Date: September 20, 2024

To: Joint Interim Committee on Addiction and Community Safety Response
Senate Interim Committee on Health Care
Senate Interim Committee on Human Services
House Interim Committee on Behavioral Health and Health Care
House Interim Committee on Early Childhood and Human Services

From: Tony Vezina, Chair, Alcohol and Drug Policy Council

Alcohol and Drug Policy Commission (ADPC) Preliminary Report and Recommendations in Accordance with House Bill 4002 Section 11

The Alcohol and Drug Policy Commission is an independent state government agency created by the legislature in 2009 to improve the efficiency and effectiveness of substance use services for all Oregonians. ORS 430.221. The ADPC accomplishes this through a comprehensive addiction prevention, treatment and recovery plan for the state and with the assistance of fourteen participating state agencies.[1] ORS 430.221 – 223.

The 2020-25 Plan is directed at three main impacts: 1) Reduce the number of Oregonians experiencing substance use disorder. 2) Reduce substance use related deaths. 3) Reduce health disparities related to substance use. Recognizing that the current plan does not actionably address the overdose crisis that Oregon now experiences, the ADPC issued the ADPC Overdose Recommendations in December 2023. The legislature acted on several of the recommendations during the 2024 legislative session, and recognized the importance of access to MOUD treatment and youth specific access needs in HB 4002.

Section 11 of House Bill 4002 (2024) requires the ADPC to conduct a study of barriers to and best practices for: (a) youth accessing opioid use disorder treatment; and (b) increasing access to medications for opioid use disorder (MOUD) treatment. The bill requires the ADPC to create a youth strategic plan in conjunction with the System of Care Advisory Council (SOCAC) and strategies to remove barriers to MOUD treatment by September 15, 2025. The bill also requires the ADPC to report to the legislature interim progress to each plan's development and preliminary recommendations by September 30, 2024 – and the following report adheres to that requirement.

For questions or more information, please contact Annaliese Dolph, Director, Alcohol and Drug Policy Commission at annaliese.dolph@oha.oregon.gov.

[1] Participating state agencies include the Department of Corrections, the Department of Human Services, the Oregon Health Authority, the Department of Education, the Oregon Criminal Justice Commission, the Oregon State Police, the Oregon Youth Authority, the Department of Consumer and Business Services, the Housing and Community Services Department, Youth Development Oregon, the Higher Education Coordinating Commission, the Oregon State Lottery Commission, the Oregon Liquor and Cannabis Commission, the Oregon Department of Veterans' Affairs or any state agency that administers or funds alcohol or drug abuse prevention or treatment services.

Executive Summary

To meet the short term 2024 youth directive as well as to inform the longer-term strategic plan for 2025, the ADPC formed both an Ad-Hoc ADPC Youth workgroup and a collaborative of ADPC commissioners and youth leaders from the SOCAC. At the direction of the ADPC Treatment Committee, the ADPC also formed a separate workgroup in June of 2024 focused on the barriers to prescribing MOUD in emergency departments (MOUD ED workgroup).

Findings: Both workgroups studied these issues through 2024 and found the following:

1. Oregon lacks statewide support for early intervention in environments where youth are most likely to be seen: schools, pediatric and primary care clinics, community settings, etc.
2. Oregon's behavioral health system lacks necessary statewide infrastructure to provide comprehensive and holistic support for families of youth with co-occurring diagnoses.
3. Treatment capacity and services for adolescents have declined nationally.
4. Oregon's Substance Use Disorder (SUD) treatment care continuum is fractured and can be challenging to navigate for those seeking care, necessitating dedicated care coordination services to support those attempting to access care for substance use disorders.
5. Efforts to widely disseminate skills, knowledge, or perspectives needed to treat OUD and other SUDs efficiently and effectively within ED settings have been unsuccessful.
6. There exists a disconnect between state and organizational policy governing SUD treatment/ provision of MOUD and the practical nature of providing care.
7. While prevailing societal stigma may contribute to some care challenges, there exists little current policy driven incentive for healthcare programs to establish SUD care workflows.

Based on these findings, the workgroups made the following long-term policy recommendations:

1. **Youth:** Support ADPC and SOCAC to develop a comprehensive youth strategic plan that provides pathways and components of a holistic, youth and family-centered system of care.
2. **Youth:** Direct partner agencies to adopt, apply and adapt the strategic plan/"Pathways and Components" guidance into rule, program guidance, grant programs, incentives, reimbursement models, and payer policy. This includes supporting early intervention and pathways to holistic support in settings in which youth are most likely to seek help/be seen.
3. **Youth:** Provide education, technical assistance, and other support to families, youth, treatment providers, and other professionals related to holistic youth support and medication treatment.
4. **MOUD:** Establish a statewide program to promote linkages of care throughout the SUD continuum of care, providing a system that supports care navigation from various levels of care, such as connecting those treated by Emergency Medical Services or Emergency Departments to appropriate follow up services such as treatment or primary care providers.
5. **MOUD**: Amend rules or other regulations that have been identified as system level factors that contribute to barriers for care or have historically impeded efforts to expand care access.
6. **MOUD:** Promote engagement of technical assistance by providers and provider organizations to accelerate the adoption and implementation of evidence-based practices and increase consistency among providers throughout the state.

For 2025, the ADPC recommends the following legislative actions to enhance the strategies above:

1. Immediately address services for youth with multiple diagnoses through funded analysis and legislative support for *Treat Right Oregon,* which aims to ensure those with Medicaid and those with minimal health coverage can receive co-occurring treatment services and other supports.
2. Fund gaps analyses specifically for youth and adolescents related to intensive outpatient treatment, residential treatment, withdrawal management, and dual licensed providers.
3. Fund the ADPC to inventory and assess the feasibility of scaling up school-based substance use screening, intervention, and referral programs. This could also include an inventory/feasibility study of intervention programs based in county corrections and child welfare.
4. Fund the ADPC to inventory current community-based SUD specialty care to better understand wait times, existing referral pathways, and current cross system relationships, such as between SUD providers and primary care providers to better understand system readiness for a Transition to Care Program. This includes understanding how best to support a statewide infrastructure that acknowledges different regional capacity, preference, or other factors.
5. Direct health systems funding to support Oregon Department of Education's Recovery Schools (9 schools by 2027) with respect to health and recovery services costs.
6. Create an endorsement for “Adolescent and Family” and “Co-Occurring” service provision for SUD certifications and fund scholarships/provider incentives to achieve these endorsements.
7. Fund education programs that support pathways for youth to engage in peer certification training as they graduate from Recovery Schools or transition out of carceral settings.
8. Provide existing programs with additional resources for family and caregiver engagement.
9. Develop and fund a multimedia public education and awareness campaign directed at youth and families about substance use disorder, community resources, and education opportunities.
10. Develop and fund a training and physician education campaign on medications for addiction treatment for all providers, and prioritize supports for youth facing providers, primary care, and emergency department MOUD initiation - including subsequent care linkages to either SUD specialty providers or primary care.
11. Repeal *ORS 430.590* to support establishment of new Opioid Treatment Programs to decrease care gaps for those seeking MOUD.
12. Fund incentive programs to encourage provider/ provider organizations to engage in training or implementation efforts that support adoption of evidence based practices for SUD, such as MOUD prescribing protocol or increasing the number of on-site MOUD prescribers.

Preliminary Report and Recommendations in Accordance with HB 4002 (2024)

Background

Section 11 of House Bill 4002 (2024) requires the Alcohol and Drug Policy Commission (ADPC) to conduct a study of barriers to and best practices for: (a) youth accessing opioid use disorder treatment; and (b) increasing access to medications for opioid use disorder (MOUD) treatment. The bill requires the ADPC to create a youth strategic plan in conjunction with the System of Care Advisory Council (SOCAC) and to provide the legislature with a plan for youth and for MOUD by September 15, 2025. The bill requires ADPC to report to the legislature interim progress to each plan's development and preliminary recommendations by September 30, 2024 – and the following report adheres to that requirement.

In order to deliver preliminary recommendations by the legislative deadline, the ADPC formed two workgroups, while continuing longer term planning and study for the development of the 2026-30 comprehensive plan for the state. Related to youth, the ADPC formed both an Ad-Hoc ADPC Youth workgroup and a collaborative of ADPC commissioners and youth leaders from the SOCAC. The ADPC Treatment Committee leads the ADPC work to prioritize access to MOUD and continues to lead on the specific study asks of HB 4002. The ADPC Treatment Committee prioritized the prescribing of MOUD in emergency departments for the first stage of the study. Due to the specialized expertise required for the discussion, the ADPC formed a separate workgroup in June of 2024 focused on the barriers to prescribing MOUD in emergency departments (MOUD ED workgroup). The MOUD ED workgroup consists of members representing a wide range of partners with backgrounds encompassing expertise from state agencies, coordinated care organizations (CCOs), emergency department (ED) physicians, substance use disorder (SUD) care providers, and other areas. The workgroup recommendations were adopted by the ADPC Treatment Committee in August 2024.

The full Alcohol and Drug Policy Commission approved the recommendations to be submitted to the legislature on September 9, 2024.

Initial Findings

Youth Substance Use Findings

The ADPC Youth workgroup found that Oregon faces three major challenges in preventing substance use related harm and treating substance use disorder for youth and adolescents.

1.) **Oregon lacks statewide support for early intervention in environments where youth are most likely to be seen**: **schools, pediatric and primary care clinics, carceral settings, community based organizations/settings, and emergency room departments**. More than 90% of people with substance use disorder started using between the ages of 12 and 18 years.[2] The National Survey of Drug Use and Health shows that youth 12-17 are most likely to seek support at school

[2] Dennis ML, Clark HW, Huang LN (2014). The need and opportunity to expand substance use disorder treatment in school-based settings. Adv Sch Ment Health Promot. 2014;7(2):75-87.

or from a primary care doctor,[3] and other analysis shows that 90 percent of youth with substance use disorder are still engaged in school.[4] Finally, the National GAIN data set shows that youth present with significant substance use and co-occurring needs at intake of a juvenile justice program.[5] Yet schools, pediatrics, and carceral settings lack consistent state funding streams, guidance, and training to provide evidence-based interventions early in a young person's onset of problematic use. State funding for substance use programming is siloed from these settings, and while local efforts exist, little is known about statewide access.

2.) **Oregon's behavioral health system lacks necessary statewide infrastructure to provide comprehensive and holistic support for families of youth with co-occurring diagnoses.** Youth with substance use disorder are very likely to have co-occurring diagnoses, yet few treatment providers in Oregon provide holistic care. According to the National Institute of Drug Use, over 60 percent of adolescents in community-based substance use disorder treatment programs also meet diagnostic criteria for another mental health issue.[6] However, in Oregon, mental health and substance use services are siloed with separate sets of regulations, limited provider crossover/coordination, and reimbursement rates unreflective of complex adolescent care.

3.) **Treatment capacity and services for adolescents have declined nationally**. Block grant and state funded admissions into substance use treatment for 12-24 year olds has been on the gradual decline for 15 years, and since 2000, the change in annual admissions to substance use treatment for adolescents 12-17 is down 77%.[7] At the same time, unmet need persists, with only 7 percent of young people aged 12-17 with substance use disorder receiving treatment.[8] Services for youth and adults are categorically different, and as resources have flowed to the adult system, Oregon has missed opportunities to systemically support strategies specific to youth and families. Previous gaps analyses and systems assessments have not included specifics about youth capacity. Investment initiatives such as Measure 110 and Certified Community Behavioral Health Centers have focused on the adult population.

Based on the above findings and feedback gathered from the SOCAC, national subject matter experts, behavioral health providers, community, and commissioners, it is clear that Oregon needs a youth strategic plan related to substance use prevention and substance use disorder treatment and recovery that is comprehensive and beyond the limited scope of medication treatment for youth opioid use disorders.[9] The ADPC is putting forward these preliminary recommendations to enhance the scope of the ADPC and SOCAC strategic planning effort, to achieve the outcomes of 1.) decreased adolescent overdoses; 2.) increased rate of youth with substance use disorder receiving treatment; 3.) increased

[3] Table 5.28a&b https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/NSDUHDetTabsSect5pe2022.htm

[4] Dennis ML, Clark HW, Huang LN (2014).

[5] Dennis, Michael, PHD (2024). Importance of Addressing Youth Health Disparities, and Improving Access to Quality Services. 2024 Joint Meeting on Youth Prevention, Treatment and Recovery in Conjunction with Pathways to Wellness Recidivism Reduction Initiative Forum.

[6] https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness#:~:text=Although%20there%20are%20fewer%20studies,diagnostic%20criteria%20for%20another%20mental

[7] Dennis, Michael, PHD (2024)

[8] https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/NSDUHDetTabsSect5pe2022.htm

[9] The recommendations are based on analyzing recent partner recommendations, including but not limited to the Oregon Council for Behavioral Health and the System of Care Advisory Council, as well as interviews and listening sessions with youth, families, systems partners and subject matter experts. Some of these recommendations can be seen in Appendix A.

rate of youth and young adults with co-occurring diagnoses that receive holistic treatment, and 4.) decreased inequities in substance use related harms in youth. The plan would 1) create youth and family centered pathways for holistic and accessible treatment for co-occurring issues, 2.) increase access to early intervention in settings in which youth and families are most likely to be seen; and 3.) support providers and increase family, youth, and peer engagement throughout the continuum of care.

It should be noted that these recommendations are oriented in treatment and recovery based on the original HB 4002 charge; however, the ADPC acknowledges that primary prevention is a critical component to a system of care for youth and adolescents. As such, the proposed strategic plan and recommendations below will incorporate and align with strategies recommended by the ADPC Prevention Committee and will promote primary prevention as a foundational lens by which we approach all work with youth and young adults.

MOUD Findings

The ADPC Treatment Committee focused on MOUD in emergency departments based on work in progress in this area by the Oregon Health Leadership Council and the feasibility of potential recommendations by September of 2024. Additionally, improved access to MOUD in the emergency department will have great impact on individuals experiencing OUD as emergency departments are frequently the first point of contact with the health system for many Oregonians experiencing substance use related health concerns. Increased access to MOUD may positively impact the likelihood of recovery for individuals seeking care for their OUD as MOUD has been shown to decrease cravings, treat withdrawal, and prevent overdose.[10][11] Ensuring access to MOUD within ED settings may be a crucial step towards decreasing overdose and addressing the current opioid crisis due to the increased risk posed by the prevalence of fentanyl within the drug supply.[12][13]

Prior to the efforts of this workgroup, the Oregon Health Leadership Council (OHLC) identified EDs in Oregon as a crucial setting for those experiencing Opioid Use Disorders, finding that 18% of those who were diagnosed with an SUD between June 2019 and June 2020 received their first SUD diagnosis in the ED, compared to a lower rate in other settings.[14] While this points to ED settings as prime locations for induction & prescribing of MOUD, most respondents (68%) of a 2022 survey conducted by Comagine Health, indicated that their ED *does not* have providers who routinely prescribe buprenorphine despite this significant need.[15] Beyond buprenorphine, other MOUD such as methadone may be unavailable despite regulations allowing for hospitals to utilize the medication to assist with withdrawal

[10] Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63 Publication No. PEP21-02-01-002. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf

[11] Weiner SG, Little K, Yoo J, et al. Opioid Overdose After Medication for Opioid Use Disorder Initiation Following Hospitalization or ED Visit. JAMA Netw Open. 2024;7(7):e2423954. doi:10.1001/jamanetworkopen.2024.23954

[12] Kaczorowski J, Bilodeau J, M Orkin A, Dong K, Daoust R, Kestler A. Emergency Department-initiated Interventions for Patients With Opioid Use Disorder: A Systematic Review. Acad Emerg Med. 2020 https://pubmed.ncbi.nlm.nih.gov/32557932/

[13] Walter LA, Li L, Rodgers JB, Hess JJ, Skains RM, Delaney MC, Booth J, Hess EP. Development of an Emergency Department-Based Intervention to Expand Access to Medications for Opioid Use Disorder in a Medicaid Nonexpansion Setting: Protocol for Engagement and Community Collaboration. JMIR Res Protoc. 2021 Apr 29;10(4):e18734. doi: 10.2196/18734. PMID: 33913818; PMCID: PMC8120420. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8120420/

[14] Oregon Health Leadership Council. Opioid Use Disorder Treatment: A Toolkit for Oregon Emergency Departments. https://ohlc.org/wp-content/uploads/2023/02/OUD-Toolkit-final.pdf

[15] Medications for Opioid Use Disorder in the Emergency Department Baseline survey results https://ohlc.org/wp-content/uploads/2023/01/MOUD-in-the-ED-Survey-Results-Report-Updated-8-2022.pdf

management or even beginning the medication as a first step to admission at an OTP for longer term care. Extended released medications (i.e., medications that do not require daily dosing) may be even less available due to costs and other challenges associated with maintaining an inventory of the medication.[16] Furthermore, most of these respondents indicated that there exists a need for more information, support, and guidance to effectively dispense & prescribe MOUD, in addition to linking to post hospital care (e.g., treatment providers, primary care). State level institutional support may be essential to ensuring this care is accessible regardless of which hospital system is providing care.[17] Model legislation for similar concepts have been drafted by LAPPA (Legislative Analysis and Public Policy Association) to support efforts to adopt similar practices.[18]

Through this process, the workgroup identified numerous systemic and programmatic challenges that pose barriers to accessing medication for opioid use disorders in emergency departments and transitions to care in the community as well as medications for other substance use disorders and potential solutions for these challenges. The workgroup identified the following key areas as relevant barriers for the efforts described in HB 4002:

- **Oregon's SUD treatment care continuum is fractured and can be challenging to navigate for those seeking care, necessitating dedicated care coordination services to support those attempting to access care for substance use disorders.** This is further exacerbated by multiple factors both unique to individuals seeking care because of differing recovery capital[19] (i.e., lack of factors that contribute to recovery outcomes such as transportation, housing, childcare, and technology access) and current systemic scarcities such as workforce shortages, organizational capacity, and availability of evidence-based practices.[20]
- **Efforts to widely disseminate skills, knowledge, or perspectives needed to treat OUD and other SUDs efficiently and effectively within ED settings have been unsuccessful.** While technical assistance (TA) and training is available[21], provided at low or no cost, and is effective when provided[22], provider/ organizational engagement with TA is too low at present to have significant impacts on increasing the quality of care provided to those experiencing SUD/ OUD in an ED setting.[23] This may be one contributing factor for the low prevalence of workflows in ED settings to provide MOUD or connect patients to existing SUD care programs. Providers express

[16] Mullen W, Hedberg M, Gadbois B, Heidbreder C. The introduction of a novel formulation of buprenorphine into organized health systems. Drug Alcohol Depend Rep. 2022 Aug 12;4:100090. doi: 10.1016/j.dadr.2022.100090. PMID: 36846578; PMCID: PMC9948815. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9948815/

[17] Bogan C, Jennings L, Haynes L, Barth K, Moreland A, Oros M, Goldsby S, Lane S, Funcell C, Brady K. Implementation of emergency department-initiated buprenorphine for opioid use disorder in a rural southern state. J Subst Abuse Treat. 2020 Mar;112S:73-78. doi: 10.1016/j.jsat.2020.02.007. PMID: 32220414; PMCID: PMC8115203. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8115203/

[18] https://legislativeanalysis.org/wp-content/uploads/2023/03/Model-Substance-Use-Disorder-Treatment-in-Emergency-Settings-Act-2.pdf

[19] Groshkova, T., Best, D., & White, W. (2012). The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths. Drug and Alcohol Review, 32(2), 187–194. https://www.nfartec.org/wp-content/uploads/2018/04/groshkova_et_al-2013-drug_and_alcohol_review.pdf

[20] Lenahan K, Rainer S., Baker R, Goren R, and Waddell, EN. Oregon Substance Use Disorder Services Inventory and Gap Analysis. https://www.oregon.gov/oha/HSD/AMH/DataReports/SUD-Gap-Analysis-Inventory-Report.pdf

[21] Opioid Response Network. https://opioidresponsenetwork.org/about-us/

[22] Opioid Response Network Case Study: https://opioidresponsenetwork.org/case-study/lessons-learned/work-with-a-clinic-experiencing-rapid-increase-in-opioid-use-disorder-patients/

[23] Huhn, Hobelmann, Strickland, Oyler, Bergeria, Umbricht, and Dunn. Differences in Availability of and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8188643/

discomfort utilizing pre-made workflows without express state agency endorsement, such as workflows provided in the OHLC toolkit.

- **There exists a disconnect between state and organizational policy governing SUD treatment/ provision of MOUD and the practical nature of providing care.** As motivation is often not a fixed variable for individuals considering change, best practices indicate that care should be provided with a level of urgency not always possible within the current care system.[24] While an individual may arrive to the ED with a desire to engage in treatment services, they may find barriers such as multiple admission processes, wait lists, "wrong doors," or enforced metrics that are in direct conflict with best practices for care.
- **While prevailing societal stigma may contribute to some care challenges, there exists little current policy driven incentive for healthcare programs to establish SUD care workflows.[25]** Reimbursement rates[26] for SUD care are significantly lower than non-SUD related services and there appears to be minimal regulatory directive and little incentive for innovation among provider organizations who might have the ability to establish SUD care workflows. For these reasons, it is possible that without financial incentives, these improvements to the health system may remain a lower priority compared to other ongoing or emergency priorities.
- **The SUD continuum of care requires significant documentation to meet federal, state[27], or other guidelines that permit provider organizations to render services**. As a result, documentation is often repeated, focused on immediate organizational needs (e.g., reimbursement requirements but not capable of long-term tracking), and is proprietary in nature, resulting in duplication of efforts throughout a patient's care experience.

The findings outlined above as well as feedback gathered via workgroups & key informant interviews with subject matter experts, behavioral health providers, hospital-based providers, community members, and commissioners, suggest a need to invest in and coordinate new and existing resources, programs, and other supports to enhance the care coordination services provided to Oregonians accessing SUD care as well as expanding the role that MOUD can play in our healthcare system. The ADPC puts forth the following recommendations to both embed this work in the ADPC strategic plan and continue to serve the role as a convener of these efforts to decrease state agency silos, decrease overdose rates, increase retention of SUD care, and increase successful outcomes related to recovery goals. The recommendations include 1.) Establishing a statewide care coordination system 2.) amending or repealing regulations, statutes, or programs that impede access to MOUD and 3.) Supporting a coordinated effort across state agencies to encourage engagement of technical assistance for MOUD across health professions.

[24] Mee-Lee, D. E. (2013). The ASAM criteria: Treatment criteria for Addictive, Substance-Related, and Co-Occurring conditions.
[25] Rosenberg NK, Hill AB, Johnsky L, Wiegn D, Merchant RC. Barriers and facilitators associated with establishment of emergency department-initiated buprenorphine for opioid use disorder in rural Maine. J Rural Health. 2022 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10862358/
[26] Behavioral Health Fee Schedule https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/bh-fee-schedule-0724.xlsx
[27] OAR 309-19 https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=313773

Preliminary Recommendations – Youth Substance Use Disorder

Recommendation 1: Support ADPC and SOCAC to develop a comprehensive youth strategic plan that provides "Pathways and Components of a Holistic, Youth and Family-Centered Treatment and Recovery System"

Recognizing that a strategic plan to address youth access to Medications for Opioid Use Disorder alone will not achieve the desired outcomes, the first consensus finding and recommendation is to support the ADPC and SOCAC to convene youth, family, and system partners to develop and formalize a strategic plan that provides system operations guidance for pathways and components of holistic, youth and family-centered treatment and recovery via the 2026-2030 ADPC Strategic Plan.[28] This Plan will:

- Emphasize the need for treatment and support for co-occurring diagnoses and needs;
- Center service delivery in shared lived experience, trauma informed practice and cultural responsiveness;
- Underscore the role of family members and caregivers, creating a system that supports families holistically, assists families and caregivers in navigating services, and engages families in all aspects of youth care and recovery;
- Enhance family and peer support, such as certified recovery mentors and family support specialists, across the continuum of care;
- Address each of the ASAM levels of care; compile evidence-based, promising, and culturally-based practice; and apply and adapt to different service settings; and
- Promote medication for substance use disorder as a critical component of care.

The ADPC and SOCAC will consult with Oregon's nine federally recognized Tribes to align this work with the updated Tribal Behavioral Health Strategic Plan in development, to support the work of the Tribes' youth substance use initiatives, and to learn from tribal partners' efforts to create a holistic youth system.

The strategic plan's pathways and components guidance will be co-designed by and include roles, instruction and guidance for youth, families, ADPC, SOCAC, all youth serving state agencies, providers, community institutions (such as schools and community-based organizations), and commercial and public payers.[29] The plan will also propose changes to statute and rules, Coordinated Care Organization (CCO) contractual requirements, reimbursement rates and payer policy, state grant and incentive programs (especially for non-billable prevention and recovery programs), and provider education and technical assistance to better support these partners in carrying out the goals of the plan. The plan will also align with and incorporate primary prevention strategies from the ADPC Prevention Committee.

The ADPC will also address the lack of knowledge, systemic support, and statewide infrastructure for adolescent treatment and recovery, especially as it relates to co-occurring diagnoses and medication treatment for substance use disorder. The ADPC believes that developing recognized guidance in partnership with youth, their families, and behavioral health system partners will create a foundation for sustainable policy-making and program development. The plan will address youth and adolescent specific barriers to care and include youth-focused non-clinical supports such as youth peer-to-peer

[28] This ADPC Strategic Plan would align with SOCAC strategic planning efforts for the same time period.

[29] The ADPC is aware of other systems toolkits and operations guidance in other states - California for example: https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf

street outreach, youth- friendly web-based resources, transportation (given many young people don't have access to a car), child-care, etc.

Short-term Policy Proposals and Immediate Strategies that support the development of a Holistic, Youth and Family-Centered Treatment and Recovery System

Recognizing the need to stabilize the current service array while also building a future system, the ADPC recommends the following for consideration in the 2025 legislative session.

Proposal 1a. Immediately address services for youth with multiple diagnoses through funded analysis and legislative support for *Treat Right Oregon.* Based on the findings above, the legislature could support the Strategic Plan's efforts with additional funding for study and implementation of a core feature of the upcoming strategic plan: access to treatment services for co-occurring diagnosis. *Treat Right Oregon* is a policy proposal from one of ADPC-SOCAC's youth collaborative members that attempts to proliferate co-occurring treatment services (to be defined by the youth collaborative, but at minimum, including support at the intersections of substance use, gambling, intellectual and developmental disability, and/or mental health) through an enhanced funding stream. The policy aims to ensure those with Medicaid and those with minimal health coverage can receive treatment services and other co-occurring supports. Creating service access regardless of insurance status/type has the additional benefit of reducing the number of systems that young people have to navigate (insurance is often difficult to navigate with limited information).[30] The ADPC is aware of OHA's Integrated Co-occurring Disorders Program (ICOD) and the Certified Community Behavioral Health Center (CCBHC) Programs that have similar aims with respect to treatment of co-occurring diagnoses and the provision of low/no-cost/sliding scale services. However, the ADPC also understands there is a need to assess and re-evaluate rules related to provision of services to young people, alleviate administrative barriers to stand up such programs for youth, and enhance reimbursement rates for complex adolescent care. The collaborative would look to promote *Treat Right* by applying the strategic plan "Pathways and Components" guidance to the integration of rules for adolescent mental health and substance use treatment, enhancement of Medicaid reimbursement rates for a holistic range of services provided to patients experiencing co-occurring diagnoses, and the enhancement of youth focused services through existing programs such as ICOD and CCBHC.

Proposal 1b. Immediately fund gaps analyses specifically for youth and adolescents related to intensive outpatient treatment, residential treatment, withdrawal management, and dual licensed providers.

Recommendation 2: Direct partner agencies to apply and adapt the strategic plan/"Pathways and Components" guidance into rule, program guidance, grant programs, incentives, reimbursement models, and payer policy. This includes supporting early intervention and pathways to holistic support in settings in which youth are most likely to seek help/be seen (Schools, Emergency Rooms, Carceral Settings, Community-Based Programs, Pediatrics and Primary Care).

[30] One group of youth cited lack of information with respect to insurance navigation as a major contributor to not seeking healthcare related to substance use issues.

Recognizing that strategic plans often lack implementation authority, the ADPC recommends the legislature direct all youth serving partner agencies to adopt, apply and adapt the "Pathways and Components" guidance, prioritizing settings such as schools, emergency rooms, primary care/pediatrics, child welfare, community-based programs (afterschool, faith-based, mentorship programs etc.), and youth/young adult justice systems. The ADPC and SOCAC would work with all youth serving state agencies, including Oregon Health Authority, Oregon Department of Human Services, Oregon Department of Education, Oregon Youth Authority, and Youth Development Oregon to achieve implementation of the guidance. As mentioned above, the ADPC and SOCAC would consult with the Tribes to align this work with existing tribal youth substance use programming and the goals of the Tribal Behavioral Health Strategic Plan. The strategic plan's "Pathways and Components" guidance could support the creation and proliferation of program specifications for screening, outpatient assessment, and low-level intervention for community settings. Based on conversations with youth and families, providing support in spaces where youth build consistent relationships and trust with their peers and/or adults with similar lived experiences increases the chances of the youth seeking help and engaging with services. Trusted community environments might help youth overcome fears of stigma, discrimination, and/or repetition of negative interactions with behavioral health staff, law enforcement or social services. The goal would be to prioritize providing systems-level support and/or evidence-based models of screenings and coordination for school and education service districts,[31] county corrections, CBOs, and other entities to proliferate promising practice, while being flexible to local needs and existing infrastructure. Pooling resources and creating hubs at county and regional levels (such as Education Service Districts) may also be necessary to alleviate pressures on smaller local entities and to support areas of the state with low population density. Planning and implementation will need to include strategies and coordination from the ADPC Prevention Committee, especially in programming, such as school screening, where primary prevention intersects with early intervention. Two examples:

- Schools: School-based programs such as Teen Intervene in Washington County, Restoring Individuals Community and Hope in Gladstone School District/Clackamas County, and Upshift in Deschutes County that employ Screening, Brief Intervention, Referral to Treatment (SBIRT) as a way of discipline diversion, prevention, early intervention, and support. School-Based Health Centers also act as an access point and referral pathway to alcohol and drug counseling. In addition to screening and brief intervention, the True North Program in Education Service District 113 in Washington provides low-barrier outpatient services for schools in 5 counties. Multnomah Education Service District, in coordination with Rivercrest Academy Recovery High School, is providing Certified Alcohol and Drug Counselor (CADC) services to component school districts, including provision of pro-social activities, early intervention work and professional support for certified recovery mentors.
- Juvenile Justice: The ADPC is also aware of Deschutes County Juvenile Justice's development of an in-house outpatient adolescent program that uses evidence-based individual and family SUD therapy. Clackamas County's Juvenile Intake and Assessment Center (JIAC) is a temporary holding facility and resource support center for youth who come into police contact or are criminally referred. All youth are offered SBIRT and based on those results provided culturally

[31] The ADPC is also aware of quite robust intervention and treatment programs through an Education Service District in Washington State and is looking to understand feasibility and needed capacity to support education partners in this work.

responsive family navigation services (via a community-based organization) including drug and alcohol referrals, counseling services, and provider connection facilitation for families.

Beyond settings for early and low-barrier intervention, the ADPC understands that very few supports exist at higher levels of care, including intensive outpatient, residential, and withdrawal management. The ADPC sees the strategy of prioritizing early intervention in low-barrier settings as a means of alleviating pressure on the higher levels of care, but the implementation of the strategic plan/"Pathways and Components" guidance will need to quickly assess and address traditional behavioral health capacity gaps for the long-term. For youth in recovery who may not have a home environment conducive to recovery, the collaborative will look at how to proliferate safe spaces for young people including drop-in, clubhouse, and community centers. Spaces should center lived experience and cultural responsiveness, allowing peers to engage in pro-social activities and seek resources for a multitude of needs.

Short-term Policy Proposals and Immediate Strategies that Support Recommendation 2

The ADPC recognizes that the need for youth SUD treatment and interventions is great, and that some implementation steps can be taken prior to the formalization of the strategic plan. The ADPC recommends the following for consideration in the 2025 legislative session.

Proposal 2a: Fund the ADPC, in collaboration with OHA and ODE, to inventory and assess feasibility of scaling up school-based substance use screening, intervention and referral programs. As mentioned above, the ADPC is aware anecdotally of programs through School-Based Health Centers, counties, education service districts, school districts, and community-based organizations working in schools, but there is no single inventory or environmental scan of capacity for all of the evidence-based and community informed practices throughout the state. To support implementation of early intervention, the inventory would assess what programs exist, promising programs (their staffing and funding models, and technical assistance/guidance needs), and systems capacity at local and regional levels to support this work. The ADPC would also recommend an inventory/feasibility study of intervention programs based in county corrections and child welfare.

Proposal 2b: Direct health systems funding to support Oregon Department of Education's Recovery Schools with respect to health and recovery services costs, including offsetting costs or supporting billing capacity. HB 2767 (2023) establishes a limited number of approved Recovery High Schools in Oregon. These schools provide students with a specialized high school education experience tailored to meet the needs of students with substance use and co-occurring behavioral health needs. The law requires the operation of recovery schools to include academic standards, substance use recovery services, graduation program evaluation, and recovery school accreditation guidance. Recovery Schools receive a base level of state education funding of $600,000 to achieve the education and service objectives above, while the true operating costs are closer to $730,000 per year. The ADPC understands that one of the major local cost drivers of operations are screenings and other services needed to uphold an environment supportive of recovery. The ADPC requests health systems funding to offset education funds with grants or billing capacity for these costs.

The ADPC also requests capacity funding to support the proliferation of the Alternative Peer Group Model[32], a promising model that can be employed by a Recovery High School or in clinical settings to support youth in their recovery. According to the Oregon Recovery High School Initiative, "*an Alternative Peer Group (APG) is a community-based, family-centered, professionally staffed, positive peer support program that offers prosocial activities, counseling, and case-management for adolescents who struggle with substance use disorders or self-destructive behaviors. […] the main focus is to offer and shape a new peer group that utilizes positive peer pressure to stay in recovery. In addition, APGs focus on making sobriety more fun than using by organizing and staffing after-school sober social functions throughout the week, weekends, and summers.*"[33] The model also has a strong family support/engagement component. The proposal seeks to establish this model in all 9 regions that will have a Recovery School, establish effectiveness in Oregon, and expand beyond recovery schools.

Recommendation 3: Provide education, technical assistance, and other support to families, youth, treatment providers, and professionals in the settings listed in Recommendation 2 as it relates to holistic youth support and medication treatment.

Fund ADPC and SOCAC, in partnership with youth, families, and youth serving state agencies, to commission the creation of education, training, professional development, and public awareness campaigns for families, youth, and youth serving professionals and providers related to holistic youth and family support. This could be done in conjunction with Proposal 1, utilizing multi-sector partnerships to apply and adapt professional best practice. Medical and behavioral health providers would benefit from systemic level support, while support for professionals in schools, carceral settings (both county and state/OYA), and community-based organizations (including faith organizations and afterschool programs) will assist early intervention and system navigation.

ADPC and SOCAC would be required to work with higher education entities and licensing boards on master's level curriculum, training, and continuing education in substance use treatment for youth. The ADPC understands there may be stigma and avoidance in the provider community, which could be partially addressed with additional education and focus. Adolescent treatment workforce trajectories could address gaps in intensive outpatient, withdrawal management and residential treatments.

Outside of formal peer certification for youth (see below), the ADPC also acknowledges youth leadership that is happening in the prevention space across the state through youth led action. In addition to supporting professionals, the guidance could explore how to support youth-led initiatives (clubs, projects, student mentor groups, health education) related to prevention and stigma, and provide pathways, such as Career and Technical Education, toward careers in prevention and behavioral health.

Short-term Policy Proposals and Immediate Strategies that Support Recommendation 3

The ADPC recognizes that youth and adolescent workforce gaps are dire and there are steps that can increase workforce engagement today. The ADPC recommends the following for consideration in the 2025 legislative session.

[32] https://pubmed.ncbi.nlm.nih.gov/27272995/

[33] https://www.oregonrecoveryschools.org/alternative-peer-groups/

Proposal 3a. Develop and fund a training and physician education campaign on medications for addiction treatment, in addition to trauma-informed, holistic youth substance use care. Behavioral health, emergency room, primary care, and pediatric providers need better understanding of indication and delivery of buprenorphine and other medications for adolescents - 90 percent of providers who have the ability to prescribe buprenorphine in the office do not.[34] Training/education and support should align with the "Transitions to Care" outlined below and focus on holistic support of the youth (including addressing underlying psychosocial needs), effectiveness of medication treatment, and clinical support (sample policies/procedures) for providers. Public awareness and education campaigns could also be tailored to specific settings, such as schools – education for school nurses, health aides, licensed mental health staff on medication management, naloxone, and more. Primary Care is already required to participate in training by the Drug Enforcement Administration and 1-hour continuing education on pain management as part of licensing – these trainings could be expanded to incorporate medications and treatment for youth substance use disorder using existing guidelines from the American Academy of Pediatrics for SBIRT as a starting place.

Proposal 3b: Scale youth and family peer support. Support greater numbers of Certified Recovery Mentors and Family Support Specialists in youth and family-centered spaces.

- **Create an endorsement for "Adolescent and Family" and "Co-Occurring" service provision for Certified Recovery Mentor (CRM) and Certified Alcohol and Drug Counselor (CADC) certifications and fund scholarships/provider incentives to achieve these endorsements.** Direct the ADPC and SOCAC, in partnership with MHACBO, to commission the development of the training and process for endorsement. Provide funds for scholarships for CRMs and CADCs to receive the training and endorsement. The workforce needs specific training related to adolescents and families, overcoming power dynamics, and creating safe spaces for adolescent recovery. An endorsement can promote training and education of youth substance use disorder for peers and certified workforce. Endorsement could help create a professional path for working with adolescents, increase the quality of care received by adolescents, and pave the way for enhanced reimbursement or incentives to employ such a workforce.
- **Fund education programs that support pathways for youth to engage in peer certification training as they graduate from Recovery Schools or transition out of county correctional settings, as modeled at the Oregon Youth Authority.** The Oregon Youth Authority (OYA) trains interested youth to become CRMs, so they can support their peers and transition to community workforce ready. Youth are transitioning out of Recovery High Schools, county corrections, and OYA with a sophisticated understanding of the recovery and treatment system, including how to navigate the system with their families. Providing a pathway to receiving certification as a CRM would generate workforce pathways and showcase systems-level expertise. In Recovery High Schools, this could be transcribed as Career and Technical Education. Similar pathways could emerge for CADCs.
- **Provide existing programs with additional resources for family and caregiver engagement.** Families and caregivers often do not receive training or peer mentorships, and sometimes lack support in navigating the system.[35] Some family-based interventions or supports may not be

[34] Amanda Risser, MD MPH (2023). Fentanyl: Everything you need to know. CareOregon, Youth Substance Use Disorder Learning Series.

[35] Based on conversation with the SOCAC Full Council in July 2024.

billable by clinical providers, leaving a gap in financing for programs like Community Reinforcement and Family Training (CRAFT) or the family engagement function of Alternative Peer Groups (APG). Finally, families need support in navigating conversations with youth about youth substance use, signs of problematic use, and engaging in services, especially in situations when young people are not ready to seek help.

Proposal 3c. Develop and fund a multimedia public education and awareness campaign directed at youth and families about substance use disorder, community resources, and education opportunities. This could center on social media buys and multimedia strategy for existing awareness campaigns and promote parent/caregiver education like SAMHSA's "Talk they Hear You" or Song for Charlie's "The New Drug Talk." The campaign would also provide supports for entities such as schools or localities to formalize such curriculums in their youth facing environments. The campaign could provide additional resource navigation and screening tools, like "Screen4Success". All media should provide culturally and linguistically tailored messaging and be based in stigma reduction. Messaging should be assets and solutions-based and widely available online and in community settings. The campaign will be developed in coordination with primary prevention partners to ensure that youth and families have access to prevention messaging in addition to navigation and intervention education.

Preliminary Recommendations – MOUD

Recommendation 1: Establish a statewide program to promote linkages of care throughout the SUD continuum of care, providing a system that supports care navigation from various levels of care, such as connecting those treated by Emergency Medical Services or Emergency Departments to appropriate follow up services such as treatment or primary care providers.

Provide funding and policy guidance for a statewide "Transition to Care" program, as has been done in other states[36][37], prioritizing connections from EMS and ED providers to less urgent settings such as community-based treatment providers. This effort would at a minimum require that the ADPC and agency partners:

- Conduct a health system inventory to determine the current ability for each hospital system to participate in the "Transition to Care" program utilizing rating tools/ processes designed to identify implementation/ system readiness[38][39]. Expanding this scope to include a current availability of same/ next day care access for primary and behavioral health care may be advised to support centralized scheduling as described below (e.g. care that is available within 24 hours). In Washington state's care coordination model, this has also been expanded to include a mechanism for scheduling via "drop in" appointment times, which is not currently a practice norm for many community-based organizations in Oregon.

[36] Scala Northwest Website https://scalanw.org/our-work
[37] California Bridge Website https://bridgetotreatment.org/addiction-treatment/ca-bridge/
[38] Hooker, S. A., Solberg, L. I., Miley, K. M., Borgert-Spaniol, C. M., & Rossom, R. C. (2024). Barriers and Facilitators to Using a Clinical Decision Support Tool for Opioid Use Disorder in Primary Care. The Journal of the American Board of Family Medicine, 37(3), 389–398. https://doi.org/10.3122/jabfm.2023.230308r1
[39] Bart G, Korthuis PT, Donohue JM, Hagedorn HJ, Gustafson DH, Bazzi AR, Enns E, McNeely J, Ghitza UE, Magane KM, Baukol P, Vena A, Harris J, Voronca D, Saitz R. Exemplar Hospital initiation trial to Enhance Treatment Engagement (EXHIT ENTRE): protocol for CTN-0098B a randomized implementation study to support hospitals in caring for patients with opioid use disorder. Addict Sci Clin Pract. 2024 Apr 11;19(1):29. doi: 10.1186/s13722-024-00455-9. PMID: 38600571; PMCID: PMC11007900. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11007900/

- Convene practitioners and administrators throughout the state to engage in a collaborative process to localize key aspects of the transition to care program ranging from determining essential order sets, workflows, or other needs, culminating in the creation of a state specific care coordination model that can be used for related technical assistance efforts such as provider training or organizational implementation. This may require consolidation of current resources or support mechanisms that provide components of the model.
- Develop a mechanism or identify a responsible body that is responsible for developing partnerships of providers from different disciplines who have historically not effectively engaged with one another (e.g., primary care and specialty SUD care) and subsequent process of "onboarding" these providers into the "Transition to Care" program. This central coordinating position is a feature of each program of similar purpose reviewed by the workgroup leading up to this recommendation.
- Collaboratively design and establish a statewide care coordination model that provides infrastructure for the "Transition to Care" program (technical assistance, funding, tracking), supporting required but localized regional care coordination efforts to address differing access challenges (i.e., service availability differs throughout the state) during improvement efforts. In similar programs, these services are provided as a combination of state or federally funded supports as well as third party contractors.
- Develop a data system and require participation of provider organizations to engage in timely tracking and data collection related to provider availability, wait times, service retention, and care transitions. These data should also capture discrepancies between recommended and available care to support future improvement efforts and can be shared readily via the ADPC dashboard.
- Establish and convene regionally focused expertise for the purpose of ongoing quality improvement, networking, and future planning to ensure the Transition to Care program can support all Oregonians who may need it, regardless of their geographic residence or other factors that historically have impeded access to care.

Recommendation 2: Amend rules or other regulations that have been identified as system level factors that contribute to barriers for care access or have historically impeded efforts to expand care access.

Direct the ADPC and other agency partners to identify and recommend statutory changes as well as enact specific rule changes that negatively impact access to effective SUD/ MOUD care. The workgroup has identified the following areas of interest:

- Current laws allow local or state authorities to prevent new Opioid Treatment Programs that provide crucial services such as prescribing methadone, buprenorphine, and other MOUD in addition to providing specialty SUD counseling services. Oregon, like many states, has rules that govern OTPs that are more restrictive than applicable federal guidelines and are often out of

step with current evidence-based practices.[40] *The workgroup recommends repealing or amending ORS 430.590[41] to eliminate this barrier to improve future access to OTPs.*

- Current IET (Initiation and engagement of substance use disorder treatment) metrics.[42] The workgroup recommends amending these metrics to align with emerging efforts (e.g., MOUD initiation) and to address immediate needs of the state, such as emphasizing care provided following an opioid overdose, linkages to care, and utilization of MOUD. This flexibility could be used to incentivize effective transitions from specific care points (e.g., residential to community based) as well as workforce modernization/ training. These changes to the IET metric should also be inclusive of the ED and care provided within these settings to promote adoption of new practices, utilization of MOUD, and effective care coordination.

Recommendation 3: Promote engagement of technical assistance by providers and provider organizations to accelerate the adoption and implementation of evidence-based practices and increase consistency among providers throughout the state.

ADPC will increase prevailing knowledge of evidence-based practices and the availability of training supports; however, the legislature may need to direct funding to support implementation, training incentives, or staffing to support communication and coordination of this dissemination work. A collaboration with agency partners involving communication strategies and leveraging existing and new workgroups is recommended to:

- Increase prevailing knowledge of currently available supports, such as the OHSU Addiction Medicine Consult line that may be essential to a future "Transition to Care" program.
- Increase the knowledge via a coordinated state agency communication strategy of existing technical assistance offered to providers and their organizations that support implementation and adoption of evidence-based practices. Since federal regulations have adjusted, removing regulatory barriers to prescribing MOUD, a knowledge base and provider comfort have been identified as barriers to increasing the number of MOUD-prescribing physicians.
- Direct OHA to study and define approved/ recommended protocols for MOUD induction, including innovations that decrease administrative burden on providers, such as creating/ disseminating "DotPhrases/SmartPhrases" created for common EHRs, such as EPIC. Efforts to study barriers have indicated this to be essential to provider utilization.[43] *Health Authority guidance has been cited by community members as a means of providing both provider and organizational comfort with adopting new protocols and increasing MOUD utilization.*

[40] Overview of Opioid Treatment Program Regulations by State. (2022, September 19). Pew.org. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/09/overview-of-opioid-treatment-program-regulations-by-state
[41] ORS 430.590 https://oregon.public.law/statutes/ors_430.590
[42] CCO Incentives https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/PlainLanguageIncentiveMeasures_English.pdf
[43] Fockele, C. E., Duber, H. C., Finegood, B., Morse, S. C., & Whiteside, L. K. (2021). Improving transitions of care for patients initiated on buprenorphine for opioid use disorder from the emergency departments in King County, Washington. Journal of the American College of Emergency Physicians Open, 2(2). https://doi.org/10.1002/emp2.12408 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7987236/

- Support and potentially fund capacity for providers and partners to engage with federally provided TA centers (ORN, ATTC, ROTA, etc…..) and technical assistance to implement evidence-based practices, establish “Transition to Care” program partnerships and components, and improve the continuum of care.
- To avoid duplication of efforts across state agencies and to support the ADPC in their charge as described in Section 1 of ORS 430.241, amend statutes to direct all state agencies that conduct research relevant to the efforts of the commission to provide the proposed efforts, evaluations, and other publications to the ADPC within a timely manner or as requested.
- To support the efforts described in Recommendation 1, make available technical assistance to assist in the implementation and onboarding of hospitals to provide the necessary support to participate in the “Transition to Care” program. This implementation support may best be provided by an entity that is able to provide individualized, organizational specific support for the duration of the initial implementation process, in line with evidence-based implementation practices.