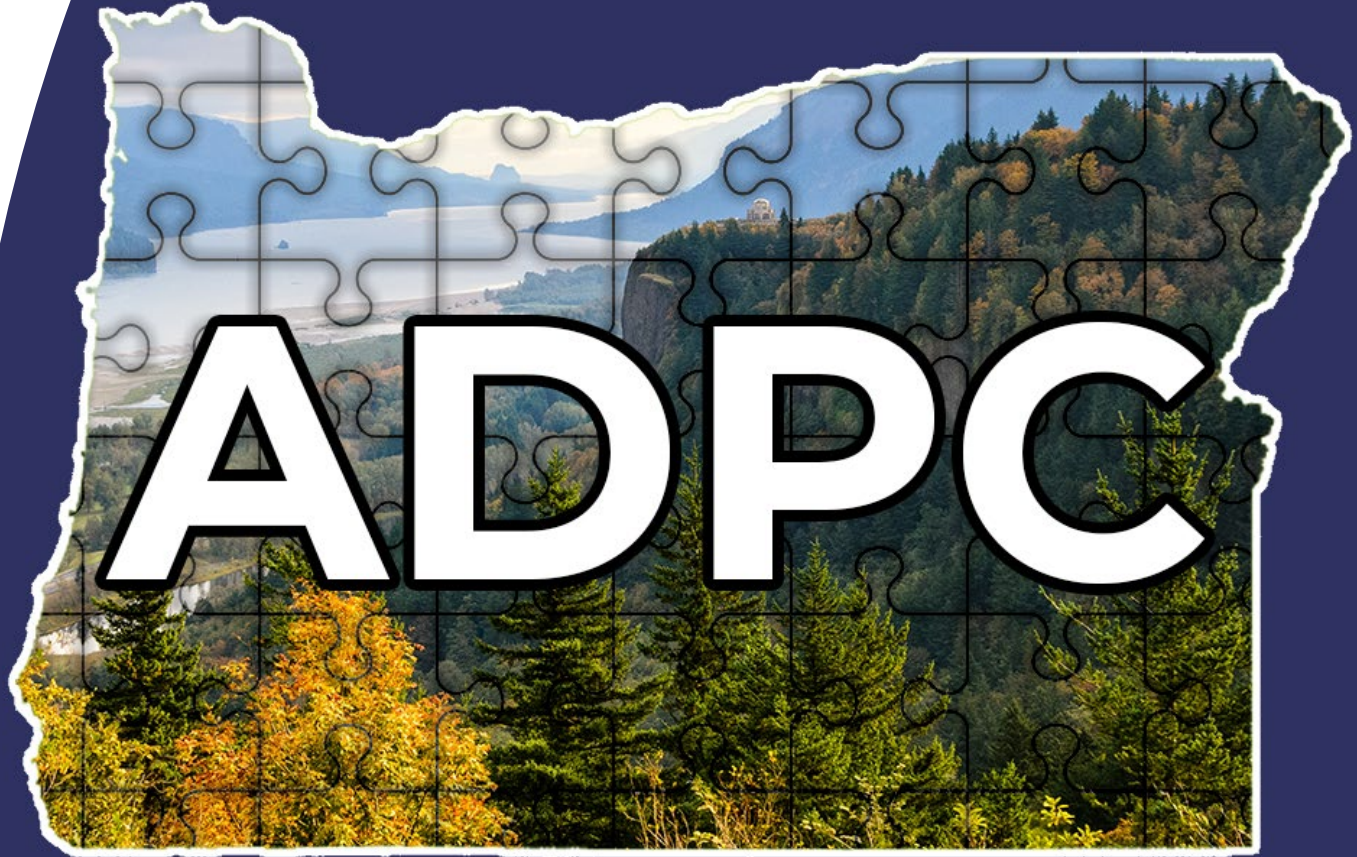


Oregon Alcohol and Drug Policy Commission

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

Treatment Committee

September 2026



Today's Agenda

Welcome & Roll Call

Director's updates

Comprehensive Plan: Discharge/
Transition Summary

Public Comment

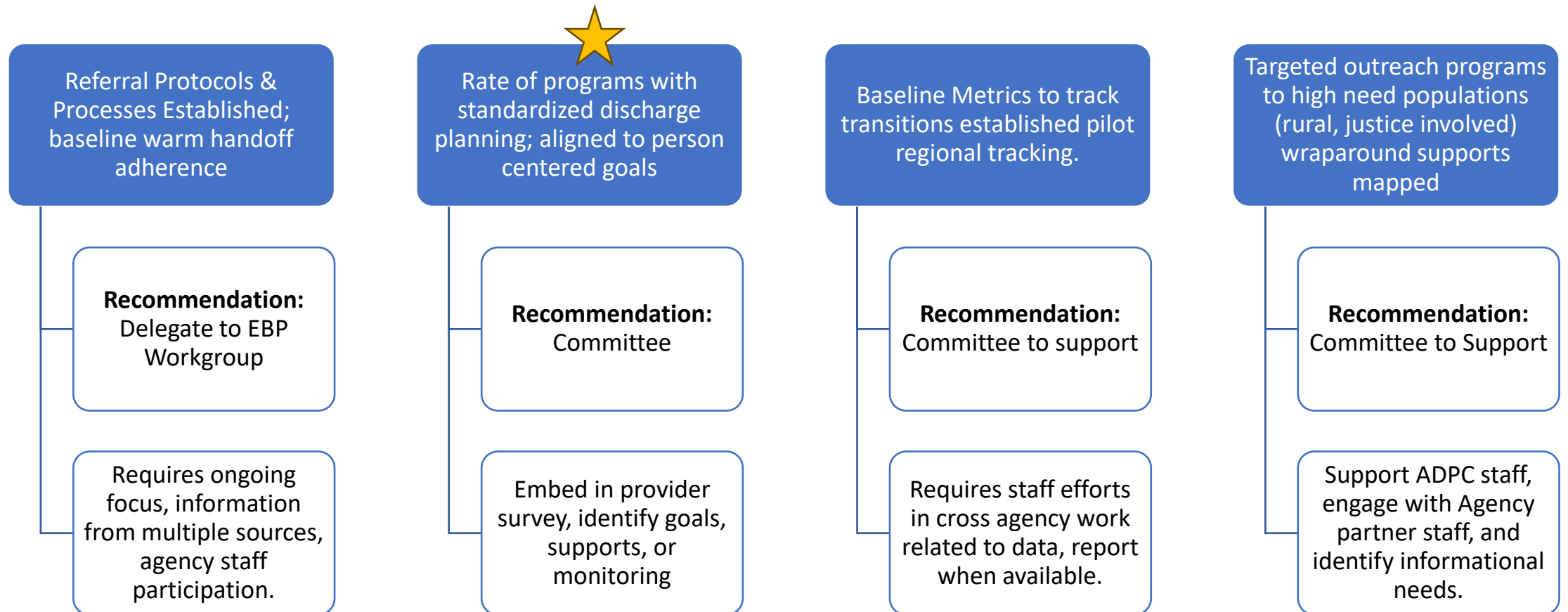
Upcoming Meetings

November Meeting lands on a holiday. November meeting is cancelled.

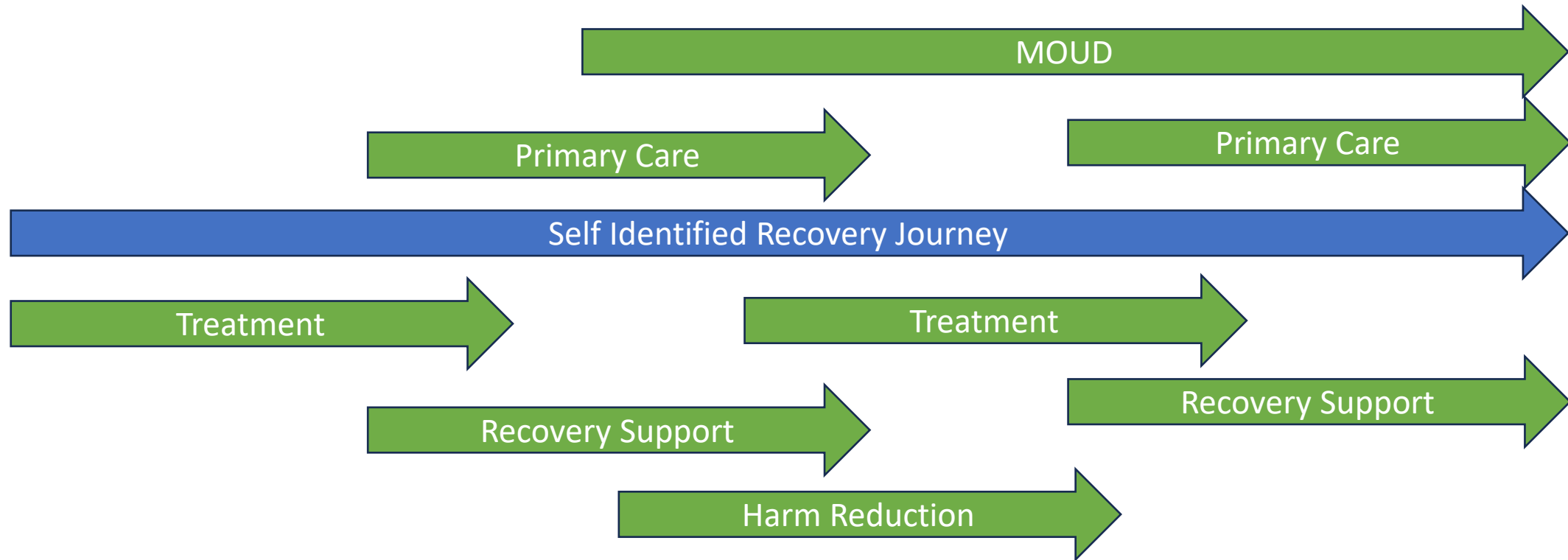
If you do still want an hour with the ADPC in November, consider attending the commission meeting on November 9th!

December Meeting-
Financial Analysis, APAC Data, and more

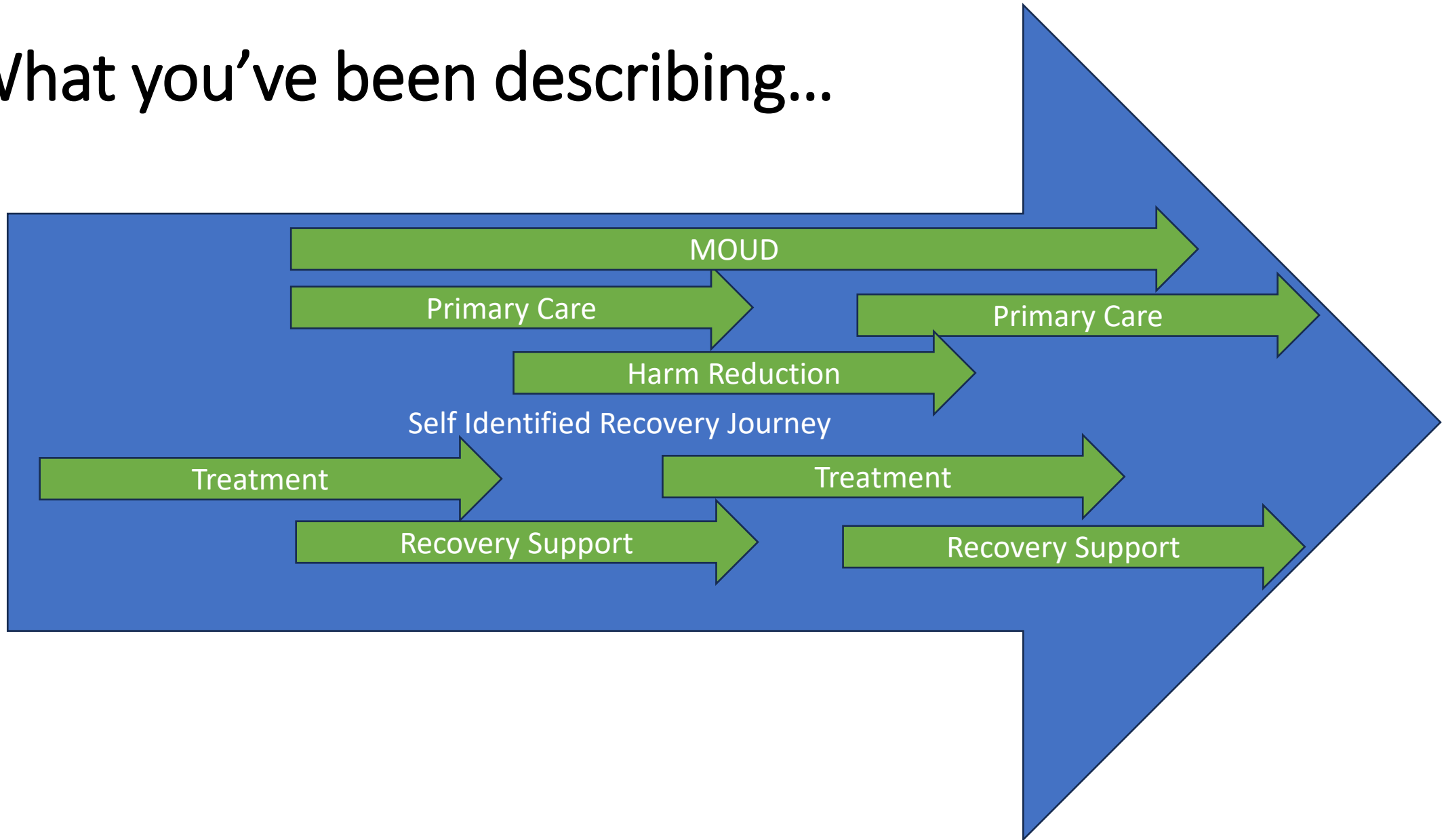
Improved Transitions



What care might be like for some...

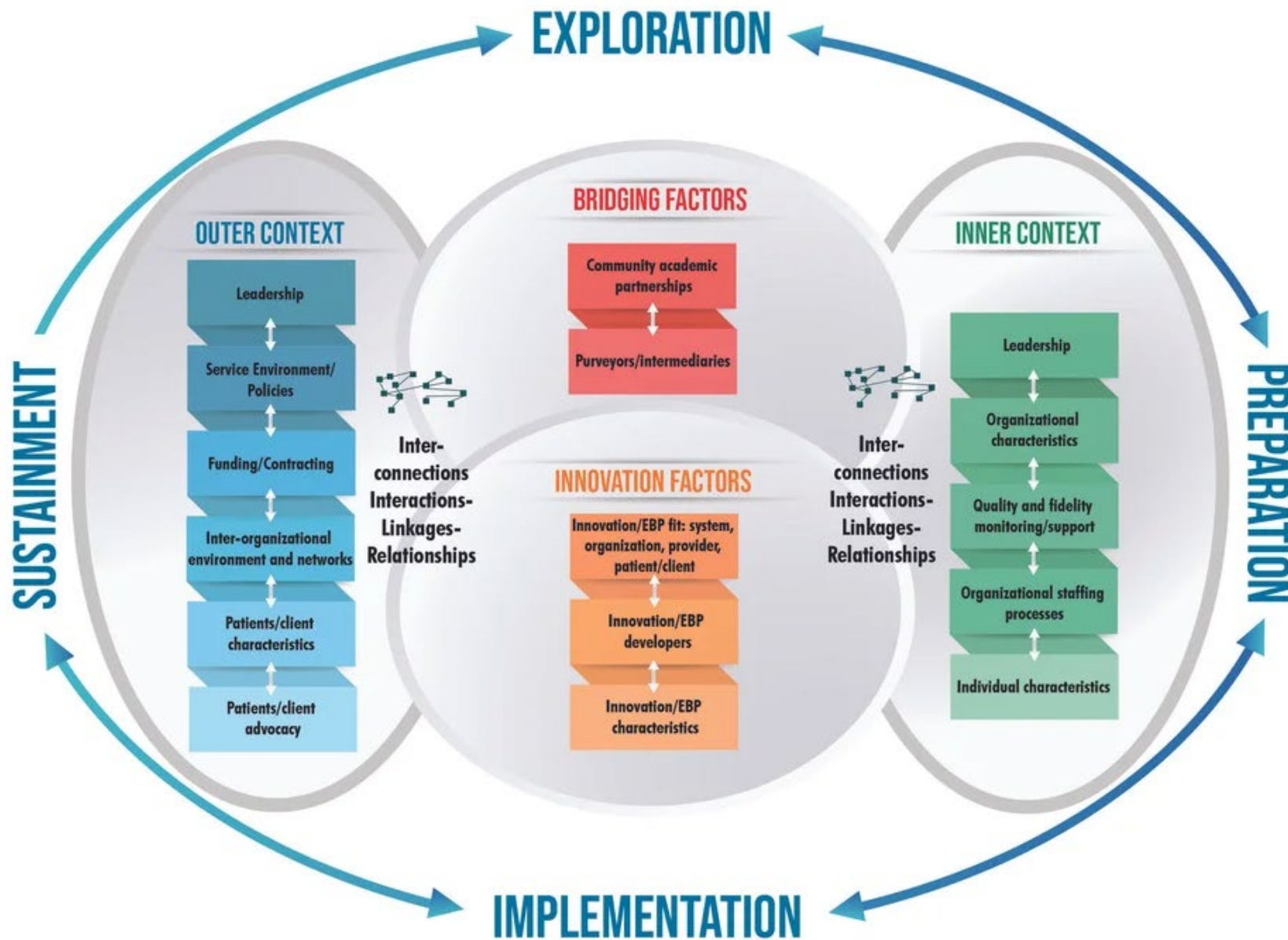


What you've been describing...



Responsibility





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.

Bridging Factor Discussion

- Which factors influence providers who already do what you are describing?
- If this is close to how you have or currently practice, what makes this feasible?
- What challenges may people say makes this too difficult?
- What would demonstrate that the transition actually occurred, beyond documenting a referral?
- What might cause people to say “we already do that, but now you’ve added extra red tape?”
- Who is ultimately responsible? When are they responsible for it?

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?

Feedback from last meeting

- Emphasize recovery is individualized, not provider derived.
- Data/ System Need: Track differences between LOC recommended and received to understand systems or practice factor.
- Discharge is relevant to where they are in the process of their care— potentially mirroring crisis planning/ crisis plans.
- Urgent and Ongoing medical needs should be addressed/ acknowledges
 - Need to highlight importance of PCP role
- MOUD and Harm Reduction are both are separate and important EBPs that should be recommended based on medical necessity and client preference.
 - Consider framing: Patient centered EBPs- SUD healthcare
- Purpose: “creates the conversation for change and planning, not just prescribing the plan.”
- Priority scaling/ planning for immediate needs.
- Specific considerations for justice involved individuals.
- Acknowledges shifting resources due to system wide changes or differential resources depending on location.
 - Ex. An immovable barrier prevents access to a necessary service but plans address this gap as best as possible.

Draft definition – Client factors

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.

Draft definition- Practitioner Factors

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 does this relate to...

Service/ Treatment Plan

Discharge Summary

Progress Notes

Assessment

Other required documentation or processes?

person-centered, planned, and integrated process

needs identification, risk reduction, medical and behavioral health continuity, recovery supports, and cross-system coordination—particularly for justice-involved populations.

“The service plan must be a written, individualized plan designed to improve the individual’s condition to the point where the individual’s continued participation in the program or level of care is no longer necessary.”

“The transition/ discharge plan...

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

Percent Centered EBP Considerations- SUD Healthcare

- 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)

Authorization

Not Required

!

Important: Please See Notes

!

This grid does NOT identify whether procedures or services are or aren't covered

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
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Themes of the discussion

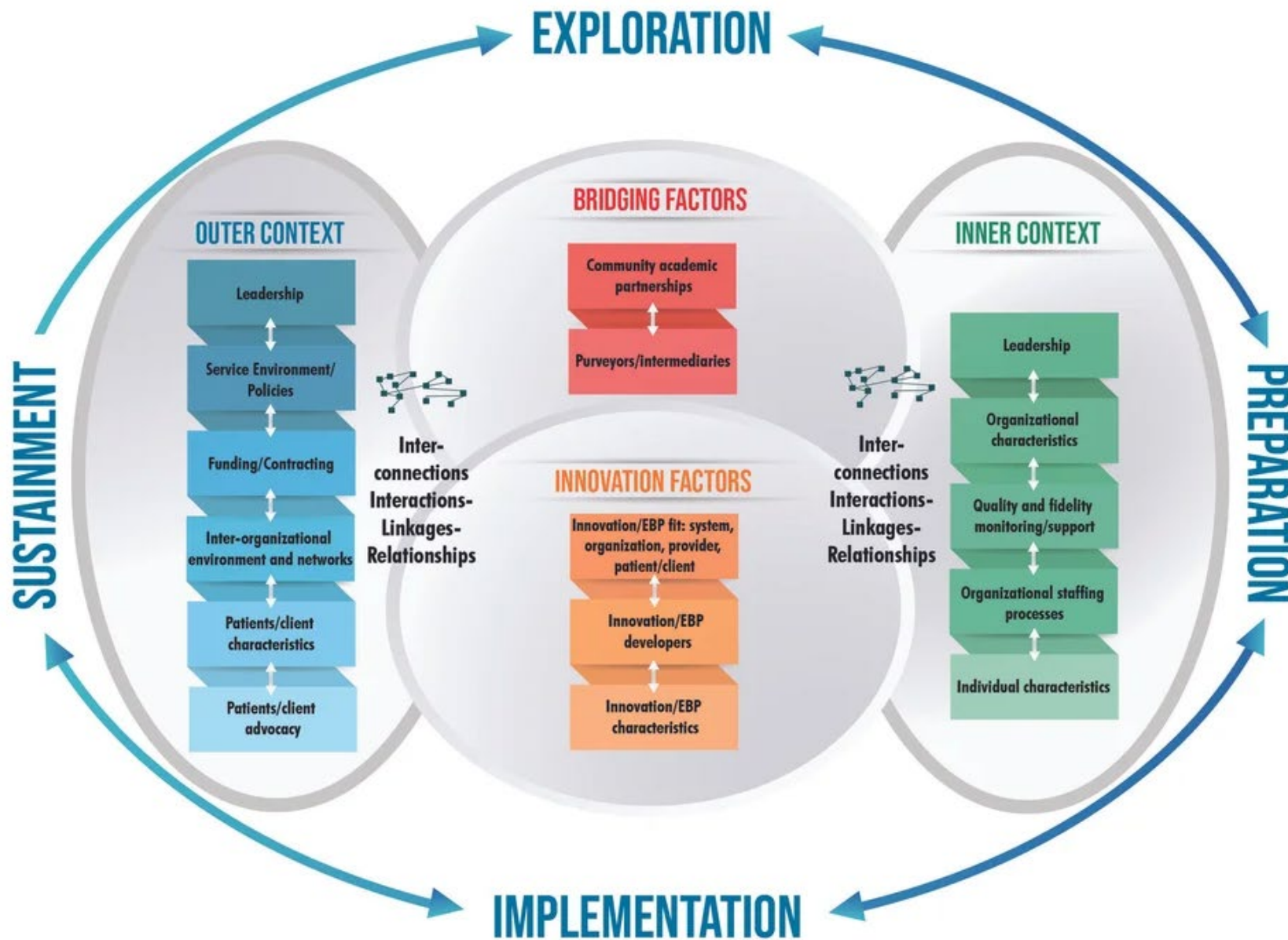
Quality, Accountability, and Audit Readiness

- 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



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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

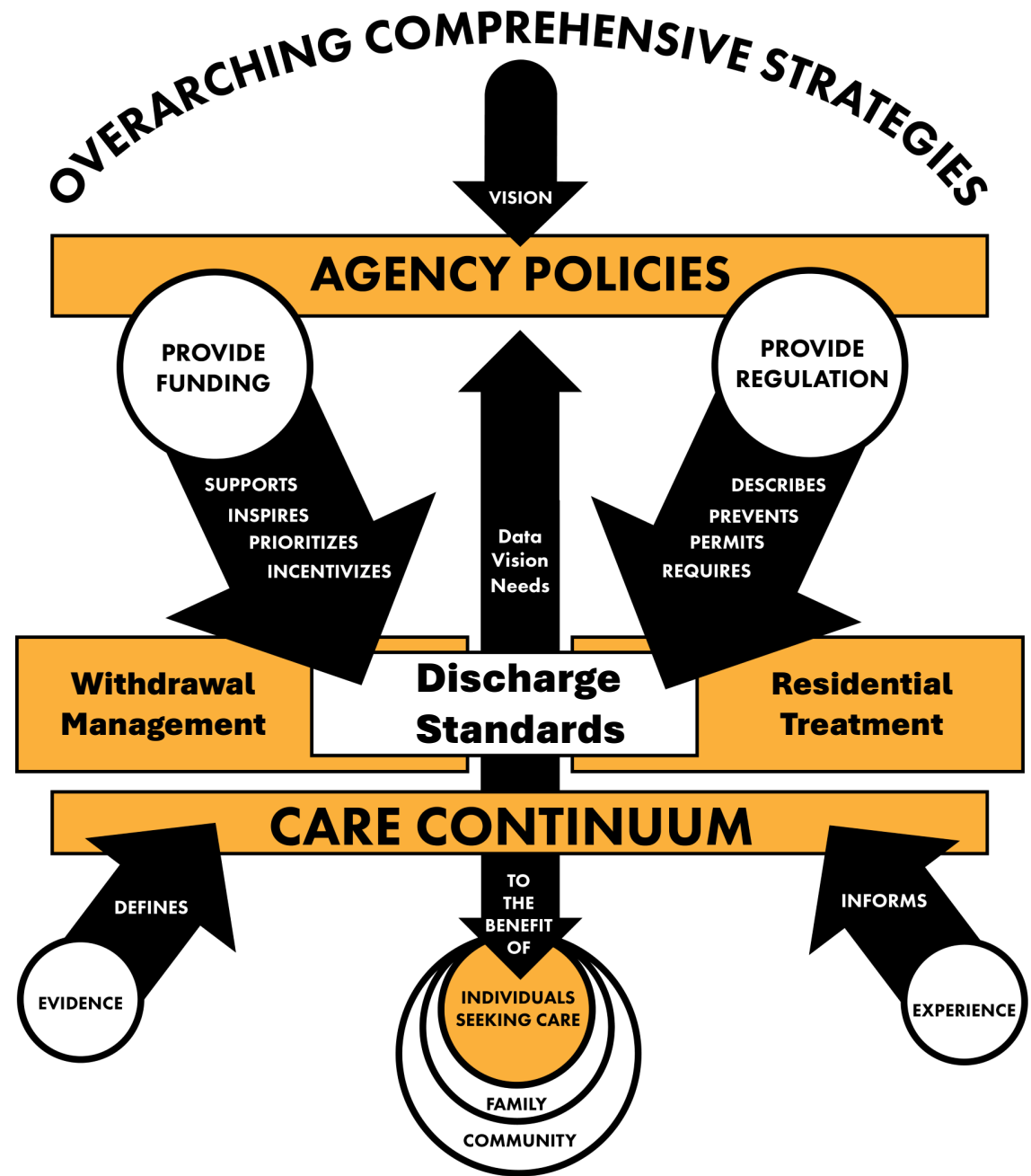


Thank you!

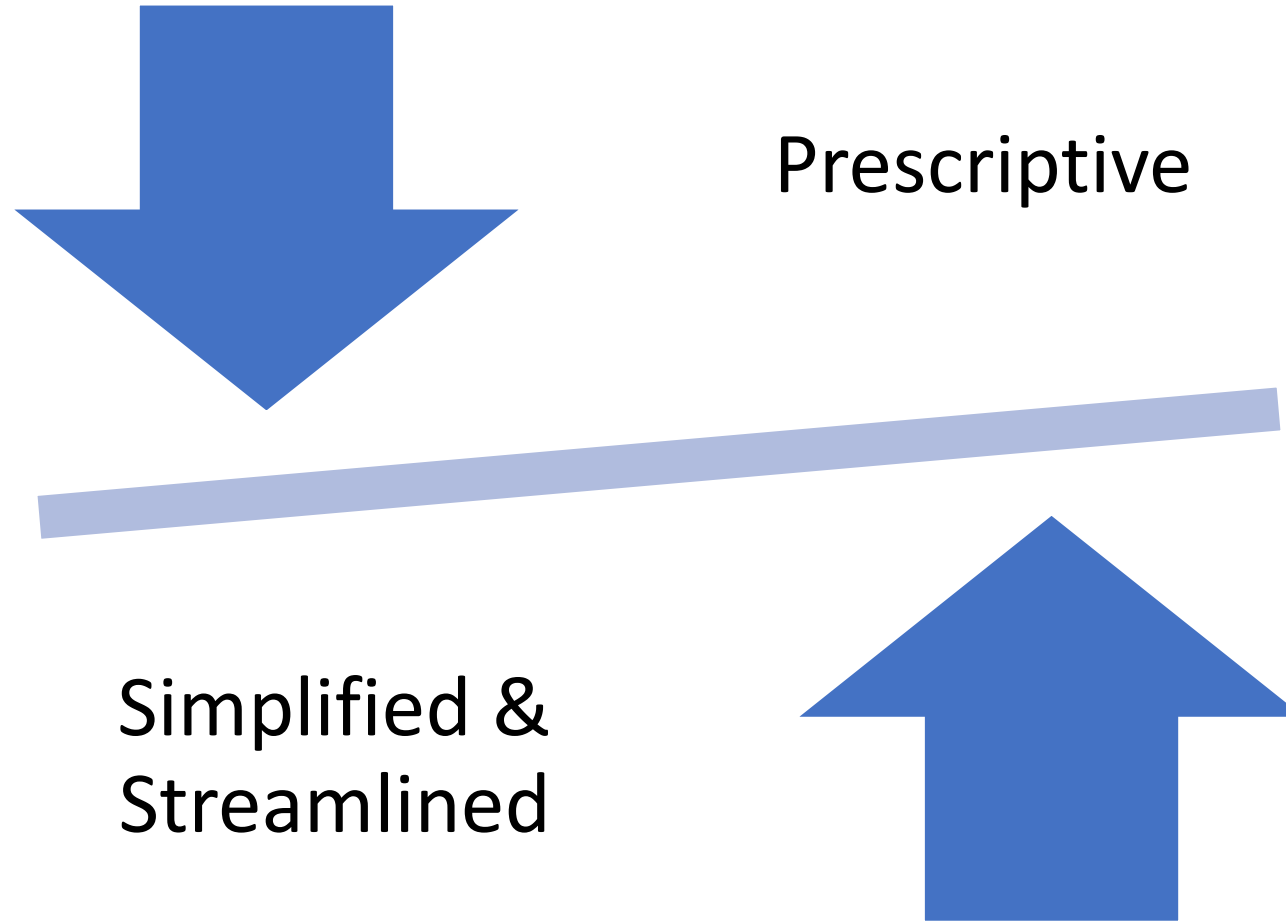
Mitch.a.doig@oha.Oregon.gov

<https://www.oregon.gov/adpc>

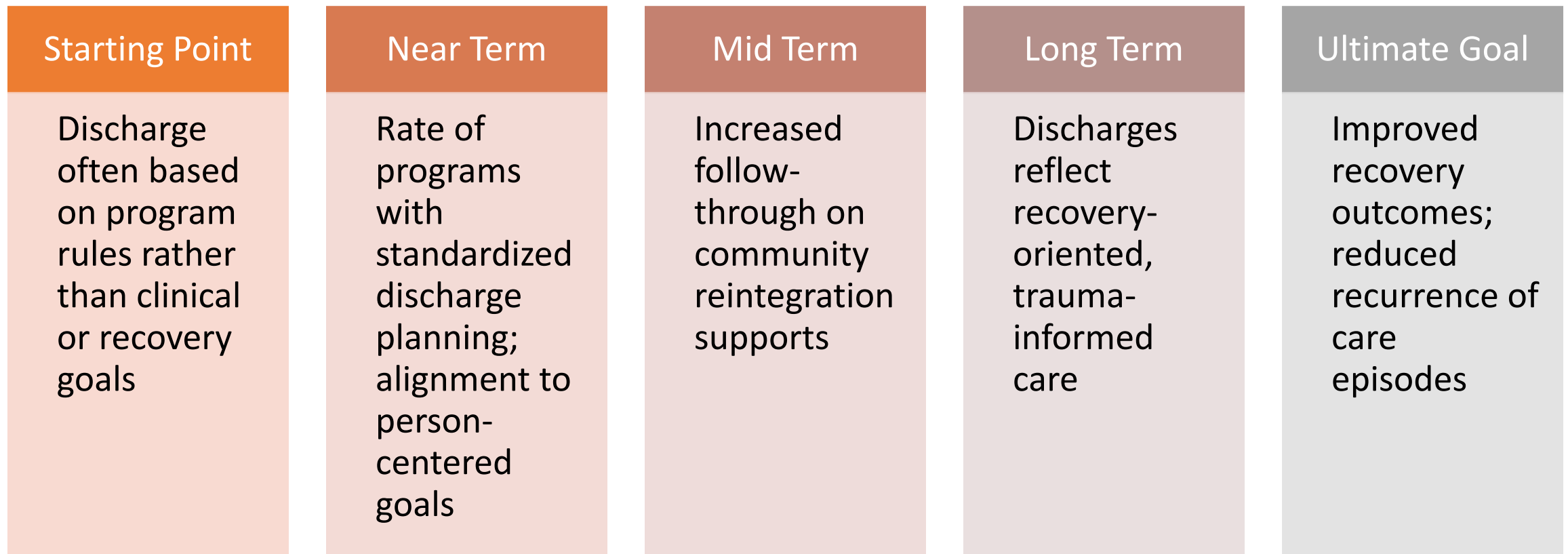
How?



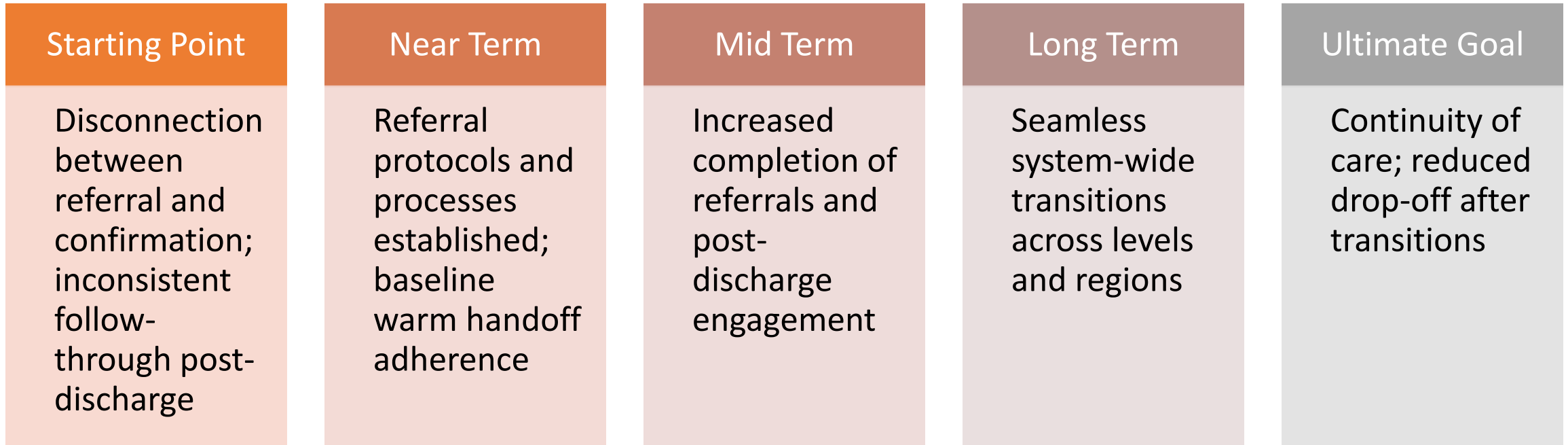
Balanced Rule Guidance: Reduces Risk & is Flexible



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



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



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