COVER
PLACEHOLDER

2020-2025

Oregon Statewide Strategic Plan

Alcohol and Drug Policy Commission

Letter from ADPC

State Strategic Planning Subcommittee Members

Key State Agency Planning Partners

Oregon Health Authority: names
Oregon Department of Human Services: names
Oregon Department of Education: names
Youth Development Division: names
Oregon Higher Education Coordinating Commission: names
Oregon Youth Authority: names
Oregon Department of Corrections: names
Oregon Department of Business and Consumer Services: names
Oregon Department of Housing and Community Services: names
Oregon State Police: names
Oregon Lottery: names
Oregon Liquor Control Commission: names

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Executive Summary

Overview

Substance misuse is a complex issue. Alcohol and other drug use kills four Oregonians each day. When tobacco use is added, the daily average death toll increases to 30 or more. Substance use disorder (SUD) is a chronic medical condition requiring ongoing medical management and attention. The lack of access to substance misuse prevention and SUD treatment and recovery support in Oregon, however, places a huge burden on state finances. A national study released in 2009 by the center on Substance Abuse and Addiction (CASA) at Columbia University conservatively estimated that nearly 10% of Oregon's entire state budget in 2005 went to pay for social and health problems associated with untreated SUDs and unaddressed use and misuse of alcohol, tobacco, and other drugs. Since then, scores of reports, studies, white papers, and action plans with hundreds of recommendations have been produced but little action has been taken. Oregon now has among the highest rates of SUDs and substance use-related problems in the nation and spending to address the social and health consequences of this epidemic has soared. When the CASA study was replicated for this planning effort, it was found that substance -related spending in Oregon had more than quadrupled by 2017 to $6.7 billion dollars—or 16.8 percent of the entire state budget—with less than 1 percent of that amount spent to prevent, treat, or help Oregonians recover from substance misuse and SUDs.

This planning process has sought to go beyond previous efforts by comprehensively uncovering and addressing the key factors and conditions that drive substance misuse and impact the quality, availability and implementation of health-promoting policies and life-saving practices and services. Toward that end, it lays out a process for developing a coordinated and sustainable state system where substance misuse policies, investments, and efforts ensure that all Oregonian have access to highly effective and culturally tailored prevention, treatment, and recovery services—as well as the supports and resources needed to maximize them.

Strategic Plan Principles

The principles that guided this planning process are summarized below.

- **Impactful.** The plan seeks to significantly reduce substance use-related problems and disparities in Oregon within the next five years and establishes multiple measurable targets and benchmarks for monitoring progress.
- **Data-based.** Strategies and activities are based on objective, reliable, and representative data and strong evidence of effectiveness.
- **Comprehensive.** The array of strategies to accomplish each goal and associated long-term outcomes encompasses prevention, treatment, and recovery support.
- **Sequenced.** Strategies and activities address the most critical needs first to stabilize this public health crisis, then provide for working further 'upstream' in coming years.
- **Strategic.** Courses of actions in the plan are matched to existing readiness to initiate forward movement, so gain early successes which can be used to advance readiness for future policy, practice, and program change.

- **Actionable.** Roles, responsibilities, timelines, and outputs associated with implementing strategies and activities are identified.
- **Measurable.** Process and outcome measures and benchmarks have been identified to monitor progress throughout the implementation of the plan.
- **Aggressive.** Implementing the plan will require significant, ongoing commitment of time and effort from a wide array of state and local partners.
- **Ongoing.** The plan is designed to be a 'living' document that is continuously reviewed and updated into the future to reflect changing needs and circumstances.

Another principle that informs this plan is the importance of intervention and harm reduction throughout the work of prevention, treatment, and recovery. **Intervention** describes a set of strategies that can be used for a range of purposes, from intervening early in harmful substance use before a SUD develops to helping individuals with SUDs access treatment. **Harm reduction** is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.[1]

Plan Goals, and Objectives

The implementation of this plan will achieve four key goals in Oregon:

- **Goal One:** Reduce substance use disorders and increase recovery
- **Goal Two:** Reduce ATOD-related deaths
- **Goal Three:** Reduce ATOD-related health disparities
- **Goal Four:** Reduce the economic burden of substance misuse on Oregon's state budget

The objectives associated with these goals involve strengthening state system coordination and effectiveness, improving the effectiveness of prevention services across the life span, ensuring rapid access to effective treatment across the lifespan, and ensuring ongoing access recovery supports and resources across the lifespan. Intervention and harm reduction are embedded in each objective, along with a focus on ensuring equitable and culturally, linguistically, and gender-specific services. This means ensuring populations at higher risk which have been traditionally underserved—including communities of color, tribal citizens, rural Oregonians, the LGBT/Queer community, older adults, persons with disabilities, people experiencing homelessness, people with low income and/or low education, and those otherwise adversely impacted by social determinants of health—have access to high quality services that are tailored to their specific needs to eliminate health disparities.

[1] Definition from Harm Reduction Coalition. https://harmreduction.org/

Methodology

This plan was developed through careful analysis of existing data, studies, reports, and the professional expertise, lived-life experiences, and insights offered by hundreds of Oregonians across the state. The major activities used to develop this plan are detailed in appendices to this report; this summary lays out the core methodology and planning principles, that were used to develop core goals and objectives.

From the beginning, the planning approach used data-driven processes to avoid common pitfalls of planning (Planning Map, Appendix B). These included:

- Approaching substance use-related problems as ***complex issues*** that require comprehensive solutions coordinated across multiple sectors
- Identifying all major contributors to problems ***before*** selecting strategies and activities
- Selecting strategies and activities which will have the ***greatest impacts***—short-, intermediate-, and long-term—on reducing substance use-related problems.

Throughout the planning process, policy, program, and needs assessment findings (appendix D) were combined with partner and stakeholder input (appendix E) to identify and map the relationships between: 1) substance use-related problems, 2) the human and system actions that contribute most to substance use-related problems, and 3) the factors and variables that drive the actions that result in substance use-related problems (appendix C). Understanding these relationships enabled planning partners to identify meaningful and measurable impacts and associated goals, objectives, and outcomes ***first***, to ensure that all strategies and activities subsequently identified in the plan would best achieve desired results.

The planning process also used a systems approach to problem solving by recognizing that substance misuse in Oregon is a complex syndemic[2] that is rooted in factors that span multiple disciplines and sectors. This systems approach to planning has involved engaging the partnership and commitment of a continuously expanding number of state agencies and regional and local stakeholders.

[2] Syndemic has been defined as a conceptual framework for understanding and addressing complex health and social issues that arise when two or more problems interact. Syndemics—which are exacerbated by social, economic, environmental, and political inequities—create more burden of harm than the sum of the separate issues that give rise to them.

OREGON STATEWIDE STRATEGIC PLAN

Our Vision: A comprehensive, statewide system where substance misuse policies, investments, and efforts support healthy Oregonians and thriving communities.

Our Mission: To provide data-informed, integrated prevention, treatment, and recovery support services through public and private partnerships using equitable and culturally, linguistically, and gender-specific services.

Our Values: Compassion, Equity, Transparency, Well-being

Our Approach: work in partnership with communities to

- Reduce the number of Oregonians living with a substance use disorder
- Reduce the number of Oregonians who die from alcohol, tobacco, and other drug (ATOD) use
- Reduce ATOD-related health disparities in Oregon

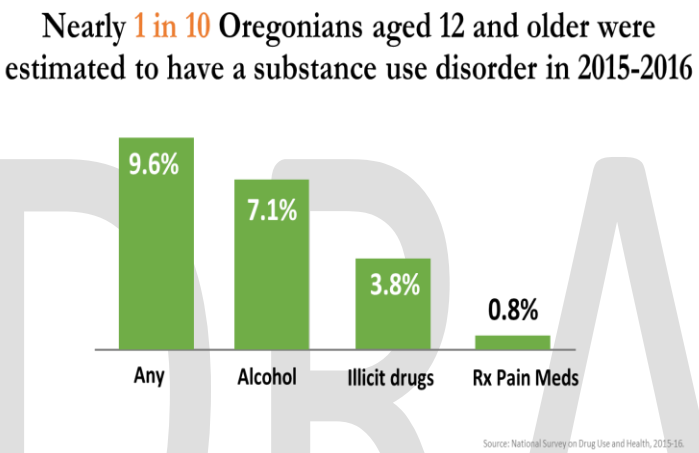
State System Partners

Oregon Alcohol and Drug Policy Commission, Convener

Oregon Health Authority
Oregon Department of Human Services
Oregon Department of Education
Youth Development Division
Higher Education Coordinating Commission
Oregon Youth Authority
Oregon Department of Consumer and Business Services
Oregon Department of Corrections
Oregon Liquor Control Commission
Oregon Lottery
Oregon Department of Housing and Community Services
Oregon Department of Transportation
Oregon State Police
Oregon Health and Sciences University

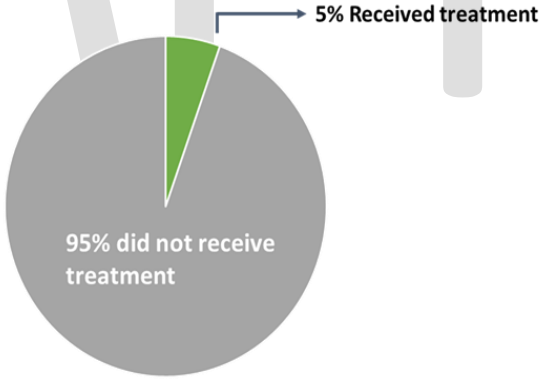
Goal 1: Reduce Substance Use Disorders and Increase Recovery

The Problem: Nearly **one in ten** of all Oregonians ages 12 and older—and **one in five** young Oregonian adults ages 18-25—are estimated to have a substance use disorder (SUD).



Alcohol use disorder (AUD) is the most common type of SUD—impacting 7 percent of all Oregonians—followed by illicit drug use disorders (3.8 percent), and pain reliever use disorders (0.8 percent). While the SUD rate in Oregon decreased slightly in recent years, the percentage of Oregonians estimated to have an AUD increased in every age group.

In 2016-2017, 329,000 Oregonians were estimated to need treatment for SUD; of these, 250,000 were estimated to need AUD treatment. During that period, however, only 5 percent—approximately 18,000 people—in need of treatment received it.



There are multiple, complex and intertwined reasons for Oregon's high rates of SUD. Reducing them significantly in the next five years is absolutely achieveable, but will require accomplishing the following:

- **Reducing the number of new cases of SUD** in the next five years, which includes dramatically reducing underage use
- **Increasing access to effective treatment** to help those struggling with SUDs move into recovery
- **Increasing retention in recovery** by increasing access to recovery supports

This actions in this plan complement and coordinate with other multidisciplinary planning efforts to reduce SUDs, including the Governor's Opioid Epidemic Task Force and Oregon Health Authority's Retail Marijuana Scientific Advisory Committee. The following two pages provide perspectives on SUD from stakeholders in the field, as well as measurable long-term outcomes.

Voices from the Field

Placeholder for stakeholder profile

Placeholder for stakeholder profile

Placeholder for stakeholder profile

Placeholder for stakeholder profile

Goal 1: Reduce Substance Use Disorders	Benchmarks	
	2022	2024
Decrease the percentage of Oregonians with a substance use disorder from 9.4 % in 2016-2017 to 6.8 % or less by 2025[i]	8.5%	7.0%

The measures below will be targeted and tracked to monitor progress toward reducing SUDs

Goal 1 Dashboard		
RECOVERY Long-term Outcome - All Ages	**Benchmarks**	
	2022	**2024**
Increase the percentage of Oregonians ages 12+ in recovery from SUD from 9.1% in 2017 to 11.4% or more by 2025[ii]	TBD	TBD
TREATMENT Long-term Outcome - All Ages	**Benchmarks**	
	2022	**2024**
Increase the percentage of Oregonians who receive needed SUD treatment from 5.0% in 2016-2017 to XX% or more[3] by 2025[iii]	TBD	TBD
PREVENTION Long-term Outcomes - Youth	**Benchmarks**	
	2021	**2023**
Decrease past 30-day alcohol use[iv]		
❖ 8th graders from XX.X% in 2019 to XX.X% or less by 2025	TBD	TBD
❖ 11th graders from XX.X% in 2019 to XX.X% or less by 2025	TBD	TBD
Decrease past 30-day binge drinking[v]		
❖ 8th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
❖ 11th graders from XX.X% in 2019 to XX.X% or less by 2025	TBD	TBD
Decrease past 30-day marijuana use[vi]		
❖ 8th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
❖ 11th graders from XX.X% in 2019 to XX.X% or less by 2025	TBD	TBD
Decrease past 30-day prescription drug misuse[vii]		
❖ 8th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
❖ 11th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
Decrease AOD-related suspensions/expulsions for K-12 students from XX.X in 201X to XX.X by 2025[viii]	TBD	TBD
PREVENTION Long-term Outcomes - Ages 18+	**Benchmarks**	
	2022	**2023**
Decrease past 30-day heavy drinking from X.X% in 2018 to XX.X% or less in 2024[ix]	TBD	TBD
Decrease past 30-day binge drinking from XX.X% in 2018 to XX.X% or less in 2024[x]	TBD	TBD
Decrease past 30-day use of illegal drugs from 4.7% in 2016-2017 to XX.X% or less in 2025[xi]	TBD	TBD
Decrease past year methamphetamine use from 1.1 % in 2016-2017 to XX.X% or less in 2025[xii]	TBD	TBD

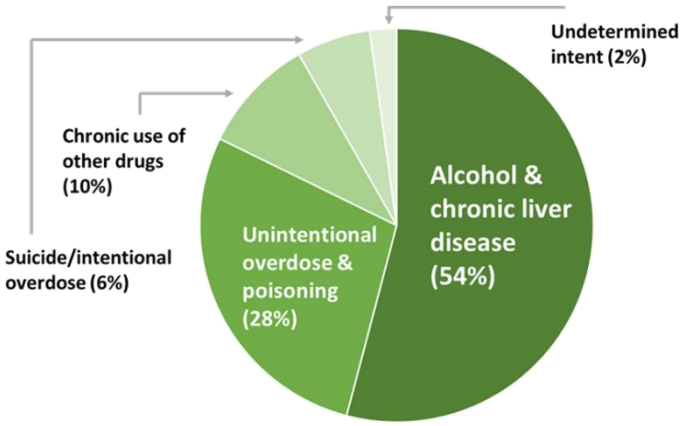
[3] This represents moving from among the last in the nation to a mid-range point

Goal 2: Reduce Deaths from Alcohol, Tobacco, and Other Drug Use

The Problem: On average, **more than four Oregonians died every day** in 2017 due to alcohol and other drug use (AOD).

Alcohol misuse was the leading cause of death: 522 Oregonians died from chronic alcoholic liver disease while another 316 died from other alcohol-induced deaths. Alcohol in combination with other drugs resulted in additional deaths due to unintentional injuries, suicides, and other causes. From 1998 to 2017, the rate of alcohol- induced deaths has nearly doubled from 11.6 per 100,000 to 21.2 per 100,000.[xiii]

1,549 deaths in Oregon in 2017 were due to alcohol or other drugs



A sharp increase in methamphetamine use in recent years is another leading cause of death. The rate of methamphetamine use in Oregon is 76 percent higher than the rest of the country and methamphetamine use now kills more Oregonians each year than prescription opioids.[xiv]

Tobacco use was linked to the deaths of 7,843 Oregonians in 2017, which comprised 21.4 percent of all deaths that year. Another 8,744 deaths in 2017 (23.9 percent) were potentially linked to tobacco.

It should be noted that—because of differences in how death data is collected and reported—these numbers only reflect confirmed deaths due to alcohol, tobacco, and other drug use. Actual numbers may be much higher.

This actions in this plan complement and coordinate with other multidisciplinary planning efforts to reduce SUDs, including the State Health Improvement Plan (SHIP) developed by the Oregon Health Authority in partnership with multiple agencies and stakeholders. Behavioral Health—which includes mental health and substance use—has been identified as one of five priorities in the 2020-2024 SHIP.

The following two pages provide perspectives on SUD from stakeholders in the field, as well as measurable long-term outcomes.

Voices from the Field

Placeholder for stakeholder profile

Placeholder for stakeholder profile

Placeholder for stakeholder profile

Placeholder for stakeholder profile

GOAL 2: Reduce ATOD-related Deaths	Benchmarks	
	2022	2024
Decrease the rate at which Oregonians die from ATODs from XX.X per 100,000 in 2017 to XX.X per 100,000 or less by 2025[xv]	TBD	TBD

The measures below will be targeted and tracked to monitor progress toward reducing ATOD-related deaths

Goal 2 Dashboard		
Long-term Outcomes - All Ages[xvi]	**Benchmarks**	
	2022	**2024**
Decrease the rate at which Oregonians die from chronic alcoholic liver disease from XX.X per 100,000 in 2018 to XX.X or less per 100,000 by 2025	TBD	TBD
Decrease the rate at which Oregonians die from other alcohol-related cause from XX.X per 100,000 in 2018 to XX.X or less per 100,000 or less by 2025	TBD	TBD
Decrease the rate at which Oregonians die from AOD overdoses from XX.X per 100,000 in 2018 to XX.X or less per 100,000 or less by 2025	TBD	TBD
Decrease the rate at which Oregonians die from AOD-related unintentional injuries from XX.X per 100,000 in 2018 to XX.X or less per 100,000 by 2025	TBD	TBD
Decrease the rate at which Oregonians die from AOD-related suicides from XX.X per 100,000 in 2018 to XX.X or less per 100,000 by 2025	TBD	TBD
Decrease the rate at which Oregonians die from chronic drug use from XX.X per 100,000 in 2018 to XX.X or less per 100,000 by 2025	TBD	TBD
Decrease the rate at which Oregonians die of tobacco- related causes from XX.X per 100,000 in 2018 to XX.X or less per 100,000 in 2025	TBD	TBD
Long-term Outcomes – Youth[xvii]	**Benchmarks**	
	2022	**2024**
Decrease past 30-day cigarette smoking		
❖ 8th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
❖ 11th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
Decrease past 30-day use of any tobacco products (including vaping products):		
❖ 8th graders from X.X% in 2019 to XX.X% or less by 2025	TBD	TBD
❖ 11th graders from XX.X% in 2019 to XX.X% or less by 2025	TBD	TBD
Decrease percentage of Medicaid members ages 13+ who currently smoke cigarettes or use other tobacco products from XX.X% in 20XX to XX.X% by 202X.[xviii]	TBD	TBD
Long-term Outcomes – Adults[xix]	**Benchmarks**	
	2022	**2024**
Decrease reported rates of past 30-day heavy drinking by Oregon adults ages 45+ from XX.X% in 2018 to XX.X% or less by 2024	TBD	TBD
Decrease reported rates of past 30-day binge drinking by Oregon adults ages 45+ from XX.X% in 2018 to XX.X% or less by 2024	TBD	TBD
Decrease past 30-day cigarette smoking among adults ages 18+ from X.X% in 2018 to XX.X% or less by 2024	TBD	TBD
Decrease the percentage of adults ages 18+ who report using e-cigarettes and/or other vaping products every day or some days from XX.X% in 2018 to XX.X% or less by 2024	TBD	TBD

Goal 3: Reduce Health Disparities Due to Alcohol, Tobacco, and Other Drug Use

The Problem: Populations in Oregon which are **disproportionately impacted** by AOD-related health issues also tend to be **significantly underserved**.

These include communities of color, tribal citizens, rural Oregonians, the LGBT/Queer community, older adults, persons with disabilities, people experiencing homelessness, people with low income and/or low education, and those otherwise adversely impacted by social determinants of health. Gender is also a factor. While 67% of AOD-related deaths in 2017 occurred among males, more than half of all intentional overdoses and suicides occurred among females. Oregonians ages 55-64 had the highest rates of AOD-related deaths in 2017, and while White Oregonians comprised the majority of AOD-related deaths, Native Americans died at more than twice their rate. Black/African American Oregonians had the highest rates of death from AOD-related unintentional injuries, followed by Native Americans and Whites.

Social Determinants of Health

Social determinants of health are **economic and social conditions that influence the health of people and communities**. These conditions are shaped by the amount of money, power, and resources that people have, all of which are influenced by policy choices. Social determinants of health affect factors that are related to health outcomes. (U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/nchhstp/socialdeterminants/faq.html)

Due to data collection issues, quantifying the specific impact of AOD-related disparities on many higher risk populations can be challenging—particularly when numbers are small, or populations are hard-to-reach. Differences in overall health outcomes in Oregon are vast, however, as illustrated in the table below.[4].

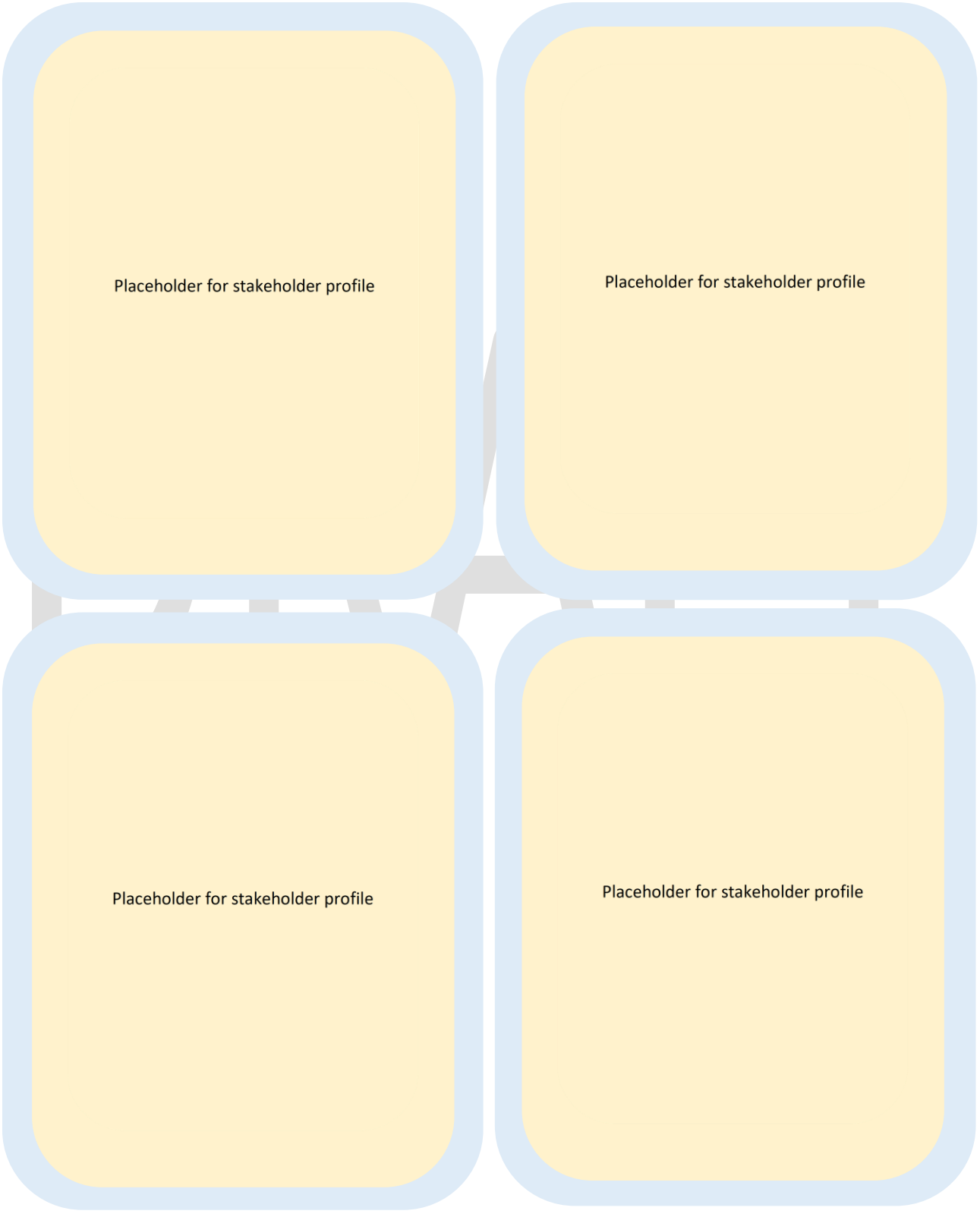
Differences in Health Outcomes among Counties and for Racial/Ethnic Groups in Oregon

Outcome	Healthiest County	Least Healthy County	American Indians/Alaska Natives	Asian/Pacific Islander	Black	Hispanic	White
Premature Death (yrs lost/100,000)	4,100	9,200	8,900	3,500	8,800	4,000	6,300
Poor or Fair Health	12%	17%	20%	11%	N/A	26%	14%
Poor Physical Health Days (avg)	3.4	4.3	4.4	2.4	N/A	3.8	3.8
Poor Mental Health Days (avg)	3.6	4.4	7.0	3.3	N/A	4.1	4.6

This actions in this plan complement and coordinate with other planning efforts to reduce SUDs, including the Tribal Behavioral Health Strategic Plan, the 2018 Statewide Housing Plan, the Oregon Developmental Disabilities Strategic Plan 2018-2023, and the 2019 Aging and People with Disabilities Strategic Plan. The following two pages provide perspectives on health disparities from stakeholders in the field, as well as measurable long-term outcomes.

[4] 2019 Oregon Health Ranking Report.

Voices from the Field



GOAL 3: Reduce AOD-related Disparities	Benchmarks 2022	Benchmarks 2024
Significantly reduce ATOD-related health disparities due to age, race/ethnicity, gender, discrimination, stigma, and inequitable access to basic resources, education, and economic opportunities.	See below	

The measures below will be targeted and tracked to monitor progress toward reducing AOD-related health disparities

Goal 3 Dashboard

Long-term Health Outcomes - All Ages	Benchmarks 2022	Benchmarks 2024
Decrease the rate at which Native Americans in Oregon die from AOD-related causes from XX.X per 100,000 in 2018 to XX.X per 100,000 or less by 2025[xx]	TBD	TBD
Decrease the rate at which racial/ethnic minority groups in Oregon die from AOD-related causes from XX.X per 100,000 in 2018 to XX.X per 100,000 or less by 2025[xxi]	TBD	TBD
Decrease the percentage of Oregonians who have an educational attainment of high school or less who report poor health status from XX.X% in 2018 to XX.X% or less by 2024[xxii]	TBD	N/A
Decrease the percentage of Oregonians who have an educational attainment of XX or less who report lack of access to health care from XX.X% in 2018 to XX.X % or less by 2024[xxiii]	TBD	N/A
Long-term Health Outcomes – Ages 45+	**Benchmarks 2022**	**Benchmarks 2024**
Reduce reported rates of past 30-day heavy drinking by Oregon adults ages 45+ from XX.X% in 2018 to XX.X% or less by 2024[xxiv]	TBD	N/A
Reduce reported rates of past 30-day binge drinking by all Oregon adults ages 45+ from XX.X% in 2018 to XX.X% or less by 2024[xxv]	TBD	N/A
Long-term Social Outcomes	**Benchmarks 2022**	**Benchmarks 2025**
Decrease the number of new substantiated cases of child abuse in Oregon where AOD use is a factor from XX.X in 201X to XX.X or less in 2025[xxvi]	TBD	TBD
Decrease the number of new Oregon children place in foster care due in part or whole to parental or caregiver AOD use from XX in 201X to XX or less in 2025[xxvii]	TBD	TBD
Decrease the number of new substantiated cases of adult abuse/neglect/self-neglect in Oregon where AOD use is a factor from XX in 201X to XX or less in 2025[xxviii]	TBD	TBD
Decrease AOD-related crime from XX.X in 201X to XX.X or less in 2025	TBD	TBD
Decrease disproportionate minority contact by law enforcement due to AOD-related issues from XX.X in 201X to XX.X or less in 2025[xxix]	TBD	TBD

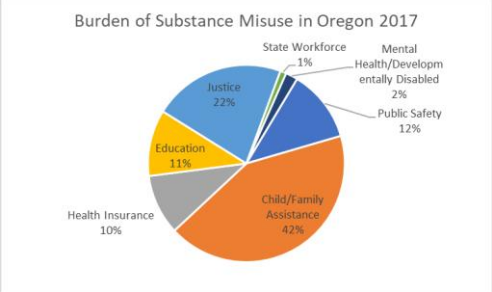
Goal 4: Decrease the Economic Burden of Substance Misuse on Oregon

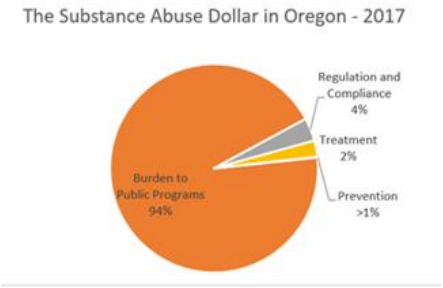
The Problem: The amount of state dollars being used to pay for substance use-related problems more than **quadrupled** from 2005 to 2017, consuming—by the most conservative estimates—nearly **17 percent of the entire state budget**.

In 2001 and 2009, CASA at Columbia University released two iconic reports—*Shoveling Up* and *Shoveling Up II*—which quantified the costs of substance use and addiction to federal, state and local governments. As part of Oregon's statewide strategic planning effort, JBS International consulted with current and former staff from Columbia University and Oregon state budget staff to use the *Shoveling Up* methodology to calculate current costs of substance use in Oregon. Had there been no change in Oregon state budget line items; the ratio of federal-to-state funding sources; or the prevalence of binge drinking, tobacco, and other drug use; Oregon would be spending $691.31 per capita in 2019 dollars on the impact of substance use to the state government.[5] Unfortunately, as the table below shows, the cost to the State of Oregon was far higher.

At-A-Glance Changes in Oregon Substance Abuse Spending 2005-2017						
	2005			2017		
	Total Spending	% State Budget	Per Capita	Total Spending	% State Budget	Per Capita
Burden Spending	$1,461,714,900	9.5	$394.98	$6,308,912,572	15.8	$1,482
Prevention	$9,830,600	<1	$47.10	$7,044,296	<1	$1.66
Treatment	$82,340,300			$168,827,299		$39.66
Regulation & Compliance	$1,592,000	1.1	$26.00	$240,475,000	<1	$56.50
Unspecified	$4,050,100	<1		N/A	N/A	N/A
Totals	***$1,732,251,900***	***11.3***	***$468.08***	***$6,725,259,167***	***16.8***	***$1580.05***

Substance use cost Oregon $1,580.05 per capita in 2017, with more spent per capita on regulating and ensuring compliance with laws governing the sale and distribution of substances ($56.50) than preventing or treating substance-related problems ($41.32). The top pie chart illustrates the distribution of substance use-related burden spending across state-funded programs. As the bottom pie chart shows, 94¢ of every dollar—$6.725 billion in state funds comprising 16.8 % of the entire state budget—paid just for the burden to public programs





The following page describes the goal of reducing the financial burden of AOD-related problems in Oregon—with associated measurable, long-term outcomes—by increasing state spending on prevention, treatment and recovery. **Shifting the investment of state funds to increase the proportion spent on prevention, treatment, and recovery will also directly support the achievement of Goals 1 -3.**

[5] The simple cost of living increase (as captured by the Consumer Price Index) between 2005 (the year of *Shoveling Up II*) and 2019 increased by a factor of 1.35.

GOAL 4: Reduce the financial burden of AOD-related Problems in Oregon	Benchmarks 2022	Benchmarks 2024
Reduce the estimated amount of state funds spent to pay for the **burden of substance use-related social and health problems** to public programs from 15.8% of the entire state budget in 2017 to XX.X% or less by 2025.	TBD	TBD

The measures below will be targeted and tracked to monitor progress toward reducing AOD-related health disparities

Goal 4 Dashboard Long-term Economic Outcomes	Benchmarks 2022	Benchmarks 2024
Justice: Decrease the estimated amount of **substance misuse/SUD burden spending** from 87.01 % of all state justice program spending to XX.X% or less by 2025	TBD	TBD
Child and Family Assistance: Decrease the estimated amount of **substance misuse/SUD burden spending** from 80.72 % of all state child and family assistance program spending to XX.X% or less by 2025	TBD	TBD
Mental Health: Decrease the estimated amount of **substance misuse/SUD burden spending** from 66.72 % of all state mental health program spending to XX.X% or less by 2025	TBD	TBD
Health Insurance: Decrease the estimated amount of **substance misuse/SUD burden spending** from 34.52 % of all state health insurance program spending to XX.X% or less by 2025[6]	TBD	TBD
Public Safety: Decrease the estimated amount of **substance misuse/SUD burden spending** from 29.23 % of all state public safety program spending to XX.X% or less by 2025	TBD	TBD
Education: Decrease the estimated amount of **substance misuse/SUD burden spending** from 17.69 % of all state health insurance program spending to XX.X% or less by 2025	TBD	TBD
Overall Investment of State Funds: Increase the proportion of funding spent to prevent substance misuse, promote health and positive social outcomes, and treat and support recovery from SUDs from less than 3¢ of every dollar spent on substance use in 2017 to XX¢ or more of every dollar spent on substance use by 2025.	TBD	TBD

[6] This is the estimate of spending that can be traced to the use of alcohol, drugs or nicotine. While there are some conditions completely attributable to drugs, alcohol or nicotine (e.g., cirrhosis of the liver, lung cancer, drug overdoses) there are others where research has determined a certain percentage of cases would not exist if not for substance use (e.g., heart conditions, diabetes, COPD, psychotic episodes). In addition, a certain percentage of accidents (e.g., motor vehicle, work related injuries, falls) and the injuries they cause are attributed to substance use. Actual treatment for alcohol and drugs IF paid by the state revenue funded public insurance would fold into this but the vast majority is from health issues created as a "byproduct" of someone's substance use. These conditions comprise the majority share of the health insurance PAR.

Objective 1: Implement a statewide system that ensures that substance misuse policies, practices, investments, and efforts are effective and result in healthy and thriving individuals and communities.						
Intermediate Outcome 1.a: Strengthen system leadership						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
1.a.1. Increase the ability of state agencies to consistently work together to **strengthen system leadership**	Convene quarterly meetings to review progress and adjust plan goals, objectives, outcomes, and implementation as needed	1/1/2020	Ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.a.2. Enhance the ability of system leadership to ensure **conceptual clarity** across disciplines and sectors	Establish mutually agreed upon and specific interagency coordination expectations and associated roles and responsibilities	1/1/2020	6/30/2020	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.a.3. Increase the ability of the system to ensure **inclusive leadership**	Establish participatory processes for all aspects of system work and identify and recruit new members as needed	1/1/2020	6/30/2020	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.a.4. Increase the ability of system leadership to ensure practices **support health equity**	Remove institutional barriers (policies, practices) that limit access to culturally appropriate and effective services	1/1/2020	12/31/2020 & ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.a.5. Increase the ability of system leadership to advance **political will** for implementing all plan strategies	Remove institutional barriers (e.g., policies and practices that perpetuate stigma) that limit readiness and will for implementing strategic plan actions among decisionmakers at state and subrecipient levels • Review and revise existing policies, requirements, and operating frameworks • Develop new policies, requirements and operating frameworks as needed	1/1/2020	12/31/2020 & ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.a.6. Strengthen the ability of system leadership to	Establish roles/expectations for members to serve as system ambassadors and enlist the	1/1/2020	6/30/2020	**Lead**: ADPC		TBD

influence others to support plan implementation	support of their networks and stakeholders for plan priorities and actions.			**Partners**: All state agency partners		
1.a.7. Increase the ability of system leadership to be **accountable**	Establish a process for regularly communicating system use of resources, activities, and outcomes to stakeholders and decisionmakers • Create an annual report format with identified data points and indicators • Create a process and timelines for collecting, compiling, and formatting information from state agency partners • Create a process for disseminating the report • Disseminate report	1/1/2020	9/30/2020	**Lead**: ADPC **Partners**: All state agency partners	Report format Data points and indicators	TBD
		1/1/2020	9/30/2020		Written process, timelines	
		1/1/2020	9/30/2020		Dissemination protocol	
		12/31/2020	Ongoing annually		Annual report	
1.a.8. Increase the ability of leadership to create a **sustainable state system** of substance misuse prevention, intervention, treatment and recovery	Establish processes for recruiting new leaders and allies during times of turnover and transition	1/1/2020	Ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
	Establish processes for coordinating, leveraging, and/or braiding funding and other resources across sectors					
	Identify/develop public-private partnerships that can advance/support system work					

Intermediate Outcome 1.b.: Increase system capacity to solve substance use problems and implement needed changes to system operations.

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			
1.b.1. Identify the **organizational structure(s),** roles, and responsibilities needed to coordinate and carry out plan activities	Establish system member roles, responsibilities, expectations & create workgroups/subcommittees needed to implement the plan	1/1/2020	3/31/2020	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD

1.b.2. Strengthen and increase the ability of **data infrastructure** to support plan implementation and outcomes	Improve infrastructure for assessment, monitoring, evaluation, and reporting;	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
	Strengthen interagency data sharing • Re-establish an interagency epidemiological workgroup	1/1/2020	TBD		TBD	TBD
	Increase ability to identify new and emerging issues quickly	1/1/2020	TBD		TBD	TBD
1.b.3. Increase system ability to recruit, develop, and retain a **highly effective workforce**	Identify core competencies and specialized knowledge, skills and abilities (KSAs) needed by each sector of the workforce	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
	Provide training and technical assistance to strengthen the KSAs needed to conduct needs assessment, mobilize partners, select/implement evidence-based and culturally tailored services/strategies across the lifespan, continuously evaluate outcomes, and revise strategies as needed	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
	Establish reimbursement and other processes needed to increase workforce retention	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.b.4. Increase system ability to monitor and secure **funding and resources** needed to carry out plan activities	Monitor and map all existing funding	1/1/2020	6/30/2020 then ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
	Identify potential for redirecting funding—including funding freed by improved outcomes—to finance needed services and strategies	1/1/2020	9/30/2020 then ongoing			
1.b.5. Increase system ability to ensure resources **support health equity**	Revise/develop policies to ensure equitable allocation of resources	1/1/2020	TBD	**Lead**: APDC **Partners**: All state agency partners	TBD	TBD
1.b.6. Increase system ability to be **accountable**	Strengthen processes for monitoring, evaluating and documenting the outcomes of investments in services and infrastructure	1/1/2020	Ongoing	**Lead**: APDC **Partners**: All state agency partners	TBD	TBD

1.b.7. Increase system ability to conduct strategic finance planning to achieve **sustainable outcomes**	Quantify the funding and other resources needed to develop/expand/ sustain services and infrastructure at the scope and reach needed to achieve plan outcomes (see appendix F)	1/1/2020	9/30/2020 and ongoing annually	**Lead**: APDC **Partners**: All state agency partners	TBD	TBD
Intermediate Outcome 1.c.: Increase the system's ability to use practices, processes, and programs that have strongest evidence of effectiveness for priority populations and problems						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
1.c.1. Increase system ability for **effective communication and information sharing** among members	Establish new and strengthen existing processes & channels of communication among system members	1/1/2020	Ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.c.2. Increase the ability of the system to reach consensus and coordinate efforts through commonly agreed upon **operating procedures and protocols**	Establish processes for decision making and conflict resolution; identify roles and responsibilities for day-to-day system coordination	1/1/2020	1/31/2020	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.c.3. Strengthen system member ability to select and implement the most effective **evidence-based practices, policies, and programs**	Strengthen processes and develop guidance to help those who receive system funding select, and implement strategies that are evidence-based, culturally tailored, and situationally appropriate for the populations and problems being targeted.	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.c.4. Increase system ability to use data to target **training and technical assistance** to improve subrecipient performance and outcomes across sectors	Use workforce assessment data and study findings to design, secure, and implement T/TA to build the core competencies and specialized KSAs the workforce needs to achieve the outcomes identified in the plan	1/1/2020	Ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.c.5. Increase system ability to conduct **effective monitoring and evaluation** processes	Identify methods, roles, and responsibilities for collecting, analyzing, and reporting data on process and outcome indicators, benchmarks, and dashboard measures identified in the plan	1/1/2020	1/31/2020	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD

1.c.6. Increase system ability to implement processes, practices, and programs that **promote health equity**	Strengthen requirements for providing culturally tailored services to those who receive system funding	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
1.c.7. Increase system ability to implement processes that document **accountable use of all resources**	Identify/monitor gaps and/or duplication in services	1/1/2020	TBD	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD
	Align expenditures to goals, objectives, and outcomes	1/1/2020	9/30/2020 then ongoing			
	Calculate shifts in dedicated and 'burden' spending	1/1/2022	2/28/2022			
	Record/disseminate information on activities to members and stakeholders	1/1/2020	Ongoing			
1.c.8 Increase system ability to adopt and implement practices and processes that lead to **sustainable results**	Identify financing strategies to develop/expand/sustain services and infrastructure at the scope and reach needed to achieve outcomes (including Medicaid waivers to expand the types and levels of services provided)	1/1/2020	9/30/2020 then ongoing	**Lead**: ADPC **Partners**: All state agency partners	TBD	TBD

Objective 2: Increase the impact of substance misuse prevention strategies across the lifespan

Intermediate Outcomes 2.a: Decrease retail access to alcohol and marijuana to underaged persons

Intermediate Outcome Indicators:

- Decrease the retail violation rate of alcohol sales to minors from XX.X % in 201X to XX.X % by 2023[xxx]
- Decrease the retail violation rate of marijuana sales to minors from XX.X % in 201X to XX.X % by 2023 (Source?)

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			
Increase KSAs of beverage servers, retail alcohol clerks, and retail marijuana clerks to **refuse sales to underage persons**				OLCC, OHA		
Increase **perception of enforcement and consequence** for violating state laws prohibiting sales of alcohol and marijuana to underage persons						

Intermediate Outcome 2.b: Decrease social access of alcohol and marijuana to underaged persons

Intermediate Outcome Indicators: TBD

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			
				OHA		

Intermediate Outcome 2.c: Decrease family norms permissive of ATOD use/misuse across the lifespan[xxxi]

Intermediate Outcome Indicators:

- Increase the rate at which students report their parents would feel it was very wrong for them to drink beer, wine or liquor regularly
  - 8th grade: from XX.X% in 2019 to XX.X% in 2023
  - 11th grade: from XX.X% in 2019 to XX.X% in 2023
- Decrease the rate at which students report their parents would feel it was very wrong for them to use marijuana
  - 8th grade: from XX.X% in 2019 to XX.X% in 2023
  - 11th grade: from XX.X% in 2019 to XX.X % in 2023

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			

Intermediate Outcome 2.d: Increase perception of harm of ATOD use/misuse across the lifespan

Intermediate Outcome Indicators:

- Decrease the rate at which students report perceiving moderate or great risk from taking one or two drinks of an alcoholic beverage nearly every day[xxxii]
  - 8th grade: from XX.X% in 2019 to XX.X% in 2023
  - 11th grade: from XX.X% in 2019 to XX.X % in 2023
- Decrease the rate at which students report perceiving moderate or great risk of smoking marijuana at least once or twice a week[xxxiii]
  - 8th grade: from XX.X% in 2019 to XX.X % in 2023
  - 11th grade: from XX.X% in 2017 to XX.X % in 2023
- Adult measures for perception of harm from misuse?
  - Tobacco: possibly could use indicators in *Evidence-Based Strategies for Reducing Tobacco Use A Guide for CCOs* to provide baselines ("Work with Partners to Reduce Tobacco Prevalence in Communities Served By the CCO")
  - Alcohol and other drugs?

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			
Increase **knowledge of the harm associated with ATOD misuse** across the lifespan, including drug and alcohol interactions						
Intermediate Outcome 2.e.: Decrease over service of alcohol in restaurants and bars and retail sales of alcohol to alcohol-impaired adults ages 21+						
Intermediate Outcome Indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
Increase KSAs of beverage servers and retail alcohol clerks to **refuse sales to persons who are intoxicated** or at risk of becoming intoxicated				OLCC		
Increase **perception of enforcement and consequence** for violating state laws prohibiting sales of alcohol to intoxicated persons						
Intermediate Outcome 2.f.: Increase the use of health-promoting policies and practices at state and local levels						
Intermediate Outcome Indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			

Increase the ability of communities to **develop/revise, implement, and enforce health promoting policies**						
Intermediate Outcome 2.g.: Strengthen the ability of the prevention workforce to prevent and reduce substance-related problems across the lifespan						
Intermediate Outcome Indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
2.g.1. Increase system ability to **recruit and develop a wide array of prevention workforce members**—including community members, volunteers, professionals, and laypersons who may not identify as being part of the prevention workforce.						
2.g.2. Increase KSAs of prevention practitioners to use **needs assessment, planning, and evaluation** to guide their work and achieve, document, and sustain desired outcomes						
2.g.3. Increase KSAs of prevention practitioners to use research to select **strategies that have the strongest documentation of effectiveness** and largest effect size for priority populations and substances						
2.g.4. Increase community capacity to design, mobilize, implement, and evaluate **grass roots efforts to prevent substance misuse** and related health and social problems across the lifespan						
2.g.5.Increase system ability to create a career path that leads to **increased retention of prevention providers and community organizers**						
Intermediate Outcome 2.h.: Increase use of effective early intervention and harm reduction						
Intermediate Outcome Indicators: TBD						

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			
2.h.1. Increase **knowledge of types and quantities of early intervention and harm reduction services needed** to enhance prevention efforts across the state	Create processes for estimating projected numbers of persons annually needing early intervention and harm reduction services—by type and level—in community and other settings[7].					
2.h.2. Increase **knowledge of the types and levels of early intervention/harm reduction that currently exist** to support prevention across the state	Create an inventory that includes private and semi-private as well as publicly funded early intervention/harm reduction strategies and resources					
2.h.3. Increase ability to maximize and **expand current effective early intervention/harm reduction capacities** for prevention while strategically targeting areas for new service development	Create a process for identifying and investing in effective early intervention/harm reduction services across the lifespan and using lessons learned to establish new services where they are most needed					
2.h.4. Increase knowledge of the types of **intermediaries needed** to increase access to early intervention and harm reduction						
2.h.5. Increase ability to identify persons at risk of health, social, or legal consequences from AOD use and **provide an appropriate intermediary** to facilitate early intervention, harm reduction, and referral to the appropriate level of needed services						
2.h.6. Increase ability to **recruit and develop early intervention/harm reduction workforce** members—including those with lived life experience.						
2.h.7. Increase ability to establish **reimbursement rates for early**						

[7] Other includes, but is not limited to, schools (e.g., SAP), places of employment (e.g., EAP), higher education, congregate living facilities, medical and psychiatric facilities, and correctional facilities

intervention/harm reduction workforce members that leads to increased retention						
2.h.8. Increase KSAs of partners, primary care providers, first responders, and intermediaries to use early and other **intervention/harm reduction modalities that have strong documentation of effectiveness**						
2.h.9. Increase KSAs of workforce to use **culturally specific early intervention/harm reduction** techniques						
2.h.10. Increase **knowledge of reimbursement and other barriers** to access to needed early intervention and harm reduction services						
2.h.11. Increase ability to **adequately reimburse** needed early intervention and harm reduction services						
Intermediate Outcome 2.i.: Increase access to alternative pain and stress management (APSM)						
Intermediate Outcome Indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
2.i.1. Increase **knowledge of types and quantities of APSM needed** to enhance prevention efforts across the state in community and other settings	Create processes for estimating projected numbers of persons annually needing APSM—by type and level—in community and institutional settings.					
2.1.2. Increase **knowledge of the types and levels of APSM that currently exist** to support prevention across the state in all community and other settings[8]	Create an inventory that includes private and semi-private as well as publicly APSM strategies and resources					
2.1.3. Increase ability to maximize and **expand current effective APSM**	Create a process for identifying and investing in effective APSM services across the lifespan and					

[8] Other includes, but is not limited to, schools (e.g., SAP), places of employment (e.g., EAP), higher education, congregate living facilities, medical and psychiatric facilities, and correctional facilities

capacities for prevention while strategically targeting areas for new service development	using lessons learned to establish new services where they are most needed					
2.1.4. Increase **knowledge of reimbursement and other barriers** to access to APSM services						
2.i.5. Increase ability to **adequately reimburse** APSM services						

Objective 3: Increase rapid access to effective SUD treatment across the lifespan

Intermediate Outcome 3.a.: Increase access to all levels and types of needed treatment

Outcome indicators:

- Percentage of adolescent and adult patients with a new episode of AOD dependence who (1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and (2) who initiated treatment and who had two or more additional services with a diagnosis of AOD within 34 days of the initiation visit from XX.X in 20XX to XX.X or more by 20XX.
- Increase the percentage of CCO patients ages 12 years and older who have had a qualifying outpatient visit or home visit during the measurement year with one or more screening, brief intervention, and referral to treatment services from XX.X percent in 20XX to XX.X percent in 202X
- Wait times for treatment
- Positive UAs

Immediate Outcomes	Strategies and Activities	Timeline		Roles	Outputs	Process Indicators
		Start	End			
3.a.1. Increased knowledge of the priority **types, levels of care, and quantities of SUD treatment needed** across the state in community and other settings[9]	Create a process for estimating annual numbers of persons needing treatment across the state—by type and level—in community and other settings.					
3.a.2. Increased knowledge of the **types, levels of care, and quantities of SUD treatment that currently exist** in all community and other settings[10]	Create an inventory that includes private and semi-private as well as publicly funded treatment services and resources (e.g., campus-based, non-profit)					
3.a.3. Increased ability to **maximize and expand existing effective treatment capacities** while strategically targeting areas for new service development	Create a process for identifying and expanding high-performing treatment services and using lessons learned to scale them up as needed					
3.a.4. Increased ability to identify persons at risk of—or experiencing—health, social, or legal consequences from AOD use and provide them with appropriate **intermediaries to facilitate access to needed treatment services**						

[9] Other includes, but is not limited to, college/university housing, other congregate living facilities, medical and psychiatric facilities, and correctional facilities

[10] Institutional includes, but is not limited to, college/university housing, other congregate living facilities, medical and psychiatric facilities, and correctional facilities

3.a.5. Increased ability of intermediaries and practitioners[11] to **connect clients to appropriate levels of treatment**	Create an online system which provides as real-time as possible information on treatment service location and availability					
3.a.6. Increased ability to use distance technologies (e.g., ECHO) to increase **access to high-quality care in underserved areas** (basic and specialized)				OHSU		
3.a.7. Increased ability to conduct research and produce **innovative new treatment solutions** for SUDs for which there are limited effective treatment modalities				OHSU		
Intermediate Outcome 3.b.: Increase access to effective intervention and harm reduction						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
3.b.1. Increase **knowledge of types and quantities of intervention and harm reduction needed** across the state in community and other settings	Create processes for estimating projected numbers of persons annually needing intervention and harm reduction services—by type and level—in community and institutional settings.					
3.b.2. Increase **knowledge of the types and levels of intervention/harm reduction that currently exist** across the state in all community and other settings[12]	Create an inventory that includes private and semi-private as well as publicly funded intervention/harm reduction strategies and resources					
3.b.3. Increase ability to maximize and **expand current effective intervention/harm reduction capacities** while strategically targeting areas for new service development	Create a process for identifying and investing in intervention/harm reduction services across the lifespan and using lessons learned to establish new services where they are most needed					
Intermediate Outcome 3.c.: Decrease barriers to treatment						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	

[11] Practitioner includes, but is not limited to those employed in social services, behavioral health, medical/primary care, education, law enforcement, and corrections

[12] Other includes, but is not limited to, schools (e.g., SAP), places of employment (e.g., EAP), higher education, congregate living facilities, medical and psychiatric facilities, and correctional facilities

		Start	End			Process Indicators
3.c.1. Increased public **awareness of SUD as a chronic public health issue** that requires medical attention and ongoing management	Create a statewide public education campaign (e.g., print, social media, broadcast) that links to the interface below.			Other potential partners: Oregon Association of Broadcasters, print, social media		
3.c.2. Increased **public knowledge of available treatment resources** and how to access them	Create user-friendly interfaces (e.g., 'warm line,' case manager, liaison, peer mentor) with the online system above to help those needing treatment and their friends and families use it					
3.c.3. Increased knowledge of the **types and quantities of basic need supports, and other resources required** to ensure those in need of treatment can access and remain in treatment						
3.c.4. Increased ability to ensure all persons in need of treatment have **access to basic need supports and other resources** required to access and remain in treatment						
3.c.5. Increased ability to **support parents experiencing addiction** by providing an assessment, parenting and family strengthening classes, and counseling						
Intermediate Outcome 3.d.: Decrease barriers to intervention and harm reduction						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
3.d.1. Increase **knowledge of reimbursement and other barriers** to access to needed intervention and harm reduction services						
3.d.2. Increase ability to **adequately reimburse** needed intervention and harm reduction services						
Intermediate Outcome 3.e.: Strengthen the effectiveness of the treatment workforce						

Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
3.e.1. Increased knowledge **of** the **types of intermediaries needed to increase access to, and retention in, treatment** (e.g., liaisons, peer mentors, case managers)						
3.e.2. Increased ability to ensure persons needing treatment have **access to an appropriate intermediary** to facilitate access to all needed treatment services						
3.e.3. Increased ability to **recruit, support, and retain treatment workforce members**—including those with lived life experience.						
3.e.4. Increased ability to provide adequate **reimbursement rates for treatment workforce members**						
3.e.5. Increased ability of primary care providers to use **treatment modalities with strong documentation of effectiveness** (including MAT) and are situationally appropriate						
3.e.6. Increased ability of behavioral health and primary care providers to use **culturally specific treatment modalities**						
Intermediate Outcome 3.f.: Strengthen the effectiveness of the intervention and harm reduction workforce						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Outputs**	**Process Indicators**	**Immediate Outcomes[4]**
		Start	**End**			
3.f.1. Increase ability to **recruit and develop intervention/harm reduction workforce** members—including those with lived life experience.						

3.f.2. Increase ability to establish **reimbursement rates for intervention/harm reduction** workforce members that leads to increased retention						
3.f.3. Increase KSAs of primary care providers, all potential first responders, and intermediaries to use **intervention/harm reduction modalities that have strong documentation of effectiveness**						
3.f.4. Increase KSAs of workforce to use **culturally specific early intervention/harm reduction** techniques						
3.f.5. Increase knowledge of the types of **intermediaries needed** to increase access to intervention and harm reduction						
3.f.6. Increase ability to identify persons at risk of health, social, or legal consequences from AOD use and **provide an appropriate intermediary** to facilitate early intervention, harm reduction, and referral to the appropriate level of needed services						
Intermediate Outcome 3.g.: Increase collection and use of data to evaluate treatment processes and outcomes						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Outputs**	**Process Indicators**	**Immediate Outcomes[4]**
		Start	**End**			
3.g.1. Increase system **knowledge of consumer experiences** in accessing and using treatment services	Create a feedback system that can continuously elicit process and outcome evaluation data from consumers and their families (e.g., phone-based app, other) about their experiences and outcomes					
3.g.2. Increase system **knowledge of consumer outcomes** from accessing treatment services	Strengthen funding recipient requirements for collecting and reporting process and outcome treatment data.					

Objective 4: Increase access to effective SUD recovery supports across the lifespan						
Intermediate Outcome 4.a.: Increase access to all levels and types of needed recovery supports						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.a.1. Increased **public awareness of SUD as a chronic public health issue** that requires medical attention and ongoing management	Create a statewide public education campaign (e.g., print, social media, broadcast) that links to the interface below.			Other potential partners: Oregon Association of Broadcasters, print, social media		
4.a.2. Increased **knowledge of the types, levels of care, and quantities of recovery support needed** across the state in community and other settings[13]	Create processes for estimating annual numbers of persons needing recovery support across the state—by type and level—in community and other settings.					
4.a.3. Increased **knowledge of the types, levels of care, and quantities of recovery support that currently exist** across the state in all community and other settings[14]	Create an inventory that includes private and semi-private as well as publicly funded recovery support services and resources (e.g., campus-based, non-profit)					
4.a.4. Increased **knowledge of the types of intermediaries needed** to increase access to, and retention in, recovery						
4.a.5. Increased ability to ensure persons in recovery have **access to an appropriate intermediary** to facilitate access to all needed recovery services						
4.a.6. Increased ability to **maximize and expand current effective recovery support capacities** while strategically	Create a process for identifying, investing in, and scaling up high-performing recovery support services and using lessons learned to establish new services where they are needed					

[13] Other includes, but is not limited to, college/university housing, other congregate living facilities, medical and psychiatric facilities, and correctional facilities

[14] Other includes, but is not limited to, college/university housing, other congregate living facilities, medical and psychiatric facilities, and correctional facilities

targeting areas for new service development						
Intermediate Outcome 4.b.: Increase access to effective intervention and harm reduction						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.b.1. Increase **knowledge of types and quantities of intervention and harm reduction needed** across the state in community and other settings	Create processes for estimating projected numbers of persons annually needing intervention and harm reduction services—by type and level—in community and institutional settings.					
4.b.2. Increase **knowledge of the types and levels of intervention/harm reduction that currently exist** across the state in all community and other settings[15]	Create an inventory that includes private and semi-private as well as publicly funded intervention/harm reduction strategies and resources					
4.b.3. Increase ability to maximize and **expand current effective intervention/harm reduction capacities** while strategically targeting areas for new service development	Create a process for identifying and investing in intervention/harm reduction services across the lifespan and using lessons learned to establish new services where they are most needed					
Intermediate Outcome 4.c.: Decrease barriers to recovery support						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.c.1. Increased ability to provide **adequate reimbursement for recovery support services**						
4.c.2. Increased **knowledge of the types and quantities of basic needs and other supports required** to ensure those in recovery can remain in recovery						

[15] Other includes, but is not limited to, schools (e.g., SAP), places of employment (e.g., EAP), higher education, congregate living facilities, medical and psychiatric facilities, and correctional facilities

4.c.3. Increased ability to provide **access to the types and quantities of basic needs supports required** to ensure those in recovery can remain in recovery						
4.c.4. Increased ability to provide **parenting and family strengthening support** to parents in recovery						
Intermediate Outcome 4.d.: Decrease barriers to intervention and harm reduction						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.d.1. Increase **knowledge of reimbursement and other barriers** to access to needed intervention and harm reduction services						
4.d.1. Increase ability to **adequately reimburse** needed intervention and harm reduction services						
Intermediate Outcome 4.e.: Strengthen the recovery support workforce						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.e.1. Increased ability to **recruit and develop recovery support workforce members**—including those with lived life experience.						
4.e.2. Increased ability to **establish reimbursement rates and create a career path** for recovery support workforce members that leads to increased retention						
4.e.3. Increased ability of primary care providers to use **recovery support modalities with strong**						

documentation of effectiveness and are situationally appropriate						
4.e.4. Increased ability of behavioral health and primary care providers to use **culturally specific recovery support modalities**						
Intermediate Outcome 4.f.: Strengthen the effectiveness of the intervention and harm reduction workforce						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.f.1. Increase ability to **recruit and develop intervention and harm reduction workforce** members—including those with lived life experience.						
4.f.2. Increase ability to establish **reimbursement rates for intervention and harm reduction** workforce members that leads to increased retention						
4.f.3. Increase KSAs of workforce to use **intervention and harm reduction modalities that have strong documentation of effectiveness**						
4.f.4. Increase KSAs of workforce to use **culturally specific early intervention/harm reduction** techniques						
4.f.5. Increase knowledge of the types of **intermediaries needed** to increase access to intervention and harm reduction						
4.f.6. Increase ability to identify persons at risk of health, social, or legal consequences from AOD use and **provide an appropriate intermediary** to facilitate early intervention, harm						

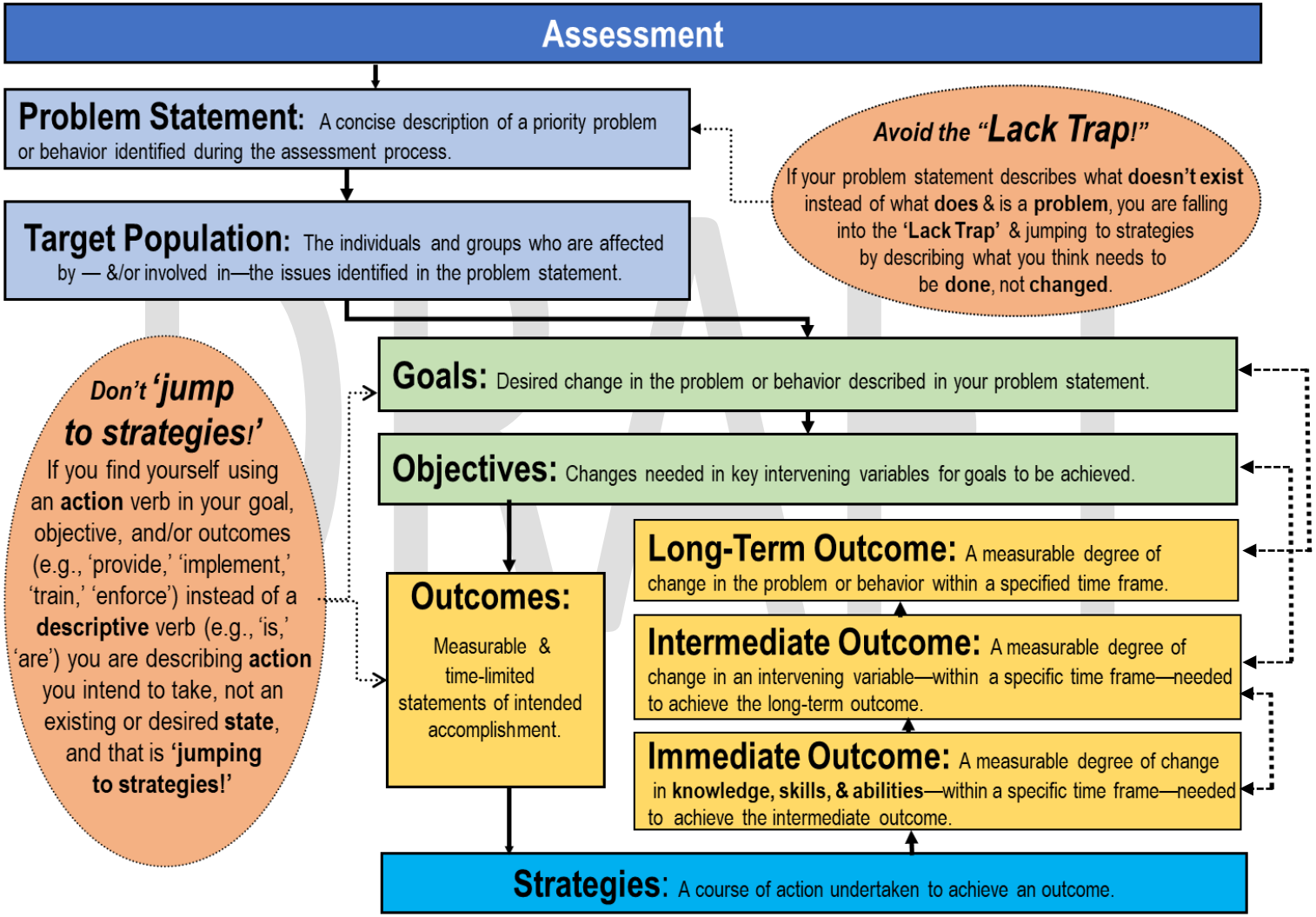
reduction, and referral to the appropriate level of needed services						
Intermediate Outcome 4.g.: Increase collection and use of data to evaluate recovery support processes and outcomes						
Outcome indicators: TBD						
Immediate Outcomes	**Strategies and Activities**	**Timeline**		**Roles**	**Outputs**	**Process Indicators**
		Start	**End**			
4.g.1. Increased **knowledge of consumer experiences** in accessing and using recovery support services	Create a feedback system that can continuously elicit process and outcome evaluation data from consumers and their families (e.g., phone-based app, other) about their experiences and outcomes					
4.g.2. Increased **knowledge of consumer outcomes** from accessing recovery support services	Strengthen funding recipient requirements for collecting and reporting recovery outcome data.					

Appendix A: DRAFT State Agency Roles & Responsibilities

Alcohol and Drug Policy Commission – State System Convener	Key State System Members														
	Health & Human Svcs		Education			Corrections		Law Enforcement		Regulation			Basic Needs Infrastructure		T/TA Research
Responsibilities	OHA	DHS	DOE	YDD	HECC	OYA	DOC	OSP	HIDTA	DCBS	OLCC	Oregon Lottery	DHCS	DOT	OHSU
SU Systems Development	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Workforce Development	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Individual & Family Strengthening/Support	■	■	■	■	■	■	■					■	■	■	
Prevent Illegal Access to Substances	■							■	■		■		■		
Prevent Misuse of Legal Substances	■	■	■	■	■	■	■					■		■	
Develop/Implement/Support Policies & Practices	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Enforce Laws & Regulations	■							■	■	■	■	■			
Assessment & Screening	■	■	■		■	■	■								■
Intervention/Harm Reduction	■	■	■	■	■	■	■	■				■			■
SUD Treatment	■					■	■					■			■
Recovery Support	■					■	■								■
Peer Support	■	■	■	■	■	■	■					■			■
Case Management	■	■	■	■	■	■	■					■			

DRAFT WORKING COPY FOR ADPC REVIEW. Please send comments to Laurie Barger Sutter, lsutter@jbsinternational.com, 402.730.4864.

Appendix B: Planning Map



Appendix C: Logic Models

Appendix D: Assessment Summary

Appendix E: Stakeholder Engagement

Appendix F: Economic Evaluation

Methodology

Burden and Dedicated Spending in Oregon by Sector

Oregon Substance Abuse Spending by Budget Sector Using 2017 S/A Share

(excludes regulation and compliance)

	Total Budget $	Total Substance Abuse $	S/A % of Agency Budget
All Affected Programs	**$15,746,826,649.76**	**$6,474,391,380.19**	**41.12%**
Burden Expenditures	**$15,705,476,554.50**	**$6,308,912,572.19**	**40.17%**
Prevention, Treatment & Research	**$175,871,595.00**	**$175,871,595.00**	**100.00%**
Adult Corrections Program Expenditures	**$905,795,167.26**	**$895,402,380.26**	**98.85%**
Burden	$1,029,923,880.00	$895,402,380.26	86.94%
Prevention, Treatment & Research	$10,392,787.00	$10,392,787.00	100.00%
Juvenile Corrections Program Expenditures	**$172,637,496.50**	**$136,811,701.15**	**79.25%**
Burden	$172,141,530.00	$136,315,734.65	79.19%
Prevention, Treatment & Research	$495,966.50	$495,966.50	100.00%
Judiciary Expenditures	**$358,041,871.00**	**$325,832,195.39**	**91.00%**
Burden	$57,735,992.00	$325,526,316.39	91.0%
Prevention, Treatment & Research	$305,879.00	$305,879.00	100.00%
Education Expenditures	**$3,994,000,000.00**	**$706,470,014.68**	**17.69%**
Burden	$3,994,000,000.00	$706,470,014.68	17.69%
Prevention, Treatment & Research			
Health Program Expenditures	**$1,903,939,442.50**	**$670,942,220.24**	**35.24%**
Burden	$1,883,000,000.00	$650,002,777.74	34.52%
Prevention, Treatment & Research	$20,939,442.50	$20,939,442.50	100.00%
Child Welfare Program Expenditures	**$3,284,125,152.50**	**$2,688,394,785.15**	**81.86%**
Burden	$3,284,125,152.50	$2,688,394,785.15	81.86%
Prevention, Treatment & Research			
Income Support Expenditures	**$78,000,000.00**	**$25,422,034.59**	**32.59%**
Burden	$78,000,000.00	$25,422,034.59	32.59%
Prevention, Treatment & Research			
Mental Health & Developmentally Disabled Human Service Expenditures	**$208,339,815.00**	**$139,603,152.63**	**67.01%**
Burden	$206,550,000.00	$137,813,337.63	66.72%

Prevention, Treatment & Research	$1,789,815.00	$1,789,815.00	100.00%
Public Safety Expenditures	**$2,500,000,000.00**	**$730,836,164.15**	**29.23%**
Burden	$2,500,000,000.00	$730,836,164.15	29.23%
Prevention, Treatment & Research			
State Workforce Expenditures	**$2,200,000,000.00**	**$12,729,026.95**	**0.58%**
Burden	$2,200,000,000.00	$12,729,026.95	0.58%
Prevention, Treatment & Research			
Human Services Prevention, Treatment & Research Program Expenditures	**$141,947,705.00**	**$141,947,705.00**	**100.00%**
Burden			
Prevention, Treatment & Research	**$141,947,705.00**	**$141,947,705.00**	100.000

Appendix G: EXAMPLE Strategic Financing Template

Strategies & activities to be launched or expanded (describe current sites, scope, and funding sources)	Scale to be Achieved # sites, # served, target populations, range of activities			Time period for strategies and activities to be implemented
	2020-2021	2021-2022	2022-2023	
Peer Mentors Currently employ 10 peer mentors in Alpha City on a 20 hour/week basis to serve 10 clients each: Funding: 5-year SAMHSA discretionary grant	• Expand to Dupont; hire 10 peer mentors at 30 hours/week to serve 10 clients each. • Hire 5 new Peer Mentors in Alpha City; increase time for all to 30 hours/week to serve 10 clients each	• Expand to Ewing; hire 10 peer mentors at 30/hours per week to serve 10 clients each. • Hire 5 new Peer Mentors in Dupont at 30 hours/week to serve 10 clients each • Sustain scope in Alpha City	• Expand to Gage; hire 10 peer mentors at 30/hours per week to serve 10 clients each. • Hire 5 new Peer Mentors in Ewing at 30 hours/week to serve 10 clients each • Sustain scope in Alpha City and Dupont	Continue indefinitely and increase scope as needed
Therapeutic Groups Currently in 4 sites (Alpha City, Bellview, Syracuse, and Palmyra); 3 groups of 12 persons per site, 2 weekly sessions per group. Funding: SAPT Block Grant	• Expand to 2 new sites: Dupont and Ewing (3 groups of 12 persons per site, 2 weekly sessions per group). • Continue scope at Alpha City, Bellview, Syracuse and Palmyra	• Expand to 1 new site: Gage (3 groups of 12 persons, 2 weekly sessions per group). • Increase from 2 to 3 sessions/week in Alpha City and Syracuse. • Sustain 2 sessions/week each in Palmyra, Dupont and Ewing	• No new sites • Increase from 3 to 4 sessions/week in Alpha City • Increase to 3 sessions/week in Syracuse • Sustain scope in Palmyra, Bellview, Dupont, Ewing, and Gage	Re-evaluate at end of year 3 to consider whether new approach or changes are needed
Retail Compliance Checks Currently funding tobacco compliance checks across Griswald County. Funding: State general funds	No expansion; use resources to cultivate a permanent home for this in the county using local resources and existing trained coalition members	No expansion; use resources to cultivate a permanent home for this in the county using local resources and existing trained coalition members	Permanent home established for continued implementation of compliance checks	'Pass baton'

EXAMPLE Strategic Financing Template

Strategies & activities to be launched or expanded (describe current sites, scope, and funding sources)	Scale to be Achieved – What Will It Cost? # sites, # served, target populations, range of activities											
	2020-2021				2021-2022				2022-2023			
	Scale	Total Cost	Current Funding	Funding Gap	Scale	Total Cost	Current Funding	Funding Gap	Scale	Total Cost	Current Funding	Funding Gap
Example: Peer Mentors												
Salaries	25 Peer Mentors at .75 FTE = 39,000 hours/year at $XX/hour	$XXX,XXX	$	$	40 Peer Mentors at .75 FTE = 62,400 hours/year at $XX/hour	$	$	$	**55** Peer Mentors at .75 FTE = 85,800 hours/year at $XX/hour	$	$	$
Fringe benefits												
Training	$											
Equipment	$											
Travel/mileage												
Materials and supplies												
Cell phone												
Administrative												
Other direct costs												
Indirect costs												

Appendix H: Selected References

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Appendix I: Glossary and Acronyms

Appendix J: Footnotes

[i] The data source for this measure is the annual National Survey on Drug Use and Health (NSDUH). NSDUH uses a weighted sample which is averaged over two years of data, so the period for this measure will be 2025-2026.
[ii] 2025-2026 NSDUH
[iii] Ibid.
[iv] Oregon Health Teen Survey (OHTS)
[v] Ibid.
[vi] Ibid.
[vii] Ibid.
[viii] Ibid.
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[x] Ibid.
[xi] 2025-2026 NSDUH
[xii] Ibid.
[xiii] 2017 Oregon Vital Statistics Data. Oregon Health Authority
[xiv] Citation
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