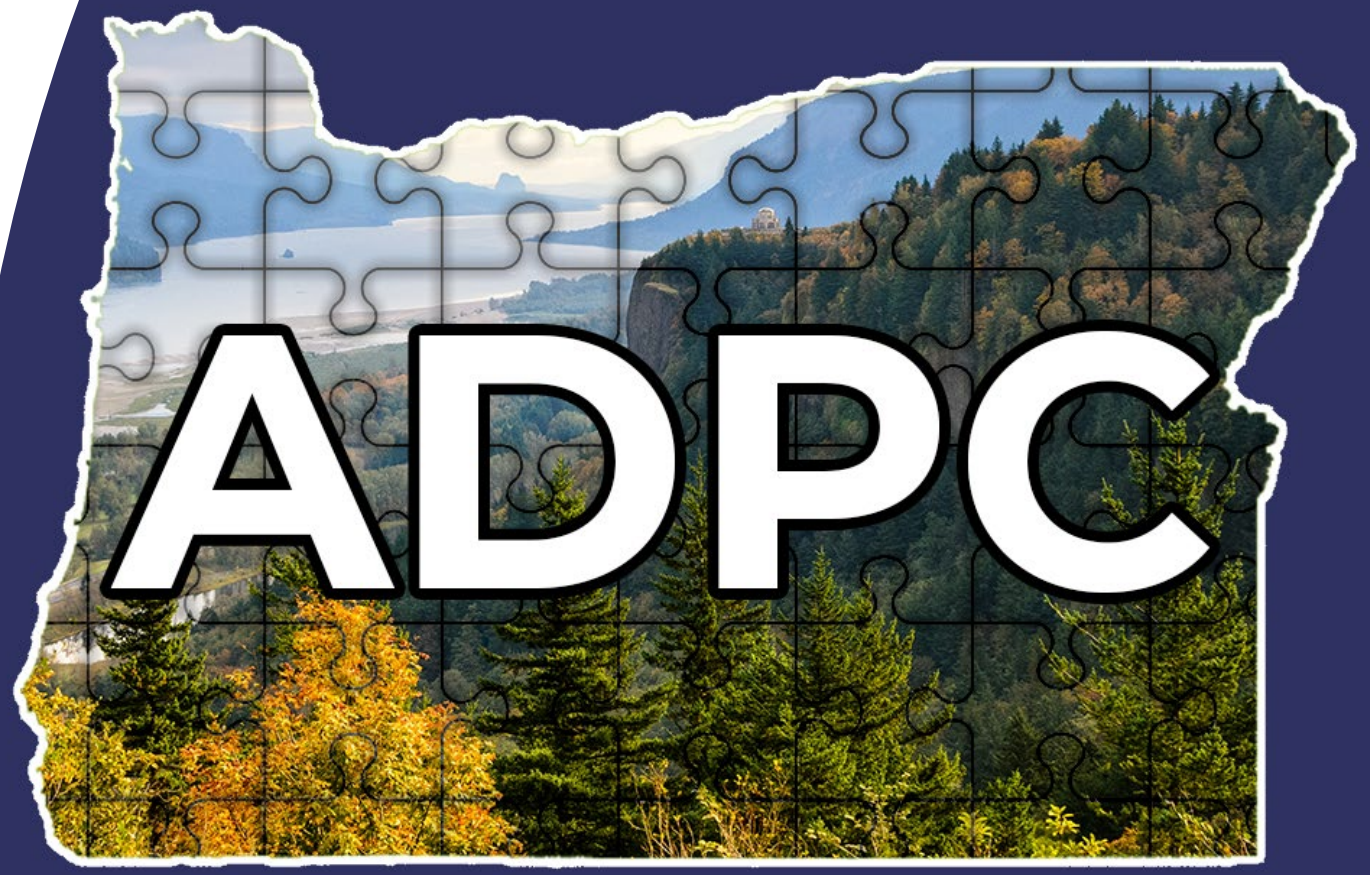
Oregon Alcohol and Drug Policy Commission

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



Treatment Committee

August 2026

Today's Agenda

- Welcome & Roll Call
- Director's updates
- Agency Partner Presentation: ASAM 4 Implementation Team
- Comprehensive Plan: Discharge & Transition Standards
- Public Comment

ASAM 4 Transition Project

ASAM - American Society of Addiction Medicine

Amanda Braxton, Project Manager
OHA Medicaid Division, Operations Analyst

8/12/26

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ASAM 4 Transition Project

American Society of Addiction Medicine

Oregon Health Authority (OHA) began planning for the transition to *The ASAM Criteria, Fourth Edition* in November 2026

This work includes updating Oregon Administrative Rules (OARs), evaluating payment models, and developing policy guidance to support implementation.

Substance Use Disorder (SUD) treatment providers are expected to implement *The ASAM Criteria, Fourth Edition* by January 1, 2028.

You can engage with the ASAM 4 Transition Project through the following options:

1) Submit feedback via the ASAM 4 Transition Project Smartsheet Form
2) Receive email updates; please complete the Partner Contact Information Form

Rule Policy

The Behavioral Health Division will:

Conduct a full analysis of existing rules to identify:

- What is essential, and
- What is informational/administrative burden

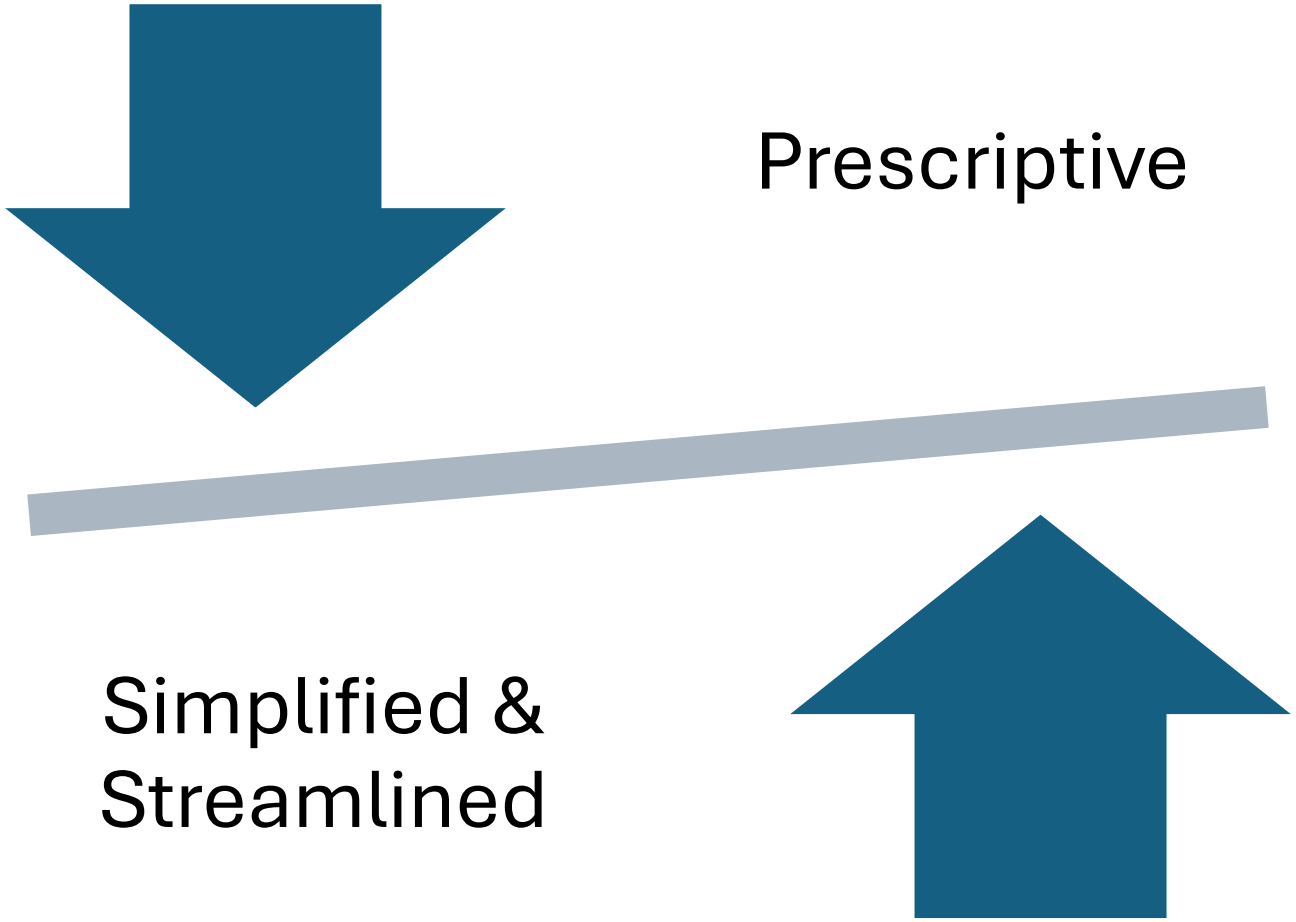
While, identifying non-essential rule items that are quality expectations and document them for future quality or technical assistance work.

Minimum Waiver Requirements for Chapter 309 Divisions 18 and 19

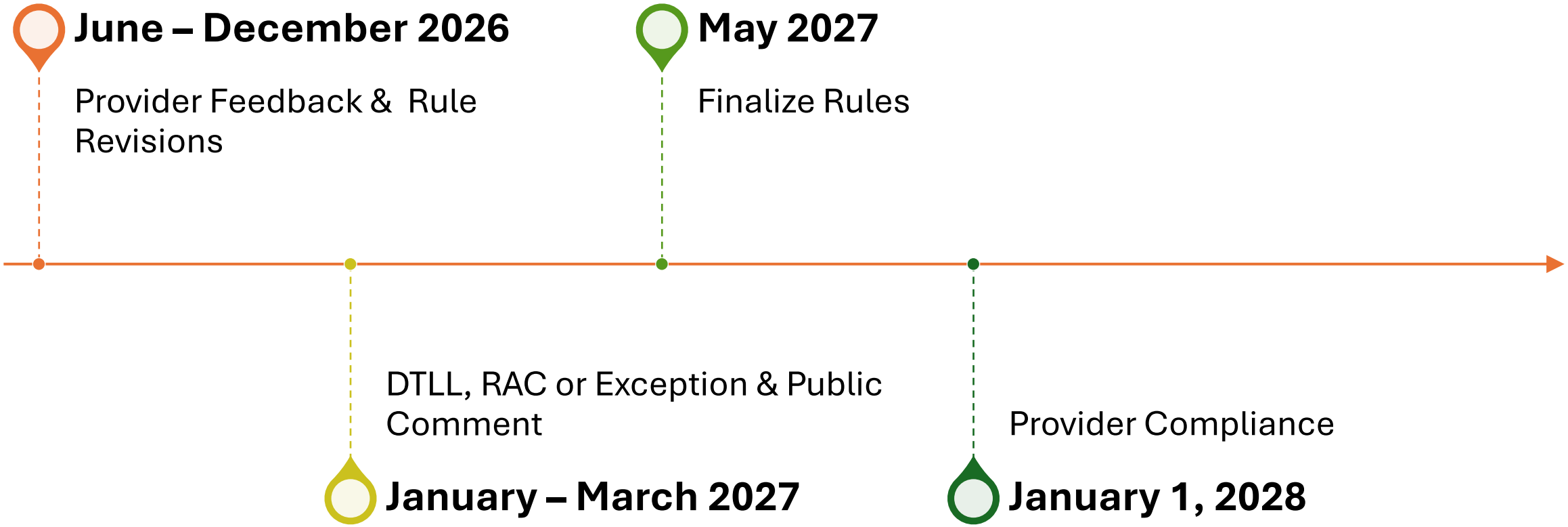
Require providers to demonstrate compliance with the following standards through documentation and review.

1. Require assessments to include all ASAM patient placement dimensions (p. 66)
2. Require placement into LOCs based on ASAM criteria and assessment results (p. 69-70)
3. Specify services required at each ASAM LOCs (p. 69 & 73)
4. Define provider qualifications and competencies for each LOCs (p. 71)
5. Define clinical care standards, including comprehensive services, staffing ratios, and service hours (p. 71)
6. Specify certification and licensure standards tied to each ASAM LOCs (p. 73)
7. Require residential programs to provide or coordinate access to MAT (p. 74)
8. Define requirements for continued stay, step-up/step-down, and discharge based on ASAM criteria (p. 69-70)
9. Require care coordination and transition planning across LOCs (p. 69-70)

Balanced OAR Guidance that promotes quality care & is flexible



Proposed Timeline – Divisions 18 & 19 Rules



Provider Feedback for ASAM Rules

Dedicate time and resources needed to establish a variety of pathways to receive feedback, including:

1. In-person and Teams/Remote regional meetings
2. Individual provider meetings, on request
3. Feedback form
4. Website with links to feedback forms and survey

Goal

- Process feedback from all sources and provide report to leadership by December 31, 2026

Next Steps – August/September 2026

Finalize provider feedback questions with the project team

Finalize provider memo sharing how can engage.

Questions or Comments?

Amanda Braxton, Project Manager
OHA Medicaid Division, Operations Analyst
amanda.j.braxton@oha.oregon.gov

Improved Transitions

Referral Protocols & Processes Established; baseline warm handoff adherence	Rate of programs with standardized discharge planning; aligned to person centered goals	Baseline Metrics to track transitions established pilot regional tracking.	Targeted outreach programs to high need populations (rural, justice involved) wraparound supports mapped
Recommendation: Delegate to EBP Workgroup	**Recommendation:** Committee	**Recommendation:** Committee to support	**Recommendation:** Committee to Support
Requires ongoing focus, information from multiple sources, agency staff participation.	Embed in provider survey, identify goals, supports, or monitoring	Requires staff efforts in cross agency work related to data, report when available.	Support ADPC staff, engage with Agency partner staff, and identify informational needs.

Things to think about…

While we review:

- What is missing?
- What isn't captured with the correct intent?
- How is this different than the current standards?
- What prevents this from happening now?

Themes of the discussion

Person Centered, Needs Driven

- Planning begins at admission
- Continuous identification of needs, strengths, preferences, and recovery goals
- Participants are active decision-makers in their own care.
- Includes specific recovery management and relapse prevention tools/ supports that are relevant to client goals.

Themes of the discussion

Planned, Structured, and Standardized

- Discharge and transition are intentional processes, not administrative events
- Standardization helps ensure equity, reduces arbitrary programmatic rules, and preserves the balance of clinical flexibility and rigid regulation.
- Should avoid “check box” style compliance while maintaining clear minimum requirements

Themes of the discussion

Clear Distinction between Discharge and Transition

- Transition: Movement within the continuum (e.g. residential to outpatient)
- Discharge: End or termination of services at that level of care
- Utilization Management derived transitions*: Resulting from a decision related to payor that may differ from clinical recommendations, which require specific planning to address patient needs and identify adequate and available supports.

*Desire to track separately to understand impact.

Themes of the discussion

Integrated Supports and Continuity

- Plans reflect adequate, available, integrated, and sufficient supports as described by ASAM.
- Transition/ discharge plans are extensions of the treatment/ care plan
- Includes cross dimensional focus as is relevant, specifically related to dimensional drivers like medical needs, behavioral health needs, social determinants, peer and recovery supports, harm reduction strategies, and crisis strategies.

Themes of the discussion

Harm Reduction and MOUD Considerations

- Ensure continuity of MOUD, especially in justice settings/ scenarios
- Offer resources to reduce risk of health and other safety concerns such as through naloxone distribution, training, supply referrals, safer-use education, etc…

Themes of the discussion

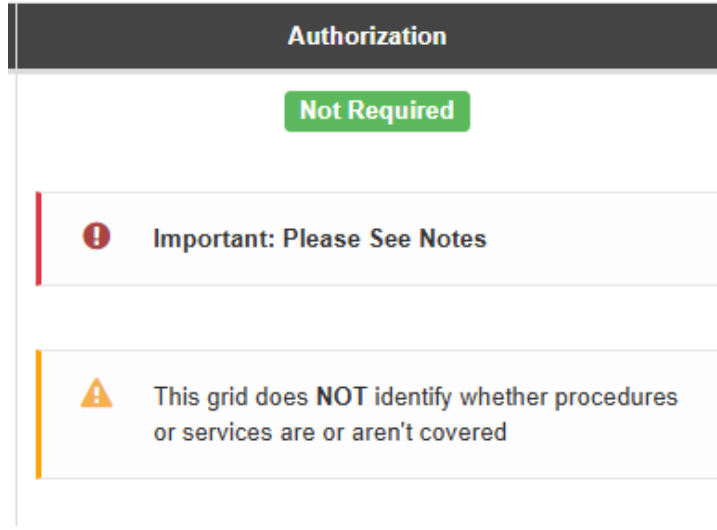
Recovery-Oriented Systems of Care Alignment

- Multidimensional approach and multidisciplinary care is a likely standard need/ expectation (not the exception)
- Serves as a roadmap for coordination across providers and systems

Themes of the discussion

Workforce and Program Support

- Training for risk-oriented conversations
- Engagement and relational skill strengthening for counselors
- Reduce program level “denial rules” to care admission (“keep calling every morning”)
- Systems-level alignment on CCO authorization challenges is a must
  (difference in authorization practices create challenges for planning discharge/ Transitions)



Inpatient Substance Use Disorder Residential and Detox services Detox services are 24-hour medically monitored services intended to minimize the negative effect of withdrawal symptoms and provide supportive treatment as substances are exiting a person's system. SUD residential is a program with a 24-hour structure, supportive recovery environment for the treatment of substance use disorders. Example: Alcohol use treatment No limit if medically necessary	Preapproval needed	All members

Themes of the discussion

Quality, Accountability, and Audit Readiness

- Ideas to tie payment to quality of care or quality of transitions
- Documentation reviews and auditor processes separate from CCO review/ utilization
- Evaluate patient awareness of discharge/ transitions decisions, especially regarding programmatic discharges.

Themes of the discussion

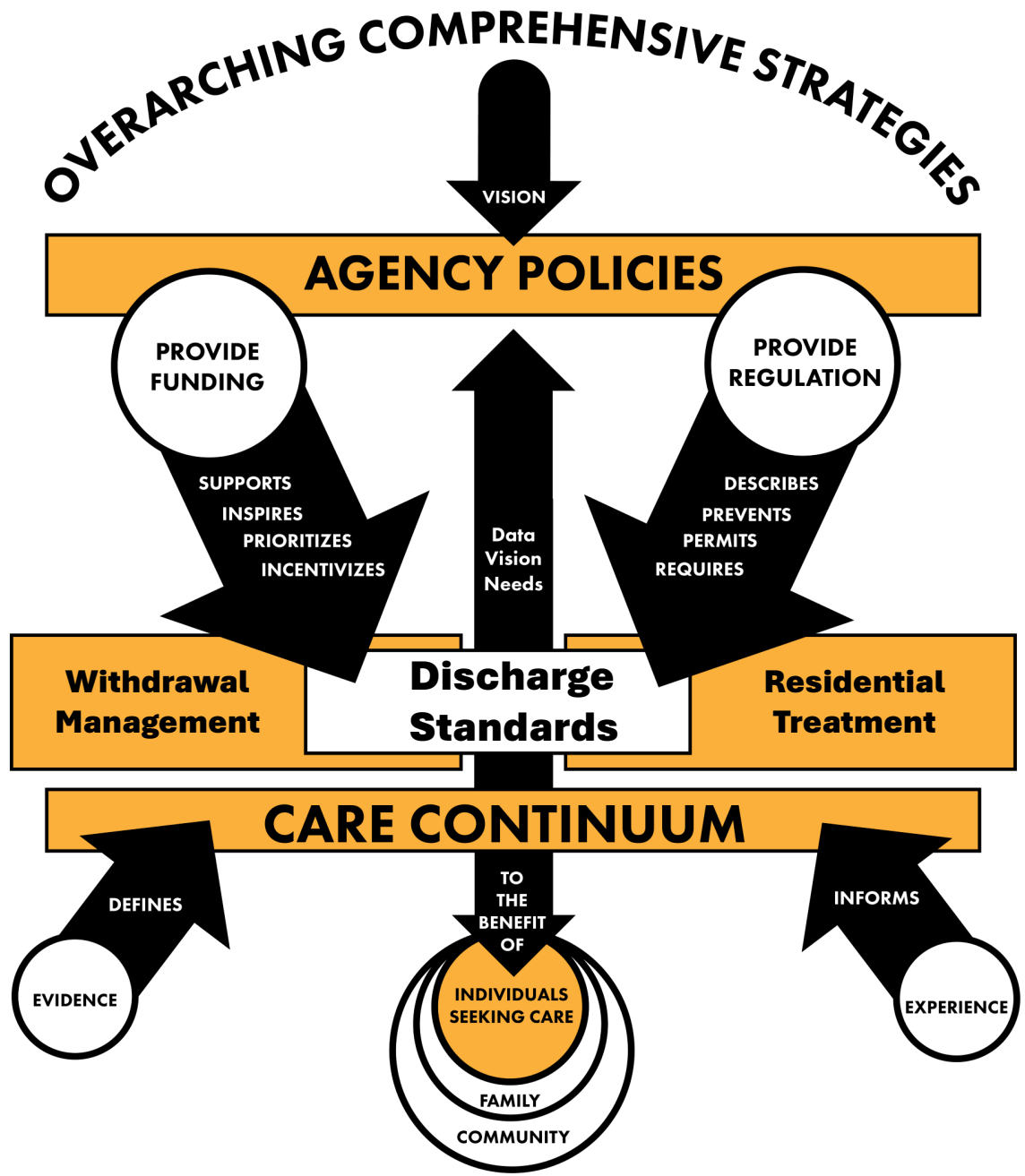
Special Populations:

- Youth
- People experiencing incarceration or other justice involvement
- People receiving care in less resource rich areas

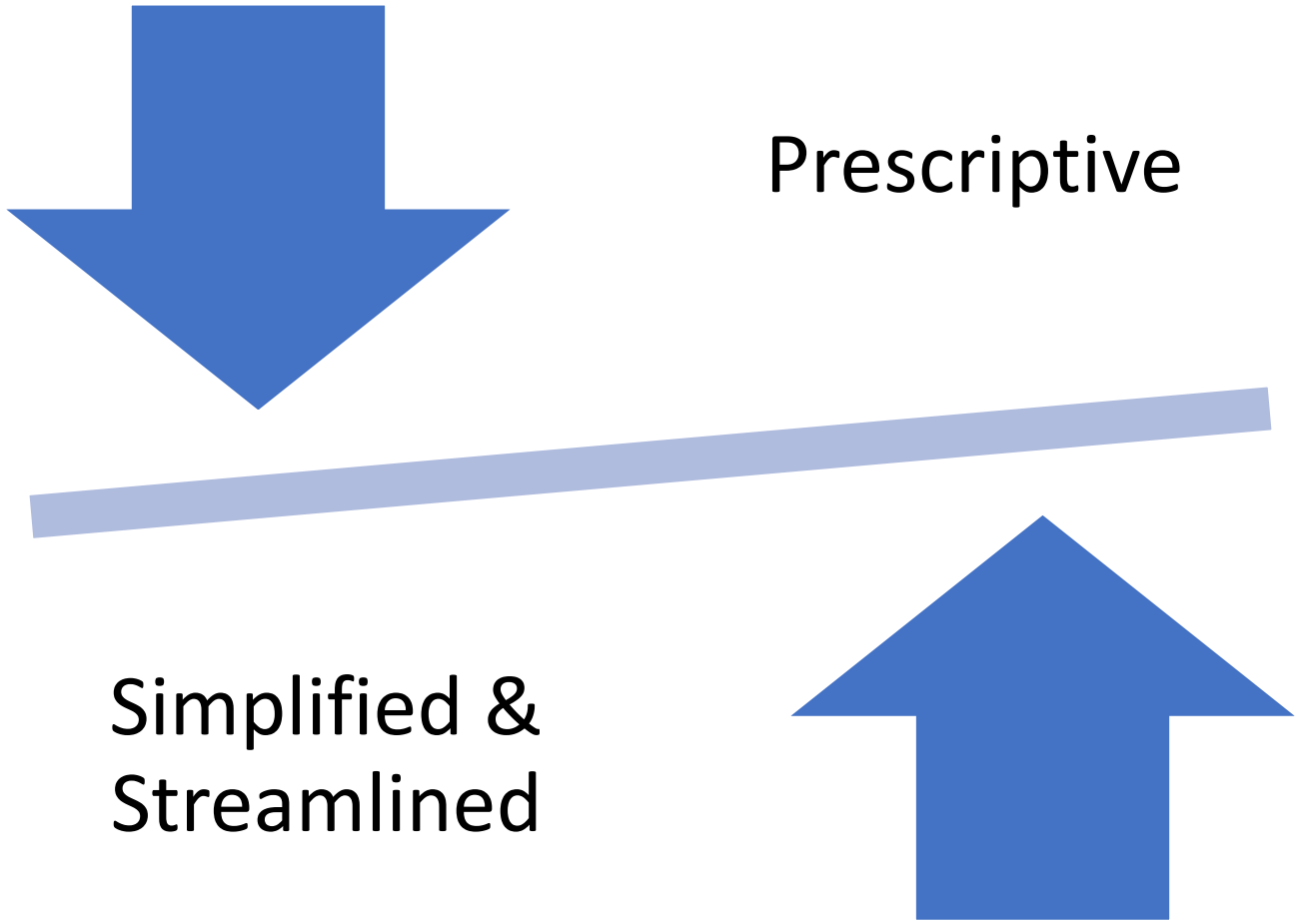
Draft definition

Discharge and transition planning in the substance use treatment continuum is a **person-centered, planned, and integrated process** which begins at admission. It ensures continuity of care by aligning services and supports with an individual's unique needs, strengths, risks, and goals. Effective plans are standardized enough to ensure equity and quality, yet flexible enough to allow clinical judgment and patient voice. They center **needs identification, risk reduction, medical and behavioral health continuity, recovery supports, and cross-system coordination—particularly for justice-involved populations**. These plans acknowledge the role of substance use treatment as just one support within a broader recovery-oriented system of care that is often necessary to support person centered outcomes tied to meaningful transitions and addressed health needs that are necessary to achieve and maintain stability.

How?


OVERARCHING COMPREHENSIVE STRATEGIES
VISION
AGENCY POLICIES
PROVIDE FUNDING
SUPPORTS
INSPIRES
PRIORITIZES
INCENTIVIZES
Data
Vision
Needs
PROVIDE REGULATION
DESCRIBES
PREVENTS
PERMITS
REQUIRES
Withdrawal Management
Discharge Standards
Residential Treatment
CARE CONTINUUM
DEFINES
EVIDENCE
TO THE BENEFIT OF
INDIVIDUALS SEEKING CARE
FAMILY
COMMUNITY
INFORMS
EXPERIENCE

Balanced Rule Guidance: Reduces Risk & is Flexible



“Develop and adopt standard discharge and transition planning practices aligned with patient-defined goals.”

Starting Point	Near Term	Mid Term	Long Term	Ultimate Goal
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

“Expand use of cross-system care coordination protocols to increase seamless transitions and consistent warm handoffs.”

Starting Point	Near Term	Mid Term	Long Term	Ultimate Goal
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

Discharge as described by ASAM:

References four definitions:

- Adequate
  - Referring to services and supports that effectively promote stability and SUD treatment participation.
- Available
  - Referring to a level of care that can be accessed during care transitions, with no gap in services such as a wait list.
- Integrated
  - Referring to care, service, and/or interventions that are providing within the program or formally through affiliated providers.
- Sufficient Support
  - Referring to more natural or communal supports in the home environment or recovery residence or professional support in a living facility that enables an individual to pursue treatment and recovery safely and effectively.

Discharge as described by ASAM:

Provides a framework for clinical decision making:

1) Continued service at the Current Level
2) Transition to a more intensive level of care
3) Transition to a less intensive level of care

The ASAM Criteria also provides level of care specific considerations for specific levels of care, ranging from Level 4 to Level 1.5* to assist in this decision making. With one exception being an allowance for Level 1.7, to ensure medications are not provided contingent upon participation in behavioral health services.

*Level 1 is now “long-term Remission monitoring,” which supports quarterly “check up” appointments to support recovery goals and address remission.

SUD 1115 Waiver Requirements:

Requirement for there to be standards and demonstrated compliance:

- Define requirements for continued stay, step-up/step-down, and discharge based on ASAM criteria
- Require care coordination and transition planning across LOCs

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

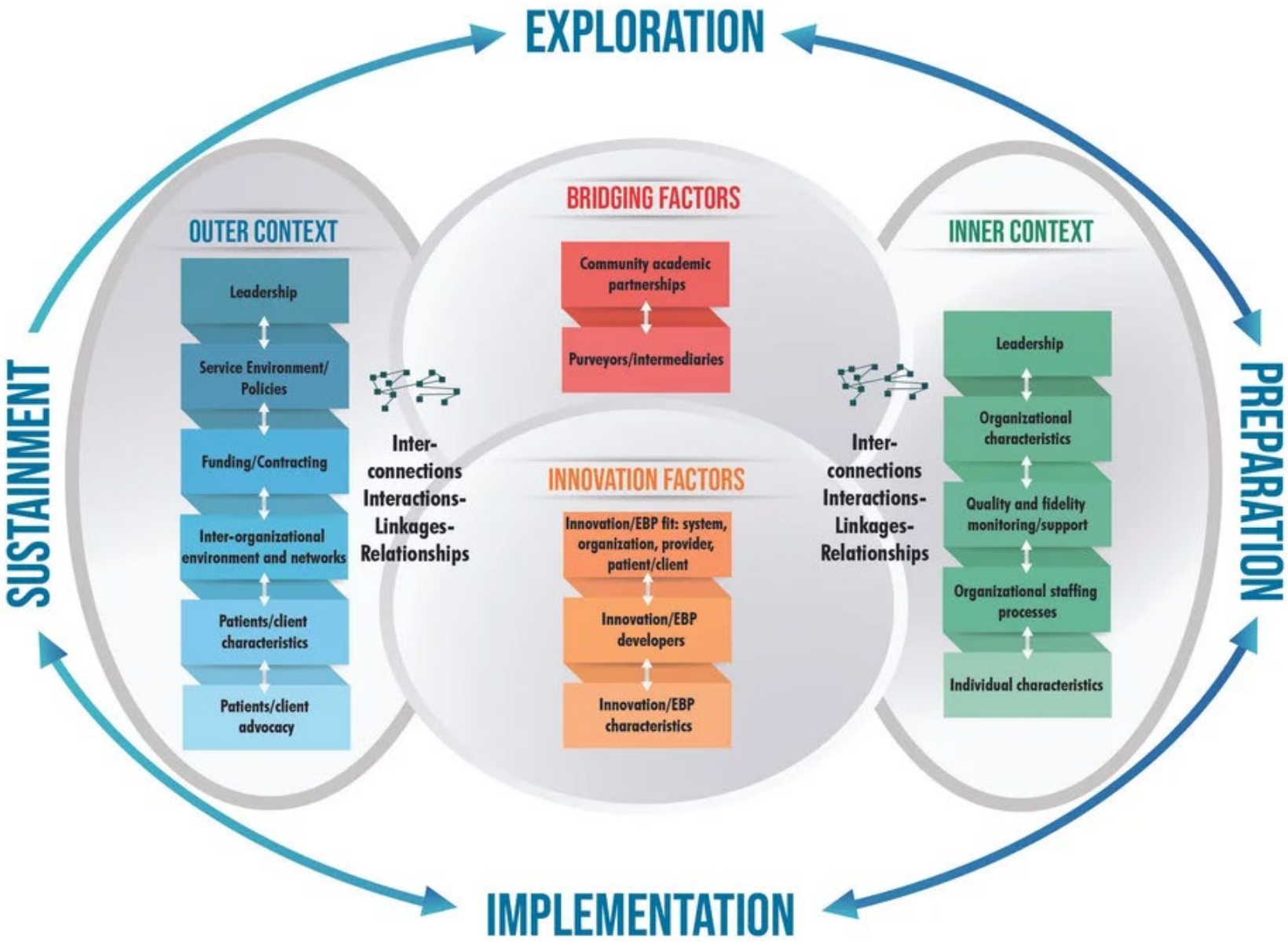
April- June (Q2) 2026

- 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



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.

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!

Mitch.a.doig@oha.Oregon.gov

https://www.oregon.gov/adpc