Oregon Alcohol and Drug Policy Commission

Improve the effectiveness of alcohol and drug abuse prevention and treatment services

#UNKNOWN!

Treatment	Specific Activities	Lead Organization	Baseline indicators	Near term impact	Mid term impact	Long term impact	Global Impact
Priority 1: Expand Equitable Access to Evidence-Based Treatment Options	Ensure all SUD specialty providers offer medications for SUD (MSUD) or demonstrate coordinated access, supported through consistent standards and reimbursement models across payors.	ADPC, OHA, DCBS, DOC, OYA	Not all providers currently offer MSUD; inconsistent standards across regions.	Number/percent of providers offering MSUD; baseline audit of CCO consistency	Increased number of providers with MSUD capability; CCOs with aligned MSUD standards	Statewide MSUD coverage across treatment settings; equitable access in rural/justice-involved settings	Reduced overdose and improved treatment retention rates
	Expand access to MSUD in carceral settings, treatment services provided in collaboration with drug/specialty courts, and via EMS/Bup pilot scaling.	ADPC, DOC, OHA, CJC, OYA	Limited availability in these settings; pilot programs exist	Number of justice/court settings coordinating access to MSUD; Expanded EMS MSUD pilot reach	Increased uptake of MSUD for those in non-traditional settings (courts, EMS)	Standard availability in all carceral/drug court settings; institutionalization of EMS pilots	Continuity of care from incarceration to community-based treatment
	Launch education campaigns and technical assistance for providers on evidence-based practices (EBPs).	ADPC	Gaps in provider knowledge; inconsistent EBP use.	Assessment of current levels and gaps around EBP utilization across providers complete, TA services available are catalogued with understanding around current utilization	Provider confidence and fidelity in EBP implementation	Broad uptake of EBPs across treatment providers	Improved patient outcomes and treatment satisfaction
	Address CCO and regulatory inconsistencies by aligning oversight mechanisms and adopting value-based payment models.	ADPC, OHA	Disparate oversight/enforcement practices; payment model misalignment	Baseline assessment of CCO policy differences; Value Based Payment pilot considered	Reduction in enforcement variation; VBPM participation; Pilot evaluation and increased participation, if effective.	Equitable care access and outcomes across regions	Systemwide accountability and fiscal sustainability, majority of providers in VBPM/APM
	Prioritize systemic implementation of common assessment tools to increase ease of access to care.	ADPC, OHA, DOC, OYA	SUD providers use a mix of assessment tools, while ASAM criteria serves as a regulatory frame, the ecosystem may benefit from adoption of more consistent assessment tools by providers and payers	Issue brief published on recommended suite of assessment tools for utilization in treatment settings	Increase in providers utilizing recommended tools; regulatory framework more explicitly guides tool options towards ADPC recommendations	Consistent assessment tool utilization increases ease of referral, shortens wait times, and reduced patient/provider/payer conflict	Increasingly common assessment protocols in wide adoption, inclusive of culturally specific tools, with evidence that referrals to services and treatment planning has been streamlined
	Ensure stability and growth of treatment services that delivery culturally specific and place-based care.	ADPC, OHA, DOC, OYA	Care gaps remain that are disparate by geography and cultural factors. Changes in migration enforcement and diversity, equity and inclusion policy further exacerbate unequal access to care	Flexible, non-federal resources identified to support sustaining and expanding SUD service support to populations put at risk by current federal policy	Existing CBOs serving high need populations remain operational, providing continuity of care. Treatment options are expanding in remote and underserved regions of Oregon	Claims analysis demonstrates more equitable engagement in treatment across Oregon, provider capacity demonstrates an increasing and consistant ability to serve underserved populations and regions	Overdose and other consequence data demonstrates reduction in overdose rates and increasing service engagement in underserved communities
Priority 2: Ensure Timely Access to the Appropriate Level of Care at All Entry Points	Ensure that providers, payors and state agencies are utilizing common frameworks to understand wait times for both identification of needed level of care, and the start of appropriate services.	ADPC, OHA, DOC, DCBS, CJC, OYA	There is inconsistency around the tracking and understanding of wait times for assessment, and further delays in accessing clinically appropriate care. Community and provider feedback reflects challenges around access, but the state lacks a coherent approach to understanding and monitoring accessibility of treatment services when an individual presents for care.	Common access framework developed and adopted, regulatory strategy to embed framework developed	Framework applied consistently across CCOs, state provided care (such as that provided within carceral settings), and state contracts	Framework in utilization at provider level for both reporting and internal QI	Consistant approaches to ensuring rapid access to assessment and treatment onset in practice across behavioral health and primary care systems, wait times consistant with acceptable levels identified in the framework
	Create baseline wait time data and transparent public reporting on access metrics.	ADPC, OHA	Lack of standardized measurement or public tracking of wait times	Treament provider survey implemented to assess current wait times for entry into care, with an eye to disparities by population, geography and level of care sought/provided.	Ongoing pipeline of reporting available to assess delays in care access where additional strategies or capacities could be implemented.	Wait times integrated in continuous quality improvement; increase in timely treatment access demonstrated through provider surveys and reports; with improvements noted by populations and across geographies.	Equitable care access; timely intervention reduces treatment severity
	Expand 24/7 access to withdrawal management services statewide.	ADPC, OHA	Limited 24/7 access in many areas; especially scarce in rural and frontier regions	Baseline mapping of current withdrawal management/stabilization sites and hours	Increased number of regions with 24/7 access; use rates improve	Universal 24/7 availability across regions	Early intervention and reduced crisis-based system reliance
	Improve referral systems to ensure individuals move from referral to care without gaps.	ADPC, OHA, CJC, DOC	Currently no statewide referral tracking system; long gaps between referral and service	Identify opportunities to improve referral pathways and efficiency through local ADPC and other collaborative strategies, and/or regional/statewide systems that can create better coordination and referrals between providers	Provider performance measurement includes referral measures relative to timeliness, accuracy on appropriate level of care and known gaps in the service array that interfere with streamlined referrals	Systemic referral strategies implemented, providers data demonstrates increased ease of referrals into appropriate treatment	Faster access to care, fewer people lost between referral and treatment
Priority 3: Facilitate Improved Transitions Throughout the Treatment and Recovery Journey	Expand use of cross-system care coordination protocols to increase seamless transitions and consistent warm handoffs.	ADPC, OHA, DOC, OYA	Disconnection between referral and confirmation; inconsistent follow-through post-discharge	Referral protocols and processes established; baseline warm handoff adherence	Increased completion of referrals and post-discharge engagement	Seamless system-wide transitions across levels and regions	Continuity of care; reduced drop-off after transitions
	Develop and adopt standard discharge and transition planning practices aligned with patient-defined goals.	ADPC, OHA, DOC, OYA	Discharge often based on program rules rather than clinical or recovery goals	Rate of programs with standardized discharge planning; alignment to person-centered goals	Increased follow-through on community reintegration supports	Discharges reflect recovery-oriented, trauma-informed care	Improved recovery outcomes; reduced recurrence of care episodes
	Create metrics and systems to track transitions across programs, including between ASAM levels and Payors.	ADPC, DOC, OHA, DCBS, OYA	No common metrics; transitions often unmeasured or vary across providers	Baseline metrics established; pilot regional tracking efforts	Centralized data infrastructure for tracking transitions launched	Wider use of transition tracking across systems and payors	Accountability and improvement in care continuity
	Prioritize high-need populations (e.g. rural, justice-involved, co-occurring) in transition planning with culturally appropriate wraparound supports.	ADPC, OHA, CJC, DOC, OYA	Fragmented services and housing gaps undermine stability post-treatment	Targeted outreach programs initiated, wraparound supports mapped	Increased support and reduced disparities for prioritized populations	Holistic, equitable recovery systems for complex-need groups	Reduced recidivism, enhanced long-term recovery success
Priority 4: Drive Quality and Accountability Across All Components of the Treatment System	Develop shared quality metrics across systems that include access, retention, outcomes, and patient experience.	ADPC, OHA, DOC, OYA	Each system defines and tracks quality differently; no shared benchmarks	Draft shared metric set; stakeholder feedback collected	Implementation across systems and provider networks	Statewide adoption of quality benchmarks across treatment system	More consistent, transparent evaluation of care effectiveness
	Build technical assistance and funding supports for smaller and rural providers to participate in reporting and QI systems.	ADPC, OHA	Small/rural providers lack capacity for quality reporting; equity gap	Number of providers receiving TA/funding; reporting participation baseline	Broader participation in quality monitoring across provider types	Equity in reporting and accountability participation	Fair and inclusive quality evaluation across the system
	Modernize oversight processes and reduce redundant audits; align with incentives and provider capacity.	ADPC/OHA	Oversight burdensome and duplicative; audits strain workforce	Inventory of existing audits; pilot streamlined models	Reduced number of redundant audits; provider satisfaction increases	Integrated, efficient accountability systems statewide	Improved trust and sustainability in oversight relationships
	Coordinate with ROADS/APAC teams to generate and return actionable insights to providers for system improvement.	ADPC/OHA	Limited use of ROADS/APAC data; lack of feedback loop to providers	Insight reports shared with providers; use of data in QI efforts begins	Increased data-informed improvements across programs	Data routinely drives care improvements and policy shifts	More adaptive, responsive treatment system using evidence