CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

IMPACTS Statewide Evaluation

GRANT CYCLE 2 REPORT

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Oregon Criminal Justice Commission

OHSU

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The authors of this report are wholly responsible for its contents.

Executive Summary

Individuals with behavioral health conditions remain disproportionately represented in Oregon's criminal justice, emergency care, and crisis service systems.[1] Improving access to community-based treatment and supports for these individuals remains a priority for Oregon policymakers.[2,3]

The Oregon Legislature created the Improving People's Access to Community-based Treatment, Supports and Services (IMPACTS) program in 2019 to expand community-based services for individuals with behavioral health needs and frequent involvement with the criminal justice system and emergency services. Administered by the Oregon Criminal Justice Commission in consultation with the Oregon Health Authority, IMPACTS provides funding to counties and federally recognized Tribes while allowing local communities flexibility in program design and implementation.[4]

This report builds on the Cycle 1 statewide evaluation, which examined the first two years of implementation when only a subset of grantees had launched services and many local programs had not yet reached full operational capacity. The current report extends the evaluation period to July 2020 – June 2024, providing four years of program observation and incorporating the experience of the 15 grantees operating across Oregon.

Using statewide administrative data and robust statistical methods, we evaluated whether IMPACTS was associated with changes in its legislatively mandated outcomes: reduced criminal justice involvement, healthcare utilization, and admissions to the Oregon State Hospital. By comparing changes in IMPACTS service areas to concurrent changes in comparison regions and adjusting for demographic and other factors, the evaluation was designed to assess IMPACTS while accounting for broader statewide changes like the Covid-19 Public Health Emergency and other behavioral health initiatives.

This evaluation found that IMPACTS was associated with:

- Notable reductions in Aid and Assist admissions to the Oregon State Hospital, as well as a slight increase in civil admissions relative to comparison regions.
- Fewer overdose events following release from incarceration, and fewer emergency department visits.
- Increased incarcerations, an unexpected finding that ran counter to program goals.
- A wide gap between the size of the target population and the number of people receiving IMPACTS services, indicating substantial unmet need for services.

Results varied across grantees, suggesting that local implementation strategies, target populations, and community contexts may influence program effectiveness.

Overall, the expanded evaluation provides evidence of improvements in several outcomes aligned with the program's goals, while pointing to areas where challenges remain. These statewide findings reflect the collective impact of a diverse portfolio of locally designed programs operating in different community contexts across Oregon.

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Acronyms

AI/AN ..... American Indian or Alaska Native

APAC ..... All-Payer All-Claims

BHRN ..... Behavioral Health Resource Network

CCSR ..... Clinical Classifications Software Refined

CHSE ..... Center for Health Systems Effectiveness

CJC ..... Criminal Justice Commission

CMS ..... Centers for Medicare and Medicaid Services

ED ..... Emergency department

HNA ..... Heritage Native American

ICS ..... Integrated Client Services

IMPACTS ..... Improving People's Access to Community-based Treatment, Supports and Services

IHS ..... Indian Health Service

LEDS ..... Law Enforcement Data System

MBD ..... Mental, behavioral, and neurodevelopmental disorders

MOTS ..... Measures and Outcomes Tracking System

NCQA ..... National Committee for Quality Assurance

OHA ..... Oregon Health Authority

OHSU ..... Oregon Health & Science University

OSH ..... Oregon State Hospital

PCS ..... Possession of a controlled substance

PHE ..... Public Health Emergency

PSRB ..... Psychiatric Security Review Board

REDCap ..... Research Electronic Data Capture

SPH ..... OHSU-PSU School of Public Health

SUD ..... Substance use disorder

Introduction

About IMPACTS

The Improving People's Access to Community-based Treatment, Supports and Services grant program was created via Senate Bill 973 in 2019, with the intent to decrease intensive service use among individuals with behavioral health needs who have frequent criminal justice or emergency services involvement (the "target population").[5]

The legislatively mandated objectives of the IMPACTS program are to:

- Reduce criminal justice system involvement
- Reduce emergency healthcare services utilization, and
- Reduce institutional placements

The program awards grants to Oregon counties and federally recognized Tribes ("grantees") to increase their capacity to deliver comprehensive community supports and services to their respective target populations. Grantees have broad latitude to define their target populations and scope their program services according to locally identified needs and priorities.

The state legislature has appropriated $10 million for IMPACTS per biennium in the last four biennia (spanning July 2019 – June 2027). The program is administered by the Oregon Criminal Justice Commission and grants are awarded through a competitive review process. During the first two grant cycles, applications were evaluated by a multidisciplinary Grant Review Committee. In 2025, House Bill 3069[6] transferred grant-making responsibilities and funding decisions to the Oregon Criminal Justice Commission.

Policy and system context

Other policies, programs, and court rulings that aim to address the needs of Oregon residents with mental health or substance use disorders may have interacted with or supported IMPACTS program goals and outcomes. Legislative investments and state efforts in recent years have prioritized improving access to care and increasing system capacity.[7] For example, Behavioral Health Resource Network grant funding established through Senate Bill 755[8] in 2021 supports community SUD-related programs by providing prevention and outreach activities at a local level. The passage of House Bill 4002[9] in 2024 established the Behavioral Health Deflection grant program that aims to direct people towards substance use treatment and other social services in lieu of arrest for possession of a controlled substance. HB 4002 also directs additional resources towards behavioral health and recovery services, including increased funding for community-based treatment.

Oregon State Hospital admission patterns were influenced by the Mosman Order[10] in September 2022, which established length-of-stay limits for Aid and Assist cases to create more hospital capacity for admitting new Aid and Assist defendants. The Order also explicitly restricted civil commitments in most cases, although some of those restrictions were relaxed in a July 2023 amendment. A timeline of additional policies that may have interacted with or affected IMPACTS program implementation and outcomes can be found in Appendix A.

About the evaluation

The legislation that created IMPACTS earmarked 3% of program funds for evaluation. The CJC engaged the Center for Health Systems Effectiveness at Oregon Health & Science University as an independent evaluator to conduct an ongoing statewide evaluation of the program's progress toward its mandated objectives. The current report presents statewide evaluation results through the end of the second IMPACTS grant cycle ("Cycle 2"), examining outcomes among grantees with active programs between July 2020 – June 2024 (Table 1).

As the third and final report in this series, this report builds on findings of the Baseline and Cycle 1 Reports and offers more robust evidence about the overall effectiveness of the IMPACTS program. Early effects of the program documented in the Cycle 1 Report included decreased convictions and associated recidivism, increased initiation and engagement in alcohol or other drug treatment, and modestly increased civil admissions to the Oregon State Hospital, which coincided with dramatic shifts in the composition of patient admissions.

This Cycle 2 Report evaluates maturing Cycle 1 grantees over an expanded time frame and includes the early performance of several newly operating grantees.

Table 1. The IMPACTS statewide evaluation is delivered as a series of reports

REPORT	DESCRIPTION	DELIVERY
Baseline Report[11]	Baseline population characteristics and service utilization pre-IMPACTS program implementation (January 2018 – December 2019)	Fall 2023
Cycle 1 Report[12]	Statewide evaluation from pre-period through IMPACTS Cycle 1 (Programs active July 2020 – June 2022)	Fall 2024
Cycle 2 Report (current report)	Statewide evaluation from pre-period through IMPACTS Cycle 2 (Programs active July 2020 – June 2024)	Fall 2026

The statewide evaluation uses linked administrative datasets from multiple state agencies to identify individuals in the IMPACTS target population and track their outcomes over time. Our evaluation compares changes in outcomes for target population individuals living in IMPACTS service areas to changes in outcomes for target population individuals living in parts of the state without IMPACTS programs ("comparison regions").

This quantitative statewide evaluation effort is complemented by qualitative evaluation by the OHSU-PSU School of Public Health, which provides additional context to inform the statewide evaluation design and interpretation of findings.[13,14]

Because IMPACTS programs differ substantially in terms of target populations, services, and local implementation approaches, statewide evaluation findings should be interpreted as the collective effects of a diverse portfolio of programs, rather than a single standardized intervention.

Proposed ongoing statewide evaluation would continue to monitor outcomes as programs mature and Oregon's behavioral health and criminal justice systems evolve, generating evidence to inform future policy and program decisions.

About the grantees

IMPACTS funding has been distributed to grantees over three grant cycles:

- During **Cycle 1** (July 2020 – June 2022), six counties and five Tribes received IMPACTS funding.
- During **Cycle 2** (July 2022 – June 2024), all Cycle 1 grantees and four new county grantees – including a two-county consortium – were funded, bringing the total number of grantees to 15.
  - From July 2024 – June 2025, funds were awarded to sustain existing grantees without opening the program to new applicants.[5]
- During **Cycle 3** (July 2025 – August 2027), four of the five Tribal grantees and all county grantees from Cycles 1 and 2 continued, and one new county grantee joined, maintaining a total of 15 grantees.

Figure 1 presents a timeline of when grantees were actively providing services, based on information reported to the CJC and SPH. This report evaluates changes in outcomes associated with the 15 grantee programs that offered services during Cycles 1 & 2 (the "post-period"), spanning July 2020 – June 2024.

Figure 1. Fifteen IMPACTS grantees delivered program services during IMPACTS Cycles 1 & 2



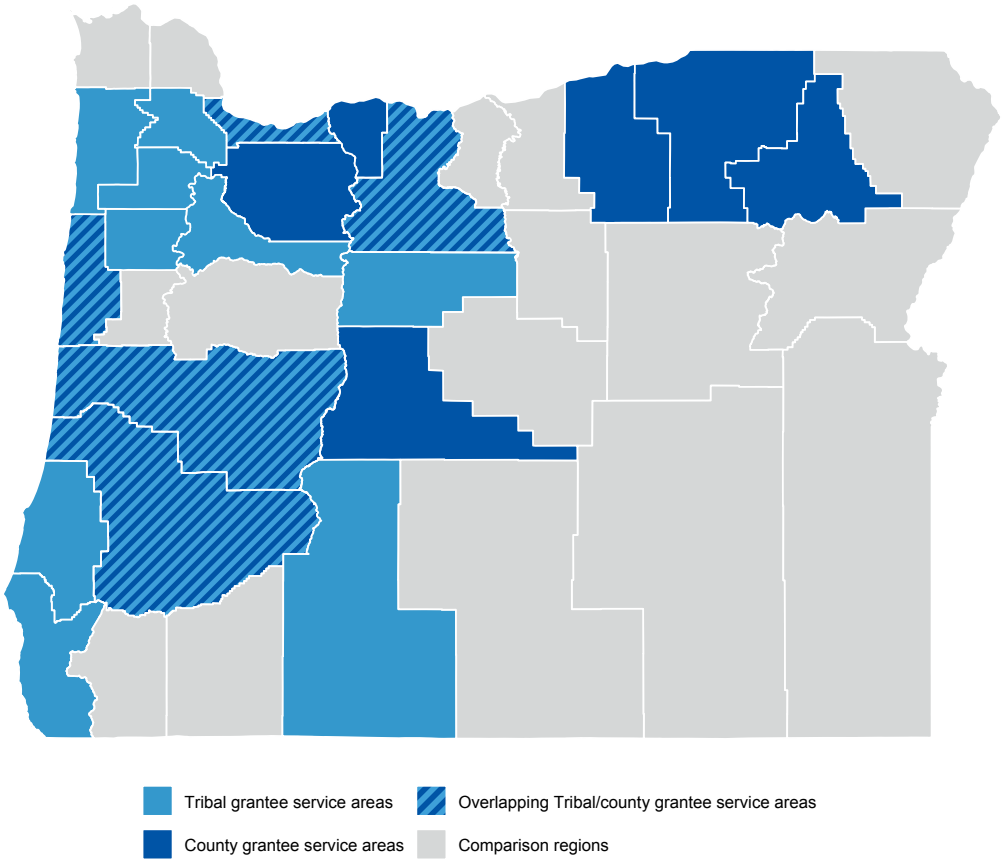
Notes. Colored dots represent time periods when grantees actively offered services. Grey box denotes the IMPACTS post-period evaluated in this report. Abbreviations. H1 = first half (January-June) and H2 = second half (July-December) of a calendar year.

Grantees faced significant challenges at the launch of IMPACTS in 2020, and had to adapt their implementation timelines, staffing plans, and outreach activities in response to the Covid-19 Public Health Emergency.[13]

Figure 2 illustrates areas where grantees actively offered services, spanning a mix of rural and urban regions across the state. Grantees had discretion to offer services across their entire region or within targeted areas.

Counties without active IMPACTS programs served as comparison regions for the current evaluation. This included Jackson County, which was awarded funding starting in Cycle 3, and areas with no grantees. It also included grantee service areas during the time periods prior to when they launched services.

Figure 2. Grantees offered services across Oregon during IMPACTS Cycles 1 & 2



Notes. County borders are used to represent approximate service areas during IMPACTS Cycles 1 & 2. These may be broader than actual areas served, because grantees had discretion to offer services throughout their entire region or within targeted areas. In addition, colonial-defined boundaries do not accurately reflect Tribal boundaries. Due to the nature of the administrative data used in this evaluation, we relied on county and zip code boundaries identified by Tribal grantees to approximate their service areas.

Grantees were permitted to tailor their program services according to local needs. Tribal grantees, for example, were housed within Tribal government departments and tended to explicitly emphasize culturally responsive and holistic care with a focus on care coordination with family and community services. County grantees sat within corrections, behavioral health, or other county departments and relied on partnerships with community providers and other local organizations for clinical and crisis services, housing supports, and data infrastructure. This flexibility in local program design distinguishes the IMPACTS program from various other state initiatives that are more prescriptive in their approaches (see Appendix A).

Table 2 offers a high-level description of grantee programs active during IMPACTS Cycles 1 & 2.

Table 2. Active Cycle 1 & 2 grantee programs varied in focus, design and funding[5]

GRANTEE	BRIEF PROGRAM DESCRIPTION	FUNDING CYCLE 1	FUNDING CYCLE 2
Clackamas County	Dedicated staff for case management and stabilization in the County Jail and Adult Probation Office	$499,988	$208,412
Confederated Tribes of Coos, Lower Umpqua, Siuslaw Indians	Team to address medical, housing, and stabilization needs in the Tribal Police Department	$322,265	$0
Confederated Tribes of Grand Ronde	Team to develop care plans and utilize family and community referrals	$290,000	$494,684
Confederated Tribes of Warm Springs	Assistance with transition from custody to service in the community	$282,743	$215,832
The Cow Creek Band of Umpqua Tribe of Indians	Intensive case management and medical and housing services	$490,841	$95,998
Deschutes County	Increased funding for existing Deschutes County Stabilization Center	$2,403,520	$2,307,835
Douglas County	Intensive Care Coordination team at the jail and the ED, increased community stabilization supports	$1,414,879	$1,837,714
Hood River County	Support for transition back into community and dedicated housing at local shelter	N/A	$137,260
The Klamath Tribes	Provide basic needs, supports and behavioral health treatment	$691,580	$376,485
Lane County	Forensic Intensive Treatment Team to provide wraparound services	$2,527,697	$319,376
Lincoln County	Law Enforcement Assisted Diversion for jail diversion and referrals to community partners	$288,490	$258,900
Multnomah County	Permanent supportive housing emphasis with dedicated staff for case management, crisis stabilization services, and peer support	N/A	$1,215,986
Umatilla & Morrow Counties	Dedicated team to provide comprehensive wraparound services including case management and counseling	N/A	$621,328
Union County	Increased funding for the Center for Human Development to support jail diversion and case management	$562,945	$300,006
Wasco County	Transitional housing tailored to meet target population needs with an on-site resident manager	N/A	$178,156

Notes. This table includes only IMPACTS grantees that offered services during Cycles 1 & 2. See Figure 1 for more details.

Findings: Target population

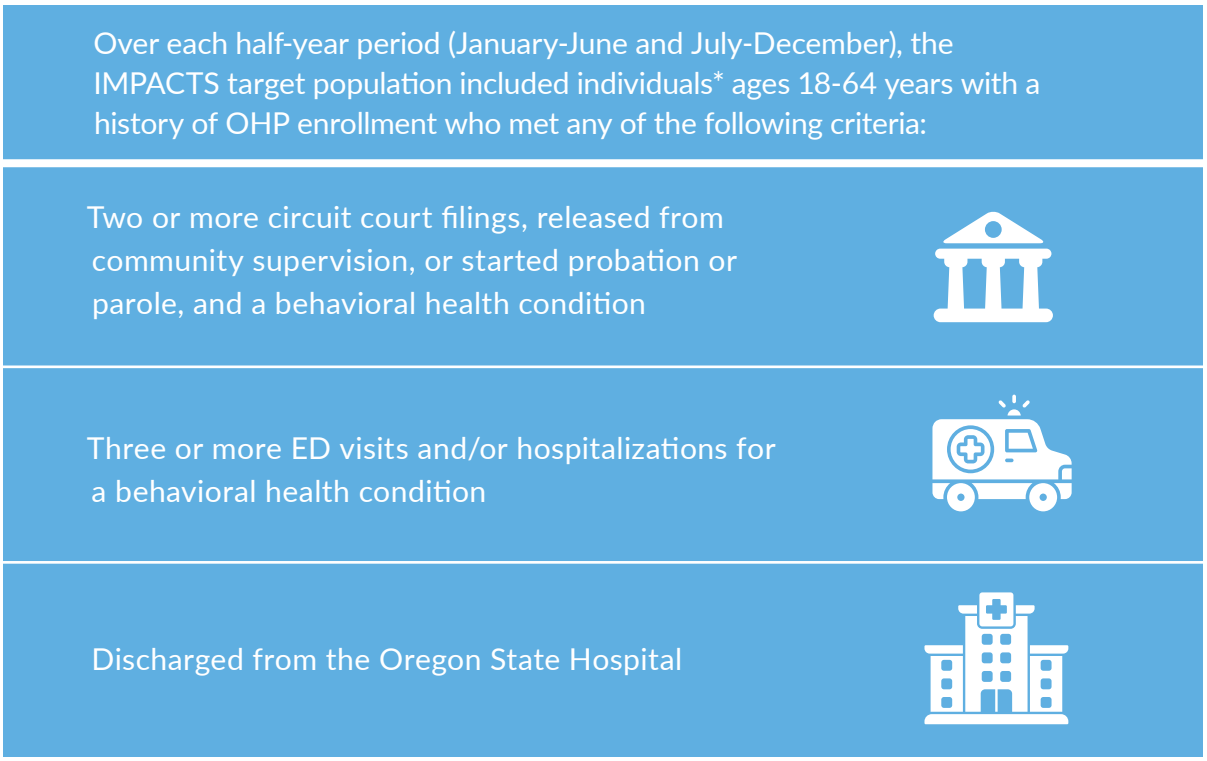
Grantees were required to define a specific "target population" within the broader IMPACTS focus on supporting individuals with behavioral health needs and frequent criminal justice or emergency services involvement. Under administrative rule, grantees had flexibility to identify and serve individuals based on local community needs and program design, resulting in variation in target populations across jurisdictions. Some grantees prioritized early intervention and preventive engagement efforts in addition to serving individuals with high levels of criminal justice, health care, or other system utilization.[4, 14]

In contrast, our statewide evaluation applied a consistent high-utilizer definition to identify individuals eligible for IMPACTS services (Figure 3). Criteria were developed in consultation with IMPACTS program staff at the CJC and informed by grantee interviews by SPH, while also being designed for implementation using available statewide administrative data.

Our evaluation included adults ages 18-64 with a history of enrollment in Oregon's Medicaid program (the "study population"). We assessed whether individuals met target population criteria in each half-year period during the evaluation time frame, allowing individuals to cycle in and out of the target population over time.

See Appendix B for more details.

Figure 3. Who is included in the IMPACTS target population for the statewide evaluation?



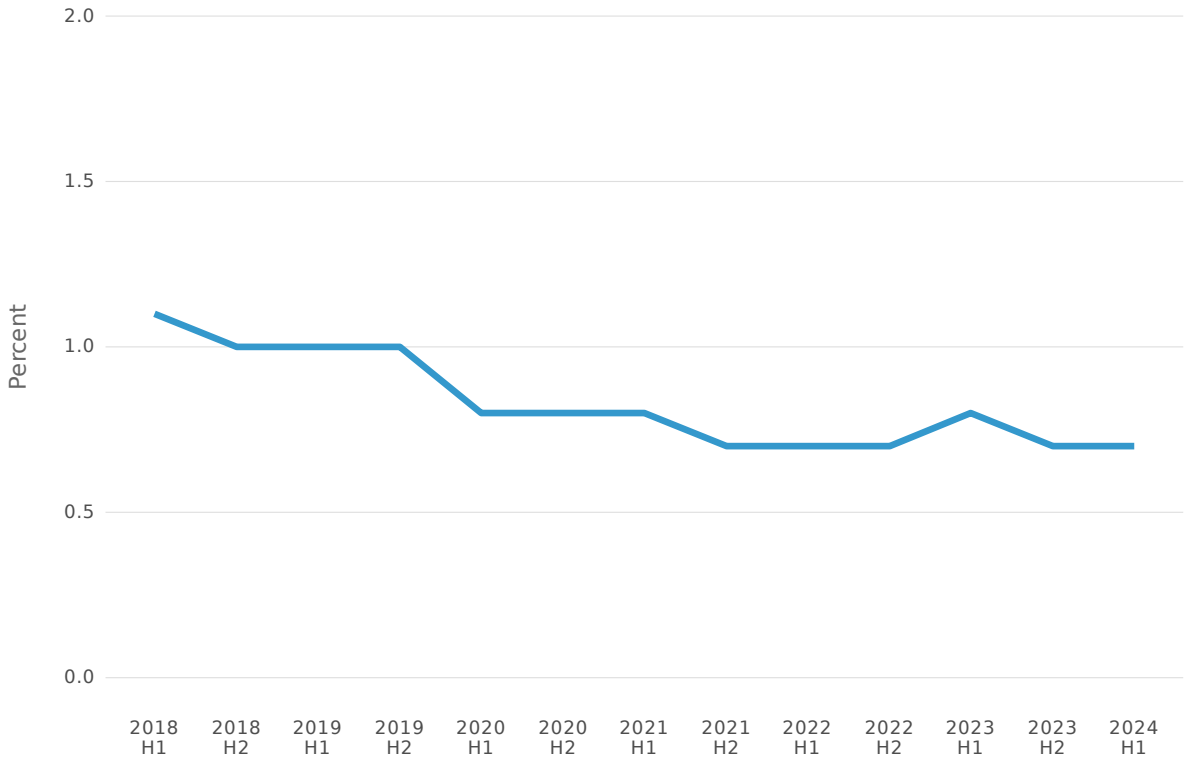
Note. In Tribal grantee service regions, individuals also must be identified as American Indian or Alaska Native to meet target population criteria.

Population size

Approximately 1% of the study population met IMPACTS target population criteria in each half-year (Figure 4). The gradual decline noted in the Cycle 1 evaluation[12] leveled off during Cycle 2.

Between January 2018 – June 2024, a cumulative 80,521 individuals, representing 5.4% of the population, qualified for the target population. Just over half (55.7%) resided in an IMPACTS service area.

Figure 4. Approximately 1% of people met the IMPACTS target population criteria

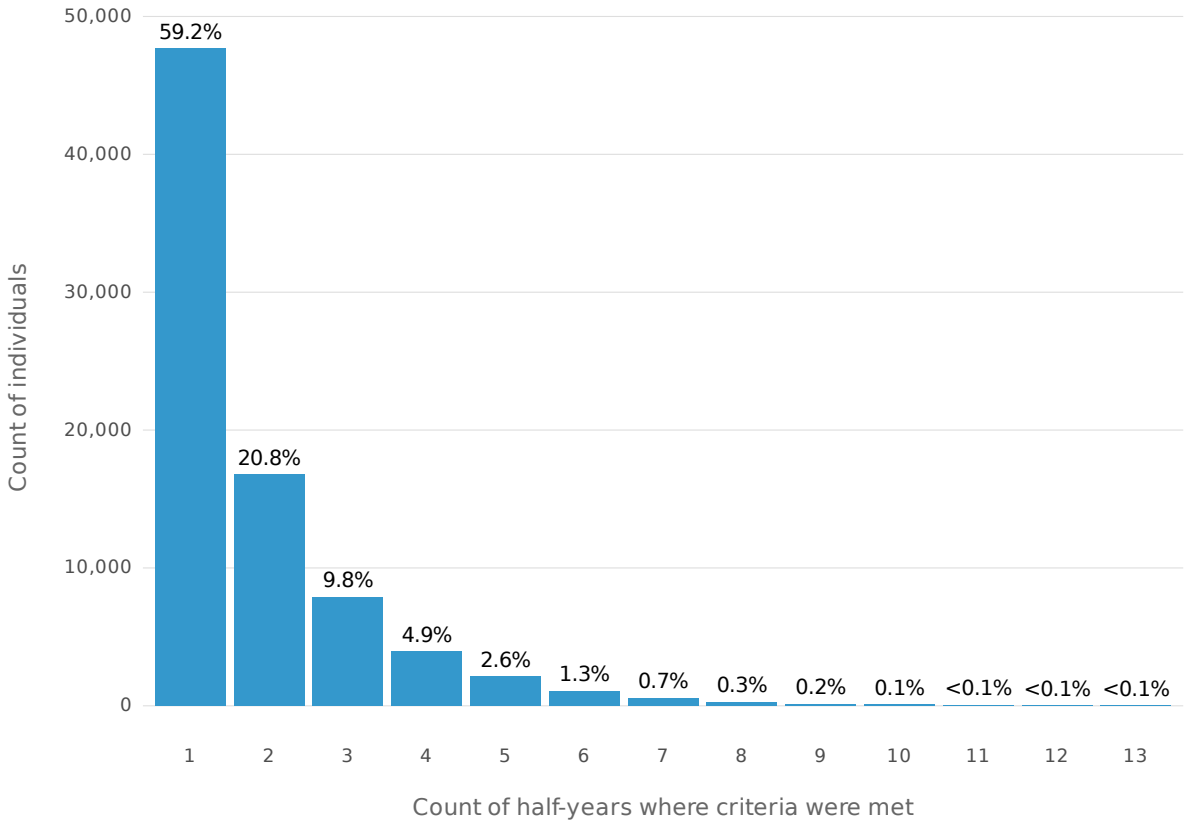


Notes. Line represents the percentage of the study population that met statewide evaluation target population criteria during a given half-year. Includes individuals residing in IMPACTS service areas and comparison regions.

How individuals qualified

Three in five individuals (59.2%) who qualified for the target population did so only once during the evaluation time frame. One in five (20.8%) qualified twice, one in ten (9.8%) qualified three times, and the remaining 10% qualified four or more times (Figure 5). This pattern is consistent with prior research showing people identified based on high service use tend to return to more average use in subsequent periods, regardless of receipt of intervention. As discussed in the Cycle 1 Report, our evaluation design helps guard against spurious findings due to this type of "regression to the mean".[12,15,16] However, this finding highlights the importance of preventive services for a broad population, in addition to targeted supports for those with sustained extreme utilization.

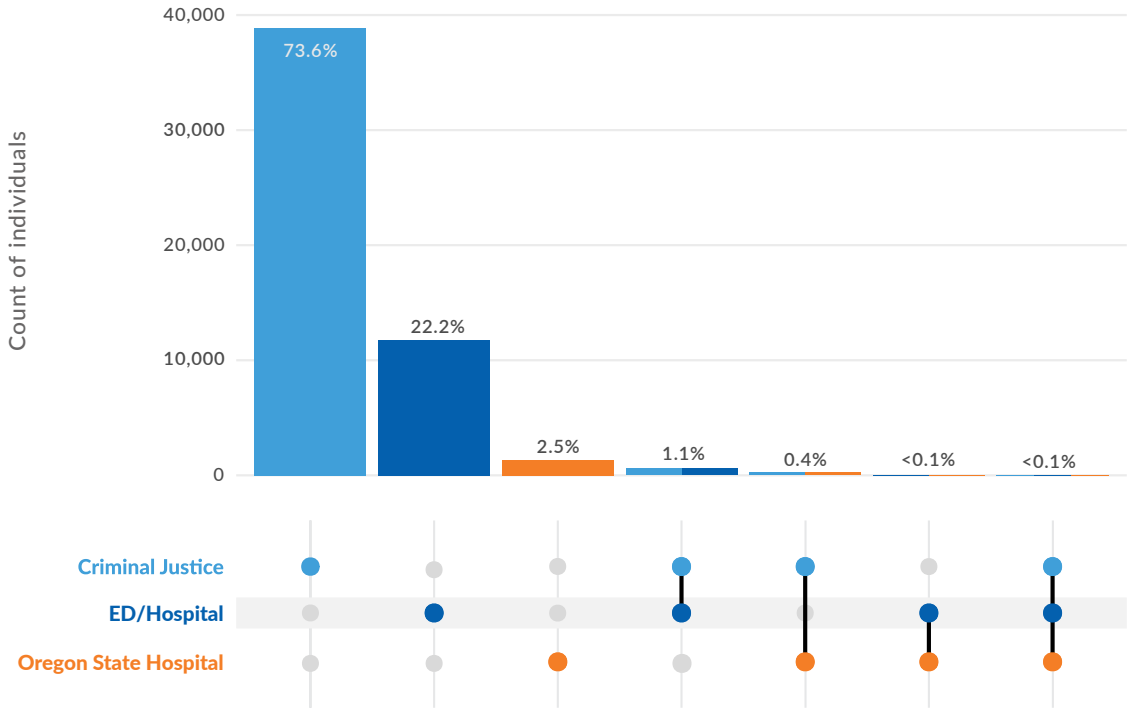
Figure 5. Most people who met target population criteria did so only once during the evaluation time frame



Notes. The evaluation time frame includes 13 half-year periods from January 2018 to June 2024. Bars show how many individuals met target population criteria a specified number of times. Includes individuals residing in IMPACTS service areas and comparison regions. Excludes individuals who never met target population criteria during January 2018 – June 2024.

Similar to the Cycle 1 evaluation, most individuals who qualified for the target population did so based on a single criterion (Figure 6). A majority (73.6%) qualified due to criminal justice involvement alone, followed by 22.2% based on emergency department or hospital visits alone, and 2.5% based only on OSH stays. Fewer than 2% of target population members met multiple qualifying criteria.

Figure 6. Most people who qualified for the target population met a single criterion, most commonly criminal justice involvement



Criminal Justice = Two or more circuit court filings, released from community supervision, or started probation or parole, and a behavioral health condition

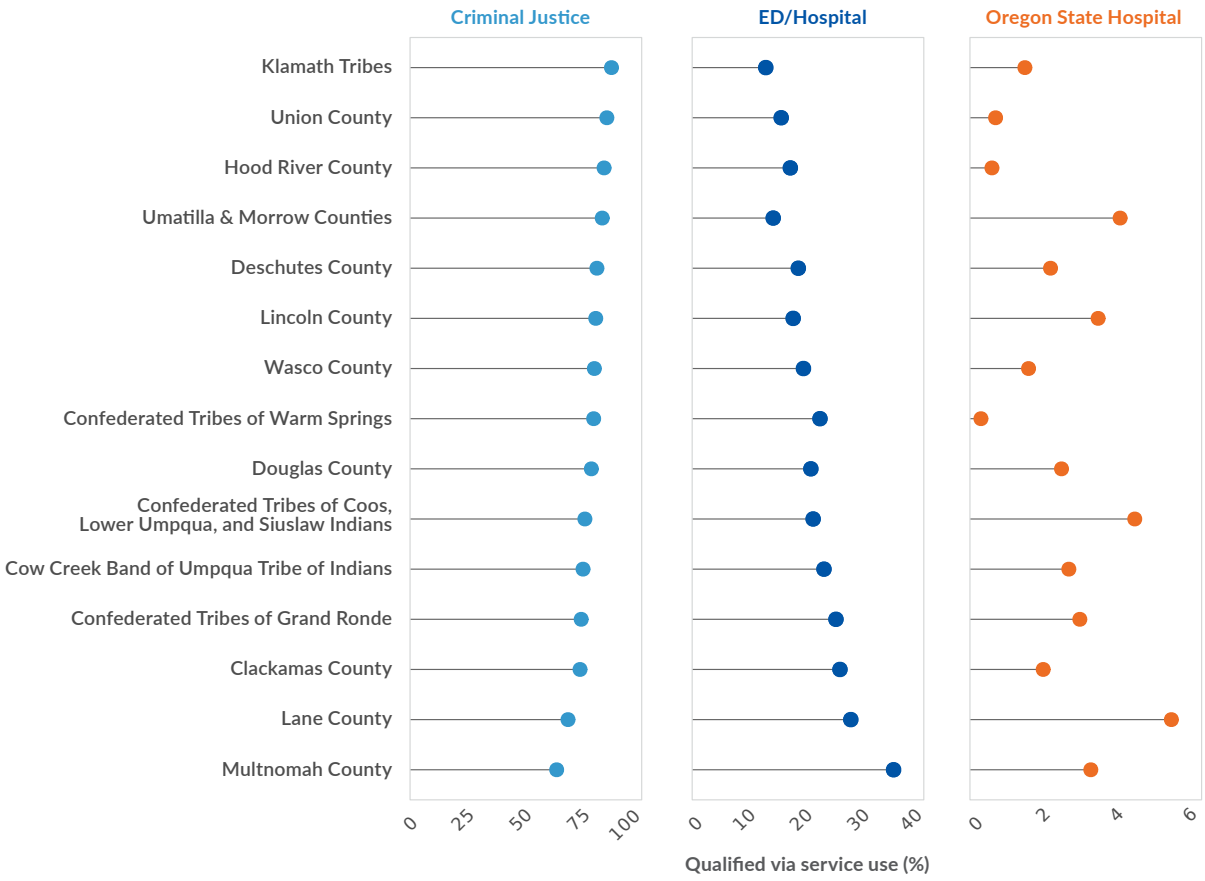
ED/Hospital = Three or more ED visits and/or hospitalizations for a behavioral health condition

Oregon State Hospital = Discharged from the Oregon State Hospital

Notes. Bars represent the number of individuals who met specific combinations of target population criteria during half-year observation periods in IMPACTS Cycles 1 & 2. Includes individuals residing in IMPACTS service areas and comparison regions. For individuals who met target population criteria in multiple periods, we display criteria that were met the first time.

This pattern of qualification was generally consistent across grantees, with some noted variation (Figure 7). Multnomah County – one of the newly participating Cycle 2 grantees – had the lowest rate of qualification based on criminal justice involvement (63.4%) and the highest rate qualifying due to emergency department and hospital visits (35.3%). Conversely, Klamath Tribes – a continuing Cycle 1 grantee – had the highest rate based on criminal justice involvement (87.1%) and the lowest for emergency department and hospital visits (12.9%). Target population qualification rates based on OSH stays varied from 0.3% for the Confederated Tribes of Warm Springs to 5.5% for Lane County.

Figure 7. How people qualified for the target population varied across grantees



Criminal Justice = Two or more circuit court filings, released from community supervision, or started probation or parole, and a behavioral health condition

ED/Hospital = Three or more ED visits and/or hospitalizations for a behavioral health condition

Oregon State Hospital = Discharged from the Oregon State Hospital

Notes. Dots represent the percentage of a grantee's target population that met a given criterion during Cycles 1 & 2. For each grantee, percents may sum to >100 if individuals met multiple criteria. Horizontal scales differ to highlight variation across grantees, particularly for criteria with small populations. Includes individuals residing in IMPACTS Cycle 1 & 2 service areas; does not include individuals residing in comparison regions. For individuals who met target population criteria multiple times, we display criteria that were met the first time.

Demographic and health characteristics

Consistent with our prior reports[11,12], the target population was more likely than the non-target population to be male and speak English, while the proportion of people living in frontier, rural and urban areas was similar. Drawing reliable conclusions about racial and ethnic composition remained difficult due to differentially missing information between the two groups (Table 3).

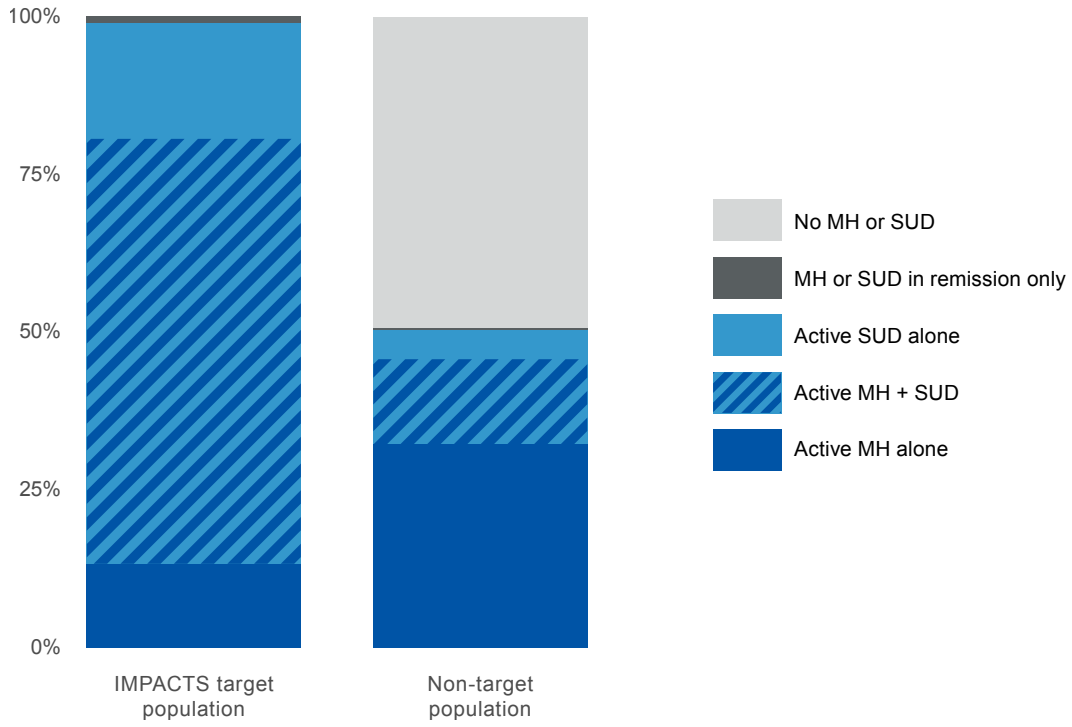
Table 3. The IMPACTS target population was more likely to be male and speak English

	IMPACTS TARGET POPULATION N = 52,796	NON-TARGET POPULATION N = 1,402,511
Age (years) – mean (SD)	37.0 (11.0)	36.1 (13.7)
Male sex – N (%)	37,931 (71.8)	655,529 (46.7)
Race-ethnicity – N (%)		
American Indian/Alaska Native	2,434 (4.6)	33,088 (2.4)
Asian	495 (0.9)	44,531 (3.2)
Black/African American	2,936 (5.6)	46,077 (3.3)
Latino/a/x	4,692 (8.9)	191,138 (13.6)
Middle Eastern/North African	92 (0.2)	4,826 (0.3)
Native Hawaiian/Pacific Islander	375 (0.7)	12,016 (0.9)
Other/Multiple Races	709 (1.3)	22,240 (1.6)
White	35,318 (66.9)	747,079 (53.3)
Unknown/Missing/Decline	5,745 (10.9)	301,516 (21.5)
Primary spoken language – N (%)		
English	51,763 (98.0)	1,229,286 (87.6)
Spanish	919 (1.7)	139,825 (10.0)
Other/Unknown	114 (0.2)	33,400 (2.4)
Geography – N (%)		
Frontier	1,707 (3.2)	37,785 (2.7)
Rural	19,195 (36.4)	485,609 (34.6)
Urban	31,894 (60.4)	879,117 (62.7)
Dual eligible (Medicaid & Medicare) – N (%)	3,686 (7.0)	75,019 (5.3)

Note. IMPACTS target population includes individuals from the study population who met target population criteria anytime during Cycles 1 & 2; non-target population includes individuals from the study population who never met target population criteria during this time frame.

All members of the target population had a behavioral health diagnosis, per IMPACTS qualifying criteria, compared with half (50.7%) of non-target population individuals. The target population had a substantially higher prevalence of substance use disorders either alone (18.4% vs. 4.6%) or in combination with a mental health disorder (67.3% vs. 13.5%) (Figure 8).

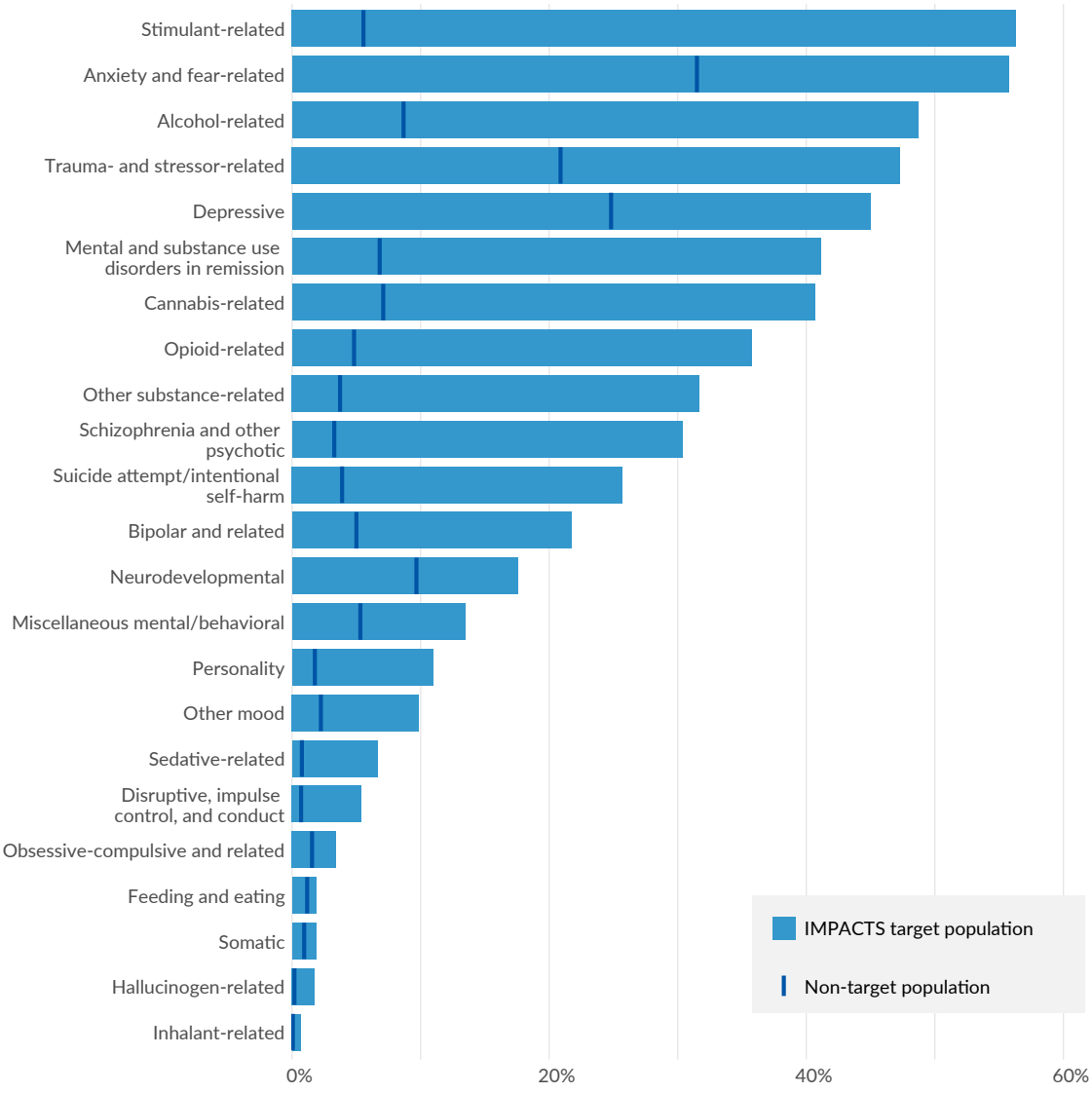
Figure 8. Nearly two-thirds of IMPACTS target population members had co-occurring mental health and substance use disorders



Note. IMPACTS target population includes individuals from the study population who met target population criteria anytime during Cycles 1 & 2; non-target population includes individuals from the study population who never met target population criteria during this time frame. Abbreviations. MH = mental health; SUD = substance use disorder.

The most common behavioral health conditions among the target population were related to stimulants (56.3%), anxiety (55.7%), alcohol (48.7%), trauma and stressors (47.3%), and depression (45.0%). Every behavioral health condition measured in this evaluation was more common among the target than non-target population (Figure 9).

Figure 9. Prevalence of specific behavioral health conditions was higher among the IMPACTS target population than non-target population



Note. IMPACTS target population includes individuals from the study population who met target population criteria anytime during Cycles 1 & 2; non-target population includes individuals from the study population who never met target population criteria during this time frame.

Comparison to individuals served

The statewide evaluation primarily uses administrative data, which provide a comprehensive picture of individuals' interactions with the healthcare and criminal justice systems. The administrative data are used to identify the IMPACTS target population based on criteria outlined in Figure 3, and to calculate outcomes. However, administrative data do not indicate whether an individual actually received IMPACTS services.

Beginning in July 2023, IMPACTS grantees began reporting information about clients they served into a Research Electronic Data Capture database.

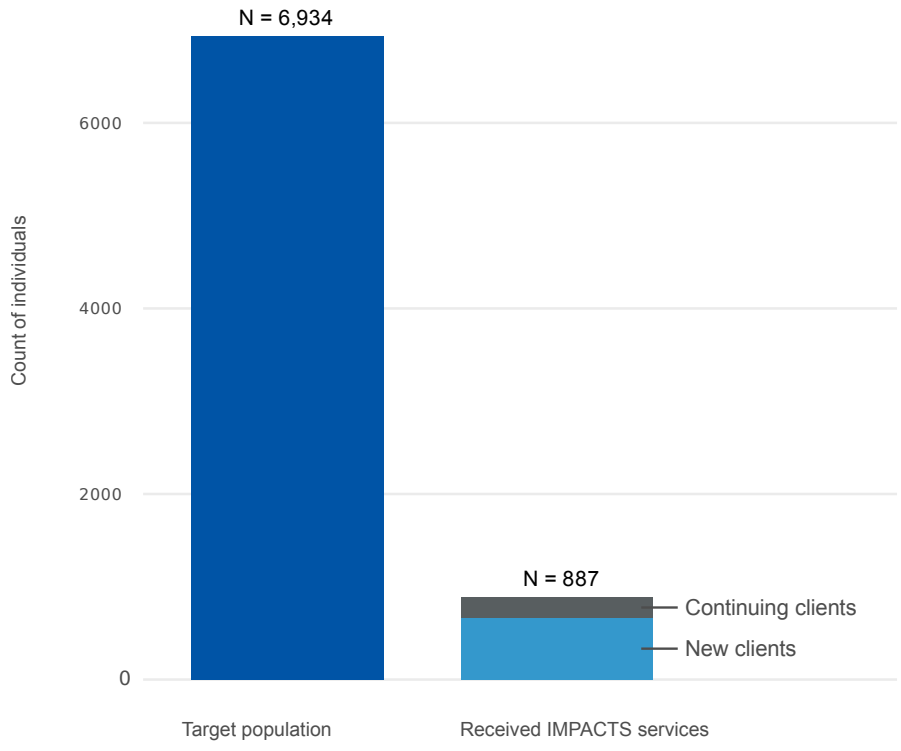
At the time of this report, sufficient REDCap data on IMPACTS grantee clients was available to compare with the target population as identified from administrative data, during the 12 months from July 2023 to June 2024.

During that 12 months, 6,934 individuals residing in IMPACTS service areas met target population criteria and 666 individuals initiated IMPACTS services; an additional 221 individuals remained actively enrolled from a previous reporting period (Figure 10).

Because administrative and grantee-reported data cannot be linked at the individual level, these counts do not necessarily represent overlapping populations. Nevertheless, the target population identified through administrative data was substantially larger (7.8 times) than the population who received IMPACTS services.

This finding suggests the need for services far exceeds the program's current capacity.

Figure 10. The target population was far larger than the population receiving IMPACTS services



Notes: The number of individuals in the target population was assessed using administrative data and includes those who lived in an IMPACTS service area and ever met target population criteria during July 2023 – June 2024. For this comparison, target population criteria were adjusted to measure eligibility over a full year of service utilization rather than the six-month periods used elsewhere in this report. The number of individuals who received IMPACTS services was assessed during the same time frame, using grantee-reported information from REDCap.

Findings: Program effects

How to interpret the findings

Fifteen grantees offered IMPACTS services during Grant Cycles 1 & 2. Our evaluation compares changes in outcomes among the target population living in grantee service areas to concurrent changes in comparison regions without active IMPACTS services.

We report statewide changes associated with the IMPACTS program overall, along with a summary of anonymized grantee-level changes.

Results are presented in table format as illustrated in Figure 11, with blue indicating outcomes that improved relative to baseline, and orange indicating outcomes that worsened. The magnitude of change is indicated by shading, as follows:

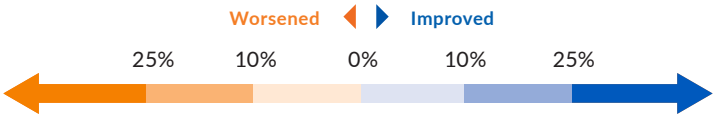
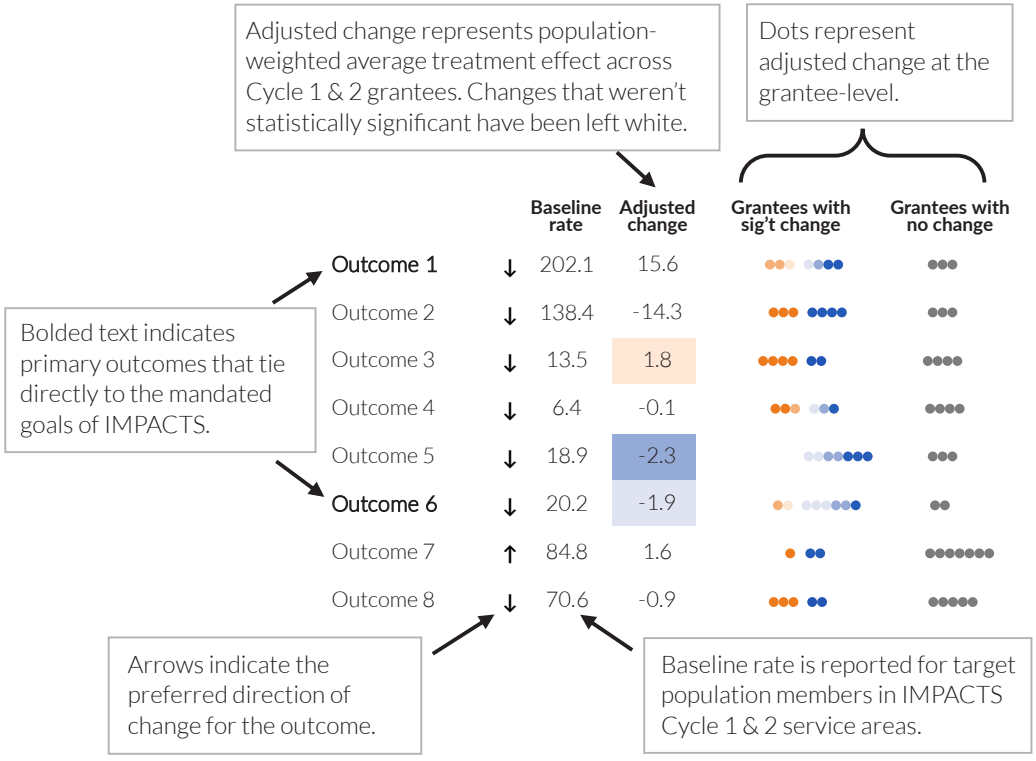


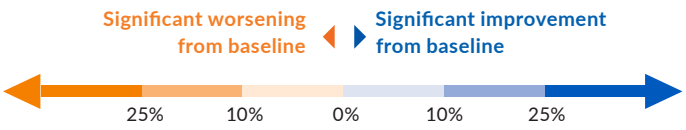
Figure 11. Example presentation of program effects



Criminal Justice

Table 4. Change in criminal justice outcomes associated with IMPACTS Cycles 1 & 2

		Baseline rate	Adjusted change	Grantees with sig't change	Grantees with no change
Convictions – All (per 1,000 people)	↓	545.4	-14.2		
Convictions – Felony (per 1,000 people)	↓	198.3	-8.8		
Convictions – Misdemeanor (per 1,000 people)	↓	388.3	-8.5		
Incarceration - All Crimes (per 1,000 people)	↓	84.8	6.1		
Incarceration - Drug Crimes (per 1,000 people)	↓	9.6	0.7		
Incarceration - Person Crimes (per 1,000 people)	↓	29.4	0.3		
Incarceration - Property Crimes (per 1,000 people)	↓	41.1	2.1		
Incarceration - Other Crimes (per 1,000 people)	↓	16.3	2.8		
Recidivism within 1 Year – Conviction (%)	↓	24.7	-0.6		
Recidivism within 1 Year – Incarceration (%)	↓	6.8	0.3		
Release from Incarceration – Medicaid Enrollment within 2 Months (%)	↑	75.9	1.5		
Release from Incarceration – Overdose within 2 Months (%)	↓	1.4	-0.4		



↑ Higher is better
↓ Lower is better

Bolded text = Primary outcome

Notes. Results based on analysis of statewide administrative data comparing changes in outcomes among target population individuals living in IMPACTS Cycle 1 & 2 service area, to concurrent changes in comparison regions. Evaluation time frame is January 2018 – June 2024. For more guidance on interpretation, see Figure 11. Abbreviation. Sig't = significant.

Convictions

Conviction rates and conviction-based recidivism continued to decline in IMPACTS service areas relative to comparison regions through the end of Cycle 2; however, in contrast to the Cycle 1 evaluation these effects did not reach statistical significance at the statewide level (Table 4). The expanded evaluation revealed a more mixed pattern of results across grantees. In the Cycle 1 evaluation, seven of 10 grantees showed favorable trends in conviction-related outcomes, compared with four of 15 grantees in the current evaluation. These findings suggest that several grantees that demonstrated early improvements were not able to sustain those gains over the longer evaluation period.

Incarcerations

Incarcerations increased by 6.1 per 1,000 target population members in IMPACTS service areas relative to comparison regions, representing a 7% rise over the baseline rate of 84.8 per 1,000. This finding extends a pattern first observed in the Cycle 1 evaluation, which also showed a small increase in incarcerations, though not statistically significant. Seven grantees saw relative increases in incarcerations, while one experienced a decrease and seven showed no change. The observed statewide increase was driven primarily by offenses classified as "other crimes" (2.8 per 1,000). This category includes a diverse mix of offenses not categorized as person, property, or drug crimes, including felony weapons offenses, witness tampering, failure to appear in court, coercion, driving-related charges, and others.

Reasons for the observed increase in incarcerations are unclear. Several broader system changes may have influenced criminal justice outcomes during the latter portion of the evaluation time frame, although it is not possible to determine the extent to which they contributed to this finding. These include the continued normalization of court operations and case processing following disruptions associated with the Covid-19 PHE, as well as implementation of House Bill 4002[9] in September 2024, which restored law enforcement authority to arrest or cite individuals for small amounts of controlled substances, formerly decriminalized in 2020 under Measure 110. Although possession charges were excluded from the assessment of outcomes in the current evaluation, changes in enforcement practices associated with House Bill 4002 may have altered patterns of criminal justice contact, potentially increasing opportunities for the detection of other offenses.

New in Cycle 2 evaluation: Incarceration outcomes are presented separately for drug, person, property, and other crimes. These additional measures provide greater context for understanding changes in overall incarceration rates.

Post-release outcomes

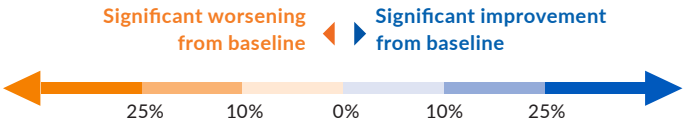
The rate of individuals experiencing an overdose event within two months of release from incarceration fell by 0.4 percentage points relative to comparison regions, representing a 29% reduction from the baseline rate of 1.4%. Two grantees experienced statistically significant decreases in post-release overdose events, while four grantees experienced small increases and nine showed no statistically significant change. Despite variation across grantees, the statewide result indicates a meaningful reduction in overdose risk following release from incarceration.

At baseline, approximately three-quarters of target population members in IMPACTS service areas were enrolled in Medicaid within two months of release from incarceration. Although Medicaid enrollment increased slightly relative to comparison regions during the evaluation period, the change was not statistically significant.

Healthcare

Table 5. Change in healthcare outcomes associated with IMPACTS Cycles 1 & 2

		Baseline rate	Adjusted change	Grantees with sig't change	Grantees with no change
Alcohol or Other Drug Treatment – Engagement (%)	↑	17.7	-0.6		
Alcohol or Other Drug Treatment – Initiation (%)	↑	34.8	1.5		
ED Visits – All (per year)	↓	3.7	-0.2		
ED Visits – Behavioral Health-related (per year)	↓	2.4	-0.2		
Inpatient Days – All (per year)	↓	3.7	-0.3		
Inpatient Days – Behavioral Health-related (per year)	↓	2.5	-0.3		
Medication-Assisted Treatment for Members with OUD (%)	↑	23.4	0.4		
Outpatient Visits – Behavioral Health Specialist (per year)	↑	15.3	-0.4		
Primary Care Physician Visits (per year)	↑	3.3	0.1		



↑ Higher is better

↓ Lower is better

Bolded text = Primary outcome

Notes. Results based on analysis of statewide administrative data comparing changes in outcomes among target population individuals living in IMPACTS Cycle 1 & 2 service areas, to concurrent changes in comparison regions. Evaluation time frame is January 2018 – June 2024. For more guidance on interpretation, see Figure 11. Abbreviations. ED = emergency department; OUD = opioid use disorder; sig't = significant.

Emergency department visits

IMPACTS was associated with relative declines in both all-cause and behavioral health-related emergency department visits (Table 5). While similar reductions were observed in the Cycle 1 evaluation, the earlier findings did not reach statistical significance. These results suggest that reductions in emergency department use became more evident as programs matured and additional grantees launched services.

Substance use disorder treatment

Alcohol and other drug treatment initiation and engagement no longer demonstrated statistically significant improvements at the statewide level, despite both measures having shown significant improvement during Cycle 1. Although several grantees continued to experience gains, there was no significant statewide effect. The specifications for these measures changed between the Cycle 1 evaluation and the current expanded evaluation, which may have contributed to this difference in findings. See the call-out box in Appendix D for more details.

Use of medication-assisted treatment among members with opioid use disorder increased modestly at the statewide level, but the change did not reach statistical significance. More than half of grantees demonstrated statistically significant improvements in medication-assisted treatment utilization, demonstrating meaningful gains among some grantees that were not reflected in the statewide result.

Hospital stays

Inpatient utilization also trended in a favorable direction. Both all-cause and behavioral health-related inpatient days decreased relative to comparison regions; however, these changes were not statistically significant, and more than half of grantees showed no measurable change.

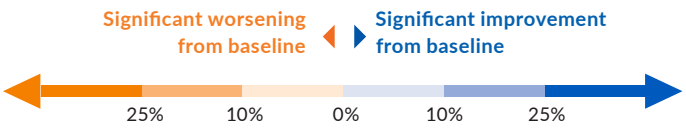
Outpatient visits

Approximately half of grantees achieved relative increases in visits with behavioral health specialists and primary care physicians. However, these improvements were offset by stable or declining utilization among other grantees, resulting in no statistically significant statewide change for either outcome.

Institutional placements at Oregon State Hospital

Table 6. Change in institutional placements associated with IMPACTS Cycles 1 & 2

		Baseline rate	Adjusted change	Grantees with sig't change	Grantees with no change
OSH Admissions – All (per 1,000 people)	↓	22.3	-3.9	●●● ●●●●●●●	●●●●●
OSH Admissions – Aid and Assist (per 1,000 people)	↓	13.7	-4.2	●● ●●●●●●●●	●●●●●
OSH Admissions – Civil (per 1,000 people)	↓	6.9	0.6	●●● ●	●●●●●●●●●●●
OSH Admissions – PSRB (per 1,000 people)	↓	1.6	-0.3	●●● ●●●	●●●●●●●●●



↑ Higher is better
↓ Lower is better

Bolded text = Primary outcome

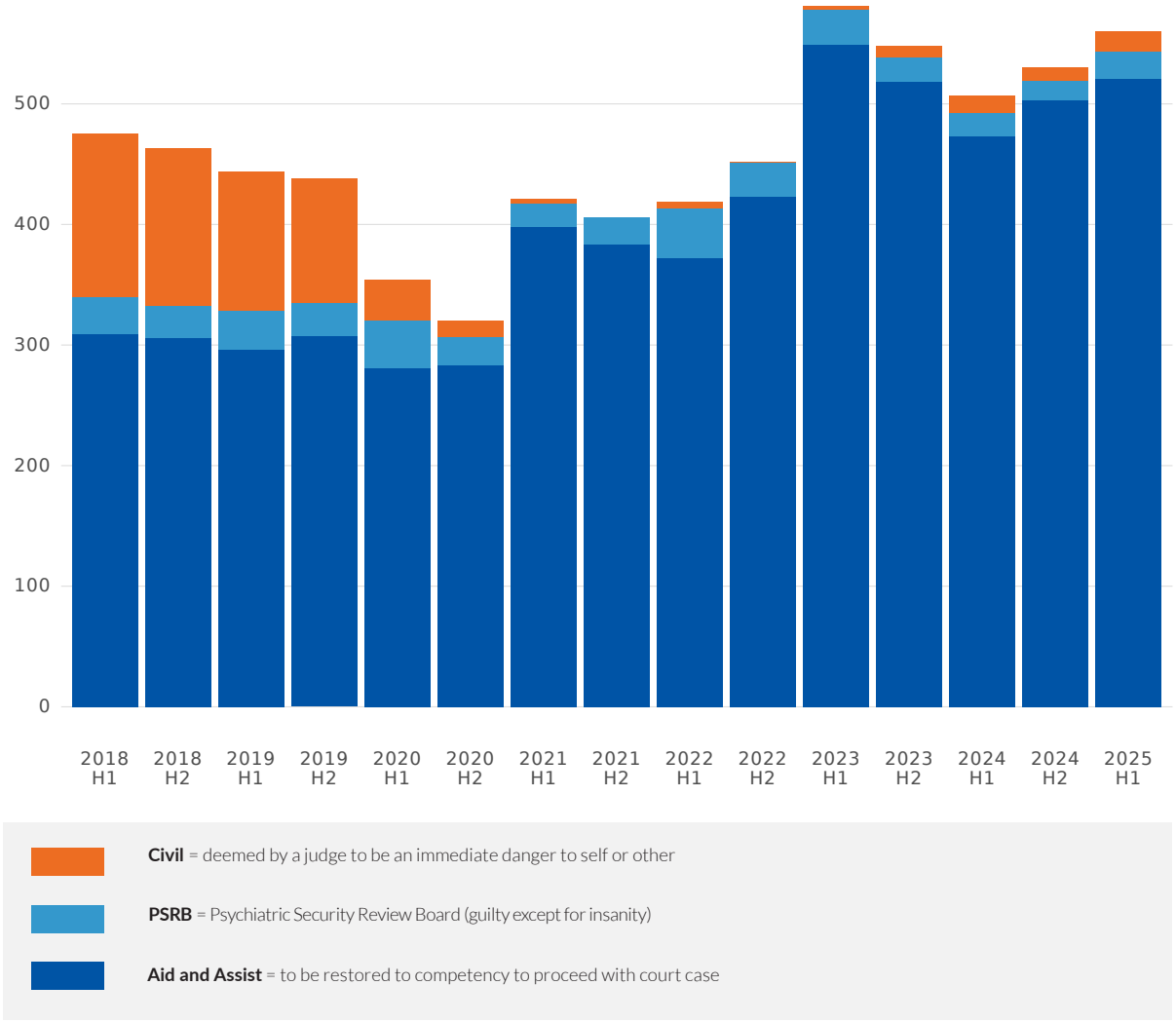
Notes. Results based on analysis of statewide administrative data comparing changes in outcomes among target population individuals living in IMPACTS Cycle 1 & 2 service areas, to concurrent changes in comparison regions. Evaluation time frame is January 2018 – June 2024. For more guidance on interpretation, see Figure 11. Abbreviations. OSH = Oregon State Hospital; PSRB = Psychiatric Security Review Board; sig't = significant.

Oregon State Hospital admissions

Oregon State Hospital admissions decreased in IMPACTS service areas relative to comparison regions, with 3.9 fewer admissions per 1,000 target population members (Table 6). This was largely attributable to a relative reduction in Aid and Assist admissions (-4.2 per 1,000 – a 30% reduction over the baseline rate) despite broader statewide pressures that increased demand for forensic beds during much of the evaluation time frame (see next page). In contrast, civil commitments showed a relative increase of 0.6 admissions per 1,000 target population members, continuing the pattern observed in the Cycle 1 evaluation.

These results suggest that changes associated with IMPACTS were concentrated within the forensic portion of the OSH system rather than occurring uniformly across all admission types. As in the Cycle 1 evaluation, the reasons for the observed changes are not clear from the current analysis and may reflect factors beyond the scope of IMPACTS-funded services.

Figure 12. Changes in Oregon State Hospital admissions continued throughout the expanded evaluation time frame



Notes. Bars represent the number of individuals in the study population (adults ages 18-64 and enrolled in Medicaid at any point during the evaluation time frame) admitted to the Oregon State Hospital. Abbreviations. PSRB = Psychiatric Security Review Board. H1 = first half (January 1 to June 30) and H2 = second half (July 1 to December 31) of a given calendar year.

A total of 6,925 admissions occurred between January 2018 – June 2024, with admissions ranging from 320 to 582 per half-year (Figure 12). Most individuals (70%) were admitted only once during the study period, while 20% experienced two admissions and 10% experienced three or more admissions.

As described in the Cycle 1 Report, the composition of OSH admissions changed dramatically during the evaluation time frame. In early 2018, nearly one-third of admissions were civil commitments, consistent with historical patterns. However, as demand for forensic services increased and OSH capacity became increasingly constrained, admissions associated with Aid and Assist orders and the Psychiatric Security Review Board were prioritized under existing statutory requirements. As a result, civil commitments were progressively crowded out, accounting for less than 1.5% of OSH admissions between 2021 and 2023.

Total admissions also reflect several major system-level events that occurred during the evaluation time frame. A decline in admissions during 2020 corresponded with temporary admission pauses related to the Covid-19 PHE. Conversely, the increase in admissions beginning in late 2022 coincided with the September 2022 Mosman Order[10], which established length-of stay limits for Aid and Assist cases that

accelerated patient turnover. The resulting rise in patient throughput allowed more individuals to cycle through the hospital, contributing to higher admission volumes despite ongoing capacity constraints. Because these changes affected OSH admissions statewide, they may have influenced admission patterns observed in both IMPACTS and comparison regions.

The final two years of the evaluation time frame reveal a modest increase in civil commitments compared with the preceding years, though they still remained far below the levels observed at the beginning of the evaluation period. A July 2023 amendment to the Mosman Order created an expedited and expanded process for admitting civil commitment patients – a process which was explicitly restricted in most instances by Judge Mosman's initial order.

Continued monitoring of OSH admissions will remain important due to recent policy changes. In 2025, Oregon enacted House Bill 2005[17], which modified the state's civil commitment standards by reducing emphasis on imminent risk and broadening the factors courts may consider when determining whether an individual meets commitment criteria. These changes took effect after the end of the current evaluation time frame and therefore could not have influenced the results presented here. However, because they may affect future patterns of civil commitment and OSH utilization, ongoing trend monitoring will provide needed context for interpreting future statewide evaluation findings.

Information on judges' orders for OSH admission preceding actual admission was not available for the current evaluation. Future evaluation efforts will continue to pursue these data to assess the extent to which admission orders ultimately result in OSH admission.

Methods

Development of the evaluation design

The statewide evaluation assesses the effectiveness of IMPACTS at achieving its legislatively mandated goals to reduce criminal justice system involvement, reduce emergency healthcare services utilization, and reduce institutional placements.

The evaluation design was informed by conversations with Criminal Justice Commission staff, other state agency staff, including the Oregon Health Authority's Tribal Affairs Director, and subject matter experts. These discussions improved our understanding of the data sources used in this report and their inherent limitations in the context of the IMPACTS evaluation.

Data sources

We used 2018-2025 administrative data from Oregon's health and criminal justice sectors (Table 7). This provided 2.5 years of pre-period data (January 2018 – June 2020), four years of post-period data covering Cycle 1 (July 2020 – June 2022) and Cycle 2 (July 2022 – June 2024), and an additional year of data for the calculation of outcomes following the end of Cycle 2 (July 2024 – June 2025). See Outcomes section for more detail on the timing of outcome measurements.

Records were linked at the individual level to allow identification of members of the IMPACTS target population, their outcomes, and their interactions with different service sectors over time.

Table 7. Overview of data sources for IMPACTS statewide evaluation

DATA SOURCE	AGENCY
Oregon Health Plan eligibility records and claims[18]	Oregon Health Authority
Oregon State Hospital admission and discharge records[19]	Oregon Health Authority
Heritage Native American roster[20]	Oregon Health Authority
Oregon Circuit Court filings[21]	Oregon Judicial Department
Community supervision administrative records[22]	Oregon Department of Corrections

Access to administrative data was permitted under data use agreements between multiple state agencies and OHSU. Data linkage was performed by Integrated Client Services[23], a shared service between the Oregon Department of Human Services and the Oregon Health Authority. For more details about the administrative data sources used in this evaluation and the linkage process, see Appendix C.

We also received total counts of the number of individuals who initiated IMPACTS services during July 2023 – June 2024, or who remained actively engaged in the program following previous enrollment.

The totals were calculated by SPH researchers using grantee-reported client information entered into a REDCap database.

Study population

The study population included adults ages 18-64 who were enrolled in the Oregon Health Plan (Medicaid) for any length of time during the evaluation time frame. Requiring enrollment in OHP allowed us to use health records to assess whether individuals met a key criterion for inclusion in the target population: having a behavioral health condition.

Excluded from our analysis were individuals with private or no health insurance. However, our Cycle 1 evaluation demonstrated that the OHP-enrolled study population accounts for the majority of individuals with community corrections records (79%), circuit court filings (70%), and Oregon State Hospital admissions (76%).[12]

For the analysis of healthcare outcomes, we excluded individuals with dual eligibility for Medicaid and Medicare, since Medicare claims were not available for this study, leaving an incomplete view of dual eligible members' healthcare services and diagnosis history.

As described below under Challenges and Limitations, target population members identified from this study population did not strictly overlap with individuals who received IMPACTS services. At the time of this report, participant-level service data were not linkable with the administrative data used in this statewide evaluation. Future evaluation will aim to more precisely identify individuals served by IMPACTS.

Outcomes

We assessed a variety of criminal justice and health-related outcomes, listed in Table 8. Bolded names indicate primary outcomes that tie directly to IMPACTS' stated goals. Additional outcomes – for example, recidivism and outpatient behavioral health visits – were included to provide a more complete and nuanced understanding of program effects.

Consistent with the Cycle 1 evaluation, we excluded offenses for low-level drug possession from our calculation of outcome measures. These were categorized as Class E violations under Oregon's Measure 110, but recriminalized in September 2024 after the passage of House Bill 4002. Future evaluation cycles that extend beyond the House Bill 4002 effective date will reconsider that exclusion.

Table 8. IMPACTS program goals mapped to evaluation outcomes

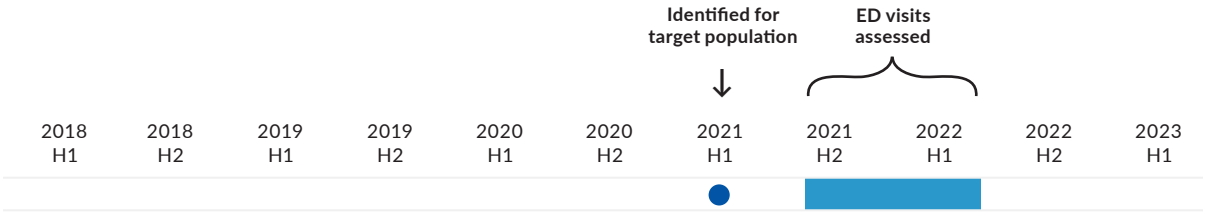
IMPACTS GOAL	OUTCOME MEASURE
Reduce criminal justice system involvement	**Convictions – All (↓)**
	Convictions – Misdemeanor (↓)
	Convictions – Felony (↓)
	Incarceration – All (↓)
	Incarceration – Drug Crimes (↓)
	Incarceration – Person Crimes (↓)
	Incarceration – Property Crimes (↓)
	Incarceration – Other Crimes (↓)
	Recidivism – Conviction (↓)
	Recidivism with 1 Year – Incarceration (↓)
	Release from Incarceration – Medicaid Enrollment within 2 Months (↑)
	Release from Incarceration – Overdose within 2 Months (↓)
Reduce emergency healthcare services utilization	Alcohol or Other Drug Treatment – Engagement (↑)
	Alcohol or Other Drug Treatment – Initiation (↑)
	ED visits – All (↓)
	ED visits – Behavioral Health-related (↓)
	Inpatient Days – All (↓)
	Inpatient Days – Behavioral Health-related (↓)
	Medication-Assisted Treatment for Opioid Use Disorder (↑)
	Outpatient Visits with a Behavioral Health Specialist (↑)
	Primary Care Physician Visits (↑)
Reduce institutional placements	**Oregon State Hospital Admissions – All (↓)**
	OSH Admissions – Aid and Assist (↓)
	OSH Admissions – Civil (↓)
	OSH Admissions – PSRB (↓)

Notes. Bolded measure names indicate primary outcomes that tie directly to the stated goals of IMPACTS. Arrows indicate the preferred direction of change.
Abbreviations. ED = emergency department; OSH = Oregon State Hospital; PSRB = Psychiatric Security Review Board

Most outcomes were measured during the year after an individual was identified for the IMPACTS target population to assess whether program supports offered sufficient stabilization to influence future outcomes.

For example, Figure 13 demonstrates that for an individual identified for the target population during January – June 2021, our evaluation assessed ED visits over the subsequent 12 months, running July 2021 – June 2022.

Figure 13. Example of outcome measurement relative to target population identification



Exceptions to this approach include outcomes for which the measurement period is intrinsically tied to a particular event date:

- Recidivism
- Medicaid enrollment after release from incarceration
- Overdose after release from incarceration

For these outcomes, measurement began concurrently with the period during which the individual was identified for the target population. For example, among individuals released from incarceration, we assessed whether they experienced an overdose event during the two months following their specific release date.

See Appendix D for more details on the outcomes included in the statewide evaluation.

Statistical approach

Our evaluation used a "staggered difference-in-differences" study design. We compared changes in outcomes for target population individuals living in IMPACTS service areas to changes in outcomes for a comparison group of target population individuals living in parts of the state without IMPACTS programs (Figure 2).

Our approach accounted for the staggered implementation of IMPACTS grantee programs. That is, the "pre-period" and "post-period" were defined on a grantee-by-grantee basis, according to the timing of their respective program launches (Figure 1).

Our models also controlled for demographic characteristics (age, sex, race and ethnicity) and how individuals qualified for the target population. We clustered standard errors at the county level to adjust for correlation in outcomes among people living in the same regions of the state, given that behavioral health funding and provision of services are routinely distributed through counties. This clustering also accounted for repeat observations among individuals who cycled in and out of the target population over time.

We assessed the robustness of our estimates to a variety of model specifications; for details, see Appendix E.

Challenges and limitations

Dynamic policy landscape

IMPACTS operated within a rapidly evolving behavioral health and criminal justice landscape. During the evaluation period, Oregon implemented numerous initiatives aimed at addressing substance use disorders, improving behavioral health service delivery, and reducing reliance on the criminal justice system for individuals with behavioral health needs. Examples include Measure 110, expansion of behavioral health treatment investments, and, later in the evaluation period, the Behavioral Health Deflection program established through House Bill 4002 (see Appendix A).

The evaluation period also coincided with the Covid-19 PHE, which created substantial disruptions across both the behavioral health and criminal justice systems. Court proceedings were delayed, hospital operations were strained, admissions to some facilities were temporarily suspended, and newly funded IMPACTS grantees faced significant challenges launching services during periods of social distancing and workforce shortages.

A key strength of this evaluation is the use of comparison regions, which helps account for external factors that affected IMPACTS and non-IMPACTS communities alike. Nevertheless, the combination of pandemic-related disruptions and concurrent statewide reforms makes it difficult to attribute observed changes solely to IMPACTS. Findings presented in this report should therefore be interpreted within the broader context of ongoing changes to Oregon's behavioral health and criminal justice systems.

Variation in local program design and implementation

A key feature of IMPACTS is the flexibility it offers grantees to define the focus and scope of their local programs. The statewide evaluation assesses the overall effects of these programs collectively, without identifying which specific program elements – such as target population focus, outreach strategies, or specific services – contribute most to observed grantee-level variation.

In addition, the statewide evaluation does not distinguish between grantee programs based on their level of maturity or robustness of implementation. Instead, all programs are considered "active" starting from the first observation period in which services were offered (Figure 1).

Qualitative data analysis conducted by SPH complements the statewide evaluation effort and provides more information about differences between grantee programs, as well as how these differences may lead to varying program results.[13,14]

Intent-to-treat approach

The statewide evaluation did not have access to data identifying which individuals received IMPACTS services. Instead, it relied on administrative data sources and an intent-to-treat approach based on residence in an IMPACTS service area and eligibility for the statewide evaluation target population. As a result, the statewide evaluation target population does not perfectly align with the population who actually received IMPACTS services.

This approach captured outcomes for more individuals than the number served by grantee programs, for several reasons:

- Some grantees defined their target populations more narrowly than the statewide evaluation criteria (Figure 3) – for example, focusing on individuals transitioning from carceral settings rather than those with frequent emergency department visits or stays at OSH.

- Some grantees focused their outreach efforts and services in specific geographic areas rather than implementing county-wide. Additionally, colonial-defined boundaries (like county or zip code) do not accurately represent Tribal service boundaries.
- We used race data from Medicaid enrollment records and the Heritage Native American indicator to identify individuals eligible for Tribal grantee services (see Appendices B and C for more details). However, these sources do not specify an individual's Tribal affiliation, which means our analysis may include members of federally recognized Tribes that did not receive IMPACTS funding.

Although IMPACTS was intended to focus on individuals with high levels of criminal justice, health care, or Oregon State Hospital utilization, grantee-reported data indicate that some IMPACTS clients did not meet the standardized high-utilizer criteria used for the purposes of statewide evaluation.[4] Thus, our approach likely included many individuals who never received IMPACTS services, while also excluding some individuals who received services but did not meet the statewide target population criteria.

As a result, our "intent-to-treat" approach assessed outcomes for a broadly-defined target population of individuals who would likely benefit from the program, regardless of their actual participation. Consequently, the measured effects may underestimate the program's impact on those who were served.

Rare outcomes

Several of the outcomes included in this statewide evaluation represent rare events, even among the target population of high utilizers with complex behavioral health needs. Examples include overdoses and OSH admissions.

The resulting "noisy" trends make it challenging to draw definitive conclusions, particularly with limited post-implementation observations available for some grantees. The strength and clarity of the evidence will become increasingly robust through ongoing statewide evaluation.

Unmeasured outcomes

The statewide evaluation uses administrative data sources to assess outcomes that tie directly to the legislatively mandated program aims of reducing criminal justice involvement, emergency healthcare services utilization, and institutional placements (see Table 7).

It also includes a limited number of secondary outcomes that provide more context for our interpretation of changes in the primary outcomes.

Local qualitative evaluation by SPH offers complementary information about a broader set of outcomes including provision of peer supports, housing services, and other quality of life indicators that provide a more holistic picture of how the IMPACTS program may influence the lives of individuals who receive services.[13,14]

CHAPTER 6

Conclusion

IMPACTS represents a significant state effort to reduce strain on criminal justice and healthcare systems through investment in locally designed programs that enhance community support for individuals with behavioral health needs and a history of intensive service use.

This report evaluated IMPACTS from its launch in July 2020 through the end of its second biennium grant cycle in June 2024. Overall, findings were broadly consistent with those reported in the Cycle 1 Report, although effect sizes and statistical significance varied. Findings in the prior evaluation reflected early results for ten Cycle 1 grantees through June 2022. In contrast, the current evaluation reflects a broader and more mature program landscape, incorporating both later-stage Cycle 1 implementation and early experience from five grantees that launched services between mid-2022 and mid-2024, including the state's most populous county, Multnomah.

At the statewide level, IMPACTS was associated with several positive effects, including fewer overdoses following release from incarceration, modest reductions in emergency department use, fewer Aid and Assist admissions to the Oregon State Hospital, and more civil commitments during a period in which such admissions were largely crowded out. However, we also observed an increase in incarcerations, driven largely by statutory offenses. Consistent with Cycle 1 findings, results varied considerably across grantees, likely reflecting differences in program design, implementation strategies, target populations, and community contexts.

Comparison of administrative and grantee-reported data revealed a substantial gap between need and capacity: the population likely to benefit from services was nearly eight times larger than the number of individuals grantee programs were able to serve.

Together, findings of this evaluation provide evidence that IMPACTS is associated with improvements in several outcomes aligned with its statutory goals, while also highlighting areas where challenges remain and additional attention may be warranted.

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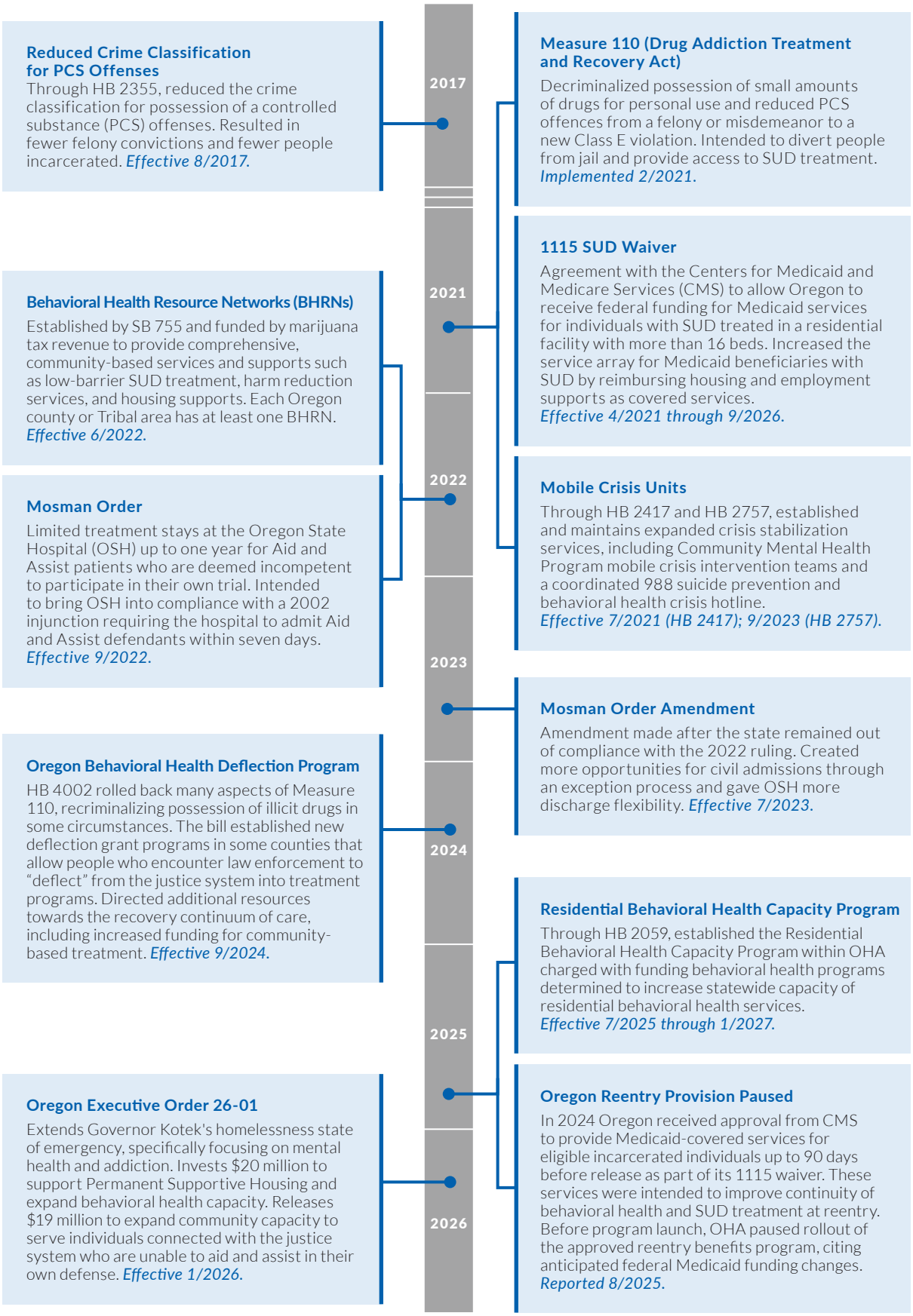
APPENDIX A

Oregon's changing behavioral health landscape

IMPACTS was one of several state efforts in recent years aimed at breaking the behavioral health/criminal justice involvement cycle and improving community support for individuals with behavioral health needs. Figure A offers an overview of particularly relevant policies rolled out during the same time frame as this evaluation and in the years immediately following IMPACTS Cycle 2.

The inclusion of a comparison group in our evaluation helps to control for these external factors. For more information about the study design, see "Methods."

Figure A. Timeline of IMPACTS and related policies



Abbreviations. BHRN = Behavioral Health Resource Network. CMS = Centers for Medicare and Medicaid Services. HB = House Bill. OHA = Oregon Health Authority. OSH = Oregon State Hospital. PCS = possession of a controlled substance. SB = Senate Bill. SUD = substance use disorder.

Identifying the target population

Identifying ED visits and hospitalizations: Emergency department visits were identified based on Current Procedural Terminology codes 99281-99285 and 99288 or revenue codes 450-459 and 981, with exceptions for laboratory-only claims.[24] For the purposes of identifying the target population, we excluded ED visits that resulted in a hospitalization to avoid double-counting episodes. We defined hospitalizations as services with a type of bill of 11 or 12, place of service code of 21 or 51, or claim type indicating inpatient (I) or inpatient crossover (A). We used the first date of service as the temporal point of reference.[25]

Identifying circuit court filings: Our analysis included court filings that were dispositioned as convicted, dismissed, or deferred. We excluded cases for pending bankruptcies. We used the offense date as the temporal point of reference.

Identifying community supervision and parole/probation: To identify individuals released from community supervision, we included custody types of incarceration, local control, parole and probation. We used release date as the temporal point of reference. We identified individuals currently on parole or probation via records with a historical admission date, an unpopulated release date, and custody type of parole or probation. We used the admission date as the temporal point of reference.

Identifying discharges from the Oregon State Hospital: Identifying individuals discharged from the Oregon State Hospital required us first to link records associated with a unique stay. We did this by matching records where the admission date from one record matched the discharge date of another record, for the same individual. Multiple records existed when, for example, an individual transferred between the Salem and Junction City campuses. Once unique stays were identified, we included individuals with a populated discharge date, using that date as the temporal point of reference.

Identifying individuals who lived in IMPACTS service areas: We used residential county and zip code information from Medicaid enrollment records to identify individuals who resided in IMPACTS service areas (see Figure 2). A limitation to this approach is that colonially-defined boundaries (such as county or zip code) do not map cleanly onto Tribal jurisdictions; hence, this approach approximated service areas for the IMPACTS Tribal grantees. If a grantee's service provisions were limited to specific cities or regions within the county, our approach overestimated individuals residing in IMPACTS service areas.

We used the Heritage Native American list of documented and verified Tribal affiliations maintained by OHA in collaboration with the Indian Health Board to identify AI/AN members (see Appendix C). Since not all AI/AN individuals register with a tribe, we also included individuals who self-reported as AI/AN during Medicaid enrollment.

Identifying individuals with a behavioral health condition: We used diagnosis codes in Medicaid claims data and admissions to the Oregon State Hospital to identify individuals with a behavioral health condition. If an individual had an undiagnosed behavioral health condition or received a diagnosis while uninsured or insured by another payer type (e.g., commercial insurance plan) during the evaluation period, we did not observe it in our dataset.

We identified ED visits and hospitalizations as being behavioral health-related if the primary diagnosis indicated a behavioral health condition. For the court filings and community supervision target population criteria, we identified individuals with behavioral health conditions from the Medicaid data based on any recorded diagnosis across the available data window (January 2018 – June 2025). Given that the Oregon State Hospital is a psychiatric hospital, we did not impose an additional behavioral health diagnosis requirement for individuals meeting the last target population criterion (see Figure 3).

Behavioral health condition diagnosis codes were from the Clinical Classifications Software Refined[26] from the Healthcare Cost and Utilization Project. This tool maps ICD-10 diagnosis codes into clinically meaningful categories. We included all categories under Mental, behavioral, and neurodevelopmental disorders except for tobacco-related disorders (Table B).

Table B. CCSR categories included in the IMPACTS statewide evaluation definition of "behavioral health condition"

CATEGORY	DESCRIPTION
MBD001	Schizophrenia spectrum and other psychotic disorders
MBD002	Depressive disorders
MBD003	Bipolar and related disorders
MBD004	Other specified and unspecified mood disorders
MBD005	Anxiety and fear-related disorders
MBD006	Obsessive-compulsive and related disorders
MBD007	Trauma- and stressor-related disorders
MBD008	Disruptive, impulse-control and conduct disorders
MBD009	Personality disorders
MBD010	Feeding and eating disorders
MBD011	Somatic disorders
MBD012	Suicidal ideation/attempt/intentional self-harm
MBD013	Miscellaneous mental and behavioral disorders/conditions
MBD014	Neurodevelopmental disorders
MBD017	Alcohol-related disorders
MBD018	Opioid-related disorders
MBD019	Cannabis-related disorders
MBD020	Sedative-related disorders
MBD021	Stimulant-related disorders
MBD022	Hallucinogen-related disorders
MBD023	Inhalant-related disorders
MBD025	Other specified substance-related disorders
MBD026	Mental and substance use disorders in remission
MBD027	Suicide attempt/intentional self-harm; subsequent encounter

Data sources and linkage

Table C provides an overview of the data sources used for IMPACTS statewide evaluation. These were chosen after a thorough review of datasets maintained by IMPACTS grantees and a variety of government entities. Ultimately, data sources were selected based on a combination of their utility to identify the IMPACTS target population and outcomes of interest, their suitability for linking at the person-level, and their availability for external research requests.

Table C. Overview of data sources for IMPACTS statewide evaluation

DATA SOURCE	DESCRIPTION
Oregon Circuit eCourt filings[21]	Oregon eCourt data contain person-based case information for the state's 36 circuit courts and the Oregon Tax Court. Data fields used to assess law enforcement contact/criminal-legal involvement include state ID number, filing date, charge penal code, charge severity, and defendant name and demographic characteristics. In the context of the IMPACTS statewide evaluation, eCourt filings serve as an indicator of criminal justice involvement, given that comprehensive jail booking data are not available from a single statewide source. Oregon eCourt data are stewarded by the Oregon Judicial Department and stored in the person-based Odyssey data management system.
Community supervision administrative records[22]	Administrative data from the Oregon Department of Corrections include information on individuals with any felony and some misdemeanor convictions, along with corresponding sentences. Only misdemeanor convictions where the individual was supervised by County Community Corrections are included, for example, misdemeanor drug possession and some domestic violence offenses. The data do not include information for individuals who were only convicted of less serious misdemeanor offenses, or those who were arrested and not convicted. Administrative records are maintained by the Oregon Department of Corrections, Research and Evaluation unit.
Oregon Health Plan eligibility records and claims[18]	Eligibility and claims data from the Oregon Health Plan (Oregon's Medicaid program) include basic demographic and coverage information as well as details about healthcare services and diagnoses received by covered members. Oregon Health Plan data are stewarded by the Oregon Health Authority.
Oregon State Hospital admission and discharge records[19]	The Oregon State Hospital dataset includes information on admissions and discharges (Salem and Junction City campuses), as well as basic demographics, referral sources, commitment typology, and circumstances of discharge. Oregon State Hospital data are stewarded by the Oregon Health Authority.
Heritage Native American roster[20]	The HNA roster includes a list of documented and verified Tribal affiliations maintained by the Oregon Health Authority in collaboration with the Indian Health Board to identify members who are American Indian/Alaska Native. The HNA roster is stewarded by the Oregon Health Authority.

DATA SOURCE	DESCRIPTION
Research Electronic Data Capture grantee-reported IMPACTS client totals	IMPACTS grantees report information about clients they serve in a REDCap database. This database includes information about client demographics and social risks, utilization histories, and provided services. The IMPACTS REDCap database is administered by the OHSU-PSU School of Public Health. SPH provided aggregated client totals to the statewide evaluation team; this data was not linkable with the other person-level datasets listed above.

Person-level linkage across these data sources was performed by Integrated Client Services, a unit within the Office of Forecasting, Research and Analysis, and a shared service between the Oregon Department of Human Services and the Oregon Health Authority.[23] ICS uses a combination of deterministic, probabilistic and manual matching to link records at the person-level across administrative data sources. The ultimate success of the match is dependent upon the quality and completeness of the source data.

Additional data sources that were of interest but not included in the statewide evaluation include:

1. **Jail bookings** data identify individuals booked into county and municipal jails pre-trial, sanctioned for violations of Community Corrections supervision, or sentenced to less than one year of incarceration. Data are maintained locally on closed, secure data systems. Data are not standardized across counties or municipalities and are not aggregated for analysis at the state level. The CJC reports on jail bookings among IMPACTS clients in the year prior to enrollment, based on grantee-reported information in REDCap.[4]

2. ***The Law Enforcement Data System***[28] is a database created for law enforcement records such as warrants, protection orders, stolen property, criminal histories, and other vital investigative files. LEDS is organized within the Department of Oregon State Police and is the control point for access to similar programs operated by other states and the Federal Government. LEDS is designed to facilitate exchange of law enforcement information between criminal justice agencies, and data sharing criteria are written into Oregon Administrative Rules. The Oregon Criminal Justice Commission has limited access to LEDS to track arrests and convictions for evaluation and planning purposes, but does not have rights to re-disclose data to other institutions or to link these data to individual-level health records.

3. **Oregon's All-Payer All-Claims**[29] reporting program contains medical, dental and pharmacy claims, payment amounts, member demographics, billed premiums, and provider information for the majority of Oregon residents. APAC includes information for individuals who have healthcare coverage through commercial insurance (including PEBB and OEBB), Medicaid and Medicare Parts A-D. APAC does not include data on individuals who are uninsured or who receive insurance through certain federal programs such as Tricare, the Federal Employees Health Benefits Program, the Department of Veterans Affairs, or (notably, for IMPACTS) the Indian Health Service. Prior to July 2022, APAC masked claims related to alcohol and drug treatment services to comply with federal confidentiality requirements under 42 CFR Part 2, limiting its utility for behavioral health evaluations. Subsequent federal regulatory changes permitted the use and disclosure of SUD treatment information for research, audit, and program evaluation purposes, enabling inclusion of these claims in APAC data submissions and substantially improving APAC's potential value for behavioral health evaluation efforts. However, limitations in data completeness, particularly between 2016 and 2021, precluded its use in the current evaluation.

4 The **Indian Health Service**[30] is an agency within the U.S. Department of Health and Human Services that provides federal health services to American Indians and Alaska Natives. Many Oregon Tribes provide healthcare services to their members through IHS facilities. Since these facilities can bill the Oregon Health Plan (Medicaid) for services similar to non-IHS facilities, access to IHS data as a separate source for information on healthcare utilization was not deemed necessary.

5 **Measures and Outcomes Tracking System**[31] data were maintained by OHA to capture select behavioral health services; they also served as a source to identify referrals to the Oregon State Hospital that did not result in an admission (e.g., due to Covid-19 PHE over-crowding). However, individual identifiers in the MOTS data were unreliable, which would have prevented us from accurately linking records across individuals. Additionally, providers were allowed reprieves from reporting services to MOTS during the Covid-19 PHE, and retroactive service capture was considered incomplete. The Business Interface object by which MOTS data could be queried was unavailable during the Cycle 1 evaluation, due to the expiration of a software contract. In March 2025, MOTS was replaced by the Resilience Outcomes Analysis and Data Submission system.[31]

Outcome specifications

Updates from Baseline and Cycle 1 Reports: Certain outcomes included in this report were calculated using updated methods or specifications and are therefore not directly comparable to results presented in the Baseline and Cycle 1 Reports.

Convictions (All, Felony, and Misdemeanor)
The conviction outcomes in the Baseline and Cycle 1 Reports were calculated using Oregon Circuit Court data extracts based on case filing date, rather than case disposition date, which was used in this report. This change provided a more complete accounting of convictions during the evaluation period, by capturing convictions regardless of when the underlying case was filed.

Sensitivity analyses indicated that this methodological change did not substantially affect findings. Nevertheless, conviction-related results reported here should not be directly compared with conviction-related results presented in earlier reports.

Alcohol or Other Drug Dependence Treatment (Initiation and Engagement)
The Baseline and Cycle 1 Reports calculated these outcomes using the 2016 HEDIS® Technical Specifications for Health Plans, while this report uses the updated 2024 HEDIS® specifications.

Although HEDIS measure updates are often limited to technical changes needed to accommodate new diagnosis, procedure, and billing practices, the definitions of Alcohol or Other Drug Dependence Treatment changed substantially between the 2016 and 2024 versions. For example, the updated specifications allow an individual to contribute multiple qualifying treatment episodes within a measurement period, whereas the former specifications selected a single episode per individual. As a result, Initiation and Engagement findings presented in this report are not directly comparable to those reported in the Baseline and Cycle 1 evaluations.

Domain: Criminal Justice

Convictions – All

Description: Number of convicted cases, reported per 1,000 individuals

Source: Oregon Circuit eCourt filings; Medicaid enrollment records

Steward: CHSE

Convictions – Felonies

Description: Number of convicted felony cases, reported per 1,000 individuals

Source: Oregon Circuit eCourt filings; Medicaid enrollment records

Steward: CHSE

Convictions – Misdemeanors

Description: Number of convicted misdemeanor cases, reported per 1,000 individuals

Source: Oregon Circuit eCourt filings; Medicaid enrollment records

Steward: CHSE

Incarceration – All Crimes

Description: Number of prison admissions, reported per 1,000 individuals

Source: Oregon Department of Corrections administrative data; Medicaid enrollment records

Steward: CHSE

Incarceration – Drug Crimes

Description: Number of prison admissions for drug crimes (excluding possession of a controlled substance), reported per 1,000 individuals

Source: Oregon Department of Corrections administrative data; Medicaid enrollment records

Steward: CHSE

Incarceration – Person Crimes

Description: Number of prison admissions for crimes against persons, reported per 1,000 individuals

Source: Oregon Department of Corrections administrative data; Medicaid enrollment records

Steward: CHSE

Incarceration – Property Crimes

Description: Number of prison admissions for crimes against property, reported per 1,000 individuals

Source: Oregon Department of Corrections administrative data; Medicaid enrollment records

Steward: CHSE

Incarceration – Other Crimes

Description: Number of prison admissions for crimes other than drug, person or property, reported per 1,000 individuals

Source: Oregon Department of Corrections administrative data; Medicaid enrollment records

Steward: CHSE

Recidivism within 1 Year – Conviction

Description: Percentage of individuals convicted of a misdemeanor or felony charge within 1 year of release from a prison or felony jail sentence or start of probation

Source: Oregon Department of Corrections administrative data; Oregon Circuit eCourt filings

Steward: CHSE

Recidivism within 1 Year – Incarceration

Description: Percentage of individuals reincarcerated within 1 year of release from a prison or felony jail sentence or start of probation

Source: Oregon Department of Corrections administrative data; Oregon Circuit eCourt filings

Steward: CHSE

Release from Incarceration – Medicaid Enrollment within 2 Months

Description: Percentage of individuals who enrolled in the Oregon Health Plan within 2 months of release from a prison or felony jail sentence

Source: Oregon Department of Corrections administrative data; Medicaid enrollment records

Steward: CHSE

Release from Incarceration - Overdose within 2 Months

Description: Percentage of individuals who experienced an overdose event within 2 months of release from a prison or felony jail sentence

Source: Oregon Department of Corrections administrative data; Medicaid enrollment and claims records

Steward: CHSE

Domain: Health outcomes

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Alcohol or Other Drug Dependence Treatment – Engagement

Formal Name: Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment

Description: The percentage of members with a new episode of alcohol or other drug dependence who initiated treatment (see Alcohol or Other Drug Dependence Treatment – Initiation) and had two or more additional services with a diagnosis of alcohol or other drug abuse within 30 days of the initiation visit

Source: Medicaid claims

Steward: HEDIS® Technical Specifications for Health Plans, NCQA

Alcohol or Other Drug Dependence Treatment – Initiation

Formal Name: Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment

Description: The percentage of members with a new episode of alcohol or other drug dependence who initiated treatment through an inpatient alcohol or other drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis

Source: Medicaid claims

Steward: HEDIS® Technical Specifications for Health Plans, NCQA

ED Visits – All

Formal Name: ED Utilization per MY

Description: Number of emergency department visits, reported per member year

Source: Medicaid claims

Steward: CHSE and Handel et al[24]

ED Visits – Behavioral Health-related

Formal Name: ED Utilization for Behavioral Health Services per MY

Description: Number of emergency department visits for behavioral health services, reported per member year

Source: Medicaid claims

Steward: CHSE and Handel et al[24] and CCSR[26]

Inpatient Days – All

Formal Name: Inpatient Days per MY

Description: Number of inpatient days, reported per member year

Source: Medicaid claims

Steward: CHSE

Inpatient Days – Behavioral Health-related

Formal Name: Inpatient Days for Behavioral Health Services per MY

Description: Number of inpatient days for behavioral health services, reported per member year

Source: Medicaid claims

Steward: CHSE

Medication-Assisted Treatment for Members with an Opioid Use Disorder

Description: The percentage of members with an opioid use disorder diagnosis who received medication-assisted treatment

Source: Medicaid claims

Steward: CHSE

Outpatient Visits – Behavioral Health Specialist

Description: Number of outpatient visits with a behavioral health specialist, reported per member year; includes psychotherapy, counseling, evaluation and management, skills training, peer services, and assertive community treatment[33]

Source: Medicaid claims, National Plan and Provider Enumeration System

Steward: CHSE

Primary Care Physician Visits

Description: Number of visits with a primary care physician[33], reported per member year

Source: Medicaid claims, National Plan and Provider Enumeration System

Steward: CHSE

Domain: Oregon State Hospital

OSH Admissions – All

Description: Number of admissions to the Oregon State Hospital, reported per 1,000 individuals

Source: Oregon State Hospital records; Medicaid enrollment records

Steward: CHSE

OSH Admissions – Aid and Assist

Description: Number of admissions to the Oregon State Hospital under Aid and Assist orders, reported per 1,000 individuals

Source: Oregon State Hospital records; Medicaid enrollment records

Steward: CHSE

OSH Admissions – Civil

Description: Number of admissions to the Oregon State Hospital under civil orders, reported per 1,000 individuals

Source: Oregon State Hospital records; Medicaid enrollment records

Steward: CHSE

OSH Admissions – PSRB

Description: Number of admissions to the Oregon State Hospital under the jurisdiction of the Psychiatric Security Review Board, reported per 1,000 individuals

Source: Oregon State Hospital records; Medicaid enrollment records

Steward: CHSE

Robustness to alternative model specifications

The estimates produced by our models are based on traditional assumptions of the difference-in-differences approach, including that trends in our outcomes during the pre-period are similar between individuals in the target population who resided in IMPACTS service areas versus comparison regions.

We visually and empirically investigated alternative model specifications to test the importance of this assumption and other model features. Specifically, we compared models that included versus excluded demographic characteristics and information on how individuals qualified for the target population, and models that adjusted versus did not adjust for differences in pre-period trends between target populations in IMPACTS service areas versus comparison regions ("de-trending").

Across most outcomes, the direction of estimated effects was consistent across model specifications. Including covariates generally had little impact on estimates, whereas adjusting for differences in pre-period trends often produced larger effect estimates and increased the likelihood of statistical significance.

Criminal justice outcomes were generally more sensitive to model specifications than other domains. In particular, measured changes in convictions, recidivism, and incarceration were more sensitive to whether pre-period trends were adjusted:

- **Convictions** (All; Misdemeanors; Felonies) – All model specifications suggested reductions in convictions in IMPACTS service areas relative to comparison regions. However, estimated effect sizes varied across specifications, and statistical significance was observed only in models that adjusted for pre-period trends. For all convictions, estimated reductions ranged from -8.0 to -67.1 convictions per 1,000 target population members across model specifications. The estimate reported in Table 4 was a non-statistically significant reduction of 14.2 convictions per 1,000.
- **Incarceration** (All Crimes; Drug Crimes; Person Crimes; Property Crimes; Other Crimes) – For overall incarcerations, Table 4 reports a small but statistically significant increase (6.1 per 1,000 people). Incarceration-related outcomes were somewhat sensitive to model specification. Detrended models generally yielded smaller estimates for incarceration related to drug, person and property crimes, while producing a larger and statistically significant increase for incarcerations related to other crime types.
- **Recidivism** (All; Convictions; Incarceration) – Similar to convictions, only the detrended models demonstrated statistical significance, and these models yielded larger effect sizes than the models based on unadjusted outcomes. In Table 4 we report a small and non-statistically significant increase in recidivism due to reincarceration (0.3 percentage points); detrended models indicated a decrease in this outcome. Overall recidivism and recidivism associated with new convictions yielded reductions across model specifications.

Taken together, these findings suggest that conclusions regarding the direction of effects were generally robust across specifications, although the magnitude and statistical significance of several criminal justice outcomes were sensitive to the treatment of pre-period trends.

This evaluation reports the results from models that included covariates but did not adjust outcomes for pre-period trend differences between IMPACTS service areas and comparison regions. We selected this specification for three reasons. First, visual and empirical assessments suggested that not all outcomes required de-trending. Second, several outcomes were relatively rare, and we sought to avoid adjustments based on potentially unstable estimates of pre-period trends. Third, given the large number of outcomes evaluated, we prioritized a consistent modeling approach across analyses rather than adopting outcome-specific specifications, which could reduce interpretability.

In general, the reported estimates were more conservative (closer to zero) and less likely to be statistically significant than estimates obtained under specifications that incorporated de-trending. As a result, our modeling approach provides a relatively cautious assessment of IMPACTS-associated changes.