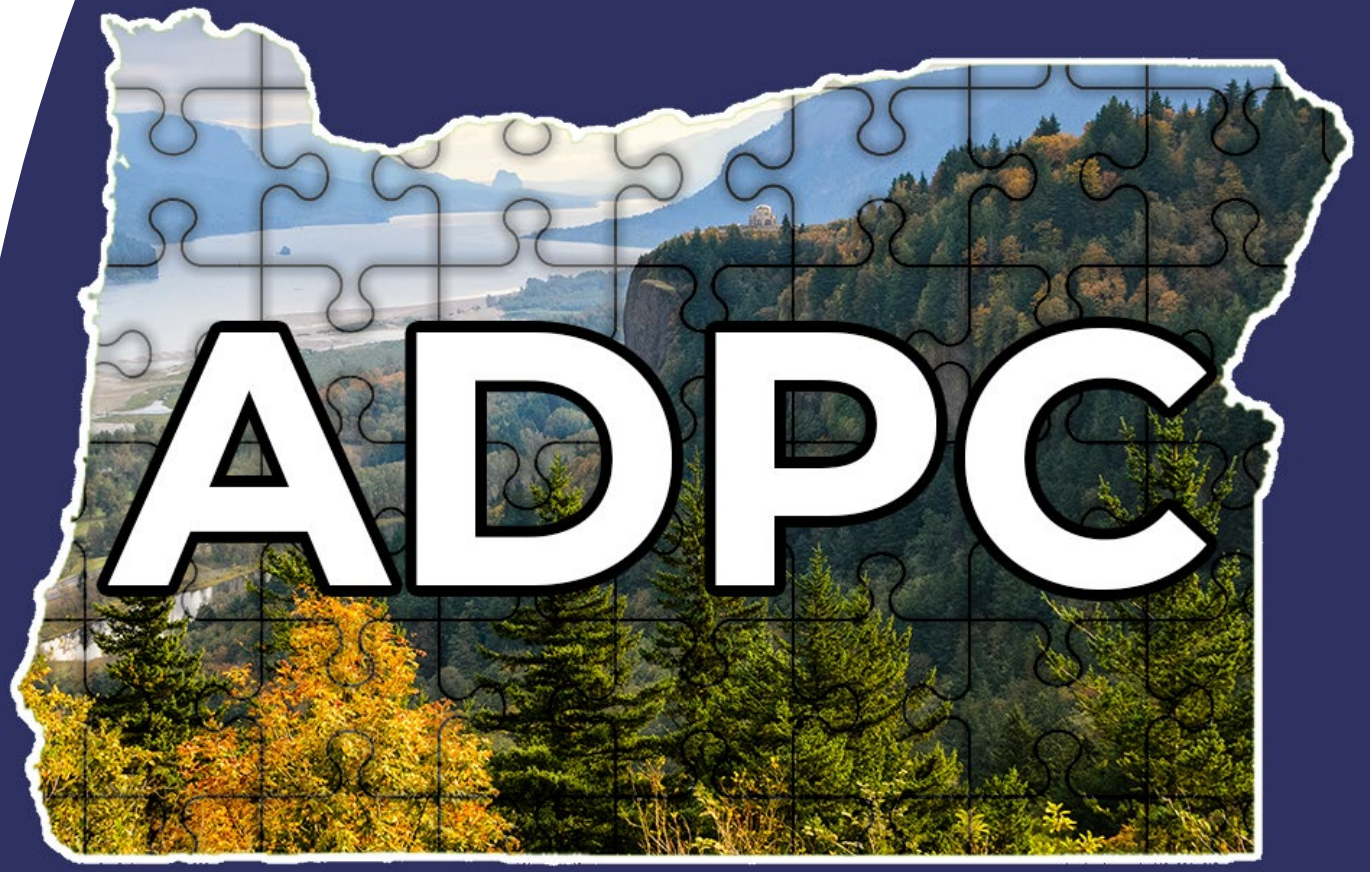
Oregon Alcohol and Drug Policy Commission

Opening doors: Achieving access, belonging, and connection across Oregon

Treatment Committee

April 2026



Today's Agenda

- Welcome & Roll Call
- Director's updates
- Healthshare Presentation
- Staff Presentation: EPIS Framework
- Comprehensive Plan: Priority and Workflows
- Public Comment

High Acuity Behavioral Health Analysis and Strategy

2026

Cat Livingston, MD, MPH
Medical Director

Background

Health Share of Oregon is the state's **largest coordinated care organization** (CCO), with approximately **460,000 members** in the Portland Metro Area.

OREGON HEALTH AUTHORITY

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OHSU

KAISER PERMANENTE®

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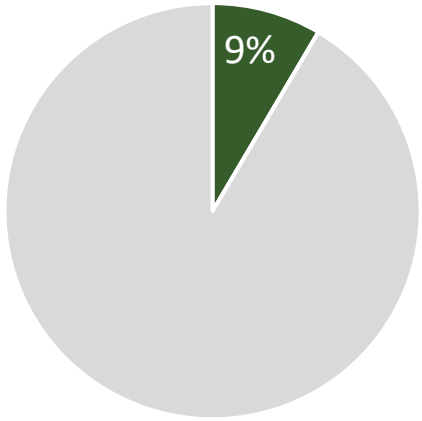
What is the High Acuity Behavioral Health (HABH) Cohort?

The HABH cohort is members with a claims diagnosis of:

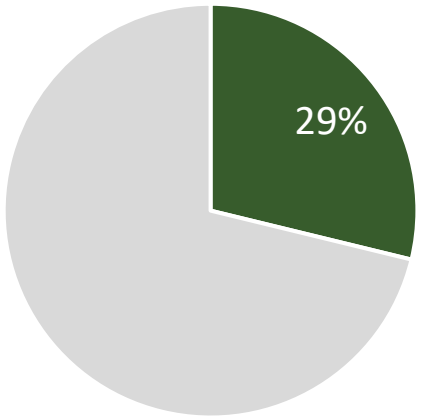
- Stimulant use disorder,
- Opioid use disorder,
- Psychosis, or
- Unintentional substance-associated overdose.

9% of Health Share adult members (~27K people)

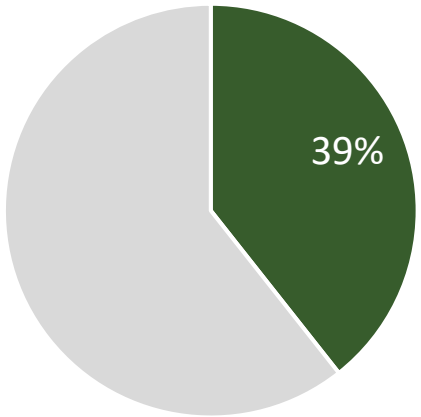
Adult Health Share members in the **HABH cohort**



Proportion of total adult costs for **HABH cohort members**



Proportion of total adult medical inpatient admissions for **HABH cohort members**



Source: 2024 claims data

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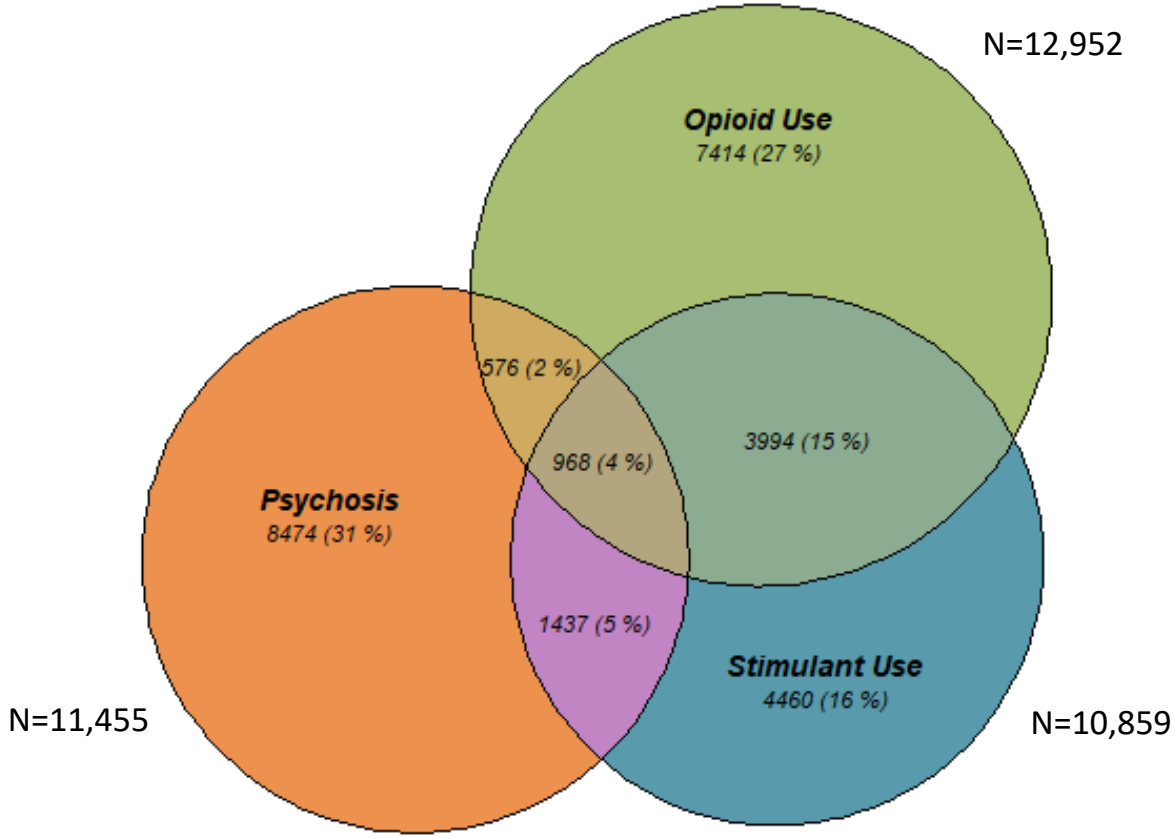
Overlap between the 3 most common HABH groups

There is significant overlap between the cohort groups – for example, 15% of all members in the high-risk cohort had diagnoses of both OUD and Stimulant Use Disorder in 2024.



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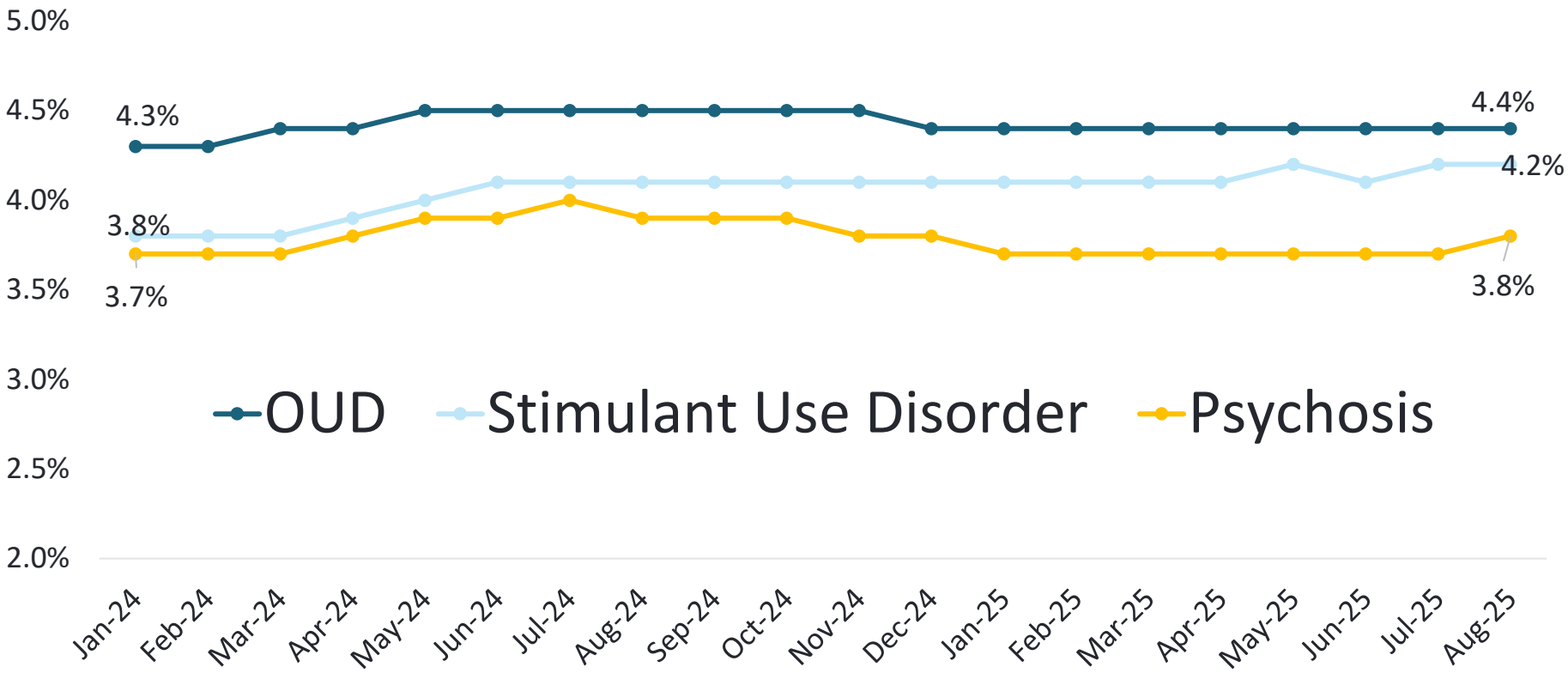
Members with stimulant use disorder were the fasting growing cohort between 2024 and 2025. About 12,000 Health Share members have a diagnosed stimulant use disorder.



10% increase between 2024 and 2025

(Compared to 2-3% increase for other two cohorts)

Data source: 2024 Health Share claims data.

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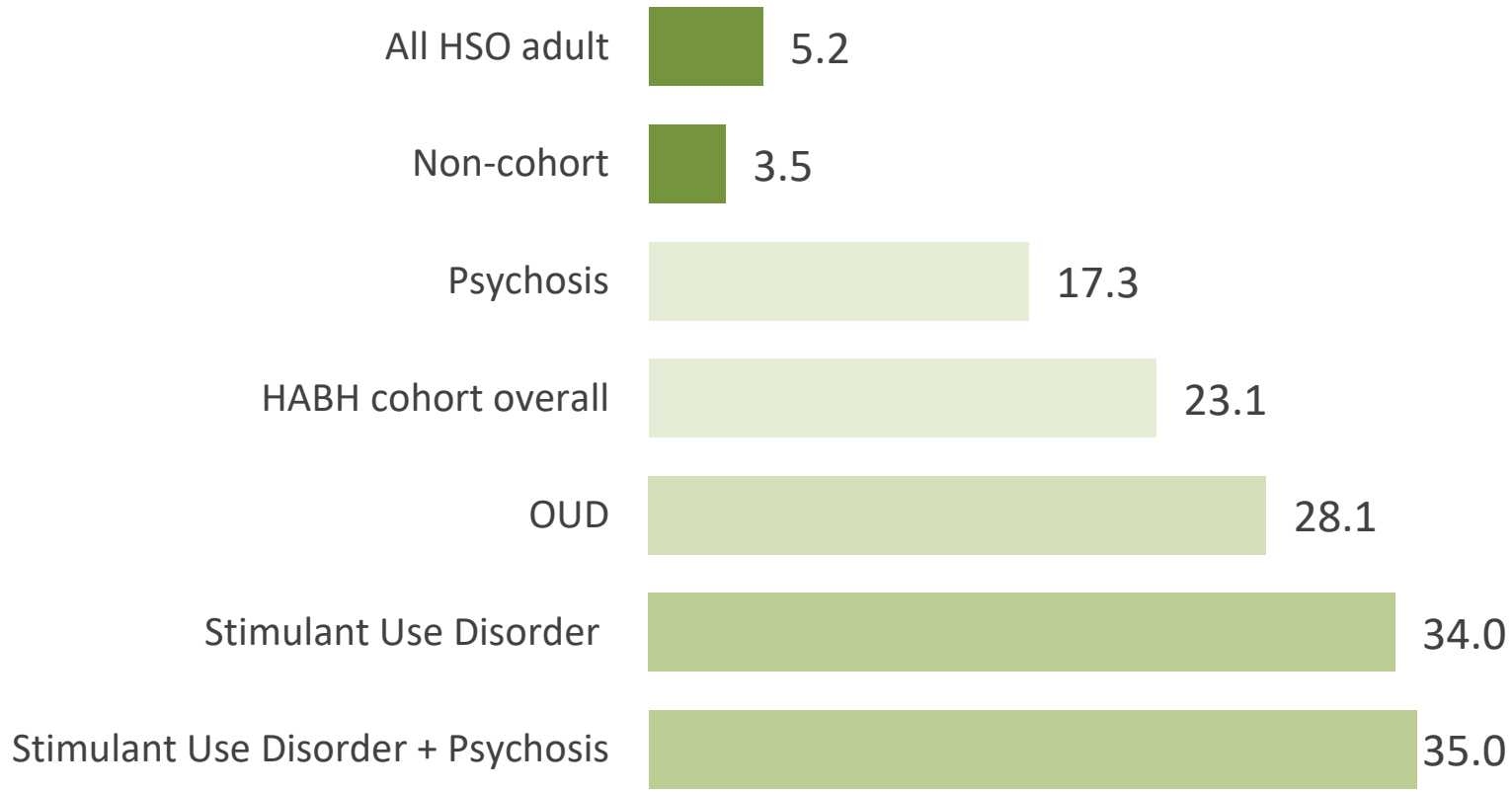
HABH Medical Inpatient Utilization

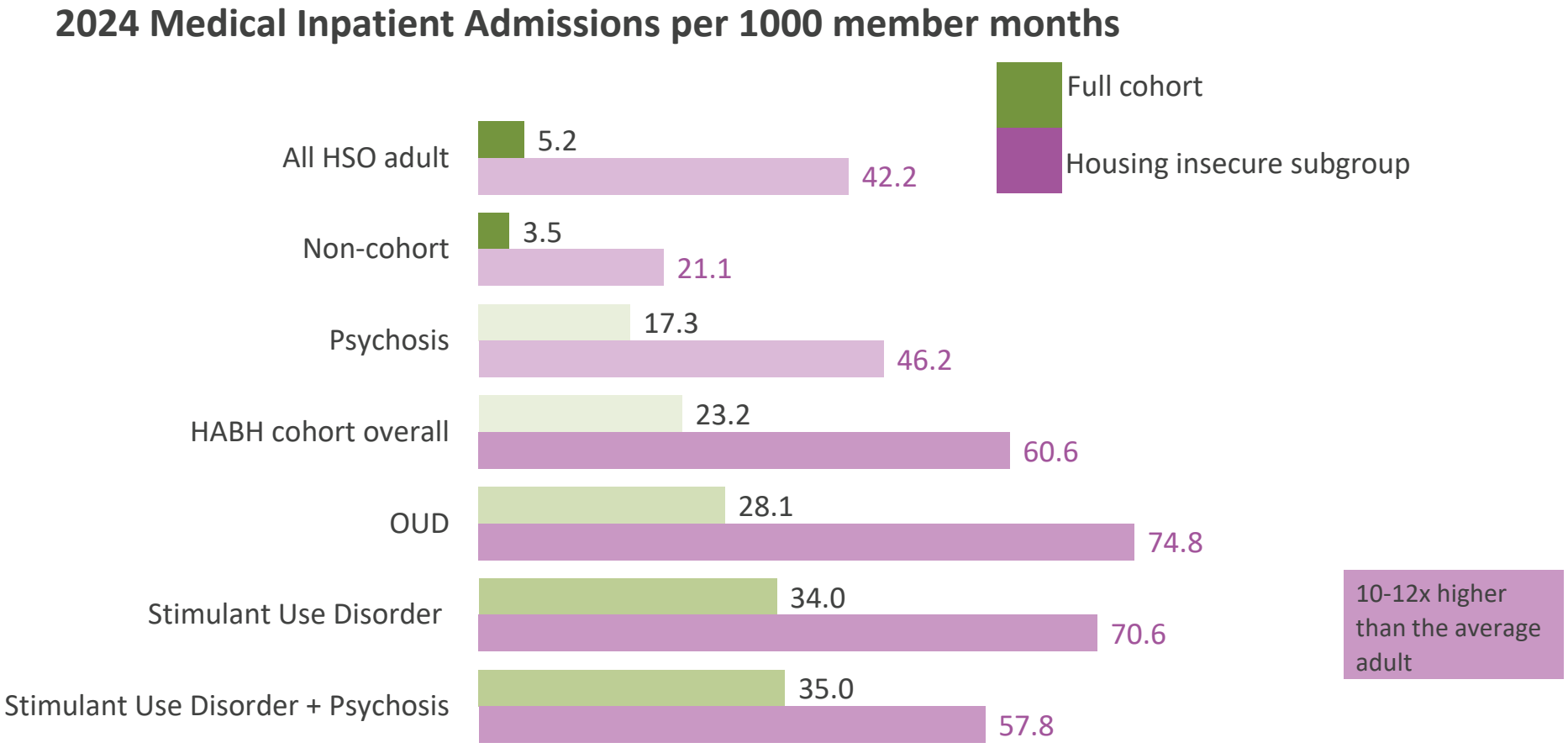
2024 Medical Inpatient Admissions per 1000 member months



5x higher than the average adult

7x higher than the average adult

HABH Medical Inpatient Utilization



Top 10 Medical Inpatient Diagnoses (2024)

	Any Cohort	Non-Cohort	Opioid Use	Psychosis	Stimulant Use	Unint. Overdose
Septicemia	1	1	1	4	1	2
Schizophrenia spectrum and other psychotic disorders	2		3	1	2	3
Depressive disorders	3	6	4	2	5	6
Hypertension with complications and secondary hypertension	4	2	6	8	3	4
Skin and subcutaneous tissue infections	5		2	7	4	5
Bipolar and related disorders	6			3	8	7
External cause codes: poisoning by drug	7		5	6	7	1
Diabetes mellitus with complication	8	3	7	9	6	10
Alcohol-related disorders	9	4	8	5	9	9
Respiratory failure; insufficiency; arrest	10		10	10	10	8
Obesity		5				
Other specified and unspecified liver disease		7				
Pancreatic disorders (excluding diabetes)		8				
Spondylopathies/spondyloarthropathy (including infective)		9				
Acute myocardial infarction		10				
Complication of other surgical or medical care, injury, initial encounter			9			
Opioid-related disorders						9

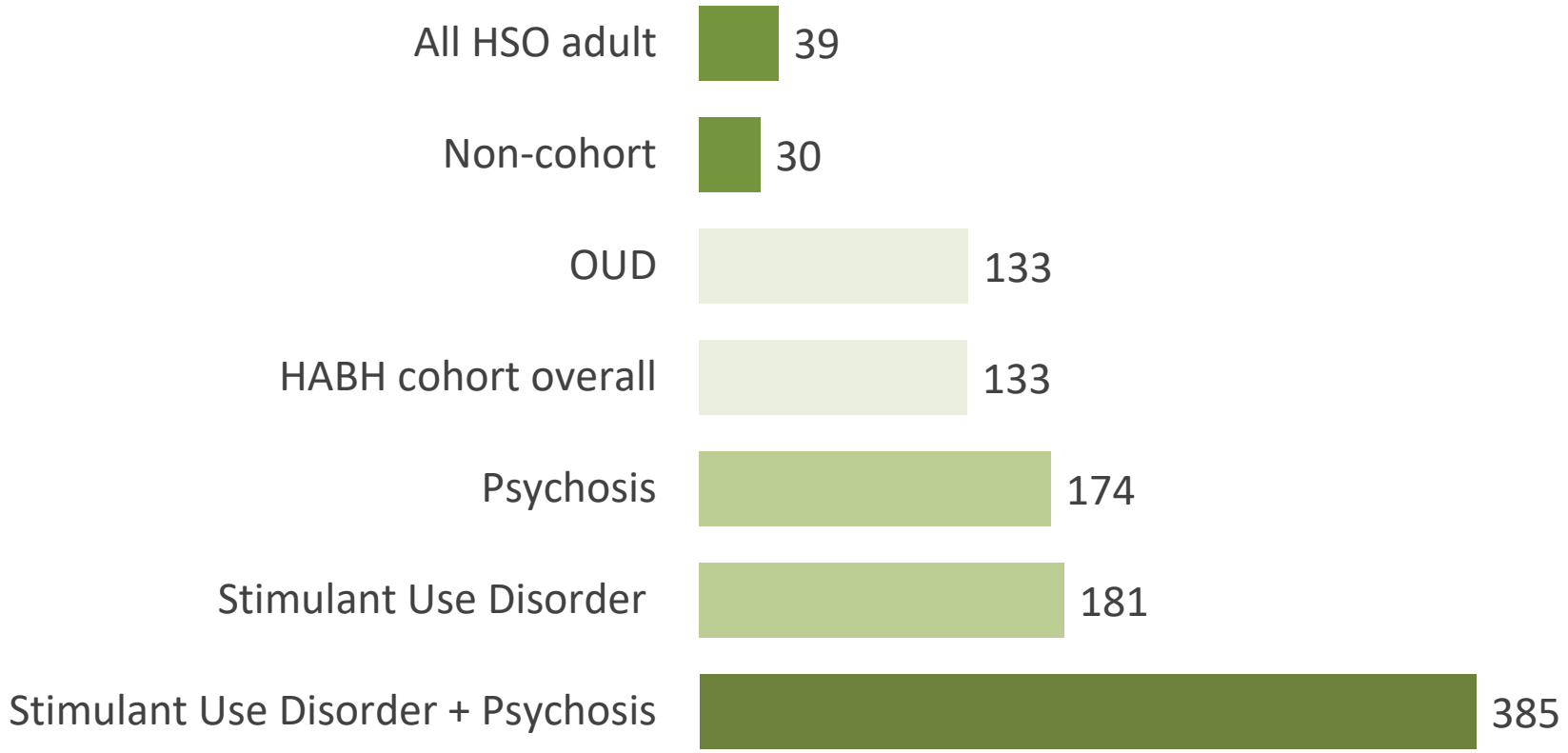
The reasons for inpatient admissions differ significantly between the HABH cohort and adult Health Share members not in the cohort.

5 of the most prevalent diagnoses for cohort members do not appear in the top 10 diagnoses for non-cohort members.

Note: Maternity IP excluded

HABH Emergency Department Utilization

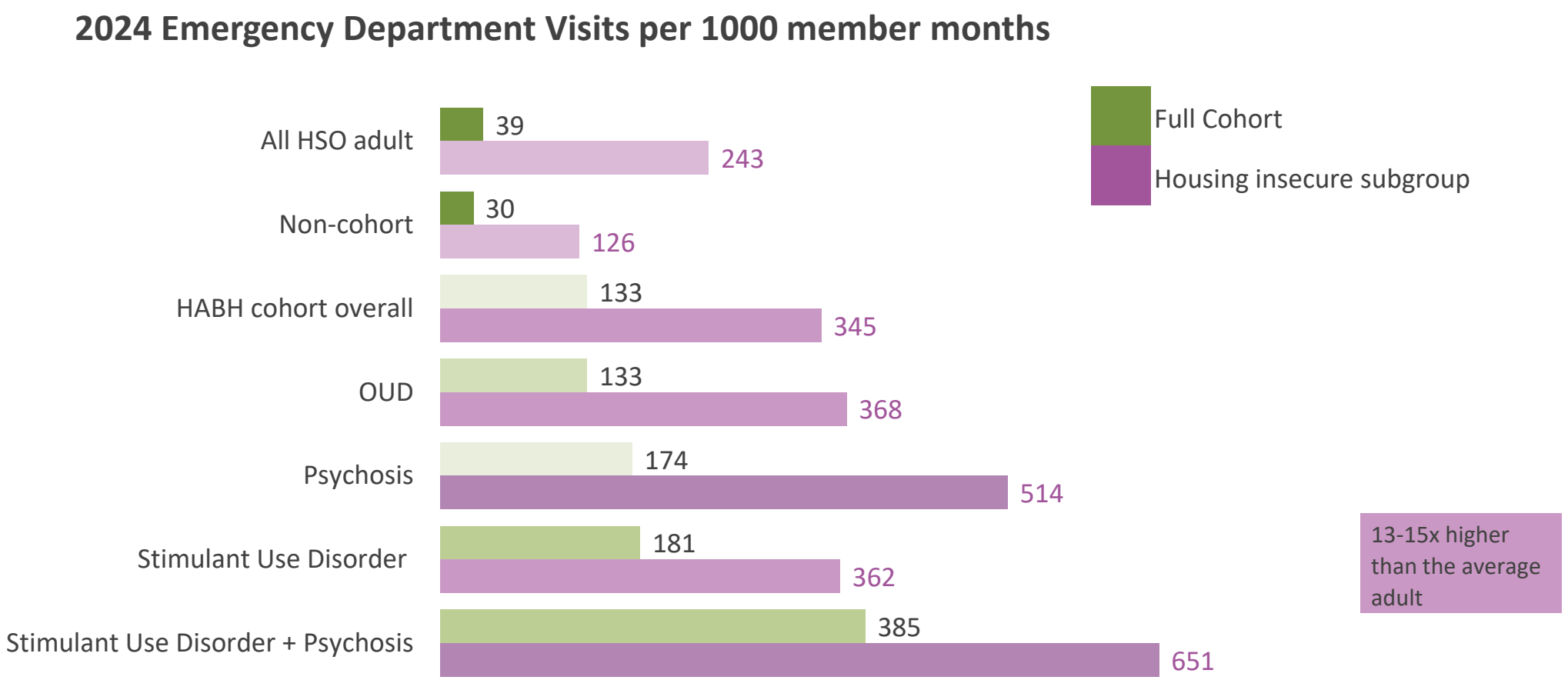
2024 Emergency Department Visits per 1000 member months



4-5x higher than the average adult

9-10x higher than the average adult

HABH Emergency Department Utilization



Top 10 Primary ED Diagnoses (2024)

	Any Cohort	Non-Cohort	Opioid Use	Psychosis	Stimulant Use	Unint. Overdose
Skin and subcutaneous tissue infections	1	3	1	5	1	2
Abdominal pain and other digestive/abdomen signs and symptoms	2	1	2	2	3	6
Schizophrenia spectrum and other psychotic disorders	3		6	1	2	3
Musculoskeletal pain, not low back pain	4	4	3	4	4	4
Nonspecific chest pain	5	2	5	7	6	9
Alcohol-related disorders	6		10	6		7
Suicidal ideation/attempt/intentional self-harm	7			3	9	
Superficial injury; contusion, initial encounter	8	7	9	9	8	8
Any dental condition including traumatic injury	9	9	7		7	
External cause codes: poisoning by drug	10		4		10	1
Sprains and strains, initial encounter		5				
Headache; including migraine		6				
Urinary tract infections		8				
Nausea and vomiting		10				
Opioid-related disorders			8			10
Anxiety and fear-related disorders				8		
Stimulant-related disorders				10	5	5

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HABH Cohort Mortality Rates

Mortality relative risk compared to non-HABH members (2024)

Age of Death	Any Cohort	Opioid Use	Psychosis	Stimulant Use	Stim Use and Psychosis	Unintentional Overdose
18 to 29	13.31	23.14	11.89	20.61	35.80	68.45
30 to 49	6.22	7.60	7.10	7.90	12.58	28.09
50 to 69	3.85	4.48	3.51	4.74	5.26	15.79
70 and above	1.96	2.23	1.93	1.67	1.94	1.71
All Adults	4.01	4.57	4.14	4.33	5.66	13.40

2-4 times higher relative risk

5-9 times higher relative risk

10-19 times higher relative risk

20+ times higher relative risk

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HABH + Housing Insecurity Mortality Rates

Mortality relative risk compared to non-HABH members (2024)

Age of Death	Any Cohort + HS	Opioid Use + HS	Psychosis + HS	Stimulant Use + HS	Stim Use and Psychosis + HS	Unintentional Overdose + HS
18 to 29	24.70	34.41	29.42	31.62	49.60	81.61
30 to 49	14.60	18.30	17.01	14.20	18.08	32.51
50 to 69	5.86	7.12	5.81	5.49	4.65	19.71
70 and above	1.55	1.57	1.53	2.14	2.40	n/a
All Adults	6.40	7.60	6.69	6.21	6.65	15.44

2-4 times higher relative risk

5-9 times higher relative risk

10-19 times higher relative risk

20+ times higher relative risk

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Housing and Health Integrated Data Set

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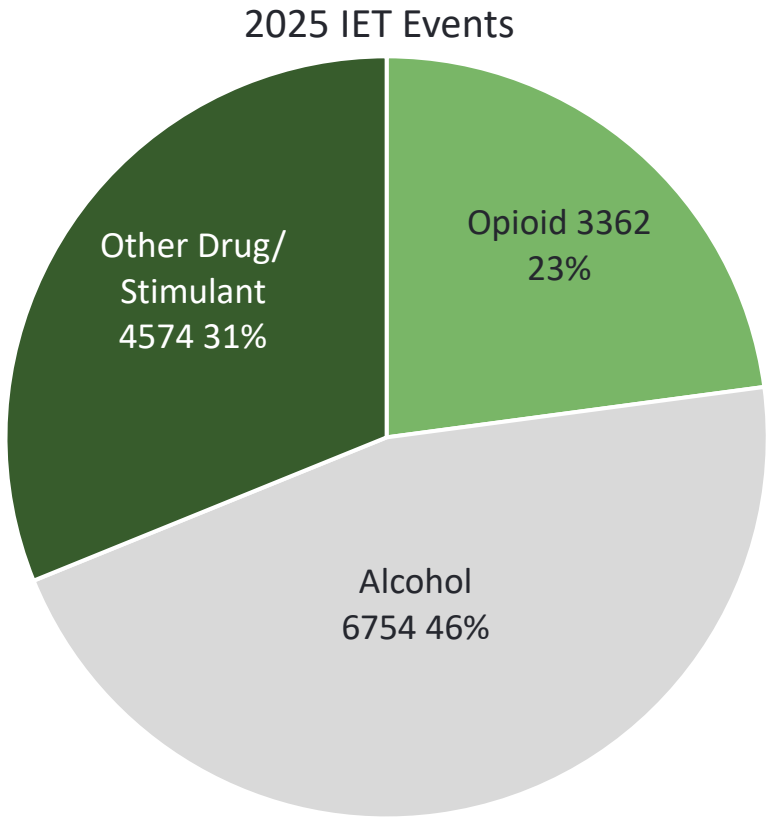
Integrated housing data (HMIS) from Multnomah County highlights (initial)

People with stimulant use disorder, OUD and/or psychosis:

- Made up **almost half of people who were actively homeless**
- Made up 1/3 of people in rapid re-housing and **more than 40% of people in coordinated entry**
- Are **twice as likely to exit from permanent supportive housing** to homelessness
- **Stimulant use disorder is especially prevalent** in this matched cohort
- Those receiving **emergency shelter or street outreach have 18x higher rates of avoidable ED visits** than non HABH Health Share adults

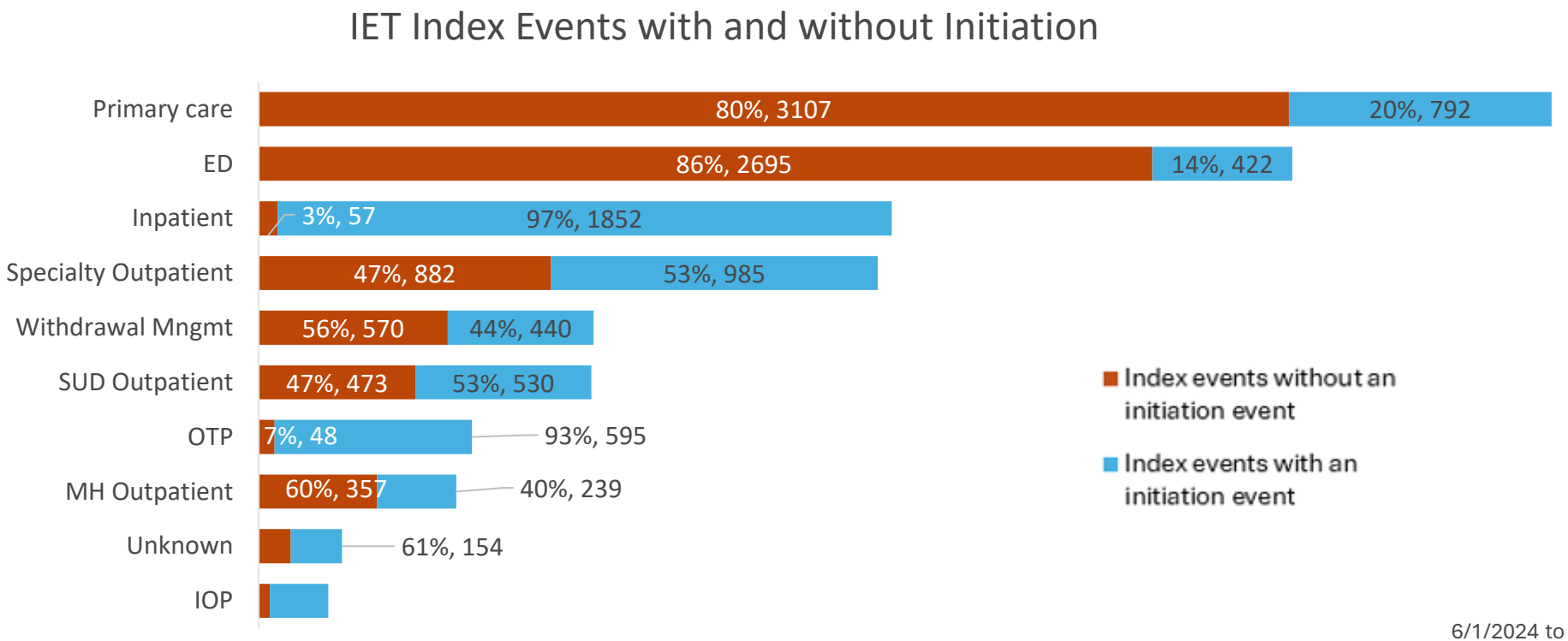
Initiation and Engagement Metric

- The IET denominator is comprised of alcohol, opioid, and other drug (which is largely stimulant).
- In 2025, more than half of IET events among Health Share members were related to HABH cohort diagnoses.



IET Initiation Rates by Setting

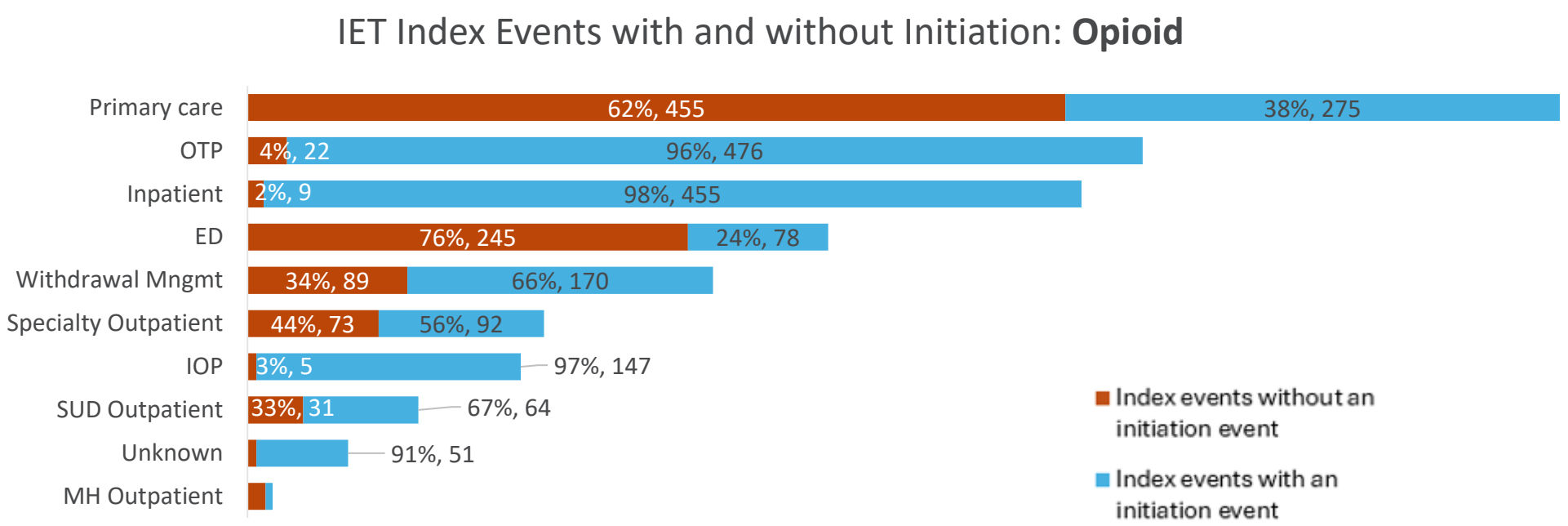
While almost half of all SUD index events (45%) resulted in treatment initiation, this varied greatly by diagnoses (index event) setting. People who receive an SUD diagnosis in primary care or the ED have the lowest rates of treatment initiation.



6/1/2024 to 5/30/2025

IET Initiation Rates by Setting: Opioid

Among members with an Opioid Use Disorder diagnosis, people with an index event in primary care or the ED have the lowest rates of treatment initiation.



6/1/2024 to 5/30/2025

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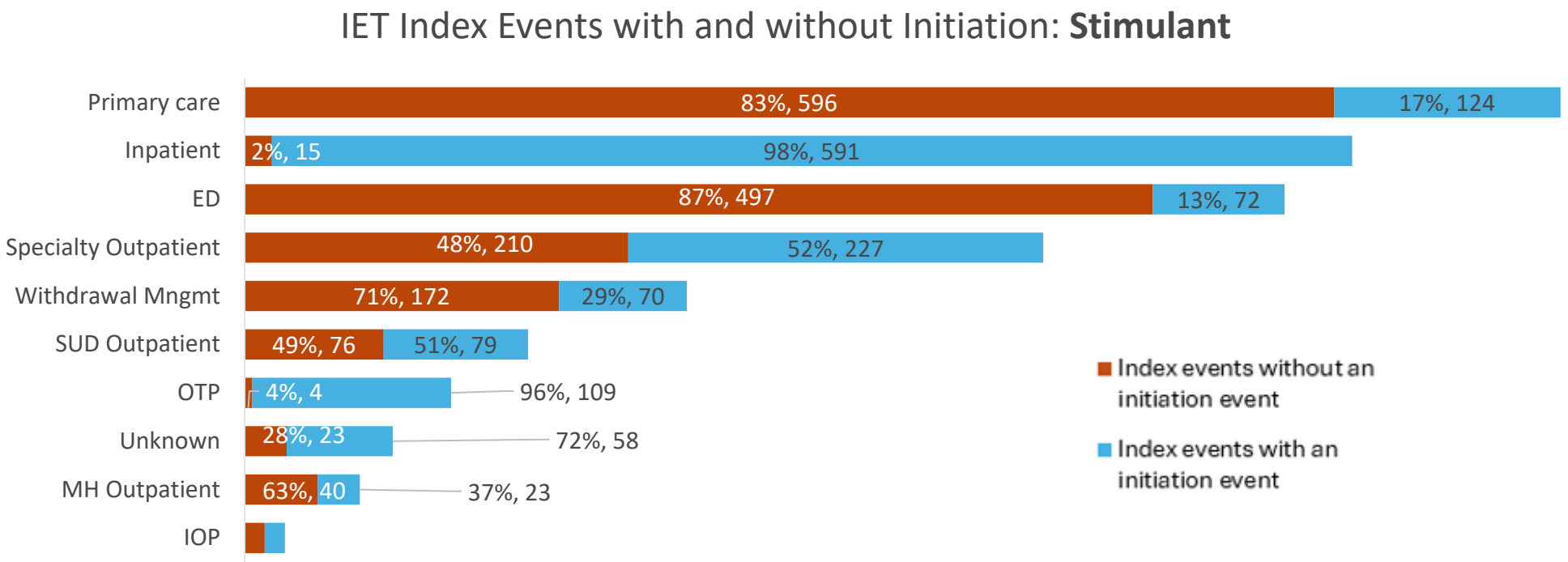
IET Initiation Rates by Setting: Stimulant

Among members with a Stimulant Use Disorder diagnosis, people with an index event in primary care or the ED have the lowest rates of treatment initiation.



6/1/2024 to 5/30/2025

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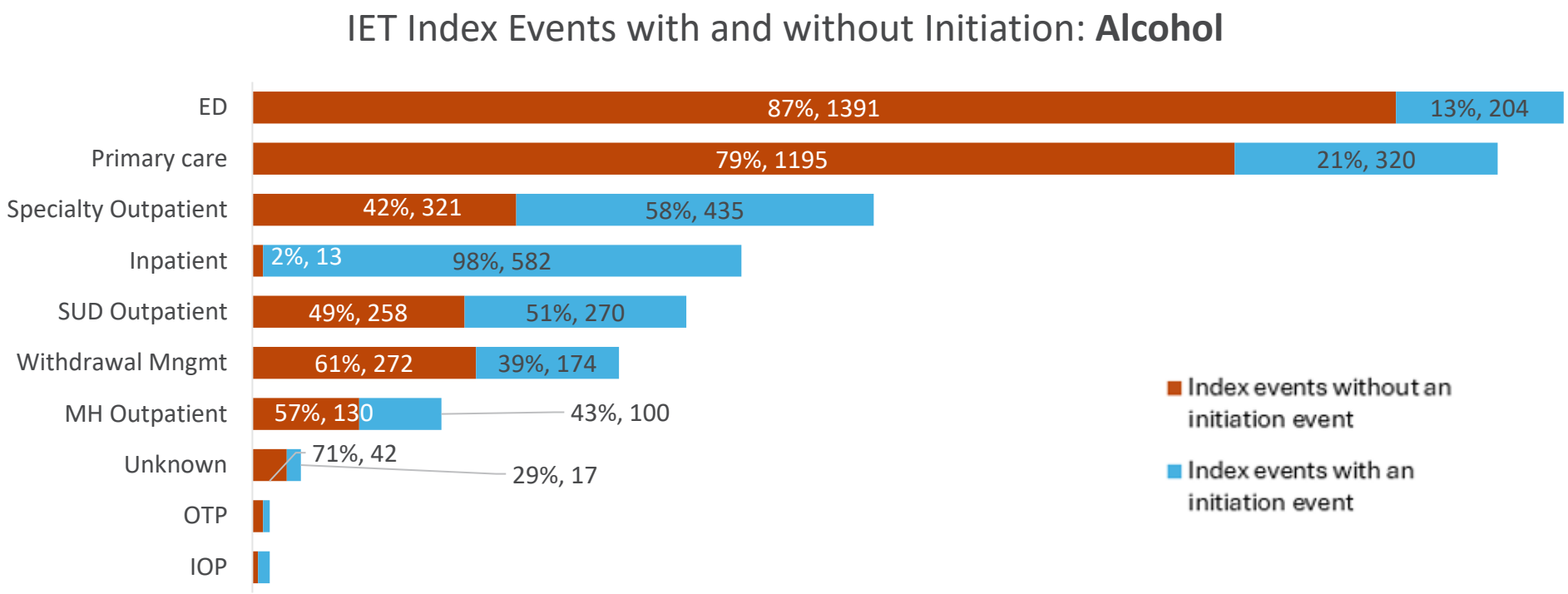
IET Initiation Rates by Setting: Alcohol

Among members with an Alcohol Use Disorder diagnosis, people with an index event in primary care or the ED have the lowest rates of treatment initiation.



6/1/2024 to 5/30/2025

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The data are compelling, now what?

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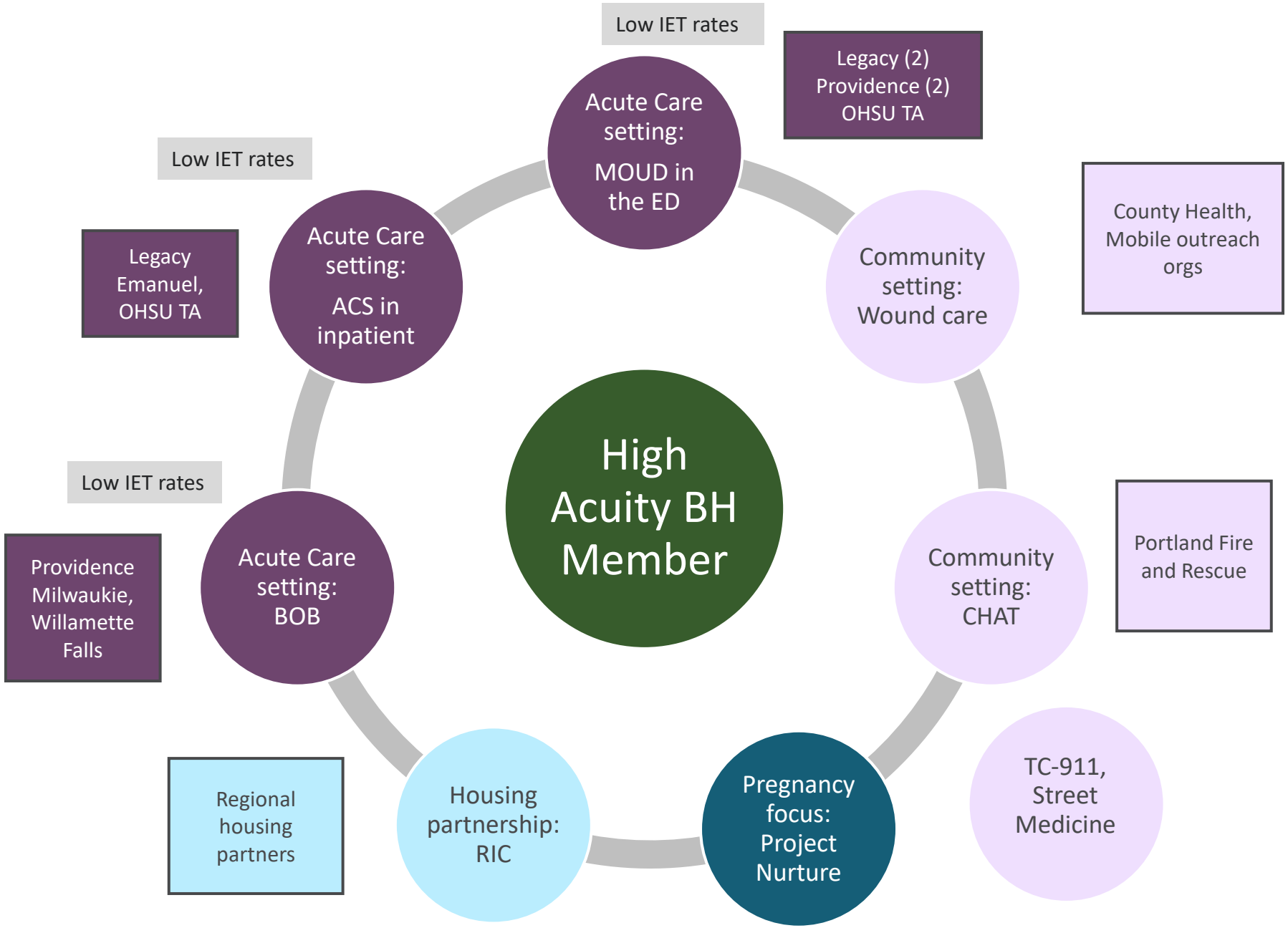
High Acuity BH Clinical and Community Interventions



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High Acuity BH Key Performance Indicators (KPIs)

Domain	KPI
Increased connection to primary care and behavioral health services	IET Metric
	SUD services
	Medication for OUD/ MPR
	Medication for AUD
	Naloxone distribution
	BH services
	Antipsychotic meds for peoples with schizophrenia
	Primary care utilization rate
	Members with 1+ primary care visit
Reduced acute care utilization	Average length of stay
	Readmission rates
	IP high utilizer rate
	IP utilization rate
	ED utilization rate
	ED high utilizer rate
	Avoidable ED utilization rate
	ED utilization wound care related
Reduced morbidity and mortality	Severe morbidity rate
	Patient mortality rate
Decreased healthcare costs	Cost/Savings

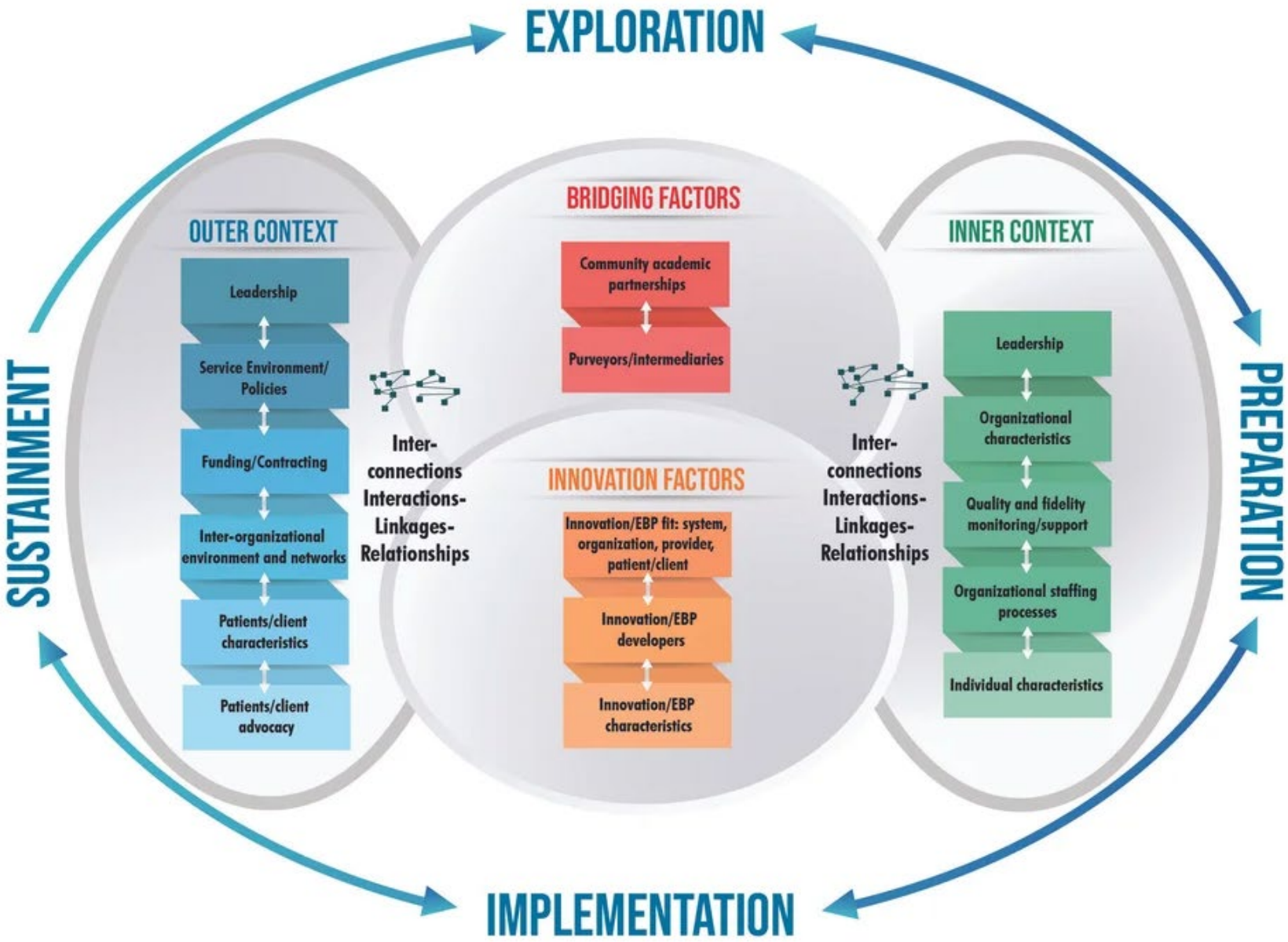
High Acuity BH Cohort Monitoring and Evaluation

Overall HABH Intervention Outcomes

- Increased connection to primary care and behavioral health services (SUD and/or MH treatment)
- Reduced acute care utilization (Inpatient and ED)
- Reduced morbidity and mortality
- Decreased healthcare costs

We will also be tracking **housing retention and successful versus unsuccessful housing placements** for members in both the HABH and HMIS cohorts.

A Metaphor…



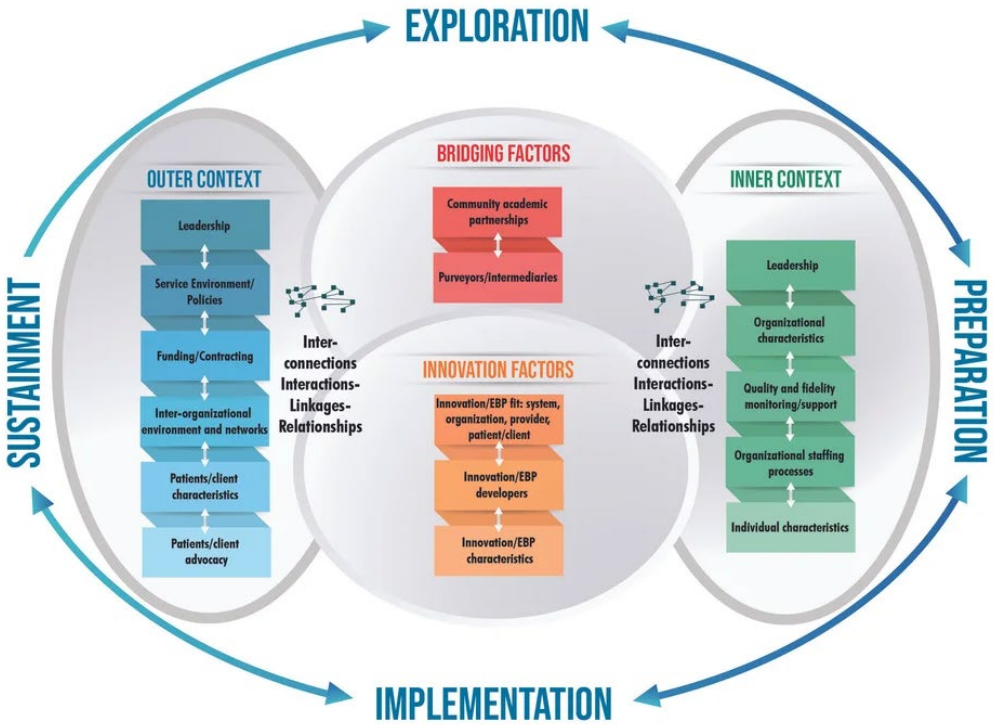
EPIS Framework

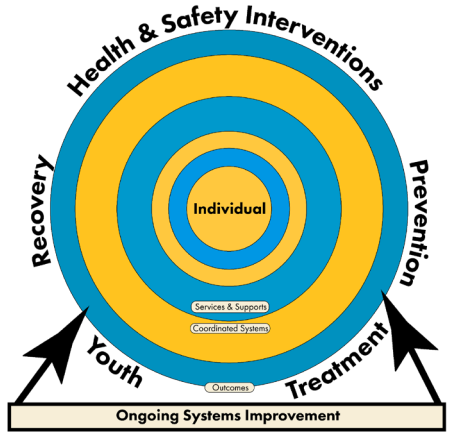
Describes the process(es), factors, and the interaction of the "system" and "programs" as it relates implementation efforts. It also is a model that can be used to provide some structure to implementation at each level.

EPIS outlines the ways that both the inner context (program level) relates to the outer context (systems) and the factors from each that make implementation and sustainability feasible.

Why does this matter?

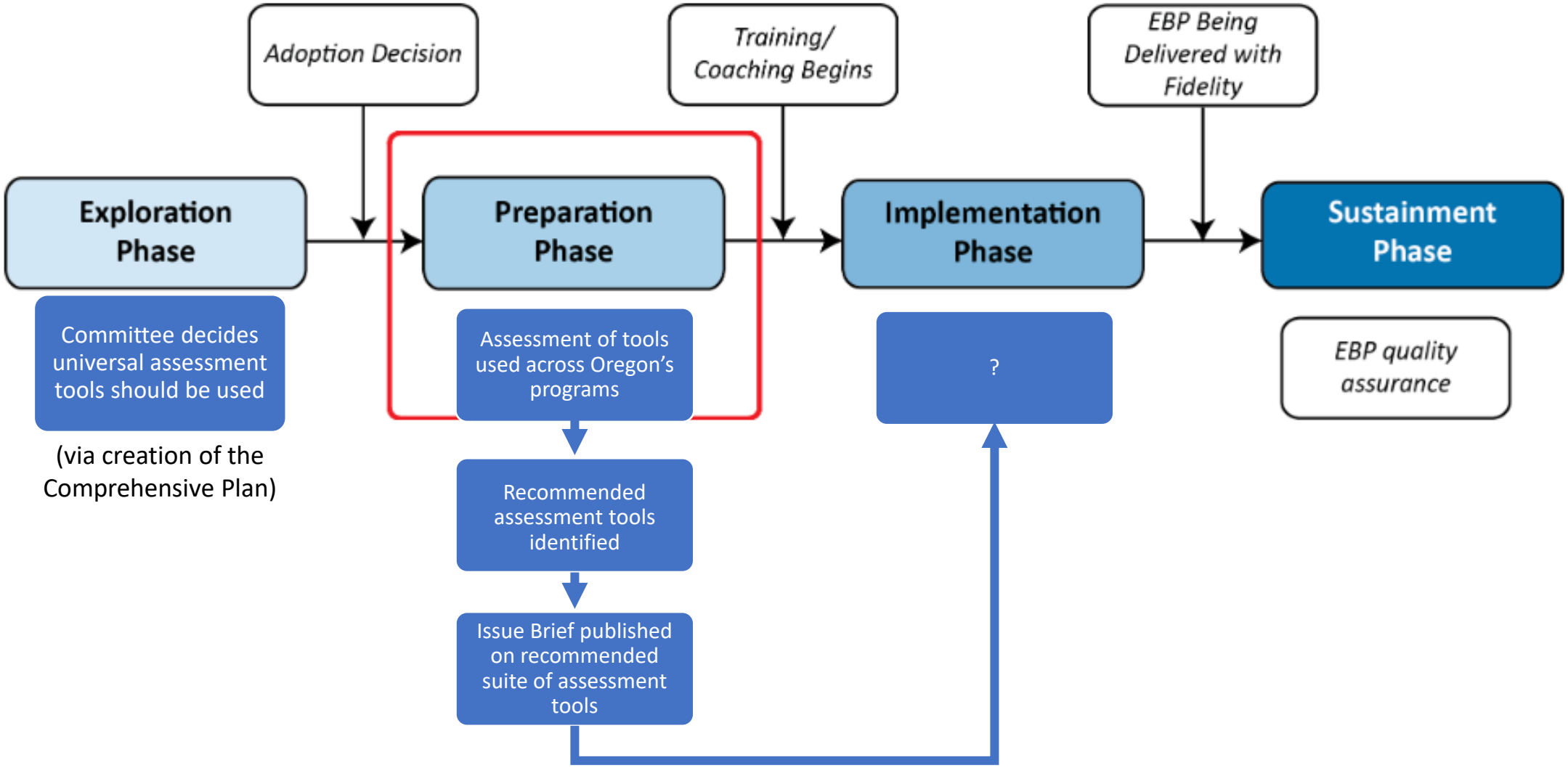
- Community Providers and Community Members told us that change “happens to them” not “with them.”
- Achieving a Recovery Oriented System of Care (ROSC) requires ***systems coordination*** occurs to support downstream efforts.
- Fundamentally, our efforts to change the system is also an eventual ***ask of providers to embark on many overlapping processes of implementation.***
- The ADPC, its committees, and workgroups can serve as the “bridge” for the service and systems level implementation, ***making sustainability more feasible and sustainment decisions more data informed***.





“Short” Term Goals

EBP/ TBP Access	Timely Access	Improved Transitions	Quality & Accountability
Number/percent of providers offering MSUD; baseline audit of CCO consistency	Common access framework developed and adopted, regulatory strategy to embed framework developed	Referral protocols and processes established; baseline warm handoff adherence	Draft shared metric set; stakeholder feedback collected
Number of justice/court settings supporting access to MSUD via partnerships with MSUD providers; Expanded EMS MSUD pilot reach	Treatment 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	Rate of programs with standardized discharge planning; alignment to person-centered goals	Number of providers receiving TA/funding; reporting participation baseline
Assessment of current levels and gaps around EBP/ TBP utilization across providers complete, TA services available are catalogued with understanding around current utilization	Baseline mapping of current withdrawal management/stabilization sites and hours as well as transportation service options	Baseline metrics established; pilot regional tracking efforts	Inventory of existing audits; pilot streamlined models
Baseline assessment of CCO policy differences; Value Based Payment pilot considered	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	Targeted outreach programs initiated; wraparound supports mapped	Insight reports shared with providers; use of data in QI efforts begins
Issue brief published on recommended suite of assessment tools for utilization in treatment settings			
Culturally specific and place based services are reliably available to those seeking them, with providers able to financially support and sustain services			


Adoption Decision
Training/ Coaching Begins
EBP Being Delivered with Fidelity
Exploration Phase
Preparation Phase
Implementation Phase
Sustainment Phase
Committee decides universal assessment tools should be used
(via creation of the Comprehensive Plan)
Assessment of tools used across Oregon's programs
Recommended assessment tools identified
Issue Brief published on recommended suite of assessment tools
?
EBP quality assurance

Exploration:
HB 4002 MOUD Study

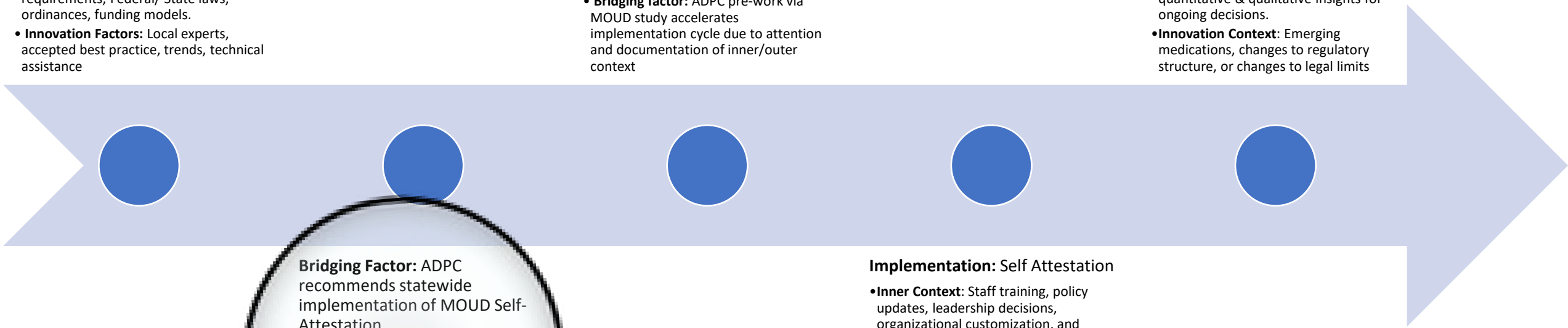
- **Inner Context:** Current Availability, admin burden, provider perspectives, stigma, and setting.
- **Outer Context:** CCO Policy, Regulatory requirements, Federal/ State laws, ordinances, funding models.
- **Innovation Factors:** Local experts, accepted best practice, trends, technical assistance

Preparation: Rule change Process for Self Attestation of MOUD access

- **Inner Context:** Requires notice of change to allow for implementation at a program level.
- **Outer Context:** Standard process exists for rule change.
- **Bridging factor:** ADPC pre-work via MOUD study accelerates implementation cycle due to attention and documentation of inner/outer context

Sustainment: Monitoring and Adjustment

- **Inner Context:** Provider's ability to identify partner prescribers or hire/ retain prescribers, communication variability, staff training needs differ, change fatigue
- **Outer Context:** Regulatory framework is applied, scope of challenge is identified, impact is monitored.
- **Bridging Context:** ADPC coordinates with ADPC partners to merge quantitative & qualitative insights for ongoing decisions.
- **Innovation Context**: Emerging medications, changes to regulatory structure, or changes to legal limits



Bridging Factor: ADPC recommends statewide implementation of MOUD Self-Attestation

- ADPC recommends implementation of a EBP providing information about the intent and purpose of the practice.
- Demonstrates knowledge of provider impact, outlines desired impact, and coordinates with agency partners impacted (outer & inner contexts)

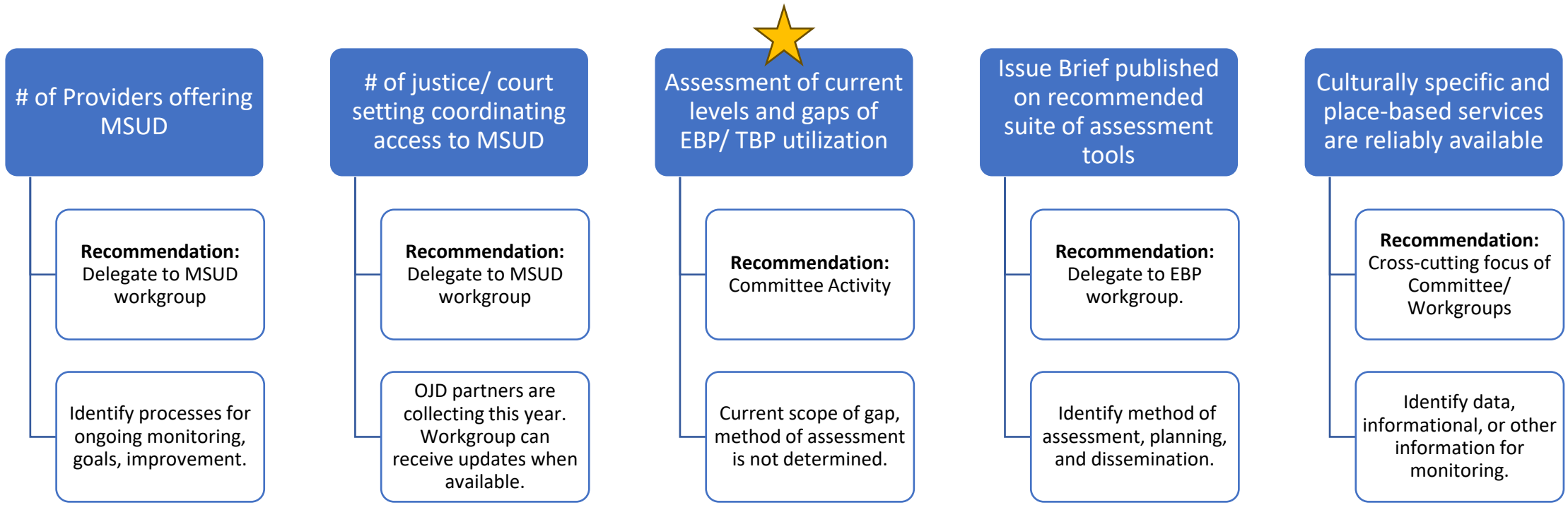
Implementation: Self Attestation

- **Inner Context**: Staff training, policy updates, leadership decisions, organizational customization, and development of monitoring processes.
- **Outer Context**: L&C identify date by which new requirement is a factor during site reviews, TA is provided
- **Bridging Factor:** ADPC Comprehensive Plan
- **Innovation Factor:** OHSU consult line best practice groups

Summary:

- EPIS offers a shared language that can be uses across disciplines.
- Provides us with a grounding framework for discussion:
  - “We are talking about the ‘outer context’ of this issue right now, let’s come back to that.”
- Enables us to maintain a ROSC aligned perspective throughout the implementation process.
- Provides a “check list” of needed factors to address at for each goal area and supports our goal of improving the system as a whole “with” and not “to” the components of our system of care.

Access to Evidence Based Practices



Timely Access

Common Access Framework Developed

- **Recommendation:** Committee Activity
- Involve data, survey, and other informational services to promote outer/inner contexts simultaneously.

Treatment Provider Survey to assessment wait times for entry into care

- **Recommendation:** Committee Support
- Support ADPC staff in cross agency collaboration to assess.

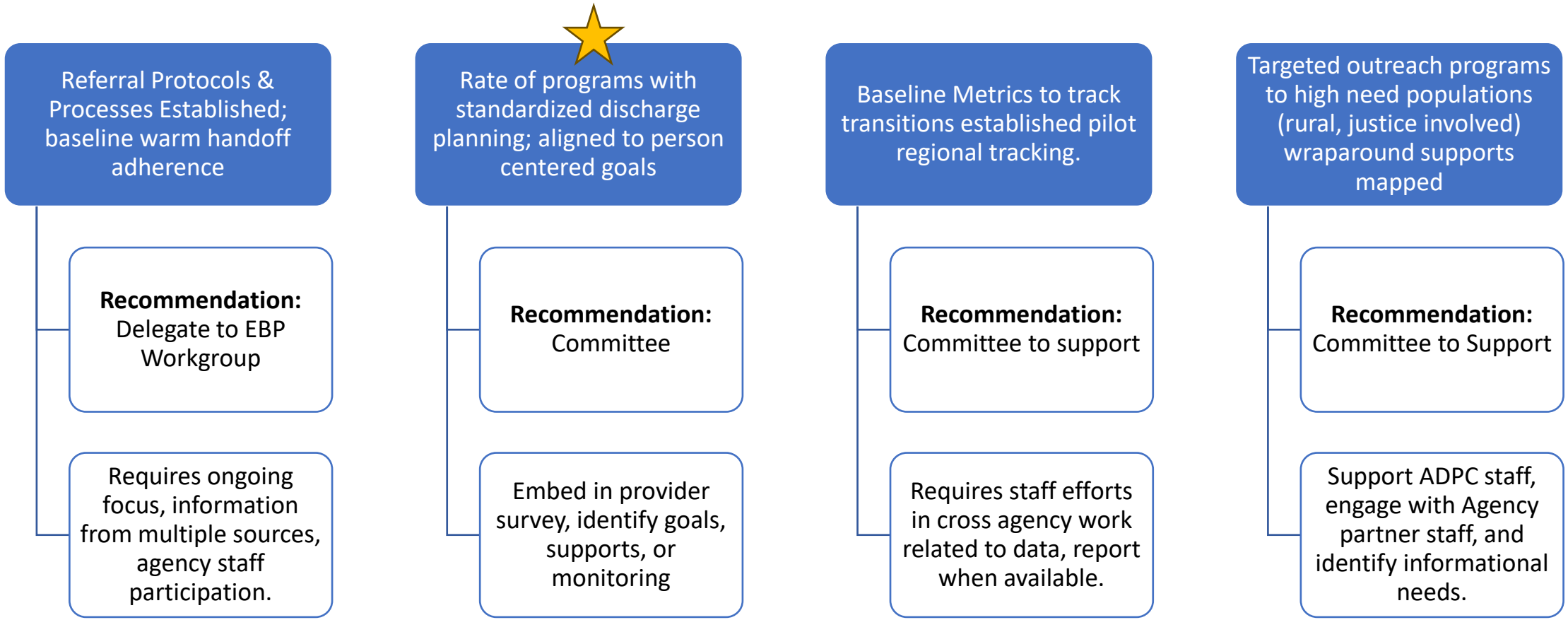
Baseline mapping of withdrawal management sites and hours

- **Recommendation:** Delegate to ADPC Staff and report/ combo with provider survey
- Informational resource requiring internal staff time, agency staff participation.

Identify opportunities to improve referral pathways and efficiency

- **Recommendation:** Cross-cutting focus of Committee/ Workgroups
- Emphasizes “No wrong door” at every process for the plan.

Improved Transitions



Quality & Accountability

Metric set drafted that includes retention, access, outcomes, and patient experience.

- **Recommendation:** Committee Activity
- Utilize provider survey to identify areas of need, baselines, etc… May recommend to agency supported committees when appropriate.

 # providers receiving TA/ funding, providers engaged

- **Recommendation:** EBP Workgroup
- Implementation measurement: Post year 2 (or prior via provider survey)

Inventory of existing audits complete

- **Recommendation:** Committee to support
- ADPC staff in cross agency work, engage in informational discussions, and updates.

Insight reports are shared with providers (ROADS/ APAC) to support QI

- **Recommendation**: Committee to Support
- Requires ROADS implementation and technical assistance. Engage with agency partner staff when available.

Discussion

Next steps:

- Committee to request formation of workgroups
  - If approved, ADPC staff will solicit applications for workgroups (Agency staff, community providers, committee members).
  - Goal: Solicit initial membership and schedule “kick off” meeting within 30 days.
- Committee to identify primary/ ongoing activity
- Next Committee Meeting Focus:
  - Comprehensive Plan Committee Actions
  - Workgroup update
  - Informational Presentation

Year 1

Actions & Activities

Jan-March (Q1) 2026

- Inventory: MSUD Access
- Inventory: ASAM Rulesets
- Inventory: Waitlist Rules
- Inventory: Required Audits
- ***Partner Activity:*** *Specialty Court Screening Process Change (OJD)*

July- Sept (Q3) 2026

- Survey: Waitlist Management Practices (WM)
- Best Practice Committee: Identify EBP TA priorities
- Inventory: Quality & Incentive Metrics
- ***Review Progress***

MONITORING: FUNDING CHANGES, AGENCY PARTNER EFFORTS, EMERGING NEEDS

April- June (Q2) 2026

- Goal: Review CCO Parity Report
- Goal: Review APAC Analysis
- Landscape Assessment: EBP/ TBP Availability
- Form Workgroups Best Practice, MSUD
- Inventory: Discharge Standards
- ***Partner Activity:*** *FCAA Benefit Pilot (OHA)*

Oct- Dec (Q4) 2026

- Best Practice Workgroup Recommendations to Federal TA Centers for 2027 work plan
- *Partner Activity: ROADS Full Implementation Goal (OHA)*
- *Review Measures & Metrics: Measuring Progress (Discharge/ Transitions)*
- ***Partner Activity:*** *SB 822 Implementation Goal (DCBS)*

EBP/ TBP Access

Timely Access

Improved Transitions

Quality & Accountability

ACHIEVES WHAT?

REDUCES

- *Substance Use*
- *Substance Use Disorders*
- *SUD related Deaths*
- *SUD Disparities*

EVIDENCE BASE

SUPPORTS

- *What shows this will be effective?*
- *What supports the implementation and sustainment of these strategies?*
- *Where else has this been done before?*

COMMUNITY INPUT

ENGAGEMENT

- *Is this what the community wants and needs?*
- *Who do we need to engage with?*
- *How do we best engage with them?*

STRATEGY

PLAN

- *How do we go about this?*
- *Are we leveraging existing information, programs, funding, etc... to accomplish this?*
- *Are we suggesting something new entirely?*

MEASURES

DATA

- *Can progress be measured?*
- *Can it be continuously monitored?*
- *How we will evaluate the success of these strategies?*
- *How will we report these outcomes?*

Cross-Cutting Values

Reduces Stigma | Equity | Centers Lived Experience | Holistic Support | Evidence & Culturally Informed | Considers Transitions

2026-2030 ADPC Overarching Priorities:

Opening doors: Achieving access, belonging, and connection across Oregon

Overarching Theme

- Increase **access** across the continuum of care

”Big Three” Outcomes

- Reduce prevalence of substance use disorders
- Reduce substance use-related deaths
- Reduce substance use-related disparities and inequities

Thank you!

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https://www.oregon.gov/adpc

Access to Evidence Based Practices

# of Providers offering MSUD	Preparation Task
# of justice/ court setting coordinating access to MSUD	Preparation Task
Assessment of current levels and gaps of EBP/ TBP utilization	Preparation Task
Issue Brief published on recommended suite of assessment tools	Preparation Task
Culturally specific and place-based services are reliably available	Sustainment Task

Timely Access

Common Access Framework Developed	Preparation Task
Treatment Provider Survey to assessment wait times for entry into care	Preparation Task
Baseline mapping of withdrawal management sites and hours	Preparation Task
Identify opportunities to improve referral pathways and efficiency	Preparation Task

Improved Transitions

Referral Protocols & Processes Established; baseline warm handoff adherence	Preparation Task
Rate of programs with standardized discharge planning; aligned to person centered goals	Preparation Task
Baseline Metrics to track transitions established pilot regional tracking.	Preparation Task
Targeted outreach programs to high need populations (rural, justice involved) wraparound supports mapped	Preparation Task

Quality & Accountability

Metric set drafted that includes retention, access, outcomes, and patient experience.	Preparation Task
# providers receiving TA/ funding, providers engaged	Implementation Task
Inventory of existing audits complete	Preparation Task
Insight reports are shared with providers (ROADS/ APAC) to support QI	Implementation Task