Oregon

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/01/2017 1.59.07 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 964093350

Expiration Date 4/5/2018

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Oregon Health Authority

Organizational Unit Health Policy and Analytics

Mailing Address 500 Summer Street NE E-86

City Salem

Zip Code 97301-1118

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Rusha

Last Name Grinstead

Agency Name Oregon Health Authority, Health Policy and Analytics

Mailing Address 500 Summer Street NE E-65

City Salem

Zip Code 97301-1118

Telephone 503-367-0479

Fax 503-945-5872

Email Address rusha.grinstead@dhsoha.state.or.us

State CMHS DUNS Number

Number 964093350

Expiration Date 4/5/2018

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Oregon Health Authority

Organizational Unit Health Policy and Analytics

Mailing Address 500 Summer Street NE, E-65

City Salem

Zip Code 97301

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Rusha

Last Name Grinstead

Agency Name Oregon Health Authority Health Policy and Analytics

Mailing Address 500 Summer Street NE, E-65

City   Salem

Zip Code   97321

Telephone   503-367-0479

Fax   503-945-5872

Email Address   rusha.grinstead@state.or.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date   9/1/2017 1:57:59 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name   Rusha

Last Name   Grinstead

Telephone   503-945-6189

Fax

Email Address   rusha.grinstead@state.or.us

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91- 616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Royce Bowlin

Signature of CEO or Designee[1]:

Title: Behavioral Health Director   Date Signed:

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Section	Title	Chapter
Title XIX, Part B, Subpart II of the Public Health Service Act		
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91- 616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _Royce A. Baxin_

Signature of CEO or Designee[1]: _R. H_

Title: _Behavioral Health Director_

Date Signed: _8/25/17_

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Royce Bowlin

Signature of CEO or Designee[1]:

Title: Behavioral Health Director   Date Signed:

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _Royce A. Bowlin_

Signature of CEO or Designee[1]: _R. Bl_

Title: _Behavioral Health Director_   Date Signed: _8/25/17_

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Royce Bowlin

Title

Behavioral Health Director

Organization

Oregon Health Authority

Signature: Date:

Footnotes:

See attachment sectioned for signed certificate

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name
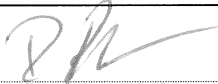
Title

Organization

Signature: _R.M._   Date: 8/25/17

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

FY 2018-19 Block Grant Application

Community Mental Health Services Plan and Report and Substance Abuse Prevention and Treatment Plan

Oregon Health Authority

9/01/2017

Comments on this application should be sent to: Rusha Grinstead at rusha.grinstead@state.or.us by 9/30/2017

This Page intentionally left blank

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Improving Behavioral Health Care in Oregon

Oregon's health care transformation has changed how health care is conceptualized, managed, delivered and financed in Oregon. There has been a significant increase in the number of people eligible for Medicaid funded health services and 95% of Oregonians were insured (Medicaid or otherwise) by the end of CY2016. Prevention, treatment and recovery services have a solid evidence base on which to build a system that promises better outcomes for people who have been diagnosed with or who are at risk for mental illness, substance use, gambling disorders and co-occurring disorders.

Oregon's Behavioral Health System

In 2013, Oregon established 16 Coordinated Care Organizations (CCOs) through a health system transformation process. The CCOs manage the physical, dental, and behavioral health benefits for individuals who have Medicaid. As a result, Oregonians are experiencing improved and more integrated care. However, behavioral health has not been as integrated within this framework as possible. The statewide behavioral health structure also relies on community mental health programs(CMHPs). CMHPs, at a minimum, maintain the mental health safety net system, manage children and adults at risk of entering or transitioning from Oregon State Hospital, manage the mental health crisis system, and community based specialty services, and require care coordination of residential services.

In 2015, Senator Sara Gelser, D-Corvallis, and Oregon Health Authority Director Lynne Saxton traveled round Oregon to meet with consumers and family members in a series of Town Halls and aimed to address the concerns heard during these meetings. In the Summer of 2016, Oregon Health Authority (OHA) convened the BHC to develop a set of recommendations to chart a new course for the behavioral health in Oregon. Director Saxton asked the BHC to make recommendations defining policy, financing, and infrastructure needs to modernize and integrate Oregon's Health System with Behavioral Health (Mental Health and Substance Use Services) for people who receive

services and their families. The BHC was comprised of nearly 50 members throughout the state that represent every part of the behavioral health system. The BHC worked for over six months to develop a set of recommendations that will transform Oregon's BH system. Stakeholders defined the problems, identified solutions and created a vision for excellence and sustainability in Oregon's BH system.

The Oregon Health Authority serves as the Single State Authority (SSA) and State Mental Health Authority (SMHA) for Oregon. Oregon's plan is to integrate care and treat mental health, substance use and other health services equitably in local communities. Mental health and substance use must be integrated clinically, operationally and financially into larger, system wide reform efforts to achieve BHC's goal.

Medicaid/Oregon Health Plan – For people on the Oregon Health Plan (OHP), behavioral health services are covered by their Coordinated Care Organizations (CCOs) if the services are covered by Medicaid. CCOs are local health entities that manage health care and coverage for people eligible for the Oregon Health Plan (Medicaid), including those also covered by Medicare. CCOs are a new development for the Oregon Health Plan beginning in 2012. They are the umbrella organizations that govern and administer care for OHP members in their local communities. Sixteen coordinated care organizations have been successfully launched statewide.

CCOs are accountable for health outcomes of the population they serve. They have a global budget that grows at a fixed rate for mental, physical and dental care. CCOs are introducing new models of care that are patient-centered and team-focused. They have flexibility within the budget to deliver defined outcomes and are accountable for 33 metrics, 17 of which are incentivized, with five of these being focused on behavioral health outcomes.

By integrating behavioral and physical health care for their members, CCOs are better able to treat the whole person, resulting in improved health outcomes. As the state continues to expand the coordinated care model, CCOs are assuming responsibility for more behavioral health services, such as substance use disorders and mental health residential treatment.

Until June 2015, the Oregon Health Authority had a separate Addictions and Mental Health Division (AMH). As of July 2015, OHA combined the Medicaid and Addictions and Mental Health Divisions into the Health Systems Division (HSD). The HSD biennial budget of $15,963,729,519.00 will be managed in two parts. The Superintendent of the Oregon State Hospital now reports directly to the Director of the Oregon Health Authority. The Oregon State Hospital employs over people and has a biennial budget of $995,681,956.00. The Health Services Division (HSD) manages the remaining federal and state funds. This new division includes member and provider services, compliance and regulation, including a contracting section, operations support and a section

devoted to data systems. HSD contracts with community providers including thirty-six community mental health programs and the sixteen Coordinated Care Organizations.

The BH policy team is in Health Policy and Analytics under the Behavioral Health Director. Health Policy and Analytics also includes the Dental Director, Chief Medical Officer and Medicaid Director, Quality Improvement and Health Analytics team.

Local mental health authorities (LMHA) are typically comprised of the County Board of Commissioners, who are responsible for the management and oversight of the public system of care for mental illness, intellectual/developmental disabilities, and substance use disorders at the community level. Local mental health authorities must plan, develop, implement, and monitor services within the area served by the local mental health authority to ensure expected outcomes for consumers of services, within available resources.

Community mental health programs (CMHP) provide care coordination and treatment for people with mental illness, intellectual/developmental disabilities, and substance use disorders. Core services include screening, assessment, and referral to providers and community organizations, as well as emergency or crisis services. All members of a community can access core services from community mental health programs, subject to the availability of funds. These safety net and crisis services play a key role in the overall behavioral health system.

Oregon State Hospital provides an essential service to Oregonians who need longer term hospital level care, which cannot be provided in the community. For adults needing intensive psychiatric treatment for severe and persistent mental illness, hospital level care provides twenty four hour on-site nursing and psychiatric care, credentialed professional and medical staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational and educational services. The role of the hospital is to restore patients to a level of functioning that allows a successful transition back to the community.

Certified Community Behavioral Health Clinics (CCBHC)

In 2016, Oregon was awarded the CCBHC Planning Grant by SAMHSA. Twenty-five million dollars in planning grants were available to states to develop applications to participate in a two-year CCBHC demonstration program. Only states awarded a planning grant are eligible to apply for the demonstration program grant. Oregon applied for, and was awarded a planning grant, as the program aligns with the state's broader health care transformation efforts, enabling Oregon to further advance behavioral health care for Oregonians. The Oregon Health Authority subsequently submitted an application to SAMSHA to be considered for participation in the 2017-2019 CCBHC Demonstration Program. In December 2016, Oregon was selected as one of eight

demonstration states. Currently Oregon has 12 CCBHC organization, with 21 sites across the state.

The 2017-2019 Demonstration Program Advisory Group, comprised of diverse stakeholders from across Oregon, representing providers, consumers, policy makers, health plans and professional associations, meets quarterly to advise the Oregon Health Authority on a variety of programmatic issues throughout the demonstration period.

CCBHCs are supposed to report on asset of measures as per SAMHSA standards to demonstrate integration of behavioral health with physical health, especially among population with Serious Persistent Mental Illness and Substance Use Disorder. In addition, Oregon has introduced 12 more standards for CCBHCs to meet in order to stay certified, which are in alignment with Oregon's Patient centered Primary Care Home standards.

Opioid State Targeted Response Grant

In May 2017, Oregon was offered the Opioid STR grant by SAMHSA, for a total award amount of $6.5 million. The OR-Opioid STR aims to 1)enhance state and community-level efforts to advance public health interventions that reduce PDO and problematic prescribing of controlled substances, 2)increase the number of DATA-waived providers in Oregon who are actively prescribing FDA approved medication for OUD, 3) enhance and expand the provision of peer support services design to improve treatment access and retention and support long-term recovery, 4) provide treatment transition and coverage for patients reentering the community from the criminal justice system,5)implement access to FDA approved medication for MAT in combination with social interventions, 6)establish statewide public education campaign on opioid and 7) establish a more robust network of recovery resources in places most affected by opioid epidemic in Oregon. This grant will supplement the existing CDC and SAMHSA grant that Oregon has and expand those efforts across the state. A continuous need assessment will be part of the grant activities. The Oregon Dept. of Corrections and Oregon Health and Human Sciences University will be two of the sub-grantees. More partnering organization will be identified with grant progress.

The project will overall aim to increase access MAT across the state. In addition a special focus would be on Oregon's Tribal communities. This is because currently the Oregon Tribes do not have a robust system of needs assessment even though opioid use disorder is a major burden in the Native American population (according to Medicaid data). The project will also keep a focus on rural and frontier counties, since in Oregon, opioid use disorder is mostly a rural issue. Despite of this high need in rural areas there is significant low access to MAT provider sin these regions. A significant proportion of this population also turns to heroin once opioid becomes too expensive to

afford, among individuals living with chronic pain. This is true in certain urban areas as well, such as the Portland Metro area since heroin is easily available.

In Oregon, Opioid Use disorder is primarily an access, training, and education issue. For example, only 30% of the DATA waived providers actually prescribe MAT medication. The STR grant project will drive the efforts of training providers on CDC's prescribing guideline, and community engagement and outreach. In addition, the Oregon Prescription Drug Monitoring Program will also be enhanced to get at least 95% of the high prescribing providers This will allow for more accurate and targeted needs assessments in moving forward.

The project will be done in collaboration with Department of Public Health, county health departments, criminal justice system, and regional Medicaid providers. Several of the infrastructure, such as ongoing evaluation, technical support, policy model, and sustainability plans, are already in place.

Public Health Division

In 2015, the Oregon Health Authority underwent reorganization, AMH merged with the Division of Medical Assistance Programs, and became the Health Systems Division. AMH policy moved to the newly formed Health Policy and Analytics Division, which is Oregon's Single State Authority. The SABG Primary Prevention funding went to the Oregon Public Health Division (PHD), Health Promotion and Chronic Disease Prevention (HPCDP) Section in March 2016.

The Health Promotion and Chronic Disease Prevention (HPCDP) section is working to integrate Oregon's alcohol and drug prevention funding, staff and projects into the Public Health Division (PHD) from the former Addictions and Mental Health (AMH) Division of the Oregon Health Authority. HPCDP is engaging a broad sector of statewide alcohol and drug partners to identify a sustainable means for an advisory body and mechanism for the planning and implementation the Alcohol and Drug Prevention and Education Program.

Within the PHD, the HPCDP section is lead for alcohol, tobacco and marijuana prevention efforts and the Injury and Violence Prevention Program (IVPP) is lead for Opioid prevention. As leads for substance abuse prevention within the Center for Health Promotion in the PHD, HPCDP and IVPP are coordinating efforts to impact community population health.

Public Health Modernization – Passed by the legislature in House Bill 3100, a plan and model was developed, to modernize Oregon's public health system to meet the basic needs and protections for the health of all Oregonians. A public health modernization assessment was coordinated by the State PHD, Public Health Advisory Board (PHAB) and local public health authorities to assess current system needs for modernization

and resources needed. A roadmap with priorities was developed for implementation over the next three years. Modernization builds upon a foundation for expanding efforts related to alcohol, tobacco, and drugprevention policies, systems and environmental change substance abuse prevention strategies that supports all Oregonians.
http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Pages/index.aspx

The six strategies of the Center for Substance Abuse Prevention (CSAP) including alternatives, community-based processes, education, environmental, information dissemination, and problem identification and referral are used to categorize prevention planning. CMHPs and tribes utilize data to select risk, protective and causal factors to target specific problem behaviors. Oregon provides services in each of the Institute of Medicine defined Universal, Selective, and Indicated populations, and OHA encourages the use of evidence-based and tribal best practices. OHA continues to provide dedicated prevention funding for all 31 CMHPs and nine federally-recognized Native American tribes.

The Strategic Prevention Framework (SPF) guides Oregon's prevention efforts. The SPF has been integrated into the Local Plan that is required by all funded counties and tribes. Oregon most recently was awarded a Partnership For Success (PFS)-SPF grant that will focus on underage drinking and high risk drinking for 12 to 25 year olds and prescription drug misuse and abuse among persons aged 12 to 25.

In order to catalyze change in the entire prevention system and assess the possible impact on different populations, the PFS allocation model will continue to allow SPF to reach high priority areas of need in all corners of the state. Details of this model will be identified by the revitalized SPF Advisory Council and the State Epidemiological Workgroup.(we need to write about revamping the SEOW. Use BG funds).

Maternal and Child Health

Oregon's Maternal and Child Health Section of the OHA Public Health Division has a long history of collaborating both within the Public Health Division and across the OHA to effectively reach pregnant and post-partum women with mental health and substance abuse issues. The goal of the MCH Section is that every mother, child and family has the best opportunity to reach their greatest potential life-long health and well-being. Our work addresses both universal and targeted approaches that promote protective factors and resilience in the early years for life-long health. Working across systems and in communities, MCH fosters safe, supportive environments for children, mothers and families; builds resilient and connected communities and families; promotes nutrition and healthy development; and improves the oral health. We implement evidence-based policies, programs and strategies across the lifespan to mitigate or enhance the health impacts of social determinants, improve health equity, and build strong social, emotional and physical health for the next generations of Oregonians. Most recently, the Health

Systems Division, Children and Family Behavioral Health Unit and MCH have worked together on issues around substance abuse and families. MCH also partners with all local public health departments and five Tribes to fund maternal and child health work that includes work around home visiting, Oregon MothersCare, and toxic stress/trauma, all of which address mental health and substance abuse issues. MCH provides funding to non-profits for mental health/substance abuse referrals and resource, and leads policy around pregnancy and opioid use with internal and external partners.

In collaboration with partners including local health departments and tribes, the MCH section supports home visiting programs. **Home visiting** is a proven strategy for strengthening families and improving the health status of women and children. Programs are voluntary and serve families with a variety of risk factors including mental health and substance abuse issues. Funding for programs comes from a variety of sources including federal, state, county, local and private funding. Home visiting is one strategy in the larger Early Learning system being developed for Oregon. The MCH section works to support healthy pregnancy through the **Oregon Mothers Care** (OMC) program which provides prenatal needs assessment appointments. Assessments include mental health and substance abuse and appropriate education and referrals are provided. OMC screens and provides referrals for both behavioral health and alcohol and other drug issues.

The MCH section has convened a **Pregnancy and Opioids Workgroup**. With a focus on primary and secondary prevention, the workgroup is developing statewide clinical guidelines on opioid prescribing among women of childbearing age, during pregnancy, identification and treatment of opioid use disorder during pregnancy and care and treatment of prenatally exposed infants. The guidelines are intended to help health care providers incorporate best practices when caring for women and their substance-exposed infants and encourage local efforts to provide coordinated care for families.

Oregon PRAMS, the Pregnancy Risk Assessment Monitoring System, is a project of the MCH section with support from the national Centers for Disease Control and Prevention (CDC). PRAMS collects data on maternal attitudes and experiences prior to, during, and immediately after pregnancy for a sample of Oregon women. The sample data are analyzed in a way that allows findings to be applied to all Oregon women who have recently had a baby. That Oregon PRAMS-2 survey interviews respondents when their child is 2 years old. Both the PRAMS and PRAMS-2 survey include questions to assess mental health and substance abuse issues. As the data is analyzed, it will be used to inform policy and program efforts moving forward.

Maternal and Child Health is primarily funded through HRSA's Title V Block Grant Program. Title V requirements address specific priorities, of which **Toxic Stress/Trauma** are included. Four counties have an MCH focus on Toxic

Stress/Trauma that include promotion of family friendly policies, outreach and education, ACE's and trauma assessment and surveillance, and trauma-informed workforce and workplace development. Title V's work to address parenting supports, as well as the MIECHV-funded home visiting programs have evolved to include a focus on ACEs and toxic stress prevention, building resilience, and developing trauma-informed systems of care in Oregon. Title V work on this priority will build upon this work with partners across systems to strengthen the foundation of safe and nurturing relationships and stable attached families in Oregon.

Oregon's 211Info Resource and Referral line is partially funded by the MCH Title V Block Grant. As part of that grant, two **MCH Specialists** provide resources to pregnant women and families, including mental health and alcohol and other drug treatment referrals. In the first 3 months of 2017, MCH Specialists received 181 calls from pregnant women and women with children requesting mental health/AOD referrals.

The MCH Section has a history of partnering with community organizations (Baby Blues Connection) around **Perinatal Mood Disorders.** The Section hosts a Maternal Mental Health website (http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/MATERNALMENTALHEALTH/Pages/index.aspx) that provides information for pregnant women, new mothers, family members and providers around Perinatal Depression and Anxiety. Community strategies, policy, legislation and data are also addressed.

With guidance from **Oregon's Retail Marijuana Scientific Advisory Committee** and focus groups with pregnant and breastfeeding women, the MCH section worked with partners to develop educational materials about marijuana use while pregnant, breastfeeding or caring for children. Materials have been shared with WIC sites, home visiting programs and other partners.

HIV Care and Treatment Program

The HIV Care and Treatment Program of the HIV/STD/TB Section of the Public Health Division provides information, referral and access to treatment for persons with mental health and substance abuse disorders. Under the Ryan White funded AIDS Drugs Assistance Program (locally known as CAREAssist), almost all persons living with HIV are eligible for financial assistance for insurance premiums and deductibles and copayments for services and medications used in the treatment of mental health and substance use disorders.   Within the Part B, Ryan White funded case management program, the SBIRT is used annually to identify persons interested in accessing treatment. Ryan White supportive services are also available to provide financial assistance. Finally, within the HOPWA funded housing programs administered by the Public Health Division, two different programs specifically meet the needs of persons

who have experienced housing related barriers as a result of mental health and substance use. Furthermore, a direct referral system is in place to ensure access to care and case management for persons transitioning out of the Department of Corrections, many of whom have a mental health and/or substance use disorder. All Part B Case Managers and Housing Coordinators have received training in motivational interviewing, harm reduction principles, and use of a trauma informed approach. An online "HIV Prevention Essentials" course, which is required of individuals providing publicly funded HIV testing and other prevention services, also includes principles related to harm reduction and a trauma informed approach.

HIV and other sexually transmitted infections, such as syphilis and gonorrhea, are reportable diseases. Oregon's 34 local county health departments are responsible for case follow-up and elicitation of sex and needle sharing partners, a process referred to as HIV/STI Partner Services. A key component of HIV/STI Partner Services is referrals to services such as mental health, substance abuse treatment, and harm reduction (e.g. syringe access) programs. Additionally, as part of the interview that takes place with individuals diagnosed with HIV or an STI, questions are posed concerning substance use which allows epidemiologists at the state and local level to track data regarding use of illicit substances as a risk factor for HIV/STIs. Given nearly all HIV positive persons in Oregon are insured or are insurable with the assistance of CAREAssist, most financial barriers to mental health and substance use treatment are removable. The bigger barriers related to access are systematic in nature, for example provider shortages and access to culturally competent providers, particularly in rural areas of the state. Persons with HIV, mental health and substance use issues are disproportionately impacted by the current housing crisis. The HOPWA funded housing programs help to stabilize persons in permanent supportive housing while they identify an appropriate treatment option.

The HIV Prevention Program uses state general funds to support syringe access programs in eight counties in Oregon. This support takes the form of funds for purchases of syringes and other supplies. The HIV Prevention Program also provides technical support and assistance to entities across the state interested in implementation of syringe access programs in their area. Syringe access programs in Oregon primarily fall into three categories: fixed location (e.g. location at a health department or community-based organization office), delivery system, or through use of a van which visits multiple locations at fixed days/times each week.

Injury and Violence Prevention

Prescription Drug Overdose Prevention: The Oregon Health Authority (OHA) Internal Opioid Initiative was launched in January 2016 to coordinate and align agency-wide activities and policy work to advance the Oregon Opioid Initiative, with leadership from the Health Systems Division, Health Policy and Analytics, and the Public Health Division. The Oregon Opioid Initiative's overarching Aim is to reduce deaths, non-fatal overdoses, and harms to Oregonians from prescription opioids, while expanding use of non-opioid pain care.

The primary goals of the Oregon Opioid Initiative are:

- Reduce risks to patients by making pain treatment safer and more effective, emphasizing non-opioid and non-pharmacological treatment.

- Reduce harms to people taking opioids and support recovery from substance use disorders by making naloxone rescue and medication-assisted treatment (MAT) more accessible and affordable.

- Protect the community by reducing the number of pills in circulation through implementation of safe opioid prescribing, storage, and disposal practices.

- Optimize outcomes by making state and local data available for informing, monitoring, and evaluating policies and targeted interventions.

Oregon is the only state that manages the Prescription Drug Monitoring Program (PDMP) within its Injury and Violence Prevention Program (IVPP). This allows direct access to data and the ability to link with death, hospitalization, emergency department, emergency medical services, and Medicaid client enrollment data. IVPP also maintains an interactive online dashboard of state and county data on controlled substance prescribing and drug overdose hospitalizations and deaths, and local health departments are trained to access and use these data to monitor progress and make data-driven decisions. The Oregon Opioid Prescribing Guidelines Task Force adopted the *CDC Guideline* as the foundation for opioid prescribing for Oregon. An Implementation Work group developed statewide goals, objectives, quality metrics, a framework to guide opioid-related work in Oregon, and a clinician toolkit and trainings. Using the *Six Building Blocks of Opioid Prescribing* self-assessment tool, a small interdisciplinary Pain Management Improvement Team (PMIT) of clinical experts provides academic detailing and practice coaching to health systems in six high burden regions to assist with guideline implementation and improved pain management practices. These two- to three-county regions are funded to hire a PDO Coordinator to coordinate prevention work and monitor outcomes, boost PDMP enrollment, host regional pain/opioid summits, post online resources, and increase public awareness. In addition to the regional summits, an annual pain symposium hosted by Oregon Pain

Guidance (OPG) has educated the medical community and others throughout the state about evidence-based pain management since 2011. IVPP sponsors an annual policy and practice academy for local health officers and administrators, launched in 2017, which will coordinate with HPCDP to include alcohol and other drugs in 2018. The Opioids in Pregnancy Work Group, led by MCH and with internal and external partners, is developing recommendations for health care providers to address pregnant women who use opioids.

Suicide Prevention: The OHA PHD administers the Oregon Caring Connections Youth Suicide Prevention Initiative with funding through SAMHSA Garrett Lee Smith Memorial Act (GLS). Oregon currently has funding for five years (2014-2019) to implement activities that align with the National Strategy for Suicide Prevention. The Oregon Caring Connections Initiative focuses on youth aged 10-24 years with a focus on at-risk youth primarily in five Oregon counties provided funds to support suicide prevention efforts. Goals of the initiative are:

- Increasing gatekeeper training to individuals serving youth to identify and refer youth at risk of suicide and increasing suicide prevention education to students, educators, and school staff.

- Providing clinical training to increase health, mental health and substance abuse clinicians trained to assess, manage and treat youth at risk for suicide.

- Improve continuity of care for youth discharged from emergency departments and inpatient psychiatric units; and for veterans and military families receiving care in the community; and improved county crisis response plans for wrap around services.

- Promote, engage and provide technical assistance to Oregon healthcare organizations around the Zero Suicide Initiative approach to provide suicide safer care.

IVPP maintains an interactive online dashboard of state and county data on suicide deaths suicide death by mechanism and factors associated with suicide, and local health departments have access and use these data to monitor progress and make data-driven decisions. Through GLS funding, IVPP works with five Oregon counties (Deschutes, Jackson, Josephine, Umatilla, and Washington) on the above stated grant goals. Each of these counties (or designated community mental health provider) has a dedicated Suicide Prevention Coordinator. IVPP also works with Oregon healthcare organizations and Oregon schools outside of these five counties on suicide prevention/intervention/postvention work.

Impaired driving: This project is in the planning and assessment phase. IVPP staff participates in a Public Health Division / Oregon Department of Transportation

partnership workgroup, and is re-establishing partnerships that will contribute to the future direction of policy development around motor vehicle interlock law in Oregon.

Intimate Partner Violence: This project is in the planning/assessment phase. Coordinated multiple projects with PHD Maternal and Child Health (MCH); Adolescent, Genetic and Reproductive Health; and Health Promotion & Chronic Disease Prevention sections and the Oregon Department of Education for prevention of sexual violence and intimate partner violence.

IVPP uses a collective impact approach for all PDO and suicide prevention projects, with the Public Health Division as the backbone organization, using established statewide metrics and performance measures.

IVDUs: The state naloxone work group and funded local public health authorities collaborate with syringe exchange programs, social service agencies, corrections, behavioral health partners and law enforcement/first responders to expand access to naloxone rescue for people experiencing overdose. Acute and Communicable Disease Program (ACDP) has a new grant to align opioid, Hepatitis C and HIV work in rural areas, and IVPP collaborates closely with ACDP on this project.

The PDO project targets specific populations based on outcomes data: people living with chronic pain, rural communities, tribal communities, and people using opioids. IVPP sponsors regional opioid summits and is planning a tribal opioid summit for 2018.

The IVPP suicide prevention efforts align with the OHA Youth Suicide Intervention and Prevention Plan (2016-2020). Implementation and evaluation of the plan is led by Health Systems Division. IVPP and Health Systems Division work together to meet the plan's activities and goals.

Tobacco Prevention, Education and the Synar Amendment
The federal Synar Amendment requires states to conduct checks of tobacco retailers to ensure they are in compliance with laws that prohibit the sale of tobacco products to people younger than 18 and report on the status of tobacco retailer compliance with these laws.
The Oregon Health Authority Public Health Division manages the Synar Program and coordinates with the Oregon State Police to conduct state sponsored compliance inspections, such as Synar and State Enforcement Inspections. Approximately 400-900 Synar inspections are conducted annually from a pool of approximately 3,350 non-age-restricted tobacco outlets in Oregon. These random, unannounced minor decoy inspections are conducted among a random sample of known tobacco retailers statewide. Oregon's retailer violation rate (RVR) for inspections conducted between October 2015-September 2016 was 4.5%. The RVR represents the number of retailers that sold tobacco to underage youth. Oregon is currently conducting the next round of

Synar Inspections and will report on the status of tobacco retailer compliance with these laws in the Annual Synar Report by December 31, 2017.

On August 9, 2017, Oregon Governor Kate Brown signed SB 754 into law, which raised the required minimum age for a person to legally buy or obtain tobacco products from 18 to 21. The law applies to conduct occurring on or after January 1, 2018. Oregon will be adapting the current Synar protocol to reflect the increase in the minimum sale age.

Behavioral Health Promotion, Prevention and Early Intervention Services and Supports

OHA supports a continuum of care based on the Institutes of Medicine model[1], which incorporates behavioral health promotion, prevention, treatment, recovery and maintenance. Behavioral health promotion is a broad concept with specific strategies, supporting wellness, early intervention and prevention of mental and substance use disorders.

Behavioral Health Promotion

Behavioral health promotion is integral to the promotion of health, which in turn is an important component in assurance of public health, or the health of the population. Emotional health promotion is one of the keys to maintaining physical and mental wellness by increasing the individual's ability to cope with normal stresses of life and their positive connectivity with family and community. Emotional health is protective against the development of mental illness, pathological gambling and substance abuse disorders. It is also protective against the development of physical illness and the impact of trauma and stigma.

Mental Illness Prevention

Each Community Mental Health Program (CMHP), subject to the availability of funds, is required to provide or ensure the provision of the following services to persons with mental disorders:

- Prevention of mental disorders and promotion of mental health;
- Preventive mental health services for children and adolescents, including primary prevention efforts, early identification and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional, behavioral and cognitive disorders, and suicide attempts in children; and

---

[1] National Research Council and Institute of Medicine (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, D.C.: The National Academies Press.

- Preventive mental health services for older adults, including primary prevention efforts, early identification and early intervention services. These services should be patterned after service models that have demonstrated effectiveness in reducing the incidence of emotional and behavioral disorders and suicide attempts in older adults.

Mental Health Promotion and Prevention Programs

Nearly $3 million in state funds has been allocated for Mental Health Promotion and Prevention awards spanning eighteen different projects and twenty counties across the state. While each of the eighteen projects is unique, many share common programs. These include Mental Health First Aid, Parenting Programs, Bullying Prevention Programs, Suicide postvention and Prevention Programs, Culturally-Specific Services and Mental Health Promotion Activities. Four projects focus specifically focus on children 3-8 to increase their skills of establishing positive peer relationships and increasing emotional self-regulation. In addition, one project continues to create and promote social marketing messages to reduce stigma and promote public awareness of mental health issues.

Behavioral Health Promotion, Prevention and Early Intervention Services and Supports OHA supports a continuum of care based on the Institutes of Medicine model[1], which incorporates behavioral health promotion, prevention, treatment, recovery and maintenance. Behavioral health promotion is a broad concept with specific strategies, supporting wellness, early intervention and prevention of mental and substance use disorders.

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

The ACE Study arose from more than seventeen thousand Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination who chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made.

---

[1] National Research Council and Institute of Medicine (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, D.C.: The National Academies Press.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Oregon has created Trauma Informed Oregon (www.traumainformedoregon.org) as a centralized resource for providers, families, adult consumers, and other stakeholders statewide, to have a reliable source of information on trauma and Adverse Childhood Experiences. Trauma Informed Oregon is also training nurses to incorporate Trauma Informed Care into their workforce training and culture as a standard in Oregon.

Parent-Child Interaction Therapy (PCIT)
PCIT is an empirically supported treatment for young children with emotional and behavioral disorders and is focused on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT provides live practice for parents through coaching with a wireless communication device by the therapist who views the parent and child (ages two-seven) through a one-way mirror. It teaches parents to develop a warm, responsive relationship with their children, to selectively reinforce pro-social and adaptive behavior while also learning to safely and consistently provide developmentally appropriate consequences to change children's negative behaviors. The average length of treatment is 16 to 20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during the course of treatment.

Preliminary research indicates PCIT can be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum who are high functioning, children who have experienced chronic trauma, families who are involved with child welfare because of harsh physical discipline, and mother-child dyads following episode(s) of domestic violence.

In 2008, four Oregon counties began to implement PCIT. In April 2014, PCIT was expanded to four additional agencies with sites in five counties, which previously did not have PCIT programs. In July 2014 seven more counties were granted funding to develop PCIT programs. These 12 PCIT sites receive on-going consultation and training during this initial phase of providing PCIT to Medicaid eligible families.

Currently there are 89 Masters Level PCIT Trained therapists providing high fidelity implementation of this evidenced based treatment to Medicaid eligible children; a slight increase since 2015. Due to a major Coordinated Care Organization Contract change in one county, 10 fully trained PCIT therapists were laid off or were reassigned to other duties. Other agencies are increasing their access to high fidelity PCIT. PCIT is

available in 18 counties (two of which do not receive funding or monitoring by OHA). An agency in an additional county has PCIT funding starting July 1st, 2017. Two universities have started PCIT programs without funding from OHA. PCIT is now available in 45 locations; an increase since 2015. There are 9 PCIT trainers authorized to train within their agencies in 5 counties, and two PCIT Internationally Certified regional trainers offering training to anyone in the state who is implementing a fidelity PCIT program. PCIT training to meet certification requirements takes a year or more to complete. Eighteen therapists from 8 counties are scheduled to begin PCIT training in August of 2017.

According to the Parenting Stress Index scores, the majority of parents entered PCIT services with their stress level in the clinical range, and left with their stress reduced to within the typical range. This was true whether or not they completed PCIT. The average improvement in Eyberg Child Behavior Inventory (ECBI) scores for families who completed treatment was 48%.

Mental Health First Aid
The Association of Oregon Community Mental Health Programs provides statewide trainings to train Mental Health First Aid (MHFA) instructors. To date 2,098 Oregon Mental Health First Aid responders have completed the training. MHFA trains individuals in the following:
- Skills to recognize the signs, symptoms and risk factors of behavioral health disorders;
- Community, professional, and self-help resources;
- Crisis de-escalation; and,
- Help to shatter stigma of behavioral health disorders.

The major barrier to training teachers in schools on MHFA is lack of staff resources. In the past, the total hours of training for MHFA has been reduced to address some of this barrier but it still significantly hinders school districts from successfully adopting the MHFA training as a standard.

Early Identification and Intervention
Screening, Brief Intervention and Referral to Treatment (SBIRT) Screening, Brief Intervention, and Referral to Treatment (SBIRT) is used to prevent, identify and reduce alcohol and drug use. OHA has partnered with CCOs and the Oregon Association of Hospitals and Health Systems to train staff and implement SBIRT in primary care, Patient Centered Primary Care Homes settings, and specialty care such as obstetrics and pediatrics. SBIRT is applied throughout all settings from fee-for-service clinics to Federally Qualified Health Centers, Rural Health Centers and tribal clinics. Hospital

implementation is focused on emergency departments, beginning with Diagnosis-Related Group (DRG) hospitals throughout the state.

SBIRT implementation has included collaboration with other healthcare initiatives, including consumer and peer involvement. The OHA SBIRT coordinator has worked with the CCO Consumer Advisory Committees, Peer Support and Wellness Specialists, Traditional Healthcare Workers, licensing boards and the rehabilitation of medical and behavioral professionals

SBIRT in Oregon promotes the use of technology to address healthcare challenges. The SBIRT Dashboard tracks implementation progress for each CCO by clinic and identifies patterns of reimbursement to problem solve the challenges of encountering SBIRT services. Telehealth has been used to improve the availability for on-demand behavioral health screening and services. Telehealth links medical clinics and community behavioral specialty care for consultation, referral and coordination of ongoing care and allows for the promotion of consultation between medical clinics for SBIRT service improvement.

Implementation of SBIRT in both CCO and hospital emergency departments are incentivized through quality pools. CCOs and hospitals can receive incentive payments for achieving SBIRT-focused benchmarks or improvement targets. Improvement targets are set at three percentage point increases from the prior year performance toward a benchmark of twelve percent.

The CCO metric tracks full (secondary) screenings and/or brief interventions performed in outpatient settings. The hospital metric tracks SBIRT internally. The hospital SBIRT measure currently includes brief and/or full screenings. Hospitals also report the brief intervention rate, but there is not an accompanying target for performance.

Young Adult Mental Health Hub Program
A mental health investment authorized in 2013 by the Oregon legislature establishes four regional mental health service and access *hubs* for young adults ages 17 through 25. This funding is focused on outreach and engagement and provides responsive, relevant and intensive community and peer-based support to young adults whose life experience has diverted their development away from a healthy and appropriate path.

This community and peer-based supportive access point is grounded in positive youth development, is strength-based and young adult focused with a goal of the program incorporating principles of trauma informed care. This philosophy is reflected in asset and strength enhancement and interpersonal connectivity and an emphasis on peer support. Four regional young adult hubs are providing mental health and medical services to approximately 200 young people.

The primary populations served are young adults who ages 17 to 25 who have:
- Spent a significant amount of time in state or local child-serving systems and as a result of that experience have lagging skills and developmental progress;
- Been referred to Early Assessment and Stabilization Alliance (EASA) but have been screened out diagnostically; and,
- Mental health and interpersonal needs which are intensive enough to place them at risk for involvement in the justice system, at risk for homelessness, and at risk for increasing marginalization.

The Family Search & Engagement program works to locate life-long connections for youth served by the hubs and fosters engagement with supportive family members and natural supports. Family Search & Engagement services are available for youth in Multnomah, Clackamas, Washington, Marion, and Lane County.

Youth hubs will supplement billable services and other funding resources and create a responsive and accessible continuum of care, including physical health, for young adults. The hubs are predicated on the idea that work to be done with marginalized young adults is outside of encounters or billable services, or prior to, between, or following the close of formalized services. The hubs are intended to close gaps between supports, and bridge resources as young adults move from one support system to another.

Figure 1.

RECOMMENDED USE OF RESOURCES FOR HUB CLIENTS

Medicaid/ Private Insurance Services

- MH Treatment
- Physical Health Treatment
- Supported employment
- Certified PDS
- Skill Development
- Psychiatric Care
- Case Management

General Fund-Hub $ Recommended Uses

- Outreach
- Engagement/pre-Contemplation
- Program Infrastructure/ Expansion
- Connections to Community Resources
- PDS until Billable
- Admin
- Reporting
- System Integration and Development Activities
- Payment for non-billable clients and other activities
- "Whatever it takes"

Emphasis for the first six months of the project was on the development of sites and program structure, hiring staff, including peer support workers, and conducting community education and referral processes. HUB staff are trained in serving LGBTQ (Lesbian, Gay, Bisexual, Transsexual, and Questioning) young adults and assisted with identifying outcome measures for all of the hubs' services. Hub managers have a monthly collaborative learning call during which challenges and successes are highlighted and work on a state vision for young adult mental health services occurs.

The outcome areas addressed by the hubs include:
- Employment and education opportunities;
- Housing stability;
- Reduction in acute care services;
- Establishing and maintaining a healthy response to mental illness;
- Reconnecting or connecting with individuals and community resources by increasing meaningful and supportive relationships, including use of family search and engagement services; and
- Avoiding the social settings that reinforce increased symptomatology, and decreased adaptation and resilience, such as inpatient psychiatric care, emergency department visits incarceration or involvement with law.

Survey data has indicated that the hubs are reaching the populations they are intended to serve and conducting activities consistent with the outcome areas listed above.

Early Assessment and Support Alliance (EASA)
EASA serves young adults 12-25 and their families, using an intensive multidisciplinary approach during what is known as the "critical period," where intervention is most effective and may prevent the long-term negative life consequences associated with chronic psychotic illness. Early intervention and treatment of psychosis assists individuals in becoming independent, healthy and safe. The restoration of normal functioning helps individuals maintain employment and support themselves and their families.
EASA's current structure offers a robust and efficient model of care while mirroring many public health strategies through integration of physical and mental health care. Utilization of this model has resulted in dramatic outcomes such as decreased hospitalization rates. The model is cost-effective in the short term and results in cost savings in the long term.

Impact and Data
Since its first investment in 2007, EASA has provided services to 1800 young adults and their families.   With the addition of federal dollars, all 36 Oregon counties are

funded to provide EASA and are developing teams, and 96% of Oregonians have access to an established team. In calendar year 2016, EASA received 957 referrals and served 715. The ongoing current caseload is 400 individuals and families throughout the state of Oregon.

In EASA, young people maintain or enter school or work (44% at intake, 55% at discharge) and decrease substance abuse (15% with severe substance abuse at intake, 9% at discharge). At discharge 59% of EASA youth are not on public disability and do not plan to apply.

Hospitalizations in the three months prior to entry have dropped from 58% in 2008 to 38%. Once in EASA, hospitalizations each quarter averaged 6%. Some programs are achieving hospitalization rates at or near zero, and community education, outreach and quality improvement effort focus on further improving these figures.

Each EASA team conducts extensive and on-going community education. In 2016 alone, EASA reached over 46,000 individuals through 350 presentations and media stories.

EASA Center for Excellence

Oregon is the first state in the U.S. to commit to universal access to early psychosis intervention, and is an established national leader. EASA has a Center for Excellence (CfE) housed at OHSU's (Oregon Health and Science University) School of Public Health.

The EASA CfE maintains collaborative partnerships with Portland State University and OHSU Child Psychiatry, and is part of the Technical Assistance Network for Children's Mental Health, has a strong affiliation with the federal initiatives Reclaiming Futures and Pathways to Positive Futures federal grant projects, and has become increasingly involved in national technical assistance activities.

During this time period, EASA Center for Excellence staff presented to state conferences such as conferences focused on CCOs, supported employment, counselors, physicians and NAMI. In addition, EASA CfE staff presented to the National Early Psychosis Association, NAMI National, the annual Child and Adolescent Research Conference in Tampa, and the National Association of State Health Programs. EASA CfE edited the 2016 edition of Focal Point Magazine (issued through Portland State University to an audience of over 20,000), with a focus on early psychosis intervention. Articles were contributed by international and national experts as well as EASA clinicians, the Young Adult Leadership Council and EASA family members. EC4E staff also participated in advising the national evaluation of federal block grant funding to early psychosis programs, and the development by NAMI national of a policy on proactive engagement of individuals with mental illness.

EASA's website added a toolkit section which includes a wide variety of materials from multiple sources. In addition, EASA is linking its efforts to Partners4Strong Minds and other entities with strong media presence.

The Center for Excellence maintains a partnership with OHSU School of Child Psychiatry, employing both the expertise of Dr. Craigan Usher MD, as a psychiatric consultant to EASA teams and Julie Magers, a family engagement and partnership expert.

Technical assistance and training staff at the EASA Center for Excellence provided weekly consultation and quarterly trainings throughout this period, training approximately 200 new staff during this time period:

Quarter	Intro	MFG	Diff Dx./SIPS	Other	Total
3rd 2015	21	29	0	0	50
4th 2015	45	0	0	combined w/clinical skills	45
1st 2016	0	0	30	0	30
2nd 2016	54	35	102	0	191
3rd 2016	0	25	63	0	88
4th 2016	50	25	0	Conference 300	375
1st 2017	17	49	22	39	127
Total	187	163	217	339	906

The EASA Center for Excellence is maintaining a centralized registry of credentialing status for all EASA clinicians through a databased established at PSU.

The emphasis of the current social marketing effort is integrating a social media presence, which includes the existing website, Tumblr, Facebook, Linked-In and Twitter. Participation in these online forums continues to grow and has become a central part of the EASA approach to working with young adults.

Young Adult Leadership

A very dynamic and engaged Young Adult Leadership Council has been established, made up of EASA graduates who want to help guide and support EASA's evolution. The council meets monthly and their vision statement speaks to their focus and enthusiasm: "The vision of the Young Adult Leadership Council is to unite the voices and strengths of young adults and their allies to build a thriving community and a revolution of hope."

The EASA Young Adult Leadership Council is actively involved in advising and developing programming for EASA and national audiences. Leadership Council members have presented at Peerpocalypse and numerous conferences including NAMI national and a research conference in Florida. The Leadership Council developed a national policy statement and an article for Focal Point magazine, and met with Paolo Del Vecchio, the director of the Center for Mental Health Services. The Young Adult Leadership Council has taken the lead on working through a social media strategy for reaching young adults. Ongoing outreach to high schools and colleges continues to occur.

EASA developed shared decision making materials in collaboration with members of the Young Adult Leadership Council. In addition, a young adult design team funded through Pathways and the Young Adult Leadership Council developed a comprehensive website, videos and written handouts which are written from the perspective of individuals who have graduated from EASA.
Statewide Training

Adult Mental Health Services
Each CMHP provides or ensures the provision of a continuum of care for adults with serious mental illness, subject to the availability of funds. These services include, but are not limited to:
- Screening and evaluation to determine the individual's service needs;
- Individual, family, and group counseling and therapy;
- Medication monitoring;
- Residential services;
- Psychiatric care in state and community hospitals; and
- Crisis stabilization to meet the needs of people experiencing acute mental or emotional disorders, including the costs of investigations and prehearing detention in community hospitals or other facilities approved by OHA for people involved in involuntary commitment procedures.

Within the limits of available funds, CMHPs provide the above services to individuals in the following order of priority:
1. Individuals who, in accordance with the assessment of a mental health professional, are:
   a. At immediate risk of hospitalization for the treatment of mental or emotional disorders, or
   b. Are in need of continuing services to avoid hospitalization, or
   c. Pose a hazard to the health and safety of themselves, including the potential for suicide, or others

     d. And those persons under 18 years of age who are at immediate risk of removal from their homes for treatment of mental or emotional disorders or exhibit behavior indicating high risk of developing disorders of a severe or persistent nature;

2. Individuals who, because of the nature of their mental illness, their geographic location or their family income, are least capable of obtaining assistance from the private sector; and
3. Individuals who are experiencing mental or emotional disorders but will not require hospitalization in the foreseeable future.

Individuals participating in mental health services assist their service providers to develop a comprehensive service plan, which specifies services and supports provided or coordinated for an individual and his or her family. The plan should be reflective of the assessment and the intended outcomes of service. The plan documents the specific services and supports to be provided, arranged or coordinated to assist the individual and his or her family, if applicable, to achieve intended outcomes. At a minimum, each plan must include:

- Measurable or observable intended outcomes;
- Specific services and supports to be provided; and
- Applicable service and support delivery details.

Mental Health Services for Older Adults

Mental health services provided to older adults through the CMHP and their contractor are limited.   This is primarily due to the fact that the majority of older adults are only on Medicare . Several CMHP use multidisciplinary teams (MDT) to address the gap in mental health services.   These teams vary from county to county and not all counties have a MDT. These teams often have representatives from Aging and People with Disabilities, law- enforcement, adult protective services with the primary focus to link vulnerable older adults with necessary mental health and social services in a seamless manner. Some CMHP use their indigent funds underinsurance for Medicare recipients with serious mental illness.

Some CMHP or their subcontractors have developed and maintained age specific services. In our most populous county one subcontractor has developed a substance use disorder program specifically for older adults called Young at Heart using the SAMHSA curriculum called Substance Abuse and Relapse Prevention for Older Adults.. Some counties have older adult peer delivered services.

OHA has convened an Older Adult & People with Disabilities Advisory Council.

Pre-Admission Screening and Resident Review (PASRR)

PASRR is a federally mandated, statutory program that requires all states to develop a comprehensive process to prescreen for serious mental illness all individuals applying for admission to a Medicaid certified nursing facility. The mandate requires a

personalized assessment and recommendations for the mental health services and a determination that nursing home level of care is appropriate for the person. Oregon Health Authority, as the State Mental Health Authority, maintains a PASRR Level II program that follows federal regulations.   In the majority of counties, CMHP are contracted to provide PASRR level II services and are expected to link individuals with a serious mental illness with the appropriate outpatient mental health services.

Enhanced Care Facilities/Enhanced Care Outreach Services (ECF & ECOS)

These programs are a collaborative partnership between OHA Health Systems Division and Aging and People with Disabilities. Services are designed to support individuals with complex mental health and complex physical health needs, with an emphasis on stabilization and community integration. Within this program, individuals can be supported in Enhanced Care Facilities or in other licensed APD community settings. Enhanced Care Facilities are APD facilities dedicated to serving individuals who qualify for this service. These programs have higher staffing ratios than traditional APD licensed settings, and mental health staff on-site 7 days a week. Mental health staff work closely with APD as they provide person-centered rehabilitative mental health treatment services. Enhanced Care Outreach Services provides intensive mental health services to individuals living in standard APD licensed settings. Services, for the most part, are delivered on site in an outreach model.

Complex Case Consultation and Care Transitions

The older adult team within OHA works closely with Oregon State Hospital staff and Aging and People with Disabilities to discharge and or divert complex BH clients to the most appropriate level of care in the community.

Older Adult Behavioral Health Initiative (OABHI)

The OABHI was launched in June 2015 and is currently entering its third year. This investment seeks to strengthen and improve the behavioral health infrastructure for older adults and people with disabilities. OHA has hired 24 older adult BH specialists across Oregon . Their core job functions promote collaboration and coordination between multiple sectors and coalition building, complex case consultation and promotion of best practices, workforce development/capacity building through training and building age friendly and resilient communities through elevating aging in our community and civic discourse and raising awareness. Between July 2016 and June 2017 there were over 1600 complex case consultations; 273 training and community events reaching 7,000 participants. This Initiative has also highlighted Statewide challenges such has Medicare as a barrier (restricted providers and reimbursement rates for BH), transportation, outreach models for treatment, lack of a geriatric

competent workforce to name a few.   This Initiative is incubating a few innovative programs to mitigate these challenges – development of a senior peer warm-line/friendship line in rural Oregon to mitigate social isolation and risk of depression and suicide, training ADRC (Aging Disability Resource Connection) staff in mental health screening and local services, providing mental health first aid (MHFA)along with the older adult module to an array of providers, a telehealth MDT for complex cases in rural Oregon , exploring enhancing our current peer delivered services certification with an add on for older adult BH using COAPS (certified older adult peer specialists), a joint OHA/APD Project ECHO Geriatric Behavioral Health Clinic for nursing homes based on the model from University of Rochester which was approved by CMS, adoption of WISE (Wellness Initiative for Senior Education) as a health promotion program in come counties, and the identification of hoarding as a problem and development of hoarding task forces.

Opioids: Access to Services and Treatment

There are currently 17 opioid treatment programs (OTPs) in Oregon. Most programs are along the Interstate 5 corridor from Portland to Medford. Seven clinics are located in Multnomah County; Marion and Lane Counties each have two; and Jackson, Washington, Deschutes and Clackamas Counties have one clinic each.

Programs are a mix of private for-profit and non-profit operated clinics, with one clinic administered by the Federal government. Approximately 19,000 individuals were diagnosed with an opioid use disorder in 2015. Methadone treatment is a mandated covered benefit through the Oregon Health Plan (OHP). OHP also cover Medication Assisted Treatment (MAT) and other recovery support services associated with OUD. Payments from OHP are made based on the services provided by the clinic. For self-pay patients, providers charge a monthly or daily rate for services. Self-pay fees range from $200.00 per month to as high as $350.00 per month.

Regulatory Requirements

OTP programs must comply with both federal and state regulations. A federally recognized accreditation body must approve all programs. In Oregon, the Commission on Accreditation of Rehabilitation Facilities accredits 13 OTP programs, and two programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Agencies are reviewed by their accreditation agencies at least once every three years. In addition, all programs must have their dispensary and dispensing process approved by the Drug Enforcement Agency (DEA). The DEA conducts random inspections of clinics to ensure compliance with medication dispensing regulations.

OHA approves OTPs in Oregon, with the exception of the federally run program. Each program is reviewed at least once every three years. In addition, current state statutes prohibit methadone programs from operating within 1,000 feet of a school, a licensed childcare facility, or a career school attended primarily by minors. Statutes also require

OTPs to obtain approval from an individual's parole/probation officer, if applicable, upon admission.

Admission Requirements

The program's Medical Director approves all admissions. Individuals being considered for methadone treatment must have a one year history, immediately prior to admission, of a continuous physical dependence on narcotics or opiates as documented by medical records, records of arrests for possession of narcotics, or records from drug treatment programs. The program must have evidence of an individual's current physical dependence on narcotics or opiates as determined by the program physician or medical director. The agency may also admit individuals where there is documentation demonstrating that medically supervised withdrawal or medically supervised withdrawal with acupuncture and counseling has proven ineffective, that a physician licensed by the Oregon State Board of Medical Examiners has documented in the patient record a medical need to administer opioid agonist medications, or if the patient is currently pregnant and opioid dependent.

Daily Operations

Clinics in Oregon are required to be open Monday through Saturday, except for federal holidays. Clinics are open early morning through early afternoon and provide dosing, counseling and urinalysis testing. Upon admission, individuals are required to pick up their medication at the clinic six days a week. Over time and with documented progress, individuals are eligible for "take home" privileges that enable them to come to the clinic less frequently. The criteria and time frame for these privileges are described in federal and state regulations.

Individuals may be enrolled and participate in medication assisted treatment (MAT) for as long as they benefit and believe they need to be on medication to maintain the positive changes and stability they have achieved since enrollment in treatment. For patients taking methadone, an average length of stay is between one and three years. If both the individual and the clinic believe the person may be successfully titrated off methadone, a therapeutic detoxification can occur. Depending on an individual's response, this detoxification period can be several months or longer.

OHA will continue to collaborate with partners, including the OHA Public Health Division, the Alcohol & Drug Policy Commission, the Prescription Drug Monitoring Program, the Governor's Prescription Drug Abuse Task Force, LMHAs, and Oregon MAT providers to address issues related to prescription opioid poisoning. Technical assistance and training is used to increase awareness and promote implementation of MAT to treat opioid addiction. OHA works with CMHPs, counties, subcontractors and other providers to monitor and ensure that priority populations receive services required by the Substance Abuse Prevention and Treatment Block Grant. Treatment outcome

improvement measures continue to be refined as part of the outcome-based contracting process and are revised in response to any new measure or performance domains that may be included in the National Outcome Measures.

Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program (PDMP) assists health care providers and pharmacists to provide patients better care in managing their prescriptions. The PDMP was started in 2011 to help individuals collaborate with their health care providers and pharmacists to determine what medications are best for them. The system allows healthcare practitioners to be able to access a database, which makes them aware of the specific medications prescribed to their individual patient, in order to provide oversight in medication management, as well as protect the overall health and welfare of their patient. The patient data is secure, and can be only accessed by individuals using the proper authentication, for the purpose of treatment planning and the healthcare needs of their individual patients.

Pharmacies contribute data to the program on specific prescription drugs, Schedule II, III and IV controlled substances, dispensed to patients. These medications place patients at risk for overdose, side effects, and increased effect when combined with alcohol and/or other drugs, risk for physical dependence, and risk for developing patterns of drug abuse. The PDMP provides practitioners and pharmacists a means to identify and address these problems.

- More than 14,900 practitioners and pharmacists have PDMP accounts in Oregon;
- In 2016, more than 1.2 million queries were made by practitioners and pharmacists;
- Approximately 7 million prescription records are uploaded into the system annually.

Access to Recovery

Access to Recovery (ATR) is a three-year $2.3 million per year competitive grant that was secured by OHA in May 2015. This is part of a federal initiative supported by SAMHSA and the Center for Substance Abuse Treatment (CSAT) to develop person-centered, community-based services to those seeking recovery. ATR emphasizes participant choice by supporting the individual's decision about what services they believe will be helpful to their recovery, as well as where they would like to receive such services. ATR has bipartisan federal support and requires service linkages to include faith-based and community-based organizations that receive payment for services through an electronic voucher management system.

ATR is currently operating in five counties: Multnomah, Clackamas, Washington, Marion, and Lane. Any individual 18 years or older who lives in the identified counties, has a serious substance use condition, and seeks supportive services to help them enter or maintain recovery is eligible for ATR services. Oregon is prioritizing active military or returning veterans, parents

mandated to Child Welfare services, young adults in transition, individuals exiting a higher level of care, including withdrawal management or residential treatment, and individuals transitioning to communities from corrections institutions who have substance use disorders. The total number of unique individuals to be served over the project period of May 2015 to April 2018 is 3,723.

Driving Under the Influence of Intoxicants (DUII) Treatment
Whether an individual enters into a diversion agreement or is convicted of DUII, the court will order the individual to set and keep an appointment with an Alcohol and Drug Evaluation and Screening Specialist (ADES). The ADES has two roles in the DUII service system:

- Screen for an appropriate referral to a state approved DUII alcohol and drug treatment program; and
- Monitor and provide the court with evidence of individual alcohol and drug treatment compliance.

During screening, the ADES will determine if an individual should be referred to alcohol and drug treatment or to a DUII information program. Factors that the ADES reviews in making a referral include blood alcohol content at the time of the arrest, previous arrest history, and other factors, including the individual's alcohol and drug use history.

Individuals referred by the ADES for alcohol and drug treatment are assessed by the treatment provider, who then develops an individualized treatment plan. While in treatment, individuals are required to demonstrate at least 90 days of abstinence from alcohol and other drugs. Individuals with a positive drug test will be required to restart the 90-day requirement. Levels of care, including the number of clinical treatment hours per week, are individualized per ASAM-PPC-2R criteria. Hours of treatment per week is between two to eight, but may be more depending on individual addiction severity level.

DUII Education Program
The requirements for DUII Education Programs are outlined in the Oregon Administrative Rules and include 12 to 20 hours of alcohol and drug education. The DUII Education programs are required to take place over a minimum of four sessions over four consecutive weeks. In addition to these drug and alcohol education requirements individuals are required to submit at least one random urine sample for testing within the first two weeks of enrollment. Individuals who produce a positive alcohol and drug test will be required to enter and successfully complete an alcohol and drug treatment program including the 90 days of abstinence as outlined above.

DUII Recovery Supports
As part of the continuum of care, recovery support services are encouraged for individuals who engage in addiction treatment following a DUII. Individuals who need

treatment will continue to have access to community recovery supports such as twelve step groups and faith based programs.

Referrals

A health profession regulatory board may refer a licensee to HPSP or a licensee may self-refer. When a board refers a licensee, HPSP will work with the board to ensure the licensee is monitored in accordance with his or her board agreement. When a licensee self-refers, HPSP will work with the licensee to develop an individualized monitoring agreement and will keep the licensee's enrollment confidential as long as the licensee is in compliance with his or her HPSP monitoring agreement.

Education and Information

HPSP provides information and education to employers, licensee associations and support networks, treatment programs and other stakeholders. Topics include an overview of HPSP and its services, the value of HPSP for self-referrals, signs and symptoms of substance abuse disorders, mental health disorders and relapse, and effective workplace supervision.

Choice Model Services

Choice Model Services, previously known as Adult Mental Health Initiative, is designed to promote more effective utilization of current capacity in facility-based treatment settings, increase care coordination and increase accountability at a local and state level. Choice Model will promote the availability and quality of individualized community-based services and supports so that adults with mental illness are served in the most independent environment possible and use of long-term institutional care is minimized. The initiative re-allocated a portion of resources historically used to develop community based licensed residential care facilities. These resources were directed to non-traditional person-centered supports in care management, a broad range of treatment services, discharge planning, and community based supports such as rental assistance.

The target population is individuals who, because of mental illness: (a) Currently reside at an institution listed in ORS 179.321 and includes patients residing within a Neuro/Gero ward at OSH in Salem, Oregon; or (b) Currently reside in a licensed community based setting listed in ORS 443.400 and includes licensed programs designated specifically for young adults in transition; or (c) Are under a civil commitment pursuant to ORS 426; or (d) Were under a civil commitment that expired in the past 12 calendar months; or (e) Would deteriorate to meeting one of the above criteria without treatment and community supports; and (f) Does not include individuals who are under the jurisdiction of the Psychiatric Security Review Board (PSRB).

Choice has improved local accountability for positive treatment outcomes through performance based contracting. Increased local control and accountability help OHA's

community partners provide high quality care at the right time, for the right duration, and at lower cost. Providers are required to stay involved with their members throughout the full service continuum, and work with the individual to develop a care plan that meets the individual's needs and choices.

Choice collaborates with local partners to enhance client self-determination by developing an Individualized Recovery Plan (IRP) for each member served. This enhanced emphasis on recovery and self-determination is expected to help lessen transition times to more independent and integrated living environments. For individuals experiencing mental illness, residential treatment helps promote and enhance skills needed to lead independent healthy lives. Many coordinated care organization (CCO) members receive this kind of treatment on a temporary basis, outside their home community. After many thoughtful discussions with CCO and behavioral health stakeholders, the Oregon Health Authority updated CCO enrollment rules to support keeping individuals in their "home" CCO when in out-of-area treatment. (The "home" CCO is the CCO the individual had prior to being placed in temporary residential treatment.)

Residential Mental Health
Adult Mental Health Residential Treatment Programs
Co-occurring behavioral disorders and serious, chronic medical conditions create the need for specialized treatment environments that provide the level of service intensity to support individuals striving toward independence. Wise use of these intense supports can improve treatment outcomes and facilitate more timely transitions to independent living. While Oregon has been implementing several important strategies to increase the availability of integrated, community-based supported housing during the last biennium, the state recognizes the continued need for licensed residential care environments that provide intense, specialized services and supports.

Individuals in licensed residential treatment participate in an individualized assessment of strengths and treatment needs to help determine the most appropriate level of care that allows the most independence. An individualized treatment plan and an Individualized Recovery Plan are developed from this assessment, outlining the services and supports to be provided in the residential setting.

Three levels of community-based residential treatment services are offered for adults with serious mental illness:
- Residential Treatment Homes (RTHs) provide services on a 24-hour basis for five or fewer residents;
- Residential Treatment Facilities (RTFs) provide services on a 24-hour basis for six to 16 residents; and

- Secure Residential Treatment Facilities (SRTFs) restrict a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures. SRTFs provide services on a 24-hour basis for 16 or fewer residents.

Type of Housing	Capacity
Adult Foster Home	590
Residential Treatment Home	290
Residential Treatment Facility	498
Secure Residential Treatment Facility	539
TOTAL	1,917

Psychiatric Security Review Board

The Psychiatric Security Review Board (PSRB) is a Governor appointed, five member multi-disciplinary board made up of a psychiatrist, a psychologist, an attorney experienced in criminal practice, a parole/probation officer and a member of the general public. This panel reviews the progress of individuals who successfully pled Guilty Except for Insanity (GEI) through the court system. The Psychiatric Security Review Board's mission is to protect the public by working with partnering agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior using recognized principles of risk assessment, victims' interest and person centered care.

The State Hospital Review Panel (SHRP) is appointed by the Oregon Health Authority and consists of the same make-up of panel members and mission as the PSRB. This panel reviews the progress of individuals who are found GEI of crimes that are non-Ballot Measure 11[1] while placed at Oregon State Hospital (OSH). SHRP has the responsibility for determining when these patients are ready to leave the state hospital on conditional release. When patients leave the hospital, PSRB is responsible for their monitoring and supervision in the community.

The PSRB and SHRP maintain jurisdiction for individuals adjudicated as GEI. As of July 1, 2015, 535 individuals were under the jurisdiction of the PSRB and 80 individuals were under the jurisdiction of SHRP, totaling 615 individuals in Oregon's forensic system. Of those under the jurisdiction of the PSRB, 146 were patients at OSH and 380 (61%) reside in the community-- observing the requirements outlined in their individual conditional release plans and through supervision and treatment supports offered by Community Mental Health Programs (CMHP).

---

[1] Ballot Measure 11 identified certain person-to-person crimes, which, upon conviction, result in mandatory-minimum sentences.

The PSRB reports to the Governor and uses a hearings process and conditional release orders to supervise people under its jurisdiction. OHA is statutorily responsible for providing mental health services to these individuals. CMHPs provide evaluations for the PSRB, SHRP, or the court, to determine if treatment in the community is appropriate and to secure resources in the community. Determination of supervision requirements and treatment for persons conditionally released into the community is also provided by CMHPs. Residential services are provided in varying levels of care including: Secure Residential Treatment Facilities, Residential Treatment Facilities and Homes, Adult Foster Care, Supported Housing, Intensive Case Management and Independent Living. Individualized community placements include, but are not limited to, the following services:

- Community risk evaluation;
- Monitoring, security and supervision;
- Case management;
- Psychotherapy;
- Residential supports;
- Supported employment and education services;
- Substance use disorder treatment services; and
- Medication management

The PSRB, SHRP and OHA continue to work with OSH Treatment Teams and CMHPs to assure that individuals are placed in the appropriate level of care and receive the services needed to live as independently as possible. OHA continues its commitment to develop residential placements that provide the necessary supports for this population to transition to the community. Five community placements were opened during the 2011-2013 biennium, and development of an additional 10 placements were completed in the 2013-2015 biennium.

Residential - Substance Use Disorder
Adult Withdrawal Management Services
Withdrawal management services include an assessment to determine medical need and the level of care necessary to manage withdrawal symptoms and the need for substance use disorder treatment. Level of care is determined based on The American Society of Addiction Medicine (ASAM PPC 2R) assessment and placement: ASAM placement level 3-WM, Residential; level 3.2-WM: Clinically Managed Residential; and level 3.7-WM: Medically Monitored Inpatient would qualify for adult detoxification services. Treatment services include 24 hour support and/or medically supervised care, medications to help alleviate and manage withdrawal symptoms, and support and observation for those who are intoxicated or experiencing withdrawal. Individuals diagnosed with a substance use disorder receive a referral to residential or outpatient substance use disorder services.

Adult Residential Addictions Services

As of July 1, 2013, Oregon's Medicaid funded addictions stabilization services, including residential and detoxification, transitioned to Coordinated Care Organizations. OHA continues to provide regulatory oversight and policy implementation for residential and withdrawal management programs. Treatment services are in safe, permanent settings and adhere to policies and procedures approved by OHA. All programs are staffed twenty four hours a day and include a wide variety of services inclusive of adult women, women with children, men with children, and adult men.

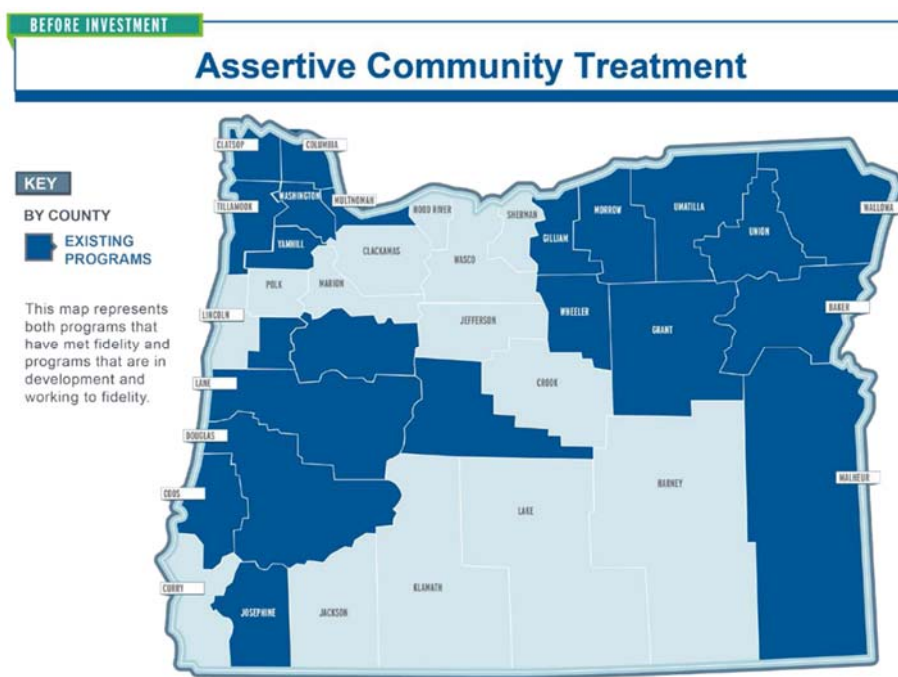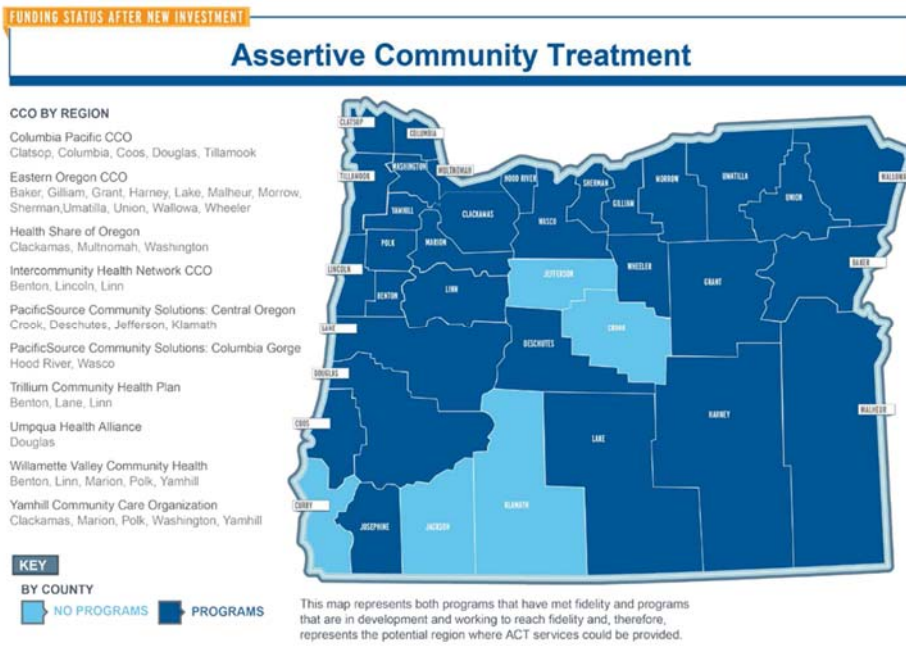**Assertive Community Treatment (ACT)**

Assertive Community Treatment (ACT) is an Evidence-Based Practice (EBP) designed to provide comprehensive treatment and support services to individuals who are diagnosed with serious mental illness. ACT services are provided by a multidisciplinary team and are designed to be provided in the most integrated setting possible to maximize independence and community integration. The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) was created to promote and implement Assertive Community Treatment (ACT) as an evidence-based practice (EBP) throughout Oregon.

The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) is funded through a contract with the Oregon Health Systems Division (HSD) and is operated in partnership with the Oregon Supported Employment Center for Excellence(OSECE) and Options for Southern Oregon, which administers the contract.

The primary goals of OCEACT are to:
o   Provide training and technical assistance. OCEACT provides training and technical assistance to educate mental health service providers about the Assertive Community Treatment model.   OCEACT statewide trainers provide expert consultation to established and developing ACT teams.
o   Help programs achieve high fidelity to the ACT model and improve quality. The OCEACT staff conducts annual fidelity reviews of ACT programs statewide. OCEACT is a resource for current and future ACT teams interested in learning more about the ACT model and improving adherence to ACT principles.
o   Organize an annual ACT conference. OCEACT sponsors an annual statewide conference on ACT and other relevant evidence based practices in mental health treatment.
o   Measure and report statewide ACT program outcomes on a quarterly basis. High fidelity ACT programs have been shown to reduce psychiatric hospitalization and utilization of acute care, improve housing stability, and improve quality of life for participants. ACT programs report on a core set of participant outcomes to measure the impact of the ACT program across Oregon.

○ Educate and advise state and local policy makers. OCEACT staff meet regularly with representatives from the Oregon Health Authority and other stakeholders to share success stories, discuss implementation issues, program outcomes, and ways to best support high fidelity ACT model service delivery.

FUNDING STATUS AFTER NEW INVESTMENT

Assertive Community Treatment

CCO BY REGION

Columbia Pacific CCO
Clatsop, Columbia, Coos, Douglas, Tillamook

Eastern Oregon CCO
Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman,Umatilla, Union, Wallowa, Wheeler

Health Share of Oregon
Clackamas, Multnomah, Washington

Intercommunity Health Network CCO
Benton, Lincoln, Linn

PacificSource Community Solutions: Central Oregon
Crook, Deschutes, Jefferson, Klamath

PacificSource Community Solutions: Columbia Gorge
Hood River, Wasco

Trillium Community Health Plan
Benton, Lane, Linn

Umpqua Health Alliance
Douglas

Willamette Valley Community Health
Benton, Linn, Marion, Polk, Yamhill

Yamhill Community Care Organization
Clackamas, Marion, Polk, Washington, Yamhill

KEY

BY COUNTY

□ NO PROGRAMS   ■ PROGRAMS

This map represents both programs that have met fidelity and programs that are in development and working to reach fidelity and, therefore, represents the potential region where ACT services could be provided.

BEFORE INVESTMENT

Assertive Community Treatment

KEY

BY COUNTY

■ EXISTING PROGRAMS

This map represents both programs that have met fidelity and programs that are in development and working to fidelity.

Community Treatment for

Children and Youth

Children ages zero through 17 are served under the children's mental health system in Oregon, with programs and services also available to young adults in transition between the ages of 14 and 25. Services are provided through the community mental health programs, and available throughout Oregon. A continuum of services exists from outpatient services to hospitalization, including long-term care in an alternative setting to the state hospital system, based in the community. Developmentally appropriate services are available to young adults in transition.

The System of Care Wraparound Initiative (SOCWI) has implemented Wraparound, a research based practice model, for communities' children with the highest levels of need and their families. The SOCWI intensive care coordination model engages a creative and collaborative process to develop a flexible, coordinated and individualized plan of services and supports in a culturally responsive manner. These services and supports are geared to meeting each young person's needs and strengths. Wraparound moves away from the historically limited array of client services, and toward coordinating across systems including Child Welfare, Developmental Disabilities, education, juvenile justice, etc., encompassing a variety of services and supports to best meet the youth's individual needs.

SOCWI was launched at three demonstration sites, comprising eight counties, in July 2010 and expanded in 2014 to an additional 12 sites comprising 30 counties. SOCWI has been successful and accomplished a transformation in children's mental health services. It uses an intensive care coordination model for cross-system planning of children's service and support needs. Data demonstrate that children in SOCWI have:

- Better health, as reflected by more children having access to a primary care physician, and improved monitoring of psychotropic medication being prescribed, in addition to having adequate effective care for emotional and behavioral challenges.
- Better care when children are able to move into long-term community-based family settings, either with their biological family, guardianship, or through adoption. Families experience better care, no longer need child welfare involvement in their lives, receive better supports and have a natural support network.
- Access to services provided at a lower cost through participation and collaboration of multiple systems. The intensive care coordination model reduces higher-cost services. This makes it possible to more children to be served at reduced cost.

- Increased levels of dignity and respect with which children, youth and families are treated with the Wraparound model as evident through anecdotes and family stories.

Guidelines for the local practice have been established through the Oregon Best Practice document, which provides a framework, tools, and strategies that align with the principles and values of Wraparound. To ensure that the quality and consistency of the model is evidenced statewide, fidelity to Wraparound is measured by two instruments: the Team Outcome Measure (TOM) and Wraparound Fidelity Index-EZ (WFI-EZ). The next phase in the System of Care approach using the Wraparound model is to continue to create a child-serving system where this is the way business is conducted in all Oregon communities, by expanding to the remaining three CCOs who are not currently participating in SOCWI. This initiative, to date, has shown that children receive better care, enjoy better health and are served at a lower cost under this System of Care.

Using this model, which supports many existing initiatives, all child-serving systems must be brought to the table for ongoing success. High-level decision makers from Oregon Health Authority, Oregon Youth Authority, Department of Human Services, developmental disabilities and Oregon Department of Education must tackle shared governance and funding of this business model for continued sustainability.

School Access to Mental Health/ School Based Health Centers
Adolescent and School health unit with HPCDP's prevention work around substance abuse prevention issues as capacity allows. Recent work includes: preparing and distributing the publications *Preventing Underage Marijuana Use: Parents' Guide to Talking with Your Kids* and *Preventing Youth from Using Marijuana: Educators' Guide*. Created an annual Adolescent Health Snapshot of health and behavioral data and presented outcomes from a policy framework. This information is shared with internal and external partners so that programs and policies can be most reflective of what adolescents experience. Information includes mental health and substance abuse issues. Oversees the Oregon School-Based Health Center (SBHCs) Program. There are 78 State-Certified SBHCs in Oregon. SBHCs receive grants for mental health capacity and/or youth-focused mental health projects. The majority of grant funds are used to support additional mental health providers in SBHCs. Grant funds are also used to support Youth Advisory Councils and Youth Participatory Action Research Projects.

- Providing Mental Health Services at SBHCs allows for timely mental health care, a strong system of care, a focus on prevention and a commitment to serving adolescents regardless of their ability to pay.

- SBHC mental health providers held behavioral health, psycho-education, support, and wellness groups for anxiety, depression, grief, and healthy relationships. These groups enabled providers to treat and work with more adolescents, do prevention work, and strengthen partnerships with school and community providers.

- SBHC mental health providers helped schools respond to mental health crisis situations by providing immediate intervention, as well as longer term grief and bereavement supports.

- Youth Action Councils assure clinic are welcoming to youth and help advertise clinic services to their peers.

- Youth Participatory Action Research topics included: mental health stigma, teen substance use, suicide prevention, sleep, effects of public displays of affection on school climate, self-esteem, stress, and awareness of mental health issues and perceived barriers to accessing care.

- Each certified SBHC is required to report on two Core Key Performance Measures (KPMs), as well as one of five Optional KPMs. Substance Abuse Screening and Depression Screening are optional KPMs. The Core KPMs are the Adolescent Well-Visit and a Comprehensive Health Assessment. Both include mental health and substance abuse screening, prevention messaging and anticipatory guidance.

School Access to Mental Health enhances the availability of mental health services to students by bringing mental health services into schools and increasing the array of mental health services available in the school building in a school-based infrastructure.

Locating services within the school setting increases accessibility for children, adolescents and their families to receive mental health services and targets youth who may not otherwise engage in traditional outpatient services. Mental health professionals in schools can also train and assist school staff in screening and early identification of mental health issues, provide consultation to support students, promote mental health and influence a positive school environment.

There are now 77 SBHCs and 95% of them have mental health providers on site. There are also 9 counties, with about 24 schools, being served outside of the SBHC program, where CMHP therapists are out stationed in schools and serving kids, from elementary through high school.

Adolescent Depression Screening

The Oregon Pediatric Society and community providers work with primary care clinics to integrate routine mental health screening within primary care to increase early detection of mental health issues in adolescents, and provide appropriate follow-up. Statewide consultation services and training are provided for primary care providers and clinics in use of an adolescent depression and substance use screening tool.

Routine screening allows primary care providers to identify youth who may need treatment but have not historically been identified. Early detection and follow up is vital for adolescent development. Untreated mental disorders can lead to harmful effects such as suicide and substance abuse. Training is provided to primary care providers with a focus on improving linkages to mental health providers and further expansion of evidence based treatment practices.

Oregon Psychiatric Access Line about Kids (OPAL-K)

OPAL-K was established and began operations in June 2014 in collaboration and partnership with Oregon Health and Sciences University, Oregon Pediatric Society, and the Oregon Council of Child and Adolescent Psychiatry. This telemedicine consultation service offers a link between pediatric or other primary care providers with providers of child psychiatric and mental health consultation, to improve integration and quality of children's mental health and physical health care. Based on proven programs used in other states, the OPAL-K model has been positively received and utilized and has already made notable impacts to treatment array across the state. This initiative is fully supported in policy and funding by the Governor and Legislature.

OPAL-K provides a physician-to-physician consultation system, linking child psychiatry expertise with primary care providers (PCPs). Objectives include:

- Same day consultation through phone or videoconference;
- Referral information made available to PCPs to assist them with links within their community;
- Provision of continuous mental health education for PCPs; and
- Face-to-face or telehealth consultation for complex cases in remote communities without access to child psychiatry services.

This service will improve mental health care delivery in primary care, improve access to timely mental health consultation and triage within primary care settings, and improve the cost effectiveness of mental health care for children and youth through early identification, consultation and access to mental health treatment. OPAL-K can prevent mental health disorders from developing and increasing in severity in children, and more effectively identify and treat children who experience mental health challenges. The majority of children and youth with mental health challenges and diagnosable illness are

initially seen and identified by primary care clinicians, and not by mental health professionals.

Child-Parent Psychotherapy (CPP)
Child-Parent Psychotherapy (CPP) is an intervention for children from birth through six years who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and are consequently experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent or caregiver to restore the child's sense of safety, attachment, and appropriate affect and to improve the child's cognitive, behavioral, and social functioning. CPP is recognized by the National Child Traumatic Stress Network and the SAMHSA National Registry of Evidence-Based Programs and Practices as having adequate cross cultural application.

The goals of this project were to:
- Identify clinicians previously trained in CPP and provide updated training;
- Implement CPP with fidelity through provision of mental health promotion and intervention services to at-risk families;
- Utilize the CPP Fidelity Tools;
- Utilize two validated developmentally appropriate measures, such as the Parenting Stress Index, to evaluate effectiveness of the intervention; and,
- Develop ongoing consultation, supervision and networking between CPP-trained therapists to maintain fidelity to the model over time.

OHA identified 42 therapists trained in CPP through other funding sources and provided training in the updated protocols. The training took place in October 2014. An additional cohort of therapists never before trained in CPP began training at the same time.

Addressing the Needs of Commercially Sexually Exploited Children (CSEC)
OHA has worked closely with community partners and the Oregon Department of Justice (DOJ) to devise a plan for creating a comprehensive statewide system to identify, respond to and treat child victims of sex trafficking.

Commercial Sexual Exploitation of Children occurs when individuals buy, trade, or sell sexual acts with a child. Sex trafficking is "the recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act[2]," *Victims of Trafficking and Violence Protection Act of 2000* (TVPA, 2000).

---

[2] Victims of Trafficking and Violence Protection Act of 2000 (TVPA) retrieved from: http://www.state.gov/j/tip/laws/61124.htm

Children who are involved in the commercial sex industry are viewed as victims of severe forms of trafficking in persons, which is sex trafficking "in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age," (TVPA, 2000). A commercial sex act is "any sex act on account of which anything of value is given to or received by any person," (TVPA, 2000).

DOJ Crime Victim's Services Division (CVSD) created an advisory committee that will address issues associated with the Commercial Sexual Exploitation of Children (CSEC) and provide recommendations on policy and procedure to DOJ, CVSD and OHA. This Agreement sets forth both agencies' expectations for the CSEC Advisory Committee.

The CSEC Advisory Committee will be modeled after the Child Abuse Multidisciplinary Intervention (CAMI) Advisory Committee and collaborates with OHA. The CSEC Advisory Committee will make policy recommendations, provide system oversight and define funding priorities for money allocated to OHA for the purpose of addressing the commercial sexual exploitation of children. The Advisory Committee will also provide collaboration and recommendations on any CSEC grants administered by CVSD in the future.

In collaboration with DOJ CVSD and OHA, the CSEC Advisory Committee provides the following:
1. Serves as a board of experts on the subject of CSEC and the Oregon system of care related to CSEC;
2. Establish statewide CSEC priorities;
3. Assists in advancing CSEC priorities on a local, state and federal level;
4. Review how state funding is spent on CSEC within the Oregon Health Authority, and provide recommendations on how best to utilize current and future funding;
5. Reviews current systems addressing CSEC, identify strengths and weaknesses;
6. Provide recommendations for the use of future CSEC funds, both public and private;
7. Assists in identifying public and private partnerships;
8. Partners with OHA to assist in ensuring successful policy implementation;
9. Participates on the CSEC advisory committee that reports to the CAMI board;
10. Works with state and local partners to establish a statewide, organized continuum of care and response for CSEC victims;
11. Develops protocol for CSEC victims grounded in System of Care values and principles; and,

---

12. Develops a State Plan with community partners and OHA staff, which address prevention, early intervention and services for potential and existing CSEC victims.

In Multnomah County a group of professionals from multiple agencies have been trained to identify and serve this population. Multnomah County has a five-bed shelter program for children who have been commercially sexually exploited. Child Welfare in Multnomah County developed a CSEC specific unit that only assists cases of children who are or have been involved in trafficking.

Federal legislation HR 4980 requires DHS Child Welfare requires child welfare to have policies and procedures for protecting and identifying children and youth at risk of sex trafficking. OHA is collaborating with Oregon child welfare on the development of these Oregon Administrative rules, policies and procedures.

Collaborative Problem Solving
Collaborative Problem Solving (CPS) is a communicational approach to working with children with social, emotional and behavioral challenges, which has two major tenets:
1. Social, emotional, and behavioral challenges in children are best understood as the by-product of lagging cognitive skills; and
2. These challenges are best addressed by resolving the precursors for challenging behavior in a collaborative manner.

OHA partners with Oregon Health & Sciences University (OHSU) for the OHSU/Think:Kids Alliance, which focuses on advancing practitioner and family member skill development in the application of the CPS model. The Alliance supports work in creating connectivity and coordination among systems and organizations utilizing CPS, and creates affordable CPS training opportunities for professionals and families throughout Oregon.

The OHSU/Think: Kids CPS Alliance[3] has strengthened and expanded its Oregon capacity significantly including:
- Trainings and Work group development, including CPS Certified Trainer Coalition, Foster Care Coalition, Parent Training Coalition, and planning for an Outpatient Provider Work Group;
- Supervision and support to individuals and agencies implementing the model, support for certification;
- Resource expansion: Full-time OHSU Co-Coordinator position, a lending library, public CPS discussion group at Legacy Emanuel Hospital, and proliferation of the model across community sectors statewide; and,

---

[3] Additional scope of work information and overview of CPS Alliance is available at:www.ohsu.edu/cps.

- Exposing new systems of care to the CPS Model including drug and alcohol programs and the Developmental Disabilities service array.

The increase in Certified Trainers across the state has expanded the availability of CPS to the public, moving service delivery to the community outside of OHSU. The Oregon CPS Alliance will effectively roll out parent group trainings and CPS support groups for families across the state, overlapping with other models such as Wraparound and practices supportive of trauma informed care.

Juvenile Fitness to Proceed
The Oregon State Legislature passed House Bill 2836 in 2013 to address Juvenile fitness to proceed throughout the state. Before this law, the state lacked a consistent standard for addressing juvenile competency. HB 2836 addresses the unique nature of juvenile fitness to proceed and establishes a standard for evaluating adjudicative competency in juvenile court and providing restorative services for juveniles who are found unfit to proceed. The bill named OHA as the certifying body for the administration of these evaluations.

Oregon Health Authority has expanded its statewide Forensic Evaluator Certification training to certify psychiatrists and psychologists who conduct forensic evaluations for juvenile defendants to include the intricacies of juvenile fitness to precede evaluations. Forensic evaluators who wish to be certified to conduct forensic evaluations on juvenile defendants must participate in this training and submit three sample reports for review by a panel convened by OHA in order to complete their certification.

HB 2836 stipulates that juveniles are not to be removed from their current placements for fitness to proceed evaluations or for restorative services unless absolutely necessary for the safety of the youth or the community. Prior to the enactment of this statute, children were often placed unnecessarily in overly restrictive settings to receive restorative services. By assuring that these services can be provided in the community in which the juvenile resides, the beds in the most restrictive levels of care can be reserved for those most appropriate for these settings.

Partnership with DHS Child Welfare
Child Welfare and OHA share the contracted services of a child and adolescent psychiatrist to provide medical direction to behavioral health and child welfare. This collaborative approach has facilitated a shared understanding and a common approach to addressing the complex mental health needs of children in the child welfare system.

DHS policy and contracts require that children who are placed in substitute care through Child Welfare receive a mental health assessment. Child Welfare policy states that all children in substitute care will be referred for a mental health assessment within 21 days of placement. CCO contractual expectations include an outcome based incentive, which

requires that comprehensive mental health assessments for children placed in substitute care by Child Welfare be provided no later than 60 days following the date of DHS custody. This measure has been incorporated into accountability measures for the CCOs. A service improvement goal has been identified to increase the percentage of children who receive timely mental health assessment to ninety percent.

Longer term goals include developing capacity for mental health assessment for children younger than age three, and that system changes extend beyond improving compliance with the assessment requirement and lead to increased capacity to provide appropriate treatment for traumatized children.

Coordinated Care Organizations are contractually mandated to provide a Child and Adolescent Needs and Strengths (CANS) assessment to all children coming into child welfare custody within the first 60 days of care, in alignment with the mental health metric described above. Reimbursement for the CANS is now a Medicaid covered service. Some CCOs have set up a rate structure to incentivize combining the CANS with the mental health assessment in an effort to achieve best practice. In addition, through the statewide expansion of Wraparound, sites are being trained on and encouraged to incorporate CANS within the child and family team setting in order to achieve best practice in the Wraparound care planning process.

Child Welfare sponsors the Target Planning and Placement Committee to review complex cases of children in the custody of Child Welfare. Caseworkers prepare a packet of case materials for review and present the case to the committee to obtain assistance in planning and consultation. The committee includes representation from Child Welfare, OHA, Education, county mental health, Aging and People with Disabilities, Juvenile Justice and any other child serving system involved in the child's case. This committee identifies gaps and barriers to system access and services, and assists caseworkers in obtaining appropriate services for children and young adults.

OHA works with Child Welfare to co-finance and co-manage much of the out-of-home mental health treatment services provided to children served through Child Welfare. CW contracts with public and private child serving agencies to provide Behavioral Rehabilitation Services for children whose primary need for out-of-home placement is not psychiatric treatment. Mental health services for children in these programs are delivered through the Oregon Health Plan.

Treatment Foster Care is a collaborative effort with Child Welfare. Treatment Foster Care is a combined service between DHS Child Welfare and OHA Oregon Health Authority administered at the local level through specific foster care providers who are supervised by the local community mental health program. It is considered the least

restrictive of residential treatment options for children in the care and custody of the state; it is a critical treatment option for children, especially in rural counties.

Child Welfare (CW) Collaboration

The reformation of Oregon Intensive Treatment Services is a noteworthy collaborative effort between the Oregon Health Authority (OHA) and the Department of Human Services (DHS) effort to improve the mental health outcomes for children and their families. Currently, Oregon's lack of intensive service capacity (PRTS/Subacute) is resulting in youth being placed in inappropriate settings such as hotels, emergency departments, detention centers and homes without adequate mental health supports.

Efforts to address the intensive services capacity decline over the past 18 months have not been successful. Oregon's largest provider of PRTS/Subacute care, Trillium Family Services, reported on March 1, 2017 that there were 95 children and youth referred to PRTS/Subacute programs with no current openings. Out of those 95 referrals, 60 were for younger children. All other programs were also at capacity with a backlog of referrals. (There is additional information at http://www.oregon.gov/oha/bhp/Pages/Behavioral-Health-Collaborative.aspx)
Gaps remain in the system in the following areas:

- Increase in numbers of youth with intensive needs relative to treatment options.
- Utilization Management (UM) criteria and processes are inconsistent among CCOs causing confusion among state agencies with custody of youth needing care and PRTS/Subacute providers.
- Not enough providers to meet demand.
- Long wait times between acceptance and admission.
- Lengthy appeals/hearings process within OHA.
- Alternative services are limited by what is available in the community.
- Discharge options are limited by what is available in the community and state wide step down options.
- Gaps in service availability impact the Guardian's (DHS) ability to provide safe and appropriate residential placement to meet the needs of the youth.
- Use of General Funds to cover intensive mental health services for individuals who have private health insurance. This is related to the fact that some private insurance providers do not cover certain intensive mental health services.

The short-term plan includes the following steps:

- Immediately assess residential homes on hospital campuses in Salem and Junction City through partnership with DHS, to provide temporary shelter for youth and utilize if needed
- Increase the fee for service reimbursement rates
- Continue to track capacity, scrutinize outcomes and monitor current needs of the system
- Make CCO contract changes to ensure quality care of the youth with the highest intensity service needs and allow for a more centralized system of care for those youth.
- Enhance Technical assistance to CCOs and partner agencies to ensure quality care coordination and avoid children's unmet behavioral health needs causing a youth to enter into an inappropriate placement and reduce trauma

The longer term plan contains the following key objectives:

- Implement detailed capacity management system to track current capacity, trends and movement between intensive levels of care.
- Conduct regular rate analyses annually to ensure providers have a sufficient reimbursement rate to continue to provide this critical service.
- Work with CCOs and partners regarding incorporating the children's mental health residential services under the capitated rates.
- Complete System of Care governance structure implementation at the state level to include CCOs, Providers, Family, Youth and Agency Partners to discuss and manage capacity issues with Intensive Treatment Services and within the entire System of Care.
- Incentivize development of community based intensive outpatient services and supports which are data driven and have demonstrated outcomes connected to higher rates of school attendance, college entrance and workforce contribution later in life and lower likelihood of truancy, delinquency and incarceration.
- Increase the quality of high fidelity Wraparound, which hinges on holding CCOs accountable for Best Practices, further investment, by CCOs into behavioral health services, the use of data from the recommended metrics to incentivize the development of intensive outpatient services including intensive in home models, and thoughtful and thorough discharge planning during transitions out of intensive behavioral health covered services with adequate notice given to the guardian or other residential care provider.

Early Learning Council (ELC)

The Early Learning Council and Oregon Education Investment Board were established in 2011, and conversations in communities were sourced into planning, strategy, and

communications. School districts, social service providers, community members, early intervention, childcare and early learning professionals, health care practitioners, educators and others convened to align collective assets towards the common goal of kindergarten readiness, using technology, best practice interventions and performance-based contracting[4]. These entities are referred to as **"Community-based Coordinators of Early Learning Services"** (hubs).

The hubs provide structure for achieving the goal that all children are ready to learn when they enter kindergarten. Children at the highest risk are the focus. Success will result from a determined concentration on outcomes and the integration of services at state and community levels. Individual, service and system measurements will be tracked with a willingness to change approaches that do not deliver success.

The overarching goals for the hubs are:
1. Children are ready for kindergarten when they arrive;
2. Children will be raised in stable and attached families; and,
3. Services are integrated and aligned into one early learning system design to achieve Goals one and two.

Children and Youth Residential Mental Health Services
Intensive Psychiatric Treatment
The Secure Children's Inpatient Program (SCIP) provides 24-hour secure residential treatment (formerly delivered in the state hospital) designed to provide intensive psychiatric treatment for children age 14 or younger, including a therapeutic school program on the residential campus. SCIP is housed in a residential facility in the Portland metro area.

Children and youth are referred to this level of care by their Child and Family team. The referral is approved at the local level and sent to OHA for final authorization for admission. The level of care needed must be between acute care hospitalization and psychiatric residential treatment service levels.

The Secure Adolescent Inpatient Program (SAIP), located in Corvallis, Oregon, provides secure residential treatment for adolescents, ages 14 to 17 years. The SAIP program also provides secure forensic mental health treatment for youth who are court mandated for restorative services, for Oregon Youth Authority crisis and petition admissions, and for the Juvenile Psychiatric Security Review Board (JPSRB) secure residential treatment.

---

[4]Stanford Social Innovation Review, *Collective Impact,* John Kania & Mark Kramer. Winter 2011.

Intensive psychiatric services are provided in coordination and with the collaboration of a Child and Family team. Services are delivered in an integrated and holistic approach in a safe and comfortable living environment that is as normalized as possible and matches the individual developmental level of the child. Both the SCIP and SAIP programs have transitioned to trauma informed practice under the Sanctuary Model. Therapies employed include:

- Collaborative Problem Solving;
- Dialectical Behavioral Therapy (SAIP);
- Cognitive Behavioral Therapy for multiple symptoms; and
- Dr. Bruce Perry's Neuro-sequential Model.

Both SCIP and SAIP programs are committed to delivering care to children and youth that:

- Deliver active psychiatric treatment in an individual plan of care developed by an interdisciplinary team under the direction of a psychiatrist who is board eligible or board certified in child psychiatry by the Oregon Board of Medical Examiners;
- Employs a multidisciplinary approach to care that includes CMHPS, CCOs, the child's school, family representatives and advocates, acute care psychiatric hospitals, juvenile justice, and children's intensive treatment service providers as indicated and appropriate for each child;
- Employs culturally relevant and competent treatment that is appropriate for the gender, age, culture, ethnicity, strengths, and individualized treatment needs of the child;
- Has a staffing model that allows for a child's frequent contact with a child psychiatrist, psychologist, psychiatric nurses, psychiatric social workers, rehabilitation therapists, and milieu staff with specialized training twenty four hours a day. Additionally, a psychologist and a psychiatrist with specialized training in forensic evaluation are available; and,
- Provides linkages with various levels of care and provides for care coordination with guardians, community partners, and continuing care providers to ensure the child's treatment is provided in the most appropriate and least restrictive setting.

Children's psychiatric residential treatment services (PRTS) and psychiatric day treatment services (PDTS) funding was transferred to the OHP in 2005 and is managed today through CCOs as part of their global budget. PDTS and PRTS programs for children who are Medicaid eligible but not enrolled with a CCO are co-managed with the CMHPs. The CMHPs conduct level of service intensity determination and approve referrals to PDTS and PRTS programs.

All CCOs are required to create linkages with community support systems including local and/or regional allied agencies. Integration of physical and behavioral health care

is a requirement of their Transformation Plans. Enrollment in a CCO provides coordination between medically appropriate treatment services for children eligible for Medicaid and many of the social supports necessary so children with severe emotional disorders can remain in their community.

PDTS and PRTS service providers are expected to collaborate with the local Child and Family Team to coordinate transitions back into the community with the goal of maintaining the child in the least restrictive setting.

Residential Services for Young Adults in Transition
Statewide residential programs and supported housing specifically designed to meet the needs of young adults continue to expand. Residential services for young adults in transition (YAT) programs serve young adults ages 17 through 25 who have mental health challenges and who may have a history of institutional care. Residential resources for young adults include five young adult Secure Residential Treatment Facilities (SRTF), an alternative to state hospital level of care; seven young adult residential treatment homes (RTHs), as well as capacity for 51 young adults in supportive housing (Table 1).

Cadenza YAT RTH is a new young adult residential treatment home that was developed and opened in the 2013-2015 biennium. Staff in the OHA Residential Programs and Services (RPS) Unit also worked closely with community-based residential treatment providers and local mental health service providers to develop a new residential treatment home for the YAT population located in Pendleton during 2013-2015 biennium. New Roads YAT RTH, operated by ColumbiaCare Services, Inc. serves young adults in the eastern Oregon region, providing housing as well as support services.

YAT-specific programming is being implemented within the OSH system. OHA has developed specific programming at various levels of care to address the needs of young adults ages 17 through 25 that are transitioning from OSH to a community residential setting. These residential options are needed to address the dramatic shortfall in services that occur due to categorical eligibility when an individual turns 18. These housing projects support expanded options. Services delivered in these residential options are engaging and relevant to young adults, including feedback from the young adults whenever possible. Programs accommodate the critical role of peers, families and friends in service delivery.

Services delivered in these residential settings serving young adults include but are not limited to:
- Money and household management;

- Supervision of daily living activities such as skill development focused on nutrition, personal hygiene, clothing care and grooming, and communication skills for social, health care, and community resources interactions;
- Assuring the safety and well-being of individuals in the program;
- Administration, supervision and monitoring of prescribed and non-prescribed medications;
- Provision or arrangement for routine and emergency transportation;
- Developing skills to self-manage emotions;
- Management of physical or health issues such as diabetes and eating disorders;
- Access to mentoring and peer delivered services;
- Promoting the positive use of leisure time and recreational activities;
- Access to supported education and supported employment resources;
- Individual, group and family counseling;
- Social and independent Living Skills training;
- Appropriate access to crisis intervention to prevent or reduce acute emotional distress;
- Development of a service plan with a safety component to ensure that a developmental and trauma informed perspective is incorporated; and,
- Specific sections addressing services and supports unique to the developmental challenges of a transition-age young adult.

Adolescent Residential Substance Use Disorder Treatment
When youth need detoxification services, they are sent to a local or regional hospital facility licensed by OHA Public Health Division. OHA licenses facilities to provide residential services to youth who are assessed as needing ASAM Level III services. Level III programs offer organized treatment services featuring a planned regimen of care in a 24-hour residential setting. Treatment is delivered in accordance with defined policies, procedures and clinical protocols. Programs are housed in or affiliated with permanent facilities where youth can reside safely. The programs are designed for adolescents needing safe and stable living arrangements in order to develop their recovery skills.

There are three levels of services available to youth needing substance use disorder treatment services. Those levels are:
- **Level III.1** – Halfway house or group home with Level I and Level II.1 services.
- **Level III.5** – Services offered in a therapeutic group home, therapeutic community, or licensed facility.
- **Level III.7** – Services offered in an inpatient or medical model residential home.

Crisis Services
Emergency Department Crisis Workgroup

Hospitals in Oregon are experiencing increasing demand in serving young people who go to emergency departments (EDs) for behavioral health challenges. Youth are waiting in emergency departments or pediatric hospital rooms, sometimes for many days, due to a lack of options for safe, therapeutic services. Families, health care providers and insurers are concerned about this growing problem. Psychiatric boarding is unlikely to be therapeutic, is at times traumatic for young people, their families and hospital staff, and it creates logistic and financial problems for hospitals.

This problem is national as well as local. Data in Oregon suggest that there is an increase in the utilization of emergency departments for children experiencing a behavioral health crisis. Hospitals report increases both in children presenting for behavioral health care within emergency departments and also in the amount of time spent waiting in the emergency department for an appropriate resource.

OHA convened a two-session workgroup to evaluate data and solicit expert opinion on the contributing factors and possible solutions to this problem. The workgroup included representatives from emergency departments, psychiatric hospital units, pediatric hospital units, sub-acute psychiatric residential treatment programs, CMHPs, intensive community-based treatment service providers, child welfare, private insurance, CCOs, family members, and young adults.

The children's mental health system must have capacity to mitigate crisis and to work with families to plan for ongoing services that will address the underlying issues. Each community's unique strengths and resources will define its strategies and solutions to creating a rapid yet therapeutic response to families faced with a behavioral health crisis. Strategies to improve local options must be developed at both state and local levels. One immediate action taken by OHA is to track the length of time that clients stay in emergency departments waiting for resources. This will be one benchmark of the system.

OHA is working with the local mental health authority and the CCOs in each region to design a plan specific to assisting children and their families to access alternative services to acute care and ED usage. The response to EDs will not be based on insurance coverage. Alternatives may include:
- Crisis stabilization ED diversion teams;
- Foster care and in home crisis respite; and
- Flexible activities or items that directly decrease ED usage.

Community Withdrawal Management Services
In anticipation of the Affordable Care Act, Oregon expanded withdrawal management services. Community withdrawal management services provide immediate and short-

term clinical support to people who are experiencing acute physical symptoms from alcohol and/or drug withdrawal and who are at an immediate health risk.

OHA provides financial support, in part, for crisis services in every community mental health program in Oregon. Some examples of crisis services include the following:

Assessment/Triage (Living Room Model) - There are currently three programs that are integrating portions of the Living Room Model into their available crisis services programs; Jackson County, Multnomah County, and Clackamas County.
Jackson County - A Living Room Model program is being designed to offer a safe, supportive, and welcoming environment and to provide a short-term, secure crisis program that allows up to ten hours of stay for five individuals. This program will add to the diversion options for individuals who may otherwise receive higher levels of care. Treatments include therapeutic crisis management; strengths based assessments; health screenings to determine health care needs; safety planning; and use of peer specialists. The January opening has been postponed to June 2015.

Multnomah County - Standing Stone Resource Room is a part of the Urgent Walk-In Clinic, as an optional support to individuals in crisis. Standing Stone is not a separate service, and is intended to function as a part of crisis stabilization and to support clients in connecting with community resources and engaging in their recovery process as they seek out or wait for ongoing treatment in the community. Consumers who are referred to Standing Stone by Urgent Walk-In Clinicians have access to the Standing Stone Resource Room for one week from the date of their referral.

Clackamas County - In 2015, Clackamas County plans to open a 23 hour receiving center, as an expansion of the existing crisis walk-in clinic, to provide a hybrid of a Living Room model and Psychiatric Emergency Department. The goal is a voluntary, low barrier setting where individuals in crisis can receive active treatment, peer support and case management and potentially avoid an emergency department visit or jail.

Crisis Residential/Respite - Oregon defines crisis respite as short-term crisis stabilization beds located in a licensed non-secure crisis respite facility. There are multiple counties in Oregon that provide crisis respite services.

Crisis Intervention Team/ Law Enforcement - During the 2013 legislative session, the Oregon Legislature allocated funds to enhance and expand jail diversion services. A contract was awarded to Performance Leadership, Inc., to conduct a CIT needs assessment, facilitate relationships between law enforcement agencies and CMHPs, develop a curriculum for both 24 and 40 hours of crisis intervention training, and to hold three regional CIT events. The project was completed in June, 2015.

Needs to be updated. While some counties utilized the funding for traditional crisis response by partnering with local law enforcement to have a licensed mental health clinician available 24 hours a day, seven days a week to respond to mental health crises, other counties invested in mobile crisis outreach. An example of each approach can be found in Marion County's Mobile Crisis Response Team and Yamhill County's Community Outreach Services (COS) program:

- Marion County's crisis services are offered through their Psychiatric Crisis Center, which operates 24 hours a day, seven days a week. Marion County has collaborated with the Marion County Sheriff's Department and the Salem Police Department to staff a mental health clinician to respond to mental health crisis situations 24 hours a day, seven days a week.
- Yamhill County's crisis services include mobile crisis community outreach services (COS) that is available 24 hours a day, seven days a week. The mobile crisis team consists of licensed psychiatric medical professionals, registered nurses, Qualified Mental Health Professionals (QMHP) and Qualified Mental Health Associates (QMHA), Certified Alcohol and Drug Counselors (CADC), and peer/crisis associate specialists and supervisors. Yamhill County uses their COS program to provide outreach to clients who have been identified through their providers as experiencing life situations that could lead to crisis situations. COS provides services to the client in the community; at their home, school, or work environment.

Collaboration with Hospital Emergency Departments and Urgent Care Systems
The Emergency Department Information Exchange (EDIE) is a real-time information exchange that enables intra- and inter-emergency department communication and notifications. The technology alerts emergency department clinicians and case managers of high utilizer and complex needs patients, so that care can be better managed and patients directed to the right setting of care.

OHA and USDOJ have a shared interest in utilizing the Health System Transformation to improve health outcomes for individuals with SMI. OHA and USDOJ have agreed to have OHA collect data on specific metrics to better understand the system and to engage in discussions regarding services and outcomes. The matrix identifies the metrics to be collected and the data dictionary provides the definition and data collection methodology for each metric. One of the identified metrics is Crisis Respite, which is referred to as "Short-Term Crisis Stabilization Beds." The data dictionary defines it as beds located in a licensed non-secure crisis respite facility. (Metric and data dictionary reference: 1.d.) This biannual metric identified 39 beds statewide in the last reporting period of January 1, 2015 - June 30, 2015. USDOJ also counts Community Crisis Beds and Sub-acute Beds.

Jail Diversion includes peer delivered services, community resources, and respite services, which are intended to reduce or eliminate jail time for people with mental illness charged with a crime. Oregon's jail diversion effort includes 13 programs in 15 counties, which have provided services to 1,305 individuals.

Recovery Support Services

OHA promotes the belief that recovery must be the common outcome of treatment and support services and an approach that promotes resiliency and develops and supports policies consistent with that outcome. This guiding principle follows the recovery model: "People get better! People Recover!" Oregon's recovery support services include supports through the key components of health, home, purpose and community; and recognize that recovery is a lifelong experience. In the past, resources have been used largely for acute treatment needs rather than ongoing recovery support. Health system transformation in Oregon has allowed resource investment in recovery support services throughout the behavioral health system, supporting an active consumer, family and youth voice in the planning of services throughout the system.

OHA has made significant investments in recovery support services. In 2014, the Office of Consumer Activities (OCA) was created to work in collaboration with OHA leadership to improve behavioral health services for the state. OCA is staffed by people who self-identify as having lived experience with a mental health or addictions condition.

OCA addresses issues important to individuals who receive behavioral health services and provides a designated, consumer voice.

A chief goal of the office is to be a cornerstone for systemic change in reshaping policies and service delivery toward more recovery-oriented system of care. The office strives for services to be more welcoming and to more fully honor each individual's dignity. The primary initiatives of the OCA include:
- Build a statewide network of peer-run programs to facilitate the sharing of promising ideas, policies, practices and procedures;
- Providing technical assistance to peer-run programs;
- Help OHA behavioral health increase peer involvement in evaluating the state's policies, planning, and programs;
- Increase representation of consumers, survivors, and former patients-including ethnic and racial groups-in local and state mental health planning activities;
- Conduct a stigma and discrimination reduction initiative;
- Reduce racial and ethnic groups' barriers to mental health and addiction services by promoting culturally competent services for peers in these groups;
- Ensure that peers have a strong voice in state mental health and substance use disorder treatment policy development, planning and practice; and,
- Coordinate an annual statewide peer conference.

Honoring the voice of consumers and survivors in mental health and addictions policy is what will give them equal footing in service delivery. The long-term goal of OCA is to promote policies and services that:

- Support mental health and substance use disorder recovery;
- Respect individuals' choices and acknowledge their self-determination;
- More fully honor individuals' dignity and ability to experience recovery;
- Promote higher levels of community inclusion, employment and education; and
- Encourage traditional providers to partner with peers and adopt practices that help people heal and recover their lives to the fullest, as they define for themselves.

Peer Delivered Services

The Center for Medicaid and Medicare Services (CMS) recognizes Peer Delivered Services (PDS) as an evidence-based practice for supporting recovery from behavioral health and addictions disorders. Peer delivered services is an array of agency or community-based services provided by peers to individuals with similar lived experience. There are four types of peer delivered services:

• An adult who has either received mental health services or self-identifies as a person in recovery, recovering or recovered from a mental health condition may provide services to an adult who is receiving mental health services;

• An adult who has either received additions services or self-identifies as a person in recovery, recovering or recovered from addictions may provide services to an adult who is receiving addictions services;

• A young adult with behavioral health concerns or challenges who has either received or self-identifies with behavioral health concerns may provide services to another young adult who has behavioral health concerns; and

• A family member who has parented a child or young adult with behavioral health concerns may provide services to another family member addressing children's behavioral health concerns.

The services are provided at all levels of mental health service delivery including: health promotion, outreach, crisis intervention, recovery support, advocacy skills, supported housing, SRT, SRTF, acute, and respite care. As a part of Oregon's health transformation efforts, Peer Support and Peer Wellness Specialists (PSS/PWS) are now organized under the as Traditional Health Workers (THW). OHA supports the use of PDS and plans to continue to increase the availability of PDS statewide.

The services are provided at all levels including health promotion, outreach, crisis intervention, recovery support, advocacy skills, and respite care. As a part of Oregon's

health transformation efforts, Peer Support and Peer Wellness Specialists (PSSs/PWSs) are now under the broader term of Traditional Health Workers (THW). OHA supports the use of PDS and plans to continue to increase the availability of PDS.

Peer Delivered Services in the Children's Behavioral Health System
Peer delivered services are effective in helping individuals build a foundation in the recovery community. This connection provides lifelong support to sustain long-term recovery. Peer delivered services for families with children or young adults assists parents to expand their understanding of and engagement in behavioral health services. This increases their capacity to assure the protective factors for children and collaborative problem solving skills for the entire family. Specialized youth support services promote the transition of youth to become progressively independent with increased resiliency skills.

- The children's mental health system has focused on workforce development to increase the availability of peers who are certified to deliver peer services. The Peer Delivered Service (PDS) Foundation's curriculum for young adults and family members is offered at least quarterly, includes content necessary for state certification, and provides more information on strategies to meet national standards and state of the art research findings for parent to parent peer support in one-to-one settings and group modality.

- The PDS curriculum also includes strength based assessment, use of lived experience, motivational interviewing, collaborative problem solving, holistic self-care, use of natural supports and community resources, cultural and linguistic responsiveness, suicide and interpersonal violence safety planning, relapse prevention, and trauma informed goal setting. The curriculum incorporates current research and information related to the education, health, and wellness needs of children, youth, and families.

As more trainings are offered, There are a 206 certified Family Support Specialists and Youth Support Specialists on the Oregon Traditional Health Worker registry. Each new class trains 18-25 individuals. They are absorbed into the workforce as soon as they complete the training. A goal is to continue the development of combined online and traditional training with both distance and in person follow-up and supervision. A peer support coach training cohort began in 2017. These coaches will provide regional supervision in rural areas as well as local supervision in more urban settings. The Oregon Administrative Rule 309 requires supervision of PDS staff by a clinician and a PDS staff person certified in that specialty (adult mental health, adult addiction, family,

or youth peer support). In 2018, the plan is to develop specialized PDS trainings on emergency services and suicide prevention and postvention safety planning.

- The Oregon Family Support Network (OFSN) developed a peer coach training curriculum that is now available for use in the communities where family support services have multiple staff. OHA contracts with OFSN and Youth MOVE Oregon (YMO) to provide PDS training and coordination to meet the need for continued development of peer delivered services both for young adults and family members of children with SED. Additionally, Family Support Specialists from all disciplines (mental health, addiction, intellectual/developmental disability, special education, and complex health care needs) across Oregon meet together with OHA staff on a monthly basis for policy updates, to identify system issues, and to plan for advocacy and training needs. The Family Workforce Association meets in person quarterly and was attended by 112 PDS family providers in 2016.

- There is a need to create a Center for Excellence for Peer Delivered Services, a collaboration of PDS staff and academicians in health outcomes, setting competency based standards for training, certification, and measurable services outcomes for the PDS. The model consists of subject matter experts of certified peer delivered services staff by discipline (adult to adult, parent to parent, and youth to youth) working with individuals at the University level who can provide research analysis. The joint effort would provide Oregon Health Authority with competency-based testing and certification for all types of peer support. It would also provide the guidance for the collection and analysis of outcomes data on the use of PDS. This body of knowledge would further modify the training and supervision/coaching mechanisms for effective PDS.

Access to Peer Support Services
Oregon Administrative Rule (OAR 309) now requires behavioral health services clinical providers to ensure access to PDS for families with children and youth. This makes it possible for Family Support Specialists (FSS) to be members of emergency department follow-up teams. It is anticipated that Family Support Specialists will also be added to outpatient teams, including CCBHC, , FQHC, and School-Based Health Center. There is a more acute need to offer Family Support Specialist services to families before they have access to regular behavioral health. When PDS were offered in one community with three FSS, in the community, all 93 families were able to maintain without having to

utilize crisis teams and hospital emergency departments until they could access outpatient services in 3-6 weeks after the initial contact with the FSS.

Peer delivered services in the adult mental health system

OHA believes recovery must be the common outcome of treatment and support services, and develops and supports policies consistent with that outcome. These values are evident in the array of peer delivered services and supports provided by independent, Peer-Run Recovery Organizations (PROs) throughout Oregon. There are 73 PROs in Oregon. Of these, 17 are chapters of Oxford House that qualify as Peer-Run Recovery Organizations. Twenty-eight of the Oregon PROs focus on mental health with the following focus:

- Ten are NAMI chapters;
- Three focus on co-occurring or both mental health and substance misuse; and
- Forty-two PROs focus on addictions related services.

In order to increase both the number and quality of PROs, OHA has supported several trainings to increase the skills of peer support and peer wellness specialists and the people who will be employing them.

Mental Health Block Grant funds supported the expansion of recovery support services in 2015-2017, including:

- Expansion of peer wellness specialists services in connection with supported education;
- Implementation of peer support specialists and dual diagnosis treatment in recovery support housing program;
- Expansion of Peer Wellness Specialist Services;
- Development of a PDS coalition in Mid-Willamette Valley;
- Implementation of PDS in an urban Native American outreach program;
- Research a Community Integration Specialists for Recovery Outcomes (CISRO) Model with Peers in Multnomah County; and
- Implementation of "Peer Paths to Wellness" in Marion and Yamhill Counties.

To support Mental Health client recovery and Person Centered Planning (IRP), AMH recently put forth an RFP for training on Person Centered/Directed Planning and Individualized Recovery Plan instruction for the Adult Mental Health Initiative Contractors. The IRP provides the framework by which services should be provided for the individuals that AMHI serves. It is a highly individualized process designed to respond to the expressed needs and desires of the individual.

OHA's identifies peer delivered services as essential and includes initiatives to increase the availability of peer delivered services throughout the state, including underserved area of the states. A key component to success in health equity will be the development

of a diverse workforce that includes the expanded use of traditional health workers in all health care settings. A measure of success in reducing stigma is increased percentage of people who receive peer-delivered services. Behavioral Health, along with Medical Assistance Programs (MAP) and other partners will develop plans for the expansion of PDS in Oregon.

Peer Delivered Services Workgroup
OHA employs a Peer Delivered Services Coordinator to support development and implementation of PDS services in Oregon. The PDS Coordinator leads the Peer Delivered Services Workgroup which meets regularly to develop recommendations to increase access to quality peer delivered recovery support services. PDS Workgroup membership is composed of OHA program staff representing substance abuse prevention and treatment, problem gambling prevention and treatment, children's mental health, adult mental health, older adult mental health, and the Oregon State Hospitals Director of Peer Recovery Supports, Medical Assistance Program (MAP) staff, Office of Consumer Activities (OCA) staff, a representative from the Office of Equity and Inclusion (OEI), and representative form Traditional Health Worker's Commission. The Committee is addressing methods to increase use of Medicaid funding for PDS, increase the peer voice in the discussions, setting standards and competencies for the PDS providers, increasing ad retaining PDS workforce, and decrease health inequity.

Traditional Health Worker's Commission
Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS) are included in the Oregon Administrative Rule (OAR) for Traditional Health Workers (THW). The rule outlines the criteria for OHA Office of Equity and Inclusion (OEI) to register and certify PSS and PWS in order for Medicaid to fund PDS services. The THW Certification and Registry through the OEI opened in winter of 2014. The rule requires that PSS take an approved OEI training program of 40 hours for PSS and eighty hours for PWS and pass a criminal background check. Over two hundred fifty peers are registered/certified, with the expectation that the number will increase with continued workforce development.

Warmline
OHA has made additional investments in recovery support services, including increasing the operating hours of the David Romprey Warmline. Community Counseling Solutions began operating the David Romprey Warmline in Oregon in 2008. The Warmline is available to all Oregon residents and is operated by peers. Individuals seeking support may call and speak to a peer support specialist. The peer will listen and support the caller. The Warmline has demonstrated success in diverting individuals to more appropriate and lower cost levels of care. Recently, the Warmline contract has been amended to include out-of-state phone numbers instead of screening them out, to ensure individuals who are residents of Oregon but have out-of-state phone numbers are not missed.

Supported Education

Supported Education, as a component of Individual Placement and Supports (IPS), Supported Employment helps people with serious mental health illness meet their education and recovery goals to become gainfully employed through participation in an education program (i.e. Adult High School Diploma, GED program, or postsecondary education).

On July 1, 2015, a Supported Education modifier for the IPS Supported Employment Medicaid encounter code was activated in MMIS. The Supported Education modifier will allow OHA to better monitor the types of services that are being delivered within the IPS Supported Employment Program. There are currently several IPS Supported Employment Programs that provide Supported Education, however, there was no way to identify clients who were primarily receiving Supported Education services without viewing case notes in the Electronic Health Record (EHR).

The Oregon Supported Employment Center for Excellence (OSECE) is working with OHA and national Supported Education experts to develop guidance for providers on Supported Education best practices.

Supported Employment

Individual Placement and Support (IPS) supported employment is an evidence-based approach to supported employment for people who have a severe mental illness. IPS assists individuals in their efforts to achieve steady employment in mainstream competitive jobs, either part-time or full-time. Supported employment services include resume building and interviewing skills, assistance with job searches and transportation to interviews. Staff members also work with clients on-the-job or debrief them after work to ensure a good transition. People who obtain competitive employment through IPS supported employment have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Individuals receiving supported employment services have been shown to reduce their use of hospitals and visits to the emergency room.

Supported Housing

In 2014, AMH partnered with the National Alliance for Mental Illness and the Oregon Residential Provider Association to develop proposals and identify community providers who will build affordable housing.

As a result of this partnership, 168 new units of affordable housing will be built in Oregon with tobacco tax funds. OHA also has had a long history of developing housing with private partnerships, notably in Villebois, a community located in Wilsonville on the site of the former Dammasch State Hospital. Over the next five years, OHA will work with the National Alliance for Mental Illness, Oregon Family and Community Services, providers, and other public and private partners to add affordable housing units for

individuals and families and for people who are disabled due to mental illness, substance use disorders and co-occurring disorders.

OHA outlines strategies to support, sustain and enhance the current recovery-oriented system of care and to increase and enhance those services. OHA aims to provide recovery support services, including those that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels, to people who are transitioning out of substance use disorders treatment and gambling disorders treatment as part of their continuing care plan to support ongoing recovery. In addition, OHA strives to improve the existing recovery-oriented system of care for people transitioning from residential to outpatient treatment for substance use disorders.

Peer support is critical in assisting parents to address the fears and immobilization associated with the stigma of possible behavioral health concerns. In 2015, Peer Delivered Services was extended to ensure 1:1 outreach and engagement for families prior to a child or youth receiving a mental health diagnosis. Peer support services assist families in communicating with their health care provider about their child or youth's mental health needs. This applies especially to families with children under the age of six and for families who are new to the availability of health care and behavioral health care.

Ensuring Cultural Competence and Health Equity through Health System Transformation

Oregon Administrative Rules (OARs) require that community mental health and addictions programs provide culturally and linguistically competent services. Oregon has significant numbers of people at risk for experiencing health disparities due to cultural, language, economic and geographic barriers. Many Oregonians are unable to attain their highest level of health due to cultural, language, and other communication barriers. When the health care system is not responsive to the cultural and linguistic needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes.

Health equity is the attainment of the highest level of health for all people. Many Oregonians are unable to attain their highest level of health because of cultural, language, and other communication barriers. When the health care system is not responsive to the cultural needs of individuals, the result is avoidable inequities in access, quality of care and health outcomes.

Cultural, linguistic and communication barriers can lead to increasing health disparities. Research demonstrates that language barriers between patient and provider create problems such as delay or denial of services, issues with medication management, underutilization of preventive services and increased use of emergency services. Racial

and ethnic minorities have higher prevalence of chronic health conditions and higher mortality rates than the general population. Moreover, for all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. For racial and ethnic minorities, access to care and health status are worse than for the general population.

In order to create a responsive, inclusive and equitable system of care, OHA has collected feedback from providers through town hall meetings across the state to develop a three year behavioral health strategic plan. Within the strategic plan is a health equity goal with strategies to reduce health disparities and pursue health equity in the behavioral health care system.

Over the next five years, OHA will partner with the OHA Office of Equity and Inclusion, Public Health, Medical Assistance Programs and both existing and new community partners and consumers to seek opportunities to support the health care needs of an increasingly diverse population. A key component to success in this area will be the development of a diverse workforce, which includes encouraging strong, targeted programs at colleges and universities as well as the expanded use of traditional health workers in all health care settings.

To assist with the implementation of the health equity goal and to support success of health equity through health system transformation for populations, OHA created the Committee on Health Equity and Policy (CHEP). The CHEP's mission is to engage and align diverse community voices to assure the elimination of avoidable health gaps and promote optimal health in Oregon. This internal committee is made up of representation from various units within Health Systems Division. The strategies CHEP will use to increase awareness, skills and knowledge about how cultural and linguistic diversity affects the delivery of health and human services include:
- Policy development;
- Training and consultation;
- Community and organizational capacity building.

Specific efforts of CHEP to support culturally competent services and increase health equity over the past year are described below.

Tribal Behavioral Health Programs
Senate Bill 770, passed by the Oregon Legislature in 2001 enacted a Government-to-Government relationship between the State of Oregon and each of the nine tribal governments. OHA meets this statute by consulting with the nine tribes on a quarterly basis at the SB 770 Health Services Cluster, the Tribal Prevention Meetings, the Oregon Indian Council on Addictions, participating in tribal relations cultural trainings, and communicating with tribal staff on a regular basis.

OHA has a dedicated staff person that serves as a tribal liaison to the nine federally recognized tribes. The tribal liaison attends tribal functions to continue building understanding and rapport with Native American communities. The liaison listens for concerns, answers questions, assists in removing barriers, and looks for opportunities to provide improved or additional services to the tribes. OHA staff solicits assistance and guidance from the liaison to ensure that cultural considerations and tribal voices are included in planning efforts around substance abuse and problem gambling prevention, addictions treatment, and mental health services.

Tribes develop biennial plans for substance abuse prevention and now also develop Mental Health Plans for the investment dollars that have been allocated by the Oregon Legislature. These plans are approved by the Tribal Council, the Tribal Health Department, or through an entity authorized by the Tribal Council.

Certified Alcohol and Drug Counselor Cohort: In 2011, tribes stated that their alcohol and drug programs had a lack of Certified Alcohol and Drug Counselors (CADC). OHA funded a training series designed to provide culturally relevant and specific addiction educational topics that would meet the addiction counselor certification training requirements in order to apply for certification examination. The goals of the training series were to increase the number of Native American certified addiction counselors in Oregon, and provide an opportunity for Native American treatment providers to shadow and co-train with professional trainers in the field of addictions with the goal of those shadowing to one day teaching the course. The initial cohort was completed in May 2014 and consisted of 15 tribal participants. Cohorts begin in the Fall of each year.

The Student Wellness Survey is conducted every two years and provides data for tribes and communities in the areas of school climate, positive youth development, mental and emotional health, problem gambling, substance use, drug free community core measures and risk/protective factors. Tribal prevention coordinators use the survey date to plan prevention programming and identify trends. Students are given the option to identify if they belonged to one of the nine federally recognized tribes in Oregon. This provides localized data for their tribal members along with data of Native Americans in their school district.

African American Population
In September 2016, the African American Treatment Summit 3 hosted 143 participants and 14 presenters with the charge of developing a list of recommendations for policy makers, stakeholders and funders necessary for developing a treatment and behavioral health system, which would be more responsive to the needs of the African American community. From the Summit, four main recommendations emerged:
1. Development of an African American Treatment Services Coalition;

2. A focus on African American Behavioral Health Prevention;
3. Implementation of African American treatment services that are administered by African Americans and based on proven practices from the African American community; and
4. Integration of the Traditional Health Workers into the Behavioral Health work force.

A planning committee is being formed to clarify the recommendations and next steps.

Hispanic and Latino Populations

The Hispanic/Latino population in Oregon was 12.8% in 2016, according to the Census Report. Studies show that patient satisfaction is higher when the patient and doctor are the same race or ethnicity. In Oregon, the ratio of Hispanic/Latino(a) behavioral health providers to the Latino(a) population served for behavioral health services is not close to being equivalent.

In August 2014, CHEP presented behavioral health data for Latino(a)s in Oregon at the Instituto Latino, a conference designed specifically for Latino behavioral health providers. CHEP distributed a survey to obtain information from a sampling of providers serving the Oregon Hispanic/Latino(a) community regarding behavioral health services and the needs and barriers to services identified by the Hispanic/Latino(a) population. The survey results have lead to the creation of recommendations regarding behavioral health in support of the Hispanic/Latino(a) community in Oregon.

Culturally Specific Services

A Culturally Specific Program is defined in the Oregon Administrative Rule as a program designed to meet the unique service needs of a specific culture and one that provides services to a majority of individuals representing that culture. OHP covers youth who are not covered by their parents' insurance. SAPT Block Grant dollars are used to enhance treatment services by providing culturally relevant treatment support, using African American mentors, artists, and storytellers. Additionally, SAPT Block Grant funding is used for culturally relevant field trips that provide youth with positive engagement activities within their community. There are few providers in Oregon who provide culturally specific services for adolescents. Central City Concern and Lifeworks Northwest in the Portland area are two such providers. Lifeworks Northwest contracts with their local CMHP to provide culturally specific addiction treatment services to underserved African American and Latino (a) youth.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

<u>Narrative Question:</u>

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

---

[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

FY 2018-19 Block Grant Application

Community Mental Health Services Plan and Report and Substance Abuse Prevention and Treatment Plan

Oregon Health Authority

9/01/2017

This page intentionally left blank

STEP TWO

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

In 2012, Oregon and United States entered into a four year agreement, under which Oregon would track and provide data about its services, access gaps, and develop a performance outcome measure matrix. After extensive negotiations, Oregon is now ready to move forward with the performance and tracking plan for adults with Serious Persistent Mental Illness (SPMI). The plan will address OHA's efforts in the next three years. OHA has hired an independent consultant, Pam Hyde, to assess OHA's performance under the Plan.

In the Plan, OHA commits to several performance outcome measures and to further data gathering and study of certain issues. Oregon also commits to quality and performance improvement measures, and to data reporting. These measures cover a broad array of subjects, including:

Assertive Community Treatment Services
Crisis Services
Supported Housing
Peer delivered Services
Oregon State Hospital Discharge and linkage to services
Acute Psychiatric Care Discharge and Linkage to Service
Emergency Department Services
Supported Employment Services
Secure Residential Treatment Facility Discharge
Criminal Justice Diversion
Quality and Performance Improvement
Data Reporting

Oregonians who struggle with mental health challenges and substance use disorders face barriers everyday getting the services and support they need. Fragmentation in the health care system has created artificial silos between physical, oral and behavioral health care, making it harder for individuals to get their needs met and for care providers to work together. In the summer of 2016, Oregon Health Authority (OHA) convened the BHC to develop a set of recommendations to chart a new course for behavioral health in Oregon. The BHC was comprised of nearly 50 members from throughout the state that represent every part of the behavioral health system. The BHC

worked for over six months to develop a set of recommendations that will transform Oregon's behavioral health system.

The recommendations from the BHC create a blueprint for the 21st century behavioral health system. These recommendations will move the entire state behavioral health system to a coordinated care model that will integrate behavioral health with physical and oral health and will provide a coordinated system so patients have a team of care and are not left out in the cold to find help on their own.

The BHC recommends the state to focus on 5 priority areas, and implement and track improvement:

Governance and Finance

Standards of Care and Competencies

Workforce Development and Retention

Information Exchange and Coordination of Care

Data and Measurement

Public Health Modernization

Public Health Modernization – Passed by the legislature in House Bill 3100, a plan and model was developed, to modernize Oregon's public health system to meet the basic needs and protections for the health of all Oregonians. A public health modernization assessment was coordinated by the State PHD, Public Health Advisory Board (PHAB) and local public health authorities to assess current system needs for modernization and resources needed. A roadmap with priorities was developed for implementation over the next three years. Modernization builds upon a foundation for expanding efforts related to prevention policies, systems and environmental change substance abuse prevention strategies that supports all Oregonians.

http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Pages/index.aspx

Prevention Integration for Drug and Alcohol

In 2015, the Oregon Health Authority underwent reorganization, AMH merged with the Division of Medical Assistance Programs, and became the Health Systems Division. AMH moved to the newly formed Health Policy and Analytics Division, which is Oregon's Single State Authority. The SABG Primary Prevention funding went to the Oregon Public Health Division (PHD), Health Promotion and Chronic Disease Prevention (HPCDP) Section in March 2016.

The Health Promotion and Chronic Disease Prevention (HPCDP) section is working to integrate Oregon's alcohol and drug prevention funding, staff and projects into the Public Health Division (PHD) from the former Addictions and Mental Health (AMH) Division of the Oregon Health Authority. HPCDP is engaging a broad sector of statewide alcohol and drug partners to identify a sustainable means for an advisory body and mechanism for the planning and implementation the Alcohol and Drug Prevention and Education Program.

Within the PHD, the HPCDP section is lead for alcohol, tobacco and marijuana prevention efforts and the Injury and Violence Prevention Program (IVPP) is lead for Opioid prevention. As leads for substance abuse prevention within the Center for Health Promotion in the PHD, HPCDP and IVPP are coordinating efforts to impact community population health.

Opioid State targeted Response
The Oregon Health Authority recently was awarded the Opioid State Targeted Response grant. This grant comes with a funding of 6.5 million and is potentially going to be renewed for a second year at the same funding level. Using this grant, in conjunction with two other SAMHSA and CDC grants, Oregon will be able to focus considerable prevention, treatment, and recovery efforts towards the opioid epidemic in the state. Oregon is near the top in the nation in rates of non-medical usage of prescription opioids, and lack of access to Medication Assisted Treatment, especially in rural and frontier areas of the state. While multilevel projects and initiatives are being driven forward at the state and local level with a sense of urgency and collaboration, there are still significant gaps in community engagement, public education, and infrastructure and workforce.
Despite the high rate of opioid misuse in the State of Oregon, it ranks in the bottom third of the states for access to Buprenorphine (Jones et al, 2015). According to the Oregon Decision Support Surveillance and Utilization Review System (DSSURS), the overall buprenorphine penetration rate in Oregon in 2015 was 6.5%, while OTP penetration rates are at 59.3%, among Medicaid population. Of the total number of Polydrug users, 80.2% are opioid users, in OHP. The Oregon Health Authority estimates that the rate of nonmedical use is twice as high when measuring only persons ages 18-25, at 15%.[1] A 2012 survey of Portland-area Syringe Exchange Program (SEP) patients discovered that 45% of patients, the majority of whom inject heroin, were first addicted to prescription opioids. One marker of use is treatment data. From 2004 to 2013, there was a 58% increase in Oregon treatment admissions where heroin was the client's

---

[1] *Multnomah County's Epidemiological Data on Alcohol, Drugs, and Mental Health 2000 to 2012 (2013)*. Oregon Health Authority, Office of Health Analytics and Addictions and Mental Health Division, State Epidemiological Outcomes Workgroup.

primary drug of choice (from 4,069 to 6,432), and a 162% increase for prescription opioids (from 1,090 to 2,861). Another marker of use for heroin is the increase in demand for syringe exchange services, where they exist. In the past 5 years, the Portland area syringe exchange service has increased by 56%.

 Among all opioid users, 22,4% are in Medication Assisted Treatment (MAT). Results from the 2013-2014 National Survey on Drug Use Health (NSDUH) tie Oregon for 6th place among all US states in non-medical use of prescription pain relievers, down from 1st and 2nd among all states in previous NSDUH surveys. In regards to buprenorphine, there remains a significant gap between need and availability. This is likely due to low availability of our DATA-waived physicians across the state. In addition, there is also a significant gap in the number of DATA-waived physicians in the state and those who are actively prescribing FDA approved medication for MAT, according to the Oregon Prescription Drug Monitoring Program. Between January and March 2016, only 30% of DATA waived physicians prescribed buprenorphine. This is a ripe opportunity for projects such as the PDO Coordinators established through the CDC PfS grant, and Project ECHO, which a partnership between Oregon Health Authority and Oregon Health & Science University to promote competence, train in prescribing guidelines, and encourage confidence in prescribing drugs for MAT and caring for individuals with SUD.

OHA is also guided by three formal advisory groups: The Addictions and Mental Health Planning and Advisory Council (AMHPAC), the Oregon Consumer Advisory Council (OCAC), and the Children's System Advisory Committee (CSAC). In addition, the Oregon State Hospital has the Oregon State Hospital Advisory Board, whose members are appointed by the Governor. Some other advisory councils and commissions that are helping Oregon achieve integration of BH and tracking our priority areas are: Health Information Technology Oversight Council, Oregon Health Policy Board, and Peer Delivered Services Core Workgroup.

Each priority area includes indicators based on the priority populations: adults with serious mental illness, children with serious emotional disorder, persons who are intravenous drug users (IDU), pregnant women with substance use disorders, parents with substance use disorders with dependent children, individuals with tuberculosis, persons living with HIV/AIDS, services for persons in need of primary substance abuse prevention. Indicators were developed to reflect the common themes that emerged as a result of the Oregon's commitment to DOJ, the recommendations of the BHC, the opioid crisis response, and block grant priorities.

- Behavioral health is integrated with the physical health and dental health care system, at every entry point.

- Health equity exists for all Oregonians within the state's behavioral health system.
- People in all regions of Oregon have access to a full continuum of behavioral health services.
- The behavioral health system promotes healthy communities and prevents chronic illness.
- The behavioral health system supports recovery and a life in the community.
- Only people who meet admission criteria are admitted to the Oregon State Hospital and for those who need it, admissions and discharges are performed in a timely manner.

Prevalence

OHA uses the Federal definition of Serious Emotional Disorder[2], which includes children and youth from birth to age 18 who currently, or at any time during the past year:
- Have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria, specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-4),
- That resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

A substance use disorder or developmental disorder alone does not constitute a serious emotional disorder although one or more of these disorders may coexist with a serious emotional disorder. This definition is used in determining prevalence, need and access.

In 2012, the estimated number of Oregon children with serious emotional disorders is 103,861. The public mental health system serves approximately 30 percent of these children.

Prevalence of Serious Mental Illness

For adults, OHA uses prevalence rates from SAMHSA's National Survey on Drug Use and Health and apply these prevalence rates to population estimates by the Portland State University Population Research Center. Pursuant to section 1912(c) of the Public Health Services Act, adults with serious mental illness are defined as:
- Age 18 and over;
- Currently have, or at any time during the past year had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-4 or their ICD-9-CM equivalent; and

---

[2] Oregon family members have specifically requested that the term serious emotional disturbance NOT be used; the term serious emotional disorder is replacing it in this document

- That results in functional impairment, which substantially interferes with or limits one or more major life activities.

The definition is used in determining prevalence, need and access. The current estimate of adults (age 18 and older) with a serious mental illness living in Oregon is 156,962. Approximately 46 percent of those adults are served in the public mental health system.

Prevalence of Youth and Adults with DSM-4 Disorder of Substance Abuse or Dependence
Substance use disorders remain a serious problem in Oregon. Opioid overdose deaths has also increased in the last five years, as has been explained earlier in this application.

Data Sources
OHA uses several administrative data systems to support monitoring of addictions and mental health services provided to residents of the State of Oregon. These data systems historically included the Client Process Monitoring System (CPMS), the Oregon Patient/Resident Care System (OP/RCS), the AVATAR System, and the Medicaid Management Information System (MMIS). Starting in 2014, OHA implemented a new data system called the Measures and Outcomes Tracking System (MOTS).

Block Grant and planning data derived from these systems are supplemented with data acquired through annual administration of modified versions of the Mental Health Statistics Improvement Project (MHSIP) Adult Services Survey, the MHSIP Youth Services Survey for Families and the MHSIP Youth Services Survey.

MOTS has replaced all data previously submitted by CPMS and is replacing OP/RCS as a data source. There is expected to be period of transition. All three administrative data sources (MOTS, OP/RCS, and MMIS) are needed to collect data on National Outcome Measures (NOMs) such as *Access/Capacity: Number of Persons Served with Demographic Characteristics.* Each data source used in the Block Grant planning is detailed below.

Measures and Outcome Tracking System (MOTS)
OHA has implemented a comprehensive behavioral health electronic data system to improve care, control cost and share information. The data system improvement project is called MOTS. This new system will allow OHA to meet business needs and requirements and will provide data that more readily supports the ability to track:
- Performance outcomes associated with services;

- Access, utilization and duration of services; and
- Improvement in the health of Oregonians through better quality and availability of healthcare, and cost effectiveness of services.

Electronic Data Capture

Currently, the majority of OHA data is collected and housed in MOTS and OP/RCS. The information housed in these two main systems is collected at admission and discharge. MOTS collects data at admission and then allows for updates to the data to occur regularly. The data collected includes status and encounter data – status data provides information during the treatment cycle, and encounter data provides information on the services provided during the treatment episode.

Collection of these data will allow OHA to better assess the array of services provided and outcomes achieved. OHA will be able to provide better data and information to stakeholders, legislators and other requesters, in addition to providing better access and analysis of data for CMHPs and their subcontractors.

OHA has been accepting MOTS electronic data submission since November 2013. Providers and other required reporters have access to different methods for this data submission:
- Electronic Data Interchange/Transfer from existing EHRs; or
- A web-based Minimum Client Entry tool.

The Oregon Patient/Resident Care System (OP/RCS)

OP/RCS is the database for all publicly funded psychiatric inpatient care delivered in state hospitals and acute care units. OP/RCS has also functioned as the primary resource for tracking individuals who have been civilly or criminally committed for mental health treatment. Psychiatric Acute Care Units of regional hospitals submit OP/RCS data about patients at admission and at discharge.
OP/RCS contains important data such as county of commitment, date of commitment, and type of commitment; the name of the facility where the patient has been committed; the dates that the patient was admitted and discharged; and patient demographics such as sex, date of birth, marital status, and living arrangement. Unfortunately, OP/RCS does not allow OHA to record the patient's Hispanic/non-Hispanic ethnicity separately from the patient's race.

After consideration of the limitations of the OP/RCS system, OHA made the business decision to contract with Netsmart Technologies, Inc. to replace OP/RCS with the Avatar Electronic Health Record system to track Hospital Data. Avatar has been implemented within the state hospital system. This leaves OP/RCS as the current

system of record for acute care hospital admission and discharges only. OHA is working to incorporate data collected from the state hospital and the acute care hospitals into MOTS.

The Medicaid Management Information System (MMIS)
MMIS provides information on services provided to persons who are enrolled in Medicaid. The information contained in MMIS includes eligibility, capitation payments, fee-for-service claims, and encounter data for persons receiving services via prepaid capitated managed care organizations. MMIS also includes all mental health, chemical dependency, pharmacy, dental, physical health services, and eligibility information for individuals enrolled in Medicaid.

Medicaid fee-for-service data and encounter data are submitted electronically and by fee-for-service billing. Managed mental health organizations and service providers have 180 days from the date of service to submit Medicaid data to the MMIS. Data from MMIS are downloaded and stored in a data warehouse for use by state analysts and actuaries responsible for rate setting.

Surveys
The Youth Services Survey for Families and the Adult Services Survey
OHA makes efforts to collect information about providers and service recipients from sources other than administrative data systems. Much of the outcome and performance measure data are collected and compiled from consumer responses to modified versions of the MHSIP Adult Services Survey, the MHSIP Youth Services Survey for Families (or YSS-F) and the MHSIP Youth Services Survey (YSS). The Adult Services Survey and YSS-F are mailed annually to stratified random samples of over 10,000 Medicaid-enrolled adults and over 10,000 parents or guardians of Medicaid-enrolled children; the consumers selected to receive these surveys are chosen on the basis of having received Medicaid-billable mental health services at some time during the last six months of the previous calendar year. In the interest of better understanding the service experiences and service needs of Hispanic individuals and people of color, OHA sends the Adult and Youth consumer surveys to *all* individuals who received services in the six-month window of interest and who are identified in OHA data systems as either Hispanic and/or of non-white race. Surveys are also available in Spanish.

Information obtained from the Adult and Youth Services surveys is used to:
- Provide feedback on OHA performance measures;
- Identify areas in need of improvement;
- Track improvement in the well-being of people served with public funds;
- Recognize those programs which are doing well; and

- Communicate results to the Governor, the Legislature, Department contractors, and the public.

OHA has worked carefully to modify the Adult and Youth Services surveys in ways that allow us to collect important information on several of the NOMs of Interest, including: employment status of adult consumers; school attendance among child consumers; and housing stability and criminal justice involvement among both adult and child consumers.

Oregon Behavioral Health Dashboard and Mapping Tool

The Oregon BH Dashboards provide a broad overview of the type and amount of behavioral health service provided in Oregon. The dashboards give information about treatment services provided to children and adults, and are grouped into two categories: mental health Treatment Services and Substance Use Disorder Treatment Services

The dashboard data comes from an analysis of paid claims in the DSSURS. It includes information treatment services provided to people enrolled in the Oregon Health Plan (Medicaid).

The data formt he BH Dashboard has also been incorporated into Oregon's BH Mapping Tool, which is an ongoing project with public facing interactive maps. The Behavioral Health in Oregon Mapping Tool is a series of maps used to display various dynamic and interactive information about the behavioral health system in Oregon. This mapping tool is an opportunity to showcase the services that are currently delivered across Oregon. Additionally this mapping tool:
- Provides a comprehensive look at Oregon's behavioral health system including identifying behavioral health service locations in each county, the numbers of Oregonians dealing with behavioral health conditions and the state funding being spent on behavioral health in each county.
- Can be used to identify gaps in Oregon's behavioral health system and help the state and local communities begin to find solutions.
- Provides information to local services for Oregonians looking for help.

More information on the maps themselves can be accessed here:
http://www.oregon.gov/oha/HPA/CSI-BHP/Documents/Behavioral-Health-Mapping-Tool.pdf

The Oregon Student Wellness Survey (SWS)
The Oregon Student Wellness survey is an anonymous and voluntary survey conducted in every even year in schools statewide and administered to 6th, 8th and 11th graders. Confidential data gathered from the survey and reports compiled from the survey data

are provided to all participating schools and school districts while the state and county data and data reports are for public access. The reports are found on the Oregon Health Authority website at http://www.oregon.gov/oha/OHA/pages/student-wellness/reports.aspx. The survey is designed to access a wide range of topics that include: school climate, positive youth development, mental health, physical health, substance use, problem gambling, violence and other risky behaviors among Oregon youth.

The SWS results are used by schools, state and local agencies, organizations and communities to assess and monitor the health and well being of Oregon youth and the environment in which they live. The survey data and report serve as a valuable tool for program planning, implementation, and evaluation. The data are essential information for communications with legislators and the public. Additionally, communities and local agencies can utilize the data to improve their ability to procure grant funding by providing baseline data.

In 2016, 63,543 Oregon students participated in the Oregon Student Wellness Survey. In total, 35 counties, 116 school districts and 414 schools were included in the survey. The survey is administered every even year and schools can choose to either use a pencil-and-paper version or an online version. The 6th and 8th grade survey is a subset of the 11th grade survey. The survey is very well received by county and Tribal prevention coordinators statewide, and their interest in utilizing the survey data is ever increasing. The survey data is consistently used by counties and school districts and the state for program planning, implementation, and evaluation, for communication with legislators, for the SPF-PFS grant, for Drug Free communities reporting, for Positive Community Norm campaign across the state and many other policy/decision making processes. Analyzing the data from the SWS not only gives OHA clear epidemiological information on substance use and behavioral health of Oregon youth, but also helps to understand correlations between various problem behaviors.

Oregon Healthy Teens (OHT) Survey
Oregon Healthy Teens (OHT) is Oregon's effort to monitor the health and well-being of adolescents. An anonymous and voluntary research-based survey, OHT is conducted among 8th and 11th graders statewide. The OHT survey incorporates two youth surveys that preceded it, the YRBS and the Student Drug Use Survey.
OHT is fundamental to ensuring that young people arrive at adulthood with the skills, interests, assets, and health habits needed to live healthy, happy, and productive lives in caring relationships with other people. The information gathered in this survey enables schools and communities to know what proportion of their young people are developing successfully and what proportion is having problems. It allows them to

assess whether the things they are doing are improving outcomes for young people. Oregon Healthy Teens monitors the factors that influence successful development. Research has shown that risk factors and assets that affect young people include family, school, neighborhood, and community characteristics. By measuring these influences as well as youth behavior, the OHT survey provides information to help schools and communities focus on the things that are most important to ensure successful youth development. As we develop a system for monitoring youth well-being, we will become better and better able to ensure that the largest possible proportion of young people achieve its full potential.

The Oregon Healthy Teens (OHT) survey assesses health topics such as tobacco and alcohol use, HIV knowledge and attitudes, eating behaviors, nutrition and exercise. The sample size varies from 1,600 to 32,000 per year, and the final data are weighted to more accurately represent Oregon students in grades 8th and 11th. OHT is conducted on odd years.

The Student Wellness Survey (SWS) was introduced in 2010 to assess school climate, positive youth development and the behavioral health of Oregon youth. It is an anonymous survey of students in grades 6th, 8th and 11th. SWS is conducted on even years.

The Public Health Division is working to consolidate OHT and SWS into a single youth survey that will serve the needs and interests of stakeholder groups.

State Epidemiological Outcomes Workgroup-

The structural changes within Oregon Health Authority (OHA) provide an opportunity to rebirth the State Epidemiological Outcomes Workgroup (SEOW). Oregon's State Health Improvement Plan (SHIP) has been developed with the collaboration of multiple sectors to address key public health and health equity issues. The SHIP is staffed by the Public Health Division (PHD) and is championed by the Public Health Advisory Board (PHAB) http://www.oregon.gov/oha/PH/ABOUT/Pages/ophab.aspx, a high-level group of cross-sector representatives tasked with advising the OHA on policy matters related to public health. The PHAB reviews statewide public health issues, and participates in public health policy development.

One of the seven SHIP priorities is substance abuse, specifically alcohol and opioid abuse. This is an opportunity to align the priorities of the SABG primary prevention funds with the overall priorities of the PHD, the PHAB, and other state-level decision-makers, including the Governor's office. The SEOW will serve as the staff SHIP team to inform the development and monitoring of the substance abuse priority in the SHIP and allocation of SABG primary prevention funds. The SEOW will also inform the PHAB regarding progress and needs related to the substance abuse priority. This arrangement provides the SEOW with the ability to inform the highest level leadership entities for health in Oregon.

Planning Steps

Quality and Data Collection Readiness

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Quality and Data Collection Readiness of Oregon

The Measures and Outcomes Tracking System (MOTS) is the key data collection and reporting system for all agencies and facilities in Oregon who are required to report behavioral health services. This includes mental health, addiction, mental health crisis, and involuntary services, that are provided in communities throughout Oregon and that are funded, in whole or in part, by public dollars.

MOTS gathers client level data. For some federal reporting, MOTS data is merged with Medicaid data for a more complete picture of publicly funded services.

Oregon's data collection is geared exclusively toward demographic data and treatment outcomes. The Oregon Health Authority (OHA) does not collect any client level prevention data.

Data is collected in MOTS via two methods: 1) Providers use the Web Client Entry tool to enter their data; 2) Providers send data electronically from their existing EHRs. Option two is used by a majority of our providers. The advantage to option two is that providers do not have to do duplicative data entry.

Oregon's current data collection and reporting system is specific to both mental health and substance abuse services. To fulfill some federal reporting requirements, analysts review Medicaid data as well.

MOTS's treatment outcome data is necessary in order to analyze what is working well and to identify areas for system improvement. The data elements collected are used to:
- Evaluate client demographics;
- Monitor and report client outcomes;
- Comply with federal and state funding and/or grant requirements to ensure adequate and appropriate funding for the behavioral health system;
- Assist with financial-related activities such as budget development and rate setting;
- Evaluate contract utilization;
- Support quality and utilization management activities;
- Analyze Health System Transformation Measures for Performance and Outcomes; and
- Respond to requests for information.

Oregon is not currently able to collect and report on the majority of the draft measures. Oregon's MOTS collects employment and criminal behavior data while individuals are in treatment, but does not collect the other measures.

Oregon has identified the following barriers to reporting on the draft measures:
- Oregon does not collect client level prevention data and does not have the infrastructure to begin collecting this information.

- MOTS has the capability to collect some of the measures; however, this would require major changes to MOTS, including the incorporation of new data fields and extensive changes to individual provider's Electronic Health Records (EHR).
- Physical disease indicators are not included in a client's EHR and are not collected in MOTS. Tracking physical health indicators, such as diabetes, would be a major undertaking for both OHA and over 200 behavioral health providers. Some of this data is available in the Medicaid system, but only for a subset of the population receiving behavioral health services.
- The MOTS reporting period is 90 days. Some draft measures would require reporting periods of 30 days, which would add significantly to the administrative burden of Oregon's providers.
- The proposed client-level measures are of limited utility based on the Oregon data collection system. Other than the Oregon State Hospital, OHA does not provide direct services, but contracts for services through County Mental Health Providers, Coordinated Care Organizations and other entities. Many of the proposed measures are of direct utility to the providers and would be of little use for state level performance monitoring.
- There are over 200 providers who use an EHR to submit the required data set to OHA. The providers would need to change their EHR at an average cost of $50,000 per EHR to comply with the draft measures. These actions will translate to increased operating costs and additional administrative work.
- All of these items are being addressed by OHA currently. The improvements would requires significant resource sin terms of finances and staff.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #:   1

Priority Area: Health equity and equal access to BH care for all Oregonians

Priority Type: SAP, SAT, MHS

Population(s):   SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

> OHA will make continued and expanded efforts to reduce health disparities and pursue health equity in the behavioral health care system. OHA will continue the adoption and utilization of electronic health records and information sharing across payers and platforms.

Objective:

> OHA will increase access among racial and ethnic behavioral patient health populations; determine the rural counties where disparities of utilization of mental health and substance use disorder treatment exist and increase access and utilization; maintain number of consumer and family members on advisory councils.

Strategies to attain the objective:

> 1. OHA, under the objectives of the Behavioral health Collaborative, will invest in an accessible workforce and establish standards and competencies across the system of care to increase access to BH care at any setting.
> 2. Gather feedback from communities and specific cultural populations to inform policy development to support health equity in the behavioral health care system;
> 3. Collaborate with the Office of Equity and Inclusion, Public Health, Medical Assistance Programs, and both existing and new community partners and consumers to seek opportunities to support the health care needs of an increasingly diverse population;
> 4. Collaborate with the tribes to revise the approval process for tribal behavioral health services to support them in providing culturally responsive services;
> 5. Work with coordinated care organizations, the Transformation Center, community mental health programs, local mental health authorities and other partners to develop strategies to encourage and facilitate regionalization of behavioral health services in rural and frontier regions where useful; and
> 6. Work with the Oregon Health & Science University OPAL-K program, the Transformation Center and others to identify strategies to develop the infrastructure and expand telehealth psychiatric services in rural and frontier regions of Oregon.

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Increased access among racial and ethnic behavioral health patient populations.

Baseline Measurement: Number of people identified in specified racial and ethnic populations who access Mental Health and Addictions Treatment in SFY 2014 was 125,203

First-year target/outcome measurement: Number of people identified in specified racial and ethnic populations who access Mental Health and Addictions Treatment in SFY 2014 was 127,707 (2% increase)

Second-year target/outcome measurement: Number of people identified in specified racial and ethnic populations who access Mental Health and Addictions Treatment in SFY 2014 was 130,261 (2% increase)

Data Source:

> The number of people identified in racial and ethnic populations who access mental health and addictions services is tracked in MOTS, DSSURS, OPRCS, and AVATAR.

Description of Data:

> See Step 2: Data Collection and Quality

Data issues/caveats that affect outcome measures::

> The targets are based on increasing access for the total population, and do not set targets for specific racial/ethnic groups due to the

numerous uncontrollable factors preventing reliable goal setting. Setting a number for the population is feasible, given the efforts OHA is engaging in to increase equity and access for all Oregonians.

Indicator #:	2

Indicator:	Maintain the number of consumer and family members' membership on the Addictions and Mental Health Planning and Advisory Council (AMHPAC), Oregon Consumer Advisory Council (OCAC) and Children System Advisory Committee (CSAC).
Baseline Measurement:	In SFY 2016, the percentage of consumers and family members on AMHPAC was 51%; 52% consumer, family member or advocate membership on CSAC; 100% consumer or family member membership on OCAC.
First-year target/outcome measurement:	Maintain consumer and family membership in SFY 2018
Second-year target/outcome measurement:	Maintain consumer and family membership in SFY 2019

Data Source:

AMHPAC, CSAC, and OCAC membership roster

Description of Data:

Each advisory council maintains a formal roster which is also available to thepublic on OHA's website

Data issues/caveats that affect outcome measures::

None

Indicator #:	3

Indicator:	Capacity management and accurate waitlist estimate for pregnant women and IVDU population
Baseline Measurement:	No baseline measure at this point
First-year target/outcome measurement:	First year target is to have a capacity management system identified and start solicitation process (if necessary)
Second-year target/outcome measurement:	Second year target is to have a capacity management system up and running for SUD, especially for pregnant women and IVDU

Data Source:

Oregon Health Authority

Description of Data:

OHA will provide description of the capacity management system to SAMHSA

Data issues/caveats that affect outcome measures::

Solicitation process takes time at the state level. Reporting might be delayed for annual report.

Priority #:	2
Priority Area:	Adults with SPMI have access to behavioral health services
Priority Type:	MHS
Population(s):	SMI

Goal of the priority area:

OHA has issued a plan to improve mental health services for adults with severe and persistent mental illness. The plan was issued after lengthy discussions with the Civil Rights Division of the United State Department of Justice.

Objective:

For several years, USDOJ investigated conditions at the Oregon State Hospital. In 2010 the investigation expanded into whether Oregon's community mental health services were sufficient to avoid unnecessary institutionalizing of adults with SPMI. Oregon plans to track several outcome measures for this population and invest in improvement efforts to improve access to MH services for this population.

Strategies to attain the objective:

Oregon has angaged in significant efforts, over the last several years, to transform its community MH services. The legislature has invested tens of millions of dollars into that effort. With the state's commitment to implement the Performance Plan through which these outcome of these efforts will be tracked, USDOJ has suspended its investigation.
In the plan, OHA commits to several performance outcomes and to further data gathering and study of certain issues.
Oregon commits to performance improvement measures, as well, and to data reporting.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	OHA will increase the number of adults with SPMI who are receiving Assertive Community Treatment
Baseline Measurement:	The FY 2015 baseline was 815 adults
First-year target/outcome measurement:	First year target will be 2000 adults
Second-year target/outcome measurement:	TBD

Data Source:

The data regarding ACT services is received via Quarterly Reports from providers.

Description of Data:

See Step 2: data collection and quality

Data issues/caveats that affect outcome measures::

OHA is still examining and identifying adequacy in ACT services within the state. Efforts to reach the first year target will help OHA determine a more specific and feasible second year target.

Indicator #:	2
Indicator:	OHA will increase the number of adults receiving mobile crisis services
Baseline Measurement:	FY 2016 baseline was 3,150 adults
First-year target/outcome measurement:	First year target will be 3,500
Second-year target/outcome measurement:	Second year target will be 3,700

Data Source:

OHA captures mobile crisis services utilizing the Measures and Outcomes

Description of Data:

See step 2: data collection and quality

Data issues/caveats that affect outcome measures::

Tracking System (MOTS). The number of individuals receiving these services is unduplicated. For instance, if the same individual received mobile crisis services multiple times through the year, they are still only counted as one.

Indicator #:	3
Indicator:	OHA will increase housing for for adults with SPMI in supported housing
Baseline Measurement:	FY 2016 baseline was 442
First-year target/outcome measurement:	First year target will be 835

Second-year target/outcome measurement: Second year target will be 1,355

Data Source:

Supported Housing is calculated using a combination of Supported Housing units developed and individuals receiving rental assistance in existing affordable housing units that meet the definition of Supported Housing.

Description of Data:

The Rental Assistance provider reporting requirements were enhanced this year to distinguish individuals in Supported Housing and those in Supportive Housing.

Data issues/caveats that affect outcome measures::

Only those in Supported Housing funded by the Rental Assistance program are included in the Supported Housing reported data.

Indicator #:   4

Indicator: Discharge from Oregon State Hospital will occur as soon as individual is ready to return to the community

Baseline Measurement: FY 2016 baseline measure was 51.7% of individuals are discharge within 30 days of Ready to Transition (RTT)

First-year target/outcome measurement: First year target is 75% discharge individuals are discharged within 30 days of RTT

Second-year target/outcome measurement: Second year target is 85% of individuals will be discharged within 25 days of RTT

Data Source:

A new tracking system was developed and implemented as part of the OSH Electronic Health Record (AVATAR) on July 1, 2016.

Description of Data:

See step 2: data collection and quality

Data issues/caveats that affect outcome measures::

None

Indicator #:   5

Indicator: OHA will reduce the rate at which adults with SPMI get admitted to the ER for the psychiatric purposes

Baseline Measurement: Baseline for FY 2016 is 1.54 per 1000 patients

First-year target/outcome measurement: First year target is 10% reduction from baseline

Second-year target/outcome measurement: Second year target is 20% reduction from baseline

Data Source:

ED visit data comes from MMIS

Description of Data:

See step 2: data collection and quality

Data issues/caveats that affect outcome measures::

The MMIS system does not have diagnostic information for everyone enrolled in Medicaid. However, OHA will review the methodology for possible narrowing of the patients in the denominator to individuals with SPMI.

Indicator #:   6

Indicator: OHA will reduce the average length of stay of civilly committed individuals in SRTF

Baseline Measurement: baseline at FY 2016 is 638 days

First-year target/outcome measurement: First year target will be 10% reduction from baseline

Second-year target/outcome measurement: Second year target will be 20% reduction from baseline

Data Source:

> SRTF data comes from MMIS

Description of Data:

> See step 2: data collection and quality

Data issues/caveats that affect outcome measures::

> None

Priority #: 3

Priority Area: People in all regions of Oregon have access to a full continuum of behavioral health services.

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

> OHA will collaborate with local mental health authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities.

Objective:

> Improvement in crisis services; reduction in reliance on emergency departments, increase availability of medication assisted treatment; reduce criminal justice involvement for young people who are involved in the Wraparound process.

Strategies to attain the objective:

> Collaborate with local mental health authorities, community mental health programs and coordinated care organizations to develop a basic service set available in all communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduced criminal justice involvement for young people engaged in the Wraparound (to fidelity) planning process.

Baseline Measurement: FY 2015 baseline was 10.8%

First-year target/outcome measurement: First target will be 2% decrease from baseline

Second-year target/outcome measurement: Second year target will be 20% decrease from baseline

Data Source:

> Progress Review (PR) reports submitted via the Children's Progress Review System (CPRS), a data portal developed by OHA for tracking required reporting on the status and progress of youth participating in Wraparound.

Description of Data:

> PR reports are submitted for each client at entry and every 90 days until exit. They include information provided by caregivers about the client's living arrangement, health care and medications, risk factors, and the Behavioral Emotional Rating Scale (BERS-2).
> Clients are included in this measure if they (1) were age 0-17 years on date of initial PR and were served within a CCO/County that provides Wraparound planning process (to fidelity) administered by OHA; and (2) their first (Entry) PR occurred during CY 2013 and is marked as SCWI; and (3) at least one additional report was submitted in CPRS for a subsequent PR as SCWI, which occurred at least 12 but not more than 15 months after Entry.
> This measure is based on results for Q20, "Child's history of / risk for delinquency," in the CPRS Progress Review. Clients with response values of 1 or 2 ("No history of delinquency" or "History of delinquency, but not in the past 30 days") are counted as not involved in criminal justice. Those with values of 3 or 4 ("Recent acts of delinquency in the past 30 days" or "In the past 30 days, severe acts of delinquency that place others at risk of significant loss or injury and place child at risk of adult sanctions") are counted as having been involved in criminal justice. Clients whose response to Q20 was 5 (deferred/unknown) or 6 (not reported) were not included in the

measure.

Data issues/caveats that affect outcome measures::

(1) Statewide expansion of Wraparound began during CY2014, which is the entry year for clients in the First Year measure. As a result, the denominator (140 clients) was nearly triple the Baseline year denominator (48), and covered a much broader and more diverse population. (2) The Wraparound sites measured in Baseline are well established, having been in operation since 2009, while the sites added during CY2014 were new. As programs mature, their outcomes typically improve, so we expect to see improvement in 2nd Year results. (3) The percentage of clients with a PR 12-15 months after Entry was much higher for Year 1 than for the Baseline year (40% vs. 27%, respectively); further study would be needed to determine how this increase in reporting might have affected the results.

Indicator #:	2
Indicator:	Reduced number of emergency department visits for psychiatric services for individuals who are enrolled in the Oregon Health Plan.
Baseline Measurement:	FY 2015 baseline was 2.45 per 1,000 members
First-year target/outcome measurement:	First year target will be 2.37/1,000 members
Second-year target/outcome measurement:	Second year target will be 2.29/1,000 members

Data Source:

Number of emergency department visits for psychiatric services is tracked in MMIS/DSSURS.

Description of Data:

See step two.: data collection and quality

Data issues/caveats that affect outcome measures::

This data represents all those covered by OHP and is not limited to individuals with serious mental illness. Community based measures designed to reduce emergency department use for psychiatric crises are likely to be most effective for individuals with serious mental illness, but should help reduce emergency department utilization for psychiatric issues for all members.

Indicator #:	3
Indicator:	Mental Health consumers in Oregon reporting improved functioning from treatment received in the Public Mental Health System.
Baseline Measurement:	`Baseline at FY 2015 was 53.1%
First-year target/outcome measurement:	First year target is 2% increase from baseline
Second-year target/outcome measurement:	Second year target is 4% increase from baseline.

Data Source:

Mental Health Statistical Improvement Project (MHSIP) survey

Description of Data:

The Mental Health Statistical Improvement Project (MHSIP) survey is a consumer satisfaction survey that goes to all medicaid enrollees who have received MH service that year.

Data issues/caveats that affect outcome measures::

Self-reported data from consumers. Certain regions have small sample size.

Priority #:	4
Priority Area:	Opioid Use Disorder and overdose death: prevention, treatment, and recovery support services.
Priority Type:	SAP, SAT
Population(s):	SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

OHA will reduce Opioid Use Disorder and increase access to MAT and RSS for those with OUD.

Objective:

Oregon is among the top 10 states to report individuals with opioid use disorder. Access to Medication Assisted Treatment is still low in rural areas of the states. In addition, recovery support is in high need for those going through treatment and trying to stay engaged in treatment.

Strategies to attain the objective:

Oregon has received several federal grants to address the state's opioid epidemic.
Oregon will increase provider workforce capacity by training more physicians, NPs and PAs to be obtain DATA waiver and prescribe MAT drugs.
OHA will also implement Naloxone training in Syringe Exchange Programs.
OHA will work with Department of Corrections to pilot a peer navigator study that will keep adults with OUD engaged in treatment after they reenter community and reduce recidivism.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased percentage of individuals with opioid dependence accessing medication assisted treatment (MAT) services, with/without methadone

Baseline Measurement: Baseline measure for FY 2016 is 19869

First-year target/outcome measurement: First year target is 5% increase from baseline

Second-year target/outcome measurement: Second year target is 10% increase from baseline.

Data Source:

Number of individuals accessing MAT services is tracked in MMIS/DSSURS and MOTS.

Description of Data:

See step 2: data collection and quality

Data issues/caveats that affect outcome measures::

Outside of methadone patients, not all patients who received MAT services for opioid dependence are required to be reported into the MOTS system; for individuals receiving buprenorphine for opioid dependence, only those receiving treatment through Medicaid coverage will be reported.

Indicator #: 2

Indicator: Number of providers who have completed Buprenorphine waiver training

Baseline Measurement: Baseline for FY 2016 is 157

First-year target/outcome measurement: First year target is 167

Second-year target/outcome measurement: Second year target is 177

Data Source:

Providers who are getting trained through Project ECHO which is being funded through the Opioid STR grant.

Description of Data:

Oregon health and Sciences University, who will be doing the training, will provide the data directly.

Data issues/caveats that affect outcome measures::

Based on timeline of training and BG annual reporting, data could be based on assumption that everyone inthe current cohort would complete training and receive waiver.

Indicator #: 3

Indicator: Number of adults with OUD who are ready to reenter the community from the correctional system and have a peer navigator for OUD treatment and recovery services

Baseline Measurement: Baseline measure is 0

First-year target/outcome measurement: First year target is 50

Second-year target/outcome measurement: Second year target is 100

Data Source:

Oregon department of Corrections

Description of Data:

ODOC is implementing a Peer Navigator Pilot program which is an EBP, for adults int he prison system with Opioid Use Disorder

Data issues/caveats that affect outcome measures::

None at this time.

Priority #:   5

Priority Area: The behavioral health system promotes healthy communities and prevents chronic illness.

Priority Type: SAP, SAT, MHS

Population(s):   SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

OHA will reduce the costs of health care by implementing continued effort in pre-treatment prevention and mental health promotion to achieve long-term reductions in misuse and dependence rates.

Objective:

Increase provision of mental health services to children ages 0-5; increase percentage of children in DHS custody who receive a mental health assessment; decrease binge drinking among 8th and 11th graders; decrease binge drinking by adults; decrease heavy drinking by adults; increase TB screenings.

Strategies to attain the objective:

1. Develop core competencies, including cultural competencies, for early childhood mental health service providers; 2. Create professional development opportunities to increase proficiency in providing treatment services to families with young children; 3. Collaborate with Medicaid Programs (MAP) and Child Welfare (DHS) to disseminate and fund mental health best practices for young children; and, 4. Utilize the Block Grant checklist during site visits to ensure compliance with Tuberculosis (TB) screenings. 5. Increase the price of alcohol. 6. Increase the number of jurisdictions covered by alcohol marketing, promotion, and retail restrictions such as limiting outlet density, price promotions, and limits on days or hours of sale, and point of purchase interventions. 7. Increase the number of colleges and universities with restrictions on alcohol promotion, sale, or sponsorship at college or university events. 8. Ensure availability of comprehensive alcohol screening, referral and treatment benefits through public and private health plans. 9. Maintain Oregon's state alcohol beverage control to prevent and reduce excessive alcohol use.

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Increased provision of mental health services to children aged 0-5.

Baseline Measurement: The percentage of children ages 0-5 who received a mental health (MH) assessment that was followed by another MH service within 60 days during SFY 2015 was 2.2%.

First-year target/outcome measurement: First year target is 2.7%

Second-year target/outcome measurement: Second year target is 2.9%

Data Source:

Medicaid enrollment and services are tracked in MMIS/DSSURS Every child entering foster care or substitute care receives both a CANS and a mental health assessment (MHA) within 60 days. The impact of full implementation of the CANS can be assessed by comparing the proportion of CANS versus other types of mental health assessments before and after that date.

During the 60-day window after MHA, all other types of mental health services are counted, including Evaluation and Management procedure codes.

Description of Data:

The denominator for this measure is the total enrollment in member-years during the SFY among children from birth to five years of age, inclusive. The numerator is the total number of children in this age group who received mental health assessment services (as defined in Indicator 3.2) during the SFY, followed within 60 days by any other type of mental health service.
Mental health services are defined as claims or encounters with both procedure code and detail diagnosis that are included in respective lists of mental health procedure codes and diagnoses. These lists are widely used for reporting of mental health services provided by Oregon Health Plan and other publicly funded mental health services in Oregon.

Data issues/caveats that affect outcome measures::

Claims and encounters for Medicaid services may be submitted up to six months after services are provided, which means that the time period covered by this measure must end at least eight months before the results are due.

Indicator #:	2
Indicator:	Children in the custody of Child Welfare receiving a mental health assessment within 60 days of entering substitute care.
Baseline Measurement:	baseline at SFY 2015 was 79%
First-year target/outcome measurement:	First year target is 81%
Second-year target/outcome measurement:	Second year target is 84%

Data Source:

Medicaid enrollment, eligibility, and services are tracked in MMIS/DSSURS. Foster care entry and placements are extracted from OR-Kids.

Description of Data:

Children are included in the measure if they meet all three criteria:
• Ages 4-17 and identified between Jan. 1 and Oct. 31, 2014, as having entered foster care;
• Continuously enrolled in the same plan with CCOA or CCOB coverage for at least 60 days from CCO notification date; and
• Remained in foster care for at least 60 days from CCO notification date.
Mental health assessment services are defined as claims or encounters with procedure codes specified for the CCO Metric "Assessments within 60 Days for Children in DHS Custody" – 90791, 90792, 96101, 96102, H0031, H1011, and H2000 with TG modifier.
Children are counted as having received a mental health assessment (MHA) if the services are provided within 60 days after CCO notification of foster entry and covered by that CCO; or occurred during the 30 days preceding CCO notification, regardless of the plan provider.

Data issues/caveats that affect outcome measures::

This measure is the same as the CCO metric "Assessments within 60 Days for Children in DHS Custody." Technical specifications are posted online: http://www.oregon.gov/oha/analytics/CCOData/Assessments%20for%20Children%20in%20DHS%20Custody%20-%202015.pdf
CANS was implemented for children in foster care in July 2014. Every child entering foster care or substitute care receives both a CANS and a mental health assessment (MHA) within 60 days. The impact of full implementation of the CANS can be assessed by comparing the proportion of CANS versus other types of mental health assessments before and after that date.
Results in year one and two may also be affected by addition of assessments provided in conjunction with psychiatric residential, day treatment, and sub-acute services, beginning in SFY 2015.

Indicator #:	3
Indicator:	Random sample of clinical records (during the biannual site visit reviews) will show tuberculosis (TB) screening is being conducted in all SAPT funded residential and MAT programs
Baseline Measurement:	SFY 2016 will established the baseline of sampled clinical records in SAPT funded residential and MAT programs that are in compliance with the Block Grant checklist for TB screening.
First-year target/outcome measurement:	SFY 2017 will establish the baseline of sampled clinical records in SAPT funded residential and MAT programs that are in compliance with the Block Grant checklist for TB screening.
Second-year target/outcome measurement:	SFY 2018 will establish the baseline of sampled clinical records in SAPT funded residential

and MAT programs that are in compliance with the Block Grant checklist for TB screening.

Data Source:

State of Oregon licensing/certification site visits and State of Oregon Block Grant checklist

Description of Data:

All SAPT funded residential and MAT providers are monitored for TB/IVDU priority population BG requirements through the BG checklist during the biannual site visit reviews. The site visits would include a random pull and review of IVDU client's case files.

Data issues/caveats that affect outcome measures::

It will require three years to establish baseline results, because quality reviews of programs are conducted once in three years by the licensing/certification unit.

Indicator #: 4

Indicator: Increase number of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for tuberculosis (TB) and c) adhering to the federally defined requirement of interim services for IVDU priority populations.

Baseline Measurement: SFY 2016 will establish the baseline of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for TB and c) adhering to the federally defined requirement of interim services for IVDU priority populations.

First-year target/outcome measurement: SFY 2017 will establish the baseline of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for TB and c) adhering to the federally defined requirement of interim services for IVDU priority populations.

Second-year target/outcome measurement: SFY 2018 will establish the baseline of SAPT funded residential and MAT providers: a) utilizing the BG Checklist, b) adhering to the federally defined requirement of interim services for TB and c) adhering to the federally defined requirement of interim services for IVDU priority populations.

Data Source:

State of Oregon licensing/certification site visits and State of Oregon Block Grant checklist

Description of Data:

All SAPT funded residential and MAT providers are monitored for TB/IVDU priority population BG requirements through the BG checklist during the site visit reviews, which occur once every three years. The site visits would include a random pull and review of IVDU client's case files.

Data issues/caveats that affect outcome measures::

It will require three years to establish baseline results, because quality reviews of programs are conducted biannually by the licensing/certification unit.

Indicator #: 5

Indicator: Past month binge drinking among 8th graders

Baseline Measurement: 5.3% baseline in 2015

First-year target/outcome measurement: 5.0

Second-year target/outcome measurement: 4.9

Data Source:

Percentage of 8th graders who report past month binge drinking from Oregon Health Teens Survey.

Description of Data:

Oregon Healthy Teens is a state developed youth survey modeled on the Youth Risk Behavior Survey. Oregon aims to decrease binge drinking among 8th graders by 20% over five years (2017-2022) from 5.3% to 4.2%. First-year and second-year targets listed above reflect a linear decrease over time (5% yearly decrease for 8th graders) based on five year state targets.

The Oregon Healthy Teens (OHT) survey assesses health topics such as tobacco and alcohol use, HIV knowledge and attitudes, eating behaviors, nutrition and exercise. The sample size varies from 1,600 to 32,000 per year, and the final data are weighted to more accurately represent Oregon students in grades 8th and 11th. OHT is conducted on odd years.

Data issues/caveats that affect outcome measures::

Latest data is not always available during the BG application process. The most recent state level reports available are from 2015 for youth.

Indicator #:   6

Indicator: Past month binge-drinking among 11th graders

Baseline Measurement: 16.5%

First-year target/outcome measurement: 15.7%

Second-year target/outcome measurement: 14.9%

Data Source:

Percentage of 11th graders who report past month binge drinking from Oregon Health Teens Survey.

Description of Data:

Oregon Healthy Teens is a state developed youth survey modeled on the Youth Risk Behavior Survey. Oregon aims to decrease binge drinking among 11th graders by 20% over five years (2017-2022) from 16.5% to 13.2%. First-year and second-year targets listed above reflect a linear decrease over time (5% yearly decrease for 11th graders) based on five year state targets.

The Oregon Healthy Teens (OHT) survey assesses health topics such as tobacco and alcohol use, HIV knowledge and attitudes, eating behaviors, nutrition and exercise. The sample size varies from 1,600 to 32,000 per year, and the final data are weighted to more accurately represent Oregon students in grades 8th and 11th. OHT is conducted on odd years.

Data issues/caveats that affect outcome measures::

Latest data is not always available during the BG application process. The most recent state level reports available are from 2015 for youth.

Indicator #:   7

Indicator: Past month binge drinking among adults

Baseline Measurement: 17.9% (2015 baseline data)

First-year target/outcome measurement: 17.5%

Second-year target/outcome measurement: 17.2%

Data Source:

Percentage of adults reporting past month binge drinking from the Adult Behavior Risk Factor Surveillance Survey (BRFSS).

Description of Data:

Oregon aims to decrease binge drinking among adults by 10% over five years (2017-2022) from 17.9% to 16.1%. First-year and second-year targets listed above reflect a linear decrease over time (2% yearly decrease for adults) based on five year state targets.

The Behavioral Risk Factor Surveillance System (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.

The objective of the BRFSS is to collect uniform, state-specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. Factors assessed by the BRFSS include alcohol use, tobacco use, physical activity, dietary practices, safety-belt use, and use of cancer screening services, among others

Data issues/caveats that affect outcome measures::

Latest data is not always available during the BG application process. The most recent state level reports available are from 2015 for adults.

Indicator #: 8

Indicator: Past month heavy drinking among adults

Baseline Measurement: 7.3% (2015 baseline data)

First-year target/outcome measurement: 7.2%

Second-year target/outcome measurement: 7.0%

Data Source:

Percentage of adults reporting past month heavy drinking from the Adult Behavior Risk Factor Surveillance Survey (BRFSS).

Description of Data:

Oregon aims to decrease binge drinking among adults by 10% over five years (2017-2022) from 7.3% to 6.6%. First-year and second-year targets listed above reflect a linear decrease over time (2% yearly decrease for adults) based on five year state targets.

The Behavioral Risk Factor Surveillance System (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.

Data issues/caveats that affect outcome measures::

Latest data is not always available during the BG application process. The most recent state level reports available are from 2015 for adults.

Priority #: 6

Priority Area: The behavioral health system supports recovery and a life in the community.

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Children/Youth at Risk for BH Disorder, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

OHA will support recovery-oriented systems of care that support person centered planning.

Objective:

OHA is committed to developing recovery support services to meet individual needs across all life domains that include safe and affordable housing, supported housing and rental assistance; supported employment, and support for pregnant women and adults with dependent children who need outpatient treatment.

Strategies to attain the objective:

• Continue to invest in rental assistance programs for individuals with mental illness;
• Continue investing in rental assistance programs for individuals in recovery from substance use disorders;
• Continue the current practice of allocating General Fund, Community Mental Health Housing Trust Fund and Alcohol and Drug-Free dollars to the development of supported housing for individuals in recovery;
• Expand partnerships with stakeholder groups;
• Ensure all community mental health programs have IPS supported employment programs;
• Increase staffing levels for Oregon Supported Employment Center of Excellence (OSECE) to provide more timely training and technical assistance to

newly developing programs;

• Develop plans for the expansion of peer delivered services and establish statewide standards for the PDS workforce; and

• Initiate, develop and maintain partnerships between OHA, DHS Child Welfare, and the community to uphold the shared responsibility of keeping children safely at home and in their communities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of individuals receiving peer delivered services for behavioral health
Baseline Measurement:	The FY 2016 baseline is 4,272 individuals
First-year target/outcome measurement:	First year target is 5% incraese over baseline
Second-year target/outcome measurement:	Second year target is 10% increase over baseline.

Data Source:

Medicaid data source is the Decision Support Surveillance and Utilization Review System (DSSURS); Non Medicaid data source is the Measures and Outcomes Tracking System (MOTS).

Description of Data:

Medicaid Data: Counts of persons receiving peer services are based on claims for procedure code H0038 (cleansed paid Medicaid claims) in the state fiscal year. Persons in treatment include persons with a claim for a mental health or substance use disorder treatment procedure code and diagnosis (for mental health that excludes persons that only have an evaluation/management code; for substance use disorders that excludes persons that only have an SBIRT code).
Non Medicaid Data: Counts are also based on a mental health or substance use disorder treatment procedure code and primary diagnosis during the fiscal year (for mental health that excludes persons that only have an evaluation/management code; for substance use disorders that excludes persons that only have an SBIRT code).

Data issues/caveats that affect outcome measures::

Only PDS services identified through billing data can be reported.

Indicator #:	2
Indicator:	Decreased arrests among individuals accessing behavioral health services who are referred by the criminal justice system.
Baseline Measurement:	Percent of individuals receiving behavioral health services who are not arrested in the 30 days prior to the latest treatment status update in SFY 15 was 66.7% for mental health and 78% for substance use disorders.
First-year target/outcome measurement:	First year target is 3% improvement over year baseline for both MH and SUD
Second-year target/outcome measurement:	Second year target is 3% improvement over first year target for both MH and SUD

Data Source:

Measures and Outcome Tracking System (MOTS).

Description of Data:

This calculation reports the percent of individuals who are not arrested in the 30 days before the last status update for persons that have information on arrests at both admission and status updates. Exclusions from the calculation include: individuals whose treatment status changed to death.

Data issues/caveats that affect outcome measures::

Since a higher number of data for this indicator comes from MMIS, rather than MOTS, the data source for this indicator may need to be revised by end of first year.

Indicator #:	3
Indicator:	Maintain percent of pregnant women and adults with dependent children who successfully complete treatment or receive at least 90 days of treatment.

Baseline Measurement:	Baseline in SFY 2015 was 80.2%
First-year target/outcome measurement:	First year target is 80.2%
Second-year target/outcome measurement:	Second year target is 80.2%

Data Source:

> Measures and Outcomes Tracking System (MOTS); Decision Support Surveillance and Utilization Review System (DSSURS)

Description of Data:

> Persons receiving Non-Medicaid services will be identified through outpatient treatment procedure codes submitted in MOTS. Persons receiving Medicaid outpatient services will be identified through claims with an outpatient procedure code. The MOTS system provides information on retention, pregnancy and parent status.

Data issues/caveats that affect outcome measures::

> majority of this population data comes from MMIS and not MOTS.

Indicator #:	4
Indicator:	Increased number of people in independent living.
Baseline Measurement:	Number of OHA funded programs throughout the state providing supported drug-free housing was 1,134 in SFY 2015
First-year target/outcome measurement:	First year target is 1,137
Second-year target/outcome measurement:	Second year target is 1,140

Data Source:

> The number of OHA funded programs providing supported drug-free housing and the number of beds available is tracked by Oxford House, Inc.

Description of Data:

> Oxford House, Inc. provides OHA with a monthly status report for Oregon.

Data issues/caveats that affect outcome measures::

> Oxford House is expanding in rural parts of Oregon, including the Oregon coast and Eastern Oregon. Oxford House hired a coordinator to serve Eastern Oregon. The focus in rural Oregon should result in a steady increase in drug-free housing.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention[*] and Treatment	$32,192,770		$256,061,676	$16,447,554	$49,295,771	$0	$0
a. Pregnant Women and Women with Dependent Children[**]	$6,360,524		$0	$0	$0	$0	$0
b. All Other	$25,832,246		$256,061,676	$16,447,554	$49,295,771	$0	$0
2. Primary Prevention	$8,584,739		$0	$0	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$201,023	$0	$0
4. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	$2,146,185		$206,800	$1,902,839	$2,425,925	$0	$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	$42,923,694	$0	$256,268,476	$18,350,393	$51,922,719	$0	$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$87,329,734	$0	$450,315,929	$0	$7,720,364
6. Other 24 Hour Care		$0	$289,326,018	$0	$58,396,634	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$10,247,815	$1,686,884,721	$0	$271,539,338	$0	$0
8. Mental Health Primary[*]		$0	$0	$0	$0	$0	$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)[**]		$1,280,977	$0	$0	$6,927,768	$0	$0
10. Administration (Excluding Program and Provider Level)		$1,280,977	$70,616,276	$0	$11,183,000	$0	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	$0	$12,809,769	$2,134,156,749	$0	$798,362,669	$0	$7,720,364

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	0	0
Women with Dependent Children	0	0
Individuals with a co-occurring M/SUD	0	0
Persons who inject drugs	0	0
Persons experiencing homelessness	0	0

Please provide an explanation for any data cells for which the stats does not have a data source.
our analytics team is still working on pulling this data table to be filled. We should be able to populate this data on the second week of September if the project officer reopens the table for us. Thank you for understanding!

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$32,192,770
2 . Primary Substance Abuse Prevention	$8,584,739
3 . Tuberculosis Services	$0
4 . Early Intervention Services for HIV[*]	$0
5 . Administration (SSA Level Only)	$2,146,185
6. Total	$42,923,694

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$1,174,822
	Selective	
	Indicated	
	Unspecified	
	Total	$1,174,822
Education	Universal	$753,822
	Selective	
	Indicated	
	Unspecified	
	Total	$753,822
Alternatives	Universal	$376,911
	Selective	
	Indicated	
	Unspecified	
	Total	$376,911
Problem Identification and Referral	Universal	$506,911
	Selective	
	Indicated	
	Unspecified	
	Total	$506,911

Community-Based Process	Universal	$2,759,377
	Selective	
	Indicated	
	Unspecified	
	Total	$2,759,377
Environmental	Universal	$2,872,896
	Selective	
	Indicated	$140,000
	Unspecified	
	Total	$3,012,896
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	$0
Total Prevention Expenditures		$8,584,739
Total SABG Award*		$42,923,694
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	
Universal Indirect	$8,444,739
Selective	
Indicated	$140,000
Column Total	$8,584,739
Total SABG Award*	$42,923,694
Planned Primary Prevention Percentage	20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☑
Military Families	☐
LGBT	☑
American Indians/Alaska Natives	☑
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☑
Asian	☑
Rural	☑
Underserved Racial and Ethnic Minorities	☑

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems		$0	$0	
2. Infrastructure Support		$0	$0	
3. Partnerships, community outreach, and needs assessment		$204,882	$167,628	$372,510
4. Planning Council Activities (MHBG required, SABG optional)	$10,410		$10,410	$40,820
5. Quality Assurance and Improvement		$51,030	$20,000	$51,030
6. Research and Evaluation		$25,514	$0	$25,514
7. Training and Education		$173,765	$39,716	$213,481
8. Total	$10,410	$455,191	$237,754	$703,355

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question
1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[25] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102?123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52?77

[26] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts, http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10; Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[27] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

[28] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index.html

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

[31] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[32] Health Care Integration, http:// samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

[33] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[34] Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[35] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[36] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

[37] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

[38] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

[39] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[40] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[41] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[42] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   For more than two decades the State of Oregon has been on the forefront of health system transformation. The Certified Community Behavioral Health Clinic (CCBCH) Demonstration program has enabled the Oregon Health Authority (OHA) to build upon existing and emerging health system infrastructures that have been central to the State's transformation progress to date to strengthen physical and behavioral health care delivery in behavioral health settings. Specifically, the OHA has leveraged its experience with the Patient-Centered Primary Care Home (PCPCH) Program, the OHA Behavioral Health Home Learning Collaborative, and the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Pilot.

   Through all of the above efforts in place, under the bigger umbrella of the Statewide Coordinated Care Model, OHA has strengthened its existing infrastructure by ensuring comprehensive whole person care to individuals whose primary contact with the health system is though the Behavioral Health system. A significant proportion of that population are adults and children with co-occurring substance use and mental health disorders.

   In 2015, Senator Sara Gelser, D-Corvallis, and Oregon Health Authority Director Lynne Saxton traveled round Oregon to meet with consumers and family members in a series of Town Halls and aimed to address the concerns heard during these meetings. In the Summer of 2016, Oregon Health Authority (OHA) convened the BHC to develop a set of recommendations to chart a new course for the behavioral health in Oregon. Director Saxton asked the BHC to make recommendations defining policy, financing, and infrastructure needs to modernize and integrate Oregon's Health System with Behavioral Health (Mental Health and Substance Use Services) for people who receive services and their families. The BHC was comprised of nearly 50 members throughout the state that represent every part of the behavioral health system. The BHC worked for over six months to develop a set of recommendations that will transform Oregon's BH system. Stakeholder defined the problems, identified solutions and created a vision for excellence and sustainability in Oregon's BH system.

   The Oregon Health Authority serves as the Single State Authority (SSA) and State Mental Health Authority (SMHA) for Oregon. Oregon's plan is to integrate care and treat mental health, substance use and other health services equitably in local communities.

Mental health and substance use must be integrated clinically, operationally and financially into larger, system wide reform efforts to achieve BHC's goal.

Patient Centered Primary Care Homes: The Patient-Centered Primary Care Home Program recognizes clinics as primary care homes and makes sure they meet the standards of care. The program is part of the Oregon Health Authority and one of the many efforts to help improve the health of all Oregonians and the care they receive. Any health care practice that provides comprehensive primary care and meets the key attributes can become a recognized Patient-Centered Primary Care Home. Recognized PCPCH clinics include physical health providers, behavioral, addictions and mental health care providers, solo practitioners, group practices, community mental health centers, tribal clinics, rural health clinics, federally qualified health centers, and school-based health centers. Recognized clinics attest to meeting the program requirements and must renew their recognition every two years. This allows clinics and the program to assess their progress and accomplishments, and gradually build on that success to achieve higher tier recognition to provide the best possible care for patients. A 2016 evaluation of the PCPCH clinics and the PCPCH model demonstrated that the program has achieved some noteworthy indicators of progress towards the accomplishment of the Triple Aim in only a few years of operation. PCPCH designated clinics have achieved significant transformation resulting in better effectiveness and coordination of primary care and behavioral health care and the larger health care system. With continued support and investment int he PCPCH program Oregon would be ablet o sustain this model, as well as build other innovative models using PCPCH standards as the guiding fundamental base.

Local Mental Health Authorities are required to plan, develop, implement, and monitor services within the area served by them to ensure expected outcomes for consumers. The CMHPs provide care coordination and treatment for people with mental illness, intellectual/developmental disabilities, and substance use disorders. Core services include screening, assessment, and referral to providers and community organizations, as well as emergency or crisis services.

Oregon's vision for a transformed health system includes health information technology (HIT) efforts that ensure the care Oregonians receive is optimized by HIT. A key near-term focus areas is the spread of health information exchange in support of care coordination between and integration Health Information Exchange is another avenue used by Oregon to a significant extent to implement better coordination and integration of primary care and behavioral health care, especially for those with co-occurring disorders.

OHA is supporting care coordination through the interoperable, secure exchange of health information between health care organizations and providers, using Direct secure messaging. CareAccord is a nationally-accredited Health Information Service Provider (HISP) providing Direct secure messaging services at no cost for organizations facing barriers to health information exchange. CareAccord also administers a Flat File Directory which assists organizations with identifying the Direct secure messaging addresses across Oregon to support use of Direct, including to meet federal Meaningful Use requirements for sharing Transitions of Care summaries. CareAccord's serves more than 160 organizations with more than 1,500 users, and its number of Direct exchange transactions nearly tripled in 2016 and is anticipated to increase further in 2017. As of May 2017, the Flat File Directory includes more than 10,000 Direct addresses from 23 interoperable, participating organizations who represent more than 550 unique health care organizations.

The Emergency Department Information Exchange (EDIE) is a web-based application that delivers alerts to allows Emergency Departments (EDs) including critical visit history and care coordination information for to identify patients with complex care needs and/or who frequently use the emergency room for their care. PreManage expands the services in EDIE to other users such as health plans, Coordinated Care Organizations (CCOs), medical groups or physicians and allows them to proactively coordinate care and improve communication through entering patient care recommendations and care histories. to improve communication and aid in the coordination of patient care.

OHA and other stakeholders are also working to improve access to the state's Prescription Drug Monitoring Program specialized registry, which contains information on controlled substances/opioid prescription fills. A new HIT gateway service will allow EHRs and other HIT systems, including HIEs and EDIE, to connect directly to the PDMP database and provide actionable data within a prescriber's workflow.

Through federal ONC cooperative agreement funding, Reliance e-Health Collaborative (a regional HIE), has worked to address barriers to information sharing and care coordination across settings, particularly for behavioral health data, by developing a common consent model.

Finally, Oregon's HIE Onboarding Program will leverage significant federal matching funds to support the initial cost of onboarding critical behavioral health (and other) providers to robust community HIEs to improve care coordination and help Medicaid providers meet Meaningful Use requirements.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Co-occurring behavioral disorders and serious, chronic medical conditions create the need for specialized treatment environments that provide the level of service intensity to support individuals striving toward independence. Wise use of these intense supports can improve treatment outcomes and facilitate more timely transitions to independent living. While Oregon has been implementing several important strategies to increase the availability of integrated, community-based supported housing during the last biennium, the state recognizes the continued need for licensed residential care environments that provide intense,

specialized services and supports.

Individuals in licensed residential treatment participate in an individualized assessment of strengths and treatment needs to help determine the most appropriate level of care that allows the most independence. An individualized treatment plan and an Individualized Recovery Plan are developed from this assessment, outlining the services and supports to be provided in the residential setting.

Three levels of community-based residential treatment services are offered for adults with serious mental illness:

• Residential Treatment Homes (RTHs) provide services on a 24-hour basis for five or fewer residents;

• Residential Treatment Facilities (RTFs) provide services on a 24-hour basis for six to 16 residents; and

• Secure Residential Treatment Facilities (SRTFs) restrict a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures. SRTFs provide services on a 24-hour basis for 16 or fewer residents.

OHA also has had a long history of developing housing with private partnerships, notably in Villebois, a community located in Wilsonville on the site of the former Dammasch State Hospital. Over the next five years, OHA will work with the National Alliance for Mental Illness, Oregon Family and Community Services, providers, and other public and private partners to add affordable housing units for individuals and families and for people who are disabled due to mental illness, substance use disorders and co-occurring disorders.

OHA outlines strategies to support, sustain and enhance the current recovery-oriented system of care and to increase and enhance those services. OHA aims to provide recovery support services, including those that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels, to people who are transitioning out of substance use disorders treatment and gambling disorders treatment as part of their continuing care plan to support ongoing recovery. In addition, OHA strives to improve the existing recovery-oriented system of care for people transitioning from residential to outpatient treatment for substance use disorders.

Peer support is critical in assisting parents to address the fears and immobilization associated with the stigma of possible behavioral health concerns. Peer support services assist families in communicating with their health care provider about their child or youth's mental health needs. This applies especially to families with children under the age of six and for families who are new to the availability of health care and behavioral health care.

All women specialized programs, both outpatient and residential, provide gender specific services and are required to provide care for specific issues, such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems. Specialized treatment programs must follow the Oregon Administrative Rules (OAR) to provide or coordinate services that meet the access needs of this population, such as childcare, mental health services, transportation and interim services if treatment is not readily available.

Treatment programs are expected to use the American Society of Addiction Medicine Patient Placement Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition in making level of care determinations. All residential programs provide transition services so that women and children can smoothly move from residential to community-based outpatient and continuing care services.

The Certified Community Behavioral Health Clinic (CCBCH) Demonstration program has enabled the Oregon Health Authority (OHA) to build upon existing and emerging health system infrastructures that have been central to the State's transformation progress to date to strengthen physical and behavioral health care delivery in behavioral health settings. Specifically, the OHA has leveraged its experience with the Patient-Centered Primary Care Home (PCPCH) Program, the OHA Behavioral Health Home Learning Collaborative, and the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Pilot.

Through all of the above efforts in place, under the bigger umbrella of the Statewide Coordinated Care Model, OHA has strengthened its existing infrastructure by ensuring comprehensive whole person care to individuals whose primary contact with the health system is though the Behavioral Health system. A significant proportion of that population are adults and children with co-occurring substance use and mental health disorders. The CCBHCs are paid at an enhanced Medicaid Match rate and are required to have at least 20 hours of on-sight primary care every week.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ◯ Yes ◯ No

and Medicaid? ◯ Yes ◯ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◯ Yes ◯ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ◯ Yes ◯ No

b) Health risks such as

    i) heart disease ◯ Yes ◯ No

    ii) hypertension ◯ Yes ◯ No

    viii) high cholesterol ◯ Yes ◯ No

    ix) diabetes ◯ Yes ◯ No

c)	Recovery supports		j⌐ Yes j⌐ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?   j⌐ Yes j⌐ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?   j⌐ Yes j⌐ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)[45], [Healthy People, 2020](#)[46], [National Stakeholder Strategy for Achieving Health Equity](#)[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

---

[45] [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf](#)

[46] [http://www.healthypeople.gov/2020/default.aspx](#)

[47] [http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf](#)

[48] [http://www.thinkculturalhealth.hhs.gov](#)

[49] [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf](#)

[50] [http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208](#)

[51] [http://www.whitehouse.gov/omb/fedreg_race-ethnicity](#)

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

      a) Race   ◯ Yes ◯ No

      b) Ethnicity   ◯ Yes ◯ No

      c) Gender   ◯ Yes ◯ No

      d) Sexual orientation   ◯ Yes ◯ No

      e) Gender identity   ◯ Yes ◯ No

      f) Age   ◯ Yes ◯ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?   ◯ Yes ◯ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?   ◯ Yes ◯ No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?   ◯ Yes ◯ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard?   ◯ Yes ◯ No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?   ◯ Yes ◯ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

---

[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

---

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?   ⌒ Yes ⌒ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

    a) ∈   Leadership support, including investment of human and financial resources.

    b) ∈   Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

    c) ∈   Use of financial and non-financial incentives for providers or consumers.

    d) ∈   Provider involvement in planning value-based purchasing.

    e) ∈   Use of accurate and reliable measures of quality in payment arrangements.

    f) ∈   Quality measures focus on consumer outcomes rather than care processes.

    g) ∈   Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

    h) ∈   The state has an evaluation plan to assess the impact of its purchasing decisions.

    Does the state have any activities related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? Yes No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   Oregon is integrating Coordinated Specialty Care teams in all counties using a standard model of care supported by the EASA Center for Excellence at Oregon Health & Science University and Portland State University. Services are delivered by local teams which are based on ACT standards of intensity (approx.. 1:10 clients per fte), including Qualified Mental Health Professional counselors, psychiatrists or psychiatric nurse practitioners, supported employment and education specialists, as well as RN nurses, peer support specialists and occupational therapists. Teams coordinate services through weekly meetings and deliver population-level community education, rapid access and outreach, assessment, treatment and transition planning. Specific ebps embedded in Oregon's CSC model include Individual Placement and Support (IPS) supported employment and education, multi-family psychoeducation following the Anderson/McFarlane model, feedback-informed treatment, Cognitive Behavioral Therapy for psychosis, Motivational Interviewing and differential diagnosis treatment, shared decision making, low-dose prescribing, and elements of Assertive Community Treatment. The model is iterative and the Center for Excellence is charged with its continual development based on data, feedback and emerging evidence.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   3. Oregon has a centralized training and fidelity review process which all sites participate in. In addition, teams receive support from the Oregon Supported Employment and Education Centers for Excellence and the ACT Center for Excellence. Individualized treatment planning and physical health integration are part of both training and fidelity review. Locally, several sites have integrated on-site primary care, but all sites integrate coordination and support for accessing primary care providers.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI?   ◉ Yes ◯ No

5. Does the state collect data specifically related to ESMI?   ◉ Yes ◯ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?   ◉ Yes ◯ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

7. The state is implementing Coordinated Specialty Care consistent with the model articulated by the National Institute of Mental Health RAISE study. CSC in Oregon has all of the same elements of CSC nationally, and has been extended throughout the state. The model is fully integrated into local mental health centers, which bring additional resources and supports and facilitate continuity of care across settings. The practice guidelines and fidelity tool currently in use by EASA can be found at http://www.easacommunity.org/resources-for-professionals.php. Programs across Oregon serve approximately 400 individuals at any point in time.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

a. Continue working toward full implementation, which involves working closely with new sites to ensure that they are meeting minimum and fidelity standards and maintaining access to CSC.
b. Continue fidelity review and program performance efforts in counties with existing programs.

c. Establish ongoing data reporting focused on core outcomes; participate in national data harmonization efforts.

d. Pilot the integration of CSC services into local systems of care in Deschutes and Lane Counties.

e. Further develop training efforts to increase web-based training options and integrated supervisory consultation and training.

f. Work with Coordinated Care Organizations and private insurers to improve identification and payment strategies.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

9. EASA Center for Excellence collects data on all community education activities, referrals, intakes and discharges. A quarterly outcome review is submitted for each person served by EASA, including diagnosis, demographics, functional outcomes and services. Data is entered remotely into OHSU's RedCap system. In addition to outcome data, all new sites funded by set-aside dollars are participating in a fidelity review process which assesses their level of implementation, strengths and areas of development.

10. Please list the diagnostic categories identified for your state's ESMI programs.

10. Diagnostic categories included in the ESMI programs include Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Schizophreniform Disorder, Bipolar I with psychosis, and Other Specified and Other Unspecified Schizophrenia Spectrum and Other Psychotic Disorder.

Does the state have any activities related to this section that you would like to highlight?

During this time period EASA completed its statewide dissemination. Several of the newer sites are still in the early stage of implementation but all sites are funded and are participating in ongoing service development. Also during this time the EASA Center for Excellence moved from Portland State University School of Social Work to the Oregon Health & Science University Portland State University School of Public Health, bringing the program under a medical school and extending HIPAA protections to its activities. EASA's data system is now being managed by the Oregon Center for Translational Research/ Data Coordinating Center, which has vast experience managing health-related data and research. These changes are anticipated to lead to significant improvements in the sophistication of EASA's ongoing development as well as new resources associated with telemedicine. Oregon is participating nationally with NIMH and SAMHSA in a data harmonization effort intended to create a national process of data collection and research. In addition, EASA Center for Excellence staff are playing national training and technical assistance roles in support of the National Training and Technical Assistance Center for Children's Behavioral Health, the National Association of State Mental Health Program Directors Association, the Westat national evaluation team, and the PEPPNET steering committee and training and technical assistance work group. During November 2016 the director of the EASA Center for Excellence was invited by Orygen to visit Australia in order to further discussions about collaboration and program development. Within Oregon, rural services development has been a primary focus, and all rural counties in Oregon are now fully engaged in implemented EASA services using a range of innovative approaches to address the unique needs of communities with low psychosis incidence. Other areas of innovation include increased integration of occupational therapy, extension of early psychosis services to broader system of care models.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ⃝ Yes ⃝ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

    Oregon prides itself on its collaborative spirit and innovative approaches to service delivery. Several initiatives and efforts in Oregon have engaged family and youth caregivers and consumers in local and statewide efforts.

    Suicide Prevention

    • One hundred experts in suicide prevention and intervention worked with OHA to develop the Oregon Youth Suicide Intervention and Prevention Plan for 2016–2020: to address the risk and protective factors that influence youth suicide. The plan was modeled after the research-based National Strategy for Suicide Prevention (NSSP), and has the aspirational goal of Zero Suicide.

    • The plan is customized to meet the unique needs of Oregonians. Building connections for youth with adults and peers, increasing resilience, promoting life-affirming decision-making skills, and improving access to quality care are all included in the design. Those that made up the 100 stakeholders volunteering for the planning process included the following: parents and youth, behavioral and physical health providers and school-based health centers. Volunteers also include coordinated care organizations (CCOs) and private insurers, schools, hospitals, OHA tribal liaisons, and military representatives. Volunteers were also made up of LGBTQ youth and young adults, representatives of minority communities, individuals who had attempted suicide, and individuals who had survived the loss of a loved one.

    • The Children's System Advisory Council (CSAC) began preparing health literacy materials for families to ensure safety after their youth are released from an emergency department. The materials also will provide guidance on transitions to outpatient care. The council plans to complete the materials in 2017.

    • CSAC and the Youth Suicide Prevention Alliance have combined efforts, establishing a youth and Young Adult Advisory Committee. The role of this committee is in part to ensure that youth voice is at the center of systems development and program planning. The young people on this committee have lived experience in systems of care, may be suicide survivors, and are regarded as the experts in quality, youth centric care.

    Juvenile Fitness to Proceed
    • Oregon's Juvenile Fitness to Proceed process relates to youth charged in juvenile court who are unable to participate in their defense due to a mental health need. Oregon's program for Restoration of fitness depends on a very specific and individualized case planning process that takes into consideration all of each youth's needs to craft a very specific treatment plan.

    Intensive Treatment Services
    • Oregon requires its providers to consider each youth's specific needs and strengths in service planning by administrative rule. Each youth is required to receive an individualized case plan that ties suggestions from a strengths and needs assessment to the interventions that are prescribed. This decreases the use of "one size fits all" approaches.

    EASA/Young Adults
    • EASA fidelity requires that the services are youth/young adult-centered. Youth voice is used in describing participant treatment

and life goals and threaded throughout the service delivery. EASA has also established a Young Adult Advisory Council. The council works with providers and system partners to evaluate fidelity, increase web-based presence, access, and ensure that young adult-relevant practices and policies are part of the way that EASA does business.
• Youth M.O.V.E. Oregon (YMO), a youth and young adult advocacy and peer support organization, has been instrumental in strengthening youth voice in behavioral health treatment. YMO has five drop-in centers in Oregon and is responsible for ensuring that young adults in local Wraparound structures have young adult representation and peer support for youth who are recipients of Wraparound supports and services.

Collaborative Problem Solving
• In the interest of empowering families in their own care, the Oregon Collaborative Problem Solving (CPS) Alliance Is rolling out parent group training and CPS support groups for families in conjunction with the SAMHSA Statewide Family Network and overlapping with other models such as Wraparound, intensive care coordination and practices supportive of trauma informed care.

Peer Workforce Development
• The children's mental health system has focused on workforce development to increase the availability of peers who are certified to deliver peer services. The Peer Delivered Service (PDS) Foundation's curriculum for young adults and family members is offered at least quarterly, includes content necessary for state certification, and provides more information on strategies to meet national standards and state of the art research findings for parent to parent peer support in one-to-one settings and group modality.

• The PDS curriculum also includes strength based assessment, use of lived experience, motivational interviewing, collaborative problem solving, holistic self-care, use of natural supports and community resources, cultural and linguistic responsiveness, suicide and interpersonal violence safety planning, relapse prevention, and trauma informed goal setting. The curriculum incorporates current research and information related to the education, health, and wellness needs of children, youth, and families.

• There are a 206 certified Family Support Specialists and Youth Support Specialists on the Oregon Traditional Health Worker registry. Each new class trains 18-25 individuals. They are absorbed into the workforce as soon as they complete the training. A goal is to continue the development of combined online and traditional training with both distance and in person follow-up and supervision. A peer support coach training cohort began in 2017. These coaches will provide regional supervision in rural areas as well as local supervision in more urban settings. The Oregon Administrative Rule 309 requires supervision of PDS staff by a clinician and a PDS staff person certified in that specialty (adult mental health, adult addiction, family, or youth peer support). In 2018, the plan is to develop specialized PDS trainings on emergency services and suicide prevention and postvention safety planning.

• The Oregon Family Support Network (OFSN) developed a peer coach training curriculum that is now available for use in the communities where family support services have multiple staff. OHA contracts with OFSN and Youth MOVE Oregon (YMO) to provide PDS training and coordination to meet the need for continued development of peer delivered services both for young adults and family members of children with SED. Additionally, Family Support Specialists from all disciplines (mental health, addiction, intellectual/developmental disability, special education, and complex health care needs) across Oregon meet together with OHA staff on a monthly basis for policy updates, to identify system issues, and to plan for advocacy and training needs. The Family Workforce Association meets in person quarterly and was attended by 112 PDS family providers in 2016.

• There is a need to create a Center for Excellence for Peer Delivered Services, a collaboration of PDS staff and academicians in health outcomes, setting competency based standards for training, certification, and measurable services outcomes for the PDS. The model consists of subject matter experts of certified peer delivered services staff by discipline (adult to adult, parent to parent, and youth to youth) working with individuals at the University level who can provide research analysis. The joint effort would provide Oregon Health Authority with competency-based testing and certification for all types of peer support. It would also provide the guidance for the collection and analysis of outcomes data on the use of PDS. This body of knowledge would further modify the training and supervision/coaching mechanisms for effective PDS.

Access to Peer Support Services
• Oregon Administrative Rule (OAR 309) now requires behavioral health services clinical providers to ensure access to PDS for families with children and youth. This makes it possible for Family Support Specialists (FSS) to be members of emergency department follow-up teams. It is anticipated that Family Support Specialists will also be added to outpatient teams, including CCBHC, , FQHC, and School-Based Health Center. There is a more acute need to offer Family Support Specialist services to families before they have access to regular behavioral health. When PDS were offered in one community with three FSS, in the community, all 93 families were able to maintain without having to utilize crisis teams and hospital emergency departments until they could access outpatient services in 3-6 weeks after the initial contact with the FSS.

Trauma Informed Care Leadership

• OHA contracts with Portland State University, Trauma Informed Oregon (TIO) to provide information and technical assistance regarding trauma informed service delivery and to increase trauma awareness statewide. The governance of Trauma Informed Oregon, incorporates both youth and family voice on the Leadership Team that advises on the activities and work products of TIO. Additionally, the Oregon Trauma Informed Advocacy Coalition (OTAC), a youth led group to increase trauma awareness among Oregon youth, is sponsored by TIO, to further incorporate youth voice into the statewide efforts to address trauma and promote trauma informed care.

4. Describe the person-centered planning process in your state.

Oregon Envisions a world where all people have positive control over the lives they have chosen for themselves. Our efforts focus on people who have lost or may lose positive control because of society's response to the presence of a disability or other conditions. This site helps us foster a global learning community that shares knowledge for that purpose.
Oregon's person centered planning website helps consumers understand how they can get more information and get involved: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/Pages/person-centered-planning.aspx

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?   ☐ Yes ☐ No

2. Are there any concretely planned initiatives in our state specific to self-direction?   ☐ Yes ☐ No

    If yes, describe the currently planned initiatives. In particular, please answer the following questions:

    a)   How is this initiative financed:

    b)   What are the eligibility criteria?

    c)   How are budgets set, and what is the scope of the budget?

    d)   What role, if any, do peers with lived experience of the mental health system play in the initiative?

    e)   What, if any, research and evaluation activities are connected to the initiative?

    f)   If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

    Does the state have any activities related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance -for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?   ◌ Yes ◌ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?   ◌ Yes ◌ No

Does the state have any activites related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

   Does the state have any activites related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

<u>Narrative Question</u>

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?　　　☐ Yes ☐ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)　　　☐ Yes ☐ No

    - ☐ Data on consequences of substance using behaviors

    - ☐ Substance-using behaviors

    - ☐ Intervening variables (including risk and protective factors)

    - ☐ Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

    - ☐ Children (under age 12)

    - ☐ Youth (ages 12-17)

    - ☐ Young adults/college age (ages 18-26)

    - ☐ Adults (ages 27-54)

    - ☐ Older adults (age 55 and above)

    - ☐ Cultural/ethnic minorities

    - ☐ Sexual/gender minorities

    - ☐ Rural communities

    - ☐ Others (please list)

X Low socio-economic status
X Self-report disability

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

    ⊖   Archival indicators (Please list)

    ⊖   National survey on Drug Use and Health (NSDUH)

    ⓑ   Behavioral Risk Factor Surveillance System (BRFSS)

    ⊖   Youth Risk Behavioral Surveillance System (YRBS)

    ⊖   Monitoring the Future

    ⊖   Communities that Care

    ⓑ   State - developed survey instrument

    ⊖   Others (please list)

    Oregon Health Teens and Student Wellness Survey youth surveys modeled on the YRBS

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?   ꞇ Yes ꞇ No

    If yes, (please explain)

    Yes, the Oregon Public Health Division use the State Health Improvement Plan (SHIP) and State Health Assessment (SHA) process to make future decisions about allocation of SABG primary prevention funds. The PHD Health Promotion and Chronic Disease Prevention (HPCDP) section has used needs assessment data to inform development of their 5 year strategic plan, inclusive of alcohol and tobacco prevention priorities.

    If no, (please explain) how SABG funds are allocated:

    Does the state have any activities related to this section that you would like to highlight?

    State Epidemiological Outcomes Workgroup - The structural changes within Oregon Health Authority (OHA) provide an opportunity to rebirth the State Epidemiological Outcomes Workgroup (SEOW). Oregon's State Health Improvement Plan (SHIP) has been developed with the collaboration of multiple sectors to address key public health and health equity issues. The SHIP is staffed by the Public Health Division (PHD) and is championed by the Public Health Advisory Board (PHAB), a group of cross-sector representatives tasked with advising the OHA on policy matters related to public health. The PHAB reviews statewide public health issues, and participates in public health policy development.
    Two of the seven SHIP priorities are substance abuse, specifically alcohol and opioid abuse and tobacco. This is an opportunity to align the priorities of the SABG primary prevention funds with the overall priorities of the PHD, the PHAB, and other state-level decision-makers, including the Governor's office. The SEOW will serve to inform the development and monitoring of the substance abuse priority in the SHIP and allocation of SABG primary prevention funds. The SEOW will also inform the PHAB regarding progress and needs related to the substance abuse priority. This arrangement provides the SEOW with the ability to inform the highest level leadership entities for health in Oregon.

    Previously and for this current biennia, County and Tribal prevention sub awardees have been asked to use data and local information to assess the needs within their communities and use allocated funding to address the priority areas based on information collected. The Oregon PHD is coordinating the development of a statewide surveillance system for alcohol and other drugs, including opioids and cannabis, which will also inform decisions about allocation of SABG primary prevention funds.

    Please indicate areas of technical assistance needed related to this section

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?   ❢ Yes ❢ No

   If yes, please describe

   Oregon currently has a Certified Prevention Specialist training program previously required and implemented by the former Addictions and Mental Health (AMH) Division (AMH), now Health Systems Division. AMH developed a Prevention Cohort Training Model in 2011. This training model focused on the IC&RC prevention domains and prepared cohort participants for application and testing for the Certified Prevention Specialist (CPS) credential.
   A significant change for this grant is the department in which it is housed. The original grant was administered by AMH. In 2015, the Oregon Health Authority underwent reorganization, AMH merged with the Division of Medical Assistance Programs, and became the Health Systems Division. The newly formed Health Policy and Analytics Division, is Oregon's Single State Authority. The SABG Primary Prevention funding went to the Oregon Public Health Division (PHD), Health Promotion and Chronic Disease Prevention (HPCDP) Section in March 2016.
   With the transition of SABG Primary Prevention funding, the Oregon PHD is assessing prevention workforce capacity needs that align with SHIP prevention strategic goals and objectives. The Oregon PHD plans to enlist technical assistance for assessment and planning to determine and ensure a plan for prevention workforce capacity and to identify appropriate entities and roles for training, including the CPS certification. The Oregon PHD HPCDP section is currently not enforcing CPS certification requirements under the previous AMH Division for SABG primary prevention funded grantees.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?   ❢ Yes ❢ No

   If yes, please describe mechanism used

   With a new five-year Strategic Plan for alcohol and tobacco, Oregon is assessing workforce capacity needs in the development of a training and technical assistance plan for the substance use prevention workforce grantees that are receiving SABG Primary Prevention Funds.
   Trainings and technical assistance offered are focused on current and emerging priority areas and are intended to develop and enhance skills necessary to effectively advance prevention policy priorities. Trainings also support networking and collaboration with peers including sharing lessons learned. Sub awardee participation is required at certain HPCDP-sponsored trainings, meetings, webinars and conference calls. Formalized training and technical assistance opportunities include but are not limited to, prevention cohort calls, Communities of Practice, Regional Support Networks and an annual Grantees and Contractors convening.

   The Alcohol and Drug Prevention Coordinators, and any staff working 0.5 FTE or more under a sub award are required to

complete all staff training requirements related to SABG Primary Prevention funded work. HPCDP reserves the right to require SABG Primary Prevention funded staff to attend any training that HPCDP deems necessary to their role and will negotiate decisions on a case-by-case basis.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

   ◉ Yes ○ No

   If yes, please describe mechanism used

   There are multiple formal mechanisms that Oregon uses to assess community readiness to implement prevention strategies supported by the Public Health Division.
   Public Health Modernization – Passed by the legislature in House Bill 3100, a plan and model was developed, to modernize Oregon's public health system to meet the basic needs and protections for the health of all Oregonians. A public health modernization assessment was coordinated by the State PHD, Public Health Advisory Board (PHAB) and local public health authorities to assess current system needs for modernization and resources needed. In 2016, the OHA, the PHAB and local public health authorities used findings from the public health modernization assessment to develop the statewide public health modernization plan. This plan includes the long-term roadmap for modernizing Oregon's public health system.

   State Health Assessment (SHA) and State Health Improvement Plan (SHIP) – The State Health Assessment, used for public health accreditation, describes the health of the population, identifies areas for improvement, contributing factors that impact health outcomes, and assets and resources that can be mobilized to improve population health. The last SHA was completed in 2012 with the subsequent development of the State Health Improvement Plan (SHIP) that includes alcohol and opioid prevention strategies. The SHA is being revised to include a public health systems assessment, health status assessment, strengths, threats and opportunities assessments, providing a more comprehensive picture of health for the state.

   PHD HPCDP Community Readiness Assessment – HPCDP implements a community readiness assessment for Tobacco Prevention and Education Programs (TPEP) across the state to determine the willingness and preparedness of each County in Oregon for actions related to local tobacco prevention and education. The intention of the assessment is to inform the development of successful cost-effective prevention interventions for future strategies, technical assistance needs and program improvement and the challenges and opportunities of program success.

   Alcohol and Drug Prevention and Education Program (ADPEP) Grantee Readiness Assessment - Oregon will be assessing SABG primary prevention funded local grantee's readiness to implement environmental prevention strategies in Fall 2017. The assessment will seek to understand how willing and prepared are communities to plan and implement policy, systems and environmental change strategies related to alcohol, tobacco and drugs. This assessment will build upon Oregon's experience with HPCDP's TPEP Community Readiness Assessment as well as the Strategic Prevention Framework Partnerships for Success (SPF-PFS) capacity assessments of local funded grantees completed in 2016.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

   The Oregon PHD plans to enlist technical assistance for assessment and planning to determine and ensure a plan for prevention workforce capacity and to identify appropriate entities and roles for training, including the CPS certification.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ◉ Yes ◯ No

    If yes, please attach the plan in BGAS by going to the <u>Attachments Page</u> and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ◉ Yes ◯ No ◯ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

    a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds

    b) ☑ Timelines

    c) ☑ Roles and responsibilities

    d) ☑ Process indicators

    e) ☑ Outcome indicators

    f) ☑ Cultural competence component

    g) ☑ Sustainability component

    h) ☐ Other (please list):

    i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ◯ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ◯ No

    If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

    Oregon's Public Health Division, Health Promotion and Chronic Disease Prevention Section (HPCDP) uses best practice standards from the Center's for Disease Control, Guide to Community Preventive Services. The Community Preventive Services Task Force, an independent, non-federal, volunteer body of public health and prevention experts, recommends several evidence-based community strategies to reduce harmful alcohol use. The Guide to Community Preventive Services systematically reviews the

effectiveness of population-based interventions to prevent excessive alcohol consumption and related health outcomes. The task force conducts a comprehensive meta-analysis of studies to determine recommended evidence-based population-level interventions.

These evidence-based strategies are included HPCDP's five-year strategic plan to address excessive drinking and harmful alcohol use. HPCDP's Strategic Council currently makes decisions regarding strategic priorities and evidence-based strategies. The Strategic Council is comprised of policy analysts, communications analysts and data and evaluation experts, in addition to the management team of the HPCDP.

Does the state have any activities related to this section that you would like to highlight?

The Health Promotion and Chronic Disease Prevention (HPCDP) section is working to integrate Oregon's alcohol and drug prevention funding, staff and projects into the Public Health Division (PHD) from the former Addictions and Mental Health (AMH) Division of the Oregon Health Authority. HPCDP is engaging a broad sector of statewide alcohol and drug partners to identify a sustainable means for an advisory body and mechanism for the planning and implementation the Alcohol and Drug Prevention and Education Program. Oregon currently coordinates with the Behavioral Health Prevention and Promotion (BHPP) Sub-Committee of the Addictions and Mental Health Planning and Advisory Council (AMHPAC) to advise on SABG primary prevention funds.

Oregon's legislature adopted SB 267 Evidence Based Programs (EBP) into law in 2003 requiring five state agencies to gradually increase the amount of funding allocated (75%) to evidence-based drug and alcohol prevention programs.

HPCDP continues to fund Counties and Tribes to implement evidence-based practices and strategies supported by SAMHSA's National Registry of Evidence-Based Programs and Oregon's Tribal Best Practices, which are practices based on evidence for Native American communities.

HPCDP is building capacity for alignment and clarity on evidence-based alcohol and drug prevention strategies through future development of an Alcohol and Drug Prevention Evidence Review Committee (ADPERC). The purpose of ADPERC is to review program efforts, data, resources, interventions, strategies, plans and evaluations for alcohol and drug prevention efforts in Oregon. The resulting consultation will inform the development and refinement of the comprehensive alcohol and drug prevention and education program in prioritizing evidence-based prevention strategies.

Please indicate areas of technical assistance needed related to this section.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

• *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

• *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

• *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

• *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

• *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

• *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) ∈ SSA staff directly implements primary prevention programs and strategies.

   b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) ∈ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) ∈ The SSA funds regional entities that provide training and technical assistance.

   e) ☒ The SSA funds regional entities to provide prevention services.

   f) ☒ The SSA funds county, city, or tribal governments to provide prevention services.

   g) ☒ The SSA funds community coalitions to provide prevention services.

   h) ∈ The SSA funds individual programs that are not part of a larger community effort.

   i) ∈ The SSA directly funds other state agency prevention programs.

   j) ∈ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

   Local interventions: Funds sub awardees (Counties, Tribes, non-profits and health equity coalitions) to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and drugs in all 36 Oregon Counties and 9 Tribes. Current strategies include: Awareness raising campaigns and activities about alcohol and drug risks, problems and solutions.

   Health Communications: Development of state media campaign through formative research on Oregonians' attitudes and beliefs about alcohol and other drugs. Create campaign material for communicating to Oregonians about risks, problems and solutions.

   b) Education:

   Local interventions: Funds sub awardees (Counties, Tribes, non-profits and health equity coalitions) to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and drugs in all 36 Oregon Counties and 9 Tribes. Current strategies include: local prevention education efforts.

c) Alternatives:

Local interventions: Funds sub awardees (Counties, Tribes, non-profits and health equity coalitions) to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and drugs in all 36 Oregon Counties and 9 Tribes. Current strategies include: Youth engagement and advocacy programs.

Tobacco Freedom Policy: Supports mental health and addiction treatment centers in Oregon with training and technical assistance to help them achieve and maintain 100% tobacco-free environments.

d) Problem Identification and Referral:

Assess Screening and Referral System: Assess quality and efficacy in alcohol screening and referral systems in primary care; Influence alcohol metrics for health system partners.

e) Community-Based Processes:

Local interventions: Funds sub awardees (Counties, Tribes, non-profits and health equity coalitions) to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and drugs in all 36 Oregon Counties and 9 Tribes. Funded examples include: Prevention coalition engagement; Community awareness raising activities; Collaboration with community partners and stakeholders.

Alcohol and Drug Prevention Integration: The Health Promotion and Chronic Disease Prevention (HPCDP) section is working to integrate Oregon's alcohol and drug prevention funding, staff and projects into the Public Health Division (PHD) from the former Addictions and Mental Health (AMH) Division of the Oregon Health Authority. HPCDP is engaging a broad sector of statewide alcohol and drug partners to identify a sustainable means for an advisory body and mechanism for the planning and implementation the Alcohol and Drug Prevention and Education Program.

f) Environmental:

Local Interventions: Funds sub awardees (Counties, Tribes, non-profits and health equity coalitions) to lead coordination and program management of local efforts to reduce the harms associated with alcohol, tobacco and drugs in all 36 Oregon Counties and 9 Tribes. Funded examples include: Community event policies; alcohol and tobacco retail and point of sale policies; Indoor Clean Air Act policy expansion; Tobacco 21 policy; Tobacco Freedom Policy (100% tobacco free environments); Raising the price of alcohol; Restrictions on alcohol marketing, promotion and retail environments; Maintenance of a controlled state to limit alcohol density.

Health Communications: Development of state media campaign through formative research on Oregonians' attitudes and beliefs about alcohol and other drugs. Create campaign material for communicating to Oregonians about risks, problems and solutions.

Tobacco Freedom Policy: Supports mental health and addiction treatment centers in Oregon with training and technical assistance to help them achieve and maintain 100% tobacco-free environments.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?   ⃝ Yes ⃝ No

If yes, please describe

Each biennium, counties and tribes complete and submit prevention implementation plans for approval and are awarded funding. These plans include the specific alcohol, tobacco and drug prevention programs, practices and strategies that the county or tribe intends to implement, and must be justified through the prevention plan activities. With the transition to the PHD, the planning and implementation of SABG funds and primary prevention strategies are supported through an integrated staff structure.
In this integrated model, HPCDP supports SABG sub awardees in a community programs model, regional support network. Sub awardees are grouped within regions and supported by a policy specialist, health system specialist, liaison, and research analyst. The community programs model established a system and process for sub awardee guidance and review of biennial alcohol, tobacco and drug prevention implementation plans.
Currently, a wide variety of strategies are conducted throughout Oregon's prevention system. Local prevention programs generally include a number of approaches used simultaneously, including: Coalition work; Multi-media campaigns; Awareness campaigns; Information and data collection; Multi-session prevention education programs; Alcohol and tobacco policy work such as creation of local ordinances; and Ongoing collaboration with community partners and stakeholders.
The Oregon PHD has a focus and priority on policies, systems and environmental change approach to substance abuse prevention and will be promoting evidence-based strategies that support this primary prevention approach.

Oregon also currently coordinates with the Behavioral Health Prevention and Promotion (BHPP) Sub-Committee of the Addictions and Mental Health Planning and Advisory Council (AMHPAC) to advise SABG funded primary prevention strategies are not funded through other means.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?　　　　　　　　　　　　　　　　　　　　　　j⌐ Yes　j⌐ No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

   a)　　ɓ　　Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks

   b)　　ɓ　　Includes evaluation information from sub-recipients

   c)　　ɓ　　Includes SAMHSA National Outcome Measurement (NOMs) requirements

   d)　　ɓ　　Establishes a process for providing timely evaluation information to stakeholders

   e)　　ɓ　　Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

   f)　　∈　　Other (please list:)

   g)　　∈　　Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a)　　ɓ　　Numbers served

   b)　　∈　　Implementation fidelity

   c)　　∈　　Participant satisfaction

   d)　　ɓ　　Number of evidence based programs/practices/policies implemented

   e)　　∈　　Attendance

   f)　　ɓ　　Demographic information

   g)　　∈　　Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

   a)　　ɓ　　30-day use of alcohol, tobacco, prescription drugs, etc

b)　　◉　　Heavy use

　　　　◉　　Binge use

　　　　◎　　Perception of harm

c)　　◉　　Disapproval of use

d)　　◉　　Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e)　　◎　　Other (please describe):

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

    For Oregon's Young Adults, ages 14-25, several systems and programs exist that enable them to live in the community at their highest potential. These include EASA, Young Adult Hub Programs, Youth M.O.V.E. Oregon, and the Housing-related services. All of these resources are designed to mitigate and stabilize any symptoms the young person is experiencing, identify strengths and barriers associated with their current circumstances, and provide enough coordinated peer, community, and behavioral health support to enable them to live as independently as they wish in the community of their choosing.

    • EASA addresses the young person's psycho-social needs holistically, allowing the young adult and their family access to a coordinated specialty team that can provide an array of necessary supports: Occupational therapy, supported education and employment, psychiatry, peer support, nursing, therapy, and case management. The goal of all of these specialties is the empowerment and self-determination of the youth.

    • Young Adult Hub Programs are a four-site pilot project designed to use outreach and engagement to connect young adults ages 17-25 to physical and mental health care. Hub programs are modeled after Australia's Headspace model for accessible and integrated service delivery and support. There are currently Hub programs in Clackamas-Multnomah-Washington, Lane, Deschutes -Jefferson-Crook, and Jackson Counties. The hub services are directed at young people who have:
    o Been diagnostically screened out of EASA (50% of referrals or approximately 1,000 young people/year in Oregon) or
    o Spent many years in state systems of care, such as juvenile justice, foster care and the homeless youth continuum and/or,
    o Been marginalized and disconnected due to extreme situational and social circumstances

    • Youth M.O.V.E. Oregon (YMO) is a young adult peer-centric organization with a national and statewide presence. YMO is the only 501(c) (3) non-profit under Youth M.O.V.E. National and is considered its leading state chapter, with direct services in most of Oregons major cities. YMO and its leaders continue to be well known and highly respected throughout the state and across the country for their efforts in youth advocacy. To assist and empower young adults as they work to navigate and improve youth-serving systems including (but not limited to):
    o Mental Health
    o Juvenile Justice
    o Education
    o Child Welfare
    o Addiction/Recovery
    o Foster Care
    • Youth M.O.V.E. Oregon (YMO) staff consult and provide training and technical assistance for youth-serving groups, organizations, and agencies nationally. They have extensive experience building, improving, and running youth/young adult programs and services, making them invaluable resources for new and evolving youth/young adult service providers. All YMO programs and services encourage the amplification of young adult voices on the local, state and national level. Young adults are encouraged to use the skills they learn to give back to their communities and advocate for system change. Above all, events, drop-in centers, and their respective programs are designed to be inclusive spaces where young people can feel safe, empowered, supported, and heard.
    Young Adult Residential Treatment Homes are located across the state. Residential services for young adults in transition (YAT) programs serve young adults ages 17 through 25 who have mental health challenges and who may have a history of institutional care. Residential resources for young adults include five young adult Secure Residential Treatment Facilities (SRTF), an alternative to state hospital level of care; seven young adult residential treatment homes (RTHs), as well as capacity for 51 young adults in supportive housing.
    • Transitional Supportive Housing focused specifically on meeting the housing, peer support and care coordination needs of youth 17-24. There are two programs currently serving this specific population, helping youth address housing barriers and make

healthy connection in communities in Lane and Marion Counties. These housing resources are integrated into both the local homeless youth continuum and the behavioral health service providers.

Juvenile Fitness to Proceed

Oregon's Juvenile Fitness to Proceed Program has statewide availability to provide Restorative Services as an outpatient service. Historically, these services were delivered solely at the adolescent psychiatric hospital. Oregon now diverts about 70 youth per year from facility-based care.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a)	Physical Health	⌐ Yes ⌐ No
b)	Mental Health	⌐ Yes ⌐ No
c)	Rehabilitation services	⌐ Yes ⌐ No
d)	Employment services	⌐ Yes ⌐ No
e)	Housing services	⌐ Yes ⌐ No
f)	Educational Services	⌐ Yes ⌐ No
g)	Substance misuse prevention and SUD treatment services	⌐ Yes ⌐ No
h)	Medical and dental services	⌐ Yes ⌐ No
i)	Support services	⌐ Yes ⌐ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	⌐ Yes ⌐ No
k)	Services for persons with co-occuring M/SUDs	⌐ Yes ⌐ No

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

For child and family Behavioral Health, Oregon doesn't have a consolidated case management "system", per se. Each service, program or practice incorporates its own case management element. As the Children's system's behavioral health investments evolve, there is evidence of emerging and consistent coordinated care regardless of the age of the service recipient. Care coordination is integrated into all aspects of specialty programs and services and present in the system of care development. Coordinated individualized care is evident in the elevation of peer support as a key treatment component and the development of child, youth, and family evidence-based and integrated approaches to care such as EASA, PCIT, Wraparound, and the ED diversion work.

Fidelity Wraparound is available to youth with Medicaid eligibility, the highest level of needs, and multi-system involvement (state specified criteria) and provides intensive care coordination. Through the CCO contract with OHA, and the implementation of Systems of Care, each region further define their own target population(s). CCOs serve youth involved in the justice system, child welfare, special education, substance use treatment, Intellectual and Developmental Disability services, youth who are medically fragile, and youth with intensive behavioral health needs. Some CCOs make Wraparound the model of care for all youth served who have intensive behavioral health needs and multi-systemic involvement. From July 2014 through 2016 the number of youth served in Wraparound increased steadily, doubling in the first nine months and steadily increasing thereafter. As of September 2016, 1535 youth were served.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Oregon has several investments linked to reducing Emergency Department boarding, psychiatric hospitalization, and lengthy hospital stays for children, youth and young adults.

• Legislation

o Oregon legislators and the governor passed several pieces of legislation in the 2017 session to address action items articulated in the Youth Suicide Intervention and Prevention Plan and across the lifespan. HB 3090 requires hospitals with emergency departments to provide certain services at release, including research-based suicide risk assessments, lethal means counseling, and safety planning. HB 3091 requires Medicaid managed care entities (Coordinated Care Organizations) and private insurers to pay for post ED discharge services, including those to reduce or manage suicide risk. Senate Bill 944
establishes a statewide management system to facilitate referrals to child/adolescent hospital level of care to improve access and timeliness.

• Emergency Department (ED) Diversion

o Eight locations in Oregon have implemented collaborative approaches to addressing youth acute psychiatric or behavioral health crises in emergency departments and within community crisis programs. These projects, started in early 2015, have already impacted the emergency department boarding levels and mitigated the need for higher levels of care and hospitalization in some

cases. Model and outcome development for this project is housed at Oregon Health and Sciences University (OHSU). The focus of the work is to assist OHA and the projects develop consistent standards of care and collect outcome data related to length of stay in hospitals, returns to hospitals during program participation, family stabilization, and connectivity with primary care and mental health providers. The emergency department data will enable the OHSU team to track visits across hospitals.

• Unity Center for Behavioral Health
o Unity provides 24-hour mental and behavioral health emergency services for adults and longer term inpatient mental health care for both adults and adolescents. The center is a joint effort between four major health organizations, and the first collaborative medical initiative of its kind in the Pacific Northwest.
o Staff at Unity initially address the immediate crisis, stabilizing the crisis and creating and coordinating an ongoing treatment plan to be utilized after discharge.
o Unity serves the Portland metropolitan area, alleviating overuse of four hospital emergency departments and wards.

• EASA
o Oregon's FEP program makes connections with young people and their families prior to and during the youth's stay in the hospital. Most sites have a direct connection with local hospitals and can be called upon to meet with the youth within 24 hours. Often this process can limit the young person's time in the hospital.

• Wraparound
o Current living arrangements of children in the Wraparound sites definitely improve and stabilize during participation in Wraparound services and supports. Twice as many children were living with family or other relatives, almost 2/3 fewer were in temporary foster care, and less than one-half as many were in psychiatric residential treatment. Better care is provided for children when their living arrangements are stabilized, and cost savings are gained when children are saved from being in costly residential treatment. Wraparound is a mechanism that can support children remaining in their homes in their communities when the local service array has the appropriate range of services and supports.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI		
2.Children with SED		

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	◯ Yes ◯ No
b)	Educational services, including services provided under IDE	◯ Yes ◯ No
c)	Juvenile justice services	◯ Yes ◯ No
d)	Substance misuse preventiion and SUD treatment services	◯ Yes ◯ No
e)	Health and mental health services	◯ Yes ◯ No
f)	Establishes defined geographic area for the provision of services of such system	◯ Yes ◯ No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

1. Describe your state's targeted services to rural and homeless populations and to older adults

Oregon is a state challenged by extreme geographic and economic diversity and disparity. The geographic majority of the state is rural and frontier, with great distances to cover and difficulties recruiting health care staff. Several efforts are underway to address disparities and create rural access to quality behavioral health care.
• OPAL-K
o Creating rural access to psychiatric care is one of the primary goals of the OPAL-K program. Nearly 1/3 of OPAL-K consultations are from rural or frontier communities. The figure below indicates the locations and types of providers enrolled in OPAL-K, evidencing the presence of the resource in the rural communities along the Oregon coast and in central and eastern portions of the state.
• Greater Oregon Behavioral Health Incorporated (GOBHI) is a managed care organization comprised of 15 county behavioral health entities providing care to families and children in frontier and rural communities. This consolidation and coordination of resources allows for cost savings and standards of care. GOBHI implements behavioral health care for two of the coordinated care organizations. The Oregon Health Authority, in coordination with GOBHI, funds training and on-going consultation in evidenced based early childhood mental health treatment. Treatment is often provided in the home or in early learning settings to reduce transportation barriers for families living in rural Oregon.

• The Children's System Advisory Council brings in members from rural sectors of Oregon and agencies that serve a variety of populations, including homeless youth and families, minority services providers, and tribal member organizations.

• Communities in rural and urban Oregon have unique strengths and challenges in responding to the crisis needs of families with children, youth and young adults. Only some communities have the capacity to respond with 24 hour mobile crisis teams. Many rely on crisis lines or suggest that individuals respond by going to their local emergency department to address an immediate psychiatric crisis. Pilots at 8 hospital emergency departments have been allocated funding to form a response team of clinical and family support staff to divert repeated use of the ED. The teams are designed provide interim services during the ED post-release time while waiting for psychiatric, clinically therapeutic, and family/youth support services through outpatient or less than hospital level of residential care.

• To address the need for expanded expertise in Early Childhood Mental Health, OHA has partnered with Portland State University (PSU) to offer a scholarship program through the PSU Infant Toddler Mental Health Graduate Certificate Program. During the Sept 2014 and June 2017 time period, 31 students received full scholarships to the one year program. In exchange for the scholarship, recipients agreed to work in agencies serving Medicaid eligible children 0-5 years old for at least one year. Scholarships were awarded based on the applicants' academic accomplishment, their experience, willingness to work in an agency serving Medicaid-eligible families of children 0-5 and, to those expressing a preference for serving in rural communities. 10 of the scholarship recipients are bilingual and/or are from a minority culture.

• The Oregon Health Authority is partnering with The Oregon Office of Rural Health at the Oregon Health Sciences University to provide financial assistance for early childhood education in a variety of mental health disciplines including counselors, psychiatrists, social workers and psychiatric nurses. Eight to ten applicants will be accepted into this loan repayment program. Applicants selected to receive loan repayment assistance must commit to practice for a period of 1 year in a site that serves at least 50% Medicaid-eligible clients.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The HSD biennial budget of $15,963,729,519.00 will be managed in two parts. The Superintendent of the Oregon State Hospital now reports directly to the Director of the Oregon Health Authority. The Oregon State Hospital employs over people and has a biennial budget of $995,681,956.00. The Health Services Division (HSD) manages the remaining federal and state funds. This new division includes member and provider services, compliance and regulation, including a contracting section, operations support and a section devoted to data systems. HSD contracts with community providers including thirty-six community mental health programs and the sixteen Coordinated Care Organizations.
The BH policy team is in Health Policy and Analytics under the Behavioral Health Director. Health Policy and Analytics also includes the Dental Director, Chief Medical Officer and Medicaid Director, Quality Improvement and Health Analytics team.

Local mental health authorities (LMHA) are typically comprised of the County Board of Commissioners, who are responsible for the management and oversight of the public system of care for mental illness, intellectual/developmental disabilities, and substance use disorders at the community level. Local mental health authorities must plan, develop, implement, and monitor services within the area served by the local mental health authority to ensure expected outcomes for consumers of services, within available resources.
Community mental health programs (CMHP) provide care coordination and treatment for people with mental illness, intellectual/developmental disabilities, and substance use disorders. Core services include screening, assessment, and referral to providers and community organizations, as well as emergency or crisis services. All members of a community can access core services from community mental health programs, subject to the availability of funds. These safety net and crisis services play a key role in the overall behavioral health system.
Oregon State Hospital provides an essential service to Oregonians who need longer term hospital level care, which cannot be provided in the community. For adults needing intensive psychiatric treatment for severe and persistent mental illness, hospital level care provides twenty four hour on-site nursing and psychiatric care, credentialed professional and medical staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational and educational services. The role of the hospital is to restore patients to a level of functioning that allows a successful transition back to the community.

System of Care Approach
Oregon is continuing to work on the development of a comprehensive system of care where the youths development is a global consideration throughout all aspects of care. Oregon strives to use NASADAD's youth treatment guide in the development of systems collaboration among youth-serving Agencies.

Oregon understands that Substance Use Disorders (SUDs) affect multiple aspects of the youth's life, including family, community, school, peers, etc. In order to the provide the best care for youth, it is important to acknowledge that youth are provided many services by other systems such as mental health, physical health care, Medicaid, child welfare, foster care, juvenile justice, education, and others. Youths' interactions across systems can afford an opportunity to link them to substance use disorder services when appropriate. Joint goals or missions, as well as interagency agreements or memoranda of understanding (MOUs), can help to facilitate cross-agency partnerships.

Treatment provider expectations:

• Providers will educate other systems or agencies on serves available to youth with substance use disorders and, similarly, seek out resources provided to youth by other systems or agencies to build partnerships and strong linkages.
• Providers will work with youth and their families to help them negotiate services across systems and coordinate referrals.
• For youth in residential treatment or correctional settings, a transition plan will be developed prior to their return to the community. This plan will include linkages to community-based agencies that will help address the youth's substance use disorder needs.
• Substance use disorder providers will coordinate case management with other systems, taking into account State and federal laws pertaining to disclosure of confidential client information.
• Providers will ensure that youth returning to community educational settings will meet with their treatment team and education officials to assist their transition back into school with consideration of their continuing clinical monitoring and recovery needs. This will include teaching educators about substance use disorders.

State training regarding EBP:

The State does not provide EBP trainings but we do have expectations that treatment programs utilize age and developmentally appropriate EBP for youth with Substance use disorder to maximize positive treatment outcomes. Oregon understands that EBPs are used most effectively when providers' treatment staff are trained and qualified to implement interventions with fidelity, so it is

expected that our treatment providers provide ample opportunities for staff training in this area. Oregon also allows for "promising practices" particularly because there is not an EBP that fits the need for every youth population needing to be served. Oregon stresses the importance that providers implement practices with the youth's and Family's cultural background in mind.

Provider Expectations:

• Providers will have an understanding of models and theories of substance use disorders as well as behavioral, psychological, physical, and social effects of psychoactive substances; they will also have knowledge/skills regarding current evidence-based and best practices for youth treatment.
• In order to use EBPs effectively, providers will ensure that staff members are adequately trained and qualified to implement the practices with fidelity.
• Provider personnel files will document training(s) and/or certification(s) in the evidence-based model(s) that the staff member is utilizing in the provision of youth services.
• Providers will be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is assured.
• Providers will utilize age, gender, developmentally, and culturally appropriate EBPs identified by SAMHSA and/or other national or State-level approved EBPs.
Evidence of Integration of SUD and MH services:

Oregon is continuing to work towards increasing SUD and MH integration, currently Oregon has several youth programs that are dually credential to treatment SUD and MH. Given the high prevalence of co-occurring SUD and MH, Oregon strives to ensure programs are equipped to screen youths' mental health issues and demonstrate an understanding of how identified mental illnesses interact with substance use disorders. Programs are also expected to provide developmentally appropriate and trauma-informed co-occurring substance use and mental health services onsite or address them through collaboration with community partners who are qualified youth-serving agencies with which linkages/care coordination has been established. Oregon is continuing to develop the full continuum of care (e.g., dual diagnosis capable/enhanced) and continue to strive to improve the services available to youth across the state, and strive to ensure equal access to similar services across the state.

Provider Expectations:

• Substance abuse treatment settings will include screening of co-occurring disorders at the time of intake as well as referrals for assessments that are specific to youth.
• Due to the prevalence of co-occurring mental health disorders in youth with substance use disorders, the providers will conduct ongoing assessments for mental health disorders in order to determine if the youth has a co-occurring mental health disorder.
• Comprehensive co-occurring treatment will address other contributing factors that may be implicated in the etiology of, treatment of, and recovery from co-occurring disorders (e.g., abuse, neglect, and domestic violence; familial substance and mental health issues; neighborhood, community, and peer factors; and legal, school, and vocational issues).
• Providers will support and encourage participation in integrated treatment and coordinated care for co-occurring disorders and work collaboratively among systems and services and family or other supportive adults as much as possible.

For child and family Behavioral Health, Oregon doesn't have a consolidated case management "system", per se. Each service, program or practice incorporates its own case management element. As the Children's system's behavioral health investments evolve, there is evidence of emerging and consistent coordinated care regardless of the age of the service recipient. Care coordination is integrated into all aspects of specialty programs and services and present in the system of care development. Coordinated individualized care is evident in the elevation of peer support as a key treatment component and the development of child, youth, and family evidence-based and integrated approaches to care such as EASA, PCIT, Wraparound, and the ED diversion work.
Fidelity Wraparound is available to youth with Medicaid eligibility, the highest level of needs, and multi-system involvement (state specified criteria) and provides intensive care coordination. Through the CCO contract with OHA, and the implementation of Systems of Care, each region further define their own target population(s). CCOs serve youth involved in the justice system, child welfare, special education, substance use treatment, Intellectual and Developmental Disability services, youth who are medically fragile, and youth with intensive behavioral health needs. Some CCOs make Wraparound the model of care for all youth served who have intensive behavioral health needs and multi-systemic involvement. From July 2014 through 2016 the number of youth served in Wraparound increased steadily, doubling in the first nine months and steadily increasing thereafter. As of September 2016, 1535 youth were served.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

    a) A full continuum of services

        i)   Screening   j Yes j No

        ii)   Education   j Yes j No

        iii) Brief Intervention   j Yes j No

        iv)   Assessment   j Yes j No

        v)   Detox (inpatient/social)   j Yes j No

        vi)   Outpatient   j Yes j No

        vii) Intensive Outpatient   j Yes j No

        viii) Inpatient/Residential   j Yes j No

        ix)   Aftercare; Recovery support   j Yes j No

    b) Are you considering any of the following:

        Targeted services for veterans   j Yes j No

        Expansion of services for:
        (1)   Adolescents   j Yes j No

        (2)   Other Adults   j Yes j No

        (3)   Medication-Assisted Treatment (MAT) j Yes j No

Narratve Question

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?   ⦿ Yes ⦿ No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services?   ⦿ Yes ⦿ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?   ⦿ Yes ⦿ No

4. Does your state have an arrangement for ensuring the provision of required supportive services?   ⦿ Yes ⦿ No

5   Are you considering any of the following:

    a)   Open assessment and intake scheduling   ⦿ Yes ⦿ No

    b)   Establishment of an electronic system to identify available treatment slots   ⦿ Yes ⦿ No

    c)   Expanded community network for supportive services and healthcare   ⦿ Yes ⦿ No

    d)   Inclusion of recovery support services   ⦿ Yes ⦿ No

    e)   Health navigators to assist clients with community linkages   ⦿ Yes ⦿ No

    f)   Expanded capability for family services, relationship restoration, custody issue   ⦿ Yes ⦿ No

    g)   Providing employment assistance   ⦿ Yes ⦿ No

    h)   Providing transportation to and from services   ⦿ Yes ⦿ No

    i)   Educational assistance   ⦿ Yes ⦿ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Oregon Health Authority (OHA) Compliance Specialists complete regular site reviews to ensure that programs meet requirements as described in the administrative standards, including those corresponding to women's treatment services. OHA revised the addiction and mental health administrative rules governing these services. The rule requirements for women's treatment services were developed by an advisory committee comprised of clients, partners from various regions of the state, and policy analysts. The rules are based on best practice guidelines that aim to address the holistic recovery needs of women and their families within an integrated and trauma-informed framework. The administrative rules strive to promote family-centered treatment through the endorsement of collaborative care principles and culturally competent practices.

Contracts between OHA and the counties, tribes, and direct contractors require that pregnant women and women with children must be prioritized.

Oregon conducts onsite reviews of each licensed residential program at a minimum of every two years, and approved outpatient programs at a minimum of every three years. The reviews evaluate each program's compliance with administrative rules that require specific programming applicable for this population. Services must include gender specific treatment, including care for issues such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems and prenatal care. Programs are reviewed to evaluate compliance with administrative rule requirements to provide or coordinate services that meet special access needs such as childcare, mental health services, and transportation.

Providers are required to submit Monitoring of Treatment Services (MOTS) enrollment and status update data on all clients served in publicly funded treatment programs licensed by OHA. In addition to general demographic information at enrollment (drug use, level of impairment, income, employment status, living arrangements, and arrest history) the MOTS system collects whether or not the client is pregnant at admission and the number of dependent children in the household.

In addition to on-site reviews and capacity reporting requirements, OHA's Women's Services Coordinator conducts technical assistance events, quarterly meetings, frequent check-ins with programs and community partners, and coordinates with Child Welfare to ensure PWWDC have priority access to treatment and wrap around services.

Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

    a) 90 percent capacity reporting requirement   ◯ Yes ◯ No

    b) 14-120 day performance requirement with provision of interim services   ◯ Yes ◯ No

    c) Outreach activities   ◯ Yes ◯ No

    d) Syringe services programs   ◯ Yes ◯ No

    e) Monitoring requirements as outlined in the authorizing statute and implementing regulation   ◯ Yes ◯ No

2. Are you considering any of the following:

    a) Electronic system with alert when 90 percent capacity is reached   ◯ Yes ◯ No

    b) Automatic reminder system associated with 14-120 day performance requirement   ◯ Yes ◯ No

    c) Use of peer recovery supports to maintain contact and support   ◯ Yes ◯ No

    d) Service expansion to specific populations (military families, veterans, adolescents, older adults)   ◯ Yes ◯ No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

    The HSD Licensing and Certification Unit complete onsite compliance reviews in accordance with OAR 309-008-0700, OAR 415-012-0050, and OAR 415-050-0010. The purpose of the reviews is to verify that state approved providers are fulfilling the requirements set forth in applicable administrative rules and statutes. During the onsite reviews, compliance specialists use the following sources of information to determine whether the provider is complying with regulations that govern activities and services to PWID and tuberculosis services:

    • Review of policies and procedures that are related to activities and services to PWID.
    • Review of policies and procedures related to tuberculosis screening and referral services.
    • Review of the medical protocols that are approved by the agency's Medical Director.
    • Interview with the agency's Medical Director.
    • Interview with agency's director and program managers.
    • Interview with SUDs treatment staff.
    • Interview with line staff.
    • Interview with clients.
    • Review of screening protocol to ensure that priority populations are given advanced admission.
    • Review of Service Records, including Assessments, Service Plans, Service Notes, and Transfer Plans.
    • Review of forms used to complete infectious disease risk screening.
    • Review of written educational and referral materials that SUDs treatment staff provide to PWID and those at risk of tuberculosis exposure.

    Corrective actions required to address identified problems: HSD compliance specialists complete summary reports within 30 days of the onsite review and submit these to the agency's director. The compliance reports contain detailed descriptions of findings of noncompliance with administrative standards and include specific instructions on corrective action requirements. The agency's director is required to submit to the HSD compliance specialist a plan of correction (POC) within 30 days from receiving the report. The POC must include a detailed summary of the activities that will be completed, timeline for corrections, and the name of all staff who are responsible for implementing and monitoring each corrective activity.

    HSD compliance specialists may also require the director to include with the POC documents to fulfill corrective action requirements. Such documents may include:

    • Updated policies and procedures that are related to activities and services to PWID.
    • Updated policies and procedures related to tuberculosis screening and referral services.
    • Records to show that staff have received training on services to PWID.
    • Records to show that staff have received training on tuberculosis screening and referral services.

• Revised forms that will be used to complete infectious disease risk screening.
• Agendas and minutes from the quality improvement committee meetings to ensure that activities and services to PWID and tuberculosis screening and referral are being carried out in accordance with the agency's policies, medical protocol, and OAR requirements.
• A written list of resources that SUDs treatment and support staff will provide to clients.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?   ◯ Yes ◯ No

2. Are you considering any of the following:

   a) Business agreement/MOU with primary healthcare providers   ◯ Yes ◯ No

   b) Cooperative agreement/MOU with public health entity for testing and treatment   ◯ Yes ◯ No

   c) Established co-located SUD professionals within FQHCs   ◯ Yes ◯ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The HSD compliance specialists may include in the onsite review reports recommendations on strategies that the agency's director can implement to remediate all areas of noncompliance with administrative standards. Corrective activity recommendations given by the HSD compliance specialist may include:

   • Revision of the agency's policies and procedures in the areas of services to PWID and tuberculosis screening and referral.
   • Review and approval of the updated medical protocol by the agency's Medical Director.
   • Revision of the agency's infectious disease risk screening form.
   • Creation of a written resource list that SUDs treatment staff will provide to clients.
   • Delivery of in-service and/or off-site trainings to SUDs treatment and support staff to build knowledge and skills in services to PWID and infectious disease risk assessment and reduction.
   • Increased clinical supervision focused on helping counselors develop counseling competencies in the area of services to PWID, infectious disease risk assessment and reduction, and tuberculosis screening and referral services.
   • Increased assessment and oversight by the agency's quality assessment committee to monitor whether activities and services to PWID and tuberculosis screening and referrals are being carried out in accordance with the agency's policies, medical protocol, and OAR requirements.
   • Implementation of chart auditing by the agency's supervising and quality assurance teams.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery?   ◯ Yes ◯ No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas   ◯ Yes ◯ No

   b) Establishment or expansion of tele-health and social media support services   ◯ Yes ◯ No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS   ◯ Yes ◯ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C§ 300x-31(a)(1)F)?   ◯ Yes ◯ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?   ◯ Yes ◯ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?   ◯ Yes ◯ No

   If yes, plese provide a brief description of the elements and the arrangement

Narratve Question

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independant Peer Review

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement   ⊙ Yes ○ No

2. Are you considering any of the following:

   a) Workforce development efforts to expand service access   ⊙ Yes ○ No

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services   ⊙ Yes ○ No

   c) Establish a peer recovery support network to assist in filling the gaps   ⊙ Yes ○ No

   d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities)   ⊙ Yes ○ No

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations   ⊙ Yes ○ No

   f) Explore expansion of service for:

        i) MAT   ⊙ Yes ○ No

        ii) Tele-Health   ⊙ Yes ○ No

        iii) Social Media Outreach   ⊙ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?   ⊙ Yes ○ No

2. Are you considering any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services   ⊙ Yes ○ No

   b) Establish a program to provide trauma-informed care   ⊙ Yes ○ No

   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education   ⊙ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)   ⊙ Yes ○ No

2. Are you considering any of the following:

   a) Notice to Program Beneficiaries   ⊙ Yes ○ No

   b) Develop an organized referral system to identify alternative providers   ⊙ Yes ○ No

   a) Develop a system to maintain a list of referrals made by religious organizations   ⊙ Yes ○ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?   ⊙ Yes ○ No

2. Are you considering any of the following:

   a) Review and update of screening and assessment instruments   ⊙ Yes ○ No

   b) Review of current levels of care to determine changes or additions   ⊙ Yes ○ No

c)	Identify workforce needs to expand service capabilities	☐ Yes ☐ No
d)	Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background	☐ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☐ Yes ☐ No

2. Are you considering any of the following:

a)	Training staff and community partners on confidentiality requirements	☐ Yes ☐ No
b)	Training on responding to requests asking for acknowledgement of the presence of clients	☐ Yes ☐ No
c)	Updating written procedures which regulate and control access to records	☐ Yes ☐ No
d)	Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure	☐ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☐ Yes ☐ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

3. Are you considering any of the following:

a)	Development of a quality improvement plan	☐ Yes ☐ No
b)	Establishment of policies and procedures related to independent peer review	☐ Yes ☐ No
c)	Develop long-term planning for service revision and expansion to meet the needs of specific populations	☐ Yes ☐ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? ☐ Yes ☐ No

   If YES, please identify the accreditation organization(s)

   i)   ⊖   Commission on the Accreditation of Rehabilitation Facilities

   ii) ⊖   The Joint Commission

   iii) ⊖   Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?   ᴊₙ Yes ᴊₙ No

2. Are you considering any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service   ᴊₙ Yes ᴊₙ No

   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing   ᴊₙ Yes ᴊₙ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state   ᴊₙ Yes ᴊₙ No

   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services   ᴊₙ Yes ᴊₙ No

   c) Preformance-based accountability   ᴊₙ Yes ᴊₙ No

   d) Data collection and reporting requirements   ᴊₙ Yes ᴊₙ No

2. Are you considering any of the following:

   a) A comprehensive review of the current training schedule and identification of additional training needs   ᴊₙ Yes ᴊₙ No

   b) Addition of training sessions designed to increase employee understanding of recovery support services   ᴊₙ Yes ᴊₙ No

   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services   ᴊₙ Yes ᴊₙ No

   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort   ᴊₙ Yes ᴊₙ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations regarding women   ᴊₙ Yes ᴊₙ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

   a) Tuberculosis   ᴊₙ Yes ᴊₙ No

   b) Early Intervention Services Regarding HIV   ᴊₙ Yes ᴊₙ No

3. Additional Agreements

   a) Improvement of Process for Appropriate Referrals for Treatment   ᴊₙ Yes ᴊₙ No

   b) Professional Development   ᴊₙ Yes ᴊₙ No

   c) Coordination of Various Activities and Services   ᴊₙ Yes ᴊₙ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?   j⌐ Yes j⌐ No

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

[Trauma](60) is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?   ◯ Yes ◯ No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?   ◯ Yes ◯ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?   ◯ Yes ◯ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?   ◯ Yes ◯ No

5. Does the state have any activities related to this section that you would like to highlight.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?   ⌐ Yes ⌐ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?   ⌐ Yes ⌐ No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?   ⌐ Yes ⌐ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?   ⌐ Yes ⌐ No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?   Yes No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women?   Yes No

3. Does the state purchase any of the following medication with block grant funds?   Yes No

   a) ∈ Methadone

   b) ∈ Buprenophine, Buprenorphine/naloxone

   c) ∈ Disulfiram

   d) ∈ Acamprosate

   e) ∈ Naltexone (oral, IM)

   f) ∈ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately?   Yes No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

   *Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

---

[64]http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65]Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention

   a) ∈ Wellness Recovery Action Plan (WRAP) Crisis Planning

   b) ∈ Psychiatric Advance Directives

   c) ∈ Family Engagement

   d) ∈ Safety Planning

   e) ∈ Peer-Operated Warm Lines

   f) ∈ Peer-Run Crisis Respite Programs

   g) ∈ Suicide Prevention

2. Crisis Intervention/Stabilization

   a) ∈ Assessment/Triage (Living Room Model)

   b) ∈ Open Dialogue

   c) ∈ Crisis Residential/Respite

   d) ∈ Crisis Intervention Team/Law Enforcement

   e) ∈ Mobile Crisis Outreach

   f) ∈ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

   a) ∈ WRAP Post-Crisis

   b) ∈ Peer Support/Peer Bridges

c)   ∈   Follow-up Outreach and Support

d)   ∈   Family to Family Engagement

e)   ∈   Connection to care coordination and follow-up clinical care for individuals in crisis

f)   ∈   Follow-up crisis engagement with families and involved community members

g)   ∈   Recovery community coaches/peer recovery coaches

h)   ∈   Recovery community organization

4.   Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;

- Recovery is person-driven;

- Recovery occurs via many pathways;

- Recovery is holistic;

- Recovery is supported by peers and allies;

- Recovery is supported through relationship and social networks;

- Recovery is culturally-based and influenced;

- Recovery is supported by addressing trauma;

- Recovery involves individuals, families, community strengths, and responsibility;

- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses

- Drop-in centers

- Recovery community centers

- Peer specialist

- Peer recovery coaching

- Peer wellness coaching

- Peer health navigators

- Family navigators/parent support partners/providers

- Peer-delivered motivational interviewing

- Peer-run respite services

- Peer-run crisis diversion services

- Telephone recovery checkups

- Warm lines

- Self-directed care

- Supportive housing models

- Evidenced-based supported employment

- Wellness Recovery Action Planning (WRAP)

Whole Health Action Management (WHAM)

- Shared decision making

- Person-centered planning

- Self-care and wellness approaches

- Peer-run Seeking Safety groups/Wellness-based community campaign

- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?   ◯ Yes ◯ No

   b) Required peer accreditation or certification?   ◯ Yes ◯ No

   c) Block grant funding of recovery support services.   ◯ Yes ◯ No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

   Yes.

2. Does the state measure the impact of your consumer and recovery community outreach activity?   ◯ Yes ◯ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Parent-Child Interaction Therapy (PCIT)
   PCIT is an empirically supported treatment for young children with significant emotional and behavioral disorders. It is focused on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT provides live practice for parents through coaching with a wireless communication device by the therapist who views the parent and child (ages 2-7) through a one way mirror. It teaches parents to develop a warm, responsive relationship with their children, to selectively reinforce pro-social and adaptive behavior while also learning to safely and consistently provide developmentally appropriate consequences to change children's negative behaviors. The average length of treatment is 16-20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during the course of treatment.

   Preliminary research indicates PCIT can be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum who are high functioning, children who have experienced chronic trauma, families who are involved with child welfare because of harsh physical discipline, and mother-child dyads following episode(s) of domestic violence. In 2008, four counties began to implement PCIT. During 2014, based on the Oregon PCIT quarterly reports from the original sites, a large expansion of PCIT services was begun. Between January 1st 2014 and June 30th, 2017 the number of PCIT programs receiving financial support for training and high fidelity implementation of PCIT has grown from 4 locations to 36 locations in 18 counties, with another county starting a PCIT program in August of 2017.

   The Oregon Health Authority supports high fidelity implementation of PCIT. PCIT provides live practice for parents through coaching with a wireless communication device, by the therapist who views the parent and child (ages 2-7) through a one way mirror. PCIT is sometimes provided in women's residential substance use disorder treatment centers and early learning settings. 1,596 Oregon children received services in PCIT programs during the 18 months ending 12/31/2016. After their fourth PCIT session Caregiver-Child Pairs are considered engaged in services. 1,095 pairs reached engagement before closing. 85 percent of them (930 pairs) demonstrated improvement in one or more of these areas:
   • Caregiver-Child Relationship
   • Positive Communication Skills
   cores on the Eyberg Child Behavior Inventory, a standardized measure of disruptive behaviors in young children.
   For Adults and Addictions:
   Act
   Choice Model
   Peer Delivered Services Core Team
   Specialized Training areas for PDS
   Office of Consumer Activities
   OSH – Recovery Planning
   County level and local programs that serve specific populations
   Tribal Support programs
   OSH – PDS
   The state recognized use of the Declaration of Mental Health Treatment (a psychiatric advance directive (PAD) for consumers as part of self-direction.

   The Oregon Health Authority supports high fidelity implementation of PCIT. PCIT provides live practice for parents through

coaching with a wireless communication device, by the therapist who views the parent and child (ages 2-7) through a one way mirror. PCIT is sometimes provided in women's residential substance use disorder treatment centers and early learning settings. 1,596 Oregon children received services in PCIT programs during the 18 months ending 12/31/2016. After their fourth PCIT session Caregiver-Child Pairs are considered engaged in services. 1,095 pairs reached engagement before closing. 85 percent of them (930 pairs) demonstrated improvement in one or more of these areas:
• Caregiver-Child Relationship
• Positive Communication Skills
• Scores on the Eyberg Child Behavior Inventory, a standardized measure of disruptive behaviors in young children.

4.   Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Oregon treatment providers strive to ensure that recovery support services begin at the inception of services (e.g., assessment, treatment and recovery planning) and continue after discharge from or completion of an individuals primary treatment episode. Continuing care and support services emphasize the importance of the continuity of the relationship between the individual and the treatment provider and reflect the multiple pathways to recovery based on the individual's delf-direction using their unique strengths, needs, preferences, experiences, and developmental stage. Participation in continuing care and recovery support services is based on the needs of the individual and their support preferences as identified through an ongoing process of clinical monitoring,self-reassessment and self- direction.
Treatment provider expectations:
• Providers will provide continuing care and ongoing support in the individual's community.
• Providers will focus on strategies to help support the maintenance of the individual's long-term wellness and recovery.
• Clinical monitoring and care will encompass efforts to develop skills for the individual to cope with their substance use such as recognition and management of triggers that may interfere with the individual's ecovery (relapse prevention) and to intervene after a lapse or setback in order to prevent a full relapse (relapse management).
• When possible and as appropriate, recovery management checkups (e.g., a discussion with the individual on their recovery) will be ongoing and target continued client skill building, relapse prevention, problem solving, and the therapeutic alliance between provider and individual.
• Providers will be aware that individuals with co-occurring disorders may be discharged from substance abuse services while still receiving services for mental health disorders and will still continue with substance abuse-related activities and recovery support services.
• Continuing care will be supported through the use of technology when available or as appropriate (e.g., web-based applications, e-mail, text messages, etc.)
• The provider will work with the individual and their supports to determine services that will aid in the understanding of the continuum of care and provide services that assist in the maintenance of the individual's recovery.
Use of Peer Delivered Services:

OAR definitions of PSS, PWS, FSS, YSS, Recovery Coach, Peer Mentor, Peer Support, Peer Support Supervisor, and Traditional Health Worker.
The use of a peer is a structured, one-to-one relationship or partnership that focuses on the needs of the individual. In the State of Oregon peers are individuals with personal lived experience with mental health, addiction, family, or youth recovery that help guide or assist the other individuals in their treatment and recovery. These services can include non-clinical, peer-based activities that engage, educate, and support individuals in making life changes necessary for recovery. Peers appropriately highlight their personal lived experience with recovery to build rapport, efficacy, and meaningful interactions with the individual receiving services. Oregon requires specific certifications and protocols for the provision of Peer delivered services (PDS), protocols and certification reviewed by the OHA Peer Delivered Services Core Team and administered by OHA Office of Equity and Inclusion's Traditional Health Worker Registry.
Treatment Provider Expectations:
• Providers will help individual's gain the skills to build/maintain positive relationships with non-drug users. This can be done through peers that facilitate participation in mutual aid groups and/or connecting the individual with prosocial activities.
• Peers will assist in the provision of advocacy, access to services, systems navigation, outreach, and support to continuing with treatment and/or recovery support services.
• Peers will assist in guiding the individual through treatment, recovery support services, and in transitioning to a life of recovery in the community.
• Providers will utilize services and supports that foster social connectedness, such as peer support, and the use of specialized recovery supports, such as electronic media and internet-based tools.
• Providers will create or connect individuals (should the individual choose) to opportunities to become recovery coaches and peer mentors as a way to give back to their community while bolstering their recovery and self-efficacy.
• Providers will partner with the educational system to develop, expand, and refer individuals for support to peer recovery networks in schools and colleges when possible.
• Peers will have the appropriate supervision as determined by the State of Oregon, and the credentialing body.

Access to Recovery (ATR): Access to Recovery (ATR) is a three-year $2.3 million per year competitive grant that was secured by OHA in May 2015. This is part of a federal initiative supported by SAMHSA and the Center for Substance Abuse Treatment (CSAT) to develop person-centered, community-based services to those seeking recovery. ATR emphasizes participant choice by supporting the individual's decision about what services they believe will be helpful to their recovery, as well as where they would like to receive such services. ATR has bipartisan federal support and requires service linkages to include faith-based and community-

based organizations that receive payment for services through an electronic voucher management system.

ATR is currently operating in five counties: Multnomah, Clackamas, Washington, Marion, and Lane. Any individual 18 years or older who lives in the identified counties, has a serious substance use condition, and seeks supportive services to help them enter or maintain recovery is eligible for ATR services. Oregon is prioritizing active military or returning veterans, parents mandated to Child Welfare services, young adults in transition, individuals exiting a higher level of care, including withdrawal management or residential treatment, and individuals transitioning to communities from corrections institutions who have substance use disorders. The total number of unique individuals to be served over the project period of May 2015 to April 2018 is 3,723.

5.   Does the state have any activities that it would like to highlight?

The Office of Consumer Activities PLN
The work of the PDS Core Team regarding PDS best practices
The work of the Behavioral Collaborative
Office of Consumer Activities

Please indicate areas of technical assistance needed related to this section.

• Peer Run Organizations (PROs) need TA on how to establish and run a business, everything from board selection to taxes, documentation and negotiating a contract with CCOs, providers, and others
• TA for all stakeholders on grant writing
• PROs need TA on federal funding and what they can and can't spend money on and others who may be administering those funds
• How to effective advocate at local, statewide and national level
• We need TA regarding the rules and guidelines regarding mandatory reporters and ideas about mitigating the unintended consequences of background checks and best practices or development
• Working with Police and restorative justice system
• Facilitation of some of the OHA-HSD policies and PDS services collaboration to solve some of those system barriers (example: MOTS system calls for PSS/PWS to enter a diagnostic code which is not best practice or legal.
• How to include problem gambling recovery in the system, especially funding

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1.   Does the state's Olmstead plan include :

      housing services provided.   Yes   No

      home and community based services.   Yes   No

      peer support services.   Yes   No

      employment services.   Yes   No

2.   Does the state have a plan to transition individuals from hospital to community settings?   Yes   No

3.   What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:
1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);

- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

    a) The recovery and resilience of children and youth with SED?   ◉ Yes ◯ No

    b) The recovery and resilience of children and youth with SUD?   ◉ Yes ◯ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

    a) Child welfare?   ◉ Yes ◯ No

    b) Juvenile justice?   ◉ Yes ◯ No

    c) Education?   ◉ Yes ◯ No

3. Does the state monitor its progress and effectiveness, around:

    a) Service utilization?   ◉ Yes ◯ No

    b) Costs?   ◉ Yes ◯ No

    c) Outcomes for children and youth services?   ◉ Yes ◯ No

4. Does the state provide training in evidence-based:

    a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?   ◉ Yes ◯ No

    b) Mental health treatment and recovery services for children/adolescents and their families?   ◉ Yes ◯ No

5. Does the state have plans for transitioning children and youth receiving services:

    a) to the adult behavioral health system?   ◯ Yes ◉ No

    b) for youth in foster care?   ◯ Yes ◉ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Wraparound and Systems of Care in Communities
• Intensive case coordination is available through fidelity Wraparound to youth with Medicaid eligibility, the highest level of needs, and multi-system involvement. Youth with co-occurring mental health and substance use disorders often fit this criteria. Some CCO's make Wraparound the model of care for all youth served who have intensive behavioral health needs and multi-systemic involvement.

• Wraparound teams include formal supports, such as mental health, peer support, SUD treatment professionals, juvenile justice, child welfare, and natural supports identified by the youth and family such as extended family, friends, 12-step sponsor or a member of the faith community. Participation in Wraparound teams by Family and Youth Support Specialists (peers) is a hallmark of Oregon's best practice model. These peers are qualified through both training and lived experience including, in many cases, recovery from substance use disorders and experience with local SUD systems and recovery community and serve both to link families to resources and provide support to parent's own recovery.

• Substance Abuse specialists and programs are also welcome to participate in the children's System of Care governance structure.

On the state's Children's System Advisory Council, there is a designated seat for an AOD provider and for a family member in recovery from substance abuse. The provider is also a member of CSAC's executive committee.

• Gaps and challenges in the system remain. Treatment availability and breadth for co-occurring disorders in youth is a limited resource in Oregon, even when providers identify the need. Additionally, many young people with intense and persistent mental health challenges such as chronic anxiety, depression, ADHD, bi-polar disorder and schizophrenia develop substance use disorders to manage their symptoms. Providers must then adopt a harm-reduction model, which is useful in some but not all cases. There are not age specific detoxification services for adolescents and young adults in Oregon.

Several of Oregon's Child and Family Behavioral Health investments promote integration of physical primary care and mental health as core service model elements.
First Episode Psychosis (FEP)
• EASA (Early Assessment and Support Alliance), the FEP system in Oregon, requires a nurse as a member of each EASA team as an element in their fidelity. Access to a primary care provider is also key and EASA participants' physical well-being is supported and monitored throughout their participation in the service. Of particular note is the monitoring of Metabolic Syndrome, which can be a precursor to diabetes and cause other physical health issues.

Psychotropic Medication Prescribing Oversight
• Children with complex behavioral and emotional challenges may require psychotropic medication for effective treatment in combination with psychosocial strategies and supports. Oregon has created a range of strategies to ensure monitoring of prescribing practices and created improved consultation for primary care providers in managing these medications:

? The Oregon Health Authority developed prescribing flags as part of an effort to identify prescribing patterns which may indicate the need for oversight. In 2015, 210 youth entered Wraparound and received services for six months or longer. Of these, fifteen children were identified to trigger pharmacy flags within the 35 days preceding their first Progress Review (90 days), representing 7.1% of the total of 210 clients. Six months after entry, 22 children were identified. Among these children were 12 from the first group and another 10 children who were not flagged at entry.
? OPAL-K (Oregon Psychiatric Access Line about Kids) was implemented in June 2014 in partnership with Oregon Health and Science University, Oregon Pediatric Society, and the Oregon Council of Child and Adolescent Psychiatry. OPAL-K, a telemedicine consultation service, provides a physician-to-physician consultation system, linking child psychiatry expertise with primary care providers (PCPs), to improve integration and quality of children's mental health and physical health care. Currently there are over 1200 Oregon physicians and health practitioners that participate in OPAL-K.
Commercial Sexual Exploitation of Children (CSEC)
• OHA partners with multiple agencies to address issues related to the sex trafficking
industry in Oregon. We fund and monitor a residential treatment facility for 12-16 girls who have been victims of commercial sexual exploitation. This involves pairing primary care interventions with mental health and substance use treatment. A primary initiative of this program is to serve the victims holistically.

• OHA is also a participant on the statewide CSEC Advisory Council and is currently involved in developing a subcommittee to engage the primary care system in screening for and recognizing potential trafficking victims. In the next year, OHA will facilitate a process for determining and disseminating the best practices for primary care providers in disrupting CSEC issues.
Intensive Treatment Services
• Oregon is currently working to improve our highest levels of mental health care. This includes continuing to analyze our service delivery to individuals with complex needs and pairing our residential providers with primary care specialists to ensure all of the medical needs of our children and families are met.
Forensic Programs
• Oregon has in place multiple collaborative programs with the juvenile justice system.
OHA coordinates the service delivery and potential conditional release of youth under
the jurisdiction of the Juvenile Psychiatric Security Review Board (JPSRB). The
JPSRB is responsible for the custody of youth who have been found Responsible
Except for Insanity in the juvenile court. This involves coordinating necessary
treatment related to each youth's individual needs. Oregon has the ability to provide
medical services and substance abuse interventions, in a very flexible manner as
required by the JPSRB.

• Oregon also has beds in our Secure Adolescent Inpatient Program (SAIP) for youth
offenders committed to the custody of the Oregon Youth Authority. These beds are for youth committed to closed custody facilities who experience psychiatric crises. This includes assessing for, and making appropriate referrals for, substance abuse programs and Intellectual/Developmental Disabilities services.

Integration of Behavioral Health and Primary Care
• Oregon intentionally regards healthcare as holistic, exemplified by the addition of the Certified Community Behavioral Health Clinics (CCBHCs) implementation and the creation of Coordinated Care Organizations (CCOs). CCOs, as the Medicaid entities in Oregon, are expected to respond to both the physical and behavioral needs of their members. As of January 2017, Oregon Health Authority contracts with Oregon's 15 Coordinated Care Organizations (CCOs), which serve Oregon Health Plan (Medicaid)

members to provide fidelity Wraparound to qualifying youth and families. Each CCO locally determines who will deliver care coordination in their community. Care coordination may be done by CCO staff, community (county) mental health programs (CMHP), Certified Community Behavioral Health Clinics or subcontracted to one of the CMHP's contracted providers.

• Ongoing efforts to cross-train primary care providers and physical health institutions about child and family mental health are increasing in Oregon. Pediatricians and primary care physicians in Oregon are receiving materials and information about early childhood mental health, suicide assessment, safety and access to lethal means, and depression, among other specific issues.

• The Oregon Pediatric Society and community providers work with primary care clinics to integrate routine mental health screening within primary care to increase early detection of mental health issues in adolescents, and provide appropriate follow-up. Statewide consultation services and training are provided for primary care providers and clinics in use of adolescent depression and substance use screening tools such as the Patient Health Questionnaire (PHQ-9) and SBIRT.

Suicide Prevention

• The Oregon Pediatric Society expanded its START provider training program to include suicide risk assessment, safety planning and lethal means counseling in classroom trainings and webinars in 2017–2019.

• One hundred experts in suicide prevention and intervention volunteered to work with the Oregon Health Authority (OHA) to develop the Oregon Youth Suicide Intervention and Prevention Plan for 2016–2020 to address the risk and protective factors that influence youth suicide. The 100 stakeholders volunteering for the planning process include the following: parents and youth, behavioral and physical health providers and school-based health centers. Volunteers also include coordinated care organizations (CCOs) and private insurers, schools, hospitals, and OHA tribal liaisons and military representatives.

• OHA's county Garrett Lee Smith grantees and the CCOs have offered a range of trainings to parents, communities and physical and behavioral health providers to increase awareness about youth suicide and build skills in working with at-risk youth. Grantees currently are considering advancing implementation of the Good Behavior Game in their local elementary schools.

Oregon Administrative Rule (OAR 309) now requires behavioral health services clinical providers to ensure access to PDS for families with children and youth. This makes it possible for Family Support Specialists (FSS) to be members of emergency department follow-up teams. It is anticipated that Family Support Specialists will also be added to outpatient teams, including CCBHC, EASA, FQHC, and School-Based Health Center. There is a more acute need to offer Family Support Specialist services to families before they have access to regular behavioral health. When PDS were offered in one community with three FSS, in the community, all 93 families were able to maintain without having to utilize crisis teams and hospital emergency departments until they could access outpatient services in 3-6 weeks after the initial contact with the FSS.

Oregon is integrating Coordinated Specialty Care teams in all counties using a standard model of care supported by the EASA Center for Excellence at Oregon Health & Science University and Portland State University. Services are delivered by local teams which are based on ACT standards of intensity (approx.. 1:10 clients per fte), including Qualified Mental Health Professional counselors, psychiatrists or psychiatric nurse practitioners, supported employment and education specialists, as well as RN nurses, peer support specialists and occupational therapists. Teams coordinate services through weekly meetings and deliver population-level community education, rapid access and outreach, assessment, treatment and transition planning. Specific ebps embedded in Oregon's CSC model include Individual Placement and Support (IPS) supported employment and education, multi-family psychoeducation following the Anderson/McFarlane model, feedback-informed treatment, Cognitive Behavioral Therapy for psychosis, Motivational Interviewing and differential diagnosis treatment, shared decision making, low-dose prescribing, and elements of Assertive Community Treatment. The model is iterative and the Center for Excellence is charged with its continual development based on data, feedback and emerging evidence.

3. Oregon has a centralized training and fidelity review process which all sites participate in. In addition, teams receive support from the Oregon Supported Employment and Education Centers for Excellence and the ACT Center for Excellence. Individualized treatment planning and physical health integration are part of both training and fidelity review. Locally, several sites have integrated on-site primary care, but all sites integrate coordination and support for accessing primary care providers.

7.   Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ◯ Yes ◯ No

2. Describe activities intended to reduce incidents of suicide in your state.

   One hundred experts in suicide prevention and intervention worked with OHA to develop the Oregon Youth Suicide Intervention and Prevention Plan for 2016–2020 to address the risk and protective factors that influence youth suicide. The plan was modeled after the research-based National Strategy for Suicide Prevention (NSSP), and has the aspiration goal of Zero Suicide. The plan is customized to meet the unique needs of Oregonians. Building connections for youth with adults and peers, increasing resilience, promoting life-affirming decision-making skills, and improving access to quality care are all included in the design. Those that made up the 100 stakeholders volunteering for the planning process included the following: parents and youth, behavioral and physical health providers and school-based health centers. Volunteers also include coordinated care organizations (CCOs) and private insurers, schools, hospitals, and OHA tribal liaisons. Volunteers were also made up of LGBTQ youth and young adults, representatives of minority communities, individuals who had attempted suicide, and individuals who had survived the loss of a loved one. Other agencies that worked with OHA were the Department of Human Services Child Welfare, Oregon Department of Education, Oregon Youth Authority, Oregon Department of Veteran Affairs, the U.S. Veterans Affairs Administration, and the Oregon Army and Air National Guards. The representatives of these groups and systems called for Zero Suicides in Oregon through collective action among health systems, schools, communities, parents and other systems that touch the lives of youth. As indicated in the plan, the newly formed Oregon Alliance to Prevent Suicide (chartered in September 2016), to oversee implementation and monitor progress on the 117 action items in the plan. The Youth Suicide Intervention and Prevention Plan is available at http://www.tinyurl.com/hr94228.

3. Have you incorporated any strategies supportive of Zero Suicide? ◯ Yes ◯ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◯ Yes ◯ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ◯ Yes ◯ No

   If so, please describe the population targeted.

   If so, please describe the population targeted.

   As specified in the Plan, the Oregon Alliance to Prevent Suicide is responsible for establishing a public policy agenda for suicide prevention and intervention for children and youth age 0-24. Committees of the Alliance launched on September 2016 and include:
   • Continuity of Care
   • Workforce Development
   • Outreach and Awareness
   • Policy and Legislation and
   • Data and Evaluation.
   A separate committee reviews Alliance initiatives for cultural responsiveness to the needs of groups at disproportionate risk of suicide. Those high-risk groups include LGBTQ youth, military members, veterans and their families, Native Americans and other minorities. It also includes those who have lost a loved one to suicide (bereavement survivors) or those who have attempted suicide (attempt survivors), who are at high risk of suicide themselves. These groups are represented on the Alliance and additional stakeholders will be included in developing activities to address the needs of these populations in 2017-2018. The Suicide Intervention Coordinator and Zero Suicide Coordinator also are working with adult behavioral health programs to

identify training opportunities for providers, especially those serving middle-age and older adults.

A Zero Suicide Coordinator was hired by OHA in 2017 to provide technical assistance and coordinate Zero Suicide initiatives at Oregon hospitals and health systems. At least 6 hospitals and health systems are in various stages of adopting Zero Suicide and others have expressed interest in proceeding. Five specific counties funded with Garrett Lee Smith Memorial Act grant dollars are working with their local hospitals and other partners to pursue Zero Suicide. Zero Suicide also is an aspirational goal of the Plan. Work is underway by the coordinators and other stakeholders to expand the aspirational goal to all Oregon communities.

The Plan addresses needed improvements to discharge and safety planning for youth leaving emergency or inpatient care. Recommendations include 48-hour check in calls continuing until a patient enters outpatient care, standardizing protocols and policies for discharge planning that includes families and services by traditional health workers, and uniform standards for research-informed, best practice suicide risk assessments, suicide safety plans and lethal means counseling as directed in the Plan. The expectation is for the Alliance to make recommendations in 2017 on a potential pilot project for follow up "caring contacts," including phone calls, emails, letters, etc., after discharge from an emergency department. Additionally, the Oregon Health Authority enacted rules for psychiatric emergency services and community mental health program crisis services in 2016, including best practices in safety planning, lethal means counseling and risk assessment.

Work on this activity also includes OHA's Emergency Department Diversion pilot projects. Pilot projects across the state are testing interventions that can divert suicidal youth and their families from repeated emergency department visits for suicidal ideation or attempts and facilitate transitions to outpatient care. A focus of the project is providing family support services at and after ED discharge.

In addition, the Children's System Advisory Council began preparing health literacy materials for families to ensure safety after their youth are released from an emergency department. The materials also will provide guidance on transitions to outpatient care. The council plans to complete the materials in 2017.

OHA has assisted a diverse work group formed by state Rep. Alissa Keny-Guyer to address discharge planning for suicidal patients at release from emergency departments. This work resulted in HB's 3090 and 3091 passed in the 2017 legislative session. Rulemaking is underway for 3090, which requires hospital EDs to adopt and implement discharge planning processes for people in behavioral health crisis, including suicide prevention interventions. 3091 requires private insurance and Medicaid to pay for an array of post-discharge services, including traditional health workers.

The Alliance and other stakeholders have started examining laws on confidentiality to promote information sharing across systems (mental health, substance use treatment and schools) and with families and families of choice, to ease the transitions from medical care to school. OHA worked with the Oregon Athletic Coaches Association on a year-long program to raise awareness of suicide risk and warning signs among school coaches, athletic trainers and athletic directors.

Does the state have any activities related to this section that you would like to highlight?

The following is a summary of the actions OHA has taken since the Youth Suicide Intervention and Prevention Plan 2016-2020 was adopted in January 2016:
• OHA, legislators and the governor passed several pieces of legislation in the 2017 session to address action items articulated in the Youth Suicide Intervention and Prevention Plan and across the lifespan. These included:
o SB 48 to advance continuing education in suicide risk assessment, management and treatment among physical and behavioral health providers and school counselors;
o SB 719 creating a system for obtaining extreme risk protection orders for individuals at risk of suicide or threat to others;
o HB 3090 to require hospitals with emergency departments to provide certain services at release, including research-based suicide risk assessments, lethal means counseling, and safety planning;
o HB 3091 to require Medicaid managed care entities (called Coordinated Care Organizations) and private insurers to pay for post ED discharge services, including those to reduce or manage suicide risk;
o SB 944 to establish a statewide management system to facilitate referrals to child/adolescent hospital level of care to improve access and timeliness.
• Best practices for community providers: OHA promulgated rules for psychiatric emergency services and crisis response services by community mental health programs (CMHPs) to include best practices in suicide risk assessment, lethal means counseling and safety planning. OHA is disseminating information to providers and agencies statewide on the research-based Columbia Suicide Severity Rating Scale, Counseling on Access to Lethal Means, and Suicide Safety Planning. Technical assistance also is being offered. The School Based Health Clinics at schools across the state will be trained in the Columbia Suicide Severity Rating Scale in the fall of 2017. Community stakeholders also funded in-person classes in the Portland and Eugene metropolitan areas.
• Education for families: The Children's System Advisory Council began developing health literacy materials for families whose children go to emergency departments for suicide crises and are discharged to their homes.
• Understanding impact of trauma: Trauma Informed Oregon began work on materials analyzing impacts of trauma and suicide. The organization is updating its trainings to include trauma and suicide.
• Training for pediatrician practices and school based health center staff: The Oregon Pediatric Society began expanding its START provider training program to include suicide risk assessment, safety planning and lethal means counseling in classroom trainings and webinars in 2017–2019.

• Safe online spaces: Through a contract and funding from OHA, Lines for Life, Youth MOVE Oregon, Reachout.com, a team of youth and other stakeholders began developing a youth-informed strategic plan, due by September 2017, to promote safe online spaces for youth.

• Reporting and information-sharing: SB 561 (2015), which mandates post-suicide information-sharing and postvention response activities in all Oregon counties, was implemented. Rules were promulgated in 2016.

o Forty-four suicides of individuals 24 years of age and younger were reported to OHA within seven days of death in 2016, as required by law. As the program ramped up in 2016, OHA identified communities with disproportionate suicide rates and provided technical assistance, including funding for Sources of Strength and CONNECT:

o Two pilots of the Sources of Strength peer-led school prevention and resiliency program began in the Albany and North Clackamas school districts with OHA funding.

o Four pilot sites were identified based on the number of youth suicides in 2016 and funded for the best practice CONNECT suicide postvention training program: Linn-Benton-Lincoln, Umatilla, Yamhill and Malheur counties. All four sites will implement CONNECT by fall 2017. The pilots are being evaluated by the University of Oregon to determine effectiveness and impact. Based on that study, funding for statewide implementation will be considered.

• Raising public awareness: OHA's county grantees and Medicaid managed care organizations (CCOs) have offered a range of trainings to parents, communities and physical and behavioral health providers to increase awareness about youth suicide and build skills in working with at-risk youth. Grantees currently are considering advancing implementation of the Good Behavior Game in their local elementary schools.

• With SAMHSA administered Garrett Lee Smith funding, OHA is funding trainings in best practice ASIST, QPR, AMSR and other gatekeeper programs. Additional state funds are supporting Mental Health First Aid.

• The Public Health Division created a web-based platform for suicide data that includes death, hospitalizations and survey data readily accessible to planners and the public. The platform also contains a storyboard that describes the problem of suicide. This platform was presented to Public Health and OHA leadership, and the Alliance. There is potential to add additional data to this platform as data sources become available. The dashboard is available at:

http://www.oregon.gov/oha/PH/DISEASESCONDITIONS/INJURYFATALITYDATA/Pages/nvdrs.aspx#dashboard

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?   ⊙ Yes ○ No

2. Has your state identified the need to develop new partnerships that you did not have in place?   ⊙ Yes ○ No

   If yes, with whom?

   Oregon Health Authority is currently making a renewed/expanded effort to partner more effectively with child welfare in meeting a capacity crisis for children and youth needing residential or more intensive levels of care, to prevent children from being cared for in motels and other undesirable arrangements. There is a significant shortage of appropriate and licensed foster care homes in the state.
   Related to the foster care crisis, is the issue of intensive service capacity. Addressing the gaps in this critical system also require expanded and focused partnerships across state systems-Department of Human Services and the Oregon Youth Authority specifically. It has also necessitated a targeted collaboration between providers of these intensive services and the state agencies.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   Oregon Health Authority, through expanded mental health investments in 2013, has become a leader in the area of trauma informed care throughout the state. The partnership with Portland State University, and their center named Trauma Informed Oregon, has gathered national attention, and is highly sought within the state for training and resources about trauma informed care. Interest in trauma informed schools was spawned by legislation in 2015, creating two trauma informed pilot schools (high schools) in an effort to reduce chronic absenteeism. The pilot is ending its first year and a report is being written summarizing the first year (not available at the time of this report). Measurement tools have been used to assist in the analysis of the success of the pilots.

The statewide System of Care Wraparound Initiative also promotes the coordination and collaboration of all systems to produce the best possible outcomes in the least restrictive settings for children and young adults who meet eligibility criteria. School systems are an integral part of these efforts.

OHA is currently in the process of analyzing and reforming Oregon's residential treatment system. A major aspect to this work is identifying more ways to serve youth in their home community, instead of in facility-based care. Oregon is working with community partners with the goal of developing more in-home intensive outpatient services that supply equivalent levels of supervision and psychiatric care without requiring a youth to be moved from his or her community.

The Oregon legislature has recently taken action to reduce the use of residential facilities to serve youth found Unfit to Proceed in Oregon's Juvenile Court. Oregon Senate Bill 49, which just passed in the 2017 legislative session, allows Restorative Services to be provided to youth in the least restrictive environment corresponding to medical necessity. OHA is pleased to be able to provide these services in community based settings.

Does the state have any activities related to this section that you would like to highlight?

Initiatives developed locally in the Portland Metro Tri-County and in Marion County are Intellectual /Developmental Disability /Mental Health collaborations. Gaps in resources, training and trained professionals to meet the needs of youth with these co-occurring health and intellectual disabilities have been identified across the state.

This group will convene 150 professionals, stakeholders, families and consumers again for the fifth time in October 2017 to continue discussion on breaking down barriers between these two child serving systems with a greater focus on treatment application and evidence based practice. Originally designed as a local convening, the annual event now draws attendees from across the state of Oregon.

The reformation of Oregon Intensive treatment Services is a noteworthy effort to improve the mental health outcomes for children and their families. Currently, Oregon's lack of intensive service capacity (PRTS/Subacute) is resulting in youth being placed in inappropriate settings such as hotels, emergency departments, detention centers and homes without adequate mental health supports.

Efforts to address the intensive services capacity decline over the past 18 months have not been successful. Oregon's largest provider of PRTS/Subacute care, Trillium Family Services, reported on March 1, 2017 that there were 95 children and youth referred to PRTS/Subacute programs with no current openings. Out of those 95 referrals, 60 were for younger children. All other programs were also at capacity with a backlog of referrals. (There is additional information at http://www.oregon.gov/oha/bhp/Pages/Behavioral-Health-Collaborative.aspx)

Gaps remain in the system in the following areas:
• Increase in numbers of youth with intensive needs relative to treatment options.
• Utilization Management (UM) criteria and processes are inconsistent among CCOs causing confusion among state agencies with custody of youth needing care and PRTS/Subacute providers.
• Not enough providers to meet demand.
• Long wait times between acceptance and admission.
• Lengthy appeals/hearings process within OHA.
• Alternative services are limited by what is available in the community.
• Discharge options are limited by what is available in the community and state wide step down options.
• Gaps in service availability impact the Guardian's (DHS) ability to provide safe and appropriate residential placement to meet the needs of the youth.
• Use of General Funds to cover intensive mental health services for individuals who have private health insurance. This is related to the fact that some private insurance providers do not cover certain intensive mental health services.

The short-term plan includes the following steps:
• Immediately assess residential homes on hospital campuses in Salem and Junction City through partnership with DHS, to provide temporary shelter for youth and utilize if needed
• Increase the fee for service reimbursement rates
• Continue to track capacity, scrutinize outcomes and monitor current needs of the system
• Make CCO contract changes to ensure quality care of the youth with the highest intensity service needs and allow for a more centralized system of care for those youth.
• Enhance Technical assistance to CCOs and partner agencies to ensure quality care coordination and avoid children's unmet behavioral health needs causing a youth to enter into an inappropriate placement and reduce trauma
The longer term plan contains the following key objectives:
• Implement detailed capacity management system to track current capacity, trends and movement between intensive levels of care.
• Conduct regular rate analyses annually to ensure providers have a sufficient reimbursement rate to continue to provide this critical service.
• Work with CCOs and partners regarding incorporating the children's mental health residential services under the capitated rates.
• Complete System of Care governance structure implementation at the state level to include CCOs, Providers, Family, Youth and Agency Partners to discuss and manage capacity issues with Intensive Treatment Services and within the entire System of Care.
• Incentivize development of community based intensive outpatient services and supports which are data driven and have demonstrated outcomes connected to higher rates of school attendance, college entrance and workforce contribution later in life and lower likelihood of truancy, delinquency and incarceration.
• Increase the quality of high fidelity Wraparound, which hinges on holding CCOs accountable for Best Practices, further

investment, by CCOs into behavioral health services, the use of data from the recommended metrics to incentivize the development of intensive outpatient services including intensive in home models, and thoughtful and thorough discharge planning during transitions out of intensive behavioral health covered services with adequate notice given to the guardian or other residential care provider.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72]http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The AMHPAC reviews the state priorities and whether the chosen indicators for the biennium reflect those priorities. AMHPAC also reviews whether needs and gaps within the system have been missed int he needs assessment. Each AMHPAC subcommittee, also does a detailed dive into the chosen indicators and whether they address the full spectrum of BH care: prevention and promotion, treatment, recovery, and housing & Olmstead.
   This BG application, cycle, due to lack of time, and as per instruction from SAMHSA, the Oregon AMHPAC will review the BG indicators on September 14th at the next AMHPAC Full council and subcommittee meeting.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i   ● Yes ● No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)?   ● Yes ● No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   Goal of AMHPAC: To educate, advocate and advise OHA for optimal quality of life for all Oregonians by the promotion of mental and behavioral wellness.
   Gathering meaningful input: AMHPAC has specific duties as required by the Behavioral Health Block Grant. These duties are:
   1. Provide input on the State Plan for Behavioral Health Services (Block Grant application) by monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state.
   2. Advocate for children, youth, young adults, adults and older adults experiencing behavioral health disorders
   3. Assess the adequacy and allocation of behavioral health services at least annually.

   membership and Input:
   1. AMHPAC membership shall consist of no more than 49% service providers and state employees.
   2. AMHPAC members shall be appointed by, and serve at the discretion of the Behavioral Health Director.
   3. The Behavioral Health Director shall consider nominations by AMHPAC prior to filling a vacant seat on the Council.
   4. Representatives of state agencies will be recommended by their agency Director and appointed by the Behavioral Health Director .
   5. At a minimum, AMHPAC shall consist of the following seats:
   • One representative of the Psychiatric Security Review Board

- One representative of the Oregon Department of Corrections
- One representative of the Oregon Health Authority Public Health Division
- One representative of the Department of Human Services Vocational Rehabilitation Division
- One Representative of Health Systems DivisionOne representative of the Oregon Youth Authority
- One representative of the Department of Human Services Aging and People with Disabilities Division
- One representative of the Department of Human Services Child Welfare Programs
- One representative of the Oregon Department of Education
- One representative of Oregon Housing and Community Services
- One representative of a Federally Recognized Tribe
- One representative of the Oregon Consumer Advisory Council
- One representative of the Children's System Advisory Council
- Two representatives of Coordinated Care Organizations
- Two mental health services providers
- Two substance use disorder treatment providers
- Two behavioral health promotion or prevention providers
- One problem gambling treatment services provider
- One problem gambling prevention services provider
- Four behavioral health advocates
- Two adults who are in recovery from a mental health disorder
- Two adults who are in recovery from a substance use disorder
- Two adults who are in recovery from problem gambling
- Two young adults in transition who are in recovery from a behavioral health disorder
- Four family members of children with a serious emotional disorder
- Two family members of children with a substance use disorder
- Two family members of an adult with a behavioral health disorder

AMHPAC meets every other month and the subcommittees create their work plans based on input form providers and consumers. After teh full council reviews subcommittee input, they forward a final recommendation with votes, to OHA leadership with specific action items for implementation.

Does the state have any activities related to this section that you would like to highlight?

AMHPAC has been critical in providing input for the Oregon behavioral Health Collaborative Legislative order. AMHPAc members have served as stakeholders in the Workforce workgroup, Standards and Competencies workgroup, and Peer Delivered Services workgroup.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018   End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Etta Assuman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1122 NE Kelly Ave Apt 123 Gresham OR, 97030	assuman.mae76@gmail.com
Nichole Bain	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		19355 SW 65th Ave, number 99 Tualatin OR,	ilovepenguins805@gmail.com
Ross Banister	Providers		P.O. Box 11 Roseburg , 97470	rsbanister@aol.com
Paula Bauer	State Employees	Oregon Youth Authority	530 Center St NE Salem OR, 97301-3765 PH: 503-373-7528 FX: 503-373-1511	paula.bauer@state.or.us
Michelle Brandsma	Parents of children with SED		PO Box 518 Dallesport WA, 98617	michelle.brandsma@gobhi.net
Juliet Britton	State Employees	Psychiatric Security Review Board	620 SW 5th Avenue Portland OR, 97204 PH: 503-229-5596	juliet.britton@psrb.org
Lisa Butler	Parents of children with SED		1300 Broadway Street NE Suite 403 Salem OR, 97301	lisa.butler@ofsn.net
Cheryl Cohen	Providers		Broadway Plaza Building Portland OR, 97201	cheryl@healthshareoregon.org
Steve Comella	Others (Not State employees or providers)		2713 Creighton St. Woodburn OR, 97071	nwtsteve@gmail.com
Rodney Cook	Providers	Clackamas County Health, Housing and Human Services	Public Services Building, CYF Oregon City OR, 97045 PH: 503-650-5677	rodc@co.clackamas.or.us
Caroline Cruz	Federally Recognized Tribe Representatives	Confederated Tribes of Warm Springs	PO Box C Warm Springs OR, 97761 PH: 541-553-0497	caroline.cruz@wstribes.org
Rebecca Eichhorn	Family Members of Individuals in Recovery (to include family members of adults with SMI)		8515 Highway 47 Carlton OR, 97111 PH: 503-852-0056	eichhorn4@hotmail.com
Michael Fernandez	Family Members of Individuals in Recovery (to include family members of adults with SMI)		234 Laural Drive Roseburg OR, 97471	mauied3802@gmail.com

Kevin Fitts	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1969 NW Johnson Street Apt 230 Portland , 97209	lonefir@gmail.com
Michael Gardner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4936 Oceana Drive Florence OR, 97439	mgardneror@gmail.com
Ken Hetsel	Others (Not State employees or providers)		745 Harris St. SE Salem OR, 97302	mentalhealthconsumer1@gmail.com
Matthew Holland	Others (Not State employees or providers)		1356 Pressler Court S Salem OR, 97306 PH: 541-971-1657	matt@synergisticreations.com
Debby Jones	Providers	YOUTH:Think	4575 Basalt Street The Dalles OR, 97058 PH: 541-506-2673	debbyj@co.wasco.or.us
Anthony Kennedy	Others (Not State employees or providers)		2975 Timberline Drive Eugene , 97405	ANTHONYKENNEDY@PITT.EDU
Karen Kern	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		537 SW Valerie View Dr. 306 Portland , 97225	k.b.kern@sbcglobal.net
Stephen Kliewer	Providers		PO Box 218 Joseph OR, 97885	Stephen.kliewer@gobhi.net
Ally Linfoot	Parents of children with SED		2051 Kaen Road Oregon City OR, 97045	alinfoot@clackamas.us
Lana McGregor	Providers	Coordinated Care Organization - AllCare	740 SE 7th Street Grants Pass OR, 97527	Lana.McGregor@allcarehealth.com
Kathleen McNeill	Providers		3436 Blueblossom Dr. Medford OR, 97504	mchar5@msn.com
Dawnell Meyer	State Employees	Oregon Department of Corrections	2575 Center Street NE Salem OR, 97301 PH: 503-378-5524	dawnell.l.meyer@state.or.us
Joe Miller	State Employees	Department of Human Services - Vocational Rehabilitation	500 Summer Street NE, E-87 Salem OR, 97301 PH: 503-945-6375 FX: 503-947-5010	JOSEPH.W.MILLER@state.or.us
Tim Murphy	Providers	Bridgeway Recovery Services	PO Box 17818 Salem OR, 97305 PH: 503-363-2021	tmurphy@bridgewayrecovery.com
Kathryn Nunley	State Employees	Department of Human Services - Aging and People with Disabilities	500 Summer Street NE Salem OR, 97301 PH: 503-947-2309	kathryn.m.nunley@state.or.us
Tammi Paul	Parents of children with SED		1300 NE Broadway Street, number 403 Salem OR, 97301	tammip@ofsn.net
Tanya Pritt	Others (Not State employees or providers)		2143 Meadows Place SE Albany , 97322	tanyampritt@msn.com

Ruth Riskedahl	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		29500 SW Montebello Dr Wilsonville OR, 97070 PH: 503-505-3953	ruthriskedahl@yahoo.com
Denna Sanders	Providers		2704 Ferndale Drive Portland OR,	dennas@laurel.org
Ron Sipress	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PO Box 368 Medford OR, 97501 PH: 541-774-3636	ronsipress@gmail.com
Jennifer Versteeg	Providers		36 SW Nye Street Newport , 97365	Jversteeg@co.lincoln.or.us
Luke Walters	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 22413 Portland OR, 97269	rev.luke@earthlightproject.org
Jeremy Wells	State Employees	Oregon Department of Education	255 Capital St NE Salem OR, 97310-0203 PH: 503-947-5634	jeremy.wells@state.or.us
Theresa Wingard	State Employees	Oregon Housing & Community Services	Public Affairs Division Salem OR, 97301	Theresa.Wingard@oregon.gov
Wes Wood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Voices of Problem Gambling Recovery	10128 SE Clatsop St Portland OR, 97266 PH: 503-481-9197	wcwbrn2bld@gmail.com
Jay Wurscher	State Employees	Department of Human Services - Child Welfare	500 Summer Street NE Salem OR, 97301 PH: 503-945-6634	jay.m.wurscher@state.or.us

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018   End Year: 2019

Type of Membership	Number	Percentage
Total Membership	46	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	24	
State Employees	8	
Providers	10	
Federally Recognized Tribe Representatives	1	
Vacancies	3	
Total State Employees & Providers	22	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Persons in recovery from or providing treatment for or advocating for substance abuse services	6	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
Planning council is yet to make recommendations to the application.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

    a) Public meetings or hearings?   ● Yes ○ No

    b) Posting of the plan on the web for public comment?   ● Yes ○ No

    c) Other (e.g. public service announcements, print media)   ● Yes ○ No

    If yes, provide URL:

    The state of Oregon, following SAMHSA's instructions, will be posting the application on the OHA website for public comment in September. Public will be allowed to comment till the grant is awarded.
    Please look for the URL to be uploaded in this section as part of our revisions in September.

Footnotes: