Oregon

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 12/10/2021 1.41.31 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 2022

End Year 2023

State SAPT DUNS Number

Number 964093350

Expiration Date

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 Steven

Last Name Allen

Agency Name Oregon Health Authority, Health Systems Division

Mailing Address 500 Summer Street NE E-65

City Salem

Zip Code 97301-1118

Telephone 503-947-5539

Fax 503-945-5872

Email Address steven.j.allen@dhsoha.state.or.us

State CMHS DUNS Number

Number 964093350

Expiration Date

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 Steve

Last Name Allen

Agency Name Oregon Health Authority Health Policy and Analytics

Mailing Address	500 Summer Street NE, E-86
City	Salem
Zip Code	97301-1118
Telephone	503-449-7643
Fax	503-947-5546
Email Address	steven.j.allen@dhsoha.state.or.us

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	9/1/2021 12:52:35 AM
Revision Date	12/10/2021 1:41:10 PM

VI. Contact Person Responsible for Application Submission

First Name	Rusha
Last Name	Grinstead
Telephone	5412502148
Fax	
Email Address	rusha.grinstead@state.or.us

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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**
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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**
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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

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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Steve Allen

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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

KATE BROWN
Governor

April 23, 2019

Virginia Simmons, Grants Management Specialist
Division of Grants Management OPS
SAMHSA
1 Choke Cherry Road, Room 7–1091
Rockville, MD 20857

RE: Oregon's Combined Block Grant Application

Dear Ms. Simmons:

This letter is regarding the state of Oregon's combined application for funds under the Mental Health Services and Substance Abuse Prevention and Treatment Block Grants. I have designated the Behavioral Health Director for the Health Systems Division to sign the set of agreements that certify Oregon's compliance with requirements for receiving the Block Grants on my behalf. The Behavioral Health Director position will be filled April 29, 2019 by Steve Allen.

Sincerely,

Kate Brown

Governor Kate Brown

cc: Kimberly A. Beniquez, MS, CADC, CCDPD, SAMHSA
Ernest Fields, SAMHSA
Patrick M. Allen, OHA
Margie Stanton, OHA
Jon C. Collins, PhD, OHA
Rusha Grinstead, OHA
File

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

State Information

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

Fiscal Year 2022

U.S. Department of Health and Human Services
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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**
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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.
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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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Steve Allen

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.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

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.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
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f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
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2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

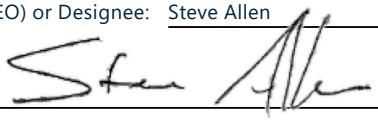
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Steve Allen

Signature of CEO or Designee[1]: 

Title: Behavioral Health Director

Date Signed: 08/31/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Oregon is grateful and excited for the opportunity to have supplemental Block Grant funds from the American Rescue Plan Act (ARPA) available to address the surge in behavioral health needs of Oregonians directly or indirectly from COVID-19. In addition, like the rest of the country, COVID-19 has also revealed the gaps in the behavioral health system as it stood before the pandemic. Over the time period of March September 2021 to October 2025, Oregon plans to invest a significant portion of the supplemental Mental Health BG funds in policies and programs that will lead to long term foundational changes in the BH system in the state. The areas of improvement will include our First Episode Psychosis program, and the Crisis System.

AREAS OF INVESTMENT

Oregon Health Authority (OHA) has identified the priority areas for mental health where investment would make a high impact. However, OHA is yet to consult with the Addiction and Mental health Planning and Advisory Council (AMHPAC) before making specific program and policy decisions. The AMHPAC is the mandatory behavioral health advisory council in Oregon required under the MHBG. However, since Oregon had decided to make the cultural shift to integrate addiction and mental health under the umbrella of BH, both SAPT and MH Block Grant fund relate decisions need to be vetted by AMHPAC.

A) 988 and the Crisis Service Delivery System: $10,567,962.75

Oregon plans to use a significant portion of the ARPA supplemental MHBG funds, including the 5% Crisis Services set aside, to implement the national Guidelines for crisis service system aka the Crisis Now Model. This will also help Oregon develop the foundational infrastructure needed in a crisis system to support successful roll out of 988 in 2022. Oregon plans to implement the three components of crisis now:

1. High Tech Air Traffic Control model centralized crisis call center
2. 24/7 centralized mobile crisis dispatch
3. Crisis Stabilization program

Oregon has hired a consultant, RI International, who is helping the State implement the Crisis Now model and has estimated a total start-up cost of up to $163,000,000 to establish crisis stabilization centers including the workforce. This means, Oregon will need every available resource to invest in the crisis system to start providing this valuable service. OHA wants to create a standardized rule for what crisis stabilization centers should look like in the state and how many should we have. In that process, OHA also plans to identify what services associated with CSCs can be reimbursed through Medicaid (with or without a waiver).

Mobile Crisis: Since 2016, Oregon has a Mobile Crisis program operating in each of the 36 counties, funded through County Fiscal Award Agreements. These services are provided by mental health practitioners who respond to behavioral health crises onsite in the community and provide face to face therapeutic response. The goal of Mobile Crisis services is to help individuals resolve psychiatric crises in the most integrated setting possible, and to avoid unnecessary hospitalization, commitment, arrest, or incarceration. Each county develops their own Mobile Crisis service model dependent upon the needs and resources of the community. The Oregon Health Authority does not mandate a specific program framework and does not

specifically require coordination with Lifeline call centers. To support our 988 system, Oregon will need to either centralize and/or standardize the mobile crisis teams across the state. The supplemental BG funds will help stand the teams up and invest in the workforce required to build the team. In addition, not all services provided by the mobile crisis teams are not covered by Medicaid at the moment such as On call 24/7 (capacity-based services, like fire and EMS); non-client-facing services; pre-commitment investigations and other services adjacent to crisis, examiner fees, documentation time, training/consulting with law enforcement, and coordination with legal counsel; and response to crisis events for hospital inpatient clients. Supplemental BG funds will help Oregon implement the Firehouse model for mobile crisis response.

Technology to support a coordinated crisis system is also another area of priority and investment for Oregon. With the anticipated launch of 988 nationwide, Oregon needs to conduct a technology needs assessment including electronic health information sharing capacity assessment to identify gaps in in information coordination, gathering and sharing across the continuum of crisis services. Block Grant funding will also help finance planning and implementation of the technology identified through the assessment.

Oregon intends to use a portion of the supplemental BG funds to implement a statewide media and marketing campaign for 988. This campaign will have strategies targeted towards specific communities who are anticipated to benefit most from the concept of 988 including BIPOC communities, providers and businesses, community partners, and Oregonians in general. This will be a four-year media and marketing campaign to socialize 988 across the state.

Crisis stabilization services*:* All counties across the state have contracts with OHA to function as the mental health safety net, providing crisis assessment, intervention, and referral services no matter the payer of those services. If a client is a part of an ACT team, then the ACT team intervenes with that client during the crisis and through any acute hospitalization. If mobile crisis can intervene on scene with the client, with and without law enforcement, that is then preferred through the crisis; case management services then engage and care coordinate with clients through acute hospitalization. Crisis stabilization services in Oregon need to be coordinated and standardized across the state especially under HB_2417 . Diverting individuals from hospitals and jail by providing a BH facility where mobile crisis teams and law enforcement can take individuals will reduce considerable pressure from the emergency departments.

B) Equity and Inclusion, and Individuals with Lived Experiences: $3,000,000

Currently, there are limited opportunities for people with lived experience to have a meaningful impact on the systems that serve them. MHBG funding will be used to develop and sustain a more robust and effective network of consumer advocates and support them in collaborating with OHA and other systems partners to transform our behavioral health system. With this funding, OHA's Office of Consumer Activities will implement the following:

- A Partners in Policy program, including a policy academy where behavioral health consumers can learn about the policy making process and how to engage with state government to co-create systems change.
- Development and support of regional consumer networks, including training; technical assistance; provision of technological equipment, travel, and childcare stipends; and hosted networking opportunities.
- An annual conference for all the various advisory councils to OHA to come together as a learning collaborative.
- Development and distribution of toolkits, written handbooks, and interactive trainings for behavioral health providers, created and delivered by people with lived experience. These trainings will focus on how to better meet the needs of marginalized or underserved communities, including people from communities of color, LGBTQ+ individuals, people who experience physical or developmental disability, older adults, and veterans.
- Development and distribution of a toolkit, written handbook, and training for OHA staff on best practices for effective and impactful community engagement. This will be designed and delivered by people with lived experience and will focus on better engagement with marginalized and underrepresented communities.
- A series of community dialogue meetings, providing OHA behavioral health leadership and staff the opportunity to connect face-to-face with behavioral health consumers around the state.

C) **Children and Adolescents with Serious Mental Illness** :

First Episode Psychosis: $2,264,072.5

MHBG investment will focus on Early Assessment and Support Alliance (EASA) program and investment evaluation with a focus on racial and regional equity and target funds based on this evaluation and the needs identified, including broader access to individuals that experience Intellectual and Developmental Disabilities. OHA will continue to increase EASA's focus and collaboration with the Oregon Tribes. Further development will include an EASA continuum of care including statewide education, clinical consultation model to fidelity implementation. Increased investment for youth and young adult engagement in program and policy development is also a priority.

OHA will also invest in the following areas to help improve access to services for children and families with SED: $3,051,652.5

- Expand the Child, Adolescent and Family Psychiatry training program through Oregon Health and Sciences University.
- Wraparound care coordination for all children and families, specifically those who are accessing care through the crisis system.
- Child and Family Behavioral Health Restorative Services for youth in Aid and Assist population.
- Expand Behavioral Rehabilitative Services for youth in residential treatment. Currently it is only available to youth in child welfare or in Oregon Youth Authority custody.
- Youth suicide intervention and prevention plan.
- A family and parent warmline which will include Spanish speaking staff.
- Increased funds for prevention and promotion efforts for mental health through the Here for You Oregon Website.

D) <u>People with Intensive Service Needs</u>

Transportation for Aid and Assist population upon discharge: $250,000

Patients who are court mandated drop no longer have jurisdiction for transportation back to local county jails. This involves separate funding source. Sources such as civil commitment do not cover this service. OHA would like to use Block Grant funds to fill this gap in the system. That will allow stabilized patients from OSH to be safely transported back and engage in local services. This will allow the person to remain stable in the community. OHA will fund non secure transportation along with personnel to coordinate the transfer of the individual from OSH to the community. If necessary, the funds will also be used to secure shelter for the individual if they don't have a safe place to go.

Room and Board bridging for individuals in Residential treatment: $500,000

When individuals get discharged from the OSH, they are covered by Medicaid on the day of discharge, however, these individuals don't have SSA or SSI yet. This is because of the time needed in the federal process for these benefits to initiate or be reactivated. It takes about six months for social security supports to start. These individuals move into residential treatment facilities where skilled staff provide treatment and recovery services. Even though the treatment services, food, and transportation are covered by Medicaid, room and board are not covered. This puts the individual at risk for eviction. This compounds with the fact that these are individuals who also have disability diagnosis but don't have the social security support yet for their disability. OHA wants to use Block Grant funds as a financial bridge until appropriate federal funds kick in.

D) **Veterans**

Veterans with SMI and Traumatic Brain Injury: $800,000

Currently Veterans' TBI research focuses on tool development. However, there is gap on funding for tool promotion, training, and rollout. There is also a gap in TBI navigators. OHA wants to initiate and evaluate at least two pilot projects of TBI care navigators across the state.

- Currently, OHA holds a contract with the Center for Brain Injury and Research (CBIRT) at the University of Oregon. Some of the current contract deliverables are to develop a screening tool for identifying brain injury in veterans, developing a position description for a veteran brain injury navigator, and recommending a rollout/implementation strategy for the screening tool. Additional funds would build on this existing work (scheduled to end in December 2021) by:
    - Funding additional testing and training associated with the screening tool. The tool, still in development, will be a modified version of the Ohio State TBI Screening Tool. The existing tool OSU TBI-ID , which is widely used, has been modified for other populations groups, such as youth (but not the veteran community).
    - Funds could go to support additional validation testing in environments like emergency departments, private practices, or even other service-connected providers' offices such as housing or social services. The OSU TBI-ID does not have to be administered by a licensed healthcare provider (but does require training), which allows for widespread use and potential impact
    - Funds would also be used to support and incentivize data collection around the validation and rollout, as well as measure impact

Veteran's conference: $75,000

Feedback received from multiple veteran and military focused workgroups highlights the challenges providers have in accessing information to best serve their veteran and military consumers. The 2019 Veterans' Behavioral Health Improvement Study – Community Forums, ASIPP small workgroup, and multiple conversations with other providers, Veterans Service Officers, and community-based organizations all identify how working across systems is crucial in being able to serve veterans in Oregon. While the federal VA system offers town halls and the ODVA offers a women's veterans conference, there isn't an opportunity for veterans and providers to come together and discuss barriers, recognize and build upon achievements, share resources, or collaborate on opportunities at the local and state level.

- A veteran/military behavioral health conference could highlight work from all OHA's suicide prevention team, community-based work accomplished through veteran-specific CBO funding, CCBHC work, as well as bring in subject matter experts from the VA and ODVA. This effort could address overarching themes that have been flagged as

challenging (ex: overview of the MISSION ACT, how to become a Community Care Network Provider, how to enroll in OHP), to local level and other service-connected community topics (ex: a panel on VBHPSS, deployment cycle training for teachers of school-aged youth)

E) Older Adults with SMI:

Dementia Screening in Primary Care: $500,000

Oregon is aging rapidly, and we know that age is the number one risk factor for dementia. In addition, individuals with serious mental illness are at a greater risk than the general public for dementia. Currently 69,000 Oregonians have a dementia (Alz. Association 2020) and it is projected to jump to 84,000 in five short years. It thus becomes critical that our primary care providers (physicians, nurse practitioner, physician assistants) and workforce are well trained in identifying, assessment and treatment of dementia. This primary care setting is important as most older adults seek all their care with their primary care provider. Thus, training providers in use of evidence- based screening tools such as SLUMS (St. Louis Mental Status) and or MoCA (Montreal Cognitive Assessment) becomes critical and then monitoring its adoption and uptake as key quality improvement targets. This training could be delivered via on-demand webinars and a pilot of academic detailing or practice facilitation here we shepherd this practice getting hardwired into a work flow and measure the confidence of the providers in terms of their skill in using and interpreting these cognitive tests.

Mental Health training modules for Adults foster home and assisted living providers and models for MH licensed residential staff on aging and aging topics : $500,000

There are huge knowledge gaps in providers of foster homes and mental health licensed homes regarding aging, aging with a serious mental illness , mental health 101 practical ADL skills. This lack of knowledge correlates with a lack of skill to work with clients with complex care needs and places that client's community tenure in jeopardy. By creating training videos that can be on demand and or presented as live/interactive we will be able to close that knowledge gap and have providers who have more confidence in working with their residents with complex care needs.

ESTIMATED BUDGET:

Program	Budget
Treatment and Recovery programs	$8,676,653.8
10% set aside: EASA	$2,264,072.5
5% set aside + crisis system	$10,567,962.7
Administrative	$1,132,036
Total	$22,640,725

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KATE BROWN
Governor

April 23, 2019

Virginia Simmons, Grants Management Specialist
Division of Grants Management OPS
SAMHSA
1 Choke Cherry Road, Room 7–1091
Rockville, MD 20857

RE: Oregon's Combined Block Grant Application

Dear Ms. Simmons:

This letter is regarding the state of Oregon's combined application for funds under the Mental Health Services and Substance Abuse Prevention and Treatment Block Grants. I have designated the Behavioral Health Director for the Health Systems Division to sign the set of agreements that certify Oregon's compliance with requirements for receiving the Block Grants on my behalf. The Behavioral Health Director position will be filled April 29, 2019 by Steve Allen.

Sincerely,

Kate Brown

Governor Kate Brown

cc: Kimberly A. Beniquez, MS, CADC, CCDPD, SAMHSA
Ernest Fields, SAMHSA
Patrick M. Allen, OHA
Margie Stanton, OHA
Jon C. Collins, PhD, OHA
Rusha Grinstead, OHA
File

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

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

Steve Allen

Title

Behavioral Health Director

Organization

Oregon Health Authority

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

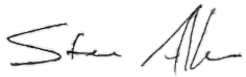
Steve Allen

Title

Behavioral Health Director

Organization

Oregon Health Authority

Signature: 

Date: 08/31/2021

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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Footnotes:

STEP ONE

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

The Oregon Health Authority's ten-year strategic goal is to eliminate health inequities. This means people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identify, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

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 with about 300,000 new members enrolled. Oregon's Health System Division administers state and federal funds to deliver and pay for health care services to over 1 million people in Oregon, primarily through the Oregon Health Plan (OHP) with 43 percent of them being children. Enrollment in OHP contributes to Oregon achieving one of the lowest uninsured rates in the nation. 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 cooccurring disorders. Preventing the need for behavioral health services through evidence based primary prevention and environmental interventions at the population level are also critically needed.

Oregon's Behavioral Health System

The Health System Division (HSD) of the Oregon Health Authority (OHA) coordinates a statewide system of integrated physical, behavioral, and oral health care that supports the triple aim of better health, better care, and lower costs by increasing access to preventive, coordinated care for Oregon's medical assistant program members and behavioral health consumers. HSD's mission is to build and advance a system of care that serves and respects the diversity, cultures and languages spoken in Oregon's communities and population. HSD administers community mental health and addiction programs statewide. These services are delivered through Tribal programs, community mental health programs, local public health departments, individual health care provider agreements, coordinated care organizations (CCOs), other managed care plans, and funding opportunities to support additional housing for individuals with severe and persistent mental illness.

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 fully integrated within this framework . 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 October 2019, the Oregon Health Authority (OHA) signed contracts with 15 organizations to serve as coordinated care organizations (CCOs) for the Oregon Health Plan's nearly 1 million members (CCO 2.0). On Jan. 1, 2020, the 15 CCOs began service to OHP members across the state. Currently, CCOs serve over 90% of OHP members. The new contracts set new requirements for CCOs to improve care for OHP members and hold down cost increases in Oregon's Medicaid program. The contracts represent the largest procurement in state history, totaling more than $6 billion for the 2020 contract year. Over the next four years, the CCOs will focus on the Governor's four priority areas: improve the behavioral health system, increase value and pay for performance, focus on social determinants of health and health equity, and maintain sustainable cost growth.

For the 2021-23 biennium, HSD's budget comprises 52 percent Federal Funds, 36 percent General Fund, 11 percent Other Funds, and 1 percent Lottery Funds. Federal revenue sources include Medicaid and the Children's Health Insurance Program for approximately 1,100,000 OHP members, as well as various federal health and substance use disorder grants. HSD's Other Funds include a hospital tax, insurers tax, an intergovernmental transfer from Oregon Health & Sciences University, tobacco taxes, the Tobacco Master Settlement Agreement, recreational marijuana taxes, the Community Housing Trust Fund, beer and wine taxes, the Intoxication Driver Program Fund and the state lottery revenues. In the 2021-23 biennium, the division anticipates decrease in many of its funding streams due to the economic downturn associated with COVID-19. In particular, impact funding streams will likely be those associated with individual's ability to spend on taxable products and with health care provider net patient revenue and insurer premium revenue. This will be accompanied by an increase demand on services through the Oregon Health Plan, as enrollment increases due to economic hardships.

Medicaid/Oregon Health Plan – The Centers for Medicare & Medicaid Services (CMS) approved Oregon's Substance Use Disorder 1115 Demonstration waiver, effective April 8, 2021, through March 31, 2026. A central part of the waiver focuses on enhancing residential treatment services as a crucial component in the continuum of substance use addiction benefits. It accomplishes this by permitting Oregon to receive federal funding for Medicaid services for individuals with a substance use disorder in residential treatment facilities with more than 16 beds.

This new federal funding, added to the resources provided in the Governor's Budget for 2021-23, allows for greater investment in Oregon's vision to prevent, identify, and treat people with substance use disorder and help them sustain long-term recovery. The other major component of this waiver increases the service array for Oregon Health Plan (OHP) members with substance use disorders, including Community Integration services composed of housing and employment support. At the guidance of CMS, the proposed Recovery Support Services were separated out from this waiver. This means peer-delivered services outside of a treatment episode will be considered for further conversation and development in the future

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. LMHA's 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 (OSH): provides an essential service to Oregonians who need longer term hospital level care for behavioral health issues, 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, treatment planning, pharmacy, laboratory, food and nutritional services, and vocational and educational services provided by credentialed professional and medical staff. The role of the hospital is to restore patients to a level of functioning that allows a successful transition back to the community.

OSH provides services to 3 primary groups of individuals: Civil Commitment, Guilty Except for Insanity (GEI), and those found unfit to stand trial, often called "Aid and Assist" in Oregon. Individuals placed at OSH under any of the 3 jurisdictions must be found to have a either a mental disorder (Civil Commitment) or a qualifying mental disorder (GEI and Aid and Assist). All are only placed at OSH after some form of court process to ensure that the individual's rights are upheld.

OHA is working to increase the utilization of community-based competency restoration while decreasing the use of hospital-based restoration. Some of the initiatives being worked on to accomplish this are increasing the availability of licensed residential housing, increasing community-based treatment resources, and reviewing the relevant

Oregon Revised Statutes. This work is being done through increases in funding, RFP's and ongoing legislative workgroups.

Certified Community Behavioral Health Clinics (CCBHC)

In 2016, SAMHSA awarded Oregon the CCBHC Planning Grant . 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.

Patient-Centered Primary Care Home Program

Oregon's Patient-Centered Primary Care Home (PCPCH) program was established in 2009 as part of the state's broader transformation efforts to achieve better health, better care, and lower costs within the health system. The intent was to improve Oregon's primary care system by developing a set of standards for primary care practices. After the legislation was passed, Oregon convened a volunteer advisory committee to develop the PCPCH standards. The committee has reconvened several times over the years to refine the standards.

The PCPCH recognition criteria is defined by six core attributes, each with specific standards under each attribute, and measures that indicate the extent to which a clinic is meeting that standard. Behavioral Health Services is standard 3.C in the PCPCH model. There are three measures for the behavioral health services standard; one is required and two are optional.

- 3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes (required)

- 3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers.
- 3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.

More than 600 primary care clinics are recognized as PCPCHs in Oregon - about 2/3 of all primary care clinics in the state. There are recognized PCPCHs in 35 out of 36 counties in Oregon and approximately ¾ of all Oregonians get their care at a PCPCH.

PCPCH recognition is attestation based, so the program conducts on-site visits to a select number of PCPCHs each year. The PCPCH program has conducted more than 320 site visits to date, over 1/3 of those in last 18 months. Each clinic will receive a site visit at least once every five years, per Oregon Administrative Rule.

Opioid State Targeted Response Grant and State Opioid 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.

Prevention and Health Promotion through the Oregon Public Health Division

Primary prevention and population-based substance use prevention initiatives are coordinated through the Oregon Health Authority-Public Health Division (OHA-PHD). OHA-PHD is developing a new model for improving coordination of Alcohol, Tobacco and Other Drugs (ATOD) Prevention systems, funding, and interventions in Oregon. Currently, six sections within OHA-PHD are responsible for implementing these wide-ranging substance use prevention efforts, with additional interventions administered through OHA's Health Systems Division (HSD).

Within OHA-PHD, the Health Promotion and Chronic Disease Prevention (HPCDP) section leads initiatives for alcohol, tobacco and marijuana prevention efforts and the Injury and the Injury and Violence Prevention Program (IVPP) leads opioid prevention priorities. Maternal and Child Health, Adolescent and School Health and the HIV Program all coordinate and implement respective programs and initiatives that aim to prevent substance use and promote physical and behavioral health along the continuum of care.

To better coordinate and integrated these efforts, the OHA-PHD organized a substance use prevention team and project portfolio through the Center for Prevention and Health Promotion's administrator. A new Alcohol and Other Drug Prevention Services Manager works to convene and coordinate aligning efforts, including working closely with OHA's Behavioral Health Addiction, Recovery and Prevention Unit and other Behavioral Health programs.

In November 2020, Oregon voters passed Ballot Measure 109, allowing the manufacture, delivery, and administration of psilocybin, a naturally occurring psychedelic. The OHA-PHD created a new Psilocybin Section and is currently in the process of hiring staff. The Section will be responsible for licensing and regulating the manufacturing, transportation, delivery, sale and purchase of psilocybin products and the provision of psilocybin services. OHA-PHD is prioritizing efforts to align this emerging work with overall ATOD prevention and other BH infrastructure.

Health Promotion and Chronic Disease Prevention (HPCDP)

The OHA-PHD Health Promotion and Chronic Disease Prevention (HPCDP) section provides leadership for prevention and health promotion initiatives in the areas of tobacco, asthma, nutrition, diabetes, arthritis, heart disease, physical activity, stroke and cancer, and substance use prevention.. HPCDP takes an integrated approach to reducing chronic diseases and premature death by focusing on the common risk factors of tobacco use, excessive drinking, physical inactivity and poor nutrition across all Oregon communities.

- **Alcohol and Other Drug Prevention and Education Program (ADPEP)**
  HPCDP continues to build a comprehensive Alcohol and other Drug Prevention and Education Program (ADPEP). HPCDP provides administration and management, data and evaluation, health communications, support for state level interventions, and funding directly to communities to plan and implement strategies that prevent alcohol, tobacco and other drug use through community mobilization efforts. This work is done in collaboration with Oregon's 36 counties, culturally specific organizations, nine federally recognized tribes, and six Regional Health Equity Coalitions (RHECs).

  Alcohol use is the third-leading cause of preventable deaths in Oregon. Excessive alcohol use—which includes binge drinking, heavy drinking, and alcohol use by people under 21 or pregnant women—can cause or exacerbate heart disease, diabetes, cancer, motor vehicle crashes, and violence. ADPEP's comprehensive program prioritizes:

  - State and community interventions: Creating environments that reduce exposure to alcohol and other drug availability, marketing and promotions to discourage excessive drinking as well as raising the price of alcohol
  - Mass-reach health communications: Researching and developing mass-reach health communications, and education that support alcohol and other drug prevention initiatives
  - Data and evaluation: Continuous monitoring of alcohol and other drug trends and program effects to identify population needs and inform future areas of focus
  - Infrastructure, administration and management: Ensuring leadership, accountability and oversight for all program strategy and expenditures

  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 strategies. Oregon implements strategies in each of the Institute of Medicine defined Universal, Selective, and Indicated populations, and OHA supports the implementation of evidence-based and Tribal Based Practices.

In summer 2021, OHA-PHD received a Centers for Disease Control and Prevention grant award for the promoting Population Health through Increased Capacity in Alcohol Epidemiology and the Prevention of Excessive Alcohol Use. This grant will enhance current Oregon Health Authority Public Health Division's (OHA-PHD) efforts to prevent excessive alcohol use and related harms. Resources will be allocated to hire and sustain an epidemiologist position within the Center for Prevention and Health Promotion to consolidate and lead analyses of alcohol-related data resources. These resources will be used to tailor and target communications across public health programs, educate and mobilize community-based partners, and influence policy decision makers to adopt and implement population-level, evidence-based interventions that prevent excessive alcohol use.

- **Tobacco Prevention and Education Program (TPEP)**

The Oregon Tobacco Prevention and Education Program (TPEP) is a statewide comprehensive program that supports tobacco prevention and helps people quit. The program has been in place for more than 20 years, after Oregon voters passed Measure 44 in 1996, which raised the price of tobacco and dedicated funding to tobacco prevention and education. In 2020, Oregon voters passed Ballot Measure 108 which raised the price of tobacco products including the price of cigarette packs by $2,00 per pack. In 2021, Oregon legislators passed statewide tobacco retail licensure which goes into effect January 1, 2022.

TPEP partners with local public health authorities, tribes and regional health equity coalitions to prevent and reduce tobacco-related deaths in every Oregon community. More than 60 percent of Oregon's TPEP funding flows directly into communities.

TPEP's strategic goals are to:

- Increase the price of tobacco products
- Promote smoke-free environments
- Protect youth from exposure to tobacco industry marketing
- Reduce access to tobacco products
- Decrease tobacco-related disparities

TPEP drives science-based interventions in each of the following areas to achieve its goals:

- State and community interventions: Creating environments where a tobacco-free life is the easy option, and youth are less likely to start using tobacco
- Mass-reach health communications: Developing media campaigns and education that support tobacco prevention initiatives and help people quit
- Supports to help people quit: Ensuring counseling and FDA-approved medication are available through quit lines and health care systems

- Data and evaluation: Continuous monitoring of tobacco use trends and program effects to identify population needs and inform future areas of focus
- Infrastructure, administration and management: Ensuring leadership, accountability and oversight for all program strategy and expenditures

Synar Amendment

Since 2012, OHA has taken several measures to effectively enforce the minimum legal sales age. These measures include:

1. Increasing the minimum legal sales age to 21
2. Expanding the types of products requested during compliance checks (cigarettes, little cigars, e-cigarettes)
3. Renegotiating an agreement with the Oregon State Police to conduct inspections
4. Instituting a reinspection process for retailers that violate the law
5. Funding local public health authorities to work on tobacco control policies
6. Implementing a comprehensive database to combine Synar, state enforcement and FDA inspections data and allow for mapping of retail locations

OHA coordinates regularly with other state enforcement agencies (Department of Revenue, Department of Justice, Oregon Liquor Control Commission and Oregon State Police) to improve and strengthen statewide enforcement efforts for tobacco.

In addition, in 2016, OHA began publicly posting results from both the Synar and the state enforcement inspections. These results include individual retailers' inspection results. Oregon's retailer violation rate subsequently dropped from 22.5% in 2012 to 15.5% in 2019. No Synar inspections took place during 2020 or 2021 due to coronavirus pandemic limitations on agency staff capacity and restrictions on indoor gatherings Adolescent and School Health Unit (OHA-PHD).

The Adolescent and School Health (A&SH) unit collaborates with HPCDP's prevention work on substance abuse prevention issues. The Adolescent Health Snapshot presents health and behavioral outcomes from a policy framework. This information is shared with internal and external partners so that programs and policies can be most reflective of the lived experiences of youth and young adults, including mental health and substance abuse issues. A&SH oversees the Oregon School-Based Health Center (SBHCs) Program, with 78 State-Certified SBHCs around 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 hold behavioral health, psychoeducation, support, and wellness groups for anxiety, depression, grief, and healthy relationships. These groups enable providers to treat and work with more adolescents, provide prevention services, and strengthen partnerships with school and community providers.

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

- Youth Advisory Councils assure clinics 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 WellVisit and a Comprehensive Health Assessment. Both include mental health and substance abuse screening, prevention messaging and anticipatory guidance.

Adolescent and School Health partners work with the Health Systems Division, Oregon Department of Education, Trauma-Informed Oregon, suicide prevention initiatives, youth-serving organizations and several community-based organizations to address mental health and substance abuse issues. Adolescent and School Health emphasizes that when youth are given accurate information, skill building opportunities and access to youth-friendly care they more like to be mentally well and less like to abuse substances.

Maternal and Child Health

Oregon's Maternal and Child Health (MCH) Section of the OHA-PHD has a long history of collaborating both within the Public Health Division and across the OHA to effectively reach pregnant and post-partum women, as well as other parents, with mental health and substance abuse issues. MCH implements evidence-based policies, programs and strategies across the lifespan to address the social determinants of health, improve health equity, and build strong social, emotional and physical health for the next

generations of Oregonians. The goal of the MCH Section is for every mother, child and family to have the best opportunity to reach their greatest potential for life-long health and well-being. The 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 a) fosters safe, supportive environments for children, mothers and families; b) builds resilient and connected communities and families; c) promotes nutrition and healthy development; and d) improves oral health.

MCH works closely with the Health Systems Division, Children and Family Behavioral Health Unit on issues around substance abuse and families. MCH also partners with all local public health departments and five federally recognized tribes to address the root causes of mental health and substance abuse through maternal and child health work. This includes home visiting for pregnant women and families with young children, Oregon MothersCare, policy and programs that address toxic stress/trauma/adverse childhood experiences, smoking, well woman care, and breastfeeding. The MCH Section has a history of partnering with community organizations (e.g., Baby Blues Connection and Postpartum Support International) around:

Perinatal Mood Disorder

MCH provides funding to 211info, a nonprofit organization that empowers Oregon communities by helping people identify, navigate, and connect with the local resources they need, to support maternal and child health information and referral services statewide that including mental health/substance abuse and other resources. MCH also leads policy development related to pregnancy and opioid use with internal and external partners.

Finally, 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.

The Section hosts a Maternal Mental Health website here:

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.

a. Home Visiting Program

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 Oregon's Early Learning system. The Oregon Legislature recently passed legislation making Oregon the first state in the nation to provide universally offered home visiting to all families of newborns regardless of insurance coverage and insurance status through the Family Connects model. This service will roll out statewide over the next 3 biennia.

b. Oregon Mothers Care Program

The MCH section works to support healthy pregnancy through the Oregon Mothers Care (OMC) program which assists pregnant women to access a variety of prenatal services including mental health and substance abuse services as needed. OMC screens and provides referrals for both behavioral health and alcohol and other drug issues.

c. Pregnancy and Opioids Workgroup

The MCH section convenes a Pregnancy and Opioids Workgroup. With a focus on primary and secondary prevention, the workgroup developed 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.

d. Oregon's Pregnancy Risk Assessment Monitoring System (PRAMS)

Oregon's Pregnancy Risk Assessment Monitoring System **(PRAMS)** is administered by the MCH section with support from the Centers for Disease Control and Prevention (CDC). PRAMS collects data monthly on maternal attitudes and experiences prior to, during, and immediately after pregnancy from a representative sample of Oregon women giving birth. The survey also asks women about their mental health and substance use during this period of their life. The sample data are analyzed in a way that allows findings to be applied to all Oregon women who have recently had a baby. The Oregon PRAMS-2 survey interviews respondents when their child is 2 years old. Both the PRAMS and PRAMS-2 survey include questions that assess mental health and substance abuse issues. Additionally, the MCH section funds the Adverse Childhood Experiences (ACEs) module of the BRFSS, to collect data regarding adverse childhood experiences of adults, which can then be analyzed for its association with adult mental and behavioral health issues. Both PRAMS and BRFSS ACEs data are used to inform public health policy and program efforts.

e. Title Five Block Grant

Maternal and Child Health is primarily funded through HRSA's Title V Block Grant Program.

Toxic Stress/Trauma

Title V requirements address specific priorities, including Toxic

Stress/Trauma. Seven 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 and other partners' work on this priority strengthens the foundation of safe and nurturing relationships and stable attached families in Oregon – a critical factor for preventing and mitigating substance abuse and mental/behavioral health problems in Oregon children and families.

Oregon's 211 Info Resources and Referral Line

Oregon's 211Info Resource and Referral line is partially funded by the MCH Title V Block Grant. Two MCH Specialists provide resources to pregnant women and families, including mental health and alcohol and other drug treatment referrals. During the first 6 months of 2019, MCH Specialists responded to 491 calls from pregnant women and women with children requesting mental health/AOD referrals.

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.

HIV Care and Treatment Program

The HIV Care and Treatment Program of the HIV/STD/TB (HST) Section of the Public Health Division provides information, referral, and access to treatment for persons with mental health and substance use 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.

Persons with HIV, mental health and substance use issues are disproportionately impacted by the current housing crisis. Within the HOPWA funded housing programs administered by the Public Health Division, one program specifically meets 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 Oregon Department of Corrections, many of whom have a mental health and/or substance use disorder.

Starting in 2019 the HST Section has also obligated $10 million over five years to support low barrier housing and in-home intensive wrap around support services for people living with significant behavioral health barriers to housing and healthcare. 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 Care and Treatment works closely with HIV and STI Prevention programs to ensure streamlined and coordinated services across the HIV continuum.

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 use 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. HST has prioritized several projects that focus on ameliorating health disparities between Latinx and non-Latinx folks in Oregon. These projects include health education and risk reduction for primary prevention, as well as outreach testing and increased harm reduction services in Latinx communities.

The HIV Prevention Program uses state general funds, federal funds, or a combination of both to support syringe access activities in 14 counties and two community-based HIV/AIDS service organizations in Oregon. This support takes the form of funds for purchases of syringes, staff time, waste disposal services, sharps containers, and other supplies. The HIV Prevention Program also provides technical support and the opportunity to apply for supplemental start-up funds 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 Program

Prescription Drug Overdose Prevention:

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 and tribal opioid summits.

Since 2016, the Oregon Health Authority (OHA) has coordinated an internal Opioid Initiative to align agency-wide activities and policy work, across the Health Systems Division, Health Policy and Analytics Division, 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.

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, the Oregon Rural Practice-based Research Network is providing academic detailing and practice coaching to 60 primary care clinics in high burden regions to assist with guideline implementation, improved pain management practices, and OUD treatment. In partnership with the Oregon Pain Management Commission, IVPP launched a new provider pain education module in July 2021, and a new pain education toolkit for patients on the Oregon Pain Guidance website, as well as a new peer training module on chronic pain with the Mental Health and Addiction Association of Oregon. SAMHSA and CDC funds are used to fund the Drug Overdose Initiative which supports counties or regions with a high burden of opioid overdose deaths and hospitalizations. Funds allocated to Local Public Health Authorities (LPHA) to complement other opioid initiatives and leverage funding throughout the county/region to reduce overdose deaths and hospitalizations. LPHAs are expected to collaborate with multi-disciplinary stakeholders and address community challenges related to drug overdoses using the following strategies:

- Establish Linkages to Care
- Support Providers and Health Systems
- Partner with Public Safety and First Responders
- Empower Individuals to Make Safer Choices
- Implement Prevention Innovation Projects

Required work consists of:

- Engage a regional multisector stakeholder group.
- Consult with stakeholders to develop/expand overdose emergency response protocols.
- Develop and implement prevention project(s) that address one or more of the above strategies.
- Assess naloxone accessibility for individuals and work with harm reductions partners.

Review, coordinate, and disseminate local data to promote public awareness.

CDC and SAMHSA funds support an annual conference on Opioids, Pain, and Addictions Treatment (OPAT) to educate the medical community, social service agencies, public health agencies and others throughout the state about evidence-based pain management and addictions treatment since 2011. CDC and SAMHSA funds have supported an annual Tribal Opioid Training academy since 2018, in partnership with the NW Portland Area Indian Health Board, and in 2021 IVPP and HSD sponsored a 3-webinar series with contractor Lines for Life on addressing Oregon's stimulant crisis. . .

IVPP is working closely with PHD's Alcohol and Other Drug Prevention Alignment Team to implement a new Shared Risk and Protective Factors Initiative aligned with the Oregon's new five-year State Health Improvement Plan, Healthier Together Oregon. The IVPP suicide prevention efforts align with the OHA Youth Suicide Intervention and Prevention Plan (2021-2025). 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.

Suicide Prevention

With strong partnerships across OHA divisions and with local partners, Oregon is a leader in statewide suicide prevention. OHA has 5 dedicated FTEs devoted to suicide prevention efforts. The five positions are spread across two departments (HSD and PHD) and three units (Injury and Violence Prevention Program, Child and Family Behavioral Health, and Adult Mental Health). The five positions include an Adult Suicide Prevention Coordinator, Zero Suicide in Health Systems Coordinator, a Public Health Suicide Prevention Coordinator, and two Youth Suicide Prevention Coordinators. Despite being spread across two divisions and several units the team functions as one cohesive unit communicating daily and meeting weekly. Although each position has a different focus, all five Suicide Prevention Coordinators share many responsibilities and are always willing to lend support to one another.

The Adult Suicide Prevention Coordinator and the Youth Suicide Prevention Coordinator positions are in HSD. The Adult Suicide Prevention position, located in the Adult Mental Health Unit, is a new position (March 2020) with its first project to develop and implement the first statewide Adult Suicide Intervention and Prevention Plan. This process is well underway with plans to move to publication within the next 2-3 months. In addition to those efforts the Adult Suicide Prevention Coordinator is the PD on the SAMSHA COVID-19 Emergency Response for Suicide Prevention grant which focuses on suicide prevention for survivors of domestic and sexual violence. This is an 18-month grant that will end in November of 2021 and is intended to build sustainable collaborations among domestic violence advocates and mental health professionals. The grant has enabled cross training opportunities between the two professions with domestic violence advocates becoming better trained in suicide intervention and mental health professionals becoming better trained in domestic violence. The grant has had many successes with several polices developed that are sustainable post award.

The two suicide prevention positions in HSD are focused on youth (ages 5-24) are in the Child and Family Behavioral Health Unit. The positions focus on different aspects of suicide prevention—one on policy and one on program. Currently the second edition of the Youth Suicide Intervention and Prevention Plan (YSIPP), a five-year state plan, is in development. The first YSIPP was published in 2016.

To support implementation of the YSIPP, the **Oregon Alliance to Prevent Suicide** (the Alliance) was created in 2016 and was charged with overseeing statewide integration and coordination of suicide prevention, intervention, and postvention activities. With more than 50 members, the Alliance represents a diverse group of organizations, advocates, youth

and survivors working to reduce suicide rates in Oregon and is a key collaborator in suicide prevention. The Alliance is charged by OHA to oversee implementation of the YSIPP. Committees of the Alliance include Executive, Transitions of Care, Workforce, Outreach and Awareness, Research and Evaluation and Schools. Workgroups consist of Firearm Safety - Lethal Means and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others (LGBTQIA+).

The Alliance operates under the administration of the **Association of Oregon Community Mental Health Programs** (AOCMHP), a non-profit whose mission is to support and advocate for Local Mental Health Authorities (county mental health programs) in their planning and management of mental health, addictions, and developmental disabilities programs to ensure an effective local system of care.

In 2019, OHA began offering a menu of evidence-based, locally energized programs that have already been successful and effective here in Oregon. These programs are stably funded, are coordinated statewide, and are available widely: Sources of Strength (for grades 3 through college), Mental Health First Aid, QPR, Youth Suicide Assessment in Virtual Environments (YouthSAVE), ASIST, and Connect Postvention. Additionally, OHA has worked with the Oregon Department of Education to provide technical assistance to schools as they develop suicide prevention plans for their districts and buildings.

The OHA COVID response Suicide Prevention, Intervention, and Postvention (S-PIP) team was created in 2020 as an inter-departmental effort to address the impact of COVID-19 on mental health and suicide behaviors. The team originally focused on youth suicide prevention but expanded its focus to include lifespan. The team continues to meet weekly.

The other two dedicated suicide prevention coordinator positions are located in the Public Health Division's Injury and Violence Prevention Program. The Zero Suicide in Health Systems Coordinator, position is also new and began in fall of 2020 after the Injury and Violence Prevention Program was awarded the SAMSHA Zero Suicide in Health Systems grant in 2020 and the grant will run through August 2025.The aim of the grant is to implement the Zero Suicide model in Oregon health systems to reduce suicide risk for adults 25 and older. The Zero Suicide Initiative enables health systems to identify, treat, refer and ensure continuity of care for individuals at risk of suicide and suicidal behaviors. Grant activities include:

- Provide consultation, training and resources for health systems, clinics and providers to support Zero Suicide implementation.
- Align efforts with Oregon Administration Rules regarding Emergency Department and In-patient discharge and care transitions for individuals experiencing a behavioral health crisis.
- Assess the culturally specific suicide prevention needs of Oregon's older adults (65 and older), adults with serious mental illness, and veterans and those that have served in the military.
- Develop and pilot specific trainings and resources for these subpopulations.

- Evaluate implementation efforts and share findings on Zero Suicide implementation and work with identified subpopulations.

OHA is currently in the process of developing an advisory committee for the grant and will include representatives from varying organizations and perspectives including the Association of Community Mental Health Programs, Oregon Association of Hospital and Health Systems, adults with lived experience related to suicide, people who have experience supporting an adult friend or family member, representative from Tribal health systems and OHA staff supporting efforts related to behavioral health.

Due to the impact that COVID-19 has had on Oregon health systems, grant activities have been delayed. The advisory committee will meet in Fall 2021 to inform grant activities to begin in 2022.

The other suicide prevention position in IVPP manages the Garrett Lee Smith Memorial Youth Suicide Prevention award (GLS), which focuses on a public health approach to youth suicide prevention. OHA has been awarded three GLS awards since 2006. The current award is in its second year with a focus on capacity-building grants to select Oregon counties, supporting suicide prevention training (gatekeeper training) in communities and youth-serving organizations, convening the annual Oregon Suicide Prevention Conference, managing the Oregon Suicide Prevention website and supporting clinician training. Highlights of recent grant work include:

- GLS is currently funding three counties to build capacity in their suicide prevention programs. The three counties, Deschutes County, Lane County and Multnomah County, have dedicated staffing toward suicide prevention, have established or are developing suicide prevention coalitions, and implementing gatekeeper training in addition to other grant activities.
- Gatekeeper training has been implemented to increase the number of persons in youth-serving organizations trained to identify and refer youth at risk. Since June 2019, a total of 2,899 individuals have received gatekeeper training through the grant.
- GLS is supporting gatekeeper training with the Oregon Department of Human Services (ODHS), including Child Welfare personnel, community partners and resource parents. In April 2021 ODHS made Question, Persuade and Refer (QPR) computer-based training required for all employees. As of June 30, 2021, 4,988 OSHD employees and community partners had completed the training. ODHS will begin delivering QPR training to resource parents in a virtual setting in Fall 2021. This training has been adapted for resource parents.
- Clinical training has provided training to over 230 individuals utilizing the Assessing and Managing Suicide Risk (AMSR) and Collaborative Assessment & Management of Suicidality (CAMS) trainings. OHAVE has achieved nearly half (47%) of the GLS 5-year clinical goal.
- OHA has developed an online training focused on how health care and direct service providers can work with rural firearm owners who may be a risk of suicide to voluntarily limit access to firearms. The training is based on research with

Oregon rural firearm owners. The course is available for free as a Continuing Medical Education offering and is an OHA-approved Cultural Competence Continuing Education training. Over 100 individuals have completed the online course. In post training evaluation, participants have highly rated the course with over 58% of participants stated that they plan on changing their practices related to lethal means counseling.

- The October 2020 Oregon Suicide Prevention Conference was cancelled dur to COVID-19 public gathering restrictions. The conference has been rescheduled to take place virtually in October 2021.

Emergency Department Surveillance of Nonfatal Suicide Related Outcomes (ED-SENSOR) project. One of ten state programs funded under this CDC pilot initiative, IVPP is using this 3-year grant to establish surveillance and reporting on suicide attempt and self-harm visits to emergency departments and urgent care centers across the state. The new monthly reports developed under this grant, available on the OHA IVPP Data and Analysis webpage, are currently distributed to more than 1,700 subscribers. IVPP has also developed an Overdose and Suicide Data Glossary for partners that provides an overview of data sources that IVPP uses to describe overdose and suicide.

In response to COIVD-19, OHA partnered with the Oregon Alliance to Prevent Suicide, an advisory committee to OHA, on providing community-based organizations to support LGBTQ+ communities during the COVID-19 pandemic. The goal of the funding, awarded as 18 low-barrier grants of up to $20,000, is to reduce risk for suicide and suicide attempts among LGBTQ+ people. In addition, grant goals included to build protective factors by increasing opportunities for life-affirming connection, resources and healthcare to vulnerable and isolated LGBTQ+ youth and adults during this time of increase isolation. Grantees received technical assistance from Trauma Informed Oregon to ensure that project design and implementation are trauma informed as well as evaluation support from OHA to develop and implement evaluation plans. Due to the success of these projects, IVPP secured additional funding through the CDC Core State Injury Prevention Program (SIPP) highly competitive expended funding combined with state general funds to undertake an impact evaluation of this project and publish results by 2026. Additionally, base SIPP funding will provide robust, partner-informed data and evaluation support for ACEs prevention among youth and wraparound “return to learn” services for rural youth with traumatic brain injury.

In addition to the five dedicated suicide prevention positions, there are several others in OHA that support suicide prevention efforts including the Older Adult Behavioral Health Project Director, Veteran Liaison, Child and Youth Acute Care Coordinator and School Mental Health Specialist (Public Health Division) and Women’s Health System Coordinator (Public Health Division).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.

Prescription Drug Monitoring Program

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.

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

Environmental Health

Environmental Health (EH) section of OHA-PHD works to identify, assess and report on threats to human health from exposure to environmental and occupational hazards, and advise Oregon communities on potential risks where they live, work, play and learn. This includes programs addressing climate change, drinking water, food safety, healthy homes and neighborhoods, radiation protection, recreation, and workplace health.

In 2020, the EH section was awarded the new Centers for Disease Control and Prevention (CDC) Building Resilience Against Climate Effects (BRACE) grant. Through this new funding stream, the EH section plans to collaborate with the HPCDP section through the Community Policy Leadership Institute (alcohol, tobacco and built environment).

The EH section work to address climate change and wildfires has expanded in recent years to focus on mental health promotion and community resiliency, including how climate change affects youth depression and mental health.

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.

Veterans and Military Behavioral Health

According to a survey that was completed by 4,000 veterans, one in four Oregon veterans experience frustration or difficulty in seeking care for mental health or substance use issues. Oregon is committed to help veterans access the tools and support they need to thrive. The Oregon Legislature invested $3.1 million over two biennia towards veteran's behavioral health. The Oregon Health Authority and Oregon Department of Veterans Affairs (ODVA) commissioned a needs assessment study to identify challenges and opportunities reforms. Produced by the Rede Group, the 2019 Oregon Veterans Behavioral Health Services Improvement Study:

- Describes the availability of behavioral health services for Oregon veterans.
- Provides findings regarding barriers veterans face in accessing behavioral health services.
- Recommends policy and other changes that may improve the accessibility and quality of behavioral health services for Oregon veterans.

The recommendations include proposed steps to strengthen services and outreach for veterans, which include:

- Reducing stigma about behavioral health issues to help more veterans feel comfortable seeking care.
- Strengthen suicide prevention programs.
- Improve care coordination for veterans and tailor services to better address the experiences those who have served in the military have faced.
- Expand the number of peer specialists who have their own first-hand knowledge of veteran's issues and can provide effective support.
- Recruit more treatment providers to serve veterans.

Following these recommendations, OHA and ODVA held 17 community forums between August and October 2019 in fifteen different locations throughout the state. The forums gathered input from Oregon communities about veteran's behavioral health needs and services.

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
- 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

In 2019-2021, the Legislative allocated more than 6 million dollars for youth suicide prevention work for 2019-2021 biennium. These funds allowed OHA, its contractors, and the Alliance to Prevent Suicide to stand up seven sustainable statewide programs for suicide prevention, intervention and postvention. The funding also allowed for increased data collection and evaluation to better inform suicide prevention partners. Strategic partnerships flourished between the Oregon Department of Education, OHA, and local stakeholders. Finally, more funds were crucial for OHA's Suicide Prevention staff to be responsive to the unique circumstances that occurred in 2020 due to COVID-19. ‘

The Staffing of the OHA Suicide Prevention team also grew from 2.0 FTE to 5.0 FTE. In March 2020, OHA also convened a team of internal subject matter experts and external stakeholders to create a COVID-19 response team, including older adults, veterans, school-based health centers, school-based mental health providers, and epidemiologists, to address COVID-19-related suicide concerns. This Suicide Prevention, Intervention and Prevention (SPIP) Team has focused on timely data (see ESSENCE report), access to care, equipping providers to transition to a virtual environment and listening to consumer voices.

Throughout the 2019-2020 contract year, the University of Oregon (UO) evaluation team continued its evaluative partnership with the Oregon Health Authority (OHA) and the Oregon Alliance to Prevent Suicide (Alliance) to support and evaluate the implementation efforts of the Oregon Youth Suicide Intervention and Prevention Plan (YSIPP). Key accomplishments and recommendations are outlined by YSIPP strategic directions:

- Healthy and empowered individuals, families, and comminutes
- Clinical and community prevention services
- Treatment and support services
- Surveillance, research, and evaluation

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.

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

[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.

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. Research from around the world shows that it is effective for families from diverse cultures and communities. 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. An adaptation of PCIT for toddlers (ages 12-24 months) teaches parents to become more attuned and responsive to their young child while helping toddlers develop emotional and behavioral self-regulation. National research indicates PCIT can also be adapted for children with anxiety disorders, developmental delays, children on the autism spectrum, 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. The average length of treatment is 16 to 20 weeks. The use of standardized instruments for data collection demonstrates improved functioning during treatment.

In 2008, four Oregon agencies began to implement PCIT with funding support from OHA to provide PCIT to Medicaid eligible families. As of January 2019, there were high fidelity PCIT programs serving Medicaid eligible families at 59 locations, in 21 Oregon counties. Two additional behavioral health clinics which were providing PCIT in 2019, have had to pause their PCIT programs due to loss of staff during the COVID-19 health emergency in Oregon. Most other Oregon PCIT programs successfully switched to providing PCIT via telehealth services. Currently there are approximately 130 trained staff on PCIT treatment teams, including certified Masters Level PCIT Trained therapists, Bachelor's level skills trainers, PCIT Within Agency Trainers, and 2 certified Regional Trainers authorized by PCIT International, Inc. to train across Oregon. Training to meet PCIT certification requirements takes a year or more to complete. All OHA funded PCIT sites receive on-going consultation, training and fidelity monitoring by OHA contracted certified Regional PCIT trainers. This has been provided virtually during the COVID-19 pandemic.

PCIT demonstrates large effect sizes in reducing child problem behavior despite high treatment attrition rates in community-based clinics. A recently published study done by the Department of Psychology at West Virginal University, in cooperation with OHA was published in Dove Press journal: Psychology Research and Behavior Management,

Reconceptualizing attrition in Parent–Child Interaction Therapy: | PRBM This study employed one of the largest PCIT community research samples ever conducted (2,787 children and their families across the state of Oregon, 1,318 with usable data) to determine how PCIT impacts both who complete treatment and those who leave treatment early. The purpose of this study was to examine the impact of PCIT on child behavior problems for families who received at least a small dose of PCIT but not enough to meet the strict mastery criteria required for PCIT treatment graduation. While families who graduated from PCIT demonstrated a very large effect size in problem behavior intensity improvements (d=1.65), families who terminated treatment early, but after attending at least four treatment sessions, still showed significant improvements in behavior problems with a medium-to-large effect size (d=0.70).

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, or 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.

OHA has been providing funding since 2014 for CPP training annually, including 18 months of reflective supervision/consultation. To date, 150 clinicians have started CPP training and approximately 35 clinicians have dropped out of the training and on-going supervision before completing training.

The current goals of this project are to:

- Implement CPP with fidelity through provision of mental health promotion and intervention services, behavioral health clinics, and Oregon Relief Nurseries to at-risk families.
- Utilize the CPP Fidelity Tools.
- Utilize the Devereaux Infant Toddler Assessment to measure outcomes starting in September 2019.
- Continue ongoing consultation, supervision, and networking between CPP-trained therapists to maintain fidelity to the model over time.

Generation PMTO (Parent Management Training- Oregon) is a family-based, trauma informed intervention with over 50 years of research from across the USA and several other countries demonstrating its effectiveness[1].

Generation PMTO can be used as a preventive program and as a treatment program. It be delivered through individual family treatment, group parent training in agencies or home-based and via telephone/video conference delivery. Generation PMTO providers are encouraged to tailor the services to meet the needs of diverse populations, family circumstances and service provider type.

Generation PMTO is effective for families with children ages 2-17 years experiencing significant social emotional or behavioral problems such as depression, hyperactivity, non-compliance, substance use, lying and stealing, or other maladaptive behaviors. Research shows that Generation PMTO also improves positive parent skills, family communication style, standard of living and marital satisfaction while decreasing coercive parenting patters parental depression and arrest rates.

OHA began a five year roll out of Generation PMTO in 2019 with a pilot project of one program starting the training. The goal of this project is to increase access to this effective family intervention across Oregon, especially in rural areas where master's level behavioral health staff are in limited supply. During the COVID-19 health emergency began in 2020, Generation PMTO providers were quick to successfully switch to providing this service via telehealth. Currently there are programs providing Generation PMTO in 11 counties and 14 locations. Another expansion is planned for 2021 which will provide funding for an additional 4-6 behavioral health programs to develop Generation PMTO programs and to develop Generation PMTO Trainers in Oregon.

[1] https://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/ and https://www.generationpmto.org/pubs

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

In 2020-2021 the Oregon Health Authority contracted with a Nationally certified TF-CBT Trainer to provide all training and consultation to qualify for certification for 115 outpatient mental health therapists statewide who serve Medicaid eligible clients. An additional 120 training slots will be offered in 2021-2023. TF-CBT is a well-supported evidence-based treatment[1] for children and adolescents impacted by trauma, and their parents or caregivers. TF-CBT has been evaluated and refined during the past 25 years to help children and adolescents across many cultures[2] recover after trauma. TF-CBT is for children 3-18 years of age, and their parent or other caregiver. Average treatment is 12-14 sessions provided in an outpatient setting and it can be provided via telehealth.

Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences such as physical or sexual abuse[3], domestic violence, and community violence, an unexpected death of a loved one, natural disasters and war.

[1] https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/

[2] https://www.nctsn.org/sites/default/files/interventions/tfcbt_culture_specific_fact_sheet.pdf

[3] https://tfcbt.org/wp-content/uploads/2019/02/TF-CBT-Child-Welfare-Information-Gateway-Fact-Sheet.pdf

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.
- 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 have 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. CCO must meet minimum population threshold & other parameters specified in OHA reporting guidance to quality for 100% of quality pool funds (in addition to meeting 75% of remaining measures) for the 2021 Incentive Measures.

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 14 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 services to approximately 300 young people at any given time.

The primary populations served are young adults who ages 14 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 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

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 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 healthy coping skills.
- 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 youth and young adults, ages 12-27, and their families, using a Coordinated Specialty Care (CSC) model, which is 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 2008, EASA has provided services to 3,833 young adults and their families. With the addition of federal dollars, 29 Oregon counties are funded to provide EASA services . In calendar year 2020, EASA received 828 referrals and served 779. The ongoing current caseload is around 400 individuals throughout the state of Oregon. In EASA, young people maintain or enter school or work (59.1% at intake, 59.4% at discharge). Hospitalizations in the three months prior to entry have dropped from 37% to 6% in the final quarter of being in the program. Community education, outreach and quality improvement efforts are focused on improving these numbers. Each EASA team conducts extensive and ongoing community education. During this 2019-2021 biennium EASA conducted 802 community education events reaching approximately 16,800 people.

<u>EASA Center for Excellence</u>

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/PSU (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 initiative Reclaiming Futures and Pathways to Positive Future federal grant projects, and has become increasingly involved in national technical assistance activities. EASA Center for

Excellence has a robust series of ongoing trainings, consultation, and technical assistance and the fall 2019 conference attended by 190 individuals is a good example of the level of energy and buy-in across the state. The development of online options has provided additional opportunities for new staff to receive rapid information and to make training more accessible. Advanced training in areas such as texting and CBT for psychosis has been developed. Regional and statewide consultation is provided routinely.

The EASA Center for Excellence is also investing in two “train the trainer” series to then train all EASA staff in Cognitive Behavioral Therapy for psychosis and Dually Diagnosing Individuals with Intellectual and Developmental Disabilities (IDD) and First Episode Psychosis. Furthermore, the EASA Center for Excellence is working with EASA Sites and the Oregon Health Authority to integrate the use of alternative models for rural and frontier counties as well as adaptation for different cultural groups. This work will be done through workgroups and consumer feedback session.

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

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.

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. 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. 9 CMHP or their sub-contractors (in 9 counties) in Oregon have developed specific older adult behavioral health programs. 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 DHS Aging and People with Disabilities (APD). Services are designed to support individuals with complex mental health and complex physical health needs that require a higher level of support than typically provided in a standard care setting.

Programs emphasize person-centered rehabilitative mental health treatment while continuing to work towards transitioning individuals into the most integrated community setting possible. OHA is responsible for collaborating with APD on managing program referrals, and for working with local providers regarding program administration and strengthening coordination between systems. There are 9 Enhanced Care Facilities that

are either APD licensed residential care facilities or units within intermediate care 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 in developing strategies to support individuals in meeting their goals. Enhanced Care Outreach Services provides intensive mental health services to individuals living in standard APD licensed settings. Services, for the most part, are delivered in the community in an outreach model. Treatment services for both ECF and ECOS programs are delivered by designated local mental health providers who have a knowledge and competencies in working with the aging population and have an understanding of the interplay between physical and mental health.

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 sixth year. This investment seeks to strengthen and improve the behavioral health infrastructure for older adults and people with disabilities. OHA has hired 25 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 health, health, and wellness promotion for older adults, 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 2020 there were 3,711 complex case consultations; 662 training and community events reaching 10,000 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 warmline/friendship line in rural Oregon to mitigate social isolation and risk of depression and suicide, training Aging Disability Resource Connection (ADRC) 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 adults BH , 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 Wellness Initiative for Senior Education (WISE) as a health promotion program in come counties, a statewide Senior Loneliness Line, delivering PEARLS an EBP depression treatment by phone and video

to rural older adults and the identification of hoarding as a problem and development of hoarding task forces.

PCIT Opioids: Access to Services and Treatment

Oregon currently has 20 opioid treatment programs (OTP) within the state; these facilities are comprehensive treatment facilities which offer counseling and other psychosocial supports, including wraparound service referrals to assist patients with mental health needs and other services. These facilities all dispense full agonist (methadone) and partial agonist (buprenorphine) medications, for the treatment of opioid use disorder (OUD). For over 60 years, this modality of treatment has been considered the “gold standard” of OUD treatment, due to its empirically proven ability to reduce harms associated with OUD, including infectious disease, illicit drug usage, overdose, and death; in addition, patients engaged in treatment through the OTP system generally show improved quality of life and reduced involvement in the criminal justice system compared to those with OUD in other care settings. Oregon has a total of 20 OTPs, and 19 of these 20 have certifications with OHA to provide “outpatient synthetic opioid replacement therapy”. All have certifications from the US Drug Enforcement Administration (DEA) and SAMHSA/CSAT Division of Pharmacologic Therapies (DPT) to dispense narcotic medication for the treatment of OUD as well as provide comprehensive therapeutic services to their clients. In Oregon, these programs are regulated by the State Opioid Treatment Authority (SOTA), who approves these programs to operate on behalf of SAMHSA DPT and serves as a liaison between the State and federal governments in terms of their management and operation, as well as the OHA HSD Licensing and Certification unit, who is responsible for issuing a State certification to operate an outpatient OTP. While a majority of Oregon’s OTPs are located in the Willamette Valley and “I-5” corridor (home to approximately 80% of Oregon’s population) several new facilities have opened in underserved rural and frontier areas of Oregon, including the Oregon Coast, and Eastern and Central Oregon. Several of these newer facilities have been supported through expansion efforts funded by Federal opioid related grant dollars. Demographically, Oregon’s OTPs have differing patient populations; while several located in Portland have significant populations of people of color, the majority of the OTPs in the state mirror’s Oregon’s overall demographic landscape, with a vast majority of the patients self-identifying as “white”.

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) was a three-year $2.3 million per year competitive grant that was secured by the Oregon Health Authority in May 2015. ATR operated in five counties: Multnomah, Clackamas, Washington, Marion, and Lane from May 2015 through April 2019, which included a no-cost extension. Through ATR 4 grant funding, OHA expanded and promoted a community-based Recovery Oriented Systems of Care (ROSC), serving 4,507 individuals. By increasing the number of providers, especially community and faith-based organizations who are trained and qualified to offer recovery services, OHA increased recovering individual's access to a wide variety of recovery support services. Oregon ATR 4 utilized SPARS data as well at the WITS voucher management system to analyze each program and the state as a whole. SPARS GPRA data shows that ATR services had a positive impact on every measure in the GPRA. Most notably was the rate of change ,135.4%, in permanent housing, which is defined as “had a permanent place to live in the community.” Another significant rate of change, 105.8%, was in Employment/Education, which is defined as “currently employed or attending school.” The following data table demonstrates the success of the ATR grant, the potential gaps in

funding, and the importance of continuing funding of community-based recovery support services following the conclusion of the ATR grant.

Measures	# Valid Cases	Percent at Intake	Percent at 6-Month Follow-Up	Rate of Change
Abstinence (did not use alcohol or illegal drugs)	3,061	83.4%	84.5%	1.4%
Crime (had no past 30day arrests)	3,063	96.0%	94.4%	-1.7%
Employment/Education (currently employed or attending school)	3,064	29.1%	59.9%	105.8%
Health/Behavioral (experienced no alcohol or illegal drug related health, behavioral, or social consequences)	3,062	88.1%	89.5%	1.6%
Social Connectedness (were socially connected)	3,064	98.8%	97.7%	-1.2%
Stability in Housing (had a permanent place to live in the community)	3,063	15.0%	35.4%	135.4%
Injection Drug Use (injected illegal drugs)	3,059	4.7%	3.8%	-20.7%
Had Unprotected Sexual Contact	370	71.6%	71.4%	-0.4%
Had Unprotected Sexual Contact with an Individual who is or was HIV Positive or has AIDS	214	0%	0%	N/A
Had Unprotected Sexual Contact with Injection Drug User	214	29.0%	30.4%	4.8%

Had Unprotected Sexual Contact with an Individual High on a Substance	214	12.6%	11.7%	-7.4%

Services for Individuals Charged with Driving Under the Influence of Intoxicants (DUII)

Oregon law (ORS Chapter 813) requires anyone charged with driving under the influence of intoxicants (DUII) – whether they are under a diversion agreement or have been convicted – to complete both a screening interview and a treatment program approved by the Oregon Health Authority (OHA).

OHA certifies Alcohol and Other Drug Screening Specialists (ADSS) throughout the state to provide screening and referral services. In addition, ADSS monitor treatment engagement and report the individuals' successful completion or failure to complete to the court. Between 11,000 and 12,000 people each year[1] are screened by an ADSS and referred to a DUII Services Program certified by OHA.

DUII Services Programs use the screening information provided by the ADSS to inform their diagnostic assessment and determine the appropriate programming for each person referred for services – either DUII Education or DUII Rehabilitation.

[1] COVID-19 has significantly impacted the ability of the courts to process DUII cases resulting in a large backlog of pending cases. Screenings and referrals in 2020 were down 49% from 2019.

DUII Education

DUII Education is for people who do not meet diagnostic criteria for a substance use disorder and have not had a previous DUII. Services consist of a minimum of 12 hours of psychoeducational services aimed at preventing DUII recidivism and reducing substance use. Approximately 10 percent of people served are eligible for DUII Education.

DUII Rehabilitation

DUII Rehabilitation is for people who meet diagnostic criteria for a substance use disorder or have had a previous DUII. DUII Rehabilitation includes the education component discussed above, in addition to individualized substance use disorder treatment services. Participants in DUII Rehabilitation services are also required to demonstrate a minimum of 90 days abstinence in order to complete services successfully. Approximately 90 percent of people referred to DUII Services Programs are required to complete DUII Rehabilitation.

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 nontraditional 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 organizations (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
Adult Mental Health Residential Treatment is defined as a 24-hour level of care that provides a range of rehabilitative and habilitative services which cannot be provided in an outpatient setting. Placement in residential treatment is appropriate if the member is not in need of a higher level of physical security and frequency of psychiatric or nursing intervention that is available on an inpatient unit. The overall goal is to provide a therapeutic environment that is both safe and least restrictive to the individual. Adult Residential Treatment includes Residential Treatment Facility (RTF); Residential Treatment Home (RTH); Secure Residential Treatment Facility (SRTF); Adult Foster Home (AFH). Residential Treatment Homes (RTH), Residential Treatment Facilities (RTF), and Secure Residential Treatment Facilities (SRTF) provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours a day. The capacity of an AFH and RTH is up to five residents and the capacity of an RTF and SRTF is 6-16 residents, though there are few contracted facilities that provide services for 16 or more residents. Most placements into these residential programs come from state hospitals and acute care facilities. An assessment and determination for admission is usually conducted by a local Community Mental Health Provider (CMHP).
HSD monitors and consults with licensed and contracted community providers to ensure appropriate services are being delivered to individuals in the least restrictive environment. Facilities are required to be licensed or accredited for the level and type of care provided and is practicing within the scope of its license.
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 (Ryan Stafford)

The Psychiatric Security Review Board (PSRB) is a Governor appointed, ten-member multi-disciplinary board made up of two, 5-member panels: Adult Panel and Juvenile Panel. Each panel includes a psychiatrist, a psychologist, an attorney experienced in criminal practice, a parole/probation officer and a member of the general public.

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 Board has jurisdiction over five different programs:

- GEI: Adults who have successfully pled Guilty Except for Insanity (GEI) through the court system (ORS 161.295)
- Civil Commitment: Adults committed through the court system as “extremely dangerous” person with mental illness (ORS 426.701).
- REI: Youth adjudicated Responsible Except for Insanity (REI)(419C.529).
- Gun Relief Program: Restoration of firearm rights for those persons previously barred from purchasing or possessing a firearm due to a mental health determination and who have petitioned to have that right restored.
- Sex Offender Classification & Relief Program: Classification or reclassification, or relief from registration requirements for those persons who have successfully asserted the GEI defense for a sex offense that resulted in assigning a risk designation.

As of June 2021, 620 individuals are under the supervision of the board as GEI; 24 individuals a committed as an “extremely dangerous” person with mental illness; and six youth adjudicated as REI. All three of these populations have the right to be considered for conditional release to the community. Presently, about 62% reside in the community across the continuum of care and under the direct supervision and treatment supports offered by Community Mental Health Programs (CMHP). These individuals are required to observe the requirements outlined in their individual conditional release plans but could be returned to the Oregon State Hospital under circumstances that are deemed to be a threat to public safety.

The PSRB reports to the Governor and the Legislature through its annual key performance measures. The primary way the Board conducts its business and meets its mission is through conducting timely, contested hearings and monitoring and supervising individuals who are under its jurisdiction and conditionally released to the community through its orders and partnership with community treatment providers. OHA is statutorily responsible for providing mental health services to these individuals. CMHPs provide evaluations for the PSRB 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 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 while maintaining public safety.

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

Adult Mental Health Residential Treatment is defined as a 24-hour level of care that provides a range of rehabilitative and habilitative services which cannot be provided in an outpatient setting. Placement in residential treatment is appropriate if the member is not in need of a higher level of physical security and frequency of psychiatric or nursing intervention that is available on an inpatient unit. The overall goal is to provide a therapeutic environment that is both safe and least restrictive to the individual. Adult Residential Treatment includes Residential Treatment Facility (RTF); Residential Treatment Home (RTH); Secure Residential Treatment Facility (SRTF); Adult Foster Home (AFH). Residential Treatment Homes (RTH), Residential Treatment Facilities (RTF), and Secure Residential Treatment Facilities (SRTF) provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours a day. The capacity of an AFH and RTH is up to five residents and the capacity of an RTF and SRTF is 6-16 residents, though there are few contracted facilities that provide services for 16 or more residents. Most placements into these residential

programs come from state hospitals and acute care facilities. An assessment and determination for admission is usually conducted by a local Community Mental Health Provider (CMHP).

HSD monitors and consults with licensed and contracted community providers to ensure appropriate services are being delivered to individuals in the least restrictive environment. Facilities are required to be licensed or accredited for the level and type of care provided and is practicing within the scope of its license.

Assertive Community Treatment (ACT)

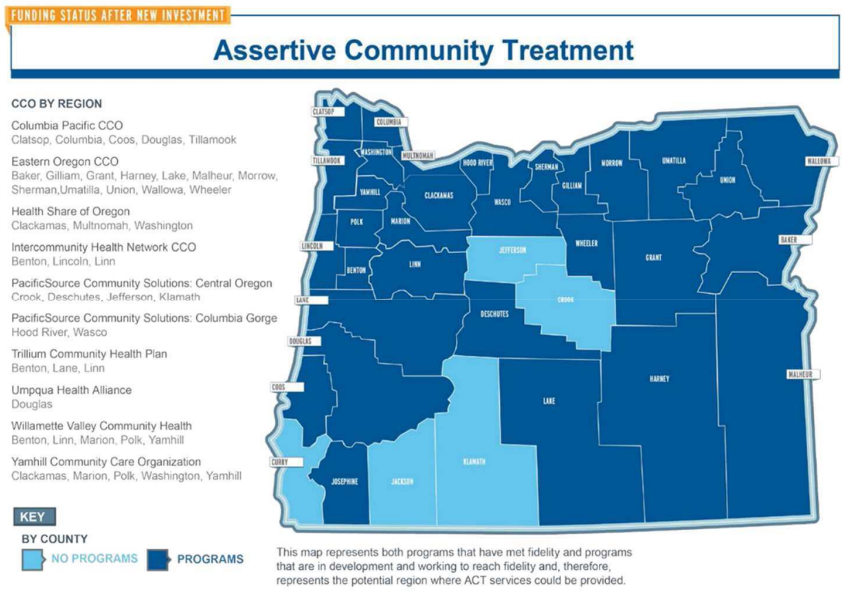
Assertive Community Treatment (ACT) is an Evidence-Based Practice (EBP) designed to provide comprehensive treatment and support services to individuals who are diagnosed with severe and persistent mental illness.. ACT services are provided by a multidisciplinary team which includes psychiatrists, therapists, substance abuse treatment specialists, certified peer specialists, employment specialists and nursing. These services 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.

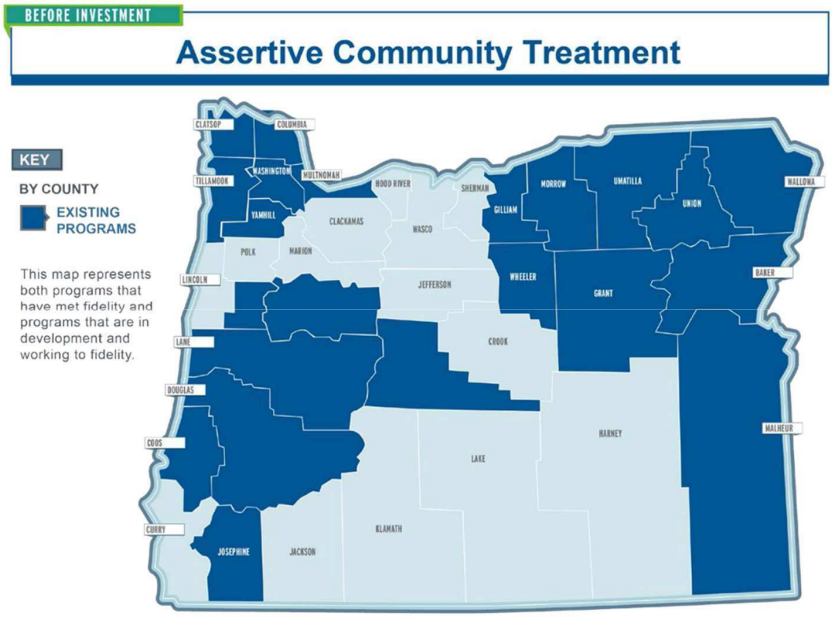
The Oregon Center of Excellence for Assertive Community Treatment (OCEACT) is funded through a contract between the Oregon Health Authority Health Systems Division (HSD) and Josephine County, who subcontracts the program to Options of Southern Oregon. OCEACT is operated in partnership with the Oregon Supported Employment Center for Excellence (OSECE), both working as programs of Options for Southern Oregon.

The primary goals of OCEACT are to:

- 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.
- Help programs achieve high fidelity to the ACT model and improve quality. The OCEACT staff conducts annual fidelity reviews of ACT programs statewide. Programs must meet a fidelity benchmark in order to be certified by OHA as ACT providers and to bill Medicaid for ACT services. OCEACT is a resource for current and future ACT teams interested in learning more about the ACT model and improving adherence to ACT principles.
- Provide an annual ACT conference, statewide trainings for ACT programs, trainings for individual programs, provide ongoing technical assistance.
- 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.





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 18 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 psychiatric care in an alternative setting to the state hospital system, based in the community. Developmentally appropriate services are available to young adults in transition.

Oregon has implemented Wraparound and local and regional System of Care governance structures. Wraparound is a research-based practice model, for communities' children with the highest levels of behavioral need and their families Wraparound engages a creative and collaborative process to develop a flexible, coordinated and individualized family/youth driven plan of services and community-based natural 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 needs as identified by the youth, including the family that supports the youth.

Wraparound uses an intensive care coordination model with family and youth peer support for cross-system planning of children's service and support needs. Data from Wraparound and System of Care implementation demonstrate that children I 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, that provides a framework, tools, and strategies to 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. Through a governor initiated and legislatively created System of Care Advisory Council, high-level decision makers from Oregon Health Authority, Oregon Youth Authority, Department of Human Services, developmental disabilities, and Oregon Department of Education-are tackling shared governance and funding of this System of Care 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 adolescent's 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, psychoeducation, 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 WellVisit 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.

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. Children who are involved in the commercial sex industry are viewed as victims of severe forms of trafficking in persons, which is defined as 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 addresses issues associated with the Commercial Sexual Exploitation of Children (CSEC) and provides 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 is modeled after the Child Abuse Multidisciplinary Intervention (CAMI) Advisory Committee and collaborates with OHA. The CSEC Advisory Committee makes policy recommendations, provides system oversight and defines 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. Establishes 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. Provides 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
12. Develops a State Plan with community partners and OHA staff, which address prevention, early intervention, and services for potential and existing CSEC victims.

Across the state a group of professionals from multiple agencies have been trained to identify and serve this population. OHA partners with a community provider in the Portland Metro area to manage a CSEC specific unit serving up to 16 female identified youth from age 11 to 16 that provides safe and comprehensive residential treatment for children who are or have been involved in trafficking.

Federal legislation HR 4980 requires ODHS Child Welfare requires 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:

- Social, emotional, and behavioral challenges in children are best understood as the by-product of lagging cognitive skills.
- These challenges are best addressed by resolving the precursors for challenging behavior in a collaborative manner.

Oregon has one of the first and most developed CPS networks in the country. Hundreds of multi-agency staff have received introductory, Tier I or Tier Two trainings over the 15 years OHA has funded this model. The Oregon Division of Education has also funded CPS trainings for school staff. Currently there are ~36 individuals certified as providers and using CPS with fidelity, and ~ 37 individuals certified as trainers in Oregon. Think Kids, the national organization overseeing CPS training and research, has updated their materials, created outcome measures, fidelity measures, and certification expectations that were not available

when many behavioral health providers attended trainings 5 or more years ago. OHA is engaging in community partner discussions about realigning Oregon's use of CPS to meet the most current Think Kids training and certification expectations. Although the OHA funding of training in CPS was paused in the first half of 2021, OHA will invest funding for CPS Implementation in 2021-2023 to meet the following goals:

1. Focus first on improving understanding and adherence of fidelity CPS in child and youth residential treatment center(s)
2. Increase proportion of CPS trained providers to become certified
3. Track outcomes consistently to add to the evidence-base of CPS
4. Explore options for continuing CPS parenting groups

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 ODHS 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. In 2019, OHA assigned a program analyst to assist Child Welfare with complex cases on a case specific basis.

ODHS 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, increasing capacity for intensive treatment services for traumatized children and partnering to support system changes to extend beyond improving compliance with the requirements.

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 FOCUS (Focused Opportunities for Children Utilizing Services) Committee to review complex cases of children in the custody of Child Welfare on an ad-hoc basis. 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 may include representation from Child Welfare, OHA, Education, county mental health, Developmental 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 that are not normally available to Child Welfare involved youth.

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.

Behavioral Health Treatment Foster Care is a collaborative effort with Child Welfare. Behavioral Health Treatment Foster Care is a combined service between DHS Child Welfare and OHA Oregon Health Authority. BRS (Behavioral rehabilitative Services) proctor care providers collaborate with their local IIBHT(Intensive In home Behavioral Health Treatment) providers to provide a treatment program to address the needs of youth who have both mental health and behavioral challenges. . 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, and aligns with Child Welfare values that children should be treated in a family environment when possible

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 continues to struggle with a lack of capacity in the Intensive Treatment Services (ITS). ITS includes Psychiatric Day Treatment Services (PDTS), Psychiatric Residential Treatment Services (PRTS), Subacute Psychiatric Residential Treatment Services (SA), Secure Inpatient Psychiatric Treatment (SIP. This capacity issue is contributing to crisis for CW supported youth needing intensive supports, sometimes 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 shortage are in progress. Two additional PRTS/SA units are being developed through joint funding. The first is a 12 bed new facility in rural Eastern Oregon that will serve youth between the ages of 7 and 14. The second is a 12 bed refurbished facility that will serve youth between the ages of 12 and 17. Continued collaboration between OHA and ODHS Child Welfare is focused on closing other gaps in the system including, but not limited to:

- Long wait times between acceptance and admission.
- Discharge options are limited by what is available in the community and statewide step down options.
- Authorization and UM processes are inconsistent among CCOs
- Not enough providers to meet demand.
- Alternative services are limited by what is available in the community.
-

The short-term plan includes the following steps:

- Continue to track capacity, scrutinize outcomes, and monitor current needs of the system
- Review and consider increase the fee for service reimbursement rates
- .
- 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.
- 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.

Children and Youth Residential Mental Health Services Intensive Psychiatric Treatment (Shannon Karsten)

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 thru 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. Intensive psychiatric services are provided in coordination and with the collaboration of a Child and Family team. Services include individual, family and group therapy, skills training and medication management. Treatment is 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.

- Therapy types employed include: Collaborative Problem Solving.
- Dialectical Behavioral Therapy (SAIP).
- Trauma Focused Cognitive Behavioral Therapy.
- Play Therapy.

- Art Therapy.
- Horticulture Therapy.
- Cognitive Behavioral Therapy for multiple symptoms.
- The Neurosequential 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 ½ through 25 who have mental health challenges and who may have a history of institutional care. Residential resources for young adults include seven young adult residential treatment homes (RTHs), as well as capacity for 51 young adults in supportive housing.

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 service.
- **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. Hospital's 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 patented 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 selfcare, 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 PeerRun 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.

Since 2014, 554 supportive and supported rental units dedicated to individuals with SPMI and SUD have been funded by OHA and Oregon Housing and Community Services for development by residential providers. All but one complex is either completed/occupied or under construction. 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 meeting with the nine tribes on a monthly 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 Tribal Affairs Director (TAD) who serves as a tribal liaison to the nine federally recognized tribes. The Tribal Affairs Director attends tribal functions to continue building understanding and rapport with Native American communities. The TAD listens for concerns, answers question, 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 TAD to ensure that cultural considerations and tribal voices are included in planning efforts to work with Tribes across Oregon.

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.

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. A second cohort started with left-over funding from the first cohort.

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 13.4% in 2019, 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 led 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.

Problem Gambling Services

Oregon has a long history of addressing the risks associated with gambling through research, prevention and education, responsible gambling guidelines, treatment, strong partnerships, and collaborations. Oregon uses the public health approach that combines prevention, harm reduction and multiple levels of treatment focusing on quality-of-life issues for individuals with problems with gambling, their families and communities.

In Oregon, it is estimated 2.6 percent of the adult population experience moderate or serious problems with gambling. It is estimated that 84,000 Oregon adults and adolescents meet the clinical diagnosis for gambling disorder, with another 180,000 at risk of developing a problem with gambling. For each person with a serious problem, many others are affected (e.g., spouse, children). One percent of Oregon Lottery revenues fund problem gambling services. The Oregon Health Authority administers the funds that provides approximately $7.5 million annually for prevention and treatment programs and services within each county.

Oregon is a national leader in preventing and treating gambling related problems, promoting informed and balanced attitudes and protecting vulnerable groups. These goals are accomplished by promoting healthy public policy, developing collaborative relationships among various stakeholder groups and providing local governments with funds to develop strategies like those used in other behavioral health systems.

Oregon provides prevention, outreach, early intervention, treatment and recovery services across the continuum of care at NO COST to the individual with a problem with gambling, and family members or concerned other impacted by the gambling. The following is a list of the type of services OHA funds provide:

- Prevention and outreach efforts, stand alone and infused into other prevention efforts such as suicide, alcohol, tobacco and other drug; 24- hour Helpline staffed by professional certified problem gambling specialists.
- A minimal intervention program involving phone counseling with a workbook.
- Outpatient treatment services in every county.
- 2 centers providing Crisis Respite care.
- 1 Residential treatment center; and
- Culturally specific and prison-based treatment programs

In fiscal year 2019-20, 709 individuals received problem gambling treatment services, along with 82 family members or concerned others impacted by the negative consequences of gambling. Forty-one individuals were enrolled in residential service. 671calls for assistance

or information were made to the Helpline. Due to statewide closures in Mid-March of the treatment as usual programs due to the pandemic, our numbers are lower than past years. Although several programs were able to transition treatment delivery services for some clients from face-to-face to remote access, this transition very slow due to a number of factors.

Strengths of Program:

- Ensuring a prevention system that is guided by the Centers for Substance Abuse Prevention (CSAP) six core prevention strategies, the Social Ecological Model, and SAMHSA's Strategic Prevention Framework.
- Ensuring culturally relevant treatment services for Latinos, African Americans, Native Americans, and Asian Americans.
- Ensuring treatment or psychoeducation for incarcerated persons and other high-risk populations.
- Implementing a program evaluation system that allows the program to gather demographic data on the individuals served, along with feedback on the services, as both help to inform decisions.
- Ensuring prevention providers conduct community readiness assessments to obtain metrics to guide future planning.
- Providing, in partnership with Oregon Lottery, access to information, help and hope through the Oregon Problem Gambling Resource web page.
- Strengthening our connections to and partnership with the emerging problem gambling recovering community.

Gaps/Need for the Future:

- Need for funding availability from the Federal level and provided to states to support problem gambling services.
- Need for designation of Federal level entity to direct national level efforts and assisting with increasing awareness that gambling carries risk through media campaigns and other efforts.
- Need for increase in multicultural and special population treatment and prevention services in Oregon and across the nation.
- Need to support a minimum of .5 FTE for prevention program in each county of Oregon.
- Need for resources to support housing availability and opportunities for individuals with gambling problems.
- Need for resources to expand and support recovery services, development of telephone peer support services.
- Need for resources to expand and support additional problem gambling treatment residential services in Oregon and nationally.

- Need for resources to include gaming disorder among the problem gambling service systems to raise awareness and train workforce to best address this emerging issue.

October 2021 Revision Request:

Step 1 – Assess the strengths and organizational capacity of the service system to address

The state mentions the SAMHSA six strategies, however does not address programs or services for the strategies. Please revise by 11/10/21 to provide more information on how the state address all six prevention strategies.

Response in red below:

Alcohol and Other Drug Prevention and Education Program (ADPEP)

HPCDP continues to build a comprehensive Alcohol and other Drug Prevention and Education Program (ADPEP). HPCDP provides administration and management, data and evaluation, health communications, support for state level interventions, and community funding directly to communities to plan and implement strategies that prevent alcohol, tobacco and other drug use through community mobilization efforts. This work is done in collaboration with Oregon's includes 36 counties, culturally specific organizations, nine federally recognized Native American tribes, and six Regional Health Equity Coalitions (RHECs).

Alcohol use is the third-leading cause of preventable deaths among people in Oregon. Excessive alcohol use—which includes binge drinking, heavy drinking, and alcohol use by people under 21 or pregnant women—can cause or exacerbate heart disease, diabetes, cancer, motor vehicle crashes accidents, and violence. ADPEP's comprehensive program prioritizes:

- State and community interventions: Creating environments that reduce exposure to alcohol and other drug availability, marketing and promotions to discourage excessive drinking as well as raising the price of alcohol.
- Mass-reach health communications: Researching and developing mass-reach health communications, and education that support alcohol and other drug prevention initiatives.
- Data and evaluation: Continuous monitoring of alcohol and other drug trends and program effects to identify population needs and inform future areas of focus.
- Infrastructure, administration and management: Ensuring leadership, accountability and oversight for all program strategy and expenditures.

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 strategies. Oregon implements strategies in each of the Institute of Medicine defined Universal, Selective, and Indicated populations, and OHA supports the implementation of evidence-based and Tribal Based Practices. Local ADPEP programs are sub-awardees (Counties, Tribes and non-profits) funded to lead coordination and management of programs, services and initiatives to reduce the harms associated with alcohol, tobacco and drugs, within the Center for Substance Abuse Prevention's (CSAP) six strategies. While this varies from sub-awardee and across communities, current funded strategies, programs and services include but are not limited to: awareness raising efforts, local prevention education and multi-session prevention education, student assistance programs, youth development and

engagement advocacy programs, Tribal Based Practices, coalition capacity building and engagement, collaboration with partners, community awareness raising events, mobilization and education about community event policies, alcohol and tobacco retail and point of sale interventions, Indoor Clean Air Act policy expansion, raising the price of alcohol, tobacco and cannabis, restrictions on alcohol marketing, promotion and retail environments and maintenance of a controlled state to limit alcohol density.

In addition to funding sub-awardees, the state ADPEP program also leads efforts to advance CSAP environmental prevention strategies in the following areas:

- **Information dissemination**: Development of a new mass reach health communications, Rethink the Drink. Development of campaign brand and health education messages for communicating to Oregonians about risks, problems and solutions about excessive alcohol use.
- **Problem ID and Referral:** Assess quality and efficacy in alcohol screening systems in primary care; Influence alcohol metrics to include SBIRT for health system partners and Coordinated Care Organizations (CCOs). The state does not directly implement SBIRT, but aims to assess, influence and ensure the intervention and system is being implemented and prioritized.
- **Environmental:** Raising the price of alcohol, maintaining state control of liquor sales to limit density, and limiting alcohol and cannabis availability.

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- **Environmental:** Raising the price of alcohol, maintaining state control of liquor sales to limit density, and limiting alcohol and cannabis availability.

There are an array of services catering to the SMI and SED population which includes the $39 million investment in the Rental Assistance Program. “Rental Assistance” is OHCS property-based & references OHA services behavioral health services mixing references to Housing Services with Behavioral Health Services. OHA RA program only offers specific “housing services” specific to private sector property management and landlord communication, which includes lease negotiation and credit repair, coordinating and referrals, and networking in the rental housing world. In addition, the Housing Assistance Services Program provides funding to 10 local to provide rental assistance and housing supports for individuals in recovery for SUD with a $2 million investment. The funding can be used for administrative services and housing. As well as, rent assistance for 24 months and may get approval for an extension and the program determines how to use the funds. Furthermore, the $3million Coronavirus Relief Funding efforts ($3M) have been dispersed to Licensed residential providers making application for funds to manage the outbreak risk related to COVID ($1.5M),and the development of new licensed homes & facilities to accommodate individuals leaving OSH. ($1.5M)

How TB services are addressed in the state

Data shows 19% of 67 people diagnosed with TB disease in Oregon during 2020 self-reported a history of substance abuse in the year leading up to diagnosis.

The OHA Tuberculosis Program core activities are to: 1. Provide technical assistance and education to local health departments, health care facilities, correctional facilities, private medical providers and others on TB screening and the medical management of tuberculosis disease and infection. 2. Collect, report and analyze data on TB. Ensure statewide policy and administrative rules related to TB reflect the data's findings. 3. Provide local health departments (LHDs) with the support needed to ensure TB infection and disease are detected early, treated appropriately and that persons with TB are treated equitably and ethically.

The Tuberculosis Program provides at no cost to local health departments medications to treat TB, payments for chest X-rays, and funds (as available) for housing, food or transportation for patients to adhere to treatment regimens. The TB Program receives funds from the Centers for Disease Control and Prevention, and State of Oregon General Funds.

The HIV Care and Treatment Program of the HIV/STD/TB (HST) Section of the Public Health Division provides information, referral, and access to treatment for persons with mental health and substance use 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.

Persons with HIV, mental health and substance use issues are disproportionately impacted by the current housing crisis. Within the HOPWA funded housing programs administered by the Public Health Division, one program specifically meets 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 Oregon Department of Corrections, many of whom have a mental health and/or substance use disorder. Starting in 2019 the HST Section has also obligated $10 million over five years to support low barrier housing and in-home intensive wrap around support services for people living with significant behavioral health barriers to housing and healthcare. 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 Care and Treatment works closely with HIV and STI Prevention programs to ensure streamlined and coordinated services across the HIV continuum.

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 use 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. HST has prioritized several projects that focus on ameliorating health disparities between Latinx and non-Latinx folks in Oregon. These projects include health education and risk reduction for primary prevention, as well as outreach testing and increased harm reduction services in Latinx communities.

The HIV Prevention Program uses state general funds, federal funds, or a combination of both to support syringe access activities in 14 counties and two community-based HIV/AIDS service organizations in Oregon. This support takes the form of funds for purchases of syringes, staff time, waste disposal services, sharps containers, and other supplies. Lastly, the HIV Prevention Program provides a Special Needs funding request mechanism meant to provide organizations the opportunity to apply for supplemental start-up

funds that can be used to initiate syringe service programs across the state. Syringe Service Program programs in Oregon have primarily fallen 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.

Services Available for People Currently Using Drugs

In Oregon, substance use services for people who use drugs, including people who are actively using drugs are provided by a variety of organizations in a wide range of settings. The Oregon Health Authority recognizes and supports evidence-based harm reduction interventions. While Oregon's Public Health Division has supported overdose prevention and syringe service interventions, over the past five years, the Behavioral Health Division also integrated harm reduction into the state's substance use disorder continuum intervention and strategy portfolio.

Harm reduction is a general term that is inclusive of a wide range of interventions, strategies and activities. Harm reduction refers to an approach that protects the life, health, and dignity of people who use drugs and their communities. An intervention is a combination of strategies and activities that together lead to specific goals or outcomes. Harm reduction interventions take place in different settings, can have varying goals and time horizons, and different focus populations or group focus. Harm reduction strategies and activities may also be incorporated as components of interventions and programs.

State Behavioral Health system joined with the Public Health Division to support overdose prevention interventions and strategies, such as naloxone distribution directly to people using drugs within existing Syringe Service Programs. From the perspective of Oregon's Behavioral Health, harm reduction interventions are one of the pillars of a comprehensive substance use response. Over the past 5 years, the Behavioral Health Division has also piloted, supported and expanded harm reduction intervention programs and strategies.

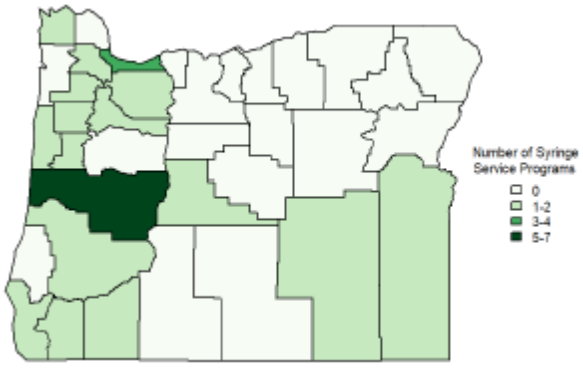
Harm reduction interventions and strategies are not bound by substance use disorder diagnostic criteria, although harm reduction interventions and strategies can be thought of along the continuum of substance use dependence from use to extreme states of dependence to substance misuse and use. Oregon categorizes the types of harm reduction interventions and strategies by their purpose or goal in relation to people who are using drugs. The general purpose or goal categories include, interventions that (a) keep people alive, (b) maintain health and support stabilization and (c) improve health and support stability. Below is a table of strategies and interventions available in Oregon for people using drugs characterized by these purposes and goals. Detailed information about the SSPs, PRIME+, Oregon HOPE, Project Nurture interventions and other overdose responses is available in the Overdose-Related Services and Projects by Oregon County, a document that is reviewed and updated regularly by the Public Health Division.

Intervention/Strategy	**Type**	**Goal/Purpose**		
		Stay Alive	**Maintain Health and Stability**	**Improve Health and Stability**
Overdose Prevention Information and Education*	Strategy	X		

Naloxone Distribution	Strategy	X		
Drug Testing – fentanyl test strips	Strategy	X		
Syringe Service Programs (SSPs)	Intervention	X	X	x
Drop-In Centers*	Intervention		X	X
PRIME+ (Peer Recovery Support Specialists/Certified Peer Recovery Mentors)	Intervention	X	X	X
Project Nurture	Intervention	X	X	X
Buprenorphine-Naloxone Treatment*	Intervention			X
Opioid Treatment Program*	Intervention			X
Contingency Management Programs*	Intervention			X

*These interventions and strategies are described in greater detail in section x of the original block grant proposal

Oregon's Syringe Service Programs



Syringe services programs (SSP) are community-based programs for people who inject drugs and are important interventions that integrate overdose and infection prevention. SSPs provide referrals to care and services. In Oregon, there are over 30 SSP sites that provide a variety of services including free sterile needles and syringes, safe disposal areas, and access to prevention services such as HIV and Hepatitis C testing. The availability of strategies is dependent on current funding. These programs are supported by multiple funders, including allowable State Public Health and Behavioral Health programs.

In a 2019 Survey of Oregon's SSPs, programs reported distributing: syringes, safer injecting and smoking supplies, naloxone, fentanyl test strips, wound care kits, condoms, personal and sharps collection boxes. Many SSP sites also reported providing overdose response training, health education and conducting rapid HIV and HCV testing and providing referrals to medical and substance use treatment. Syringe Service Programs. Over half of SSPs also distributed personal hygiene kits and food to clients. Syringe Service Programs reported multiple funders, including state and local Public and Behavioral Health, Coordinated Care Organizations (CCOs), local community foundations and hospitals, agency general funds and donations. Approximately 80% of programs that responded to the 2019 SSP survey indicated that funding was unstable to very unstable.

Oregon's PRIME+ Program

The aims of the PRIME+ program are to provide peer-based harm reduction support for persons currently using drugs who present to medical settings, including hospitals, emergency departments, urgent and clinical care to

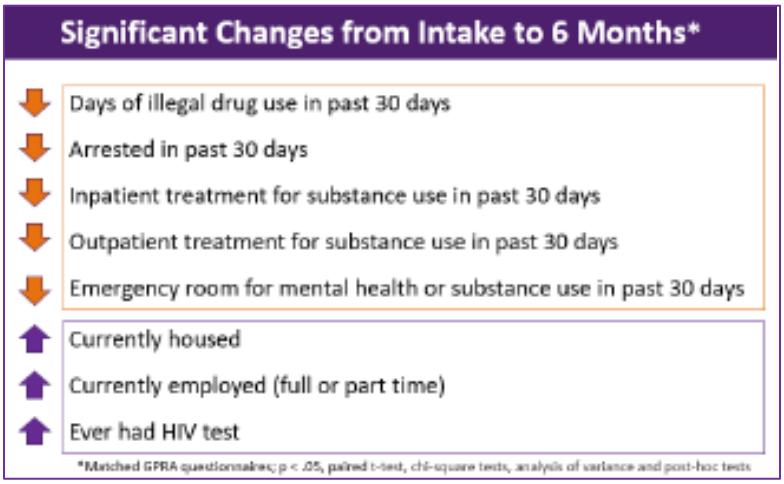
1. Prevent overdose and injection-related infections;

2. Access hepatitis B, HIV, and hepatitis C testing, and other preventive care; and

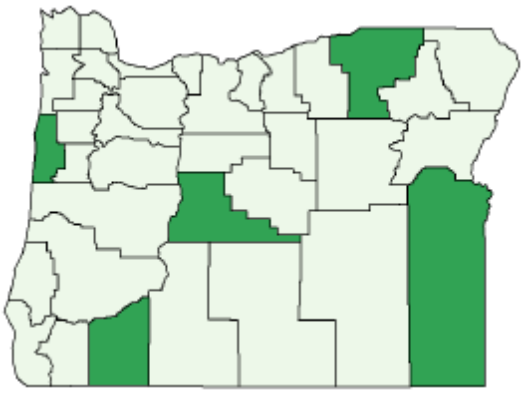
3. Link interested participants with substance use treatment, primary care and HIV/hepatitis C treatment.

From January 2021 through September 30, 2021, PRIME+ documented engaging 1,601 participants. PRIME+ participants are individuals who agreed to receive individual level peer support and provided contact and other identifying information. Nearly half of participants worked on or created new goals with peers, and/or discussed physical or mental health. More than a third received crisis or emotional support and a quarter discussed recurrence of use prevention.

PRIME+ peer sites were required to complete GPRA questionnaires with participants at intake and 6- month follow-up. Research Making Change (RMC) released a report on PRIME+ GPRA results in July 2021 that summarized results. A snapshot of significant changes from intake to 6 months are below.



Oregon's Project Nurture



Project Nurture is an innovative care model integrating maternity care, substance use treatment, and social service coordination. The model was piloted in three sites in Portland, Oregon beginning in 2015. Project Nurture provided pregnant people with access to peer support specialists, clinical care, and links to social services.

Oregon Health Authority Health Systems Division (OHA HSD) Behavioral Health Services is building on lessons learned from the Project Nurture pilot to expand and adapt this program for sustainable implementation. The expansion project will include six sites across Oregon, with a specific focus on rural areas and sites serving BIPOC families. In addition to geographic expansion, enhanced elements may be incorporated such as a cross-site peer learning collaborative, mental health counseling to address trauma, and the opportunity for recovery peers to receive doula certification. OHA is collaborating with Comagine Health to support sites in incorporating elements of the Project Nurture pilot that best fit the needs of the communities they serve with the available resources. The expansion project will also include a collaboration with Department of Health Services (DHS) Child Welfare in developing training and materials for Child Welfare workers and sites to facilitate coordination related to maternity stays and Plans of Care. The expansion project will be formally evaluated by Oregon Health & Sciences University.

Case Statement for BG Investment in Peer Delivered Services:

Peer Run Organizations (PRO), Recovery Community Organizations (RCO) and Peer Drop-in Centers: These organizations serve their community across the continuum of care. They provide outreach and engagement and direct peer services to individuals in SUD or MH treatment and recovery. Anyone can walk in through the door and a peer will work with the individual to assess their needs and support them through other community services, referrals, and support such as employment and housing. They also coordinate with local residential programs through a strong referral relationship all the way to an MOU relationship where the peer can serve the individuals at the residential Tx facility but is employed by the peer run organizations. There are a few peer run organizations that have just initiated service but there is still a huge gap in statewide network. The largest need for investment in these initiatives is in underserved urban regions and in frontier counties where social determinants of health and physical access to treatment and recovery facilities are limited. Priority need with Black, Indigenous, and Persons of Color communities within these regions.

RCO's work to develop engaging communities to shift cultural perspectives around Substance Use and Mental Health, creating and promoting sustainable, attractive and healthy designs for living across the continuum of care from Prevention, Intervention to long term resiliency and recovery. Recovery Community Centers are also cost-effective models of long-term recovery supports backed by emerging scientific efficacy evidence. The best practice for operating recovery centers is one done by a recovery community organization (RCO). RCO's are peer-run recovery organizations that provide non-clinical recovery support services. RCO's have historically been funded on the eastern coast, but in recent years national best practices have emerged. These efforts have recently gained the interest of national addiction research leader John Kelley and his team at the Harvard Medical Institute. The Recovery Research Institute is doing a special series on the importance of Recovery Centers in creating a holistic continuum of care. There currently exists an emergence of RCOs in Oregon.

Utilizing RCO models has considerable Return on investment:

- Recovery Centers provide social support for hundreds daily
- Recovery Centers will focus on outreach and engagement, which is especially important as the state moves to replace criminal justice-based interventions and referrals to treatment.
- Other benefits of Oregon recovery centers can be found in a recently completed program evaluation conducted by Comagine Health on 4D Recovery, the report can be found here: www.4drecovery.org/annualreport

For Example:
1)Stronghold which is a peer run organization and serves Indigenous Folx in the Klamath areas.
2) Painted Horse recovery, providing recovery supports to Indigenous Folx in the Urbanized context within Portland metro plus area. Not only do they coordinate with regional providers but also coordinate with local BIPOC led Recovery Community Organizations.
3)Northwest Instituto Latino de Adicciones a Latinx/Hispanic run Peer Initiative.
4)Push Movement, an RCO owned by Persons in Long Term Recovery utilizing skateboarding and street culture to provide outreach and engagement with the local street community in Portland areas.

5)4D Recovery Centers. A leader in the RCO model for several years, currently operating 3 Recovery Community Centers, fully staffed with outreach and Peer Workers. Also, providing extensive levels of Technical Assistance around the state for startup RCO's.

In addition, recruitment for a peer services coordinator that will focus on addressing the "SPMI" Peer Service Delivery as it relates to ACT, Aid & Assist, and Mobile, is in process.

OHA would like to continue funding and supporting these organizations so they can expand their workforce and outreach to communities, provide trainings to new and upcoming organizations. This will also help develop a network of peer run organizations across the state that are specific to indigenous and BIPOC communities.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care 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 M/SUD system of care.
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, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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.

Oregon Health Authorities (OHA) 10-year goal (by 2030) is to eliminate inequalities in health outcomes, particularly for people who need behavioral health services. This means people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. OHA seeks to ensure behavioral health services are simple to access, responsive to people's needs, and result in meaningful outcomes for people. COVID-19 has had a profound impact on people who receive behavioral health services and how services are provided. As the pandemic continues does the needs for enhancing and expanding behavioral health services and support will continue. There are two tools that help understand OHA's next steps for community engagement, action planning and accountability.

State Health Assessment and State Health Improvement Plan

Every five years the Oregon Health Authority Public Health Division describes the health of our state through the State Health Assessment (SHA). In 2018, a health equity analysis was completed as part of the (SHA). One way in which OHA uses works to prioritize health equity is by elevating the Oregon State Health Improvement Plan (SHIP). To develop the 2020-2024 State Health Improvement Plan, the Public Health Division used the *Mobilizing for Action through Planning and Partnerships (MAPP)* framework, widely used by CCOs and local health departments. From August of 2019 – July 2020, over 100 partners from a variety of sectors came together in subcommittees of the PartnerSHIP to identify strategies, measures and develop work plans for implementation. Subcommittees included PartnerSHIP members, additional subject matter experts, and people with lived experience.

The State Health Assessment and engagement with community partners helps to inform the SHIP. The SHIP is a five-year external-facing plan that identifies our state's health priorities with strategies that will lead to improvements in outcomes. This work is in addition to, and supportive of OHA's 10-year goal to eliminate health inequities. The SHIP is a key initiative of the Oregon Health Authority (OHA) that aims to advance health equity. The SHIP is intended to inform Community Health Improvement Plans (CHIPs), and state agency policies, partnerships, and investments. Oregon's State Health Improvement Plan (SHIP) addresses the leading causes of death, disease, and injury in Oregon through

evidence-based and measurable strategies intended to improve the health of all people in Oregon.

Health inequities persist for individuals and communities based on factors such as race, gender, sexual orientation, geographic location, income, and education. Without specifically addressing inequitable health outcomes, Oregon will not be successful in achieving its goal of optimal health for everyone. The 2020-2024 SHIP will be addressing five priority areas: institutional bias; adversity, trauma, and toxic stress; behavioral health; equitable access to preventive care; and economic drivers of health including housing, transportation and living wage. OHA is launching the 2020-2024 SHIP as a tool for our state's recovery from COVID-19. Co-created with over 100 community partners, the SHIP is designed to respond to priorities that communities identified in 2018 and 2019. Prior to COVID-19, social determinants of health were identified as critical to health in our state. The COVID-19 pandemic has worsened the short- and long-term trajectory in each of these five priority areas, making implementation of the SHIP even more critical. To begin to address these issues, each priority will be addressed by a subcommittee that will use their experience, expertise, and capacity to create a SHIP that identifies evidence based and innovative strategies for policy, system, and environmental changes. Members were recruited based on learned or lived understanding of the topic area, genuine interest in the success of the SHIP, and ability to actively participate in the SHIP process.

In addition to the SHA and SHIP, health equity has been prioritized by the nine-member Oregon Health Policy Board (OHPB), which serves as the policymaking and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population-health. The 2010 Action Plan for Health has been updated by the Oregon Health Policy Board with a new roadmap that moves beyond the implementation phase and toward an upstream approach that advances health system transformation. It creates a framework that focuses on root causes of poor health outcomes, social determinants of health, health equity and use of evidence-based approaches while continuing to build out improvements to care coordination, data collection and measurement, and payment methodologies.

Alcohol and Drug Policy Commission (ADPC) Strategic Planning

In close collaboration with the State Health Improvement Plan, the Alcohol and Drug Policy Commission (ADPC) Strategic Plan is working to improve of the effectiveness and efficiency of state and local alcohol and drug misuse prevention and treatment services. Oregon, like much of the rest of country, needs system transformation. In part to achieve these goals the ADPC, under the leadership of Governor Kate Brown, along with our state agency partners, adopted a comprehensive strategic plan, pursuant to ORS 430.242. The plan seeks to identify:

1. Processes and resources to create, track, fund, and report on strategies for systems integration, innovation, and policy development

2. Strategies to reduce Oregon's substance use disorder (SUD) rate, including preventing SUD and promoting recovery
3. Strategies to reduce morbidity and mortality related to SUD.

When fully implemented, the plan will sustain system transformation. This strategic plan will be the state's blueprint for saving lives. System transformation is not an inexpensive or easy undertaking; it requires the commitment and will to accomplish the greatness that is Oregon.

The Alcohol and Drug Policy Commission (ADPC) is an independent state government agency that was created by the Oregon Legislature to improve the effectiveness and efficiency of state and local Substance Use Disorder (SUD) prevention, treatment and recovery services for all Oregonians. The Alcohol and Drug Policy Commission (ADPC) purpose is to improve the effectiveness and efficiency of state and local SUD prevention, treatment and recovery services for all Oregonians.

Community engagement

In fall of 2018, the Oregon Health Authority – Public Health Division (OHA-PHD) convened a process to develop the 2020-2024 State Health Improvement Plan (SHIP). A community-based steering committee, called the PartnerSHIP, was formed to set the vision and values, and identify the priorities for the 2020-2024 SHIP. The PartnerSHIP first identified 14 strategic issues that need to be addressed to improve health in our state which are Safe, affordable housing, Access to mental health, Access to care, Living wage, Adverse child and life experiences, trauma and toxic stress, Tobacco use, Obesity, Suicide, Incarceration, Climate change, Food insecurity, Institutional bias, Violence, and Substance use Although all the identified issues are important for improving health in our state, it isn't feasible to address all 14. Therefore, a number of avenues were created to solicit community feedback on which of the 14 issues should be addressed in the 2020-2024 SHIP.

Seven community-based organizations were funded to solicit feedback from marginalized communities, community members were invited by OHA-PHD to complete an online survey (in either English or Spanish), and agencies and other interested persons were invited to submit comment via email, social media, and other convenings. Feedback was received by the OHA-PHD between November 13, 2018 and January 31, 2019.

FEEDBACK FROM COMMUNITY BASED ORGANIZATIONS OHA-PHD funded seven community-based organization to solicit feedback from marginalized communities:

- Eastern Oregon Center for Independent Living (EOCIL) —Serves the disability community in 13 rural and frontier counties of Eastern Oregon.

- Micronesian Islander Community (MIC) (of Asian Pacific American Network of Oregon)— Serves the Micronesian and Pacific Islander community, including Compact of Free Association (COFA) citizens, throughout the Willamette Valley.
- Next Door—Serving Latinx and Native American communities throughout the Columbia River Gorge area via its Health Promotion Services, Nuestra Comunidad Sana (Our Healthy Community).
- Northwest Portland Area Indian Health Board (NPAIHB)— Serves all federally recognized tribes in Idaho, Oregon, and Washington, including the 9 tribes located in Oregon.
- Q Center—LGBTQIA+-identified persons living in the Portland metro area.
- Self Enhancement Inc. (SEI)— Provides education, advocacy, and wraparound support services for the African American/Black community and other underserved youth and families across the Portland metropolitan area. 2020-2024 SHIP: Summary of community feedback
- Unite Oregon—Serving people of color, immigrants and refugees, and LGBTQ-identified people in Jackson and Josephine counties.

These organizations used a variety of methods to solicit feedback based on the unique needs and preferences of the community. Methods include distribution of electronic and paper-based surveys, community listening sessions, and door to door conversation with neighbors.

Public Health Modernization

Passed by the legislature in House Bill 3100, a plan and model were 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 Public Health Division, 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 policies, systems and environmental change for substance abuse prevention strategies that supports all Oregonians.

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

Alcohol and Other Drug Prevention

In 2015, the Oregon Health Authority (OHA) reorganized and transitioned alcohol and drug primary prevention responsibilities to the Public Health Division (PHD). While this was a significant change, it was also an opportunity to leverage additional resources, grow a robust statewide comprehensive program and strengthen coordinated leadership at the state and locally for alcohol and other drug prevention in Oregon.

To advance coordinated leadership for prevention, the OHA-PHD developed a new model for improving coordination of Alcohol, Tobacco and Other Drugs (ATOD) Prevention systems, funding, and interventions in Oregon in 2020. Currently, six sections within OHA-PHD are responsible for implementing these wide-ranging substance use prevention efforts, with additional interventions administered through OHA's Health Systems Division (HSD). The Alcohol and Other Drug Alignment team will work to advance and coordinate a variety of substance use prevention strategies in Oregon.

Prevention service needs vary widely across domain settings, the lifespan, ethnicity and race, risk factors and local communities and tribes. However, a persistent and growing population-level need and gap in Oregon is excessive alcohol use among Oregonians. Excessive alcohol use drives many of Oregon's most pressing health and social challenges. Alcohol is the third leading cause of preventable death and disease, and Oregon has the 3rd highest substance use disorder rate and 4th highest alcohol use disorder rate in the nation, affecting about 339,000 and 250,000 Oregonians respectively in 2018-191. Over the past 20 years, alcohol-related deaths in Oregon have increased nearly 37%, and in 2019 alcohol was responsible for nearly 2,200 deaths. Excessive alcohol use costs the Oregon economy $4.8 billion per year, including lost workplace productivity, health care expenses, criminal justice costs, and motor vehicle crash related costs.

To address this issue through a population-level, policy-focused public health approach, OHA enlisted the PHD's Health Promotion and Chronic Disease Prevention (HPCDP) section to administer the SABG primary prevention SAMHSA funded resources. In addition to supporting local and tribal prevention infrastructure with funding, the program has been working with state and local partners and other stakeholders to implement evidence-based strategies to reduce excessive alcohol use and related harms. These strategies include raising the price of alcohol, ensuring access to comprehensive alcohol screening, referral, and treatment benefits, maintaining state control for distilled spirits, and increasing regulation of alcohol outlet density and retail environments and limiting exposure to and access to alcohol.

While this policy focus represents a necessary upstream shift, some key elements of a comprehensive program remain under-resourced and a systems service need, including

surveillance and evaluation, and mass-reach health communications. To address these system and population service needs, the OHA plans to leverage additional resources from the Centers for Disease Control and SAMHSA's supplemental funding to build and maintain new mass-reach health communications infrastructure for prevention and surveillance and evaluation staffing and data resources. Addressing these infrastructure needs will ensure information is shared in an accessible manner and that local program, coalitions, stakeholders and decisionmakers are better engaged and equipped to support a unified, more equitable public health approach to prevent excessive alcohol use.

Data sources for primary prevention

The Oregon Health Authority maintains and monitors several population-based data sources to identify primary prevention needs.

- **Adult surveys**

  The Behavioral Risk Factor Surveillance System (BRFSS) and the National Survey on Drug Use and Health (NSDUH) are primary data sources used to monitor risk behaviors, mental health and substance use disorders, and disease prevalence for Oregon adults.

- **Youth surveys**

  Over the past decade, OHA has conducted two separate youth surveys – the Oregon Healthy Teens Survey (OHT) in odd years and the Student Wellness Survey (SWS) in even years. To improve data quality, reduce the burden on schools and students, and meet the data needs of local communities, OHA will launched a single integrated Student Health Survey (SHS) in the Fall of 2020. Over the course of 2018-19, OHA engaged youth, educators, local public health authorities, and other government agencies through listening sessions, interviews, community presentations, and surveys. Through this feedback, partners have helped shape important content and process decisions. This engagement process has also prompted opportunities to hear from new partners and continue an open dialogue with stakeholders to ensure that data needs are met, and has set the stage for ongoing cross-sector collaborative work that is central to primary prevention.

- **Oregon Student Health Survey (SHS)**

  The SHS is a census-based survey of Oregon 6th, 8th and 11th-graders. All public schools with students in these grades are invited to participate. The survey covers 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. Data and reports from the survey are

provided to all participating schools and school districts, and state and county data reports will be posted publicly.

Because of changes in survey methodology and timing of administration, data from the SHS will not be directly comparable to the prior Student Wellness Survey or the Oregon Healthy Teens survey. Changes in outcome measures that are affected by the shift in data collection during the grant period will be noted in reports. Ultimately, the SHS will improve data reliability and accuracy. Quality data is essential for schools, state and local agencies, and local communities to best inform decisions about funding, programs, and other interventions to advance robust primary prevention efforts.

• **The Oregon Student Wellness Survey (SWS)**
The SWS was last conducted in 2018. The survey was a census-based survey conducted in every even year in schools statewide and administered to 6th, 8th and 11th graders.
https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/student-wellness.aspx

• **Oregon Healthy Teens (OHT) Survey**
The OHT was last conducted in 2019. The survey was conducted every odd year in a sample of schools statewide and administered to 8th and 11th graders.
https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Pages/index.aspx

State Epidemiological Outcomes Workgroup (SEOW)
OHA-PHD Health Promotion and Chronic Disease Prevention Section's Surveillance and Evaluation Team (SET) is made up of data analysts, evaluation specialists and epidemiologists. This team serves as the foundation of Oregon's SEOW. The SEOW coordinates with a network of data analysts and researchers from OHA Health Systems Division, OHA Health Policy & Analytics Division and external organizations to guide planning for the implementation of prevention best practices and to inform strategic planning. The SEOW also enlists support from contractors to support specialized data collection and evaluation work.

The SEOW ensures that the priorities of the SABG primary prevention funds align with the overall priorities of the PHD, the Public Health Advisory Board (PHAB), and other state-level decision-makers. The SEOW monitors the behavioral health substance use priority in the State Health Improvement Plan (SHIP) and SABG primary prevention priorities. The SEOW will also inform the PHAB regarding progress and needs related to

the substance use priority. This arrangement provides the SEOW with the ability to inform the highest-level leadership entities for health in Oregon.

The SEOW promotes high quality data and robust surveillance systems that are needed to best inform primary prevention efforts. The SEOW leads and contributes to many data quality improvement efforts, such as development of the new Student Health Survey and investigation of alternative methods to collect data from vulnerable and hard-to-reach populations in Oregon.

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 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

[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.

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.

Future Gaps:

Oregon has identified the following gaps and needs in Behavioral Health Services. House Bill 2086 was passed in 2021 legislative session, directs Oregon Health Authority to address these gaps.

- Advance health equity
- Detect and treat mental health and substance use disorders earlier and effectively
- Timely access to full continuum of behavioral health care
- Treatment that is responsive to individual needs and leads to meaningful improvements in their lives.
- Access to affordable housing that offers independence and is close to providers, community resources and public transportation.
- Supply, distribution, and diversity of the behavioral health workforce needs to provide appropriate levels of care and access to care in the community.

Program and Services

- Section 1: Establish programs that are peer and community driven that ensure access to culturally specific and culturally responsive behavioral health services for people of color, tribal communities, and people of lived experiences.
- Provide medical assistance reimbursement for tribal-based practices.
- Section 2: Reimburse the cost of co-occurring mental health and substance use disorder treatment services paid for on a fee-for-service basis at an enhanced rate.
- Section 3: Provide one-time start-up funding for behavioral health treatment program that provides integrated co-occurring disorder treatment.

- Section 4: Conduct a study of reimbursement rates for co-occurring disorder treatments, including treatment for co-occurring intellectual and developmental disability and problem gambling disorder.
- Section 5: From the general fund, amount of $10,200,000 may be expended to carry out sections 2 and 4.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: The behavioral health system promotes healthy communities and prevents chronic diseases - including addiction, across the lifespan.

Priority Type: SAP

Population(s): PWWDC, PP, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Children/Youth at Risk for BH Disorder, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, All Oregonians)

Goal of the priority area:

OHA will reduce the health care costs by implementing population level prevention and mental health promotion efforts to achieve long-term reductions in substance use, misuse, dependency and related negative health outcomes related to substance use.

Strategies to attain the goal:

- Increase the price of alcohol.
- Increase the number of jurisdictions covered by alcohol marketing, promotion, and retail restrictions such as limiting outlet density, price promotions, and limits on days or hours of sale, and point of purchase interventions.
- Ensure availability of comprehensive alcohol screening, referral and treatment benefits through public and private health plans.
- Maintain Oregon's state alcohol beverage control to prevent and reduce excessive alcohol use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past month binge drinking among 8th graders

Baseline Measurement: 5.3%

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

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 eight years (2017-2025) 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.

Data issues/caveats that affect outcome measures:

Latest data is not always available during the BG application process. Data targets align with OHA's Public Health Division State Health Improvement Plan which uses baseline data from 2015.

Indicator #: 2

Indicator: Past month binge-drinking among 11th graders

Baseline Measurement: 16.5%

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

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 eight years (2017-2025) 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 eight year state targets.

Data issues/caveats that affect outcome measures:

Latest data is not always available during the BG application process. Data targets align with OHA's Public Health Division State Health Improvement Plan which uses baseline data from 2015.

Indicator #: 3

Indicator: Past month binge drinking among adults

Baseline Measurement: 17.9%

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

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 eight years (2017-2025) from 17.9% to 16.1%. First-year and second-year targets listed above reflect a linear decrease over time.
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. Data targets align with OHA's Public Health Division State Health Improvement Plan which uses baseline data from 2015.

Indicator #: 4

Indicator: Past month heavy drinking among adults

Baseline Measurement: 7.3%

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

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 eight years (2017-2022) from 7.3% to 6.6%. First-year and second-year targets listed above reflect a linear decrease over time based on eight 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. Data targets align with OHA's Public Health Division State Health Improvement Plan which uses baseline data from 2015.

Indicator #: 5

Indicator: Per capita alcohol consumption among those age 14 and older

Baseline Measurement: 2.7

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

Data Source:

National Institutes of Alcohol Abuse and Alcoholism (NIAAA). Apparent per capita alcohol consumption: National, state, regional trends surveillance report

Description of Data:

Per capita alcohol consumption is calculated by standardizing the gallons of alcohol sold in the state and dividing it by the total population aged 14 and above.

Data issues/caveats that affect outcome measures:

This measure does not vary widely from year to year.

Priority #: 2

Priority Area: Health equity and equal access to behavioral health 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, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access among racial and ethnic BH patient populations

Baseline Measurement: Number of people identified as racial and ethnic minorities who accessed BH treatment in

2020

First-year target/outcome measurement: Access to BH treatment by racial and ethnic minorities increased by 2% from baseline

Second-year target/outcome measurement: Access to BH treatment bu racial and ethnic minorities increased by 2% from year 1

Data Source:

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

Description of Data:

Data is collected from the three different data sources which use unique identifiers for individuals accessing services. Numerator is individuals with at least one MH or SUD claim and denominator is individuals in the systems identifying as racial and/or ethnic minority.

Data issues/caveats that affect outcome measures:

Targets are set based on increase access for total population.

Indicator #: 2

Indicator: Maintain the number of consumers and family members on the Addiction and Mental Health Planning and Advisory Council

Baseline Measurement: 51%

First-year target/outcome measurement: at least 51%

Second-year target/outcome measurement: at least 51%

Data Source:

AMHPAC roster

Description of Data:

The AMHPAC maintains a membership roster that is regularly updated

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 3

Indicator: Capacity Management and accurate waitlist estimate for pregnant women and families with children

Baseline Measurement: No baseline measure at this point

First-year target/outcome measurement: establish baseline using the new capacity management and referral tracking system for individuals with OUD: number of providers enorlled in database

Second-year target/outcome measurement: 100% SUD and MH treatment providers are enrolled in the database by 2022

Data Source:

OHA SUD Capacity Management and referral tracking database

Description of Data:

Real time data collected and reported through the database which is maintained by a contracted vendor' Lines for Life

Data issues/caveats that affect outcome measures:

Database still under construction. Target completion - 9/30/21

Priority #: 3

Priority Area: Adults with SMI have access to BH 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 illness. The was after lengthy discussions the Civil Rights Division of United State Department Justice.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Adults with SMI who received Assertive Community Treatment services

Baseline Measurement: 815

First-year target/outcome measurement: 5% increase over year two's target

Second-year target/outcome measurement: 5% increase over year three's target

Data Source:

MMIS: MEDICAID DATA

Description of Data:

All individuals who are covered under Medicaid/OHP

Data issues/caveats that affect outcome measures:

Complete data for indigent individuals are not available.

Indicator #: 2

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

Baseline Measurement: 1.54 per 10000

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

Second-year target/outcome measurement: 10% reduction from first year target

Data Source:

MMIS

Description of Data:

See step 2: data collection and quality

Data issues/caveats that affect outcome measures:

N/A

Priority #: 4

Priority Area: People in all regions of Oregon have access to full continuum of BH services

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, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

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

Strategies to attain the goal:

Collaborate with local mental health authorities, public health authorities, community programs and coordinated care organizations to develop a basic set of services for prevention, treatment and recovery in all communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduced number of ER visits for individuals enrolled in OHP

Baseline Measurement: 2.45/1000 member

First-year target/outcome measurement: 3% decrease from baseline

Second-year target/outcome measurement: 3% decrease from baseline

Data Source:

MMIS

Description of Data:

Numerator is number of individuals who have an ER claim for BH services and denominator is number of individuals enrolled in OHP.

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 reduce emergency department use for psychiatric crises are likely be most effective.

Indicator #: 2

Indicator: Increased number of individuals accessing Medication Assisted Treatment (MAT)

Baseline Measurement: 19,869 individuals with OUD

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

Data Source:

MMIS

Description of Data:

Numerator is number of individuals who had a claim for MAT and denominator is number of individuals in OHP who had a diagnosis of OUD.

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 3

Indicator: Number of individuals receiving peer delivered services

Baseline Measurement: 4,272

First-year target/outcome measurement: 5% improvement over baseline

Second-year target/outcome measurement: 5% improvement over first-year target

Data Source:

MMIS

Description of Data:

Numerator is number of individuals who have a claim for Peer delivered Services and denominator is number of individuals in OHP

Data issues/caveats that affect outcome measures:

Claims for PDS are not separately identifiable in MMIS when PDS is part of a a capitated payment.

Priority #: 5

Priority Area: Treatment and Recovery support for pregnant women and families with children

Priority Type: SAT, MHS

Population(s): PWWDC

Goal of the priority area:

OHA will establish accurate tracking of capacity management and wait-list data for PWWDC who are seeking to access SUD treatment., also ensure timely delivery services this population

Strategies to attain the goal:

OHA is working on building a capacity management and wait-list data tracking system for PWWDC who need SUD, MH, OUD treatment. BG funds will help establish that in the next biennium. Second year target 80.2%

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain the percentage of PWWWDC who successfully complete treatment or receive at least 90 days of treatment

Baseline Measurement: 80.2%

First-year target/outcome measurement: 80.2%

Second-year target/outcome measurement: 80.2%

Data Source:

MOTS and MMIS

Description of Data:

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

Data issues/caveats that affect outcome measures:

Majority of data comes from MMIS

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$30,870,454.50		$328,183,825.26	$19,105,690.00	$67,642,735.00	$0.00	$0.00		$7,233,094.13	$6,663,214.00
a. Pregnant Women and Women with Dependent Children[c]										
b. All Other	$30,870,454.50		$328,183,825.26	$19,105,690.00	$67,642,735.00				$7,233,094.13	$6,663,214.00
2. Primary Prevention[d]	$8,232,121.20		$0.00	$0.00	$0.00	$0.00	$0.00		$1,928,825.10	$1,665,803.50
a. Substance Abuse Primary Prevention	$8,232,121.20								$1,928,825.10	$1,665,803.50
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services					$207,858.00					
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$2,058,030.30		$215,969.31		$3,320,130.00	$3,353,666.67			$482,206.28	
10. Crisis Services (5 percent set-aside)										
11. Total	**$41,160,606.00**	**$0.00**	**$328,399,794.57**	**$19,105,690.00**	**$71,170,723.00**	**$3,353,666.67**	**$0.00**	**$0.00**	**$9,644,125.51**	**$8,329,017.50**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

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

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Footnotes:
Admin Costs for the State have increased due to better reporting tools.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$2,281,118.00			$7,250,295.44			$1,310,778.80		$2,264,072.50
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$28,392,879.00	$34,067,127.00	$357,186,350.00		$306,542,689.00	$0.00		
7. Other 24-Hour Care			$0.00		$43,261,558.47					
8. Ambulatory/Community Non-24 Hour Care		$18,248,945.00		$2,346,025.00	$341,325,828.09					$8,676,652.80
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$1,140,560.00	$212,873,170.00		$256,768,639.00			$655,389.40		$1,132,036.00
10. Crisis Services (5 percent set-aside)[g]		$1,140,560.00						$11,141,620.60		$10,567,962.75
11. Total	**$0.00**	**$22,811,183.00**	**$241,266,049.00**	**$36,413,152.00**	**$1,005,792,671.00**	**$0.00**	**$306,542,689.00**	**$13,107,788.80**	**$0.00**	**$22,640,724.05**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	1,288	1,103
2. Women with Dependent Children	8,665	7,374
3. Individuals with a co-occurring M/SUD	6,703	6,693
4. Persons who inject drugs	6,001	5,336
5. Persons experiencing homelessness	3,966	2,239

Please provide an explanation for any data cells for which the state does not have a data source.

The numbers n this table are not 100% inclusive because Oregon does not collect data at this level for non-Medicaid population.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$15,435,227.00	$14,466,188.25	$13,326,428.00
2 . Primary Substance Use Disorder Prevention	$4,116,060.60	$3,857,650.00	$3,331,607.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Administration (SSA Level Only)	$1,029,015.00	$964,412.55	
6. Total	**$20,580,302.60**	**$19,288,250.80**	**$16,658,035.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 (SABG); 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 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 required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services 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'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.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal			
	Selective			
	Indicated			
	Unspecified	$558,769		
	Total	**$558,769**	**$0**	**$0**
2. Education	Universal			
	Selective			
	Indicated			
	Unspecified	$373,796		
	Total	**$373,796**	**$0**	**$0**
3. Alternatives	Universal			
	Selective			
	Indicated			
	Unspecified	$373,796		
	Total	**$373,796**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selective			
	Indicated			
	Unspecified	$186,898		
	Total	**$186,898**	**$0**	**$0**
	Universal			

	Selective			
5. Community-Based Process	Indicated			
	Unspecified	$1,369,518		
	Total	**$1,369,518**	**$0**	**$0**
6. Environmental	Universal			
	Selective			
	Indicated			
	Unspecified	$1,253,256		
	Total	**$1,253,256**	**$0**	**$0**
7. Section 1926 Tobacco	Universal			
	Selective			
	Indicated			
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified	$0		
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$4,116,033**	**$0**	**$0**
Total SABG Award[3]		**$20,580,303**	**$19,288,251**	**$16,658,035**
Planned Primary Prevention Percentage		**20.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]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: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct			
Universal Indirect			
Selective			
Indicated			
Column Total	**$0**	**$0**	**$0**
Total SABG Award[3]	**$20,580,303**	**$19,288,251**	**$16,658,035**
Planned Primary Prevention Percentage	**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

State completed form 5a.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☑	☐	☐
Military Families	☐	☐	☐
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems				$300,000.00	
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SABG optional)	$220,957.00				
5. Quality Assurance and Improvement	$55,034.00				
6. Research and Evaluation	$27,515.00				
7. Training and Education	$187,399.00				
8. Total	**$490,905.00**	**$0.00**	**$0.00**	**$300,000.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 10/01/2021 MHBG Planning Period End Date: 10/01/2022

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support					$300,000.00	
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)	$10,410.00			$10,410.00		
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education						
8. Total	**$10,410.00**	**$0.00**	**$0.00**	**$10,410.00**	**$300,000.00**	**$0.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] 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.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

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.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] 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.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] 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 M/SUD include: developing models for inclusion of M/SUD 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.[30] 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 M/SUD 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[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD 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.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] 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.[36] 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.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.[39] 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 M/SUD 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.[40]
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.[41] 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.

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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.

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 cooccurring 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 provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and 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 cooccurring 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 communitybased 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. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (•) Yes ( ) No

b) and Medicaid? (•) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

Oregon Health Authority

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (•) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (•) Yes ( ) No

b) Health risks such as

ii) heart disease (•) Yes ( ) No

iii) hypertension (•) Yes ( ) No

iv) high cholesterol (•) Yes ( ) No

v) diabetes (•) Yes ( ) No

c) Recovery supports (•) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (•) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (•) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

BH workforce reimbursement rates.

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

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD 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)[45].

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."[46]

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[47]. 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[48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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, sexual orientation, gender identity, 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 M/SUD 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) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD 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

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Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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 M/SUD 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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center 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. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. 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."[53] 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 M/SUD 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)**[54] are best practice guidelines for the SUD treatment. SAMHSA 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)**[55] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. KIT 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.

[49] 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

[50] 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.

[51] 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.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. 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.

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG 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.

The Oregon Health Authority funds the Early Assessment and Support Alliance (EASA), a network of programs across Oregon that provide rapid identification, support, assessment, and treatment for youth ages 12 to 27 who are experiencing the early signs of psychosis. EASA is designed as a transitional program, with the goal of providing the education and resources an individual experiencing first episode psychosis needs to be successful in the long-term. Available in 29 Oregon counties, EASA programs are effective, two-year programs with long-lasting results.
The EASA program is a Coordinated Specialty Care (CSC) program, which is a team-based, multi-element approach. The EASA programs include all key roles and services outlined in Coordinated Specialty Care programs, including individual and family therapy, case management, supported employment, family education, primary care coordination and pharmacotherapy. The EASA programs also use peer delivered services and occupational therapy.
As a coordinated specialty care program, EASA uses multiple EBPs as a multi-element approach including: CBT for psychosis, Individual Placement and Support (IPS), multifamily psychoeducation, motivational interviewing, evidence-based prescribing and elements of Assertive Community Treatment (ACT), although the EASA program does not use the entire

fidelity model of ACT.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Oregon state promotes the EASA programs by investing in the EASA Center for Excellence, which focuses on technical assistance, statewide community education and fidelity reviews. The EASA Center for Excellence works with the Oregon Health and Science University, School of Psychiatry, as well, to continue to improve on treatment, stay up to date on current national and international research and provide consultation for individual EASA sites.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with 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.

EASA is a coordinated specialty care (CSC) program, which is a recovery-oriented treatment program for people with first episode psychosis. CSC promotes a collaborative approach to treatment with a team of specialists and the client and family. The team of specialists include, but are limited to, case management, family education, multifamily psychotherapy and supported education and employment. EASA also offers peer delivered services and occupational therapy.
IPS is a model of supported employment for individuals with serious mental illness using the evidence-based practice of supported employment,
Cognitive Behavioral Therapy for psychosis is an evidence-based practice used to reduce the distress associated with symptoms of psychosis and improve functioning.
The EASA programs use a harm reduction, recovery-oriented approach to dual diagnosis of first episode psychosis and substance use disorders, which is integrated into CSC.
The EASA programs offer Multifamily Groups, which is based in organizational problem-solving and clinical practice. The groups are a space for families to learn more about mental health symptoms and recovery and to emphasis a family's important role in the recovery process.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

The EASA Center for Excellence is investing in two "train the trainer" series to then train all EASA staff in Cognitive Behavioral Therapy for psychosis and Dually Diagnosing Individuals with Intellectual and Developmental Disabilities (IDD) and First Episode Psychosis. The EASA Center for Excellence is also working with EASA Sites and the Oregon Health Authority to integrate the use of alternative models for rural and frontier counties as well as adaptation for different cultural groups. This work will be done through workgroups and consumer feedback session.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The EASA Center for Excellence collects data from the EASA program sites through REDCap software, which then is reported to the Oregon Health Authority and back to the sites once it is cleaned and analyzed.

10. Please list the diagnostic categories identified for your state's ESMI programs.

For the EASA program, individuals must have received a diagnosis within the past year that meets criteria for schizophrenia spectrum disorder or bipolar disorder with psychosis and be between the ages of 12-27. EASA sites also serve individuals with psychosis risk syndrome; however this work is not funded with Mental Health Block Grants funds.

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

Sustainability of funding through billing Medicaid and private insurance

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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 team 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, education, 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 assertively promotes an environment with a strong equity lens where all Oregonians regardless of their disability status have autonomy/agency and control over the lives they have chosen for themselves. Oregon has cultivated a culture that prioritizes and celebrates each person's strengths, talents, gifts and their hopes and dreams – across our continuum of care and across other human services sectors. Our efforts also include our ability to identify and protect those at risk of losing this control of their lives due to society's response, often a default paternalism to their disability status or other compromising condition. The core philosophy for PCP is valued and adopted – that the person and the people closest to them are the experts about their service needs and how these service needs should be delivered. This process is driven by the person and includes others chosen by the person.
https://comagine.org/program/oregon-behavioral-health-support/providers

One of the ways Oregon engages consumers and their caregivers is through Wraparound, a fidelity care coordination model that centers youth and families in their journey toward improved wellness. Wraparound provides support to youth and families based on their needs and strengths. Oregon also invests in System of Care infastructure. System of Care, is a philosophy of centering youth and famliies at the policy and program level in order to create supports and services that are needed by youth and families. System of Care operates at the state and local CCO and county levels.

4. Describe the person-centered planning process in your state.

The PCP process is codified into our Oregon Administrative Rules (OAR) as fundamental processes. These rules help the Department carry out statutory requirements and act in accordance with the Agency mission. The OAR's mandate the creation of a person- centered plan using the principles of PCP , and monitoring and updating the plan at regular intervals.

Wraparound is one of the person centered planning processes in Oregon. Wraparound is a medicaid program which supports youth who experience complex needs and are involved in mutlipte child serving systems. Wraparound is a fidelity care coordination model.

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

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6. 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 M/SUD 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 M/SUD 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 M/SUD 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 program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

All intermediaries, providers and entities that contract with Oregon Health Authority have clear language included in their contracts to adhere to Federal Block Grant consistent with the statutory and regulatory framework to ensure program integrity. Contract administrators are the first line in ensuring that the funds are spent in accordance with grant/program regulations and guidelines. This is operationalized through regularly scheduled site /audits/visits to monitor compliance. If provided adequate metrics or parameters, the Governance & Process Improvement compliance team can track and follow-up on any indicators. This will provide another level of quality assurance and completeness/
compliance. Oregon Health Authority has developed a robust infrastructure for program integrity and compliance – including an organizational wide Program Integrity Unit and Internal Audits and Consulting, a shared service with OHA and the Department of Human Services.

Please indicate areas of technical assistance needed related to this section

No TA requested.

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7. 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**[56] 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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

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?

3. 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.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (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)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [x] Others (please list)

Self-report disability
Low socio-economic status

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)
- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [ ] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

Oregon Student Health Survey youth survey based on YRBS

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

Yes, the Oregon Health Authority Public Health Division (OHA-PHD) uses the State Health Improvement Plan (SHIP) and State Health Assessment (SHA), population-level data from youth and adult surveys process to inform select SABG primary prevention funds. The PHD Health Promotion and Chronic Disease Prevention (HPCDP) section uses data to inform development of primary prevention strategic plans and state-level initiatives, inclusive of alcohol and tobacco prevention priorities. OHA-PHD continues to allocate SABG Primary Prevention resources to local communities and tribes consistently determined by previous funding formulas in the former Addictions and Mental Health Division of OHA.

At a local level, county and tribal prevention grantees use data and local information to assess the needs within their communities and use allocated funding to address priority areas based on information collected. OHA 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.

If no, (please explain) how SABG funds are allocated:

Narratve Question

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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 has a Certified Prevention Specialist (CPS) credential program certified by the Mental Health and Addiction Counselor Certification Board of Oregon (MHACCBO). The training model is focused on the IC&RC prevention domains and prepares participants for application and testing for the CPS credential.

The Oregon Health Authority Public Health Division (OHA PHD) continues to assess prevention workforce capacity needs that align with alcohol and other drug prevention strategic goals and objectives and ensure a plan for sustainable prevention workforce capacity. OHA-PHD does not require CPS certification requirements for SABG primary prevention funded grantees. The Oregon Public Health Association Addiction Prevention Section coordinates courses and training of trainers to ensure sustainable CPS training resources. OHA PHD makes sure to provide documentation for participation in CPS eligible trainings to support prevention specialists in securing and maintaining training hours.

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

OHA-PHD supports training and technical assistance for the substance use prevention workforce grantees that are receiving SABG Primary Prevention Funds. Training supports alcohol, tobacco and other drug prevention in local and tribal communities by providing ongoing training and technical assistance on policy, systems and environmental change strategies to build community capacity to achieve local objectives and statewide strategic goals.
Operational and strategic support provides grantees ongoing opportunities for mentoring, group coaching, training, collaboration with peers including sharing lessons learned and successful strategies. Grantee 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, Learning Institutes, Regional Support Networks, an annual Grantees and Contractors convening and biennial Place Matters Conference.
The Alcohol and other Drug Prevention and Education Program Coordinators, and any staff working 0.5 FTE or more are required to complete all staff training requirements related to SABG Primary Prevention funded work.

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 primary 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 purpose of Oregon's State Health Improvement Plan (SHIP) is to identify population-wide priorities and strategies for improving the health of people in Oregon. The SHIP serves as the basis for taking collective action on key health issues in Oregon. The SHA was recently 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.

A new SHIP has been developed for 2020-2024, which includes a Behavioral Health priority area (including mental health and substance use). The Oregon Health Authority Public Health Division convened a PartnerSHIP to inform and develop the 2020-2024 State Health Improvement Plan. The Public Health Division used the Mobilizing for Action through Planning and Partnerships (MAPP) framework, widely used by Coordinated Care Organizations (CCOs) and local health departments. The priorities were finalized after the PartnerSHIP reviewed data from the SHA and feedback from more than 2,500 people gathered through online surveys and other events led by 7 community-based organizations that serve marginalized communities.

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.

OHA PHD has previously assessed regularly assesses organizational grantee capacity to understand how willing and prepared communities are to plan and implement policy, systems and environmental change strategies related to alcohol, tobacco and other drugs. Previous community readiness assessments include OHA PHD's Tobacco Prevention and Education Program (TPEP) Community Readiness Assessment as well local assessments done through Oregon's Strategic Prevention Framework Partnerships for Success (SPF-PFS) grant funded

Narratve Question

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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 **Attachments Page** and upload the plan

Yes. Please see attached reports: Health Promotion and Chronic Disease Prevention 2017-2025 Strategic Plan draft and the State Health Improvement Plan 2015-2019Alcohol and Drug Policy Commission Strategic plan as part of the Oregon. In close collaboration with the State Health Improvement Plan, the Alcohol and Drug Policy Commission (ADPC) Strategic Plan is working to improve of the effectiveness and efficiency of state and local alcohol and drug misuse prevention and treatment services

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

OHA'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 eight-year strategic plan to address excessive drinking and tobacco 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.

OHA HPCDP continues to fund Counties and Tribes to implement evidence-based practices and strategies supported by SAMHSA's evidence-based practices resource center and Oregon's Tribal Best Based Practices, which are practices based on evidence for Native American communities.

OHA enlists support from the Behavioral Health Prevention and Promotion (BHPP) Sub-Committee of the Addictions and Mental Health Planning and Advisory Council (AMHPAC) to advise and the conference of Local Health Officials periodically to provide feedback on SABG primary prevention funds.

Narratve Question

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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 regional 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.

Mass Reach Health Communications: Development of state media messages through formative audience assessment on Oregonians' attitudes and beliefs about alcohol and other drugs. Create campaign brand and health education messages for communicating to Oregonians about risks, problems and solutions about excessive alcohol use.

b) Education:

Local interventions: Funds local grantees (Counties, Tribes, non-profits and Regional 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, multi-session prevention education.

c) Alternatives:

Local interventions: Funds sub awardees (Counties, Tribes, non-profits and Regional 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 development and engagement and advocacy programs.

d) Problem Identification and Referral:

Local interventions: Funds local grantees (Counties, Tribes, non-profits and Regional 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: student assistance programs and youth focused problem identification and referral services.

Assess Screening and Referral System: Assess quality and efficacy in alcohol screening and referral systems in primary care; Influence alcohol metrics to include SBIRT for health system partners and Coordinated Care Organizations (CCOs).

e) Community-Based Processes:

Local interventions: Funds sub awardees (Counties, Tribes, non-profits and Regional Health Equity Coalitions) to lead coordination and program management of local efforts to prevent and reduce the harms associated with alcohol, tobacco and drugs in all 36 Oregon Counties and 9 Tribes. Current strategies include: Prevention coalition engagement; community awareness raising activities; collaboration with community partners and stakeholders.

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 strategies 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 and tobacco; restrictions on alcohol marketing, promotion and retail environments; maintenance of a controlled state to limit alcohol density.
Mass Reach Health Communications: Development of state media campaign through formative research on Oregonians' attitudes and beliefs about alcohol and other drugs. Create campaignCampaign development and health education messages for communicating to Oregonians about risks, problems and solutions about excessive alcohol use.

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

The OHA PHD has a focus and priority on policies, systems and environmental change approach to substance use prevention and promotes evidence-based strategies that support this primary prevention approach. The planning and implementation of SABG funds and primary prevention strategies are supported through an integrated program structure.
In this integrated model, OHA PHD HPCDP supports local grantees in a community programs model and regional support network. Grantees 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 grantee guidance and review of biennial alcohol, tobacco and drug prevention implementation plans.
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.
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 and social norm campaigns; information and data collection; youth development to promote protective factors and reduce risk factors; partnerships with enforcement for sustainable resources to reduce youth access to alcohol and tobacco; multi-session prevention education programs; alcohol and tobacco policy work such as creation of local ordinances to reduce youth access and exposure to advertising; and ongoing collaboration with community partners and stakeholders.
OHA PHD currently coordinates with the Behavioral Health Prevention and Promotion (BHPP) Sub-Committee of the Addictions and Mental Health Planning and Advisory Council (AMHPAC) and the Conference of Local Health Officials (CLHO) to advise SABG funded primary prevention strategies are not funded through other means.

Narratve Question

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Evaluation

1. Does your state have an evaluation plan for 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 **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [ ] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [ ] 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)** [x] Numbers served
- **b)** [ ] Implementation fidelity
- **c)** [ ] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [ ] Attendance
- **f)** [ ] 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)** [ ] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use
- [x] 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

9. Statutory Criterion for MHBG - Required for 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.

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.

CCOs are responsible for Intensive Care Coordination (ICC) services. The requirements described in this rule are in addition to the general care coordination requirements and health risk screenings described in OAR 410-141-3860 (Integration and Coordination of Care) and 410-141-3865 (Care Coordination Requirements). ICC is provided to “prioritized populations” – older adults, individuals who are hard of hearing, deaf, blind or have other disabilities. These individuals have complex or high health care needs, or multiple /chronic conditions or serious or persistent mental illness or are receiving Medicaid-funded long-term care services and supports (LTSS).

System of Care Approach

Oregon is continuing to work on the development of a comprehensive system of care where the youth’s 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. OHA is a key partner, with other child serving agencies, with the statewide System of Care Advisory Council. This was newly established by legislation in 2019 to improve the effectiveness of state and local systems of care that provide services, including behavioral health, to youth by providing a centralized and impartial forum for statewide policy development and planning. The primary duty of this Council is to develop and maintain a state system of care policy and a comprehensive, long-range plan for a coordinated state system of care that encompasses public health, health systems, child welfare, education, juvenile justice, and services and supports for mental and behavioral health and people with intellectual or developmental disabilities.

2. Does your state coordinate 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 or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

For Child & Family BH Services, each 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 such as CATS (Crisis and Transition Services). For Child and Family BH, case management tasks for the different programs are performed by Youth and/or Family Peer Support Specialists, or by assigned Case Managers within the programs.
For Adult BH Services, each CMHP has an ENCC (Exceptional Needs Care Coordinator) staff position whose role is to :
-Early identification of those aged, blind, or disabled OMAP members that have disabilities or complex medical needs.
- Assistance to ensure timely access to providers and capitated services.
- Coordination with providers to ensure consideration is given to unique needs in treatment planning.
- Assistance to providers with coordination of capitated services and discharge planning.

- Aid with coordinating community support and social service systems linkage with medical care systems as necessary and appropriate.

Co-ordinated Care Organizations are contracted to provide intensive care coordination (ICC) for prioritized populations including the creation of a comprehensive intensive care coordination plan that is a collaborative, comprehensive, integrated, and inter-disciplinary written document.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Fidelity Wraparound is available to youth with the highest level of need and multi-system involvement and provides intensive care coordination. Through the CCO contract with OHA, and the implementation of Systems of Care, each region further defines 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.
On the adult BH services side OHA has created a "warm hand-off" policy and procedure to be implemented by all CCO for high-risk care transitions from acute psychiatric in- patient settings to outpatient or sub-acute setting. In addition, CCO's have had a long-standing pay-for-performance metric for medical/psychiatric appointment of individuals within 7 days of discharge from an acute -psychiatric setting.

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 M/SUD 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	82336	0
2.Children with SED	35766	0

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.

Oregon does not estimate incidence of SMI and SED. Planning is usually based on prevalence of these populations which is based on survey and claims data through MMIS

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. 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

a. Describe your state's targeted services to rural population.

Oregon is a state challenged with geographic and economic diversity and disparity. It is the 10th largest state in size with 98,381 sq/miles. Much of the State is rural and frontier, with great distances to cover and difficulties recruiting and retaining health care professionals and staff. Several efforts are underway to address disparities and create rural access to quality behavioral health care.

•OPAL – K and OPAL – A

Creating rural access to psychiatric care is one of the primary goals of the OPAL-K & A program (Oregon Psychiatric Assessment Line – Kids & Adults). Nearly 1/3 of OPAL consultations are from rural or frontier communities. The figure below indicates the locations and types of providers enrolled in OPAL-A, 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 MCO comprised of 15 county behavioral health entities providing care to families and children and adults 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 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.

The OHA Child and Family Behavioral Health staff, in coordination with the OHA Public Health Division's Maternal, Infant, Early Childhood Home Visiting program began providing scholarships for master's Level Mental Health providers and other early childhood professionals to participate in the Infant Toddler Mental Health Graduate Certificate Program at Portland State University in 2015. The purpose of these scholarships is to increase the behavioral health workforce expertise to address the gaps in the current children's system of care regarding Social Emotional and Behavioral Health services for young children, especially in rural areas of the state. Since 2015, 67 Masters level mental health specialists have completed the yearlong, 23 credit hour, Graduate Certificate Program; another 10 have been accepted to the program and will receive full scholarships to participate starting fall of 2021. One participant this year had to pause their attendance due to being called to duty by the National Guard. 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. Bilingual/bicultural scholarship candidates are also given preference and in 2020-2021, half of the graduates spoke a second language. Community partners indicate that there is still a significant need for trained providers to whom they can refer young children for Behavioral Health services.

OHA has made targeted investments to increase the capacity or rural providers to treat Opioid Use Disorder (OUD). These investments created OTPs in several rural towns: Grants Pass, Roseburg, Seaside, Coos Bay, Pendleton, and Medford. In additional they have increased the capacity of office- based MAT in traditional SUD systems of care. It also invested in a broad range of addiction psychiatry ECHO programs to increase capacity and engagement of rural providers . OHA has created a clearing house system for the distribution of harm reduction supplies – needles and naloxone - throughout Oregon including rural Oregon to address the opioid crisis.

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b. Describe your state's targeted services to the homeless population.

Oregon is a state challenged with geographic and economic diversity and disparity. It is the 10th largest state in size with 98,381 sq/miles. Much of the State is rural and frontier, with great distances to cover and difficulties recruiting and retaining health care professionals and staff. Several efforts are underway to address disparities and create rural access to quality behavioral health care.

Having a safe and stable place to live is essential for people recovering from a serious mental illness. However, a lack of affordable housing and access to timely, innovative behavioral health services are root causes that Oregon is addressing. The Oregon Legislature in its 2021 session, established $130m to explore housing and residential services for people with behavioral health needs. OHA has also advanced a robust policy agenda around social determinants of health (SDoH) with an emphasis on health is housing. Current sampling of specific state wide programs are:

• Rental Assistance Program (individuals with SPMI)
• Housing Assistance Services Program (individuals with SUD)
• Projects for Assistance in Transition From Homelessness (PATH)

OPAL – K and OPAL – A

Creating rural access to psychiatric care is one of the primary goals of the OPAL-K & A program (Oregon Psychiatric Assessment Line – Kids & Adults). Nearly a third of OPAL 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.

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To address the needs of rural youth and young adults and youth and young adults experiencing homelessness, the Oregon Health Authority has taken a multi-pronged approach. There are four Young Adult HUB sites that serve young people ages 14-25, with a specific focus on youth experiencing homelessness, LGBTQIA2S+ youth and multisystem involved youth. These programs serve eight counties in Oregon and approximately 300 youth and young adults per year. These programs serve young people regardless of insurance and continue to be evaluated to make sure they are culturally responsive, developmentally appropriate and person centered, all with a strong emphasis on peer support services. Most of the HUB sites work closely with Oregon first episode psychosis program, the Early Assessment and Support Alliance (EASA). OHA in collaboration with the EASA Center for Excellence and the local sites are planning to start a workgroup in January 2022 with rural EASA sites to develop a more appropriate model to accommodate the specific challenges the sites face to ensure all young people who meet criteria are being service regardless of geographic location. These learnings will help advance services for all youth and young adults in rural counties. Furthermore, the Oregon Health Authority and Portland State University received the 5-year Healthy Transitions SAMHSA grant in 2018 to improve access to treatment and support services for youth and young adults who have serious mental health challenges and have disengaged in services. The two services sites are in Lane and Douglas counties, both with majority rural

areas. The grant is in its third year and has been adapting to the challenges of COVID-19 and reaching young people who are isolated due to geographic location. The Oregon Health Authority is also working with our statewide youth peer support organization, Youth ERA, on multiple projects, including expanding online peer support services for hard-to-reach youth, increasing, and supporting youth peer support specialists statewide, with a specific focus on Wraparound and System of Care, and supporting over 2,000 high school students to participate in a weeklong social emotional peer support training called UPLIFT.

c. Describe your state's targeted services to the older adult population.

Oregon has a growing older adult population (age 65 and older) and is 18.2% . It is projected to reach 22% by 2030 when the last of the baby boomer generation will turn 65 years old. Much of the older adult population resides in rural areas of Oregon.

The Older Adult Behavioral Health Initiative (OABHI) was launched in June 2015 and is currently its sixth year. Oregon has been recognized as a leader in addressing the behavioral health needs of older adults and people with physical disabilities . The Oregon Health Authority makes an annual investment of $3.5 million resulting in 25 positions called older adult BH specialists in all 36 counties many of them rural and frontier. This investment seeks to strengthen and improve the behavioral health infrastructure for older adults and people with disabilities. 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. These positions also promote health and wellness for older adults . Between July 2016 and June 2020 there were 3,711 complex case consultations: 662 training and community events reaching 10,000 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. The Initiative is incubating a few innovative programs to mitigate these challenges – development of a senior peer warmline/friendship line in rural Oregon to mitigate social isolation and risk of depression and suicide, training Aging Disability Resource Connection (ADRC) 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. Our newest pilot project in Eastern Oregon – this area is considered rural and frontier – is delivering evidence- based depression treatment called PEARLS
(Program to Encourage Active Rewarding Lives for Seniors) via telephone and video ((use of tablets). The Oregon Health Authority has also funded the Senior Loneliness Line , a phone support line for seniors, which is a free, state-wide resource and well utilized by rural older adults.

A joint OHA/Aging and People with Disabilities (APD) Project ECHO Geriatric Behavioral Health Clinic for nursing homes based on the model from University of Rochester was approved by CMS and started in 2018 – the first of its kind on the West Coast. . This ECHO project has currently completed 2 cohorts with 35 nursing facilities . The goal of this clinic is to build the capacity of nursing staff especially in rural and frontier areas to better identify and assess mental health issues in their residents and learn about best practices.

Six rural/frontier CMHP have developed age specific Older Adult Programs with dedicated staff, who are developing geriatric behavioral health core competencies.

OHA also funds an annual Geriatric Behavioral Health Conference very year in June. We especially target mental health providers and PASRR Level II clinicians from rural areas to participate in this conference.

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

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 Superintendent of the Oregon State Hospital (OSH) now reports directly to the Director of the Oregon Health Authority. The Oregon State Hospital employs 2,425 staff and has a biennial budget of $726,189,045 for 2021-23. The Health Systems Division (HSD) manages the remaining federal and state funds. This 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 fifteen 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.
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System of Care Approach
Oregon is continuing to develop a comprehensive System of Care approach that will combine and integrate efforts to conduct family and youth centered care across agencies for youth in Oregon
• 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.

State training regarding EBP:
The State does not directly provide EBP trainings, but we do have expectations that treatment programs utilize age-specific and developmentally appropriate EBP 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. OHA expects treatment providers to give amply opportunities for staff training. Oregon also allows for " promising practices" as there ai snot a single EBP that fits the needs for every population – child, youth, and adult . By centering equity, OHA has made it a priority to implement practices that are culturally and linguistically appropriate. For example , OHA funds training in EBP for mental health clinicians through the Association of Community Mental Health Programs (AOCMHP). Through added funding from OHA, the AOCMHP were able to coordinate Advanced Mental Health and Suicide Intervention/Treatment skills trainings for the CMHP workforce. Trainings offered are: ABFT (Attachment Based Family Therapy), AMSR (Assessing Managing Suicide Risk), CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention) , DBT (Dialectical Behavioral Therapy) , CAMS (Collaborative Assessment and Management of Suicidology) .
For children/youth services training: Wraparound and CATS (Crisis and Transition Services) all have centers at universities (Portland State University and OHSU) that train, Wraparound has a fidelity model built into CCO contract and OHA holds a contract with University of Washington to measure fidelity. The EASA Center for Excellence does the fidelity reviews for the EASA sites and is in charge of training the staff. OHA funds the Oregon Center on Behavioral Health Justice and Integration which provides information, facilitation, training and technical assistance for anyone working in Oregon's behavioral health and justice systems including interdisciplinary groups, teams, and individuals with an emphasis on working with and through Local Public Safety Coordinating Councils (LPSCC). They provide training in the Sequential Intercept Model (SIM) and in creating Crisis Intervention Teams through training. This helps jurisdictions across the state implement and improve systemic and programmatic efforts in treatment of individuals with serious behavioral health needs, neurocognitive conditions, and/or intellectual/developmental disabilities who come into contact with the justice system, while ensuring accountability and public safety.
OHA will analyze and coordinate with other federal and legislative resources to ensure that Block Grant funds are invested as safety net programs and to fill gaps in the system.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

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	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) 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 Has your state identified a need for 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, and custody issues? ( ) 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 or certified 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.

Oregon uses standard contract language in all contracts with counties and sub-contractors to assure compliance through the A-133 audit requirement and also through routine audits of state licensed facilities. OHA has updated boiler plate contract language for policies and procedures around corrective action plans.

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, if applicable	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for 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 (e.g., 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.

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. Has your state identified a need for 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.

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.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ○ No

2. Has your state identified a need for 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.CÂ§ 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

Criterion 8,9&10

Service 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. Has your state identified a need for 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 services 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. Has your state identified a need for 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, such as 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. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** 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. Has your state identified a need for 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. Has your state identified a need for 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 including 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.

OHA requests technical assistance regarding development and implementation of an Independent Peer Review Program.

3. Has your state identified a need for 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) Development of 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, such as the 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? (●) Yes ( ) No

2. Has your state identified a need for 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 (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) 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 opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Performance-based accountability: (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) 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 (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ( ) Yes (●) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) 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 ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

b) Professional Development ( ) Yes (●) No

c) Coordination of Various Activities and Services ( ) Yes (●) No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.oregon.gov/oha/ph/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Pages/index.as

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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 2020-FFY 2021? ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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[58] paper.

57 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.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD 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 M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD 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.

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Footnotes:

Environmental Factors and Plan

13. 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.[59]

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.[60]
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 the Health Insurance 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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.	

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Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

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], 49 [4], and 63[5].

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.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

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)** ☐ Naltrexone (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?

**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.*

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] 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 M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"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 M/SUD 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.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Under HB 2417 OH is implementing an improved crisis system to align with the national best practice of Crisis Now model. This will help Oregon be prepared for 988 in July 2022. OHA is looking to use MHBG set aside as well as general MHBG funds to help expand and enhance the following components of the crisis system: 988 call center, mobile crisis response (Firehouse model), stabilization services, and follow up services.

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

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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 ( ) No

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.

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

Recovery Community Organizations (RCOs) are Peer Run Organizations providing a variety of peer-based recovery support services, including Peer Services, Recovery Centers, Housing, and Harm Reduction. Nationally, there are over 141 accredited RCOs, with only one (4D Recovery) in Oregon. This year, Tony Vezina worked with BIPOC communities to develop several RCOs, including Painted Horse Recovery, Northwest Instituto Latino, WomanFirst Transition Center, and the Miracles Club. These efforts resulted in the formation of an RCO Association charged to increase RCO infrastructure
Peer Run Organizations (PRO), Recovery Community Organizations (RCO) and Peer Drop-in Centers: These organizations serve their community across the continuum of care. They provide outreach and engagement and direct peer services to individuals in SUD or MH treatment and recovery. Anyone can walk in through the door and a peer will work with the individual to assess their

needs and support them through other community services, referrals, and support such as employment and housing. They also coordinate with local residential programs through a strong referral relationship all the way to an MOU relationship where the peer can serve the individuals at the residential Tx facility but is employed by the peer run organizations. There are a few peer run organizations that have just initiated service but there is still a huge gap in statewide network. The largest need for investment in these initiatives is in underserved urban regions and in frontier counties where social determinants of health and physical access to treatment and recovery facilities are limited. Priority need with Black, Indigenous, and Persons of Color communities within these regions.

RCO's work to develop engaging communities to shift cultural perspectives around Substance Use and Mental Health, creating and promoting sustainable, attractive and healthy designs for living across the continuum of care from Prevention, Intervention to long term resiliency and recovery. Recovery Community Centers are also cost-effective models of long-term recovery supports backed by emerging scientific efficacy evidence. The best practice for operating recovery centers is one done by a recovery community organization (RCO). RCO's are peer-run recovery organizations that provide non-clinical recovery support services. RCO's have historically been funded on the eastern coast, but in recent years national best practices have emerged. These efforts have recently gained the interest of national addiction research leader John Kelley and his team at the Harvard Medical Institute. The Recovery Research Institute is doing a special series on the importance of Recovery Centers in creating a holistic continuum of care. There currently exists an emergence of RCOs in Oregon.
Utilizing RCO models has considerable Return on investment:

• Recovery Centers provide social support for hundreds daily

• Recovery Centers will focus on outreach and engagement, which is especially important as the state moves to replace criminal justice-based interventions and referrals to treatment.

• Other benefits of Oregon recovery centers can be found in a recently completed program evaluation conducted by Comagine Health on 4D Recovery, the report can be found here: www.4drecovery.org/annualreport

Continued funding and investment are also needed by organizations that are showing tremendous positive outcomes for their community.
For Example:
1)Stronghold which is a peer run organization and serves Indigenous Folx in the Klamath areas.
2) Painted Horse recovery, providing recovery supports to Indigenous Folx in the Urbanized context within Portland metro plus area. Not only do they coordinate with regional providers but also coordinate with local BIPOC led Recovery Community Organizations.
3)Northwest Instituto Latino de Adicciones a Latinx/Hispanic run Peer Initiative.
4)Push Movement, an RCO owned by Persons in Long Term Recovery utilizing skateboarding and street culture to provide outreach and engagement with the local street community in Portland areas.
5)4D Recovery Centers. A leader in the RCO model for several years, currently operating 3 Recovery Community Centers, fully staffed with outreach and Peer Workers. Also, providing extensive levels of Technical Assistance around the state for startup RCO's. Additionally, a hire that focuses on PDS related to ACT, Aid & Assist, and Mobile crisis will be recruited.

OHA would like to continue funding and supporting these organizations so they can expand their workforce and outreach to communities, provide trainings to new and upcoming organizations. This will also help develop a network of peer run organizations across the state that are specific to indigenous and BIPOC communities.

• OHA will spend $2,000,000 on peer run organizations, RCO's and drop-in centers to establish a statewide network. Funding will pay for staff who are certified peers in Oregon, program supervisors, and community outreach coordinators, trainings, curriculum development etc.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The OHA Health Systems Division (HSD) recognizes the value of peer-delivered services in transforming a behavioral health system of care based on recovery. The division works with consumers, survivors, stakeholders and Oregon's peer network to:
• Develop strategies to increase the use and availability of peer-delivered services (PDS);
• Influence health policy and improve enrollment and use of peers in expanded insurance options and integrated health care programs;
• Promote the development of PDS training programs and certified peers representing Oregon's diverse population, including those with military experience and young adults.
OHA has implemented multi-dimensional projects in an effort towards the above goals across the State of Oregon. This in includes Internal support and development as well as facilitation of community partnerships to include the breadth and depth of expertise within the field of PDS across Oregon.

In addition the above mentioned Peer Delivered Services, the Office of Consumer Activities and the Peer Delivered Services Coordinator have done extensive community engagement to identify and provide opportunity to expand Oregon's Peer Delivered Services System. This is in an effort to reach communities in need and provide Recovery Support Services to individuals outside clinical Medicaid services across the individuals entire continuum of care from community prevention/intervention all the way

through long term recovery support i.e. 5 years of continuous recovery and beyond. The majority of PDS in Oregon now exists outside of the Medicaid system with 70+ PRO's operating across the state providing peer services.

Additionally, OHA began piloting the Prime Plus Peer Project in 2018 and expanded if further in 2019 and 2020. The Prime Plus Peer Project builds on work that was initially started during the Oregon Legislative Session of 2018 (HB4143), the Prime Plus Initiative Pilot was started to begin addressing concerns related to opioid use disorder and overdose prevention. The program utllizes the lived experience of peer recovery mentors to engage community members around recovery support, relapse and overdose prevention, and harm reduction.

5. Does the state have any activities that it would like to highlight?

We would like to highlight OHA's recent investment in historically underfunded Black, Indigenous and Persons of Color peer organizations. OHA has supported this work through the provision of technical assistance, contract development and community advocacy and coordination.

The Office of Consumer Activities and the Peer Delivered Services Coordinator remain dedicated to include consumer voice and concerns in all aspects of behavioral health.

The last year, OHA has invested in developing a recovery oriented system of care. Peer Support Specialists, Certified Recovery Mentors, Family Support Specialists, and Youth Support Specialists are at the center of this work. This model includes Peer Run Organizations and Recovery Community Centers, all staffed by Peers.

Peer Run Organizations and Peer Drop-in Centers: These organizations that serve their community across the continuum of care. They provide outreach and engagement and direct peer services to individuals in SUD or MH treatment and recovery. Anyone can walk in through the door and a peer will work with the individual to assess their needs and support them through other community services, referrals, and support such as employment and housing. They also coordinate with local residential programs through a strong referral relationship all the way to an MOU relationship where the peer can serve the individuals at the residential Tx facility but is employed by the peer run organizations. There are a few peer run organizations that have just initiated service but there is still a huge gap in statewide network. There is still need is in underserved urban regions and in frontier counties where social determinants of health and physical access to treatment and recovery facilities are limited. Indigenous communities in rural regions and BIPOC communities in urban regions are at the highest need for more investment in Recovery Supports, RCO's and peer run organizations.

Recovery Community Centers are cost-effective models of long-term recovery supports backed by emerging scientific efficacy evidence. The best practice for operating recovery centers is one done by a recovery community organization (RCO). RCO's are peer -run recovery organizations that provide non-clinical recovery support services. RCO's have historically been funded on the eastern coast, but in recent years national best practices have emerged (https://facesandvoicesofrecovery.org/arco/rco-best-practices/). These efforts have recently gained the interest of national addiction research leader John Kelley and his team at the Harvard Medical Institute. The Recovery Research Institute (https://www.recoveryanswers.org/) is doing a special series on the importance of Recovery Centers (ihttps://www.recoveryanswers.org/research-post/recovery-community-centers-associated-with-well-being/)in creating a holistic continuum of care. There currently exists an emergence of RCOs in Oregon, led by several local leaders. Recovery Centers in Oregon currently provide social support for hundreds daily. Recovery Centers will focus on outreach and engagement, which is especially important as recent legislation moves to replace criminal justice-based interventions and referrals to treatment to a Recovery Oriented RSS based service model.

The OHA Problem Gambling Services Unit has developed a problem gambling specific training curriculum for peers already trained as PSS, CRMs and other THW's. Additionally, there is a a Certified Gambling Recovery Mentor designation for peers that have had lived experience of gambling addiction.

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

Recommendations:

• Large Scale investment in RCO's using various investments, including BG Funding.

• BG funding should be used to create/sustain admin infrastructure, pay for direct services, and brick and motor operations.

• BG funds used for RCO's should have a disproportionate investment in culturally specific programs, including Afro, Latinx, Native, Youth-centric models as they are disproportionally affected by addiction and have the least amount of service infrastructure.

• BG investments into RCO's should be done with accompanying technical assistance that is requested by the organizations themselves.

• BG investments into RCO's should be made into organizations that align with best practices models.

• BG funding should be at the following levels per center: $500,000 - $750,000 for operations cost, and at least $100,000 for start-up costs.

Funding this proposal will accomplish the following:
1. Increase RCO infrastructure through the formation of the RCO association.
2. Provide stabilization funding for the RCO Association members increase recovery rates in priority populations.
Outcomes/Reporting
RCO Association The association will develop standards of RCO practice, provide training, expand knowledge of service model and propose accreditation recommendations to OHA.
RCO Agencies The RCO agencies will develop business practices, open recovery centers or expand current center operations, provide peer delivered services, engage in harm reduction activities, and support recovery housing.

Budget Total: $3,000,000 annually over 5 years
Budget Detail
RCO Association Total: $100,000
Staffing: $70,000
Conference: $10,000
Membership Meetings: $3600
Marketing: $5,000
Membership Recruitment Activities: $12,000
RCO Member Support Painted Horse Recovery $580,000
Miracles Club $580,000
NWIL $580,000
WomanFirst $580,000
4D Recovery $580,000

RCO Association Member Brief
Each member of the RCO Association has a specialty population focus and provides similar recovery support services. A short description of each organization is below.
The Miracles Club focuses on Black/African American communities, providing recovery center, peer, and recovery housing services.
Northwest Instituto Latino Addicciones focuses on the Latinx and Spanish-speaking communities, providing recovery center, peer, recovery housing, education, and harm-reduction services.
Painted Horse Recovery focuses on the Native communities, providing recovery center and peer services.
WomanFirst Transition Center focuses on African American women transitioning from jail, providing recovery housing and peer support services.
4D Recovery focuses on young adults and the LGBTQ communities, providing recovery centers, peer, recovery housing, harm reduction, leadership development, and technical assistance services.

References Support Recovery Community Organizations
www.4drecovery.org/annualreports
https://www.recoveryanswers.org/addiction-research-summaries/building-research-infrastructure/
https://addiction.surgeongeneral.gov/sites/default/files/chapter-5-recovery.pdf

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

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

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

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18. Children and Adolescents M/SUD 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.[63]. 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.[64]. 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.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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 M/SUD 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).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]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.

[65]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.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **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 M/SUD 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 M/SUD 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.)

https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/System%20of%20Care%20Overview.pdf

7. Does the state have any activities related to this section that you would like to highlight?

Oregon legislators established the System of Care Advisory Council in 2019
https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/SOCAC.aspx

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

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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.

Suicide Prevention

With strong partnerships across OHA divisions and with local partners, Oregon is a leader in statewide suicide prevention. OHA has 5 dedicated FTEs devoted to suicide prevention efforts. The five positions are spread across two departments (HSD and PHD) and three units (Injury and Violence Prevention Program, Child and Family Behavioral Health, and Adult Mental Health). The five positions include an Adult Suicide Prevention Coordinator, Zero Suicide in Health Systems Coordinator, a Public Health Suicide Prevention Coordinator, and two Youth Suicide Prevention Coordinators. Despite being spread across two divisions and several units the team functions as one cohesive unit communicating daily and meeting weekly. Although each position has a different focus, all five Suicide Prevention Coordinators share many responsibilities and are always willing to lend support to one another.

The Adult Suicide Prevention Coordinator and the Youth Suicide Prevention Coordinator positions are in HSD. The Adult Suicide Prevention position, located in the Adult Mental Health Unit, is a new position (March 2020) with its first project to develop and implement the first statewide Adult Suicide Intervention and Prevention Plan. This process is well underway with plans to move to publication within the next 2-3 months. In addition to those efforts the Adult Suicide Prevention Coordinator is the PD on the SAMSHA COVID-19 Emergency Response for Suicide Prevention grant which focuses on suicide prevention for survivors of domestic and sexual violence. This is an 18-month grant that will end in November of 2021 and is intended to build sustainable collaborations among domestic violence advocates and mental health professionals. The grant has enabled cross training opportunities between the two professions with domestic violence advocates becoming better trained in suicide intervention and mental health professionals becoming better trained in domestic violence. The grant has had many successes with several polices developed that are sustainable post award.

The two suicide prevention positions in HSD are focused on youth (ages 5-24) are in the Child and Family Behavioral Health Unit. The positions focus on different aspects of suicide prevention—one on policy and one on program. Currently the second edition of the Youth Suicide Intervention and Prevention Plan (YSIPP), a five-year state plan, is in development. The first YSIPP was published in 2016.

To support implementation of the YSIPP, the Oregon Alliance to Prevent Suicide (the Alliance) was created in 2016 and was charged with overseeing statewide integration and coordination of suicide prevention, intervention, and postvention activities. With more than 50 members, the Alliance represents a diverse group of organizations, advocates, youth and survivors working to reduce suicide rates in Oregon and is a key collaborator in suicide prevention. The Alliance is charged by OHA to oversee implementation of the YSIPP. Committees of the Alliance include Executive, Transitions of Care, Workforce, Outreach and Awareness, Research and Evaluation and Schools. Workgroups consist of Firearm Safety - Lethal Means and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others (LGBTQIA+).

The Alliance operates under the administration of the Association of Oregon Community Mental Health Programs (AOCMHP), a non-profit whose mission is to support and advocate for Local Mental Health Authorities (county mental health programs) in their planning and management of mental health, addictions, and developmental disabilities programs to ensure an effective local system of care.

In 2019, OHA began offering a menu of evidence-based, locally energized programs that have already been successful and effective here in Oregon. These programs are stably funded, are coordinated statewide, and are available widely: Sources of Strength (for grades 3 through college), Mental Health First Aid, QPR, Youth Suicide Assessment in Virtual Environments (YouthSAVE), ASIST, and Connect Postvention. Additionally, OHA has worked with the Oregon Department of Education to provide technical assistance to schools as they develop suicide prevention plans for their districts and buildings.

The OHA COVID response Suicide Prevention, Intervention, and Postvention (S-PIP) team was created in 2020 as an inter-departmental effort to address the impact of COVID-19 on mental health and suicide behaviors. The team originally focused on youth suicide prevention but expanded its focus to include lifespan. The team continues to meet weekly.

The other two dedicated suicide prevention coordinator positions are located in the Public Health Division's Injury and Violence

Prevention Program. The Zero Suicide in Health Systems Coordinator, position is also new and began in fall of 2020 after the Injury and Violence Prevention Program was awarded the SAMSHA Zero Suicide in Health Systems grant in 2020 and the grant will run through August 2025.The aim of the grant is to implement the Zero Suicide model in Oregon health systems to reduce suicide risk for adults 25 and older. The Zero Suicide Initiative enables health systems to identify, treat, refer and ensure continuity of care for individuals at risk of suicide and suicidal behaviors. Grant activities include:

• Provide consultation, training and resources for health systems, clinics and providers to support Zero Suicide implementation.
• Align efforts with Oregon Administration Rules regarding Emergency Department and In-patient discharge and care transitions for individuals experiencing a behavioral health crisis.
• Assess the culturally specific suicide prevention needs of Oregon's older adults (65 and older), adults with serious mental illness, and veterans and those that have served in the military.
• Develop and pilot specific trainings and resources for these subpopulations.
• Evaluate implementation efforts and share findings on Zero Suicide implementation and work with identified subpopulations.

OHA is currently in the process of developing an advisory committee for the grant and will include representatives from varying organizations and perspectives including the Association of Community Mental Health Programs, Oregon Association of Hospital and Health Systems, adults with lived experience related to suicide, people who have experience supporting an adult friend or family member, representative from Tribal health systems and OHA staff supporting efforts related to behavioral health.
Due to the impact that COVID-19 has had on Oregon health systems, grant activities have been delayed. The advisory committee will meet in Fall 2021 to inform grant activities to begin in 2022.
The other suicide prevention position in IVPP manages the Garrett Lee Smith Memorial Youth Suicide Prevention award (GLS), which focuses on a public health approach to youth suicide prevention. OHA has been awarded three GLS awards since 2006. The current award is in its second year with a focus on capacity-building grants to select Oregon counties, supporting suicide prevention training (gatekeeper training) in communities and youth-serving organizations, convening the annual Oregon Suicide Prevention Conference, managing the Oregon Suicide Prevention website and supporting clinician training. Highlights of recent grant work include:

• GLS is currently funding three counties to build capacity in their suicide prevention programs. The three counties, Deschutes County, Lane County and Multnomah County, have dedicated staffing toward suicide prevention, have established or are developing suicide prevention coalitions, and implementing gatekeeper training in addition to other grant activities.
• Gatekeeper training has been implemented to increase the number of persons in youth-serving organizations trained to identify and refer youth at risk. Since June 2019, a total of 2,899 individuals have received gatekeeper training through the grant.
• GLS is supporting gatekeeper training with the Oregon Department of Human Services (ODHS), including Child Welfare personnel, community partners and resource parents. In April 2021 ODHS made Question, Persuade and Refer (QPR) computer-based training required for all employees. As of June 30, 2021, 4,988 OSHD employees and community partners had completed the training. ODHS will begin delivering QPR training to resource parents in a virtual setting in Fall 2021. This training has been adapted for resource parents.
• Clinical training has provided training to over 230 individuals utilizing the Assessing and Managing Suicide Risk (AMSR) and Collaborative Assessment & Management of Suicidality (CAMS) trainings. OHAVE has achieved nearly half (47%) of the GLS 5-year clinical goal.
• OHA has developed an online training focused on how health care and direct service providers can work with rural firearm owners who may be a risk of suicide to voluntarily limit access to firearms. The training is based on research with Oregon rural firearm owners. The course is available for free as a Continuing Medical Education offering and is an OHA-approved Cultural Competence Continuing Education training. Over 100 individuals have completed the online course. In post training evaluation, participants have highly rated the course with over 58% of participants stated that they plan on changing their practices related to lethal means counseling.
• The October 2020 Oregon Suicide Prevention Conference was cancelled dur to COVID-19 public gathering restrictions. The conference has been rescheduled to take place virtually in October 2021.

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 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

Adults and older adults a risk of suicide

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

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

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 , like the rest of the country, is experiencing a forensic crisis where an ever- growing number of individuals with M/SUD encounter the criminal and juvenile justice systems. To promote a better understanding of the root causes of this increase and to promote strategies appropriate for diversion and alternatives to incarceration, OHA has partnered with the Oregon Judicial Department (OJD) to create a joint policy committee. One of the policy options is the exploration of creating regional behavioral health centers which will be rapid stabilization centers in the community. This is work that has been advanced by the GAINS Center from which Oregon is currently receiving technical assistance for implementation. OHA is also exploring the synergies with the rapid implementation of 988 and their work with the OJD. OHA is working with county's Community Mental Health programs to establish the Crisis Now model with the goal of diverting individuals from using emergency department visits and from punitive sentencing.

OHA is a key partner, with other child serving agencies, with the statewide System of Care Advisory Council. This was newly established by legislation in 2019 to improve the effectiveness of state and local systems of care that provide services, including behavioral health, to youth by providing a centralized and impartial forum for statewide policy development and planning. The primary duty of this Council is to develop and maintain a state system of care policy and a comprehensive, long-range plan for a coordinated state system of care that encompasses public health, health systems, child welfare, education, juvenile justice, and services and supports for mental and behavioral health and people with intellectual or developmental disabilities. The Council has already issued several recommendations to the Governor and legislature and will issue the first strategic plan in late 2021.

To support the implementation of Suicide Prevention Plan, the Oregon Alliance to Prevent Suicide (the Alliance) was created in 2016 and was charged with overseeing statewide integration and coordination of suicide prevention, intervention and postvention activities. With more than 50 members, the Alliance represents a diverse group of organizations, advocates, youth, and survivors working to reduce suicide rates in Oregon and is a key collaborator with the Public Health Division/IVPP in suicide

prevention. The Alliance is charged by OHA to oversee implementation of the YSIPP which is currently in revision for 2021-2025. Committees of the Alliance include Executive, Transitions of Care, Workforce, Outreach and Awareness, Research and Evaluation and Schools.

Centering its work around equity, OHA has launched Healthier Together Oregon (HTO) its 2020–2024 State Health Improvement Plan for Oregon. HTO is a five-year plan that identifies our state's health priorities and is a key initiative of the Oregon Health Authority. It includes strategies that will lead to better health outcomes. HTO is a tool for anyone wanting to improve their community's health. It is meant to inform community health improvement plans and state agency policies, partnerships and investments. HTO's primary goal is to achieve health equity. The HTO identified five priorities:

a. Institutional bias
b. Adversity, trauma and toxic stress
c. Behavioral health
d. Economic drivers of health, and
e. Access to equitable preventive health care

https://healthiertogetheroregon.org/wp-content/uploads/2020/08/Healthier-Together-Oregon_fullplan-1.pdf

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

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and 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 an Advisory/Planning Council (PC).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 PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

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 M/SUD 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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Currently OHA is in the process of engaging the Addiction and Mental Health Planning and Advisory Council to weigh in on the MHBG investments based on state priorities. OHA will complete that process by September 30, 2021. In person discussions with the SSA are the approach to this engagement. The council meets every other month. The council has representation across the continuum of care. Recommendation from council goes to the state BH Director for approval and review. The council wants to ensure hat regular MHBG funds ae coordinated with supplemental MHBG funds received through COVID relief and ARPA.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe 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.

The AMHPAC communicates in person directly with the BH Director. The BH Director, based on legislative priorities and data driven outcomes, identifies areas of priority in BH for the state. Following this, the BH director tasks the council with drafting recommendations for achieving the goals and objectives of the identified priorities. The council has a 51% representation of consumers and families. In addition there are specific subcommittees focusing on the following: BH Treatment, Recovery Support Services, BH Prevention, and Olmstead and Housing.

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

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70] 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.

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Footnotes:

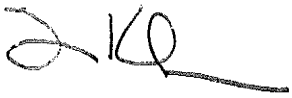
Dear SAMHSA Project Officer,

This letter is to assure SAMHSA that Oregon has an Addiction and Mental Health Planning and Advisory Council (AMHPAC) since 2009 to support and advise the state on the combined Block Grant https://www.oregon.gov/oha/HSD/AMHPAC/Pages/Resources-Council.aspx .
AMHPAC regularly works with OHA to identify behavioral health priorities and gaps in the BH system and appropriate areas to invest dollars and effort.

AMHPAC reviews and provides feedback on Oregon's Block Grant application and report every year. Please refer to attached feedback from AMHPAC on the FY 22-23 Block Grant application and report.

AMHPAC has four subcommittees dedicated to BH Treatment, recovery, Housing, and Prevention. Feedback and recommendation form each of the subcommittees are taken up to the AMHPAC full council which approves recommendation to be moved to OHA's leadership for response and/or implementation. AMHPAC is currently working with OHA on restructuring the process of Block Grant review to move towards a more efficient workflow.

AMHPAC Chair
Stephen Kliewer



8/25/2021

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

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)			
Paula Bauer	State Employees	Oregon Youth Authority		
Michelle Brandsma	Parents of children with SED/SUD			
Lisa Butler	Parents of children with SED/SUD			
Steve Comilla	Others (Advocates who are not State employees or providers)			
Rodney Cook	Providers			
Caroline Cruz	Representatives from Federally Recognized Tribes			
Rebecca Eichorn	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kevin Fitts	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Christy Hutson	State Employees	Oregon Department of Corrections		
Joe Miller	State Employees	Oregon Department of Human Services		
Kathryn Nunley	State Employees	Vocational Rehab: Aging andPeople with Disability		
Steve Sanden	State Employees	State Housing Agency		
Luke Walters	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jeremy Wells	State Employees	Oregon Department of Education		
Jay Wurscher	State Employees	State Social Services and Child Welfare		

Footnotes:

We have members from the listed state agencies in the revision requested and the Oregon Health Authority serves as the State Medicaid agency.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**16**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	1	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Total Individuals in Recovery, Family Members & Others	**8**	**50.00%**
State Employees	7	
Providers	1	
Vacancies	0	
Total State Employees & Providers	**8**	**50.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* 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?

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

If yes, provide URL:

https://www.oregon.gov/oha/HSD/AMHPAC/Pages/Block-Grants.aspx

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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Footnotes:

Oregon plans to update this section after two full weeks of public comment and consumer vetting process. Also, public comments are uploaded through the website provided. https://www.oregon.gov/oha/HSD/AMHPAC/Pages/Block-Grants.aspx

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes: