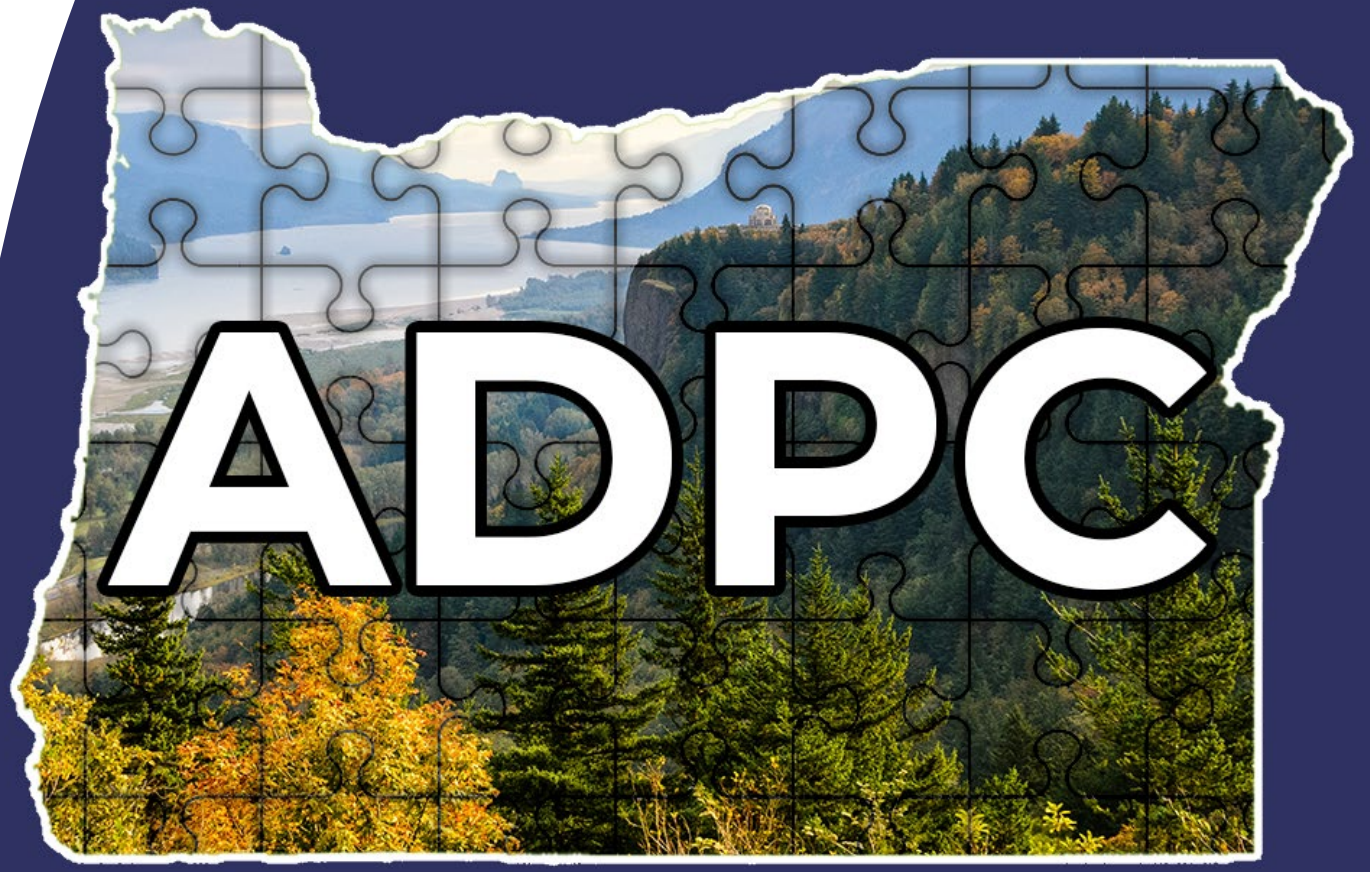
Oregon Alcohol and Drug Policy Commission

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

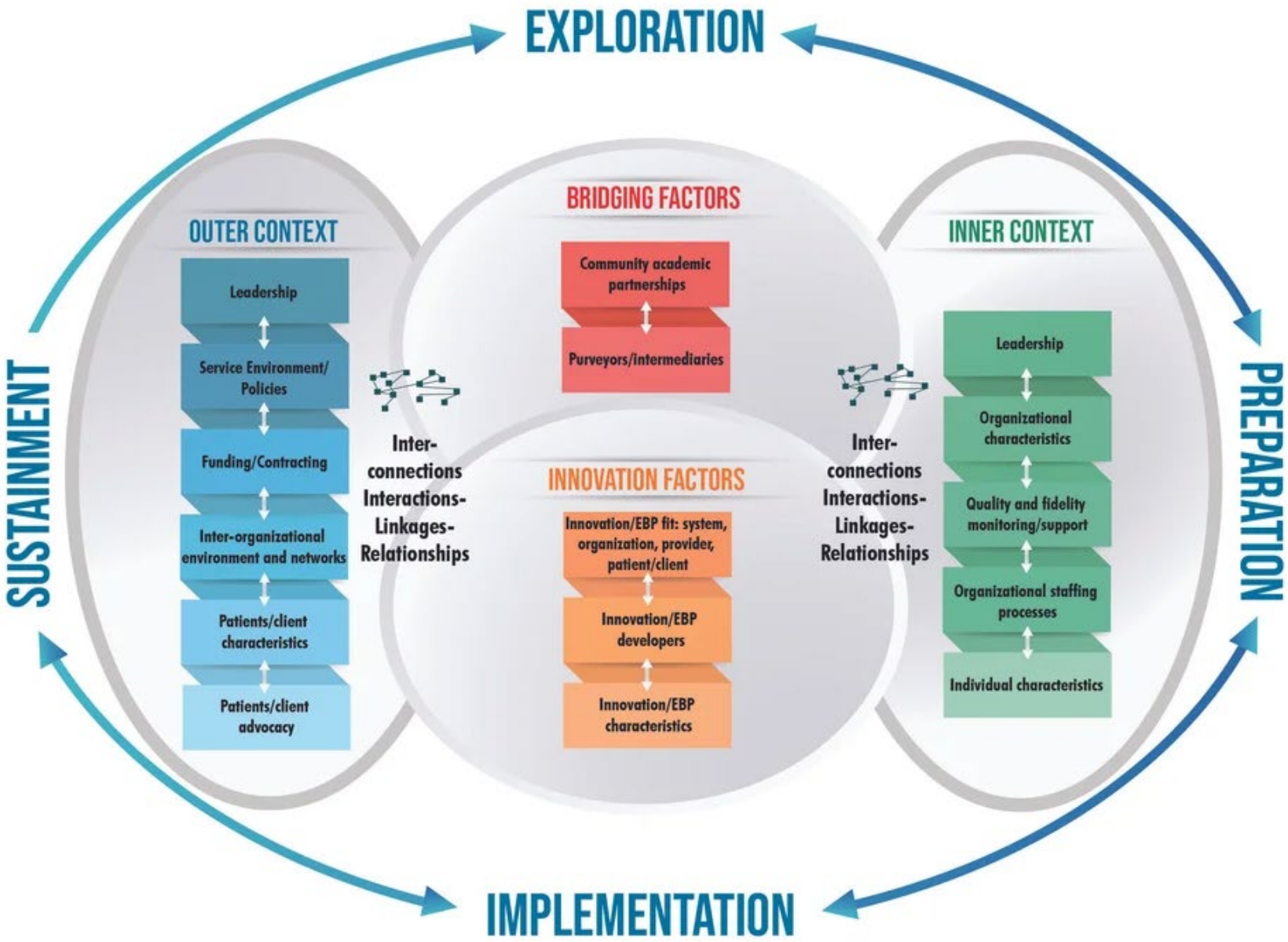
Treatment Committee

April 2026



Today's Agenda

- Welcome & Roll Call
- Director's updates
- Comprehensive Plan: Discharge & Transition Standards
- Public Comment



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.

Improved Transitions

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

Discharge as described in Rule:

Residential:

"Transitioning" means a 90-day period which begins when an individual is discharged from an inpatient or residential stay back to a community setting.

Outpatient:

(5) Decisions to transfer individuals must be documented including:

(a) The date of the transfer;

(b) The reason for the transfer;

(c) For substance use disorder and co-occurring services, ASAM level of care recommendation and overall determination of the severity of risk the individual is experiencing at the time of transfer;

(d) Referrals to follow up services and other behavioral health providers; and

(e) Outreach efforts made as applicable and as defined in these rules.

Adolescent Outpatient:

(B) Adolescent programs shall have program staff knowledgeable about adolescent development and experienced in engaging and working with adolescents.

(c) Arrange transfer of individuals to all other ASAM Levels of Care as indicated; and

Individual Rights:

Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

Discharge as described in Rule:

309-018-0155
Transfer and Continuity of Care

(1) Providers shall maintain direct affiliation with or close coordination for referral to other levels of care and other types of services and supports to coordinate biomedical, psychological, pharmacotherapy, laboratory, community engagement, educational, vocational and other such services and supports that are not offered by the provider.

(2) Prior to transfer, providers shall:

(a) When applicable, coordinate and provide appropriate referrals for medical care and medication management. The transferring provider shall assist the individual to identify the medical provider who provides continuing care and to arrange an initial appointment with that provider;

(b) Document a transfer summary of treatment services; and

(c) Report all instances of transfers on the mandated state data system.

(3) A transfer summary of treatment services shall include:

(a) The date of transfer;

(b) The reason for the transfer;

(c) When transfer is to another provider, identify the provider where services are to be transferred, including contact information and date of admission or description of steps for the individual to access services;

(d) For substance use disorder treatment services, a summary of the current ASAM data for all dimensions, risk assessment, the ASAM assessed Level of Care established for the purposes of transfer of services, and any other recommendation(s) for the next assessed ASAM Level of Care, including other community services; and

(e) A summary statement describing the effectiveness of services to assist the individual and, when applicable, their family in achieving the objectives contained in the service plan.

Discharge as described in Rule:

309-018-0155

Transfer and Continuity of Care (cont)

(4) A transfer summary of support services shall be made available in writing to the individual as requested and include:

(a) Where appropriate, a plan for personal wellness and resilience, including relapse prevention;

(b) Identification of resources to assist the individual and family, if applicable, in accessing recovery and resiliency services and supports;

(c) Referrals to follow up services and other behavioral health providers; and

(d) When services are transferred due to the absence of the individual, the provider shall document outreach efforts made to re-engage the individual or document the reason why such efforts were not made.

(5) To the extent permitted or required by applicable confidentiality laws, when the transfer summary of treatment services is sent to another provider or level of care, it shall be sent in advance of the individual's entry into services at another provider or the next level of care. To the extent permitted by law, all other documentation contained in the Service Record that is requested by the receiving provider shall be furnished, within 14 days of receipt of a written request for the documentation.

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.

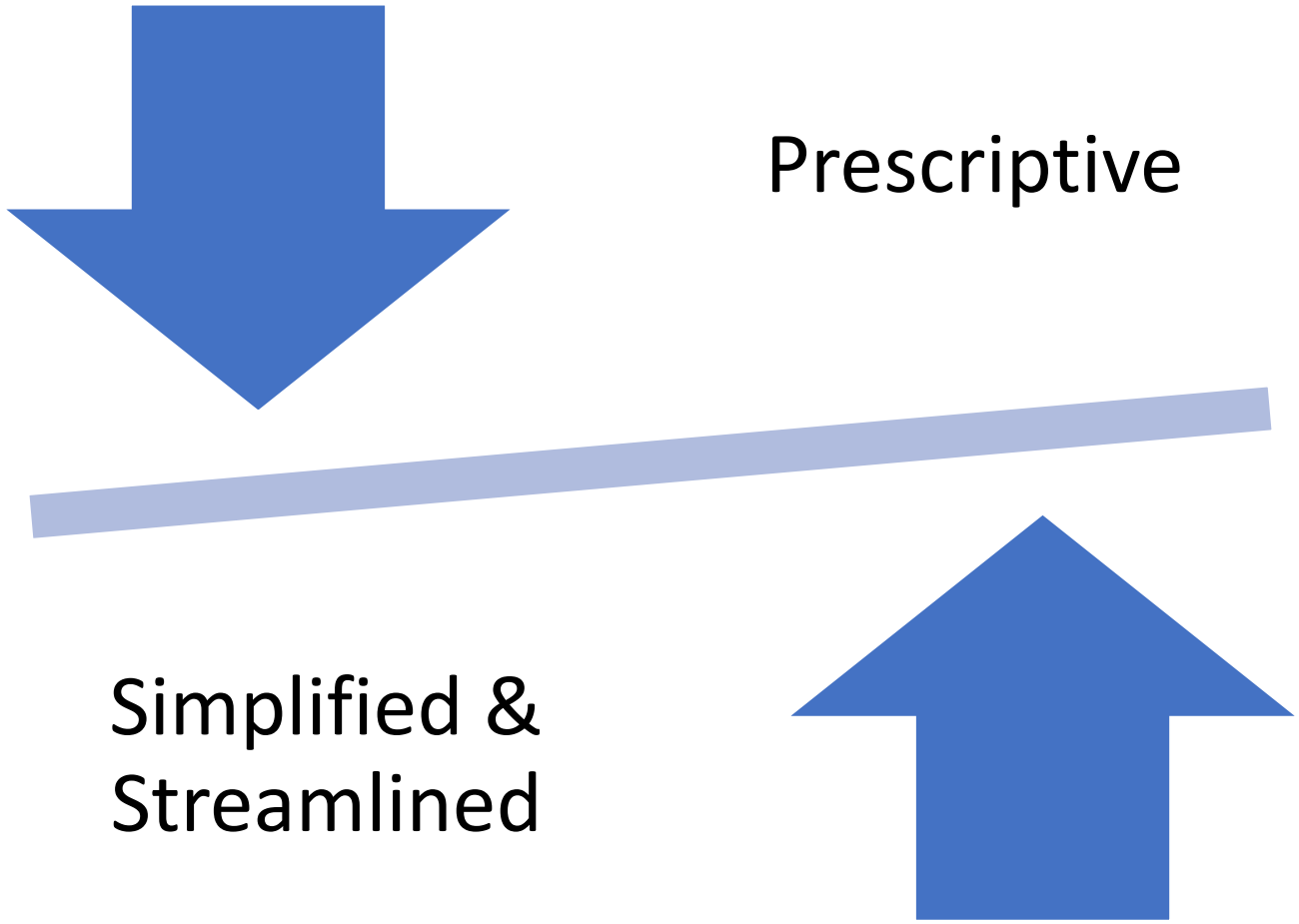
*Level 1 is now “long-term Remission monitoring,” which supports quarterly “check up” appointments to support recovery goals and address remission.

SUD 1115 Waiver Requirements:

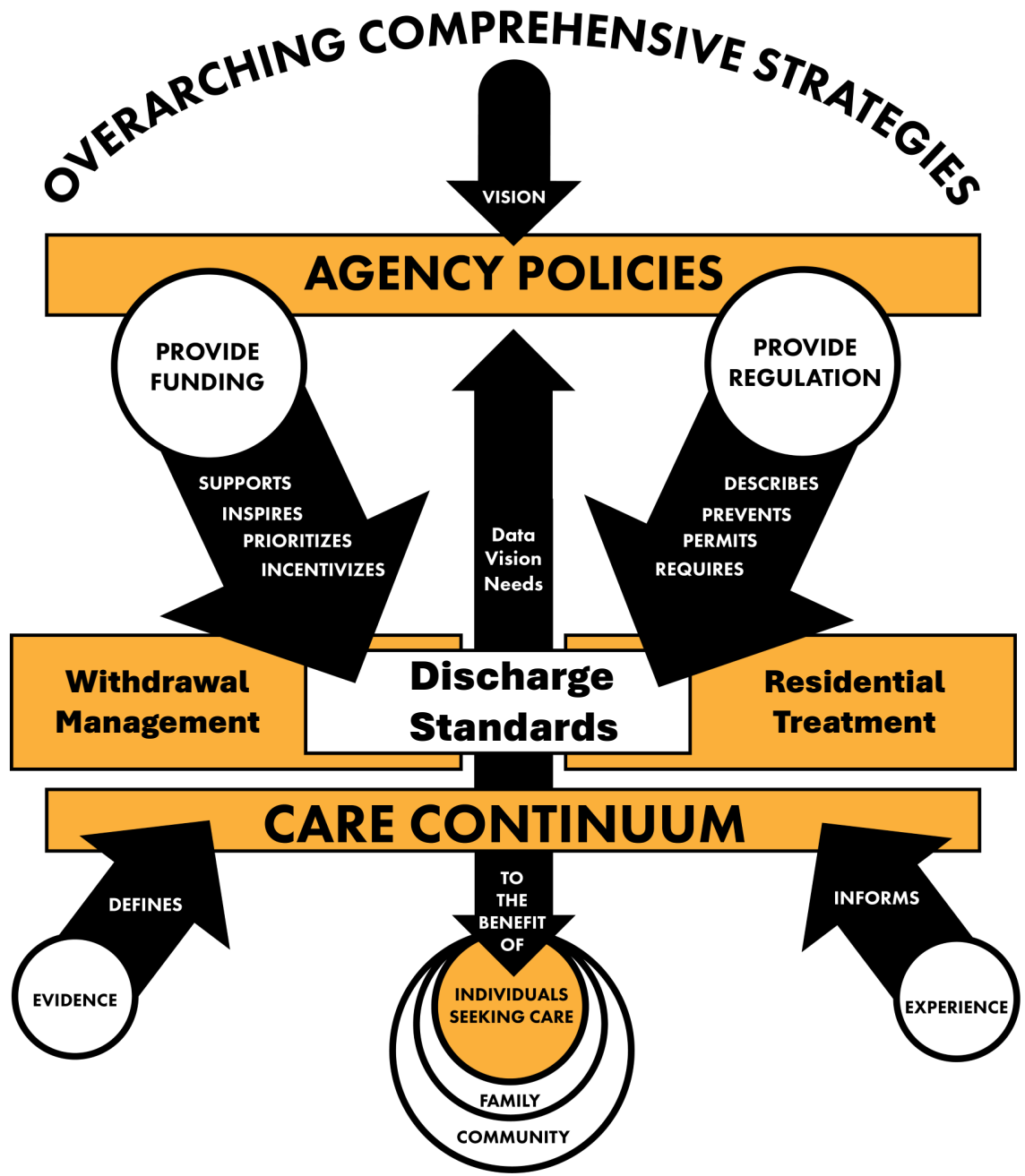
Requirement for there to be standards and demonstrated compliance:

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

Balanced Rule Guidance: Reduces Risk & is Flexible



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

“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

Discussion

What does a “standard discharge planning” process mean?

What are the levers we need to impact this, in alignment with the plan?

Is deferring to ASAM sufficient? Why or why not?

What will the survey help us understand?

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

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