor (5 pts): Little to no relevant experience shown.

Work Plan and Timeline (25 points)

5 – Excellent (25 pts): Clear, detailed methods and timeline; realistic and aligned with goals.

4 – Good (20 pts): Mostly clear with small gaps in detail or feasibility.

3 – Satisfactory (15 pts): Basic plan, limited specifics or tight timeline.

2 – Weak (10 pts): Vague or unrealistic.

1 – Poor (5 pts): Missing or unfeasible.

Budget and Cost Proposal (15 points)

5 – Excellent (15 pts): Clear line items, reasonable costs, great value for scope.

4 – Good (12 pts): Justified and reasonable but could use more clarity.

- **3 – Satisfactory (9 pts):** Acceptable cost, some vague or missing budget info.
- **2 – Weak (6 pts):** Unclear or seems inflated.
- **1 – Poor (3 pts):** Unreasonable or unjustified.

References (10 points)

- **5 – Excellent (10 pts):** Strong endorsements from highly relevant projects.
- **4 – Good (8 pts):** Good references, minor gaps in relevance or recency.
- **3 – Satisfactory (6 pts):** Basic references, not all fully aligned.
- **2 – Weak (4 pts):** Weak references or lack of detail.
- **1 – Poor (2 pts):** Missing or irrelevant.

Interview (10 points)

- **5 – Excellent (10 pts):** Clear, engaging, aligns with proposal, shows team strength.
- **4 – Good (8 pts):** Mostly aligned and clear, some minor gaps.
- **3 – Satisfactory (6 pts):** Adequate but lacks energy or full alignment.
- **2 – Weak (4 pts):** Unclear, off-message, or team unprepared.
- **1 – Poor (2 pts):** Confusing or unprofessional.

Appendix B

Number of Clients Treated by County

Clay 925	Putnam 687
Greene 1,022	Sullivan 687
Hendricks 746	Vermillion 558
Marion 832	Vigo 4,431
Owen 319	Other 928
Parke 428	TOTAL **11,563**

Charity Care

$4,016,995

Units of Service

Outpatient Visits
272,683

Inpatient Days
4,632

Residential Days
12,352

Employment Visits
186

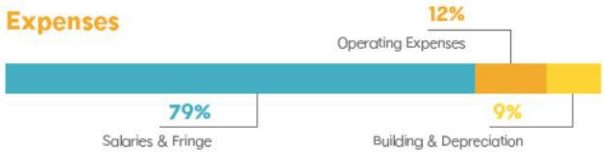
Primary Care Visits
5,372

Home Visits Infant/Toddler Services
(Healthy Families & Early Head Start)
1,223

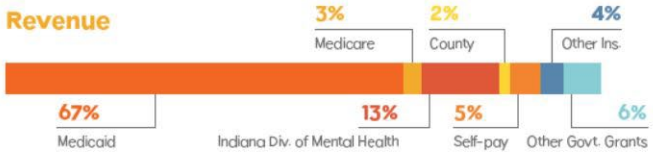
Early Head Start Classroom Days
1,624

FISCAL YEAR STATS

Expenses



Revenue



CCBHC IS HERE!

Hamilton Center is one of eight Community Mental Health Centers to be selected for Indiana's Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration pilot.

Hamilton Center Inc. has been selected by the State of Indiana to help lead the charge in the transformation of community mental health. The organization's selection in the Certified Community Behavioral Health Clinic (CCBHC) demonstration marks a significant milestone in the ongoing effort to enhance mental health and substance use disorder services across the state. This designation will allow Hamilton Center and the State of Indiana to reimagine how healthcare services are delivered, better integrating behavioral and primary healthcare.

The CCBHC Medicaid Demonstration Program provides states with sustainable funding that will help expand access to mental health and substance use services, supporting the national efforts to tackle the country's mental health and addiction crises and transform the county's behavioral health system. Indiana Congressman Larry Bucshon is co-sponsoring a bill, Ensuring Excellence in Mental Health Act, which will be critical in establishing the infrastructure needed to achieve a long-term vision of the CCBHC model.

Key components of the CCBHC model include:

- 24/7/365 Access to Crisis Services.
- Comprehensive Outpatient Mental Health and Substance Use Services.
- Care Coordination: Integrating primary care and behavioral health services.
- Quality and Accountability: Adopting evidence-based practices and continuously monitoring outcome.

In addition, the CCBHC initiative is also expected to reduce non-emergent emergency room visits, divert individuals from incarceration to treatment, increase access to medication assisted treatment and invest in the healthcare workforce in our communities.

> "Hamilton Center has been preparing for several years to position itself to respond to this new healthcare model."
>
> Melvin L. Burks, *President & CEO*

FISCAL YEAR HIGHLIGHTS

Secured The Joint Commission's Gold Seal of Approval® for Behavioral Health and Addiction Accreditation for WIN Recovery Knox and Hendricks counties. Hamilton Center's opioid treatment program. This accreditation demonstrates continuous compliance with performance standards and quality that reflects Hamilton Center's commitment to providing safe and quality patient care.

Received a $1 million continuation grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) to continue work on Hamilton Center's transition in becoming a Certified Community Behavioral Health Clinic.

Received a $422,424 Community Crisis Response Partnership grant from the Indiana Family and Social Services Administration – Division of Mental Health and Addiction, which will be used to further Hamilton Center's ability to respond to crises 24 hours a day, seven days a week in Sullivan County.

Awarded a $4,462,483 Crisis Receiving and Stabilization Services contract from the Indiana Family and Social Services Administration– Division of Mental Health and Addiction to add a crisis stabilization unit in Vigo County and launch a new mobile crisis hub in Sullivan County.

Trained close to 200 people in Mental Health First Aid and Youth Mental Health First Aid including employees with THRIVE, Sullivan Public Libraries, Sullivan County Community Hospital, various central and west-central Indiana school corporations, Mental Health America, several addiction recovery centers and several EMTs in the area.

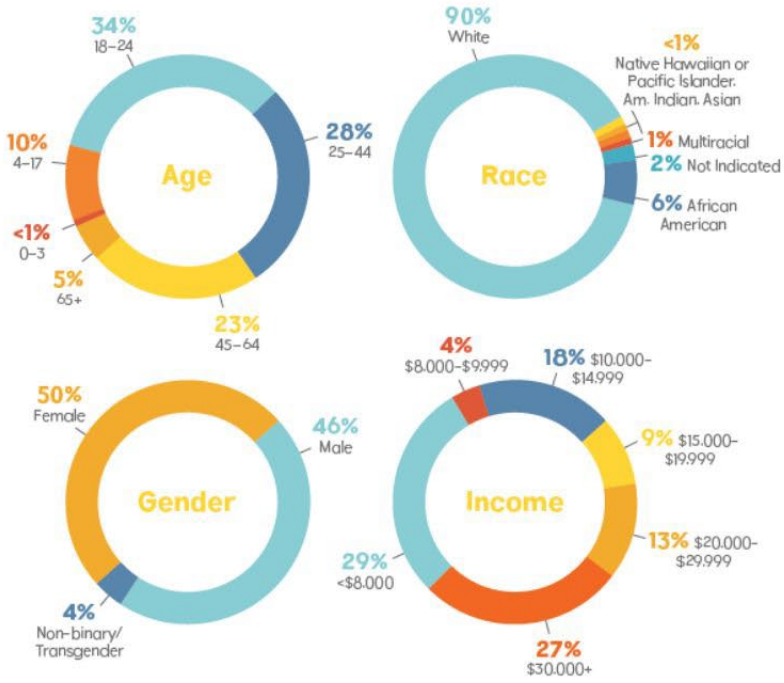
Offered support to 60 individuals over four crisis response events, providing 58 hours of in-kind crisis services to the community.

Provided a total of 147 hours of in-kind services to Southwest Parke School Corporation and North Central Parke School Corporation.

Secured a new partnership with L.O.S.S. (Local Outreach to Suicide Survivors) Team. This is a team housed with Mental Health America (MHA) and provides support to those affected by suicide.

Awarded up to $666,768 from the State of Indiana's Family and Social Services Administration (FSSA) for the purpose of major repairs and maintenance to existing group homes.

CLIENT DEMOGRAPHICS



Outpatient Services

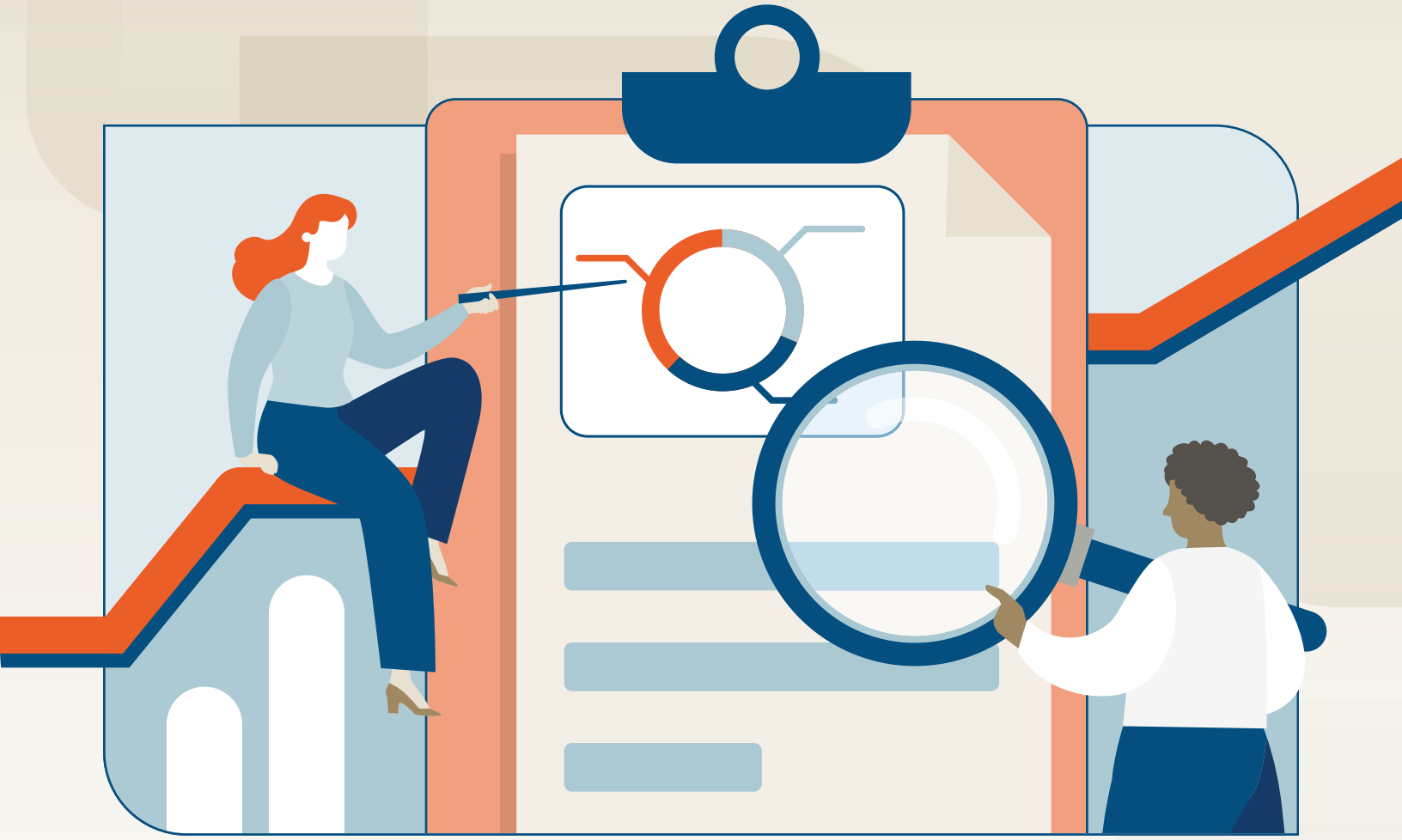
Most Common Diagnoses (in order of prevalence)

1. Generalized Anxiety Disorder
2. Major Depressive Disorder
3. Post-traumatic Stress Disorder


This Annual Report covers Hamilton Center's 2024 fiscal year. July 1, 2023 – June 30, 2024
Vigo County
CORPORATE OFFICE
620 Eighth Ave.
Terre Haute, IN 47804
812.231.8323
ACCESS TO SERVICES
812.231.8200
800.742.0787
CHILD & ADOLESCENT SERVICES
500 Eighth Ave.
Terre Haute, IN 47804
812.231.8376
EMPLOYMENT SOLUTIONS
1616 Wabash Ave.
Terre Haute, IN 47807
812.231.8355
GRACE CLINIC HEALTH PROFESSIONAL
622 8th Ave.
Terre Haute, IN 47804
812.231.8377
STEVENS CENTER FOR ADDICTION RECOVERY
66 Wabash Ct.
Terre Haute, IN 47807
812.231.8171
WIN RECOVERY
88 Wabash Ct.
Terre Haute, IN 47807
812.231.8484
Clay County
1211 E. National Ave.
Brazil, IN 47834
812.448.8801
Greene County
1200 N. 1000 W. P.O. Box 553
Linton, IN 47441
812.847.4435
431 E. Main St. P.O. Box 69
Bloomfield, IN 47424
812.384.9452
Hendricks County
900 Southfield Dr.
Plainfield, IN 46168
317.837.9719
WIN RECOVERY
401 Plainfield Commons Dr.
Plainfield, IN 46168
317.268.2941
Knox County
WIN RECOVERY
1433 Willow St.
Vincennes, IN 47591
812.494.2215
Marion County
2160 N. Illinois St.
Indianapolis, IN 46202
317.937.3700
Owen County
909 W. Hillside Ave.
P.O. Box 595
Spencer, IN 47460
812.829.0037
Parke County
215 N. Jefferson St.
P.O. Box 123
Rockville, IN 47872
765.569.2031
Putnam County
239 Hillsdale Ave.
Greencastle, IN 46135
765.653.1024
GRACE CLINIC HEALTH PROFESSIONAL
239 Hillsdale Ave. Suite A
Greencastle, IN 46135
765.653.1024
Sullivan County
2134 Mary Sherman Dr.
Sullivan, IN 47882
812.268.6376
Vermillion County
510 S. Main St.
P.O. Box 406
Clinton, IN 47842
765.832.2436
800.742.0787 | www.hamiltoncenter.org
HAMILTON CENTER, INC.
ASPIN

NATIONAL COUNCIL for Mental Wellbeing

CCBHC
Community Needs Assessment Toolkit



JANUARY 2024

CCBHC-E National Training & Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

This publication was made possible by Grant No. 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

Overview

This toolkit is a resource for Certified Community Behavioral Health Clinic (CCBHC) organizations, including Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC-Expansion grantees, completing the required needs assessment in preparation for implementation. It highlights practical frameworks, resources and tools that organizations can use to plan and execute a high-quality needs assessment in their local communities.

Toolkit Goals

This toolkit will:

- Increase understanding of CCBHC community needs assessment requirements, as set forth in the updated CCBHC Certification Criteria issued by SAMHSA in March 2023.
- Support CCBHC organizations in the planning, design and implementation of their community needs assessment.
- Explain how CCBHCs can use the community needs assessment to inform staffing, partnerships and services.
- Describe how community needs assessment findings can be incorporated in the process of continuous quality improvement (CQI).

How to Use This Toolkit

The community needs assessment is the foundation of the CCBHC model. This toolkit is a resource designed with the needs and assets of community-based behavioral health organizations in mind. While some CCBHCs may have evaluators on staff, we recognize that many are approaching this process with more limited resources. This toolkit offers guidance that will allow all organizations to plan and execute a community needs assessment that will meet the requirements set forth by SAMHSA in the national CCBHC Certification Criteria, and, most importantly, yield valuable insights to inform clinic services, staffing, partnerships and strategy.

For Additional Resources and Support

The National Council for Mental Wellbeing's CCBHC-E Training and Technical Assistance Center is committed to advancing the CCBHC model by providing SAMHSA CCBHC-Expansion Programs (including CCBHC-E, CCBHC-PDI and CCBHC-IA) training and technical assistance related to certification, sustainability and the implementation of processes that support access to care and evidence-based practices. To access additional information, learn about upcoming events, and request technical assistance, visit the CCBHC-E Training and Technical Assistance Center.

This publication was made possible by Grant No. 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

Acknowledgments

This toolkit was developed in 2023 by Bowling Business Strategies in partnership with the National Council for Mental Wellbeing's CCBHC-E Training and Technical Assistance Center. It reflects the requirements set forth in SAMHSA's updated CCBHC Certification Criteria.

We are especially grateful to the following individuals who provided input, feedback and support on the development of this toolkit.

National Council for Mental Wellbeing CCBHC-E Training and Technical Assistance Center

- **Samantha Holcombe**, MPH | Senior Director, Practice Improvement
- **Clement Nsiah**, PhD, MA | Director, Practice Improvement
- **Renee Boak**, MPH | Consultant and Subject Matter Expert
- **Blaire Thomas**, MA | Project Manager
- **Ritu Dhar**, MPH | Project Coordinator

Key Informant Interviewees

- **Mary Blake**, BA | Senior Public Health Advisor, Center for Mental Health Services, SAMHSA
- **Jessica Crowe**, LICSW | Senior Director, Clinical Projects, Child & Family Services Inc.
- **Elizabeth Cumpton** | Government Program Officer, Center for Mental Health Services, SAMHSA
- **David DeVoursney**, MPP | Director, Division of Service and Systems Improvement, Center for Mental Health Services, SAMHSA
- **Leigh Fischer**, MPH | Principal, TriWest Group
- **Joan Lodge**, LCSW | Grant Management Administrator and Community Liaison, Rosecrance
- **Gail Raney**, MPP | Administrator, Rosecrance
- **Jesse Sieger-Walls**, MSW, LCSW, PhD | Principal and Director of Population Health, TriWest Group

Table of Contents

Overview 1

Toolkit Goals 1

How to Use This Toolkit 1

For Additional Resources and Support 1

Acknowledgments 2

Community Needs Assessment: The Foundation of the CCBHC 5

- The Needs Assessment as the Foundation of the CCBHC 5
- Key Drivers of the Needs Assessment 5
- The Needs Assessment Cycle 7

Core Requirements of the Community Needs Assessment 9

- SAMHSA's Requirements for the CCBHC Community Needs Assessment 9

Preparing for Your Needs Assessment 11

- Building the Foundation of Your CCBHC 11
- Planning Your Needs Assessment 13
- Staffing Your Needs Assessment 15
- Working With a Consultant 17
- Partnering With Academic Institutions and Other Community Partners 18
- Defining Your Guiding Questions and Goals 18
- Creating an Assessment Plan 23

Quantitative Data 24

- The Role of Quantitative Data in Your Needs Assessment 24
- Quantitative Data Examples 25
- Using Internal Data 29
- Using External Data 30

Table of Contents

Qualitative Data **31**

The Role of Qualitative Data in Your Needs Assessment 31

Qualitative Data Sources. 31

Collecting and Analyzing Qualitative Data 33

Engaging Community and Partners **34**

The Importance of Community Engagement. 34

SAMHSA's Requirements for Community Input in the Needs Assessment 35

Engaging Who You're Not Serving 36

Best Practices to Engage the Community 37

Putting It All Together. **40**

What Should the Needs Assessment Look Like? 40

Integrating Your Findings Into Everyday Practice 40

Integrating Your Findings Into Your CQI Process 42

Communicating the Findings and Next Steps 43

Appendix | Focus Studies **44**

Engaging LGBTQ+ Populations. 45

Providing Low-barrier MOUD 48

Identifying and Addressing Housing Insecurity 52

Practical Tools

List of Data Sources

Needs Assessment Outline

Interview Scripts and Thematic Organizer

Data Comparison Tool

Community Needs Assessment: The Foundation of the CCBHC

The Needs Assessment as the Foundation of the CCBHC

All CCBHCs are required to provide a comprehensive range of outreach, screening, assessment, treatment, care coordination and recovery supports based on a needs assessment specific to their service area. While CCBHCs are required to serve all individuals across the lifespan in need of behavioral health services in their geographic area, SAMHSA also expects that CCBHCs will focus their efforts on specific groups facing health disparities, as identified by the community needs assessment.

The overarching purpose of the community needs assessment is to understand what needs exist in your community and what your CCBHC can do to address them.

All CCBHCs, including SAMHSA CCBHC-Expansion Program grantees, are required to conduct a community needs assessment every three years, or more frequently per state-specific requirements. The findings of your community needs assessment should inform your decisions about CCBHC design and implementation.

As with all aspects of the CCBHC model, organizations must meaningfully involve people with lived experience of mental and substance use conditions and family members in the needs assessment process. These may include individuals who have received/are receiving services from the clinic and their family members; individuals in organizations that are run and operated by peers or family members; individuals who are peer or family advocates or work in advocacy programs; and other stakeholders with lived experience and their family members. In addition, the community needs assessment is a unique opportunity to build relationships and meaningfully engage your staff, external partners and community leaders.

Key Drivers of the Needs Assessment

CCBHCs provide coordinated, person- and family-centered care to help individuals recover, be healthy and live fully within their communities. Because the CCBHC model encourages the provision of accessible services and evidence-based practices that are tailored to each community, the needs assessment is the foundation of the CCBHC model. Furthermore, in states that are implementing a statewide CCBHC program — as part of the Section 223 Demonstration Program or otherwise — the state will set expectations for the services and evidence-based practices provided by CCBHCs. It will be important to assess community needs with these expectations in mind.

Your community needs assessment should explore and identify:

- Treatment and recovery needs in your community across the lifespan, including the needs of all sub-populations (e.g., racial, ethnic, gender and sexual minorities) who experience disparities in access to behavioral health services.

- Physical health and social needs experienced by people in your service area, including children and youth.
- Available services, including evidence-based practices, and support in your service area, and any notable gaps or workforce shortages.
- Entry points to treatment and missed opportunities for engagement.
- Those who may be in need of behavioral health services but are not engaging in them.
- Unmet health-related social needs, such as food insecurity or inadequate or unstable housing.
- Barriers to accessing services and support, including transportation, income, culture and technology.
- Cultural and linguistic needs of populations of focus in your catchment.

> Specific CCBHC criteria are tied to the community needs assessment including **staffing, language and culture, services, locations, service hours** and **evidence-based practices**. Therefore, the community needs assessment must be thorough and **reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth and families.**
>
> *SAMHSA CCBHC Certification Criteria, Appendix A, March 2023 (emphasis added)*

All services offered at the CCBHC, including care coordination and selection of evidence-based practices, should be driven by the findings of your community needs assessment.

Key drivers of the needs assessment process include:

- **Community Needs and Barriers to Care:** Seeking a more comprehensive and data-driven understanding of community needs in your service area.
- **Community-responsive Staffing and Services:** Building on the foundation of community needs to inform your service array, locations and hours of operation, staffing model and staff training plan.
- **Effective Partnerships and Care Coordination:** Developing more effective and strategic partnerships for care coordination and services.

When you deeply understand the needs of your community, you can design and implement services that are more accessible, effective and responsive to those needs.

> **We have used our community needs assessment for decision-making and prioritization across our organization. We point to our needs assessment findings when we are advocating both internally and externally for resources to support our CCBHC.**
>
> *Joan Lodge, LCSW, Rosecrance*

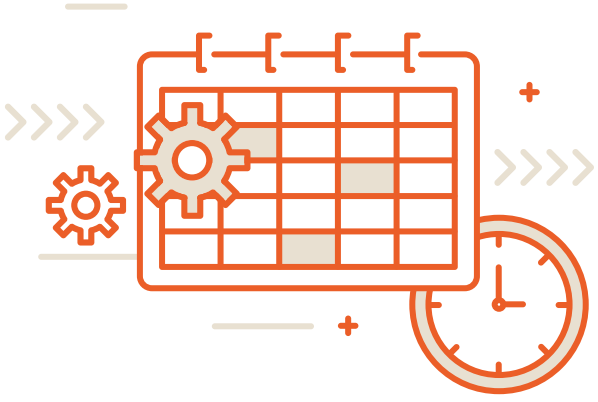
The Needs Assessment Cycle

Community needs and assets change and evolve over time. As a result, the community needs assessment is an ongoing process. This cycle includes planning and prioritizing areas of inquiry; engaging stakeholders; data collection and analysis; making sense of the data and prioritizing findings; sharing findings; developing a plan to implement strategies that are linked to findings; evaluating progress using a continuous quality improvement (CQI) framework; and then beginning again.

Informed by the Association for Community Health Improvement, American Hospital Association (2023). Community Health Assessment Toolkit.

The major action steps in the CCBHC community needs assessment process are outlined in the following.

MAJOR STEPS IN THE NEEDS ASSESSMENT PROCESS		
1	**Reflect and Plan**	Assemble your needs assessment team, define your guiding questions and create your assessment plan.
2	**Build Relationships**	Identify who needs to be engaged in the needs assessment process (internally and externally) and conduct outreach.
3	**Collect and Analyze Data**	Collect, compile and analyze data, including qualitative and quantitative data from internal and external sources.
4	**Prioritize Findings**	Determine your findings and prioritize them for implementation.
5	**Communicate Results**	Report findings to key stakeholders, including community advisors, partners, clients and their family members, and organization staff.
6	**Develop Action Plan**	Develop a plan to integrate your needs assessment findings into clinic services, operations and staffing.
7	**Implement Strategies**	Implement your action plan strategies that align with the findings of your needs assessment.
8	**Evaluate Progress**	Evaluate your ongoing progress.



Core Requirements of the Community Needs Assessment

SAMHSA's Requirements for the CCBHC Community Needs Assessment

SAMHSA sets out requirements and expectations for the community needs assessment process in the CCBHC Certification Criteria. Organizations are encouraged to review the CCBHC Certification Criteria in their entirety before beginning the needs assessment process. All CCBHCs should be prepared to attest to their compliance with the updated criteria by July 1, 2024.

Several sections of the CCBHC Certification Criteria speak to the needs assessment process and how findings should be integrated into clinic services, operations and staffing. The most detailed description of the community needs assessment requirements can be found in Appendix A, excerpted in the subsequent callout.

The community needs assessment comprises the following elements:

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 designated collaborating organizations (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 determinants 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.
4. Cultures and languages of the populations residing in the service area.
5. Identification of the underserved population(s) within the service area.
6. A description of how the staffing plan does and/or will address findings.
7. Plans to update the community needs assessment every three years.
8. Input with regard to:
    - Cultural, linguistic, physical health and behavioral health treatment needs.
    - Evidence-based practices and behavioral health crisis services.
    - Access and availability of CCBHC services including days, times and locations, as well as telehealth options.
    - Potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.

SAMHSA CCBHC Certification Criteria, Appendix A, March 2023

(Note: Additional guidance on required and recommended sources of input for element 8 can be found later under "Engaging Community and Partners.")

The findings of your community needs assessment should inform your decision-making around services and staffing and guide the day-to-day operations of your CCBHC. The CCBHC Certification Criteria specifically note the following areas where the community needs assessment should inform CCBHC services and implementation.

The Needs Assessment Should Inform	Including	Criteria
Staffing	Development and documentation of a staffing plan, including clinical, peer and family support, and other staff, that is responsive to the findings of the needs assessment.	1.a.1 1.b.2
	Clinical and nonclinical staff appropriate to the population(s) receiving services.	1.a.2
	Management team appropriate for the size and needs of the clinic.	1.a.3
Accessibility	The languages commonly spoken within the community served, and which languages require language assistance/translation services.	1.d.4
	Services being provided during times that meet the needs of the population served, including some evening and weekend hours.	2.a.2
	Services being provided at locations that meet the needs of the population served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate, home-based services.	2.a.3
	Walk-in hours include evening hours that are publicly posted.	4.c.1
Outreach	The CCBHC conducts outreach, engagement and retention activities to support inclusion and access for underserved individuals and populations.	2.a.6
Partnerships	Partnership development plans with local service providers and agencies created based on the population served, the needs and preferences of people receiving services, and other needs identified.	3.c.3
Services	The selection of evidence-based practices.	4.f.1

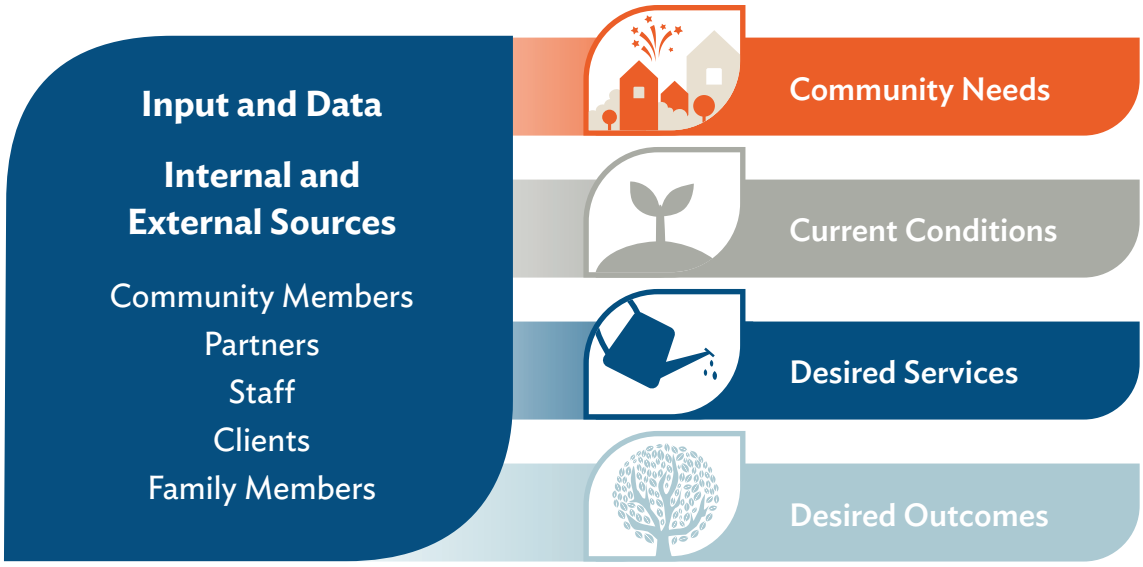
These are the minimum requirements noted in the CCBHC Certification Criteria. In addition to these requirements, CCBHCs may also find it helpful to incorporate needs assessment findings into many other aspects of their clinic operations and strategy. For example, needs assessment findings can also inform staff training plans, care coordination, data collection and CQI processes. These and other best practices are described in more detail in the following and illustrated using concrete examples in the **Focus Studies** appendix.

Preparing for Your Needs Assessment

Building the Foundation of Your CCBHC

The community needs assessment is the foundation of the CCBHC model. When a CCBHC invests sufficient time, effort and resources into the needs assessment process, it pays dividends in the long run. A superficial approach to the process will result in a document that sits on a shelf, while a strategic approach will lead to actionable findings.

In the CCBHC Certification Criteria, SAMHSA defines the needs assessment as a "systematic approach to *identifying community needs* and *determining program capacity to address the needs* of the population being served." Your CCBHC needs assessment should identify current community needs and conditions — including current service availability and gaps — and then build on those findings to inform CCBHC services that are linked to desired outcomes. This process should be informed continually by data and input from internal and external sources.



A well-done community needs assessment will:

- Deepen your understanding of community needs and challenge your assumptions.
- Ensure alignment between the services you offer and what your community actually needs.
- Ensure appropriate allocation of energy and resources across your organization.
- Help you find new partners for care coordination and outreach.
- Boost effectiveness of services, enhancing staff and client satisfaction.
- Change the way things are done at your organization.

Ideally, your needs assessment findings will help you:

- Assess your CCBHC's current capacity.
- Identify and clarify service gaps to be addressed.
- Examine internal and external factors that affect access to and quality of care.
- Align evidence-based practices, services and organizational policies (e.g., training and staffing) with the community's needs.
- Identify opportunities to increase access and engagement to reduce behavioral health disparities.

EXAMPLES OF DIFFERENT TYPES OF DATA

Quantitative

- Publicly available estimates describing behavioral health conditions, including co-occurring physical health conditions and other factors related to recovery.
- State data on social drivers of health, population-level outcomes and Medicaid utilization, as available.
- Internal and external service utilization data.
- Internal and external staffing data (e.g., workforce trends, turnover rates).
- Self-report data from clients and staff (e.g., functioning, satisfaction).

Qualitative

- Interviews and focus groups with internal and external stakeholders, including input from people served and family members.
- Organizational documents and community-level reports.

CCBHCs can use a mix of quantitative and qualitative data for their needs assessment. This can include existing, publicly available state and local data and reports, data from your clinic electronic health record (EHR), surveys and interviews. Other sources include state-collected data as available, as well as state-level data from sources such as the Centers for Disease Control and Prevention's Behavioral Health Risk Factors Surveillance System (BRFSS). When designing your needs assessment, you should ensure data collection includes mechanisms for input from people served by your CCBHC and relevant communities in your service area. Consider how to address barriers to participation and seek out input from communities that you may not currently be serving. The final product should inform your strategic approach to program expansion, community outreach and staffing.

NEEDS ASSESSMENT REQUIREMENTS FOR SAMHSA CCBHC GRANTEES

There are two tracks under SAMHSA's CCBHC-Expansion program — CCBHC-Planning, Development and Implementation (PDI), and CCBHC-Improvement and Advancement (IA). Both require recipients to conduct a community needs assessment consistent with the CCBHC criteria requirements. However, the grant requirements for when each cohort must submit are slightly different.

CCBHC-PDI grantees are required to complete the community needs assessment within six months of the award. Grantees must also complete a follow-up needs assessment within six months prior to the start of Year 4 and submit an updated attestation to meeting the CCBHC Certification Criteria.

CCBHC-IA grantees are required to conduct a needs assessment within three years of their most recent needs assessment. Therefore, grantees may have to conduct at least one and possibly two community assessments over the life of the project, which translates to conducting one every three years or within three years of the most recent assessment. Overall, CCBHC-IA grantees are required to complete/update a community needs assessment no later than three years after the most recent one.

The National Council for Mental Wellbeing's CCBHC-E National Training and Technical Assistance Center is available to support SAMHSA CCBHC-PDI and CCBHC-IA grantees at all stages of development. See the CCBHC New Grantee Resource Guide for more information.

Planning Your Needs Assessment

You should identify a single point person at your organization who will lead the needs assessment process. This person should be supported by a multidisciplinary steering committee. Often, but not always, the point person for the CCBHC needs assessment will be the CCBHC program director. If you choose to engage a consultant to support the needs assessment process, they may also be a part of this guiding team.

Your needs assessment team will steer the needs assessment process from beginning to end and help ensure that there are sufficient resources to complete all activities and put findings into practice.

YOUR NEEDS ASSESSMENT TEAM WILL:

- Define the goals and guiding questions for the assessment.
- Identify the target populations for assessing needs and services.
- Identify existing data sets that may contribute to the assessment.
- Determine how data will be collected and used.
- Determine the timeline for the process.
- Determine the strategic use of the findings.

A successful needs assessment requires your team to approach the process with a sense of curiosity about how your organization might improve its service offerings to better meet the needs of the community. The needs assessment process offers a wonderful "excuse" to engage the people you serve and your local partners, educate them about the CCBHC model, and deepen your relationships. It is also an opportunity to engage staff at all levels of your organization, including frontline staff.

To create this toolkit, the authors spoke to CCBHC directors who had recently led community needs assessments, as well as professional evaluators who worked with CCBHCs to conduct them. They shared some success strategies and pitfalls, as outlined in the following.

CHARACTERISTICS OF AN EFFECTIVE NEEDS ASSESSMENT

- **Aligned with CCBHC Criteria:** The needs assessment team understands CCBHC requirements and purposefully seeks out information that will help the organization better align with the CCBHC model.
- **Focused Inquiry:** The team prioritizes several guiding questions early in the process, which helps them identify the most relevant data sources.
- **Staff Involvement:** Leadership views the needs assessment process as an opportunity to develop skills among staff and hear perspectives from all levels of the organization.
- **Partner Involvement:** Leadership views the needs assessment as an opportunity to build better and/or new partnerships with external stakeholders and organizations.
- **Input from People with Lived Experience and Family Members:** The team seeks substantive input from people with relevant lived experience. This includes people served by the clinic, as well as individuals the clinic may not currently be reaching.
- **Findings Tied to Practice:** The team considers all needs assessment findings in the context of their daily practice and works with leaders across the organization to make changes to better address unmet needs and gaps in care.

COMMON PITFALLS TO AVOID

- **Lack of Connection to CCBHC Services and Operations:** The needs assessment includes information that is not relevant to the CCBHC model. This may be more likely to happen when the team is overly reliant on existing needs assessments conducted by local hospitals.
- **Lack of Focus:** The team does not prioritize guiding questions early on, leading to unfocused and inefficient lines of inquiry.
- **Insufficient Staffing/Resources:** Leadership asks one person (typically the CCBHC Program Director) to research and write the needs assessment mostly by themselves, on top of their other job responsibilities. One person, working alone at their desk, cannot create an effective needs assessment.
- **Lack of Broader Community Engagement:** The team falls back on client surveys as the primary means for collecting information from people with lived experience. It is important to also seek feedback from people that you are not serving.
- **Too Much Content:** The needs assessment team feels overwhelmed by the amount of data available and they decide to include all of it. A lack of prioritization makes it harder to communicate findings across the organization and put them into practice.

Staffing Your Needs Assessment

A best practice for the CCBHC community needs assessment is to identify a single point person at your organization who will lead the needs assessment process, with the support of a steering group. Members of the steering group may include fiscal and executive leadership, and quality and IT directors. Depending on the structure and capacity of your organization, you may want to include HR, communications, population health, or evaluation staff as well.

You should also include representatives with lived experience and family members involved in clinic governance or CQI activities in this steering group. People with lived experience of mental health and substance use challenges, and their family members, may provide especially helpful insights and expertise that can inform your needs assessment's design and execution.

COMMUNITY NEEDS ASSESSMENT DESIGN AND PLANNING:
Potential Contributions from People with Lived Experience

- Provide insights for effectively engaging those in the community with, or at risk of, mental health and substance use challenges.
- Provide insights for effectively engaging family members of those with, or at risk of, mental health and substance use challenges.
- Advise on questions for focus groups to elicit meaningful input from those receiving or in need of services.
- Identify data collection methods and approaches that will be well received by community members.
- Participate in data collection activities such as focus groups.

To launch your needs assessment process, you will need to:

- Identify your steering group members, ensuring multidisciplinary representation and, to the extent possible, diversity related to race, ethnicity, culture, disability, gender identity and/or sexual orientation.
- Develop a plan to engage staff in the process, in addition to the people on the steering group.
- Identify and engage the data stewards that have access to relevant data sets.
- Determine whether you want to engage a consultant and, if so, what the scope of their engagement will be.
- Consider partnerships with local colleges, universities or research centers.
- Consider engaging interns, students and volunteers.

While the steering group will be involved in the needs assessment process from the beginning to the end, many other organizational stakeholders have an important role to play in the completion of the needs assessment. The following outlines some concrete examples of how different team members can be leveraged for the needs assessment process.

HOW DIFFERENT STAFF ROLES CAN SUPPORT THE NEEDS ASSESSMENT PROCESS	
Role	**Sample tasks (not an exhaustive list)**
CCBHC Program Director	Serve as project manager for the needs assessment process; convene steering group; manage consultant and volunteers; ensure team has a clear understanding of CCBHC requirements and the purpose of the needs assessment.
Executive	Provide input on guiding questions and prioritization of goals; ensure CCBHC program director has sufficient resources to complete the needs assessment.
Fiscal	Provide input on guiding questions and prioritization of goals; advise on implementation strategies.
Quality	Provide input on guiding questions and prioritization of goals; incorporate findings into CQI processes.
IT	Run reports on client demographics and service utilization; work with steering group to develop new reports aligned with goals of needs assessment and on the reporting of outcome measures to SAMHSA.
Clinical	Advise on evidence-based practice alignment with community needs; share information on clinical resources and needs, as well as on current measurement of client response to treatment and associated gaps.
Peer/Recovery/Family Support	Share information on community resources and gaps; advise on outreach and engagement strategies; inform or participate in data collection strategies to ensure respectful engagement of people with lived experience; share their own lived experience to inform findings.
Community Health Workers and Other Paraprofessionals	Share information on community resources and gaps; facilitate connections to community resources and partners; provide perspective on opportunities to better address clients' social needs.
People Receiving Services	Share their own lived experience to inform findings and recommendations; provide perspective on opportunities to better address clients' social needs.
HR	Provide data on staffing array and turnover; facilitate staff engagement with the process.
Communications	Develop summaries of findings; promote findings internally and externally.
Community Advisory Board	Provide input on guiding questions and preliminary findings; advise on outreach and engagement strategies.
Board of Directors	Use needs assessment findings to inform strategic decision-making across the organization.

Working With a Consultant

A CCBHC may hire a consultant to help complete the needs assessment. If you choose to go this route, it is important that the CCBHC maintains oversight and leadership of the process. Ideally, the consultant would facilitate the needs assessment process, execute certain tasks and guide the needs assessment team through the development of priorities and data analysis. In this way, the CCBHC team remains part of the process from beginning to end, and ultimately makes the decisions regarding the populations of focus and the priorities the CCBHC will address.

Consultants can be expensive. Many CCBHCs have had success using consultants for certain parts of the needs assessment process. For example, you may decide that you only need consultant support to analyze quantitative data, or perhaps you need project management and facilitation support to help plan the initiative and keep the team on track.

Effective management of a consultant involves clear communication, ongoing monitoring, and fostering a collaborative environment to ensure successful outcomes. The following notes some effective strategies for managing a consultant.

STRATEGIES FOR MANAGING A CONSULTANT	
Clearly define objectives	Clearly communicate your expectations, project goals and desired outcomes to the consultant. Make sure they understand what needs to be achieved.
Establish open communication	Maintain regular and open lines of communication with the consultant. Encourage them to ask questions, provide updates and seek clarification as needed.
Set realistic deadlines	Agree on achievable deadlines for deliverables and milestones. Ensure the consultant understands the timeline and hold them accountable for meeting the agreed-upon deadlines.
Provide necessary resources	Equip the consultant with the resources they need to perform their work effectively. This includes access to relevant information, data, tools and any other required support.
Monitor progress	Regularly monitor the consultant's progress and provide constructive feedback. Review their work, track milestones and address any concerns or issues promptly.
Foster collaboration	Encourage collaboration between the consultant and your internal team. Facilitate effective knowledge transfer, encourage idea sharing and create an environment that promotes teamwork.
Maintain clear expectations	Continuously communicate your expectations regarding quality, scope and any other relevant factors. Regularly touch base on progress and ensure that the consultant's work aligns with your organization's standards.
Manage scope creep	Keep an eye on scope creep, which refers to the expansion of project scope beyond the originally defined boundaries. Clearly define the project scope and address any changes or additional requirements through formal change management processes.
Provide feedback and recognition	Offer feedback and recognition for the consultant's work. Acknowledge their achievements, provide constructive criticism and show appreciation for their efforts.

Partnering With Academic Institutions and a Range of Community Partners

Consider partnering with academic institutions and other community partners on your needs assessment. Local public health schools are ideal partners, as they have graduate students seeking internships who are trained in statistics, epidemiology and community needs assessment. Find a public health program in your area at aspph.org. You may also look into college or university programs in health education, social work or public administration for interns. Interns can assist with collecting community data and providing technical support.

The CCBHC community needs assessment is an opportunity to reach out and build rapport with other entities with overlapping interests. The work that you do for your CCBHC community needs assessment can become a learning resource for the entire community.

Some CCBHCs may find it helpful to partner with local health departments, funders, hospitals or federally qualified health centers (FQHCs) on aspects of the needs assessment process. For example, the local health department may collect and analyze data related to health needs that could be leveraged for the CCBHC needs assessment. A local funder may be interested in partnering on a series of stakeholder interviews to better understand community resources and gaps. Local FQHCs and hospitals may be able to share relevant information from their own community needs assessment processes, or team up with you on community engagement efforts (e.g., a shared town hall). Community-based organizations that provide services and supports, Tribal entities, and organizations that are peer- or family-run all bring important perspectives to the needs assessment. Partnering with them can help develop your connections to communities that historically may not have engaged in services, and ensure that your needs assessment reflects the needs of the community served by your CCBHC.

Defining Your Guiding Questions and Goals

A key early task for the CCBHC needs assessment team is to define the goals of the needs assessment and prioritize guiding questions. You should not begin collecting or analyzing data until the steering group — which will ideally include members of your organization's executive, clinical and quality teams — has defined and prioritized focused areas of inquiry that are meaningful to your CCBHC.

The CCBHC community needs assessment is not a "blank slate" exercise. As a community-embedded organization that works to meet people's needs every day, you already know a lot about your community and your community's needs. If you are a new SAMHSA grantee, you can look to the statement of need that you wrote for your CCBHC-PDI or CCBHC-IA grant as a jumping-off point. You may also be able to build on your Disparities Impact Statement (DIS) — which is required specifically for SAMHSA grantees to identify disparities in care for population groups most at risk of poor outcomes — and develop an action plan for addressing and closing indicated gaps. For additional suggestions on how to integrate information from your DIS into your CCBHC community needs assessment, see the Needs Assessment Outline developed as part of this toolkit.

To kick off the needs assessment planning process, it may be helpful to facilitate a team conversation around the following questions:

COMMUNITY NEEDS AND BARRIERS TO CARE

- How can we better understand our community's needs?
- Are there any potential trends that we are aware of anecdotally that we would like to explore further?
- What are some populations in our area that likely have unmet needs?

COMMUNITY-RESPONSIVE STAFFING AND SERVICES

- How can we strategically staff and provide services that are more aligned with community needs?
- Are there opportunities to improve the accessibility of the services we provide, such as expanding service hours and locations?
- How can we address issues that impact access, such as transportation to and from appointments, cultural humility and linguistic accessibility?

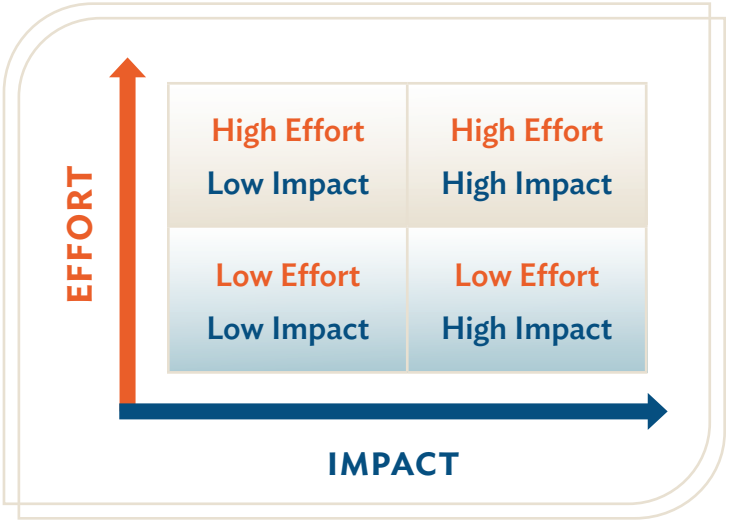
COMMUNITY NEEDS AND BARRIERS TO CARE

- What outreach or referral partnerships would be helpful to grow or develop?
- How can we improve the system of care in our area?

This early conversation can include a broad array of staff perspectives. For example, peer/recovery/family support and paraprofessional staff may have excellent insights on community needs and service gaps that would be helpful to know early in the needs assessment planning process.

Through internal conversations, you can generate, refine and prioritize areas of focus for your needs assessment. One way to prioritize is to consider potential focus areas in the context of your organization's ability to meet the CCBHC requirements. It may be helpful to evaluate potential focus areas using an effort-to-impact quadrant model.

Place each focus area being considered in one of the quadrants. Would choosing a particular area of focus have a higher or lower impact on your organization's ability to meet CCBHC model requirements? What level of effort would



be involved? Would it build on your strengths, or would you need significant support to implement? None of these considerations should eliminate a potential area of focus. Rather, you can aim to balance priorities.

Every CCBHC needs assessment should center around specific guiding questions. Each guiding question that you develop will help you narrow down a broad topic of interest into a specific area of focus, as depicted in the following figure.

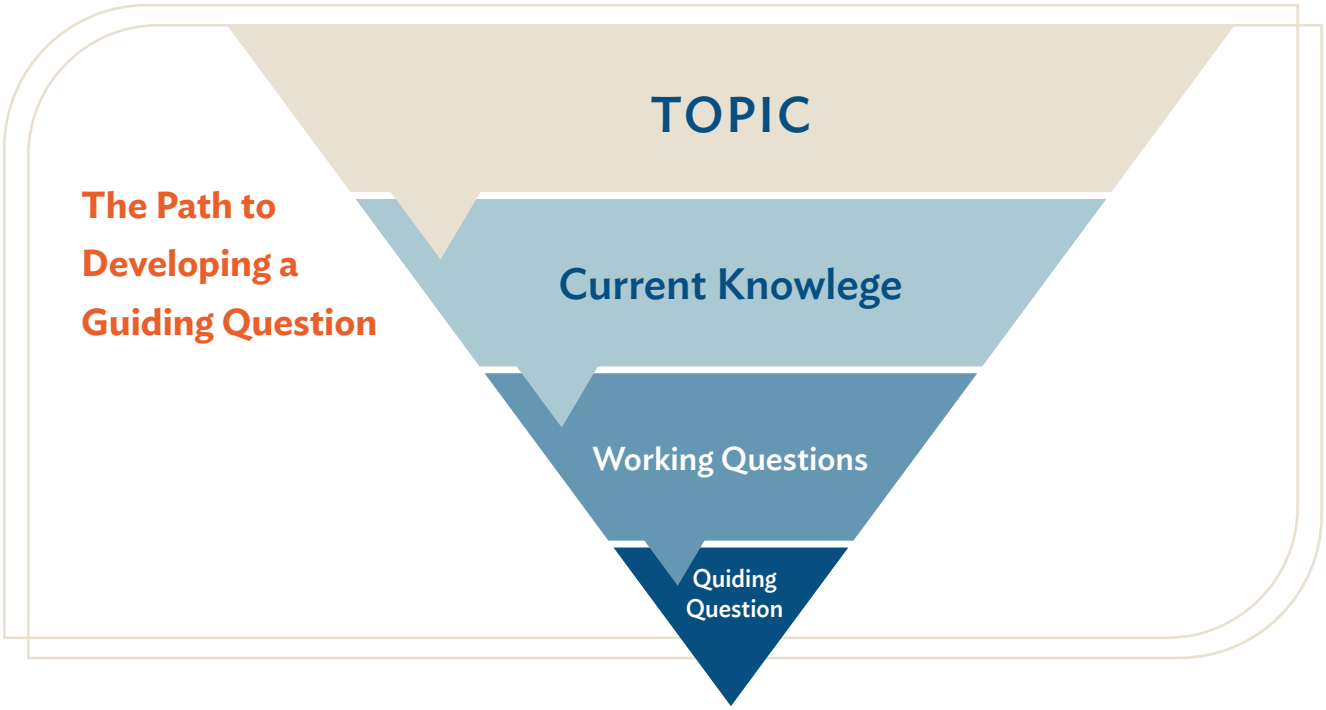


Image adapted from Marquez, et al (2022). Step-by-Step Guide to Community-Based Participatory Research. Nevada Minority Health and Equity Coalition. University of Nevada, Las Vegas.

Your guiding questions will help you define the path forward for your needs assessment and keep you on track throughout the process.

The following table offers some ideas for needs assessment guiding questions. *You should make your guiding questions even more specific based on your local community's unique characteristics and needs.* For example, if people experiencing homelessness are a population of focus for your CCBHC, you might ask, "Are the clinical services we offer aligned with the needs of the homeless population in our area?" rather than the more general "Are the services that we currently offer aligned with the needs of the community?" For additional specific examples of guiding questions tailored to community needs and populations of focus, see the Focus Studies appendix at the end of this toolkit.

Sample Guiding Questions for Your Needs Assessment[1]

COMMUNITY NEEDS AND BARRIERS TO CARE

Service Area Characteristics	▪ What are the demographics of the community (e.g., age, gender, race, ethnicity)? ▪ What languages are spoken in the community? ▪ How many veterans and/or armed service members live in the community? ▪ Where do people live (e.g., what towns, neighborhoods)? Are certain subpopulations centered in certain areas? ▪ Where do people work (e.g., what are the major industries, who are the major employers)?
Mental Health and Substance Use Conditions and Related Needs in Our Service Area	▪ What is the prevalence of behavioral health needs in our community? ▪ Are some populations dying of preventable diseases at rates dissimilar to other groups? ▪ Are there any health conditions that disproportionately impact different segments of the community? ▪ Are there specific populations at higher risk of poor outcomes, or at rising risk that need to be engaged more frequently or earlier? ▪ Are some geographic areas in the community experiencing adverse events/negative outcomes (e.g., overdose) at a higher rate? ▪ Are some populations accessing emergency and crisis services disproportionately? If so, why?
Economic and Social Drivers of Health in Our Service Area	▪ Do barriers to access to health care or other necessary health-related resources exist within the community? What are they? ▪ What transportation resources are available and what transportation-related needs persist?

1. Several questions in the table were drawn from: Marquez, E., Smith, S., Tu, T., Ayele, S., Haboush-Deloye, A., & Lucero, J. (2022). A step-by-step guide to community based participatory research. Nevada Minority Health and Equity Coalition. University of Nevada, Las Vegas. This excellent resource guide may be helpful to your needs assessment steering group, even if your CCBHC is not using a Community-based Participatory Research (CBPR) framework. It is available online: https://nmhec.org/wp-content/uploads/CBPR-Toolkit_FINAL_v3_ada.pdf

COMMUNITY-RESPONSIVE STAFFING AND SERVICES

- Are there populations with mental health and substance use treatment needs that we are not currently serving?
- Which populations in the community show consistently poor outcomes related to mental health and substance use issues (e.g., people who experience homelessness, have engaged with law enforcement, have a history of overdose, show increased use of inpatient/emergency department services)?
- When we compare our current client population to the community at-large, what disparities do we see?
- To what extent is our organization meeting the cultural and linguistic needs in the community?
- Are the services that we currently offer aligned with the needs of the community?
- Are the evidence-based practices we deliver aligned with the needs of the community?
- Does our staff reflect the community served?
- How can we better address barriers to access in our community?
- What can we do to address the major social drivers of health that are negatively impacting health outcomes in our community?
- What are barriers to engagement and retention among our population and how can we address them?

EFFECTIVE PARTNERSHIPS AND CARE COORDINATION

- How do people (in general, or specific populations) get referred to us or enter our system?
- At what point in the process are those who are referred most likely to disengage or "fall through the cracks"?
- Are there trusted service providers in our community who are especially effective at reaching and/or serving a population of focus?
- What are some strategies (e.g., outreach, care coordination, data tracking) that could help us meet our goals for services and/or outcomes?

Creating an Assessment Plan

Once you have assembled your team and defined your guiding questions, it is time to make a plan to implement the needs assessment. Your assessment plan should:

- Determine what information you will need to answer your guiding questions.
- Describe how you will get the information.
- Identify who needs to be involved at each step.

The following simple table can be used for planning purposes. It may be helpful to build a more detailed project management spreadsheet or tracker to set internal deadlines, assign tasks and hold team members accountable.

CORE ELEMENTS OF THE ASSESSMENT PLAN	
Guiding Questions	What does the needs assessment seek to answer?
Indicators	What information is needed to answer your guiding questions?
Data Sources	Where will the data specific to your guiding questions be sourced from?
Data Collection	How will the data be collected and compiled?
Time Frame	What is the time frame to complete activities?
Data Analysis	How will the data be analyzed?
Communicating Results	How will findings be documented and communicated?
Responsible Person	Who is responsible for completing each activity?

Adapted from Marquez, et al. (2022). A step-by-step guide to community based participatory research. Nevada Minority Health and Equity Coalition. University of Nevada, Las Vegas.

As you develop your needs assessment plan, remember that your organization's health information technology team — and possibly your EHR vendor — are important partners for your CCBHC needs assessment. As experts in your data systems, they should be engaged early in the community needs assessment process. Your IT team should be informed about your guiding questions and the CCBHC criteria related to data collection, tracking and reporting, and be able to determine whether your organization is tracking data that will help inform your guiding questions and align with the criteria. The team should also help to identify the different types of reports your IT systems are able to create to make the data accessible for tracking and reporting. If you are working with DCOs, it will be important to engage their IT teams early in the planning process as well.

Quantitative Data

The Role of Quantitative Data in Your Needs Assessment

A comprehensive and useful community needs assessment should include different types of data to better understand your community's resources and needs, and your CCBHC's capacity to meet those needs. Both quantitative and qualitative data are critical elements of your CCBHC needs assessment. This section of the toolkit provides information, resources and tips on how to integrate quantitative data into your community needs assessment process.

Quantitative data is information that can be represented numerically. This data can be counted, compared and categorized.

For many people, it can be overwhelming identifying which quantitative data sources and indicators to include in a community needs assessment. Because CCBHCs provide a wide range of services in their communities, it can be difficult to identify the specific quantitative data measures that are essential to include. It is important to understand that the primary role of quantitative data in the community needs assessment is to inform and answer your guiding questions.

If you find yourself getting overwhelmed with available data sources, it may be helpful to ask yourself, "What guiding question does this data point help to answer?" to refocus your inquiry.

Your CCBHC community needs assessment should be tailored to your organization's specific guiding questions, as defined during the needs assessment planning process. Gathering quantitative data for your needs assessment should not simply be a data dump of all the available health-related data about your community.

A common pitfall for many new CCBHCs is directly repurposing their local hospital's community needs assessment. This often results in an unfocused end product with too much information, a lot of data tables, and findings that are not closely linked to the organization's services, the CCBHC model, or the behavioral health needs of the community. While the local hospital's needs assessment may provide you with some helpful information, the data you use in your needs assessment should closely correspond to your community's behavioral health needs and your organization's CCBHC services.

Quantitative Data Examples

As exemplified in the following table, quantitative data can be analyzed in different ways to better understand your community, your organization's current role in the community, the impact of the services you deliver, and any gaps that may need to be addressed.

Quantitative Data Can Help You Understand:	Examples of Quantitative Data Elements	These Help Your CCBHC:
Community Demographics	People's age, racial and ethnic backgrounds, income and other factors.	Determine populations of focus for services. Develop outreach plans. Offer culturally appropriate care across the lifespan.
Community Behavioral Health Needs	Incidence and prevalence of mental health conditions and substance use disorders (SUDs), and related measures (e.g., overdose rates).	Determine community trends in behavioral health needs. Understand health disparities and develop targeted intervention strategies. Draw conclusions about where and how CCBHC services should be expanded to meet community needs.
Community Social Needs	Statistics regarding housing insecurity, food insecurity and education level.	Develop strategies to address social drivers of health. Identify care coordination partnerships.
Your Organization's Current Services	Utilization reports, client satisfaction survey results, and trends in client assessment scores over time.	Identify service gaps (when reviewed considering the needs of the larger community). Understand what's working well and what needs improvement. Identify disparities in access or outcomes among client subgroups.
Your Organization's Staffing	Count of staff types and level of effort.	Identify staffing gaps.

A note on terminology: You may find health statistics that refer to incidence rates and prevalence rates. Incidence refers to the number of individuals in a population with a new diagnosis during the time period, while prevalence refers to the number of individuals in a population with a diagnosis in the time period. For example, a person diagnosed with HIV in 2022 will be counted in both the incidence rate and prevalence rate for 2022. A person living with HIV in 2022 who was diagnosed at an earlier date will only be included in the prevalence rate for 2022. Either measure is appropriate to review as part of your community needs assessment.

SAMHSA requires that CCBHCs be able to collect, track and report on data related to nine categories (see CCBHC Certification Criteria 5.a.1). When exploring internal organizational data and external data sources for your needs assessment, it is useful to keep these nine categories in mind. The following provides a description and examples of quantitative data for each category, as well as potential data sources.

CCBHC REQUIREMENTS: DATA COLLECTION, REPORTING, AND TRACKING		
CCBHC Data Element	**Quantitative Data Examples**	**Potential Data Sources**
1. Characteristics of people receiving services	▪ Demographic data, including age, gender, race/ethnicity, geographic setting, primary language spoken and immigration status. ▪ Social determinants of health data, including income level and poverty status, insurance status, education level, employment status, housing status, access to transportation, healthy food access, disability status, military or veteran status and justice-involvement status. ▪ Mental health and SUD incidence and prevalence data by different population groups, including data illustrating health disparities. ▪ High-incidence physical health concerns and drivers of mortality.	▪ Internal service utilization data ▪ External data
2. Staffing	▪ Number of staff. ▪ Number and types of professional licenses held by staff. ▪ Staff-to-client ratios. ▪ Number of trainings provided to staff. ▪ Staff turnover rates. ▪ Number of staff trained to deliver specific evidence-based practices or with specialty designations (e.g., trauma, eating disorder, tobacco cessation).	▪ Internal organizational data ▪ Data from DCOs

CCBHC REQUIREMENTS: DATA COLLECTION, REPORTING, AND TRACKING *continued*		
CCBHC Data Element	**Quantitative Data Examples**	**Potential Data Sources**
3. Access to services	• Number and types of outreach activities conducted by organization. • Number of days and hours specific services are available. • Waitlist times for initial evaluation, initial services and clinical services. • Number of people accessing different types of services. • Number and types of groups accessing different services, including telehealth\telemedicine. • Disparities related to access to services, including the identification of underserved groups and groups facing transportation-related barriers that could be alleviated through telehealth.	• Internal service utilization data • Internal organizational data • Data from DCOs and care coordination partners
4. Use of services	• Number of people engaging in services within a given time. • Average number of treatment engagements by client by service type (e.g., retention data). • Trends in treatment disengagement. • Disparities related to engagement in services, including identification of underserved groups.	• Internal service utilization data • Partnering organization data
5. Screening, prevention and treatment	• Number and types of screenings offered at organization. • Number and types of screenings conducted with clients within a given time. • Number and types of preventive services provided within a given time. • Number and types of treatment services offered at organization. • Number and types of treatment services provided to clients within a given time.	• Internal service utilization data • Partnering organization data

CCBHC REQUIREMENTS: DATA COLLECTION, REPORTING, AND TRACKING *continued*		
CCBHC Data Element	**Quantitative Data Examples**	**Potential Data Sources**
6. Care coordination	▪ Number of formal care coordination agreements. ▪ Number of informal care coordination partners. ▪ Number of different types of care coordination partners. ▪ Number of care transitions. ▪ Number and types of health IT systems used. ▪ Number and types of co-located services.	▪ Internal and external service utilization data ▪ Internal organizational data ▪ Partnering organization data
7. Other processes of care	▪ Number and types of other processes of care.	▪ Internal service utilization data ▪ Partnering organization data
8. Costs	▪ Per capita costs for services. ▪ Staffing costs, including direct costs and average cost per service by position. ▪ Indirect costs. ▪ Other operating costs.	▪ Determine populations of focus for services. ▪ Develop outreach plans. ▪ Offer culturally appropriate care across the lifespan.
9. Outcomes of people receiving services	▪ Self-reported client data. ▪ Self-reported community data. ▪ Validated health assessment outcomes. ▪ Service utilization data (e.g., rates of emergency department and hospital utilization over time).	▪ Self-report data from clients

Using Internal Data

Your organization offers a wealth of quantitative data to use in your needs assessment. To effectively use internal data, you should:

1. Develop your guiding questions as part of your needs assessment planning process.
2. Understand the CCBHC criteria related to data collection requirements.
3. Engage your IT team or EHR vendor.
4. Maximize your EHR by running different types of internal data reports that are aligned with the nine categories noted in the CCBHC criteria (see the previous table), as well as primary care screening and monitoring, such as blood pressure, body mass index and/or other vitals.

Consider working with your team members to run different types of internal data reports to better understand:

- Demographic information about the populations you are serving.
- Diagnostic categories among people served.
- Service utilization.
- Clinical outcomes.
- Current staff capacity.
- Service effectiveness (e.g., timeliness, waiting lists, satisfaction surveys, requests for after-hours services).
- Referral sources, including memoranda of understanding.

Many IT systems and EHRs can be configured to meet organizations' specific needs. If your current systems are not able to produce the types of information and reports necessary to meet CCBHC criteria, you should work with your team and vendors to understand what modifications are available.

The needs assessment is also an opportunity to create your own quantitative data collection instruments. For example, organizations can create feedback surveys that ask clients to report on how satisfied they were with a particular service by selecting a response from a scale of options (e.g., not at all satisfied, somewhat satisfied, satisfied, very satisfied). By assigning a number to each of the categories, the quantitative data can be analyzed to understand the average level of satisfaction and the range of responses among the respondent group.

Similarly, many validated assessment tools that you probably use in your practice, including the Perceived Stress Scale, Patient Health Questionnaire-9 and General Anxiety Disorder-7, are also structured this way. Pulling an EHR report to explore quantitative data trends associated with these assessment tools can help you understand the impact of services on clients over a given time.

Using External Data

In addition to internal data, there are numerous external quantitative data sources that can be tremendously useful for your CCBHC needs assessment. External data can help you better understand your community's special populations and the needs that exist in your service area. By also helping to drive further exploration of why certain disparities, needs or gaps exist, this data can inform your CCBHC planning related to partnerships, activities and services.

The benefit of incorporating external data is that the hard work of collecting and analyzing the information has been done for you. The challenge is that the amount of external data available can be overwhelming when trying to decide which data points to include.

External data should be used in a focused way, linked to your guiding questions and the CCBHC criteria. Depending on the information you are seeking, external quantitative data may be available at the local, regional, state or national level. Whenever possible, it is best to use data that is most specific to the community you are describing. Local and regional public health, mental health and social services agencies are often reliable sources for community-level data. Other helpful sources for local data are hospital community needs assessments, which often include local and regional incidence and prevalence data, service utilization data, and information about social determinants of health. Local and regional coalitions and associations may also be good sources of community-level data, including coalitions supporting specific populations, such as LGBTQ+ communities, people with disabilities, veterans, and people experiencing homelessness and housing instability.

Using state and national data as benchmarks in comparison to local data is a good way to provide additional context about your community. Consider, for example, that you compare local Point in Time (PIT) Count data to state data and find that your community's rate of people experiencing homelessness is five times higher than the state average. This can help initiate further exploration on why the disparity exists and inform planning efforts to improve housing stability for community members. The Data Comparison Tool, developed as part of this toolkit, is a useful and practical resource for benchmarking.

When exploring external data resources, remember that your CCBHC application and your state's CCBHC planning grant are excellent sources of data. The List of Data Sources developed for this toolkit also provides links to a wide variety of online quantitative data resources. These include data published by SAMHSA and other federal agencies, as well as reliable nonprofit sources such as Kaiser Family Foundation. In addition to data on demographics and health needs, this practical resource includes data sources related to social drivers of health, such as housing and food insecurity.

Qualitative Data

The Role of Qualitative Data in Your Needs Assessment

As with quantitative data, the primary role of qualitative data in the community needs assessment is to inform and answer your guiding questions. Qualitative data includes information and concepts not represented numerically. It provides critical information that:

- Adds shape and depth to quantitative findings.
- Fills gaps where quantitative data does not exist.
- May spur new questions and data searches.
- Helps build community relationships for addressing needs and opportunities.

Qualitative data sheds light on who, what, how and why. Together, qualitative and quantitative data can impart the full picture of the unique strengths and challenges of your CCBHC and the community you serve, and can help you prioritize findings in your needs assessment.

Qualitative Data Sources

Typical approaches to collecting qualitative data include interviews, focus groups (defined as an approach to bringing a group of six to 10 people together to provide feedback about a particular topic), and observation.

Qualitative data sources include stakeholders within your organization, as well as key leaders and organizations in the community, region and state. Current, past or potential clients, and members of the board of directors or advisory boards can also provide a unique perspective on the organization's strengths and gaps.

Internal and external documents can be sources of qualitative data for your needs assessment. For example, it may be helpful to review internal documents such as the organization's training curricula, policies and procedures, and communication materials to the client and the community. It can also be helpful to review external documents such as community-level reports, service maps, reports from public health departments, and needs assessments completed by local hospitals, school districts and/or health care advocacy organizations that describe community assets, deficits, strengths and challenges.

Qualitative data is helpful at many stages of the needs assessment, including early in the planning process. For example, engaging staff at all levels of your organization in the development of your guiding questions and soliciting input about community needs and CCBHC services can be very valuable.

Additional information on types of key informants and how to engage them is provided in the following.

> **We held a listening session with staff on strengths and barriers in our services as we were becoming a CCBHC. Staff had great reflections and really got into the discussion of what could be improved and how. Staff seemed to really 'get' the needs assessment process and how they could participate in it.**
>
> *Jessica Crowe, LICSW, Child & Family Services Inc.*

Input From Staff and Other Internal Key Informants

Within your organization, key informants include staff at all levels (clinical and administrative), current consumers and their family members, and advisory board members. Staff, people served and advisors can help the needs assessment team identify strengths and challenges at your organization.

Staff insights — from their daily interactions with clients and experience implementing workflows and processes — are critical. Listening to the voices of the frontline staff not only provides an opportunity to learn from those closest to the work, but it makes them feel heard, helps them learn about the CCBHC model, and engages them in considering the strengths, needs and potential changes for the organization in becoming a CCBHC.

For example, if your organization is looking to reduce the waitlist for services, leaders could utilize a staff meeting to walk through the appointment scheduling and intake process and hear from staff what the challenges are in getting people in for services. Another organization brought its client council together to discuss governance and how to improve incorporating client input into its work. Council participants reported feeling that their voices had been heard and that their perspectives were important to the organization's work.

Input From People With Lived Experience

The CCBHC model is centered on the client. Therefore, it is important to incorporate the perspective of people with lived experience of mental health or substance use challenges. Qualitative approaches include interviews or focus groups with past, current or potential clients, and/or peer/family support staff and advisory board members. You may also wish to engage external groups that represent people with lived experience and their families. For example, your organization can reach beyond its clinic walls to interview peer organizations to identify community needs and lived experience voices. This can include Statewide Consumer Networks, which are national and local peer organizations, such as YouthMove, the National Consumer/Consumer Supporter TA Centers, and recovery community organizations. You can also engage family organizations (e.g., National Alliance on Mental Illness, Family-run Executive Director Leadership Association, Statewide Family Networks).

The Interview Scripts and Thematic Organizer developed for this toolkit has a sample script for interviewing a person with lived experience or their family member, as well as scripts for community advisory boards and partner organizations.

Input from Community Leaders and Service Providers

Input from leaders in the community enables you to understand how the people you serve and services you provide fit into the larger context of service provision. Key leaders in the local area, region and state can describe where services are lacking and identify opportunities to collaborate to serve existing and new populations. Considering your guiding questions, you should choose to talk to leaders who can reflect on the community and on who is and is not receiving services that are aligned with the CCBHC model. Key stakeholders may include representatives from other organizations, such as primary care providers, hospitals, opioid treatment programs, and recovery centers and community-based organizations (e.g., transitional housing and social service agencies).

You may also wish to engage public health and local foundation leaders along with representatives from organizations that serve special populations. These can include shelters for people impacted by intimate partner violence, organizations that advocate for people identifying as LGBTQ+, and agencies serving youth at high risk of experiencing mental health and substance use challenges.

For example, an organization undertaking the CCBHC community needs assessment wanted to understand disparities in care and outcomes for the LGBTQ+ youth population. As part of the needs assessment process, they reached out to local organizations and coalitions that had experience working with LGBTQ+ populations, and found that the lack of sexual health education and services was a problem for LGBTQ+ school-aged youth. In response, the organization started a workshop for LGBTQ+ youth, and updated its intake forms, progress notes and clinical summary documents to reflect LGBTQ+ identities and expressions.

CCBHCs have found that other organizations who serve populations they have not yet reached can help connect more people to CCBHC services. Engaging these organizations in the needs assessment process can open new pathways to referrals and case management partnerships. For example, food banks often serve newly settled immigrants and refugees who may have experienced trauma in their country of origin. Engaging the food bank as part of the community needs assessment can inform findings, and it is also an opportunity to educate food bank staff about available services. The food bank staff could share language- and literacy-appropriate information on your organization, and in turn, agencies can expand culturally competent behavioral health services for immigrant and refugee populations.

Lastly, engaging state and regional leaders will offer a broader perspective of strengths and challenges, as well as state-level initiatives that may support or enhance your organization's work.

Collecting and Analyzing Qualitative Data

See the Interview Scripts and Thematic Organizer for interview facilitation examples. There are different scripts for engaging a person with lived experience (or a family member), or an existing or potential partner agency, as well as facilitating a group discussion with your organization's community advisory board.

There are many ways to collect and analyze information via qualitative interviews and focus groups. When interviews are conducted online, it can be easy to record and automatically create a full transcript of each interview. There are user-friendly online tools that can help teams identify, tag and analyze key themes in recorded interviews. If you work with a professional evaluator, you may also find that they have robust tools for coding and analyzing interview data.

However, you do not need to use a special software program or detailed coding approach to yield important insights from your qualitative interviews. The thematic organizer in the Interview Scripts and Thematic Organizer is a simple but effective note-taking matrix that you can use to record key themes during focus groups and qualitative interviews.

Engaging Community and Partners

The Importance of Community Engagement

Engaging the community is essential for understanding the role your organization plays in supporting the community's health and recovery. Community engagement plays an important dual role of deepening existing partnerships and planting the seed for relationships with new groups, community leaders and service providers that could work with your CCBHC.

Community engagement is critical for your CCBHC:

- To ensure its services reflect the needs and population of the service area.
- To reach people your organization has not engaged.
- To build partnerships that will help you better serve your clients.
- To meet SAMHSA's requirements for community input in the community needs assessment.

The organizations and stakeholder groups you choose to engage with should be informed by the guiding questions of your needs assessment. Sharing your objectives and areas for discussion with the stakeholder in advance of meeting with them will enrich the discussion. Also, organizations who refer people to your CCBHC for services, as well as organizations that receive outbound referrals from your organization, can help your team build a continuum of care that provides access to comprehensive and coordinated behavioral health care.

Many additional entities could provide input, including primary care and specialty physical care (e.g., perinatal care, cancer treatment), faith-based organizations, community centers, and/or organizations that meet socioeconomic-driven needs such as transportation, food insecurity, housing, employment and help with utilities. Ideally, the community groups that you engage through the needs assessment will include people who face health disparities because of age, gender, race, ethnicity, or language and literacy. Strong partnerships with these groups can mean identifying and removing barriers, thus achieving better access to care (e.g., through language supports). By connecting with services in the community, your CCBHC will be better able to plan robust and effective care coordination that leverages public health, physical and behavioral health, and social services in the area.

As you engage partners in your needs assessment, consider:

- How are you currently working with each partner? What is working well, what are the challenges and what are the opportunities to build a stronger partnership?
- Do you have at least one clear point of contact at the organization? Are they in a position to strengthen the partnership?
- Are you able to share data on the people you both serve with the partner?

SAMHSA's Requirements for Community Input in the Needs Assessment

Community input is an element in many of SAMHSA's requirements for CCBHCs. The CCBHC Certification Criteria speak to the several specific requirements in the needs assessment related to community input. Specifically, SAMHSA notes that CCBHCs must seek input regarding four areas as part of their needs assessment: *needs, services, access to care, and barriers.*

COMMUNITY STAKEHOLDERS WHO SHOULD PROVIDE INPUT IN THE NEEDS ASSESSMENT

	Stakeholder Group	Language from Criteria
1	**Clients and People With Lived Experience**	People with lived experience of mental and substance use conditions, and individuals who have received/are receiving services from the clinic, conducting the needs assessment.
2	**Health Centers**	Health centers (including FQHCs in the service area).
3	**Health Departments**	Local health departments (note: these departments also develop community needs assessments that may be helpful).
4	**Inpatient and Outpatient Providers**	Inpatient psychiatric facilities, inpatient acute care hospitals and hospital outpatient clinics.
5	**Veterans Affairs**	One or more Department of Veterans Affairs facilities.
6	**Schools**	Representatives from local K-12 school systems.
7	**Crisis System Partners**	Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines.

Source: *SAMHSA CCBHC Certification Criteria, Appendix A (March 2023)*

SAMHSA also notes in the criteria that CCBHCs should engage with other community partners, especially those who also work with people receiving services from the CCBHC, and populations that historically are not engaging with health services. It may be helpful to engage with established CCBHCs, as well, to gain insights into the process.

Engaging Who You're Not Serving

The questions guiding your needs assessment should prioritize identifying who you are not serving in your community. A foundational component of the needs assessment is to understand the demographics of your service area and compare it with the demographics of who is currently served by your CCBHC. Where are the gaps? Once you know the gaps, you can proactively reach out to organizations or community leaders who can help you engage with that population.

A first step is to collect data on current client demographics (age, gender, race/ethnicity, sexual orientation, among others), and review it in relation to data that is available on the service area. Identify data gaps and brainstorm how to reach these groups, including where you are likely to reach them. Then you can develop a list of possible connections — individuals and organizations — that can connect you. Your governing or advisory board is an important resource for identifying groups not served.

As you plan your outreach strategies, consider how best to approach and address each group. If you are unsure of the appropriate person or group to meet with, develop a list of people who may be able to help you determine the right stakeholder and hold informal conversations with them to learn more. When meeting with people you are not currently serving, it is an opportunity to share your organization's work, the objectives of the needs assessment, and the range of ways they can provide input.

Topics to explore, at minimum, with these stakeholders include:

- Where they receive services currently.
- What behavioral health services they are not receiving.
- What is important to them in the services they receive.
- What barriers they have faced in accessing care.
- How your organization can establish a more welcoming environment.

Other approaches to engage people you are not serving involve expanding capacity within your organization. Consider building staff cultural competency for working with specific populations and/or hiring staff who are multilingual. Another opportunity is to contract with a translation service to support staff with new populations.

Best Practices to Engage the Community

GUIDING PRINCIPLES FOR COMMUNITY ENGAGEMENT

The following principles, informed by the Community-based Participatory Research framework, reflect the intention to recognize the community's role and take a collaborative and equitable approach to engaging the community and partners.

- Communities are unique, complex, and based on at least one shared characteristic.
- Each community member brings a unique and valuable set of skills, experiences and resources.
- The topics addressed are relevant problems local to the community.
- The aim is to generate new knowledge and translate it into goal-oriented action that can benefit the community and the organization.
- Results and lessons learned should be shared in useful, understandable and respectful ways internally, and with the community and interested stakeholders.

Source: *Marquez, E., Smith, S., Tu, T., Ayele, S., Haboush-Deloye, A., & Lucero, J. (2022). Step-by-Step Guide to Community-Based Participatory Research. Nevada Minority Health and Equity Coalition. University of Nevada, Las Vegas.*

GENERAL TIPS FOR THE COMMUNITY INPUT PROCESS

- Choose guiding questions to explore when engaging stakeholders. Stakeholder input may be especially helpful when:
  - Cultural barriers or gaps in knowledge exist.
  - Quantitative data does not drill down to the local level.
  - Data is limited and does not reflect the full service area.
  - Exploring the needs of special populations that the organization has not previously served.
  - Interviews or focus groups will provide a range of perspectives on the topic.
- Define your objective for speaking with each stakeholder group.
- Identify the stakeholder representative(s) who can best help you meet your objective.
- Determine the approach to speaking with the representatives: interview, focus group or informal conversation.

Outreach

The community needs assessment is a collaborative effort. The more people in your community feel invited and welcome to provide input, the more input you are likely to receive.

Suggestions for communicating your needs assessment include:

- Letting the community know that your organization is doing a community needs assessment.
- Developing a template describing the needs assessment purpose and process, and the request for input, to share with staff and the community through:
  - Staff meetings.
  - Community meetings and listservs.
  - Meetings with local representatives.
  - A letter and email with a broad list of stakeholders.
- Welcoming community input and provide a means for input that is easily accessible, such as a suggestion box in the waiting room or an email address (for example, NAsuggestions@agency.com) shared broadly).
- Ensuring that communication about the needs assessment is provided in different languages.
- Communicating updates throughout the process (e.g., through an electronic newsletter, a posting in a community newspaper, or community meetings).
- Sharing your findings and implementation plan with the community when the needs assessment has concluded.

Stakeholder Interviews and Focus Groups

Approaches for engaging stakeholders include interviews, focus groups and informal conversations. Interviews may be prioritized for stakeholders with a broader understanding of the community, since one-on-one conversation will allow you to delve deeper on key topics. Focus groups may be best when the group dynamic will enrich the conversation and show the dimensions of a topic. One example is a special population where you can better understand the range of perspectives in that population.

For stakeholder interviews, look at existing networks, associations or leaders who share a common interest or are already engaged in work related to your interests. Take into consideration historical context (personal and institutional) where applicable.

TIPS FOR STAKEHOLDER INTERVIEWS

- Create interview protocols that explain the purpose of the conversation and include key questions.
- Provide questions in advance to interviewees.
- Use a standardized template to take notes in the interview.
- Staff each interview with an interviewer and a notetaker.
- Share the notes and discuss with others in your organization.
- Identify key points and tie to guiding questions and existing or new themes from other interviews, focus groups and quantitative data.

TIPS FOR FOCUS GROUPS

- Develop open-ended questions for discussion that can be translated into actions.
- Be prepared to ask follow-up questions to deepen understanding of statements.
- Avoid leading questions.
- Create opportunities for everyone in the group to participate. Informal polls can promote more discussion and involve more people.
- Provide anonymous options (e.g., written responses) for understanding the group and/or asking sensitive questions.
- Record and transcribe the focus group, if possible, to accurately report the participants' thoughts and ideas.
- Summarize responses for both commonalities and unique perspectives.
- Compare themes from the group with themes you have identified though other sources.
- Provide summaries back to community organizations for review and suggestions.

See the Interview Scripts and Thematic Organizer for examples of interview facilitation scripts and a notes collector template.

Each potential partnership and its goals will depend on the partnership dynamics and each partner's priorities. For example, in your conversations with hospitals in your service area, you could explore opportunities to set up admission, discharge and transfer notifications, or other mechanisms for data sharing and care coordination.

Before considering partners, it is important to determine your capacity for a partnership. Then, once you've identified a potential partner, spend time getting to know the organization and its staff.

These partnership development activities can become part of your action plan as you put your needs assessment findings into practice.

Putting It All Together

What Should the Needs Assessment Look Like?

Once you have completed your data collection (quantitative and qualitative), compiled the information and analyzed your findings, it is time to put it all together. This may feel like a daunting task, but remember that the final product does not have to be a 50-page, exhaustive report. The Needs Assessment Outline provides an example approach for putting it together.

Consider how you will use the needs assessment: to share findings with staff, board and advisors, partners, leaders, and stakeholders in the community, and to inform your decisions about CCBHC design and implementation.

Other formats to consider include slide decks, visuals, and briefs on key topics. The needs assessment will be referred to throughout CCBHC implementation until the next needs assessment is prepared three years later. Creating an organized, user-friendly format for reviewing and discussing findings will make the needs assessment more useful and effective.

Integrating Your Findings Into Everyday Practice

Before integrating findings into practice, you will need to identify your priorities. While your guiding questions are intended to drive your process, priorities will evolve as information is gathered and new questions arise. To develop priorities, the needs assessment team will need to thoroughly review and discuss the findings that build on strengths and address gaps, in support of your CCBHC design and implementation. You can document these priorities in your implementation plan that informs requirements for staffing, accessibility, outreach, partnerships and services.

The implementation plan is action-oriented and moves ideas to action by defining goals and objectives that are specific, measurable, achievable, relevant and time-bound (SMART). The implementation plan will lay out your CCBHC's action steps and time frames for moving forward.

The following shares examples of how needs assessment findings can be translated into practice.

PRACTICAL EXAMPLES OF INTEGRATING FINDINGS INTO...	
Staffing Plan	■ Ensure staffing to meet identified needs in the community, such as sufficient number of staff, and staff with appropriate training and/or credentials for services. ■ Revise staff positions to reflect new workflows for care coordination and associated roles. ■ Develop new IT positions for data analysis and reporting. ■ Revise trainings at orientation and annually for staff on the CCBHC's evidence-based practices,
Service Array	■ Incorporate evidence-based practices aligned with community needs. ■ Make adjustments to the intensity and frequency of identified service offerings. ■ Define population-specific care pathways. ■ Enhance your consumer outreach, engagement and retention activities. ■ Include an assessment of suicide risk and a plan for responding to positive screens.
Language Access	■ Find and offer language resources (e.g., bilingual staff, language line, translated materials) for the specific languages identified as needing access to care. ■ Train staff on how to support consumers with limited language proficiency.
Operations	■ Inform clinic hours of operation, including walk-in, evening and weekend hours. ■ Inform location of services: clinic, community-based school-based and home-based services
Partnerships	■ Establish a partnership plan that supports care coordination and robust bidirectional referrals. ■ Strengthen existing partnerships through a written agreement on roles in referrals, data sharing, and ongoing communication channels. ■ Partner with organizations that serve special populations to improve access and culturally competent care.

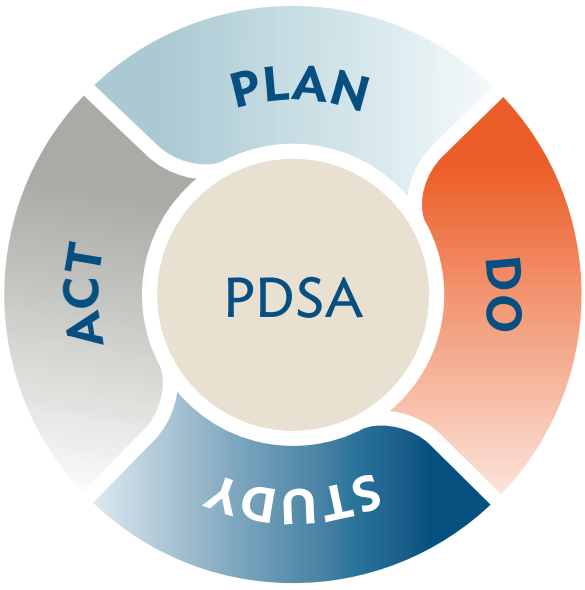
Integrating Your Findings Into Your CQI Process

The needs assessment key findings, priorities and implementation plan should become a core part of your CQI plan and processes. For example, if you incorporate new services for adolescents, including outreach to youth-serving agencies, it will be useful to evaluate demographics, service utilization, and client and staff feedback after implementation. If you review quantitative (e.g., number of services and types provided, parent survey) and qualitative (e.g., staff feedback) data six months after services begin, you can reflect on what is going well and address where changes are needed through the CQI process. The CQI process drives evaluation of the action items.

The CQI plan is a CCBHC-wide, data-driven plan for clinical services and clinical management. If your organization does not currently have a formal CQI plan, consultation development and implementation guidance is available through the National Council for Mental Wellbeing's CCBHC-E National Training and Technical Assistance Center.

The following outlines one approach for incorporating findings into your CQI plan and evaluating progress.

- **Review** the key findings you have prioritized for action.
- **Ask** how you will know you're making progress on those action items.
- **Identify** the desired outcomes for the action items.
- **Choose** an implemented action item to evaluate.
- **Incorporate a Plan-Do-Study-Act approach** to test if the action item is leading to the desired outcome.
    - ***Plan:*** Predict what will happen in implementation.
    - ***Do:*** Implement the action item.
    - ***Study:*** Review the results. Was our prediction verified?
    - ***Act:*** Revise the approach based on what was learned and repeat.



Communicating the Findings and Next Steps

Once you complete the needs assessment process, it will be time to share the findings and next steps with staff, partners, key leaders, and stakeholders engaged in the process and community members in the service area. You will continue to receive feedback in this process that could shape your implementation.

Dissemination of the findings should be tailored to the audience, whether staff, people served, partners or community members. Consider providing visuals (e.g., graphs, charts) that clearly reflect findings and takeaways. Communicate the findings and aspects of the prioritization and implementation processes (e.g., "We found X, so we are doing Y, and we'll revisit Z later").

It will be important to share the findings internally first — in all staff and department meetings — leaving room for discussion and reflection on the process and next steps. Incorporating an internal review period will provide room for essential feedback for making updates and revisions, while building internal understanding and commitment to the findings, prior to sharing outside the organization.

Consider the following ideas for dissemination to external stakeholders.

POTENTIAL PUBLIC DISSEMINATION METHODS	
Infographics on social media	Summary available in site waiting rooms
Website publication: summary or final needs assessment	Webinar presentation open to community participation
Presentation at local community events	Press release
Presentation to convened partners	Published summary in community paper

The community needs assessment forms the bedrock of your CCBHC and provides a special opportunity to build and deepen relationships with your community, staff and partners. By approaching this process with careful consideration and intent, your needs assessment can serve as a valuable tool for making informed choices regarding services and staffing, as well as directing the everyday functioning of your CCBHC.

APPENDIX | Focus Studies

The following Focus Studies offer practical, concrete examples of how a CCBHC can use the needs assessment process to guide improvements in services, staffing and operations. While each focuses on a different topic, they all include the same components:

- Opportunity and Relevance to the CCBHC
- Sample Guiding Questions for the Needs Assessment
- Quantitative Data Sources
- Community Engagement and Qualitative Methods
- Potential Partner Organizations
- Ways to Put Needs Assessment Findings Into Practice
- Ways to Incorporate Findings Into CQI
- Advocacy Opportunities
- Examples

These vignettes are intended to illustrate the value of the needs assessment process and provide applied examples of the best practices described in this toolkit.

Engaging LGBTQ+ Populations

Opportunity and Relevance to the CCBHC

Care that recognizes the needs of people who identify as lesbian, gay, bisexual, transgender, questioning and other diverse sexual orientation and gender identities and expressions (LGBTQ+) can address disparities and reduce stigma for this population. LGBTQ+ people of all ages disproportionately experience more instances of mental health and substance use disorders (SUDs), suicidality, and poorer wellbeing outcomes than their heterosexual and cisgender peers.[2] The term LGBTQ+ is broad and encapsulates many identities, and, as such, many different needs.

Behavioral health disparities can be attributed to:

- Increased stress caused by pervasive rejection, discrimination and stigma.
- Emotional distress associated with stressors around self-acceptance and coming out.
- Emotional or physical abuse from unsupportive family members and communities.
- Discrimination in health care, employment and housing.
- Bullying in school.
- Lack of social programs specializing in LGBTQ+ services.
- A shortage of health care providers with knowledge about LGBTQ+ needs.

To reduce disparities, agencies can offer tailored, culturally responsive, and evidence-based substance use and mental health services specific to LGBTQ+ needs. To meet these needs, it is critical to consider intersections between sexual orientation/gender identity and age (adult, youth, child), ability, race and class.

Sample Guiding Questions for the Needs Assessment

- To what extent is our organization meeting the needs of the LGBTQ+ population in our service area?
- What might impede people who identify as LGBTQ+ engaging with our organization?
- What opportunities does our organization have to create a welcoming and affirming environment for people of diverse sexual orientations and gender identities and expressions?
- What do we know about the sexual orientation and gender identities of people in the population we currently serve? How do our services respond to their needs?
- To what extent does our staff receive training on the experience and needs of people who identify as LGBTQ+?
- How can we better address the needs of people who identify as LGBTQ+?

2. National Institutes of Health, National Institute on Drug Abuse (n.d.). Substance Use and SUDs in LGBTQ* Populations. Retrieved from: https://nida.nih.gov/research-topics/substance-use-suds-in-lgbtq-populations

- What other systems do LGBTQ+ people with unmet behavioral health needs engage with? For example, school counselors or teachers, community centers, social venues or online support groups.
- Who are our key informants and trusted gatekeepers that would help us understand the behavioral health needs and how to engage LGBTQ+ populations?
- What are the other intersectionality/interconnections with LGBTQ+ identities that we need to consider in providing whole-person care? For example, disproportionately high HIV rates, disparities in access to cancer care and other care, and higher rates of suicide.
- How can we partner to acknowledge and better understand these unmet needs and create referral pathways?

Quantitative Data Sources

CCBHCs often lack internal data, and sufficient local data on LGBTQ+ populations is often hard to find. The following outlines some state and national data resources.

- State data resource:
  - Movement Advancement Project
- National data resources:
  - Trevor Project (young people)
  - Center of Excellence on LGBTQ+ Behavioral Health Equity
  - Human Rights Campaign (policy)
  - National Center for Transgender Equality: U.S. Transgender Survey (2022 survey results not yet available at time of publishing)
  - Center for American Progress: The State of the LGBTQ Community in 2020
  - Center for American Progress: How to Collect Data About LGBTQ Communities

Community Engagement and Qualitative Methods

- Interviews with local, regional and/or state LGBTQ+ advocacy and/or service organizations; gender alliances in high schools and colleges.
- A focus group of teachers and other school staff who support gender alliances on the unmet behavioral health needs of young people.
- A focus group of clients who identify as LGBTQ+ to discuss experiences and opportunities to create affirming environments.
- Interviews with pastors, teachers and community leaders who provide welcoming and affirming environments and who can advise on other individuals to engage in interviews.
- Interviews with other health care agencies that have created welcoming and affirming environments.

Potential Partner Organizations

- Local, regional or state LGBTQ+ advocacy and/or service organizations.
- Local school and university gender alliance groups.
- State agencies supporting LGBTQ+ services.

Ways to Put Needs Assessment Findings Into Practice

- Use surveys and/or focus groups to determine staff perceptions and concerns about serving LGBTQ+ populations. Apply findings to structure trainings to address misperceptions, discuss stigma and its impact, and share specific health care needs in the range of sexual orientations and gender identities.
- Change patient forms and associated EHR fields to reflect inclusive language.
- Change benefits and policies to reflect inclusive staff practices.
- Incorporate people with mental health conditions and SUDs who identify as LGBTQ+ on advisory boards and/or the board of directors.
- Engage LGBTQ+ population and community partners in consultation on CCBHC programming and culture/climate.
- Seek out agencies who are engaged with intersections, such as schools and HIV clinics, as potential partners .

Ways to Incorporate Findings Into CQI

- Track responses to sexual orientation and gender identity questions. Discuss implications for services and additional staff trainings.
- Track treatment engagement and retention for LGBTQ+ clients.
- Review diagnostic trends of LGBTQ+ clients.
- If a specific treatment program is utilized, measure pre- and post-treatment functioning/outcomes among LGBTQ+ clients.

Advocacy Opportunities

- Work with your state provider association to share how your organization created a more welcoming and affirming environment.

Examples

Guiding Question	Finding	Incorporating Into Practice	Incorporating Into CQI
How can our organization better address the needs of people who identify as LGBTQ+?	Our organization has only anecdotal data on the sexual orientation and gender identities of our clients.	Pilot adding sexual orientation questions on the intake assessment. Develop a follow-up protocol. Train staff on why and how to ask these questions, and how to follow up.	Review baseline data on responses to intake questions and follow-up. Revise questions and processes as needed. Incorporate quarterly review of rates and responses and related discussion of results into CQI meetings.
	Staff expressed discomfort with discussing sexual orientation with clients.	Establish peer leaders to discuss these concerns with small groups of staff.	Review response rates and coach staff with low rates on how to ask the questions and respond to answers.

Providing Low-barrier MOUD

Opportunity and Relevance to the CCBHC

Medications such as buprenorphine and methadone treat opioid use disorder (OUD) safely and effectively. Medications for OUD (MOUD) can reduce overdose deaths/save lives and improve people's quality of life. It can also reduce HIV and hepatitis C (HCV) incidences. Low-barrier MOUD means providing medications for OUD consistently, with easy access to care, regardless of the person's current stage of change, race, socioeconomic status, ability to pay or other challenges.

The guiding principles defining the parameters of a medication-first, low-barrier approach to OUD treatment include:

1. **Same-day treatment entry and medication access.** With an ongoing risk of overdose, any treatment delay, whether due to waiting lists, prior authorizations, or clinical protocols, can be deadly.
2. **Harm reduction approach.** This principle acknowledges the priority and urgency of the goal to reduce harm from substance use, rather than achieve abstinence.
3. **Flexibility.** Mandatory protocols for in-person appointments, psychosocial counseling, meeting attendance, or drug testing all serve to reduce the likelihood that a person can successfully initiate and maintain medication therapy.
4. **Wide availability in places where people with OUD go**. This includes CCBHCs, as well as nontraditional settings, such as emergency departments, syringe services programs and mobile treatment sites.

Stigma surrounds people with OUD and the provision of MOUD. As a societal barrier, views that stigmatize MOUD, if unaddressed, can undermine reaching people in need and completing treatment. Providers, staff, family members and the clients themselves can perpetuate stigma. Addressing stigmatizing attitudes, beliefs and concerns about misuse at the organization, client and community level is critical in supporting MOUD access.

Populations at special risk for OUD:

- Adults, ages 35-44.
- Disadvantaged populations facing health and socioeconomic disparities. Consider factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation.
- Pregnant and postpartum people.
- Veterans and members of the Armed Forces.

Sample Guiding Questions for the Needs Assessment

- What do we know about the extent of opioid use and overdose in our service area?
- To what extent is our organization serving people with OUD in our service area?
- How long do people have to wait for initiation on MOUD?
- What are the requirements for MOUD? For example, is counseling generally required? Do people need to return for daily dosing? Is telehealth an option for appointments?
- From the client's perspective, how flexible is the MOUD program?
- What are the demographics (age, gender, race, etc.) of the people with OUD we are serving? Which populations are we not serving, especially those at special risk?
- What barriers exist for our organization in offering access to MOUD in our service area? How can we address these barriers to increase access in our service area?
- To what extent does our staff understand the benefits of low-barrier MOUD and the risks of not providing it?
- How can we address potential and existing stigma in our organization, client base and community?
- To what extent do we train staff on treating OUD and using non-stigmatizing language? What is the staff's reported level of comfort in treating people with OUD?
- What training and resources does our team need to provide low-barrier MOUD? Are there successful examples of other programs like ours from which we can gather best/promising practices?
- How can our organization better address OUD in our service area?
- Who in our service area is providing MOUD (e.g., opioid treatment programs providing methadone and buprenorphine, office-based opioid treatment)? How can we collaborate with them to improve our capacity for MOUD?

- What systems (e.g., emergency departments, emergency medical services) in our service area engage with people who have overdosed? How can we partner with them to provide MOUD?
- How can we partner with criminal justice settings to provide linkage to MOUD?

Quantitative Data Sources

- Kaiser Family Foundation: State Health Facts — Mental Health and Substance Use, Opioid Overdose Deaths.
- Opioid Misuse Tool (by county)
- SAMHSA: Buprenorphine Treatment Practitioner Locator
- Centers for Medicare and Medicaid Services: T-MSIS Substance Use Disorder (SUD) Data Nook: Treatment of SUD in Medicaid, 2019
- State-level data on number of offices by county that provide buprenorphine.
- State-level data on number of overdoses by county.
- Data on numbers of people with OUD served from local agencies providing inpatient, residential and group home SUD services.
- Organization data on demographics, diagnoses, treatment and status of current and past clients with OUD.
- Organization data on OUD policies, procedures and protocols.
- Organization data on trainings provided related to addressing OUD.

Community Engagement and Qualitative Methods

Interviews in your service area or region with:

- Peer-operated and/or -run programs (e.g., peer respites, wellness and recovery centers, clubhouses, peer advocacy programs).
- Family-run advocacy and support programs (e.g., National Alliance on Mental Illness affiliates, family respite programs).
- Substance abuse recovery services (e.g., 12-step programs, recovery homes).
- Inpatient and residential treatment services.
- Harm reduction services, such as syringe services and naloxone distribution programs.
- Opioid Treatment Programs (OTPs).
- Primary care practices, federally qualified health centers.
- Emergency departments, emergency medical services.

- Jails, prisons, or community or drug courts.
- Veteran-serving agencies.
- Agencies serving disadvantaged populations.
- Clients who are receiving MOUD.

Interviews and/or focus groups with direct service and clinical staff to discuss providing MOUD to clients.

Potential Partner Organizations

The previously noted agencies are potential partner agencies as well in supporting MOUD services.

Ways to Put Needs Assessment Findings Into Practice

- Develop a working group to provide recommendations on eliminating barriers to MOUD, such as completing physical assessments, blood work, and counseling, before providing MOUD.
- Discuss implementing MOUD with staff, from clinicians to the front desk, and address concerns.
- Train staff on providing MOUD, including contradictions to common stigmas.
- Pilot MOUD in one practice or population, engaging a team of staff and providers to test and adjust approaches.
- Partner with a high-impact system such as a jail, prison or emergency department to create a referral pathway into MOUD.
- Review data on reasons for refusing MOUD and discuss; identify barriers and ways to eliminate them.
- Partner with recovery support groups to strengthen the continuum of care.

Ways to Incorporate Findings Into CQI

- Regularly review data on MOUD initiation rates compared with OUD diagnoses over time by practice and provider.
- Regularly review data on client retention on MOUD and outcomes, including overdose data.
- Review incidence of HIV and HCV since starting or initiating MOUD.

Advocacy Opportunities

- Communicate your successes and how you addressed challenges with other physical and behavioral health provider agencies.
- Be a champion for reducing stigma for people with OUD.

Examples

Guiding Question	Finding	Incorporating Into Practice	Incorporating Into CQI
How can our organization better address OUD in our service area?	Community agencies providing harm reduction have few referral options for people seeking MOUD.	Partner with these agencies, establish points of contact, and create a seamless same-day referral pathway to MOUD initiation.	Review data on client-reported referral sources. Review the rate of completed referrals, identify gaps and discuss perceived barriers.
	Emergency departments are not initiating buprenorphine for overdose survivors.	Develop an MOUD Bridge Clinic in our organization where providers can initiate MOUD for overdose survivors.	Develop objectives for referrals to the Bridge Clinic and track, review and discuss the referral results.

Identifying and Addressing Housing Insecurity

Opportunity and Relevance to the CCBHC

According to the U.S. Department of Housing and Urban Development (HUD), housing insecurity encompasses most types of housing challenges, including difficulty finding affordable, safe and/or quality housing; having unreliable or inconsistent housing; and overall loss of housing, potentially leading to homelessness.

Housing insecurity has a direct impact on health:

- Households whose housing costs exceed 30% of the income (considered cost-burdened) have little left over to spend on food, clothing, utilities, transportation, and health care and prescriptions.
- Substandard housing exposes people to health and safety risks, such as vermin, mold, water leaks and inadequate heating or cooling systems.
- Homelessness has been shown to precipitously deteriorate one's health.
- Housing insecurity is a major adverse childhood experience that can lead to poor child development with long-term health impacts.

It has a greater impact on some more than others (e.g., children who move frequently are more likely to have chronic conditions and poor physical health).

Sample Guiding Questions for the Needs Assessment

- To what extent is our organization supporting people in our service area who are housing insecure?
- What subpopulations are impacted by housing insecurity?
- How can we, as a CCBHC, address the needs of the families and individuals who are housing insecure?
- How do the behavioral health needs of people who are housing insecure differ from standard populations? Do their needs differ to enable them to access behavioral health services?
- How do we determine, of those who are housing insecure, who are most at risk of losing their housing?
- What resources are available for eviction prevention and handling landlord disputes?
- What assistance programs are in our area that can help with homelessness prevention and/or rapid rehousing?
- Who are the existing housing and homelessness assistance providers?
- How can we work with these agencies to ensure the people in our service area receive assistance with housing?
- How can our agency better address the needs of people who are housing insecure?

Quantitative Data Sources

- Shelter Resources: HUD.gov/FindShelter enables you to identify the shelter resources in your area. Note that these are temporary housing resources and will not provide permanent housing to clients.
    - Types of shelter available in the service area, their average census, and waitlists:
        - Single sex
        - Families
        - Mothers with children
        - Group homes
- Continuum of Care: At HUD.gov/FindShelter, you can also search for your local Continuum of Care. This is the local body that manages all shelter resources and all referrals to supportive housing.
- Point in Time (PIT) counts: A count of sheltered and unsheltered people experiencing homelessness on a single night in January. Required annually by the U.S. HUD.
- Broken down by age, gender, etc.
- National Low Income Housing Coalition: Housing Needs by State
- National Association of Counties: Affordable Housing Toolkit for Counties. This source provides the percentages of cost-burdened homeowners and renters by county.

Community Engagement and Qualitative Methods

- Understand how housing insecurity impacts health and how the CCBHC can support its service area through:
  - Interviews with key supportive housing organizations to understand triggers to losing housing and the role of health and behavioral health in supporting people's housing needs.
  - Interview clients to understand what (i.e., key moment or event) is leading to their housing insecurity.

Potential Partner Organizations

To understand the response to housing insecurity in your community, it should be noted that a majority of our housing resources are organized around these subpopulations:

- Families with children
- Adult-only households
- Veterans
- People fleeing intimate partner violence

It is likely that housing service organizations will specialize in one or multiple of the previously mentioned subpopulations. Other subpopulations to consider are:

- Teenagers/teens leaving foster care
- Returning citizens/returning from jail, prison
- Moms with new babies
- Unemployed people

Potential partners may include:

- Local Homelessness Continuum of Care
- Local supportive housing providers and service agencies
- Homelessness prevention agencies
- State Housing and Finance Agency
- Homeless liaisons at local school districts
- Veterans Affairs Office and Hospital
- Local public housing authorities
- Medical/legal partnership or legal aid
- Nonprofits that build housing (e.g., Habitat for Humanity)

- Nonprofits that make repairs for low-income and senior homeowners
- Emergency shelters
- Sober living
- Intimate partner violence agencies and domestic violence shelters
- Transitional housing
- Group homes
- Find Help/online resource and referral source

Ways to Put Needs Assessment Findings Into Practice

- Define goals and practical approaches for addressing housing insecurity. For example:
  - Ensure patients are referred to resources to address their housing needs.
  - Identify related needs for patients with housing insecurity (e.g., affording/accessing prescriptions, food, clothing or diaper banks, formula, utility payment support programs (LIHEAP), transportation).
- Establish partnerships with organizations and/or programs that address housing, such as the coordinated entry system in your community. Provide referrals to this system's centralized intake for those at risk of losing or who have lost their housing.
- Establish partnerships with organizations that provide necessities (e.g., food, clothing, diapers, formula, utility support).
- Revise or begin using a vetted screening tool (e.g., PRAPARE) that includes questions for housing insecurity.
- Train staff to ask questions and provide support in developing their comfort with asking and responding.
- Provide referral processes and pathways, identifying responsible staff and follow-up.

Ways to Incorporate Findings Into CQI

- Run quarterly reports on social drivers of health screening rates and identify follow-up completed.
- Review changes in screening rates; discuss and test changes that may increase screening rates.
- Review a set of screens that identify housing insecurity and review the follow-up and outcomes from it.
- Discuss and test changes that may increase follow-up.
- Study impact of partnering with housing-related and basic needs agencies and resources to determine how to best leverage them.

Advocacy Opportunities

- Share data on the impact of housing insecurity on health with state, regional and local entities that could strengthen affordable housing options.
- Collect and share stories on the impact of no or unstable housing on the health of the people you serve.

Examples

Guiding Question	Finding	Incorporating Into Practice	Incorporating Into CQI
How can our organization better address the needs of people who are housing insecure?	Our organization has only anecdotal data on the housing status of people who receive services.	Add housing status questions to the intake assessment. Develop a follow-up protocol. Train staff on why and how to ask these questions, and how to follow up.	Review baseline data on responses to screening questions and follow-up. Develop a report that enables quarterly review of rates and responses. Incorporate discussion of results into CQI meetings.
	Staff expressed discomfort with asking people about housing (e.g., a concern that housing is "not what we do.")	Invite local housing speaker to share health and housing challenges of clients at a staff meeting and answer questions.	Review screening rates and coach staff with low rates on how to ask the questions and respond to answers.