Plan Table 1. Priority Area and Annual Performance Indicators – Required for MHBG & SUPTRS BG

States should follow the guidelines presented above in Framework for Planning and Planning Step 2 to complete Plan Table 1. States are to complete a separate table for each state priority area to be included in the MHBG and SUPTRS BG. Please enter the following information into WebBGAS:

1. Priority area (based on an unmet service need or critical gap): After this is completed for the first priority area, another table will appear so additional priorities can be added.

2. Priority type: From the drop-down menu, select SUP – substance use primary prevention, SUT – substance use disorder treatment, SUR – substance use disorder recovery support services, MHS – mental health service, ESMI – early serious mental illness, or BHCS – behavioral health crisis services.

3. Required populations: Indicate the population(s) required in statute for each Block Grant as well as those populations encouraged, as described in IIIA Framework for Planning. States must include at least one performance indicator for each required population. For example, at least one priority area must be denoted SUP (substance use primary prevention, priority type) and PP (persons in need of substance use primary prevention, required population). From the drop-down menu select:

a. SMI: Adults with SMI

b. SED: Children with an SED

c. ESMI: Individuals with ESMI including psychotic disorders

d. BHCS: Individuals in need of behavioral health crisis services

e. PWWDC: Pregnant women and women with dependent children who are receiving SUD treatment services

f. PP: persons in need of substance use primary prevention

g. PWID: Persons who inject drugs

h. EIS (Early Intervention Services)/HIV: Persons with or at risk of HIV/AIDS who are receiving SUD treatment services

i. TB: Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or

j. PRSUD: Persons in need of recovery support services from substance use disorder

k. Other- Specify (Refer to section IIIA of the Assessment and Plan)

4. Goal of the priority area. Goal is a broad statement of general intention. Therefore, provide a general description of what the state hopes to accomplish. It is required for there to be at least one goal related to the primary prevention priority area that addresses one or more of the six prevention strategies and proposed populations to be served.

5. Objective. Objective should be a concrete, precise, and measurable statement.

6. Strategies to attain the objective. Indicate program strategies or means to achieve the stated objective.

7. Annual Performance Indicators to measure achievement of the objective. Each performance indicator must reflect progress on a measure that is impacted by the Block Grant. At least one performance indicator should be created for each population specified under the priority area. A performance indicator must have the following components:

a. Baseline measurement from where the state assesses progress

b. First-year target/outcome measurement (Progress to the end of 2026)

c. Second-year target/outcome measurement (Final to the end of 2027)

d. Data source

e. Description of data; and

f. Data issues/caveats that affect outcome measures

Plan Table 1. Priority Area and Annual Performance Indicators

Priority Area: Connect all people in Oregon to behavioral health services and supports when and where they need them.
2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS):
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):
Goal of the priority area: **Measure, incentivize, and increase timely access to responsive behavioral health services and supports across the life course, in the community**.
5. Objective: **Ensure treatment demands in the state are met**.
6. Strategies to attain the objective: **Enhance and expand youth and young adult behavioral health access at all levels of care, with a focus on priority populations in home and community-based services.** **Enhance and expand older adult behavioral health access at all levels of care (continuum of care)**

Expand access to home and community-based services in each county in Oregon for people with serious mental health or substance use challenges. **Incorporate the availability of responsive services delivered by providers in CCO and open card networks in relation to member demographics as part of network adequacy reviews.**

Annual Performance Indicators to measure achievement of the objective:

Indicator#1 **Increase treatment and services provided to Older Adults**
a) Baseline measurement (Initial data collected prior to and during 2026): **Older adults age 60 and older served by CMHP**
b) First-year target/outcome measurement (Progress to the end of 2026): **25% increase from baseline**
c) Second-year target/outcome measurement (Final to the end of 2027): **50% increase from baseline**
d) Data source: **Medicaid Claims data (MMIS)**
e) Description of data: **billable services**
f) Data issues/caveats that affect outcome measures: **Medicaid claims data do not include all individuals in Oregon, only those enrolled in Medicaid. Claims data has a delay of 3-6 months. Race/ethnicity data is self-report and has a high occurrence of "other".**

Indicator#2 **Increasing number of individuals accessing Medication Assisted Treatment (MAT)**
a) Baseline measurement (Initial data collected prior to and during 2026): **24,292**
b) First-year target/outcome measurement (Progress to the end of 2026): **+2%**
c) Second-year target/outcome measurement (Final to the end of 2027): **+2%**
d) Data source: **All-Payer Claim Database (APCD)**
e) Description of data: **The voluntary Oregon All-Payers Claim Database (APCD) at Comagine Health contains data from about 80% of Oregon. In particular, our Commercial data is not fully complete as some payers choose not to participate.**
f) Data issues/caveats that affect outcome measures: **Only people with access to medical services, as demonstrated by a medical claim, are included in this data set. Not everyone who has a substance use disorder has been diagnosed.**

Indicator#3 **Increase the number of community education and outreach events to about EASA: Early Assessment and Support Alliance and Early psychosis for primary care providers.**

a) Baseline measurement (Initial data collected prior to and during 2026): **10.5 (4 quarter average from 2024 Q3 - 2025 Q2) outreach events to medical providers. Indicator goal: Increase program community education and outreach to Primary Care Providers based on pathway to care feedback from EASA Family Council members, as this has been identified as a missed opportunity for EASA program referral. Expected outcome: We will see an increase in the referrals coming from Primary Care Providers and ideally a decrease in referrals from higher level of care providers (Hospitals, EDs). See Data issues/caveats below.**
b) First-year target/outcome measurement (Progress to the end of 2026): **28 outreach and education events to primary care providers.**
c) Second-year target/outcome measurement (Final to the end of 2027): **56 outreach and education events to primary care providers.**
d) Data source: **Agency staff enter data into the EASA Center for Excellence's REDCap project, which is comprised of several databases. That data is used for the analysis.**
e) Description of data: **Community outreach to primary care providers is recorded in the outreach and education REDCap database. "Primary Care Provider" is a categorical, integer valued, variable. There is an "Other" option that, if selected, will allow data entry into an open text field. The source of a referral is recorded in the participant REDCap database, it is an integer valued categorical variable. There is an "Other" option that if selected, will allow data entry into an open text field.**
f) Data issues/caveats that affect outcome measures: **Before 8/22/25 the more granular category of "Primary Care Provider" did not exist, it was more generally included in the "Medical Provider" category. This makes establishing a baseline number of community education events to primary care providers difficult; however, this category has now been added. Other issues are: standard errors that arise with data entry such as accidentally selecting the wrong category, or filling an unclear response into the "Other" open text field.**

Indicator#4 **Adults with SMI who received Assertive Community Treatment services**
a) Baseline measurement (Initial data collected prior to and during 2026): **Increase capacity by at least 2.5% per end of year capacity (Jan 1 – Dec 31, 2025). With Phase Two of Tool for Measuring Assertive Community Treatment (TMACT) Transition, "Practice the Model" begins Jan 1, 2026, with Projection fidelity reviews for all ACT Teams. "Projection" refers to a mock/practice fidelity review that will not have negative impacts to certification however will be used to support the creation of a technical assistance plan to assist ACT Teams to address areas that need improvement in preparedness for full TMACT implementation in 2028. .**

b) First-year target/outcome measurement (Progress to the end of 2026): **Goal to increase capacity by 2.5%. Improving health outcomes and identifying success of data and landscape restructure. 2026 will be first full year of all revamp strategies to be in place simultaneously.**
c) Second-year target/outcome measurement (Final to the end of 2027): **5-6% increase per capacity in 2025 , and at least 2 new ACT programs to improve service availability. Benchmark fidelity rating requirements will be established and enforced to promote high fidelity**
d) Data source: **Compiled data from both OHA direct data source and Oregon Center for Excellence of Assertive Community Treatment (OCEACT) data collection**.
e) Description of data: **Combination of qualitative & quantitative service delivery and participant relative data in conjunction with fiscal needs assessment**.
f) Data issues/caveats that affect outcome measures: **The learning curve and culture shift of a new fidelity scale.**

Priority Area: Bolster the behavioral health workforce.
2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS):
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):
4. Goal of the priority area: **Recruit, retain, and expand the capacity of the behavioral health workforce to provide culturally and linguistically responsive care**.
5. Objective: **Increase the number of people incentivized to pursue or sustain a career in behavioral health**.
6. Strategies to attain the objective: **"Skill up" the behavioral health workforce through training and education in best practices to increase the confidence and competency of providers to better treat and support those accessing care.** **Retain and expand the behavioral workforce building on the 2021–2023 legislative session's House Bill (HB) 2235 and HB 2949 workforce investments — continuing rate increases and other provider incentives.** **Meaningfully include best practices that are within incentives offered to increase and maintain the workforce.**
7. Annual Performance Indicators to measure achievement of the objective:

Indicator#1 **Increase the number of behavioral health workforce that are trained in suicide prevention for youth and young adults**

a) Baseline measurement (Initial data collected prior to and during 2026): **82% of behavioral health providers reported taking a suicide prevention, intervention or postvention training in 2024** **80% of participants attend 100% of ECHO sessions**
b) First-year target/outcome measurement (Progress to the end of 2026): **85% of behavioral health providers will have taken a suicide prevention, intervention or postvention training** **50% of specialty BH ECHO participants will attend 80% of sessions.**
c) Second-year target/outcome measurement (Final to the end of 2027): **85% of behavioral health providers will have taken a suicide prevention, intervention or postvention training** **80% of specialty behavioral health ECHO participants will attend 100% of sessions**
d) Data source: licensing boards reporting **ORPRN (Oregon Rural Practice-Based Network) ECHO Hub**
e) Description of data: **Counts of participants, percentage of behavioral health re-licensees that report having taken a suicide prevention, intervention or postvention training** **Counts of participants at each ECHO session**
f) Data issues/caveats that affect outcome measures: **Occasionally, there are extenuating circumstances for why a licensing board cannot gather and report this data to OHA. Typically, there are no issues**.

Indicator#2 **Increase the children's behavioral health workforce trained in Evidence Based Practices (EBP) and promising practices**
a) Baseline measurement (Initial data collected prior to and during 2026): **290 trainees completed training in Parent Child Interaction Therapy, Child Parent Psychotherapy, Generation PMTO and Parenting through Change, Trauma Focused Cognitive Behavioral Therapy, Nurtured Heart Approach and Collaborative Problem Solving in 2025.**
b) First-year target/outcome measurement (Progress to the end of 2026): **Train over 320 providers**
c) Second-year target/outcome measurement (Final to the end of 2027): **Train over 340 providers**
d) Data source: **Reports from contractors**
e) Description of data: **Number of individuals completing the trainings**
f) Data issues/caveats that affect outcome measures: **This counts number of trainees in each training. Many individuals take more than one training and can be counted multiple times. This is especially true for early childhood practitioners.**

Indicator#3 **Number of individuals trained as Family Support Specialists**
a) Baseline measurement (Initial data collected before and during 2026): **97 (2024)**
b) First-year target/outcome measurement (Progress to the end of 2026): **100**
c) Second-year target/outcome measurement (Final to the end of 2027): **110**
d) Data source: **Contractor data**

e) Description of data: **Count of individuals completing the Family Support Specialist Foundations 40-hour training.**
f) Data issues/caveats that affect outcome measures: **OHA currently has one provider for this training and data. If others add this curriculum, then data may become more difficult to track**.

Indicator#4 **Increase behavioral health providers trained in older adult core competencies for complex populations (TBI, I/DD, Multi-morbidity, SMI & Dementia) through ECHO.**
a) Baseline measurement (Initial data collected prior to and during 2026) **XXX of participants in all older adult behavioral health ECHO programs and participation rate**
b) First-year target/outcome measurement (Progress to the end of 2026):**50% of specialty ECHO participants will attend 80% of ECHO sessions.**
c) Second-year target/outcome measurement (Final to the end of 2027):**80% of specialty behavioral health ECHO participants will attend 100% of ECHO sessions**
d) Data source: **ORPRN ECHO Hub**
e) Description of data: **Counts of participants at each session**.
f) Data issues/caveats that affect outcome measures: **None anticipated**

Indicator#5 **- Increase the number of child psychiatrists and developmental pediatricians being trained in Oregon.**
a) Baseline measurement (Initial data collected prior to and during 2026): **3**
b) First-year target/outcome measurement (Progress to the end of 2026): **8**
c) Second-year target/outcome measurement (Final to the end of 2027): **8**
d) Data source: **Internal data provided by contractors**
e) Description of data: **Count of Fellowships**
f) Data issues/caveats that affect outcome measures: **Issues with recruitment or Fellows exiting the program early could impact the number of participants.**

Indicator#6**: Recruit or retain workforce to address high vacancy rates and present actionable recruitment and retention plans for high-need service areas, such as mobile crisis, residential SUD, and other critical behavioral health service gaps.**
a) Baseline measurement (Initial data collected prior to and during 2026): **Work to start 2026**
b) First-year target/outcome measurement (Progress to the end of 2026): **Contract with 5 entities, 37 individuals served.**
c) Second-year target/outcome measurement (Final to the end of 2027): **Contract with 15 entities, 110 individuals served.**
d) Data source: **OHA contracting data**
e) Description of data: **Internal OHA tracking**
f) Data issues/caveats that affect outcome measures: **Work is continuing to define the focus for this workforce investment program.**

Priority Area: Adopt a "Behavioral Health in All" policy.
2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS):
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):
4. Goal of the priority area: **Address upstream social determinants of health and structural challenges through a primary prevention lens**.
5. Objective: **Increase the utilization of health-related services among people with severe mental illness and substance use-related needs.**
6. Strategies to attain the objective: **Enhance and expand behavioral health supports for early childhood by providing training, clinical supports, and education to providers and families of young children.** **Reduce stigma and foster behavioral health and wellness by engaging individuals with lived expertise, families, peers and community partners in outreach efforts to raise awareness and connect people to services.** **Develop and utilize an equitable funding distribution model that supports primary prevention and treatment service needs in a responsive way.**
7. Annual Performance Indicators to measure achievement of the objective:

Indicator#1 **Increase the number of clinicians trained to offer early childhood mental health supports.**
a) Baseline measurement (Initial data collected prior to and during 2026):**12**
b) First-year target/outcome measurement (Progress to the end of 2026): **13**
c) Second-year target/outcome measurement (Final to the end of 2027): **14**
d) Data source: **Portland State University records**
e) Description of data: **Scholarships awarded for the Portland State University early childhood mental health credential.**
f) Data issues/caveats that affect outcome measures: **None anticipated.**

Indicator#2 **Maintain the number of people with lived experience and family members on the Addiction and Mental Health Planning and Advisory Council (AMHPAC)**
a) Baseline measurement (Initial data collected prior to and during 2026): **51%**
b) First-year target/outcome measurement (Progress to the end of 2026): **At least 51%**
c) Second-year target/outcome measurement (Final to the end of 2027): **At least 51%**

d) Data source: **AMHPAC membership roster**
e) Description of data: **AMHPAC maintains a membership roster that is regularly updated**
f) Data issues/caveats that affect outcome measures: **None anticipated**

Indicator#3 **Increase number of data presentations, fact sheets, other awareness efforts related to suicide highlighting how SDoH work (such as economic stability, education, access to health care, stable housing, and strong and connected communities) is connected to reducing suicide risk.**
a) Baseline measurement (Initial data collected prior to and during 2026): **0**
b) First-year target/outcome measurement (Progress to the end of 2026): **5**
c) Second-year target/outcome measurement (Final to the end of 2027): **7**
d) Data source: **Oregon Health Authority's Suicide Prevention Team and website**
e) Description of data: **Artifacts such as fact sheets, presentations, resource guides**
f) Data issues/caveats that affect outcome measures: **None anticipated**

Indicator#4**: Partner with Local Mental Health Authorities (LMHA) and Community Mental Health Programs (CMHP) to design equitable funding methodologies for allocating resources through County Financial Assistance Agreements (CFAA).**
a) Baseline measurement (Initial data collected prior to and during 2026): **Baseline data collected from approved Local Plans & Budgets and HB 4092 Cost Study results.**
b) First-year target/outcome measurement (Progress to the end of 2026): **Equitable funding methodology options identified and under consideration in collaboration with LMHAs and CMHPs.**
c) Second-year target/outcome measurement (Final to the end of 2027): **Equitable funding methodology(ies) for use in the CFAA determined and implementation plan developed**.
d) Data source: **Local Plans & Budgets, HB 4092 Cost Study data & analysis, CFAA fiscal reports, ROADS**
e) Description of data: **Local Plans & Budgets are submitted by each LMHA/CMHP describing how funds awarded in the CFAA are projected to be used to provide non-Medicaid covered behavioral health services, HB 4092 Cost Study data and analysis provides historic information on actual expenditures for CFAA funded services (7/1/2021 through 6/30/2025); CFAA fiscal reports will collect information on actual expenditure for CFAA funded services beginning January 1, 2026; ROADS, the mandated state data system, collects service utilization data for publicly funded behavioral health services that are not covered by Medicaid**
f) Data issues/caveats that affect outcome measures: **Outcome measures are dependent on LMHA/CMHP collaboration and compliance with reporting requirements**.

Priority Area: **Build system capacity.**

2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS):
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):
4. Goal of the priority area: **Measure, monitor, and close the statewide gap in treatment capacity.**
5. Objective: **Decrease the number of people accessing the emergency department for behavioral health visits.**
6. Strategies to attain the objective: **Further integrate and expand crisis services (e.g., 988, mobile crisis) to ensure same-day care for individuals experiencing behavioral health crises.** **Secure youth-specific substance use disorder funding to build a robust continuum of care for youth prevention, harm reduction, treatment, peer supports, and recovery.** **Increase the number of active high-acuity behavioral health treatment beds across the state.**
7. Annual Performance Indicators to measure achievement of the objective:

Indicator#1 **OHA will reduce the Emergency Department (ED) utilization and boarding rate for adults with SMI and Children with SED**
a) Baseline measurement (Initial data collected prior to and during 2026): **ED discharges for behavioral health, ages 0 – 25, July 2022 – June 2023: total 10,664; Boarding 11%.**
b) First-year target/outcome measurement (Progress to the end of 2026): **ED discharges for behavioral health, ages 0 – 25 under 9,500 individuals; Boarding 11%**
c) Second-year target/outcome measurement (Final to the end of 2027): **ED discharges for behavioral health, ages 0 – 25 under 9,500 individuals; Boarding 10.5%; OHA will add adult data to reporting, highlighting Older Adults.**
d) Data source: **Hospital Utilization and Boarding Data (Health Policy and Analytics)**
e) Description of data: **Ages 0 -25: All patients admitted to the Emergency Department with "treat and release" discharges with an applicable behavioral health primary diagnosis code, including those transferred to another hospital. Excludes those who were admitted to the Ed and who are then admitted to the same hospital.**
f) Data issues/caveats that affect outcome measures: **This data has a 3-6 month delay. Data does not reflect individuals who are admitted directly to the admitting hospital's acute or**

medical beds. Baseline data may change dramatically as we review use of primary diagnosis to broaden the capture of reality of ED billing practices. We will begin with youth and young adult data and add adult data year 2.

Indicator#2 – **Increase Mobile Crisis Intervention Services (MCIS) programs**
a) Baseline measurement (Initial data collected prior to and during 2026): **90% of counties have 24/7 mobile crisis teams meeting OAR standards; 82% of mobile responses resolved without hospitalization.**
b) First-year target/outcome measurement (Progress to the end of 2026): **95% of counties meet OAR standards; ≥85% of mobile responses resolved without hospitalization.**
c) Second-year target/outcome measurement (Final to the end of 2027): **100% of counties meet OAR standards; ≥88% of mobile responses resolved without hospitalization.**
d) Data source: **County Financial Assistance Agreements data reporting, Medicaid claims data**
e) Description of data: **Service delivery metrics, staffing compliance, response times, and outcome tracking from CMHPs.**
f) Data issues/caveats that affect outcome measures: **Variability in rural and frontier county capacity; workforce shortages may affect service consistency.**

Indicator#3 – **Increase Mobile Response and Stabilization Services (MRSS) Programs**
a) Baseline measurement (Initial data collected prior to and during 2026): **80% of counties implementing MRSS-aligned services; 85% of youth avoid hospitalization or law enforcement involvement.**
b) First-year target/outcome measurement (Progress to the end of 2026): **90% of counties implement MRSS; ≥88% of youth avoid hospitalization or law enforcement involvement**.
c) Second-year target/outcome measurement (Final to the end of 2027): **100% of counties implement MRSS; ≥90% of youth avoid hospitalization or law enforcement involvement.**
d) Data source: **County Financial Assistance Agreements data reporting, Medicaid claims data, RedCap data system with Oregon Health and Science University.**
e) Description of data: **Youth crisis response metrics, stabilization service engagement, and follow-up care linkage.**
f) Data issues/caveats that affect outcome measures: **Inconsistent data collection across counties; limited baseline data for MRSS-specific metrics; challenges in tracking long-term outcomes.**

Indicator#4 **Increase the number of Youth Psychiatric Residential, Substance Use Disorder and Adult Residential Beds**
a) Baseline measurement (Initial data collected prior to and during 2026): **Youth Psychiatric Residential Treatment Facilities (PRTF): 327 licensed beds; youth SUD residential: 85 licensed beds**

b) First-year target/outcome measurement (Progress to the end of 2026): **Youth PRTF: 356 licensed beds; Youth SUD residential: 107; OHA will add Adult data to reporting.**
c) Second-year target/outcome measurement (Final to the end of 2027): **Youth PRTF: 356 licensed beds; Youth SUD residential: 107**
d) Data source: **OHA Licensing data**
e) Description of data: **Count of licensed beds**
f) Data issues/caveats that affect outcome measures: **The metric records licensed capacity, programs run at below this level.**

Priority Area: **Improve transparency and accountability:**
2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS):
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):
4. Goal of the priority area: **Establish public transparency and accountability for the outcomes of the statewide behavioral health system**.
5. Objective: **Establish public-facing dashboards that demonstrate accountability and transparency for funds invested in the behavioral health system.**
6. Strategies to attain the objective: **Implement a statewide naloxone distribution strategy and increase access to naloxone in the communities with greatest need.** **Develop public-facing dashboards for key areas of the behavioral health system that illustrate the investment of public funds and the outcomes.** **Improve data collection to better reflect services provided in the community and outcomes for the individuals using those services**.
7. Annual Performance Indicators to measure achievement of the objective:

Indicator#1**: Establish a publicly visible dashboard that describes statewide PRTF information on referrals and census data.**
a) Baseline measurement (Initial data collected prior to and during 2026): **Internal monitoring.**
b) First-year target/outcome measurement (Progress to the end of 2026): **Testing of a dashboard**

c) Second-year target/outcome measurement (Final to the end of 2027): **Availability of an externally facing dashboard.**
d) Data source: **OHA's statewide referral and capacity monitoring data system**
e) Description of data: **Information on referrals to PRTFs, their disposition and program census data.**
f) Data issues/caveats that affect outcome measures: **Requires programs to continue to report data daily into the system.**

Indicator#2 **Implement a statewide naloxone distribution strategy, and increase access to naloxone in the communities with greatest need.**
a) Baseline measurement (Initial data collected prior to and during 2026): **316,209 naloxone doses distributed in 2024.**
b) First-year target/outcome measurement (Progress to the end of 2026): **+ 2%**
c) Second-year target/outcome measurement (Final to the end of 2027): **+2%**
d) Data source: **Save Lives Oregon Initiative**
e) Description of data: **Agencies order naloxone needed for distribution through central web portal. The data represents the number of doses ordered.**
f) Data issues/caveats that affect outcome measures: **Potential price issues, for example increased price of naloxone, could affect outcome measures.**

Priority Area: **Treatment and Recovery support for pregnant women and women with dependent children (PWWWDC)**
2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS): SUT, MHS
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER): PWWDC
4. Goal of the priority **OHA will establish accurate tracking of capacity management and waitlist data for PWWDC who are seeking treatment**.
5. Objective: **To increase treatment access and retention**.
6. Strategies to attain the objective: **OHA continues to build a capacity management and waitlist data tracking system for PWWDC who need SUD, MH, and OUD treatment.**
7. Annual Performance Indicators to measure achievement of the objective:

Indicator#1 **Maintain the percentage of PWWWDC who successfully complete treatment or receive at least 90 days of treatment**
a) Baseline measurement (Initial data collected prior to and during 2026): **80.2**
b) First-year target/outcome measurement (Progress to the end of 2026): **80.2**

c) Second-year target/outcome measurement (Final to the end of 2027): **80.2**
d) Data source: **ROADS and MMIS**
e) Description of data: **Persons receiving non-Medicaid services will be identified through outpatient treatment procedure codes submitted in ROADS. The ROADS system provides data on retention and pregnancy and parenting status.**
f) Data issues/caveats that affect outcome measures: **Majority of data comes from MMIS. OHA intends to add data indicators to this Priority Area Second-Year target.**

Indicator#2 **Increase access to licensed childcare and respite care for women in substance use disorder treatment with dependent children**
a) Baseline measurement (Initial data collected prior to and during 2026): 20% of current facilites have access to licensed childcare
b) First-year target/outcome measurement (Progress to the end of 2026): **20%**
c) Second-year target/outcome measurement (Final to the end of 2027): 50%
d) Data source: Provider report
e) Description of data: **Providers report at mandatory quarterly workgroups for PWWDC residential programs**
f) Data issues/caveats that affect outcome measures: **Requires programs to report licensed childcare availability status at quarterly meeting.**

Priority Area: The behavioral health system promotes healthy communities and prevents chronic diseases – including substance use disorders and overdose across the lifespan.
2. Priority Type (SUP, SUT, SUR, MHS, ESMI, BHCS): SUP
3. Population(s) (SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD, OTHER):
4. Goal of the priority area: **OHA will work to eliminate health inequities by 2030 by implementing population level prevention and health promotion efforts to achieve long-term reductions in substance use, misuse, dependency, overdose and related negative health outcomes related to substance use. reductions in substance use, misuse, dependency, overdose and related negative health outcomes related to substance use.**
5. Objective:
6. Strategies to attain the objective: **Excessive Alcohol Use • Increase the price of alcohol • Increase the number of jurisdictions covered by alcohol marketing, promotion, and retail restrictions such as limiting outlet density, price promotions, and point of purchase interventions • Implement community-level interventions and Tribal Based Practice to prevent substance misuse • Maintain Oregon's state alcohol beverage control to prevent and reduce excessive alcohol use. • Maintain prevention funding infrastructure to Oregon communities and Nine Federally Recognized Tribes Overdose • Increase local capacity for multisector coordination, community outreach, and overdose prevention • Implement community-level interventions that address stigma and access to ensure that people who use drugs are treated respectfully and can access resources • Collaborate with health system partners to provide clinician education on evidence-based practices for pain management and screening, diagnosis, and linkage to care opportunities for people who use drugs**

• Strengthen public health and public safety partnerships to achieve common goals related to population safety • Expand community-based linkages to care to support access to resources for prevention, treatment, and recovery • Maintain prevention funding infrastructure to Oregon communities and Nine Federally Recognized Tribes
7. Annual Performance Indicators to measure achievement of the objective:
Indicator#1 Past month binge drinking among 8th graders
a) Baseline measurement (Initial data collected prior to and during 2026): **1.6**
b) First-year target/outcome measurement (Progress to the end of 2026): **1.6**
c) Second-year target/outcome measurement (Final to the end of 2027): **1.6**
d) Data source: **Oregon Student Health Survey (SHS) – 2024 Baseline data**
e**)** Description of data: **SHS is a state-developed voluntary school-based survey modeled on the Youth Risk Behavior Survey (YRBS). Beginning in 2024, SHS is administered on an annual basis (was previously every other year). First and second year targets maintain substantial COVID-pandemic decline in binge drinking among youth.**
f) Data issues/caveats that affect outcome measures: **Survey methods and data reporting continue to evolve as part of PHD's Data Modernization efforts. Recruitment and school participation have declined over time due to the COVID pandemic and increasing demands on classroom time. In 2023, legislation was passed to require school district participation, but implementation and enforcement is unclear.**

Indicator#2 **Past month binge drinking among 11th grader**s
a) Baseline measurement (Initial data collected prior to and during 2026): **5.7%**
b) First-year target/outcome measurement (Progress to the end of 2026): **5.7%**
c) Second-year target/outcome measurement (Final to the end of 2027): **5.7%**
d) Data source: **Oregon Student Health Survey (SHS) – 2024 Baseline data**
e**)** Description of data: **Survey methods and data reporting continue to evolve as part of PHD's Data Modernization efforts. Recruitment and school participation have declined over time due to the COVID pandemic and increasing demands on classroom time. In 2023, legislation was passed to require school district participation, but implementation and enforcement is unclear.**
f) Data issues/caveats that affect outcome measures: **Survey methods and data reporting continue to evolve as part of PHD's Data Modernization efforts. Recruitment and school participation have declined over time due to the COVID pandemic and increasing demands on classroom time. In 2023, legislation was passed to require school district participation, but implementation and enforcement is unclear.**

Indicator#3 **Past month binge drinking among adults**
a) Baseline measurement (Initial data collected prior to and during 2026): **16.3% (2023)**
b) First-year target/outcome measurement (Progress to the end of 2026): **5% improvement over baseline**
c) Second-year target/outcome measurement (Final to the end of 2027): **5% improvement over first year target**

d) Data source: **Oregon Behavioral Risk Factor Surveillance System (BRFSS)**
e. Description of Data**: The Oregon BRFSS is a collaborative project of the Centers for Disease Control and Prevention (CDC), and U.S. states and territories. The BRFSS, administered and supported by the Behavioral Surveillance Branch (BSB) of the CDC, is an on-going data collection program designed to measure behavioral risk factors in the adult population 18 years of age or over living in households**.
f) Data issues/caveats that affect outcome measures: **Oregon shifted the methodology for the state-added sample starting in 2024 to improve generalizability to the overall population. Uncertainties at the CDC's Division of Population Health may impact future BRFSS data collection.**

Indicator#4 **Decrease per capita alcohol consumption among those age 14 and older**
a) Baseline measurement (Initial data collected prior to and during 2026): **2.80**
b) First-year target/outcome measurement (Progress to the end of 2026): **5%improvement over baseline**
c) Second-year target/outcome measurement (Final to the end of 2027): **5% improvement over first year target**
d) Data source: **National Institutes of Alcohol Abuse and Alcoholism (NIAAA). Apparent per capita alcohol consumption: National, state, regional trends surveillance report - 2022 Baseline data**
e**)** Description of data: **S Per capita alcohol consumption is calculated by standardizing the gallons of beer, wine and distilled spirits sold in the state and dividing it by the total population aged 14 and above.**
f) Data issues/caveats that affect outcome measures: **This measure does not vary widely from year to year. Uncertainties at the National Institutes of Health may impact future data collection and reporting**

Indicator#5 **Decrease the number of opioid overdose visits to Emergency Departments (ED) by 5 percent in five years.**
a) Baseline measurement (Initial data collected prior to and during 2026): **3378**
b) First-year target/outcome measurement (Progress to the end of 2026): **3378**
c) Second-year target/outcome measurement (Final to the end of 2027): **3344, or decrease 1% from the baseline**
d) Data source: **2024 Emergency department visit discharge data**
e**)** Description of data: **Includes any opioid-related overdose regardless of intention (examples: unintentional, self-harm, harm to others, undetermined, etc.) among Oregon residents. [ICD-10: T40.1X-T40.4X and T40.6X]**
f) Data issues/caveats that affect outcome measures: **The majority of overdoses occur outside of a medical setting and may not show up at emergency departments**

Indicator#6 **Reduce unintentional/undetermined opioid overdose deaths by ten percent in five years**
a) Baseline measurement (Initial data collected prior to and during 2026): **1070**
b) First-year target/outcome measurement (Progress to the end of 2026): **1070**
c) Second-year target/outcome measurement (Final to the end of 2027): **1040, or decrease at least 2% from the baseline**
d) Data source: **State Unintentional Drug Overdose Reporting System (SUDORS)**
e**)** Description of data: **SUDORS collects deaths resulting from acute drug toxicity directly. Drugs include street drugs such as heroin, cocaine, and hallucinogens; prescription drugs; and over-the-counter drugs. A drug overdose death could be any manners including suicide and homicide. SUDORS collects only unintentional and undetermined drug overdose deaths. Opioid overdose death includes any deaths that had at least one opioid listed as a cause of death. The opioid includes illicitly manufactured fentanyl and fentanyl analogues, heroin, prescription opioids, and any other opioids.**
f) Data issues/caveats that affect outcome measures: **Overdose death is only the tip of the iceberg of drug overdoses. Deaths make up a small percentage of overall drug overdose.**

The federal government will work with states to monitor whether they are meeting the goals, strategies and performance indicators established in their plans, and to provide technical assistance as needed. This will include work with states during the year to discuss progress, identify barriers, and develop solutions to address these barriers.

If a state is unable to achieve its goals as stated in its application(s) as approved by the federal government, the state will be asked to provide a description of corrective actions to be taken. If further steps are not taken, the state may be asked for a revised plan to achieve its goals and objectives.