Oregon

UNIFORM APPLICATION
FY 2008

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Oregon
DUNS Number: 623575339-

Uniform Application for FY 2008 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Department of Human Services

Organizational Unit: Addictions and Mental Health Division

Mailing Address: 500 Summer Street NE E86

City: Salem Zip: 97301-1118

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Karen Wheeler

Agency Name: Addictions and Mental Health Division

Mailing Address: 500 Summer Street NE E86

City: Salem Zip Code: 97301-1118

Telephone: 503-945-6191 FAX: 503-378-8467

E-MAIL: karen.wheeler@state.or.us

III. STATE EXPENDITURE PERIOD

From: 7/1/2006 To: 6/30/2007

IV. DATE SUBMITTED

Date: 9/18/2007 ☐ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Karen Wheeler Telephone: 503-945-6191

E-MAIL: karen.wheeler@state.or.us FAX: 503-378-8467

Form 2 (Table of Contents)

State:
Oregon

UNIFORM APPLICATION FOR FY 2008 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Oregon

Name of Chief Executive Officer or Designee: Bruce Goldberg, MD

Signature of CEO or Designee:

Title: Director, Department of Human Services **Date Signed:**

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

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

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Director, Department of Human Services

APPLICANT ORGANIZATION	DATE SUBMITTED
State of Oregon, Dept. of Human Services, Addictions and Mental Health Division	

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____ , if known: _____	
Congressional District, *if known:* _____	**Congressional District**, *if known:* _____
6. Federal Department/Agency:	**7. Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. Federal Action Number, if known:	**9. Award Amount,** if known: $
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

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Standard Form – LLL -A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

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

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

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

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

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

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

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

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

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

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

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

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

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

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, Department of Human Services
APPLICANT ORGANIZATION State of Oregon, Dept. of Human Services, Addictions and Mental Health Division	DATE SUBMITTED

State:
Oregon

FY 2005 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2005 is reflected on Line 8 of the Notice of Block Grant Award

$16,381,672

Oregon

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal 1

Objective: The Addictions and Mental Health Division (AMH) will expend block grant funds to maintain a continuum of substance abuse treatment services through county/tribal financial assistance agreements and direct contracts with community-based substance abuse treatment providers.

FY 2005 (Compliance):
During FY 2004, AMH (then OMHAS Office of Mental Health and Addiction Services) utilized the Institute of Medicine's (IOM) Spectrum of Intervention to frame the elements of an effective AOD service system, based on the current body of research evidence. The Spectrum of Intervention model includes the following essential service elements: prevention, (universal, selected, and indicated); treatment (case identification and treatment); and maintenance of treatment effectiveness (compliance with long-term treatment and aftercare or continuing care).

Oregon's substance abuse treatment services are delivered through contractual arrangements among the state, counties, tribes, managed care entities, and a network of community-based providers. The state Medicaid agency, the Division of Medical Assistance Programs (DMAP) contracts with managed care plans (Fully Capitated Health Plans (FCHP)) to deliver a limited range of treatment services to Oregon Health Plan (Oregon's 1115 Waiver Medicaid program) clients. Services supported by Substance Abuse and Prevention Treatment (SAPT) block grant funds are targeted to low-income clients who do not quality for the health plan, as well as extended services for health plan clients who need extended support. Health plans and counties contract with community-based providers to deliver services at the local level. The state contracted with community mental health programs and tribes to deliver outpatient continuum of care services with block grant funds and state general funds. Per contract definition, Continuum of Care services consist of case management, clinical services, and continuing care or aftercare. This approach provides more flexibility for the counties, tribes, and treatment providers delivering services to tailor services to the unique needs of the populations they serve. Under the previous funding methodology (prior to 2001), providers were held to utilization standards based on the number of funded treatment slots. Under the Continuum of Care approach, providers must meet certain quality improvement outcomes: Engagement, Retention, Completion, and Reduced Use.

Oregon's publicly funded treatment system offers five levels of care including:

> Level .05 (Early Intervention) Non-residential education and informational services designed to intervene with individuals at risk of developing substance use disorders. Services include individual counseling, educational sessions, group or family counseling.
>
> Level I (Outpatient Treatment) Non-residential treatment services (usually less than 9 hours per week) provided to the individual in regularly scheduled face-to-face therapeutic sessions. Service may include individual, group and family counseling, pharmacotherapies, case management and long-term support for relapse prevention.

Level II (Intensive Outpatient) A structured, non-residential evaluation, treatment, and continued care service for those individuals who are abusing or are dependent on alcohol and other drugs and who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include, but are not limited to, day treatment, correctional day treatment, evening treatment, and partial hospitalization.

Level III (Residential Treatment) Structured programming that provides assessment, treatment, rehabilitation and twenty-four hour observation and monitoring for alcohol and other drug dependent clients. This level of service also provides 24-hour observation, monitoring and treatment for individuals who are suffering from alcohol or other drug intoxication or withdrawal.

Level IV (Medically Managed Inpatient Treatment) is not supported by the SAPT block grant, but is part of the continuum of treatment services in Oregon. This service is financed by the DMAP through contracts with FCHP. This is an organized service delivered in an acute care inpatient setting. Services are delivered by an interdisciplinary staff of addiction-credentialed physicians and other appropriate credentialed treatment professionals.

Goal 1

FY 2007 (Progress):
Maintaining and Strengthening the Continuum: Throughout FY 2007, AMH continued to support a continuum of substance abuse treatment services as described above through county and tribal financial assistance agreements. Regional residential services continue to be funded through a combination of direct contracts, county contracts, and local options. These agreements continue to support the continuum of care service model vs. the traditional slot funding methodology. AMH continues to refine the quality improvement measures published in quarterly Treatment Improvement Reports (TIR), in an effort to improve statewide treatment outcomes associated with engagement, retention, completion, and reduced use. In addition, the discussion of National Outcome Measures (NOMS) has influenced our work in refining the outcome improvement reports. These efforts are strengthened by Oregon's participation in the NIDA funded Network for the Improvement of Addictions Treatment (NIATx) project, NIATx 200. At least 30 outpatient providers are participating in this initiative are have varied access to the NIATx tools including peer learning sessions, process improvement coaches, web site tools, and other assistance including data collection and analysis capacity building.

New Investments: The 2007 Legislature approved new investments in addiction treatment for families who are involved in the child welfare and Temporary Assistance for Needy Families (TANF) programs and are at risk or already involved in the child welfare system due to parental addiction. This initiative represents an opportunity to strengthen partnerships between child welfare, TANF, and behavioral health services both at the state and local levels. The ITRS initiative increases treatment capacity for parents needing residential and intensive outpatient services as well as housing supports. ITRS includes funding for 30 residential beds to serve 90 parents annually, 20 dependent children's beds serving 60 children annually, intensive outpatient treatment for 1,332 clients per year, and 14 more recovery homes available for TANF and child welfare families. The Legislature requires ITRS outcomes to ensure that the funds are used appropriately. The outcomes include:

- Preventing out of home placement when families can safely stay together;
- Reuniting parents and children;
- Reducing average length of stay in foster care, and;
- Increasing job placement for TANF participants.

Strengthening regulations and providing policy guidance: AMH is still in the process of revising administrative rules governing the provision of addiction and mental health services in an effort to align the rules with principles of recovery, resiliency, evidence-based practices, cultural competency, as well as to provide administrative and operational efficiencies to the system. Draft rules are under review by management that encompasses addictions and mental health services. AMH is preparing to convene an advisory committee to review and provide input into these rules within the next 30 – 45 days.

Equitable funding to support the continuum: AMH worked with stakeholders including counties, tribes, providers, the Governor's Council on Alcohol and Drug Abuse

Programs, and the Oregon Prevention, Education, and Recovery Association to refine an equitable funding allocation formula that applies to outpatient alcohol and drug treatment funding during 2007. This process included an analysis of census / population data, prevalence data, methods for funding distribution by other states, per capita funding for each Oregon county and tribe from a variety of sources including state general funds, SAPT block grant, beer and wine tax revenues, Medicaid, and other local funding at the disposal of these intermediaries. A policy and plan for redistributing the funds was adopted by AMH and is currently being implemented with new investments made by the Oregon Legislature. The Legislature approved $4 million for the alcohol and drug equity budget package in order to being all Counties and Tribes up to a base funding allocation. Fortunately, since new investments have been made to support this effort, it is not necessary for AMH to redistribute the funds that were available during the 2005 – 07 biennium which would have resulted in losses for some counties and gains to other counties and tribes. It is important to note that under the new formula, all of the Oregon tribes will be brought up to a base allocation of funding for alcohol and drug outpatient services.

New initiatives and integration: On March 27, 2007, Governor Theodore Kulongoski signed an executive order to implement statewide the transformation of the delivery of behavioral health services to Oregon's children, young people, and their families. The order creates the Statewide Children's Wraparound Steering Committee, charged to create a plan that will: 1) provide services and support as early as possible so that children can be successful in their homes, schools and communities; 2) make services available based on the individual needs of the child and family – rather than on system requirements; and 3) maximize the resources available to serve children and families across systems, so that services most appropriately and effectively meet the behavioral health needs of Oregon's children. The substance abuse prevention and addiction services for children and adolescents is an important component of the service delivery system for children, youth and families and one that will be integrated into the Wraparound model. In the coming months, a final report from the steering committee will be published and plans for administrative, budget and financing, as well as workforce development and policy alignment to this model will begin taking shape as Oregon moves toward implementing this approach statewide.

AMH, DMAP, and PHD have been working with many partners on a variety of initiatives that relate to behavioral health and primary care. In particular the need for these two areas of care to be more closely linked and integrated has been recognized for some time. Challenges in the current system of care will be considered from the perspectives of the client/consumer, clinic, managed care, mental health, emergency room, or primary care practitioner. This work will continue into the next biennia and will be a major focus for AMH, state and local partners in primary and behavioral healthcare.

Goal 1

FY 2008 (Intended Use):
AMH intends to continue to use county and tribal financial assistance agreements to support a continuum of substance abuse treatment services statewide in 2006. SAPT block grant funds will continue to support outpatient and social detoxification services throughout the state.

The 2007 Legislature provided additional investments in addiction treatment services for addicted families who are involved in the child welfare system and/or Temporary Assistance for Needy Families (TANF) where there is significant risk of involvement in the child welfare system. The Intensive Treatment and Recovery Service (ITRS) initiative increases treatment capacity for parents needing residential and intensive outpatient services. ITRS funds 30 residential beds to serve 90 parents annually, 20 dependent children beds serving 60 children annually, intensive outpatient treatment for 1,332 clients per year, and 14 more recovery homes available for TANF and child welfare families. The Legislature requires outcomes to ensure that the funds are used appropriately. The outcomes include:

- preventing out of home placement when families can safely stay together;
- reuniting parents and children;
- reducing the average length of stay in foster care, and;
- increasing job placement for TANF participants.

Throughout FY 2008, AMH and CAF will refine operational and administrative systems related to the ITRS initiative and work with intermediaries and providers to implement the services with accountability to ensure the focus on performance and outcomes as intended by the Legislature. The ITRS referral form will track and monitor all Children, Adult and Family (CAF) clients referred to addiction treatment for an assessment. A database managed by AMH will collect client information on timely access to addiction treatment, monitoring the time between referral and assessment. A collaborative system design and implementation workgroup comprised of AMH and CAF will continue working on the operational framework and administrative methodology to implement and sustain this initiative. During 2008, this will include conducting data analysis with matched datasets from AMH and CAF, reviewing programs and services in the local communities, and reporting on performance and system outcomes.

For the entire outpatient addiction service system, treatment outcome improvement measures will continue to be refined as part of the outcome based contracting process and in response to any new measures or performance domains included in the National Outcome Measures (NOMS).

AMH will continue working on a new needs assessment and capacity building initiative for addiction services which will result in a clearly document statement of need and capacity building strategy for the next six years. Oregon builds state budgets biennially so the strategy will encompass three biennia, 2009 – 11; 2011 – 13; and 2013 – 15. The epidemiological data and prevalence data will assist Oregon as we generate community

insights and capacity needs for budget development over the next six years. This work will highlight capacity needs along the continuum of services including prevention, treatment, and recovery support services. Budget development for the 2009 – 11 biennium will be informed, in part, through this effort.

The Oregon Children's Wraparound initiative will be a major emphasis for the AMH adolescent alcohol and drug treatment provider system and the substance abuse prevention system. The final report from the Oregon Children's Wraparound Steering Committee will be available mid-October 2007 and will provide the foundation for policy, administrative and financing changes that must be implemented throughout the child and family service delivery system to fully implement Oregon Children's Wraparound. This work is expected to be carried out over the next 4-5 years and is a major system change initiative for AMH and partners serving children with behavioral health needs and their families.

The primary and behavioral health integration project is another major system change initiative for AMH and the department. AMH is exploring the Screening, Brief Intervention, Referral and Treatment (SBIRT) model with partners in primary care including the Fully Capitated Health Plans, primary care providers, Oregon Health and Science University and others as a component of this effort. AMH is monitoring SAMHSA's discretionary grant programs web site for release of the SBIRT announcements and maintaining formal and informal contacts with stakeholders who have expressed an interest in partnering with AMH on this opportunity.

Oregon

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

- Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
  - Universal Direct. Row 1—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
  - Universal Indirect. Row 2—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices).This also could include interventions involving programs and policies implemented by coalitions.

- Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated.

FY 2005 (Compliance)

During FY 2005, the AMH allocated prevention funding to each of the thirty-six counties and nine federally-recognized tribes in Oregon. In addition, three statewide projects were funded. AMH also focused prevention efforts on a variety of strategies and programs to reduce underage drinking, especially among 8th grade girls.

Under the umbrella of the Institute of Medicine framework, prevention services were targeted to universal, selected or indicated populations utilizing the Risk/Protective Factor Framework (Communities that Care Model) developed by Dr. David Hawkins and Dr. Richard Catalano. Listed below is a summary, by CSAP Strategy, of Oregon's prevention activities for FY 2005. This data has been collected from prevention contractors using the Minimum Data Set (MDS) for prevention web-based database. FY 2005 was the fifth year that MDS reporting was a requirement of county financial assistance agreements for county/tribal and statewide prevention contractors.

Strategy	Number of Services	Percent of Services	Total Served	Males	Females
Alternative Activities	2,850	26.6%	103,036	50,798	52,238
Community-Based Services	1,936	18.1%	19,493	7,400	12,093
Drug-Free Workplace	32	0.3%	2,112	1,107	1,005
Prevention Education	2,824	26.4%	20,455	9,634	10,821
Environmental Strategies	115	1.1%	0	0	0
Information Dissemination	1,592	14.9%	164,639	81,348	83,291
Problem ID & Referral	1,347	12.6%	6,387	2,816	3,571
Totals	**10,696**	**100%**	**316,122**	**153,103**	**163,019**

A brief summary, by CSAO strategy, of the types of services provided with SAPT Block Grant funds follows:

Alternative Activities:

- Each county and tribe developed activities, consistent with their local implementation plan, and comprehensive county plan, to provide drug-free alternatives for youth.

Included were after-school programming, after-prom and graduation activities and incentive programs for those working to improve grades and attendance in school.

Community-Based Services:

- AMH prevention specialists provided a variety of training and technical assistance to assist local community coalitions develop and implement local strategies. A major focus of these activities was underage drinking prevention.
- A statewide underage drinking prevention summit was held in May 2005 to highlight the problem in Oregon. A list of priorities and recommendations were developed and delivered to the Governor's Council on Alcohol and Drug Abuse Programs as "Oregon's Strategy to Combat Underage Drinking."

Drug-Free Workplace:

- Workdrugfree, a statewide contractor promoting drug-free workplace strategies and programs, promoted and implemented the evidence-based program, "Team Awareness Training." In addition, a number of statewide drug-free workplace strategies were developed and adopted as an important strategy of the Oregon Business Plan.

Prevention Education:

- An ongoing focus on parent education provided the ability to fund and implement a number of parenting curricula across the state. These included Active Parenting 1234, Families in Action, Latino Parenting Education, Love & Logic, Making Parenting a Pleasure, Parents as Teachers, Parents Who Care, Positive Parenting, Strengthening Families, Strengthening Multi-Ethnic Families, The Incredible Years, and others.
- A number of school-based curricula were also implemented during FY 2005. These included Choosing Not to Use, Families And Schools Together, Life Skills Training, Protecting Ones Self and Others, Reconnecting Youth, Smart Moves, Project STAR, Project Alert, Here's Looking at You, Second Step, Steps to Respect, and others.

Environmental Strategies:

- Communities and tribes have continued to review alcohol and drug policies at schools, at local fairs and celebrations, on tribal lands, and enforcement-related policies. These efforts have been directed primarily at underage drinking access and availability, as well as to provide equal enforcement and adjudication within the community.
- Many communities have adopted the Meth Watch program locally and have implemented strategies to reduce methamphetamine use and manufacturing. This has included public information campaigns to educate local merchants, landlords and other community members about effective approaches to prevent methamphetamine precursor products from being sold or used in the production of methamphetamine.
- Reward and reminder visits to assess retailer compliance with state and local laws regarding alcohol and tobacco sales to minors have also been utilized.

Information Dissemination:

- SAPT Block Grant funds have provided a statewide alcohol and other drug Resource Center/RADAR site, local public awareness campaigns, and internet listserv, and a statewide information and referral helpline.

Problem Identification and Referral:
Block Grant funds have provided student assistance and employee assistance programs in a number of counties, and a statewide YouthLine for those seeking information or referral for alcohol and drug-related issues, including treatment for addiction.

Goal #2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective , or Indicated.

FY 2007 (Progress)

The 2003 Oregon Legislature passed Senate Bill 267 which requires that a number of state agencies, including the Department of Human Services, insure that a progressive minimum amount of funding spent by the agencies be for evidence-based programs. The threshold for the 2007-09 biennium requires at least 50% of all Department funds be spent on evidence-based programs.

AMH has analyzed data from the 2005 and 2006 Oregon Healthy Teens Survey and determined that underage drinking rates among 8th and 11th grade students continues to be considerably above national averages. Because of these elevated rates of use, many Counties and Tribes have prioritized underage drinking prevention efforts in their biennial implementation plans.

Current statewide prevention strategies focus on reducing underage drinking, implementation of community development strategies using the Communities that Care model, and the implementation of a statewide parenting program. In addition, and in combination with the state's Enforcing Underage Drinking Laws (EUDL) Block Grant funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), gender-specific services are being implemented in a number of counties in response to the increasing rates of underage drinking among girls. A brief summary on activities being conducted under each of the six CSAP strategies is as follows:

Alternative Activities:

- Each County and Tribe is currently implementing their local plan to offer programs and activities consistent with locally developed priorities. Target populations vary , so the types and numbers of services provided are different in each area of the state. Activities are designed to provide youth with positive ways to spend their time so that they are better able to resist the use of alcohol and other drugs.

Community-Based Strategies:

- AMH is currently rolling out a statewide initiative to increase the number of active community coalitions. In conjunction with the Center for Substance Abuse Prevention, a cadre of facilitators are currently attending a series of training of trainers sessions to provide a training group to implement the Communities that Care model locally. New coalitions will focus on the reduction of alcohol and other drug use locally. Coalition members will include the business and faith communities, parents, teachers, youth, law enforcement, and others. Local strategies will be consistent with the local coordinated and comprehensive plans developed in each county.
- AMH will be implementing a statewide parenting program over the next two years. The evidence-based "Strengthening Families 10-14" program will be available to as many as 70 communities across the state. AMH will provide the training and technical assistance

to teams of up to four trainers and recruiters in each implementing community. In addition, the legislature has provided funding for all costs required to insure that the program is implemented with fidelity. An evaluation of the project will provide valuable information as to the success of local and statewide implementation.

Environmental/Social Policy:

- Underage drinking prevention continues to be a major focus of county and tribal implementation plans for FY 2007. In conjunction with the Oregon Liquor Control Commission (OLCC), AMH continues to provide funding locally for educating communities about laws regarding underage drinking and to provide training and technical assistance to local law enforcement on the effective strategies for reducing underage drinking.
- AMH continues to support and promote local communities implementing Oregon's Meth Watch strategies. Local coalitions continue to educate local merchants, landlords and other community members about effective approaches to prevent precursor products from being sold or used in the production of methamphetamine.

Information Dissemination:

- An underage drinking media campaign is primarily supported with EUDL Block Grant funding, but is augmented with additional funds locally. The media campaign currently reaches approximately 95% of Oregon's population through student-developed radio advertisements, print advertisements, and letters to the editor and opinion/education articles. The three primary messages to parents through the "Face it parents" campaign are: "One in three Oregon 8th graders is drinking…..Your child could be one;" "Alcohol harms young minds;" and "All children need rules about underage drinking."

Problem Identification and Referral:

- All county and tribal contracts require that problem identification and referral are components of the local prevention program. Community Mental Health Programs (CMHP) function as the single point of contact for this purpose. Oregon Administrative Rules (OAR) governing prevention services require that anyone who presents with a problem or referral must have access to an assessment and be referred to an appropriate service.
- Through SAPT block grant dollars, AMH supports a statewide Helpline and Youthline that provides referral to local treatment and prevention services. This service is available in every county.

Goal #2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective , or Indicated.

FY 2008 (Intended Use)

High need populations identified through the local planning processes will continue to be targeted service recipients. Each quarter the county planning and implementation teams are required to report progress toward identified outcomes through the MDS system. Through consistent program evaluation, AMH insures adequate progress toward identified outcomes and implementation plan adjustments are made as appropriate.

Three main focus areas will dominate statewide prevention efforts in FY 2008. These include the continuation of three existing projects: An emphasis on underage drinking prevention; Implementation of the "Strengthening Families 10-14" program; and continued development of local community coalition.

In conjunction with the state's EUDL Block Grant funding, gender-specific services targeting young girls will also continue. The evidence-based program, "Friendly PEERsuasion" will continue to be implemented in additional communities where data shows usage rates at their highest.

County and tribal funding will continue to be provided through financial assistance agreements with the department. AMH projects the number of services and recipients will remain consistent with those identified in previous fiscal years, barring significant budget reductions. Information on activities to be conducted under each of the six CSAP strategies during 2006 is as follows:

Alternative Activities:

- Each county and tribe has developed a plan to offer programs and activities that are consistent with local needs. Target populations vary, so the types and numbers of services provided will be different in each area of the state. Services will be provided on an ongoing basis. These activities are designed to provide youth with positive ways to spend their time so that they are better able to resist the use of drugs.

Community Based Strategies:

- Oregon's goal is to increase the number of community teams that are organized for the purpose of reducing drug use locally. These teams are multi-disciplinary and include citizens from the business and faith communities, parents, teachers, youth, law enforcement, and others. Local strategies are developed consistent with the implementation plans and the SB 555 coordinated and comprehensive plan. AMH prevention specialists will continue to assist communities in developing their teams. SAPT block grant funds will be used for training, technical assistance and team activities that fall under other strategies. The Strategic Prevention Framework model will be used as a platform to move the local and regional teams forward with underage drinking prevention strategies.

Prevention Education:

- The primary focus areas will be parenting and family-management, community coalition building and maintenance, underage drinking, and gender-specific services.
- Statewide prevention efforts will focus on mentoring and peer-leader/peer-helper programs and ongoing classroom presentations. The objectives are to increase the skills of parents and peer helpers to set appropriate rules and boundaries and to assist youth they influence to develop skills that will aid in their resisting use of drugs and alcohol.

Environmental/Social Policy:

- Oregon's focus in FY 2008 will continue to be on reducing underage drinking across the state, with targeted efforts on college campuses and rural areas.
- In partnership with the Oregon Liquor Control Commission (OLCC), AMH will continue work to educate communities about laws and norms and offer training on implementing effective community policies and practices.
- The community team training will focus on how communities can engage key leaders to bring a stronger focus to the problem of drug and alcohol use.
- Through the Governor's Council on Alcohol and Drug Abuse Programs, AMH will guide local implementation statewide.

Information Dissemination:

- Public awareness campaigns will continue to target parents with the focus of increasing awareness of the importance of talking with their children about alcohol and marijuana.
- Materials will be developed by AMH and distributed through local county prevention programs, or developed locally with funds awarded from the SAPT block grant. Emphasis in 2008 will be on underage drinking and methamphetamine.

Problem Identification and Referral:

- All county and tribal contracts require that problem identification and referral are components of the local prevention program. The CMHP function as the single point of contact for this purpose. OAR governing prevention services require that anyone who presents with a problem or referral must have access to an assessment and be referred to an appropriate service.
- Through SAPT block grant dollars, AMH supports a statewide Helpline and Youthline that provide referral to local treatment and prevention services. This is a service that is available in every county.

State:
Oregon

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☐ Yes ☒ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☒ Yes ☐ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☐ Yes	☐ Yes	☒ Yes
☒ No	☒ No	☐ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☐ Yes ☒ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	☐ Yes	☐ No	☒ Unknown
Dissemination of materials?	☒ Yes	☐ No	☐ Unknown
Media campaigns?	☐ Yes	☒ No	☐ Unknown
Product pricing strategies?	☐ Yes	☒ No	☐ Unknown
Policy to limit access?	☐ Yes	☒ No	☐ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☐ Yes ☒ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☐ Yes ☒ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☒	☐	☐
Alcohol	☐	☒	☐	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? 0

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 70

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Oregon

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal # 3: An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22 (b) (1) (C) and 45 C.F.R. 96.124 (c) (e)).

FY2005 (Compliance)
Oregon Alcohol and Other Drug (AOD) providers are required to meet the SAPT Block Grant contractual requirements prioritizing pregnant women, providing prenatal services, and childcare. Regulations are documented via the Federal Regulations and Oregon Administrative Rule (OAR) 415-051-0000 through OAR 415-051-0070, OAR 415-051-0110, and OAR 415-051-0040. (AMH) staff monitors requirements described above through on site reviews. AMH uses the *Substance Abuse Prevention and Treatment (SAPT) Block Grant Monitoring Checklis*t during the review to ensure residential and outpatient providers are in compliance. Noncompliance with administrative rules or contract requirements is described in an onsite review report and corrective action is taken.

The 2005 SAPT Block Grant reported two objectives. The first goal was for local partners in the early childhood system of care to connect with substance abuse providers to ensure parents and their children have adequate resources and support. Four pilot early childhood behavioral health projects were created in 2005 as part of AMH Early Childhood State Incentive Cooperative (SIG) agreement with SAMHSA.

The pilot programs are ended in March 2007. Program evaluation has indicated that the pilot projects met their objectives. Further analysis indicates a need for additional resources to improve services to young children and their families after the pilot ends. In addition, shared funding with other agencies is the collaborative activity that occurs least often related to linking early childhood and behavioral health services.

The second goal was the implementation of the Oregon Children's Plan that focused on prevention and early intervention services to children 0-8 and their families, who have or are at risk for developing mental health or substance abuse problems. Funding was distributed to seven projects. Four of the projects are near completion as described above. During the last 18 months, sites have developed the use of standardized instruments or direct observation of change and have reported those outcomes to AMH. The remaining projects continue to be monitored for effectiveness.

Goal # 3: FY2007 (Progress)
Programs approved and designated to primarily provide alcohol and other drug (AOD) treatment services to women shall provide gender specific treatment, pursuant to the general standards for alcohol and other drug abuse treatment agencies (OAR 415-051-000 through 415-051-0070, 415-051-0110, Federal Requirements and CMHP contracts). Site reviews conducted in all five regions found that addiction treatment agencies are providing gender specific programs. Some programs offer gender specific residential treatment and at termination refer clients to gender specific outpatient programs.

Addiction and Mental Health informed services, trauma specific services, and gender issues related to trauma. The revision incorporates the latest research and outlines an action plan on how to initiate the steps necessary to implement trauma informed services in addiction treatment agencies in Oregon

Training on Fetal Alcohol Spectrum Disorders (FASD) was provided to publicly funded agencies in Oregon. The goal was to establish a neurobehavioral conceptual foundation for reframing the meaning of presenting symptoms of FASD as a brain-based physical disability and support application of this principle in addictions and mental health settings.

The 2007 Legislature approved addiction treatment funds for families who are clients of child welfare and Temporary Assistance for Needy Families (TANF) and are at risk or already involved in the child welfare system due to alcohol and drug problems. The Intensive Treatment and Recovery Service (ITRS) initiative increases treatment capacity for parents needing residential and intensive outpatient services as well as housing supports. ITRS funds 30 residential beds to serve 90 parents annually, 20 dependent children beds serving 60 children annually, intensive outpatient treatment for 1,332 clients per year, and 14 more recovery homes available for TANF and Child Welfare families. AMH will monitor outcomes to ensure that the funds are used appropriately and report back to the Legislature in 2009. The outcomes include:

- preventing out of home placement when families can safely stay together,
- reuniting parents and children,
- reducing average length of stay in foster care, and;
- increasing job placement for TANF participants.

An ITRS referral form will track and monitor all Children, Adult and Family (CAF) clients sent for an alcohol and drug assessment. A database established and maintained by AMH will collect client information on timely access to addiction treatment. A collaborative system design workgroup comprised of AMH and CAF are working on the operational framework and administrative methodology to implement and sustain this initiative.

Oregon AMH received a Performance Partnership Grant Core Technical Review on October 30, 2006. The Center for Substance Abuse Treatment (CSAT) recognizes that Oregon needs some help in this area. CSAT recommends technical assistance to develop a state monitoring system or prioritize pregnant women and women with dependent children. This item is identified as a top priority in the SSA in the response to CSAT for the core technical review.

Goal # 3: FY2008 (Intended Use)
AMH revised the state's trauma policy to include information on trauma informed services and trauma specific services. AMH objective is to develop a statewide strategic plan and provide technical assistance on implementing trauma informed services for addiction providers.

The Pilot Fidelity Project was created to prepare AMH staff and alcohol and other drug (AOD) providers to conduct fidelity reviews on Evidence-Based Practices (EBP) and to develop protocols for the AMH fidelity review process. The 2008 goal is to provide technical assistance to treatment agencies on how to implement their own fidelity review. One of AMHs objective is to do a fidelity review on trauma specific services used by AOD providers in their gender specific groups.

Work is underway in developing consistent guidelines and OAR for co-occurring disorders treatment. A number of publicly funded community mental health programs have implemented co-occurring disorder treatment. AOD agencies also provide co-occurring disorder treatment either through in-house services or collaborative partnerships with mental health providers.

The 2007 Legislature funded the Intensive Treatment and Recovery Service (ITRS) initiative to increases treatment capacity for parents needing residential and intensive outpatient services. It is a cross-system collaborative approach that encompasses CAF, addiction providers, recovery support services (peer delivered services and housing supports), and early childhood system partners. An IRTS referral form will be used to authorize AOD treatment and monitor all CAF clients in treatment. This will be a major emphasis for AMH in the next 12 months.

Project FEAT (Family Early Advocacy and Treatment) is a 5-year project funded through the DHS. This project's goal is to develop an optimal, effective model of policies and procedures in Oregon to implement provisions of the Child Abuse Prevention and Treatment Act (CAPTA) for substance exposed newborns. Currently, significant identification and treatment barriers exist including inconsistent maternal drug testing, referral, and follow-up services as well as no clear Oregon state policies related to prenatal drug exposure and CAPTA.

Potential priorities including standardizing screening tool, policy changes, and legislative action in prevention and treatment for substance exposed newborns.

Another strategic initiative AMH plans to focus on is an initiative of Partners, Children and Families (PCF). The initiative focuses on young children at risk of out-of-home placement because of family alcohol and drug issues, with emphasis on prevention. A work group identified TANF families with children at risk of entering the child welfare system.

Developers of this two-year initiative are exploring work across systems and service provider boundaries to bring focus to parent-child interactions. This work may include training, educational opportunities, service delivery adjustments and or statute changes.

The understanding is that providers tend to focus on their customer, either a parent or a child, without considering the relationship between them. For example, an AOD provider may focus on the parent without considering the effects of the situation on the child. This focus is more

than an attitude to the provider. It may also be a result of the service delivery model used, rules that prohibit cross system approaches, real or perceived financial barriers, or lack of information about resources available to assist the family environment beyond a particular service recipient.

One component of this initiative being explored is to implement workforce development strategies that would infuse knowledge of child development, attachment, and other areas related to parent-child interactions into the services provided through all services systems.

Oregon

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2005. In a narrative of up to two pages, describe these funded projects.

Attachment B: Programs for Pregnant Women and Women with Dependent Children

The following is a list of contracted residential and outpatient treatment providers who deliver services for pregnant women and/or women with dependent children. Capacity is reflected in the number of beds licensed, not necessarily funded.

Programs	Location	Sub-State Region	I-SATS	Level of Care	Capacity
Residential					
Letty Owings Center	Portland	1	OR901034	3	56
CODA New Directions	Portland	1	OR102674	3	24
Lifeworks- Project Network	Portland	1	OR100985	3	50
NARA	Portland	1	OR100462	3	33
Volunteers of America- Women's Program	Portland	1	OR101023	3	52
Lifeworks-Mountaindale	Hillsboro	2	OR103573	3	20
Willamette Family Treatment Services - Parenting/Non-Parenting	Eugene	3	OR104225	3	29
Cascadia-Bridgeway	Salem	3	OR101585	3	5
Milestone Family Recovery	Corvallis	3	OR100538	3	15
Eastern Oregon Alcoholism Foundation	Pendleton	4	OR750407	3	15
ADAPT	Roseburg	4	OR901562	3	18
On Track, Inc	Medford	4	OR101908	3	35
New Directions- Northwest	Baker City	5	OR104175	3	28
Outpatient					
{Outpatient programs have a Letter of Approval for women-specific programs, but no dedicated funding for women-specific services.}					
ASAP Treatment Services	Portland	1	OR750829	1 & 2	
Cascadia	Portland	1	OR100850	1 & 2	
Changepoint, Inc	Portland	1	OR901471	1 & 2	
Changepoint, Inc	Gresham	1	OR103144	1 & 2	
CODA- New Directions Family Treatment	Gresham	1	OR102674	1 & 2	
DePaul Adult Treatment Center	Portland	1	OR750688	1 & 2	
In Act, Inc	Portland	1	OR101551	1 & 2	
Legacy Emmanuel Hospital- Project Network	Portland	1	OR100985	1 & 2	
Stay Clean, Inc	Portland	1	OR102195	1 & 2	
Lifeworks	Portland	1	OR750514	1 & 2	
Cascadia	Hillsboro	2	OR000021	1 & 2	
Changepoint, Inc	Beaverton	2	OR104001	1 & 2	
Changepoint, Inc	Canby	2	OR104019	1 & 2	
Clackamas County Mental Health	Oregon City	2	OR101874	1 & 2	

Programs	Location	Sub-State Region	I-SATS	Level of Care	Capacity
Clackamas County Mental Health	Sandy	2	OR103615	1 & 2	
CODA Tigard Recovery Center	Tigard	2	OR900747	1 & 2	
Benton County Treatment Program	Corvallis	3	OR750126	1 & 2	
Bridgeway, Inc	Salem	3	OR901588	1 & 2	
Bridgeway, Inc	Stayton	3	OR100994	1 & 2	
Bridgeway, Inc	Woodburn	3	OR100165	1 & 2	
Columbia Community Mental Health	St. Helens	3	OR900796	1 & 2	
Discovery Counseling	Corvallis	3	OR102865	1 & 2	
Discovery Counseling	Lincoln	3	OR102047	1 & 2	
Discovery Counseling	Newport	3	OR102716	1 & 2	
Discovery Counseling	Waldport	3	OR104258	1 & 2	
Lincoln County Behavioral Health	Newport	3	OR900739	1 & 2	
Linn County Mental Health	Albany	3	OR900549	1 & 2	
Linn County Health and Human Addiction	Lebanon	3	OR103086	1 & 2	
Linn County Health and Human Addiction	Sweet Home	3	OR103094	1 & 2	
Milestone Family Recovery	Corvallis	3	OR100538	1 & 2	
Polk County Mental Health	Dallas	3	OR900267	1 & 2	
Tillamook Family Counseling Center	Tillamook	3	OR301391	1 & 2	
Lifeworks	Seaside	3	OR000381	1 & 2	
Lifeworks	Astoria	3	OR000381	1 & 2	
Willamette Family Treatment Services	Eugene	3	OR104225	1 & 2	
Yamhill County CD Program	McMinnville	3	OR100587	1 & 2	
ADAPT	Grants Pass	4	OR103425	1 & 2	
ADAPT	Roseburg	4	OR103524	1 & 2	
ADAPT	North Bend	4	OR000261	1 & 2	
BestCare Treatment Services, Inc	Bend	4	OR100648	1 & 2	
Choices Counseling Center	Grants Pass	4	OR101734	1 & 2	
Curry County Mental Health	Gold Beach	4	OR750761	1 & 2	
Genesis Recovery Center	Central Point	4	OR101536	1 & 2	
Klamath Alcohol and Drug Abuse, Inc	Klamath Falls	4	OR103037	1 & 2	
Klamath Community Treatment Center	Klamath Falls	4	OR103888	1 & 2	
On Track, Inc	Medford	4	OR101908	1 & 2	
Rogue Valley Addictions Recovery Center	Medford	4	OR750738	1 & 2	
BestCare Treatment Services, Inc	Madras	5	OR103540	1 & 2	
BestCare Treatment Services, Inc	Redmond	5	OR100874	1 & 2	
Center for Human Development	La Grande	5	OR301367	1 & 2	
Confederated Tribes of Umatilla	Umatilla Indian Reservation	5	OR750415	1 & 2	
Deschutes County Mental Health	Bend	5	OR900556	1 & 2	

Programs	Location	Sub-State Region	I-SATS	Level of Care	Capacity
Grant County Center for Human Development	John Day	5	OR750803	1 & 2	
Harney Behavioral Health	Burns	5	OR750092	1 & 2	
Lifeways Behavioral Health	Ontario	5	OR900507	1 & 2	
Lutheran Community Services	Lakeview	5	OR104035	1 & 2	
Lutheran Community Services	Prineville	5	OR750530	1 & 2	
Mid-Columbia Center for Living	Condon	5	OR100876	1 & 2	
Mid-Columbia Center for Living	Hood River	5	OR901687	1 & 2	
Mid-Columbia Center for Living	The Dalles	5	OR301201	1 & 2	
Morrow Wheeler Behavioral Health	Boardman	5	OR104191	1 & 2	
Morrow Wheeler Behavioral Health	Heppner	5	OR102450	1 & 2	
Safe Haven	Ontario	5	OR100501	1 & 2	
Umatilla County Mental Health	Pendleton	5	OR900192	1 & 2	
Wallowa Valley Mental Health	Enterprise	5	OR750167	1 & 2	

All women-specific programs provide gender specific services and are required to address issues for women such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, housing and financial problems. Programs are required by OAR to provide or coordinate services that meet the special access needs of this population, such as childcare, mental health services, and transportation.

Providers are required to use the American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC 2R) in making level of care determinations. All residential programs provide transition services so that women and children can smoothly move from residential to community-based outpatient and continuing care services. This requirement is monitored by AMH through periodic onsite inspections and analysis of treatment outcomes improvement reports.

Each of the residential providers has designed programs so that mothers enrolled in treatment can bring their young children with them. Generally, cribs or infant beds are placed in the mother's room, although some programs offer suites where adjoining rooms can accommodate older children. Children's beds are not included in the capacity numbers provided in this section. All women's specific residential programs offer therapeutic childcare and parent training as part of the services.

Staff working in women's specific programs must have specialized training and must possess qualifications that include formal training and education in women's treatment needs and family counseling.

Funded residential programs for pregnant women and women with dependent children are generally regionally based with the highest concentration along the I-5 corridor from the

Portland metropolitan area to Medford in southern Oregon. Oregon's population is most highly concentrated in this area.

Two of the residential programs target specific minority populations. Project Network specializes in treating African American women and NARA (Native American Rehabilitation Association) specializes in services for Native American women. Two programs offer specialized services for young pregnant females: Willamette Family Treatment Services and DePaul Treatment Services.

Outpatient services specifically designed and approved for women are located in all 36 counties in Oregon. Outpatient providers work closely with residential providers to ensure continuity of care and with other providers who offer early childhood services and supports.

Providers are paid for residential services based on full utilization of the contracted number of bed days. Because Medicaid funds a large portion of funding for residential treatment, residential service utilization is monitored each quarter by matching Client Process Monitoring System (CPMS) data with Oregon Health Plan encounter data. Financial recoupment occurs in counties that are underutilized or providing less than the contracted amount of bed days. Residential programs are required to maintain their own waiting lists. Procedures for ensuring priority admission for pregnant women and IV drug users pursuant to SAPT block grant requirements are reviewed and monitored during the onsite review process.

Utilization for outpatient services is monitored based on CPMS data submitted and verified during onsite program reviews. Until March 2003, outpatient programs rarely had waiting lists, as a result of the inclusion of alcohol and drug treatment coverage in the OHP in 1995. However in March 2003, this benefit was limited to only those categorically eligible for Medicaid. This reduction in coverage significantly limited outpatient treatment capacity in some areas. The areas most impacted were the rural areas of the state, including eastern Oregon and coastal regions. On August 1, 2004, chemical dependency treatment coverage was restored to a relatively small number of people. FCHP, which provide alcohol and drug treatment coverage for the categorically eligible in OHP are required by contract to pass on to providers the mandate to see clients the same day for emergency care. Additionally, pregnant women and others requiring urgent care must be seen within 48 hours and IV drug users must be seen within 10 days for routine care.

Drug free housing remains a critical issue. Women all too often utilize higher levels of care such as residential primarily because their living environment is incompatible with sobriety. Those same women, when provided a safe, drug free environment, could be successful with outpatient or intensive outpatient treatment. Women who successfully complete residential treatment are faced with difficulties finding safe, affordable housing options. Oregon has been able to continue allocating resources to local communities to support high-risk families including drug free housing, rental assistance, and housing coordination. There are 60 Oxford houses for women, 291 residents in 9 Oregon counties. Additional housing development will be possible due to new investments made by the 2007 Legislature.

Oregon

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2005 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2005 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Goal 3
Attachment B-Part 2

1. Identify the name, location, NFR ID number, type of care, capacity and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

These residential programs served the following in FY 2005, FY2006 and FY 2007. See Attachment B for the list of outpatient programs serving pregnant women and women with dependent children.

Programs	Location	Sub-State Region	I-SATS	Level of Care	Capacity	Amount of Funds
Residential						
Letty Owings Center	Portland	1	OR901034	3	56	1,105,950
CODA New Directions	Portland	1	OR102674	3	26	389,820
Lifework- Project Network	Portland	1	OR100985	3	50	1,053,390
NARA	Portland	1	OR100462	3	62	941,700
Volunteers of America-Women's Program	Portland	1	OR101023	3	52	DOJ
Lifeworks-Mountaindale	Hillsboro	2	OR103573	3	20	444,570
Willamette Family Treatment Services - Parenting/Non-Parenting	Eugene	3	OR104225	3	32	1,022,730
Cascadia-Bridgeway	Salem	3	OR101585	3	31	282,510
Milestone Family Recovery	Corvallis	3	OR100538	3	15	240,900
Eastern Oregon Alcoholism Foundation	Pendleton	4	OR750407	3	36	521,220
ADAPT	Roseburg	4	OR901562	3	24	624,150
On Track, Inc	Medford	4	OR101908	3	23	716,130
New Directions- Northwest	Baker City	5	OR104175	3	30	372,300

The following table includes service utilization and demographic information related to treatment for women, women with children, and pregnant women.

Activity	FY 2005	FY 2006
# of pregnant women admitted to treatment	1,134	1,163
# of pregnant women completed treatment	447	366
# of pregnant women abstinent at completion	329	240
# of women terminated from treatment	318	328
# of women admitted to treatment / dependent children	7199	6456
# of children staying with clients in residential treatment	Number incorrect last year.	62

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22 (b) (1) (C) in spending FY 2005 block grant and/or State funds?

Set asides from the block grant for these clients have been determined by calculating the percentage of total clients served who are pregnant women and/or women with dependent children. This percentage was applied to the total block grant expenditures for the year to derive block grant funds to be claimed for the set-aside.

Oregon does not reimburse providers on a fee-for-service basis including services for pregnant women and women with children in alcohol and drug outpatient and residential treatment. Contract requirements specify in each of the financial assistance agreements between DHS-AMH and the counties, tribes, and direct contractors to prioritize pregnant women and women with children.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

Oregon conducts onsite reviews of each licensed residential program at a minimum of every two years, and approved outpatient programs at a minimum of every thee years. These reviews ensure that contractual requirements to give priority admission to pregnant women and women with dependent children are met. Further, the reviews evaluate each program's compliance with administrative rules that require specific programming applicable for this population. Services must include gender specific treatment, including care for issues such as social isolation, self-reliance, parenting, family/relationship difficulties, domestic violence, and housing and financial problems. Programs are reviewed to evaluate compliance with administrative rule requirements

to provide or coordinate services that meet special access needs such as childcare, mental health services, and transportation.

Providers are required to submit Client CPMS enrollment and termination data on all clients. CPMS is a database that tracks clients in publicly funded treatment programs in Oregon. In addition to general demographic information at enrollment (drug use, level of impairment, income, employment status, living arrangements, arrest history) the CPMS system collects whether or not the client is pregnant at admission and the number of dependent children in the household. Termination data identifies if the pregnant client was abstinent from substance abuse in the last 30 days prior to delivery of her infant, and if the client was able to comply with the child welfare service agreement during treatment to sufficiently progress toward regaining custody of children.

Oregon AMH received a Performance Partnership Grant Core Technical Review on October 30, 2006. CSAT recognizes that Oregon needs some help in this area. CSAT recommends technical assistance to develop a state monitoring system or prioritize pregnant women and women with dependent children. This item is identified as a top priority in the SSA in the response to CSAT for the core technical review.

4. What sources of data did the State use in estimating treatment capacity for the utilization by pregnant women and women with dependent children?

The CPMS system, described above, is Oregon's database for clients served in the public treatment system. The database indicates, among other things, the total number of clients served, the number of women served, whether or not the woman is pregnant at admission, and the number of dependent children in the household. The CPMS system also tracks source of income and insurance availability to determine those clients who are eligible for contracted services, making it possible to determine actual utilization of public funded treatment beds.

AMH funds treatment capacity in each county and several tribes. The counties and tribes either provide the services directly or sub-contract with local private, nonprofit organizations. Counties, tribes and programs are provided quarterly quality improvement reports that highlight utilization patterns and report progress in meeting estimated treatment demand. AMH provides ongoing training and technical assistance to providers on using the CPMS forms for proper data collection.

For women participating in residential treatment services, CPMS data is matched with Medicaid encounter data to determine bed-day utilization and calculate the daily rate paid to providers.

5. What did the State do with FY 2005 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children.

Women's Commission on Alcohol and Drug Issues received SAPT Block Grant funds to develop trainings on gender specific issues. The first training concentrated on clinical issues

related to gender specific treatment and was given at the annual Northwest Addiction Conference. The second training targeted administrators and covered evidence based practices and the implication for women's treatment. The third training covered developmental stages for co-occurring disorder program development for women. These are stand-alone training sessions and that can be given at conferences, workshops, etc.

The Office of Family Health was awarded a three-year grant to build capacity in the Oregon toll-free maternal and child health hotline, "SafeNet", for responding to women's health needs at any age. As a component of this grant, Department of Human Services is establishing a SafeNet - Women's Health Coordinating Council (WHCC) to inform and guide comprehensive women's health activities throughout Oregon. AMH participated and provided technical assistance in the area of addiction services for women.

AMH along with other Department of Human Service organizations published *A Prenatal and Newborn Resource Guide for Oregon Families*. A page was added for alcohol and drug screening and information. This was a collaborative approach to providing information for healthy pregnant mothers and their children after birth.

AMH participates with other Department of Human Service divisions in a three year Center for Disease Control grant on Fetal Alcohol Spectrum Disorders (FASD) Prevention Project, Individual-Level intervention program to prevent alcohol-exposed pregnancies among women who are binge drinking, are sexually active and not using contraception. The goal of this project is to reduce alcohol-exposed pregnancies in Oregon by conducting individual-level interventions. It is expected that these individual-level interventions will promote positive motivational one-on-one messages to encourage pre-conceptual women to either not consume alcohol, or use contraception. This is a health education project which requires counseling skills applicable to motivational interviewing. No long-term intensive therapy or crisis intervention will occur on a regular basis. The intervention population includes university and high-school students and Native American women.

AMH published a trauma policy to draw attention to the importance of providing trauma-informed services. In this "decade of the brain" and with a national awakening supporting recovery and resiliency, it is essential that professionals understand the neurobiological impact of trauma, attachment, and substance abuse disorders, and why trauma-informed policies are necessary. AMH developed and provided a four-hour workshop to Oregon's alcohol and drug agencies on the need for trauma –informed systems and the role that alcohol and drugs has on both diminishing and exacerbating symptoms. Approximately, 200 people were trained.

Oregon

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #4: IVDU Services

Goal #4: An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements.

FY 2005 (Compliance):
AMH uses the revised Block Grant Monitoring Checklist, developed with technical assistance from SAMHSA in 2004, to conduct improved monitoring of provider compliance with contract requirements for provider reporting, access to services, interim services and outreach activities. AMH enlisted the assistance of Department of Human Services District offices to assist in identifying areas in which capacity issues have arisen for DHS clients including child welfare and TANF families.

Goal #4: FY 2007 (Progress):
In 2005, AMH required counties to include how they will use the 2007-2009 biennial county planning process to address block grant compliance issues, including the 90% capacity reporting, the 14-120-day performance requirement, delivery of interim services, outreach activities, and monitoring requirements. AMH continues to conduct onsite reviews of programs using the revised Block Grant Monitoring Checklist.

AMH has been developing a comprehensive data system that will capture needed information. The Behavioral Health Integration Project (B-HIP) is an effort to replace the current data systems used for reporting mental health and chemical dependency treatment services by the community and hospital behavioral health treatment programs. The new system is to be completed within three years.

AMH implemented the new equity funding formula based on population and prevalence that began July 1, 2007. This new formula addressed inequities in the funding distribution of the SAPT bock grant, state general funds and beer and wine tax revenues.

AMH provided relevant training and technical assistance for providers and local partners during 2007 specifically targeted for medication assisted therapy. A greater proportion of opioid treatment clients have used drugs intravenously creating a higher risk for infectious diseases. These trainings and technical assistance efforts focused on the positive benefits of opiate replacement therapy associated with reducing infectious disease transmission including the spread of HIV, Hepatitis C and other infectious diseases as well as lowering health care and emergency room costs.

Goal #4: FY 2008 (Intended Use):

AMH is revising the OARs to integrate both mental health and substance use programs. AMH will assure that the same level of requirements and accountability with regard to IVDU risk assessment requirements remains in the new rule. AMH will provide technical assistance to alcohol and drug providers and intermediaries to comply with the new rules and improve treatment access and utilization monitoring.

Targeted training and technical assistance for medication-assisted therapy will be repeated in 2008 for parts of the state not included in the 2007 training.

Oregon

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2005 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C: Programs for IVDU

1. How did the State define IVDUs in need of treatment services?

Oregon defines IVDUs in need of treatment services a persons who administer intravenously their primary or secondary drug of choice through a six dimensional alcohol and drug assessment consistent with the American society of Addiction Medicine Patient Placement Criteria, second revision (ASAM, PPC 2-R) conducted by a certified addictions counselor and the state licensed program.

2. …..requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the state when the program has reached 90 percent of tits capacity. Describe how the state ensured that this was done. Provide a list of all such programs that notified the state during FY 2005 and include the programs I-SATS ID number.

Contractual agreements with intermediaries and providers require that programs provide notice to AMH upon reaching 90% capacity. To assist in monitoring the 90% capacity a checklist that was developed with technical assistance from SAMHSA was implemented in 2004 and continues to be used by the regional alcohol and drug specialists.

3. …requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the state ensured that such programs were in compliance with the 14-120 day performance requirement.

   The AMH contracts include a requirement that IVDUs be admitted within 14-120 days and that they be prioritized for admissions and interim services are provided during the time in between. Onsite reviews confirm compliance with these requirements.

4. …requires that any program receiving amounts from the grant provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the state ensured that outreach activities directed toward IVDUs was accomplished.

AMH contracts require providers to conduct infectious disease risk assessments on all clients and to refer those engaging in high-risk behavior to their primary care physician or local health clinic for further evaluation and testing. The local county health departments provide routine infectious disease rise assessments, testing, and counseling as needed for clients accessing STD, TB, Hep C, family planning and prenatal classes.

Oregon

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)
   (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a)
   (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b)
   (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Attachment D: Program Compliance Monitoring

Notification of Reaching Capacity

AMH contracts require providers to serve priority populations first and to provide interim services or referrals when there is insufficient capacity. AMH conducts regular onsite reviews of all providers to monitor compliance with administrative rules and contract requirements, including capacity reporting requirements associated with SAPT.

Prior to the site review, agencies are mailed the "SAPT Block Grant Monitoring Checklist". This checklist is completed by the program prior to the review to educate the provider of the federal requirements and to identify whether the program is out of compliance with any of the related SAPT requirements. Any compliance issues related to the SAPT Block Grant requirements will be discussed with the provider at the time of the review. AMH remains focused on developing a new data system to replace our current CPMS database. This project, known as B-HIP, Behavioral Health Integration Project, will eventually replace CPMS. One of the primary system requirements already identified is waitlist/capacity management. This system is several years from implementation.

AMH continues to conduct statewide meetings with CMHP directors and with the OPERA, the alcohol and drug treatment providers' organization, to remind service delivery system participants of the importance of compliance with SAPT requirements.

Monitoring Strategies for Tuberculosis Services

AMH administrative rules require all programs to have their clients complete an infectious disease risk assessment upon admission. The assessment includes tuberculosis, HIV/AIDS and other infectious diseases. For high-risk clients, providers must make referrals to county health departments for further testing and treatment. AMH monitors compliance with these requirements through onsite reviews conducted by AMH staff. A high level of compliance with this requirement has been established across the state and no specific concerns were noted for FY 2006.

Compliance Monitoring for Treatment Services for Pregnant Women

AMH contracts require that pregnant women be given priority in admission to state-funded programs. The AMH administrative rules require that all providers refer pregnant women for prenatal care within two weeks of admission. The rules also require that providers refer pregnant women for a physical exam and appropriate lab testing within 30 days of admission to the program.

In addition to these standard requirements, providers applying for approval as specialized women's treatment programs must meet additional requirements for treatment planning, services, referrals and staff training.

Through onsite reviews of providers, the AMH staff monitors all of the requirements described above. AMH conducts these reviews every two years for residential providers and every three years for outpatient programs.

The reviews include an examination of a sample of client or patient records, interviews with program staff, and a review of the program's written policies and procedures. The process includes a review of the response forms completed anonymously by allied agencies. Noncompliance with administrative rule or contract requirements is described in an onsite review report. The report identifies the corrective action needed and the timelines for completing the corrective action. The AMH staff may verify accomplishment through subsequent onsite inspections. AMH will continue to monitor the system closely. We will continue working to ensure timely and effective treatment and referral for pregnant women.

Oregon

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #5: FY 2005 (Compliance):

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

Objective: AMH will make available tuberculosis services to each individual receiving treatment for substance abuse by ensuring agreements are in place between local treatment providers and local public health departments through the regulatory review process.

During 2005, AMH required substance abuse treatment providers to conduct infectious disease risk assessments with all clients. This requirement is specified in the OAR governing alcohol and drug treatment programs. The Infectious Disease Risk Assessment and Procedures were most recently revised in 2001. All substance abuse treatment providers utilized this tool. AMH monitored compliance with the requirements through regulatory, onsite reviews. AMH staff members ensured that the requirements were effectively implemented and provided follow-up technical assistance using the revised risk assessment tool, procedures developed for implementing the tool and treatment improvement publications available through SAMHSA. Alcohol and drug treatment programs rely on linkages with local public health agencies to provide infectious disease testing and follow-up health services.

Goal #5: FY 2007 (Progress):

Substance abuse treatment providers continue to utilize the infectious disease risk assessment tool for their clients. This requirement remains in the OARs governing alcohol and drug treatment programs. All Oregon physicians and other health care providers are now required to report patients with verified or suspected cases of active tuberculosis to local health departments within one working day of identification. The OARs mandate inpatient and residential substance abuse treatment clients, as well as the provider's staff of the facility to test for tuberculosis (TB) yearly. Tests are done at the local health departments in each county, or at a physician's office.

Some programs have incorporated the testing services into the agreements with their Medical Director. The local health department evaluates all identified positive results and determines a drug treatment regimen to combat the TB infection. Compliance with the requirements in treatment facilities is monitored by regulatory onsite reviews by the AMH staff. Counselor training associated with the administration of the infectious disease risk assessment is refined by collaboration between AMH and DHS, Public Health Division, Addiction Counselor Certification Board of Oregon (ACCBO) and other training resources. AMH and ACCBO continue collaboration on requirements specified in the OARs concerning tuberculosis infection among the client population served by public funded programs, and legal and ethical issues.

Goal #5: FY 2008 (Intended Use):

AMH will continue to coordinate training activities associated with TB infection, and continue to require the use of the risk assessment tool by substance abuse treatment providers. AMH will continue collaboration with DHS, Public Health, the Addiction ACCBO, and other training resources to reach the largest potential group of addiction counselors throughout the state. AMH staff will continue to monitor compliance with the requirements under this section through regulatory onsite reviews and follow-up technical assistance with the substance abuse treatment programs. AMH will continue to monitor the PHD TB program of any changes in reporting protocols, and actively participate in efforts to eliminate TB in Oregon.

Oregon

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #6: FY 2005 (Compliance):

Objective: AMH will ensure treatment is provided for persons with substance abuse problems. AMH will emphasize making early intervention services for HIV available statewide and will monitor service delivery through their regulatory review process.

According to the PHD's HIV Data and Analysis State of Oregon HIV / AIDS Summary, trends in the data in Oregon indicate increasing men who have sex with men injection drug users (MSM/IDUs) and decreasing heterosexual injection drug users IDUs for HIV/AIDS cases in 2005. Of the 292 newly diagnosed HIV/AIDS (218 HIV and 74 AIDS) cases in Oregon in 2005, 20 (7%) were (MSM/IDUs) and 19 (6.5%) were (IDUs). According to Disease Status among people living with HIV/AIDS in Oregon as of 6/30/2005, AIDS diagnoses reported 12.7% IDU and 8.6% MSM/IDU as risk for infection. From the same report, HIV non-AIDS diagnoses reported 10.5% IDU and 7.5% MSM/IDU respectively as risk for infection. According to Disease Status among people living with HIV/AIDS in Oregon as of 6/30/2005 by sex, 26.3% of females reported IDU as risk for infection. Multnomah County (Portland Metro Area) was identified as having the most newly diagnosed HIV/AIDS cases (167, 57%) according to Oregon Cases by County of Residence and Year of Diagnosis. However, the numbers of recent HIV infections remain small and are decreasing probably due to successful prevention strategies. AMH required substance abuse treatment providers to conduct HIV/infectious disease risk assessments with all clients during FY 2005. This requirement is specified in the Oregon Administrative Rules governing alcohol and drug treatment programs. Compliance with the requirements was monitored by regulatory onsite reviews. AMH staff members ensured that the requirement had been effectively implemented by providing follow-up technical assistance.

Goal #6: FY 2007 (Progress):

An AMH staff member continues to be represented at the quarterly HIV Statewide Planning Group (HIV-SPG) Meeting. The HIV-SPG is a 40-member group, comprised of community representatives, local health department staff and HIV prevention activists. The HIV-SPG develop an annual HIV prevention comprehensive plan for the state of Oregon using Center for Disease Control (CDC) guidelines and best practices. OAR specify the requirements for HIV/infectious disease risk assessments, follow-up care and referrals for substance abuse treatment providers. AMH monitors program compliance with the requirements through regulatory onsite reviews. Anonymous and confidential HIV testing is available through local county health departments at low or no cost. Substance abuse treatment providers continue working relationships with local county health departments. Clients identified at intake by the HIV/infectious disease risk assessment tool as being at risk of HIV infection are referred for further HIV testing and counseling services. AMH works closely with ACCBO to: 1) Develop and refine counselor training associated with the administration of the HIV/infectious disease risk assessment tool; 2) Develop referral policies to local public health and follow-up services; and 3) Address legal and ethical issues concerning HIV/AIDS among the population served by publicly funded programs.

Goal #6: FY 2008 (Intended Use):

AMH will continue to coordinate training activities associated with HIV, and continue risk assessment and referral of clients to the local health department for follow up HIV counseling and testing services. AMH staff will work with the ACCBO to refine the administration of the risk assessment tool and counselor training associated with referral and follow-up services.

AMH plans to develop a product with the PHD to assist addiction treatment providers to understand the preventative, clinical and treatment elements related to the Hepatitis C Virus and blood borne pathogens. These efforts will increase attention to infectious disease prevention and screening protocols among the substance abuse treatment providers.

AMH will continue to monitor compliance with the OARs by conducting onsite reviews and will provide follow-up technical assistance to substance abuse treatment programs. AMH staff will continue to participate in the quarterly HIV Statewide Planning Group (SPG) meetings. Through these meetings, collaboration between statewide agencies will plan and evaluate HIV prevention services and establish HIV prevention priorities for the state.

Oregon

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))
For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);

- the role of the single State authority (SSA) for substance abuse prevention and treatment; and

- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;

- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;

- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and

- technical assistance.

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV.

AMH requires in its administrative rules and in its contracts that all providers conduct infectious disease risk assessments on all clients. Those screened to be at high risk for HIV, TB and other infectious diseases are referred for further testing to the county health department. An AMH regional coordinator reviews outpatient providers every three years and residential providers every two years for contract and rule compliance. Reviews of client records continue to confirm that most programs are in substantial compliance with screening requirements. In instances in which compliance is not complete, findings are identified and corrective actions, with timelines, are communicated to providers in the final onsite review report. Yearly follow-up onsite reviews are standard to monitor compliance with any corrective action plans.

State expenditures for TB in FY 2005 were $230,253.

Tuberculosis Prevention and Treatment

The local county health departments are responsible for testing and treating persons who are TB infected. The single state authority for public health and communicable disease is the Department of Human Services, PHD. The role of the PHD TB Program is to prevent and control the spread of tuberculosis in Oregon by:

- Focusing on the identification and treatment of cases of active TB and TB infection in Oregon.
- Providing TB medication for TB clients through local health departments.
- Providing support for Directly Observed Therapy (DOT) programs at local health departments.
- Collecting and evaluating surveillance data to ascertain TB is treated appropriately.
- Providing expert consultation, education and outreach activities.

At the state level, the DHS, PHD tracks the number of identified cases and estimates statewide treatment costs for TB services. For 2005, Oregon's TB case rates decreased from the previous year to 2.2 per 100,000 (81 cases). The majority of Oregon's TB patients are treated using the internationally recognized strategy of (DOT. This ensures that people with TB receive quality medical care and restricts further spread of the disease to others in the community. Oregon is now very near the national goal of TB elimination.

HIV Prevention and Treatment

The same contract and administrative rule requirements for screening and referral that are applied for TB are also applied for HIV. All clients in alcohol and other drug treatment undergo an infectious disease risk assessment. Referral to the county health department for testing and treatment are made when indicated. The risk assessment and procedures for administering the tool were revised in 2001. A Spanish translation of the tool is available to download from the internet. Clients who have used drugs intravenously within the last 30 days are required to undergo a physical examination, appropriate laboratory testing for infectious diseases and a serology test for HIV. AMH monitors compliance with these administrative rule requirements

through onsite reviews that occur every three years for outpatient programs and every two years for residential programs. AMH increases the frequency of reviews if substantial non-compliance is found.

The role of the HIV Program of the DHS, PHD, is defined as follows:

- Measure the impact of the epidemic in Oregon, forecast its future course and severity, and identify populations for targeted prevention activities.
- Facilitate HIV prevention activities through local health departments, community-based AIDS service organizations, the media, schools, corrections, and public education (including local community planning and program implementation).
- Serve HIV-infected persons to coordinate their case management, enrollment in the AIDS Drug Assistance Program, emergency assistance, and referral for social supports.
- Develop public policy, monitor quality of program delivery, provide fiscal oversight of funds both within the program and with local health departments and community-based organizations, and provide technical assistance.

Oregon PHD reports 292 newly diagnosed AIDS/HIV cases in 2005. A first-ever positive Western Blot confirmatory test that occurred in 2005 indicates a newly diagnosed case.

Oregon

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2005 (Compliance): (participation OPTIONAL)

FY 2007 (Progress): (participation OPTIONAL)

FY 2008 (Intended Use): (participation OPTIONAL)

Goal #7: FY 2005 (Compliance):

Objective: AMH will expand the number of group homes for recovering substance abusers, with particular emphasis on expanding access for recovering women.

In FY 2005, Ecumenical Ministries of Oregon (EMO) continued to administer the Oregon Recovery Homes revolving loan fund under a contract with AMH. EMO conducted outreach, reviewed and approved loan applications, monitored loan payments and provided monthly reports on all activities relating to the loan fund. In late 2003, the Oregon Housing and Community Services Department agreed to provide funding for a second Outreach Coordinator who began work in January 2004. Attachment F summarizes these activities in detail.

Goal #7: FY 2007 (Progress):

Oregon continues to make substantial progress in this area. As of June 2007, there were 150 Oxford Houses in Oregon housing over 1,100 persons in recovery from alcoholism and drug addiction. Since July 2006, the state-funded Outreach Coordinators, who are both former Oxford House residents, directly assisted with opening 14 new Oxford Houses in eight counties located throughout Oregon. Publicity materials continue to be distributed through posters and brochures, a new web site (www.oroxfordhouse.org) for Oxford Houses of Oregon is under construction and will be available soon.

On July 28, 2005, as a result of the competitive solicitation process, Central City Concern (CCC) was selected as the contracting agency in partnership with The Recovery Association Project (RAP) to provide services that support the development, operation and expansion of Oregon Recovery Homes (ORH). This included administering the ORH revolving loan fund and providing ORH outreach coordination services.

This contract supports two full-time ORH outreach coordinator positions and a partially funded ORH program manager. The outreach coordinators assist with the establishment of new homes (especially expansion outside of the Portland and Salem metropolitan areas), provide assistance to stabilize existing homes that encounter difficulty, coordinate with service providers and individuals in recovery, publicize the availability of homes operated under the Oxford House charter, and report on progress. Washington County Community Corrections continues to fund another Outreach Coordinator to work in the Washington County geographic area. In February 2007, the Oregon Housing and Community Services Department agreed to provide some funding to be used toward the program manager position making it a full-time position dedicated to ORH and responsibility for supervision and support of the outreach coordinators.

On September 21-24, 2006, all three ORH staff participated in the annual Oxford House World Convention held in Wichita, Kansas. On October 28, 2006, the 9th Annual Oxford House Workshop was held which provided training for approximately 300 Oregon Oxford House members. On June 1-3, 2007, the Oxford House Leadership Summit provided training on leadership skills to State Association and Chapter members. In June 2007, the department paid for early registration for ten Oregon Oxford House members to attend the annual Oxford House World Convention to be held on August 30 – September 2, 2007 in Washington D.C. The first Oxford House Northwest Women's Conference is currently being planned for spring 2008.

Goal #7: FY 2008 (Intended Use):

Oregon will continue to support the revolving loan fund and outreach coordinators. The number of homes will continue to expand and will include new homes in additional Oregon counties. AMH staff continues to work with Central City Concern (CCC), the Recovery Association Project, and the ORH staff to identify additional resources to sustain and fund further outreach staff positions. Some noteworthy developments are as follows:

- Through the Children's Health and Safety Initiative approved by the 2007 Oregon Legislative Assembly, three additional outreach coordinators will be funded in the 2007-09 biennium.

- Because of recent research completed by De Paul University, AMH has proposed that the Oxford House model be adopted as an "evidence-based practice" under ORS 182.515, an Oregon law that requires increasing use of evidence-based practices by community service providers.

- In response to a recent court decision centering on the application of residential landlord-tenant laws to recovery homes, AMH submitted a legislative concept that would have restored exemption for recovery homes and enable them to operate as substance-free environments supportive of recovery. The legislation was not successful as proposed but resulted in a compromise that will allow expedited evictions for individuals who relapse in a recovery home.

In addition to continuing support for the ORH revolving loan fund and outreach coordinators, AMH will continue to support "alcohol and drug free" housing through two other efforts:

- A total of $1 million has been made available in each of the past four biennia to assist the development of alcohol and drug free housing for individuals in recovery. This funding is allocated through a consolidated application process with Oregon Housing and Community Services. In the 1999-2001 biennium, $1 million assisted the development 63 units in 8 projects located in 6 Oregon counties and valued at over $12 million. In the 2001-2003 biennium, the second $1 million assisted the development of 72 units in 7 projects located in 5 Oregon counties and valued at over $15 million. In the 2003-05 biennium, another $1 million assisted the development of 88 units in 7 projects located in 6 Oregon counties and valued at over $30 million. In the 2005-07 biennium, the fourth transfer of $1 million is assisting the development of 45 units in 6 projects located in 6 Oregon counties valued at over $6 million.

- Extending an effort initiated in the 1999-2001 biennium, AMH contracts out over $1 million to seven counties and one Tribe to provide rent subsidies and housing coordination services to families and individuals receiving substance abuse treatment who, without this supportive housing intervention, would likely be homeless and/or relapse. As of the quarter ending March 2007, a total of 1,943 recovering persons were assisted in achieving residential stability and continued sobriety through these services. Of the total served, 740 households were families re-uniting with children. Program evaluation data demonstrate that the rent

subsidies and housing coordination services helped participants to achieve residential stability, employment and increased income.

Oregon

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2005 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2005 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

Attachment F: Group Home Entities and Programs

This attachment summarizes compliance for FY 2005. A list of all entities that received loans from the revolving loan fund is provided at the end of the narrative responses.

Number and amount of loans made. A total of 25 new loans were made during FY 2005. These loans totaled $91,004. An individual listing of loans is provided below.

Amount available in fund. The amount available at the beginning of FY 2005 was $32,574.79. The balance in the account ranged from $9,510.70 to $34,925.21, and averaged $18,093.14.

Source of funds. The source of funds for the revolving loan fund is federal block grant dollars and state general fund. After the initial investment of $100,000 to establish the fund, an additional $40,000 was added in April 2000 and an additional $20,000 was added in November 2000.

Loan requirements, application procedures, loans made, repayments, problems encountered. Requirements for loans are as follows:

1. The house must be registered as a non-profit organization or affiliated with a non-profit, i.e. chartered by Oxford Houses Inc., and there must be a minimum of six recovering alcoholics and/or addicts.
2. The loan will not exceed $5,000.
3. The loan is to be repaid in 24 equal payments, due on or before the 20th day of each month. A fee of $25.00 is assessed for late payments.
4. Loan funds can be used for first and last month's rent, security deposits, utility deposits, and to purchase furniture.
5. The borrower must maintain the house as an alcohol and drug-free environment.
6. Residents must remain alcohol and drug free.
7. The residents will pay the cost of the housing.
8. The house will be operated as a self-managed democracy.

Applicants for loans provide a list of names of the prospective house members. Each person on the list must complete a loan application. Each person on the list is asked to supply an employer contact telephone number, if employed, and three other references. The loan agreement form is sent to all members and must be signed and returned by each. In approving loans, the following guidelines are used: (a) A prospective Oxford House recovery home must have the support of its Chapter. (b) The members of the house must demonstrate that they will be capable of repaying the loan; usually this means two-thirds of the house will have reliable incomes. (c) There must be a signed lease agreement before a loan is granted. (d) It is strongly recommended that loan applicants do not use other house members or loan applicants as references.

The typical turnaround time for a loan application is two weeks. Staff work closely with applicants to help them through the application process.

As previously mentioned, 25 new loans were made during FY 2005. Repayments totaling $60,477.83 were received during this same year. In response to late or missed payments in some homes, the late fee was increased and some loans were restructured or are in the process of being paid off by sponsoring chapters.

Managing entity, agreement and monitoring. EMO, a private, non-profit corporation, continued to administer the revolving loan fund. The management of the fund by EMO was through a direct contract with the AMH. The department monitored the fund and loan operations through monthly reports submitted by EMO. The reports indicate the last payment from each house, the current balance for each loan, and any late fees. The report is accompanied by deposit slips, the monthly bank statement for the fund, and individual recovery home statements. The report identifies new loans, loans paid off, and repayments. There are copies of all checks received or sent to recovery homes for that month.

Changes from previous year. None

The following entities received loans from the revolving loan fund during FY 2005.

Name of House	**Loan Amount**
Marlin	$1,800
Mellow	$1,942
Ridgegage	$4,000
Capitol	$4,650
Blue Moutain	$4,000
Center	$4,012
McMinnville	$2,500
Flamingo	$5,000
Silverton	$1,500
Belmont	$2,500
Serenity	$5,000
Raintree	$5,000
Greer	$2,500
Greg Wolf	$4,000
West Salem	$4,600
Clackamas Hills	$5,000
Parrott House	$5,000
Lincoln Beach	$3,500
The Elements	$4,000
Ramona	$2,500
Sikora	$5,000
Oasis	$4,000
Dry Creek	$2,500
Elm Street	$4,000
Taylor Park	$2,500
Total	**$91,004**

Oregon

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 45 C.F.R. 96.130 and 45 C.F.R.96.122(d)).

- Is the State's FY 2008 Annual Synar Report included with the FY 2008 uniform application?
  Yes No
- If No, please indicate when the State plans to submit the report:
  mm/dd/2007

Note: The statutory due date is December 31, 2007.

Goal #8: An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and to enforce such laws in a manner than can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18. (See 42 U.S.SC. 300x-26, 45 C.F.R. 96.130 and 45 C.F.R. 96.122(d)).

- Is the State's FY 2008 Annual Synar Report included with the FY 2008 uniform application?
  ☐ Yes ☒ No

- If No, please indicate when the State plans to submit the report: 11/01/2007

Note: The statutory due date is December 31, 2007.

Oregon

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #9: FY 2005 (Compliance):

Objectives:

- Oregon will ensure that providers give pregnant women preference in admission.
- Oregon will maintain requirements for providers to refer pregnant women to another provider when necessary to ensure immediate access to care.
- Oregon will ensure that contractors and providers continue to conduct outreach activities to inform pregnant women of the availability of treatment services.

Pursuant to the federal regulations and OAR 415-051-0000 through OAR 415-051-0070 and OAR 415-051-0110, AMH requires priority substance abuse treatment for all pregnant women and women with dependent children entering publicly-funded programs. Through the county financial assistance agreements, Oregon maintained its contract requirements that providers prioritize pregnant women for access to care. Contracts for state funded treatment providers require that, in the case of delayed admission, the program must provide interim services. These services include education and referral to counseling about infectious diseases, referral to prenatal care, referral to medical care, referral to self-help support groups, education about the effects of alcohol and drug use on the fetus, and crisis intervention.

Fully capitated health plans that manage the chemical dependency treatment benefit for the Oregon Health Plan are required by contract with the DHS to pass on to providers the mandate to see clients the same day for emergency care. Additionally, pregnant women and others requiring urgent care must be seen within 48 hours and IV drug users must be seen within 10 days for routine care. AMH and the DMAP jointly monitor compliance with these requirements through onsite reviews and contract audits.

Goal #9: FY 2007 (Progress):

Pursuant to the Federal Regulations and Oregon OAR 415-051-0000 through OAR 415-051-0070 and OAR 415-051-0110, the AMH requires priority substance abuse treatment for all pregnant women and women with dependent children entering publicly-funded programs. AMH continues to monitor contract compliance through onsite inspections, reviews and audits. For pregnant women who are involved in the child welfare system or the self-sufficiency (TANF) system components of the DHS, capacity for screening and linking these women to services has been enhanced throughout the state at the local Service Delivery Area (SDA).

Goal #9: FY 2008 (Intended Use):

AMH will continue to monitor contract requirements and compliance with administrative rules through onsite inspections of providers. Inspections consist of clinical record reviews, staff interviews, and reviews of program documents. Using the checklist developed in 2004, AMH will continue to monitor providers to assure that they are meeting the requirements of prioritization of pregnant women and delivery of interim services. Fully Capitated Health Plans (FCHP) will also continue to monitor their providers for contract compliance. AMH will continue to partner with the department's child welfare and self-sufficiency (TANF) areas in an effort to improve and enhance case coordination and linkages to provide more immediate access to treatment services for pregnant women. AMH will work with CMHP to improve transportation options for pregnant women receiving treatment.

Oregon

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G: Capacity Management

AMH contracts with all thirty-six counties and nine tribal governments to provide alcohol and drug treatment and prevention services. Counties have the first right of refusal to directly provide services or subcontract them. Counties are required to develop comprehensive implementation plans each biennium outlining how they will deliver services along the continuum of care for all population groups, including intravenous drug users and pregnant women. The plans result in contracts that outline specific funding amounts for each service type. Residential services are funded and paid for in terms of bed days. Should a subcontractor within a county not meet utilization, counties may shift resources to other providers. Should the county fall short, resources may be shifted to other regions.

Counties are paid for residential services based on full utilization of the contracted number of bed days. Residential services are monitored each quarter by matching CPMS data with OHP encounter data. Financial recoupment occurs in counties that are underutilized or providing less than the contracted amount of bed days. Residential programs are required to maintain their own waiting lists. Procedures for ensuring priority admission for pregnant women and IV drug users are reviewed and monitored during the onsite review process.

Utilization for outpatient services is monitored based on CPMS data submitted and verified during onsite program reviews. Until March 2003, outpatient programs rarely had waiting lists, as a result of the inclusion of alcohol and drug treatment coverage in the Oregon Health Plan (OHP) in 1995. However in March 2003, this benefit was limited to only those categorically eligible for Medicaid. This reduction in coverage significantly limited outpatient treatment capacity in some areas. On August 1, 2004, chemical dependency treatment coverage was restored to a relatively small number of people. FCHP, which provide alcohol and drug treatment coverage for the categorically eligible in OHP are required by contract to pass on to providers the mandate to see clients the same day for emergency care. Additionally, pregnant women and others requiring urgent care must be seen within 48 hours and IV drug users must be seen within 10 days for routine care.

AMH has historically issued quarterly quality improvement reports to the counties. The reports provided outcome information regarding total services delivered in each county and for each of the subcontracted providers. These reports are currently being developed to capture and report more relevant outcome measures, including access and engagement. The data for these reports is provided by CPMS.

Oregon is a participant in the Robert Wood Johnson Foundation's Resources for Recovery project. Oregon's work in this area has focused on developing a more recovery-oriented system of care, through linking levels of care and developing recovery support services. As part of this project, there has been discussion about developing an integrated residential waitlist, although logistic barriers have prevented its implementation. This project will continue to explore overcoming these obstacles.

AMH has also initiated the Behavioral Health Data Improvement Project. This project is currently focused on developing system requirements for a new data collection and reporting

system. This system will eventually replace CPMS and potentially other legacy systems. One of the primary system requirements that have already been identified is waitlist/capacity management. This system is several years from implementation.

Oregon funds a statewide toll-free information and referral phone system through the Oregon Partnership to ensure access to information regarding the availability of treatment or prevention programs or specific services throughout the state.

Oregon AMH received a Performance Partnership Grant Core Technical Review on October 30, 2006. The Center for Substance Abuse Treatment (CSAT) recognizes that Oregon needs some help in this area. CSAT recommends technical assistance to develop a state monitoring system or prioritize pregnant women and women with dependent children. This item is identified as a top priority in the SSA in the response to CSAT for the core technical review.

The total amount of funds expended to comply with the requirement to develop capacity management and waiting list systems for intravenous drug user and pregnant women is $192,775.

Oregon

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #10: An agreement to improve the process in the state for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

Objective: AMH will continue to improve the process for referring individuals to the most appropriate treatment.

FY 2005 (Compliance):

The division adopted the American Society of Addiction Medicine Patient Placement Criteria, 2nd Edition Revised (ASAM PPC-2R) in 2002 for outpatient and residential programs. At that time, AMH also implemented a training and technical assistance program to ensure adoption of ASAM PPC-2R at the program level

In 2003 the rules for Synthetic Opiate Treatment Programs (SOTP) were changed to include ASAM PPC-2R. Prior to the change, SOTP rules described two levels of treatment (stabilization and maintenance) and prescribed minimum treatment contacts regardless of individual needs. The changes were made in response to changes in federal rules and recommendations from various sources, including the 1997 NIH Consensus Statement on Effective Medical Treatment of Opiate Addiction. The change allowed providers significantly increased flexibility in treatment placement by removing administratively mandated treatment contacts and allowing individualized treatment.

Throughout 2005, AMH monitored program compliance in implementing and utilizing ASAM criteria through regulatory onsite inspections. The division continued to provide technical assistance and consultation for providers as needed in an effort to enhance the utilization of ASAM criteria among outpatient (including synthetic opiate treatment programs) and residential providers in 2005.

Goal 10
FY 2007 (Progress):

ASAM PPC-2R remains a statewide standard to provide a clinical terminology and a system for placement consistent with national standards. ASAM PPC-2R is also a more effective tool for placing clients with co-occurring disorders in appropriate services.

The division continues to monitor implementation and utilization of ASAM PPC-2R through regulatory onsite inspections and technical assistance activities statewide. Use of the criteria is enforced by entities managing the Oregon Health Plan chemical dependency benefit, the managed health plans known as FCHP, in the quality assurance and utilization management functions carried out to ensure appropriate placement and utilization of services.

The division is still involved in an administrative rule revision process including rules governing the provision of mental health and addiction services. Two of the primary goals driving this rule revision relate to improving the process for referring individuals to the most appropriate treatment and include promoting service continuity and promoting recovery and resilience. In addition to this effort, the division adopted a Resilience and Recovery Policy Statement during 2006. The policy statement reads: AMH promotes resilience and recovery for people of all ages who experience or are at risk for psychiatric and/or substance use disorders. The principles of resilience and recovery guide services supported by AMH. Recovery must be the common outcome of services. AMH develops and supports policies consistent with the principles of resilience and recovery. Policies governing service delivery systems will be age and gender appropriate, culturally competent, evidence-based and trauma informed and attend to other factors known to impact individuals' resilience and recovery. The statement is intended to guide AMH efforts to promote a more recovery oriented system of care and to recognize resilience as "a universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity." Further, "resilience reflects a person's strengths as protective factors and assets for positive development."

Referral to appropriate treatment modality is important, however, AMH is also concerned with treatment access and retention in the appropriate levels of care to promote positive clinical outcomes. Client access to and retention in publicly funded outpatient treatment is affected by a number of factors. Some of these factors include inadequate funding, reduced workforce development, excessive and duplicative paperwork, inadequate data collection and analysis, and ineffective transitions between levels of care. AMH is participating along with four other states in the NIATx 200 project funded by NIDA. This project will assist the state, intermediaries, and providers to use data to inform program decision-making improving outcomes associated with the NIATx aims to improve access, engagement, and retention.

Goal 10
FY 2008 (Intended Use):

AMH will continue to offer training and technical assistance aimed at increasing provider competency in the use of ASAM PPC-2R. The division will also continue to monitor implementation and compliance through onsite client record reviews. These reviews will also serve to identify technical assistance needs. As we progress through the process to revise administrative rules, maintaining focus on developing a system of care approach will be key so that the publicly funded chemical dependency resources are used in the most efficient and clinically appropriate manner. AMH will also provide training and technical assistance to NIATx 200 provider participants related to data collection protocols and will offer feedback to the providers in the form of formal and informal reports based on the data that capture the NIATx aims: access, retention and engagement.

Oregon

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b))

FY 2005 (Compliance):
The Addictions and Mental Health Division (AMH) workforce development plan and activities facilitate the implementation of our mission which is "promoting recovery (and resiliency) through culturally competent, integrated, evidence-based practices treatments of addictions, mental illnesses, and emotional disorders."

The AMH workforce development unit, in support of the division's mission, offers technical assistance and training in four primary focus areas: essential, evidence-based practices (EBPs), integrated services and culturally competent/trauma informed programs. Definitions of the four areas follow:

- **Essential:** Those efforts, which facilitate compliance with federal, state and agency rules including National Outcome Measures (NOMS).
- **Evidence-Based Practices:** Those efforts, which support the identification, implementation and sustainability of EBPs.
- **Integrated Services:** Those efforts that support the delivery of integrated services to those with both a mental health and substance use disorders and efforts that integrate client recovery services.
- **Culturally Competent and Trauma Informed Programs**: Those efforts that facilitate the implementation of AMH policies regarding program development in these areas.

FY 2005 (Compliance):

AMH provided the following services in meeting its charge and in compliance with the requirements and commitments made in the block grant application.

Essential
AMH provided technical assistance and training to facilitate provider compliance with federal, state and agency rules. Examples include:
- Delivering American Society of Addiction Medicine ASAM PPC-2R training to over 150 substance abuse providers;
- Delivery of courses facilitating complete and accurate AMH data collection forms for treatment, CPMS to over 120 participants;
- HIPAA and confidentiality regulation compliance to 170 addictions professionals;
- Ethics to 40 providers; and,
- HIV andiInfectious diseases to 120 substance abuse professionals.

Evidence-Based Practices (EBPs)
AMH supports the delivery of EBPs to clients, families and communities. Examples of events designed to support implementation and maintenance include the following:

- Four day institute, "The Leading Edge: Shaping the Future of Recovery", for over 300 professionals in partnership with the Northwest Institute of Addiction Studies (NWIAS);

- Training and technical assistance for implementation of Motivational Interviewing (MI) to over 100 participants statewide;
- Follow-up technical assistance to 30 providers who implemented the Matrix Model; and,
- Clinical supervision to over 50 clinical supervisors in collaboration with Northwest Frontier Addiction Technology transfer Center (NFATTC).

Integrated Services
The following are examples of workforce development efforts to integrate and increase the delivery of culturally competent and trauma informed services:

- AMH, in collaboration with Head start, the Commission on Children and Families and the Department of Education trained 175 substance abuse, child care and education professionals in effective models for identifying, treating and case managing young children and their families affected by substance use;
- AMH facilitated the Oregon Underage Drinking Summit for 172 professionals who met to develop strategies and plans for their communities; and,
- Delivered the course "Outreach and Case-Management for People with Co-occurring Disorders" to 170 mental health, substance abuse and housing professionals to reduce homeless among this population.

FY 2007 (Progress):
AMH workforce development unit focused efforts this year on service and systems improvement efforts including integration of substance abuse and mental health services, EBPs their implementation with fidelity and certification of prevention specialists.

Service and Systems Improvement Projects
The following projects are examples of efforts to meet the NOMs of increased access to service, retention in treatment, and cost effectiveness as well as teaching successful implementation of change processes that will facilitate change needed to improve outcomes:

- Ten addictions prevention and treatment programs participated in the Service Improvement Project (SIP). Each program was trained in and received coaching from an AMH staff and a previously trained peer coach for nine months in the SAMHSA "Change Book" process as well as the NIATx change model. Changes ranged from increasing access to implementing Motivational Interviewing and Matrix Model EBPs.
- The Change Leadership Project provided individual development plans and practice for providers in the management of change in behavioral health care systems. AMH participated in the NFATTC's leadership project with 25 providers, many of whom were people in long-term recovery. Each of the participants received training in change management.
- Training and technical assistance were provided on site for three programs implementing "Integrated Dual Disorder Treatment" toolkit. Each program was at a different place in the implementation process and the project including fidelity reviews will continue for up to one year.

Evidence-Based Practices
AMH efforts to meet Oregon's legislative mandate to expend funds on EBPs and support the spirit of the NOM regarding use of EBPs are supported by the workforce development's unit's effort to "increase the relevance, effectiveness and accessibility of training and education in providing EBPs". The following are examples of those efforts:

- The Fidelity Project provided training for AMH staff and peers with expertise in one of the EBPs identified by AMH in research, fidelity reviews and change processes. Programs included Matrix, Drug Court, Seeking Safety, and current efforts are underway to train prevention professionals in delivering Strengthening Families Program 10 – 14 with fidelity. The teams of two, AMH staff and the peer reviewer conducted fidelity reviews of programs who applied to be reviewed. (The process and results are now being reviewed.)
- Learning events were delivered on the following; Motivational Interviewing, Clinical Supervision, Dialectal Behavioral Therapy, Co-occurring Disorders, Brain Development and Cultural Competency, Medicated Assisted Therapy for Opiate Dependence, Fetal Alcohol Syndrome Disorders (several to specific tribes), and Ethics.
- AMH continued to provide trainings to meet administrative requirements such as CPMS.

Certification of Prevention Specialists
In support of the Annapolis Coalition goal to "Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness," AMH delivered the majority of course requirements to a state-wide co-hort of 25 prevention providers who need to become certified based on new regulatory requirements established by the Division in the OAR governing community substance abuse prevention programs. In addition, AMH provided

training to meet the hours of those currently certified including ethics, pharmacology, evaluation, and other requirements. AMH co-sponsored the Violence Prevention Institute and is co-sponsoring the National Prevention Network conference to be held in Portland this year with Washington and Alaska.

Goal #11: FY 2008 (Intended Use):

AMH workforce development unit plans to focus on the following goals in the next two years:

- Developing skills and resources to facilitate provider ability to meet the NOMs including implementation of EBPs and increasing access/capacity and treatment retention.
- Significantly expanding the role of individuals in long-term recovery to provide care and supports to others and fostering leadership development among all segments of the workforce.
- Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.
- Delivery of culturally competent and trauma informed services and programs in alignment with the Division's cultural competency plan and trauma policy.

Evidence-Based Practices: Implementation, Fidelity and Sustainability
AMH will continue with the System Improvement Projects using the NIATx model and Change Book model to help programs select and implement EBPs. At least 30 programs will participate in the NIATx 200 project to increase access, retention, and engagement and understand how to apply effective management strategies including using data to improve clinical outcomes. The division will continue to train, develop peer reviewers and conduct fidelity reviews during 2008.

AMH will continue to provide trainings, technical assistance, and immersion projects to identify, implement and sustain the following EBPs: Motivational Interviewing, Matrix Model; Integrated Dual Diagnosis Treatment using COMPASS as a fidelity tool, Drug Courts, Medication Assisted Recovery and Clinical Supervision.

Members of the NIATx 200 will receive scholarships to attend a leadership series sponsored by Portland State University as well as other leadership development courses approved by AMH.

AMH will continue to work with counselor accreditation bodies, universities and community colleges to ensure that curricula related to mental health and addiction services focus on prevention and treatment EBPs.

Significantly expand the role of individuals in recovery to provide care and supports to others
AMH will deliver training and technical assistance statewide on "Building Recovery Oriented Systems of Care Using Peer Delivered Services". We plan to support a conference for "families in recovery" with NFATTC and PSU with a mentoring component. People in recovery and family members will be accepted into leadership trainings including one co-sponsored by NFATTC and will participate in the development of competencies for those delivering peer supports.

Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.
AMH will deliver a Prevention Specialist Institute to provide course work and preparation for people to be certified. Leadership development and working with the recovering community will be included as elements of this work. AMH will provide statewide training and technical assistance for three EBPs: Communities that Care, Strengthening Families Program 10 – 14 and

Parent Child Interactions Therapy. AMH prevention staff will provide technical assistance on-site for implementing practices identified by CSAP and the National Registry of Evidence-based Practices and Programs (NREPP).

Delivery culturally competent and trauma informed services
AMH will deliver training and technical assistance to support the implementation of AMH's policies promoting culturally competent and trauma informed services.

These are examples of those efforts; on site training on the EBP "Seeking Safety", co-sponsorship of a conference on the culture of poverty, conference sessions on gender specific treatment models, and the incorporation of the policies, suggestions for implementation in all AMH workforce development offerings.

The 2007-09 AMH training plan reflects integration of training projects for the prevention and treatment of mental health, substance abuse, and problem gambling (See Appendix for 2007 – 09 AMH Workforce Development Plan). More information regarding the workforce development plan is available from Shawn Clark, AMH Workforce Development Manager, 503-945-9720, shawn.clark@state.or.us

Oregon

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #12: An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28© and 45 C.F.R. 96.132)).

FY 2005 (Compliance):

Through the use of biennial county implementation plans, the AMH ensures collaboration between state and local partners and stakeholders in planning for and delivery of prevention and treatment services.

Counties and tribes were required to submit biennial plans for treatment and prevention services that include written collaboration agreements with significant community partners, including corrections child welfare, employment, TANF, education and the local Commissions on Children and Families. Senate Bill 555 (passed in 1999) continues as a legislative mandate to collaborate planning and delivery of services for at-risk youth and their families.

Contracts with providers continue to require collaboration, with special emphasis on FCHP providing member services for at-risk youth and their families. Administrative rules continue to require providers to document collaboration and referral in clinical and service records, which are monitored during the onsite review process.

Goal #12: FY 2007 (Progress):

State statutes continue to mandate collaboration among all state and local partners providing services to children 0-18 and their families. State and local partners include those agencies and organizations providing planning and services relating to ATOD alcohol and drug treatment, mental health/co-occurring disorder treatment, juvenile justice prevention, teen pregnancy prevention, school retention, positive youth development, early childhood development systems and others. An executive order signed in July 2002 reinforced the requirement for collaborations at the state and local levels described in state statutes. This executive order also required state agencies to work collaboratively to develop formal interagency agreements and required the development of a state plan for the planning and delivery of services for children 0-18 and their families.

AMH and partners in Oregon's child welfare agency, DHS Children, Adults and Families, have worked extensively to coordinate services. In 2007, AMH and child welfare agencies continued working to ensure close collaboration between alcohol and drug treatment providers and child welfare field staff. Child welfare continues to staff branch offices with alcohol and drug specialists who assist conducting screening services and providing linkage and referral for families who need access to treatment services.

AMH continues to coordinate services with the Department of Corrections and local community corrections agencies. Oregon has been a leader in developing treatment drug courts, and in 2006 the Oregon Governor's Methamphetamine Task Force, Addiction Treatment Subcommittee recommended a broad expansion of treatment drug courts statewide.

AMH collaborated with the OYA in 2007 to implement substance abuse services, transition, and community support for youthful offenders with substance abuse problems who are ready to be released from correctional facilities. The OYA is piloting the implementation of the Global Assessment of Individual Needs (GAIN) assessment tool and the Cannabis Youth Treatment Series manuals in one of its programs in an effort to implement evidence-based practices. AMH, with OYA, submitted a technical assistance request to CSAT to support training and implementation of components of the Cannabis Youth Treatment / Motivational Enhancement Therapy protocols. Training and technical assistance events began in fall 2006.

AMH continues to work closely with the state tobacco prevention and education program to ensure that planning and service delivery at the state and local levels strengthen the continuum of care for all Oregonians. Additionally, planning and services are closely coordinated between prevention and treatment, and with other state agencies such as Juvenile Justice and the Department of Education in the area of underage and high-risk youth alcohol use.

New Initiatives and Integration: On March 27, 2007, Governor Theodore Kulongoski signed an executive order to implement statewide the transformation of the delivery of behavioral health services to Oregon's children, young people, and their families. The order creates the Statewide Children's Wraparound Steering Committee, charged to create a plan that will: 1) provide services and support as early as possible so that children can be successful in their homes, schools and communities; 2) make services available based on the individual needs of the child

and family – rather than on system requirements; and 3) maximize the resources available to serve children and families across systems, so that services most appropriately and effectively meet the behavioral health needs of Oregon's children. The substance abuse prevention and addiction services for children and adolescents is an important component of the service delivery system for children, youth and families and one that will be integrated into the Wraparound model. In the coming months, a final report from the steering committee will be published and plans for administrative, budget and financing, as well as workforce development and policy alignment to this model will begin taking shape as Oregon moves toward implementing this approach statewide.

AMH, DMAP, and PHD have been working with many partners on a variety of initiatives that relate to behavioral health and primary care. In particular the need for these two areas of care to be more closely linked and integrated has been recognized for some time. Challenges in the current system of care will be considered from the perspectives of the client/consumer, clinic, managed care, mental health, emergency room, or primary care practitioner. This work will continue into the next biennia and will be a major focus for AMH, state and local partners in primary and behavioral healthcare.

Goal #12: FY 2008 (Intended Use):

DHS will continue consolidation and integration efforts. During 2008, AMH will move forward on the following collaboration efforts:

- AMH will continue to work on enhancing service system infrastructure and financing strategies to increase capacity to provide accessible, effective, comprehensive, integrated, and evidence-based treatment services for persons with co-occurring substance abuse and mental health disorders.
- AMH will continue to collaborate with the Governor's Task Force on Methamphetamine, the Criminal Justice Commission, and the Oregon Judicial Department to implement the legislatively mandated expansion of drug treatment courts.
- AMH will continue to work on increasing collaboration between treatment providers and child welfare field staff.

In 1999, Oregon legislatively included comprehensive planning for implementation of prevention services as a requirement. The coordinated and comprehensive state level planning process described in this legislation is now known as "Partners for Children and Families." This process included the AMH, the Juvenile Justice Commission, and the Commission on Children and Families. However, Oregon's nine federally recognized tribes and the Asian Pacific American Community Support and Service Association (APACSA) were not included. Therefore, AMH and the Juvenile Justice Commission will continue to meet with the tribes and APACSA quarterly. Other agencies such as the OYA, State Tobacco Prevention and Education Program, Suicide Prevention, Indian Health Services, Oregon Department of Education and other guests attend these meetings for coordination and collaborative planning.

The overall strategies will continue to focus on reducing underage drinking, implementing community development strategies and improving parenting skills. AMH will also add a focus on methamphetamine prevention to correspond with the Governor's Methamphetamine Task Force efforts. Efforts to strengthen the implementation of evidence-based school prevention strategies into the programs and services offered throughout Oregon's K-12 educational system will continue to be a priority.

Since 1995, the AMH prevention unit has utilized data collected from the counties. This data is published as county profiles and is used in each county as part of their planning process. AMH uses the risk and protective factor framework and the information provided in the Oregon Healthy Teens Survey. With this data, the division can estimate the number of youth, families, and communities who would benefit from the three levels of prevention services. These are universal, selected and indicated. Counties use this demographic information provided by AMH for targeting population groups by age, gender and ethnicity. AMH has received technical assistance through CSAP in redesigning the county profiles to be in line with the NOMs and to serve as a useful tool for state and local policy makers in carrying out the stages included in the Strategic Prevention Framework. The county profile is an information and data resource that will assist Counties in 2008 by:

- Providing a snapshot of substance abuse, poverty, and other risky behaviors.

- Summarizing risk factors and protective factors for each domain: community, school, family, and individual/peer domain.
- Guiding counties in their efforts to focus services on the highest need as indicated by this data.

Services will be offered at the local level through contracting, partnerships, and statewide use of AMH prevention staff and statewide contractors. Targeted technical assistance will be provided by AMH prevention specialists to assist counties and tribes to analyze the risk and protective factor data, identify effective strategies for their target populations, and implement evidence-based prevention strategies and programs.

The Oregon Children's Wraparound initiative will be a major emphasis for the AMH adolescent alcohol and drug treatment provider system and the substance abuse prevention system. The final report from the Oregon Children's Wraparound Steering Committee will be available mid-October 2007 and will provide the foundation for policy, administrative and financing changes that must be implemented throughout the child and family service delivery system to fully implement Oregon Children's Wraparound. This work is expected to be carried out over the next 4-5 years and is a major system change initiative for AMH and partners serving children with behavioral health needs and their families.

The primary and behavioral health integration project is another major system change initiative for AMH and the department. AMH is exploring the Screening, Brief Intervention, Referral and Treatment (SBIRT) model with partners in primary care including the FCHP, primary care providers, Oregon Health and Science University and others as a component of this effort. AMH is monitoring SAMHSA's discretionary grant programs web site for release of the SBIRT announcements and maintaining formal and informal contacts with stakeholders who have expressed an interest in partnering with AMH on this opportunity.

Oregon

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2005 (Compliance):
AMH provided alcohol and drug treatment and prevention services through counties, tribal centers, and direct contractors. Allocation of resources and service delivery were guided by county and tribal level plan developed with technical assistance from the AMH. AMH provided county level estimated needs for treatment and prevention services that augmented and enhanced local special need identification and prioritization of services. AMH also worked with county planning committees on identifying high risk and/or underserved populations and trained prevention coordinators and providers.

AMH awarded grants to counties, tribes, and direct contractors on a competitive basis. County and tribe grant applications identified and prioritized special needs for women, women with children, and minority populations particularly African Americans and those with Hispanic and South East Asia background. Direct contractors and county contracted providers provided treatment services in a residential setting to women, women with children and African American adolescents. AMH also provided housing services to children younger than 18 and whose parents are in residential treatment for alcohol and drug abuse. AMH working with counties and Indian tribes identified special needs for culturally competent treatment and prevention services.

AMH provided standard and intensive outpatient services across the state to those identified to have high need for treatment, those coming out of residential services and those who are on the wait list for residential treatment.

AMH performed preventive activities intended to strengthen protective factors and overcome temptations to abuse alcohol and drugs. There was special emphasis on school-based preventive activities including after school programs. Teaching parenting skills, basic life skills, and engaging unrepresented minorities in community activities dominated prevention efforts statewide.

FY 2007 (Progress):

AMH completed developing the SEOW to fully functional status. The SEOW is composed of comprehensive group of stakeholders including: agencies that supply or use data regarding alcohol, illicit drugs or tobacco; state, county and tribal substance abuse prevention coordinators; research organizations and universities; Governor-appointed councils and committees; and substance-related professional associations. The SEOW compiled three epidemiological profiles on substance use and consequences in Oregon -- one on alcohol, one on illicit drugs and another on tobacco use. The profiles include extensive data tables and charts showing levels, patterns, and trends in substance use on 75 indicators using data from 11 different data sources. The profiles also shed light on substance use related problems and their consequences by sex and age subgroups.

The AMH continued its implementation of the underage drinking program to reduce youth alcohol drinking, discourage early onset of alcohol drinking, and raise community awareness of the harm alcohol inflicts on the youth and the community. In 2007, the AMH launched a media campaign over statewide media and Oregon State University and University of Oregon sports radio networks to raise awareness about the danger of alcohol drinking. The media campaign encourages parents to talk to their children about alcohol and set and enforce rules to prevent damages associated with drinking before they happen. The AMH also financed a statewide multi-disciplinary training conference on enforcing underage drinking laws. Participants included law enforcement, treatment and prevention providers, judges, district attorneys, OLCC inspectors and community coalition members. The program also conducted public education, developed community coalitions, and strengthened local and state level youth access policies.

AMH continued working with stakeholders including the Indian tribes both at county/local and state level. AMH funded adult and youth residential and both Level I and Level II outpatient treatment services through county, tribal and directly contracted providers. AMH is providing alcohol and drug treatment enhancement or support services including housing for children whose mothers are in intensive outpatient treatment and are at risk of losing their children to the state child welfare programs. AMH provides non-clinical or housing services to children whose parents are in residential treatment and youth and adult residential treatment clients.

The outpatient treatment programs continued to serve those identified to have high treatment needs for alcohol and drug abuse, those coming out of residential treatment, and those on the waiting list for residential treatment. This continuum of care includes individual or group therapy; detoxification for those who need physical withdrawal; and methadone treatment services. Methamphetamine specific treatment services are partly provided in collaboration with other agencies to address parenting, employment, and housing issues. AMH works with other agencies to assure the reintegration of treated clients with their communities.

Life skills including parenting skills development classes are provided across the communities in English as well as in Spanish language when necessary. AMH provides funding and technical assistance to schools for school-based preventive activities provided to students and their families. Certain counties including Jackson county in Southern Oregon have identified specific

needs for high risk youth in general and for at risk middle school girls in particular. These at risk populations are the target of the life skills development activities youth, peer, and family education. Certain counties including Washington County have expanded their bi-cultural preventive and treatment activities to address identified needs for culturally competent services. The federally recognized Indian tribes are participating actively in AMH's preventive activities.

FY 2008 (Intended Use)

AMH intends to continue providing, both preventive and treatment services through the community of county, tribal, and directly contracted providers. AMH has estimated needs and demand for treatment services for 2008 (see Form 8). Financial assistance awards already awarded on a competitive basis for the 2007 - 2009 biennium based on identified needs. A wide range of local and state level stakeholders, preventive and treatment service providers, and county and state staff participated in identifying and prioritizing the critical needs in several dimensions including level of service, target population, and cultural competency. AMH provided guidelines, the necessary data, and technical assistance.

AMH will continue providing treatment services in a residential setting to pregnant women, women with children, and minorities. AMH will continue identifying and treating clients among the general population with demonstrated needs for treatment. Support services for dependent children and housing for those in residential treatment will continue in the 2008 fiscal year. Outpatient treatment (Level I & Level II), detoxification, methadone treatment will remain the core functions of the treatment program across the state. The growing methamphetamine abuse in urban and rural areas alike will be the focus of our prevention and treatment effort.

AMH intends through SEOW to, (a) update the state level epidemiological profiles; (b) develop and implement data improvement plan, county level epidemiological profiles, and web-based user-friendly interactive data system; and (c) submit state and regional level National Outcome Measures (NOMs). AMH also will continue its work on limiting youth access to alcohol through the underage drinking program.

Lack of resources continues to be of major concern at local and state level in meeting the growing need for preventive and treatment services.

Oregon

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal 14: The Addictions and Mental Health Division agrees to ensure that no program funded through the block grant will use funds to provide individuals with needles or syringes so that such individuals may use illegal drugs.

Objective: AMH will use its contracts to require that no contractor or subcontractor will use block grant or other AMH funds to provide individuals with hypodermic needles or syringes.

FY 2005 (Compliance):
AMH continued to maintain the relevant contract requirement and did not find any noncompliance during this period.

Goal 14

FY 2007 (Progress):

AMH continued compliance monitoring intermediaries and funded providers through the contract compliance and onsite review process. We have not found any noncompliance during this period.

Goal 14
FY 2008 (Intended Use):
The division will continue to monitor this requirement through the onsite review and contract monitoring process.

Oregon

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #15: FY 2005 (Compliance):

Objective: AMH will assess and improve the quality and appropriateness of block grant funded treatment services through independent peer review.

DHS, AMH, has designed and implemented an independent peer review process to be consistent with criteria and guidelines established in Public Law 102-321, Subsection 1943 (1) (A) and (B). The initial identification of the agencies and the peer reviewers started in 2005 but due to resource constraints and other priorities related to the 2005 Legislative Session, initiation of the peer review process did not take place until 2006.

GOAL #15: FY 2007 (Progress):

AMH has piloted a fidelity review project, ten programs were accepted, some SAPT block grant funded programs applied and volunteer peer reviewers in partnership with AMH staff are currently completing their assignments and reporting the results from the EBP fidelity reviews. Some of the practices reviewed include, Drug Court, Matrix, Seeking Safety and Strengthening Families Program. A report summarizing the process, the products, the results of the reviews and recommendations to AMH for direction in training, technical assistance and next steps will be distributed to the AMH EBP Steering Committee and Stakeholder Group for review and comment. The evaluations to date from the program staff indicate that the process was helpful and the preparation for the review should include teaching on the purpose of the review, the individual tool and how the points are determined etc. The providers indicate that they believe the process will improve their delivery.

Samples of preparation letters, report formats are available on the website.

Goal # 15: FY 2008 (Intended Use):

AMH will continue to implement an independent peer consultation/review process in 2008. The 2008 process will concentrate on EBP reviews using fidelity tools. DHS is adopting proven practices in addictions and mental health services. The Oregon Legislature directed DHS and four other state agencies to spend increasing shares of public dollars on evidence-based services, culminating in 75 percent by the 2009-11 budget period. Approved practices, which have undergone independent review, are found on the DHS Web site.

At least five percent of the programs funded with SAPT block grant dollars will participate in the process. The project goal is to conduct fidelity reviews and develop protocols for the AMH peer review fidelity process. AMH will review the 2008 process and make improvements and enhancements to the process by modifying tools, forms procedures, and recruiting additional programs and peer reviewers as appropriate. This report will provide the basis for discussion about trends in the application of addiction technologies and areas where technical assistance and targeted training is needed.

Oregon

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2006 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the Single State Authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2006 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

AMH is required by Oregon Revised Statute 182.525 (ORS 182.525) to report to the Legislature increasing proportions of expenditures supporting EBPs. By the 2007-09 biennia, 50% of AMH funds for those populations at risk of emergency psychiatric services and/or criminal or juvenile justice involvement are to support EBPs. AMH has proceeded on the assumption that all of its clinical and prevention services are subject to the requirements because of the elevated risk of the populations served with public funds, and has developed its plans and implementation processes accordingly.

Over the past several years Oregon's service delivery system has made substantial progress in the adoption of EBPs. AMH developed an operational definition of EBP for mental health, addiction and prevention services, established a policy and procedure for identifying, evaluating, approving and listing EBPs and programs. Oregon's efforts are the results of collaboration between providers, consumers, researchers, state agencies, managed care organizations and other stakeholders.

In 2006 and early 2007, AMH began focusing on fidelity of practice implementation for those practices that were fairly widely implemented according to provider surveys. Fidelity is important as the effectiveness of a particular EBP depends on how accurately the provider has followed or replicated the essential elements of the model defined in the research. Incomplete or ineffective adherence may result in outcomes not meeting expectations. AMH designed a pilot project to develop "peer" providers to conduct, evaluate and refine then teach other providers how to conduct fidelity reviews.

Fidelity Pilot Project

The Fidelity Pilot Project is the first time that AMH systematically trained and developed AMH staff and" peer" provider staff to perform fidelity reviews and deliver technical assistance as a result of the review. AMH began the fidelity pilot process by selecting the practices including mental health and substance abuse treatment and prevention practices. The following are the practices selected:

- Assertive Community Treatment
- Drug Courts-**substance abuse**
- Integrated Dual Disorder Treatment-**substance abuse and mental health**
- Illness, Management, & Recovery
- Matrix Model-**substance abuse----Based on use of the EBP**
- **Motivational Interviewing**
- Seeking Safety-**substance abuse and mental health**
- Strength-Based Case Management
- Strengthening Families Program **substance abuse prevention**

- Supported Employment
- Wraparound (Children's)

The goal of this project is to collect data and develop protocols for the AMH fidelity review process, to prepare AMH staff and "peer" providers to conduct fidelity reviews and increase provider knowledge about the implementation of the EBP practice reviewed. The long term goal is to develop a learning community comprised of "peer reviewers" and providers. As there are limited resources to pay for fidelity reviews, AMH is soliciting programs willing to lend staff to review practices and in turn have their practices reviewed by the "peer" providers from another program.

After selecting the practices to review, AMH initiated an application process to recruit substance abuse and mental health treatment and prevention providers to participate in fidelity review of the EBP they identified. Fourteen applications were received and ten provider programs were reviewed. (The list is available upon request.) Concurrently AMH opened an application process to recruit "peer" providers to participate in the fidelity pilot project as peer reviewers. AMH received 34 applications and accepted 10 providers to participate. Selection of providers was based on expertise in the area of the EBP practices selected as well as geographical representation. (This list is also available upon request.)

Training was provided to the "peer" reviewers along with AMH staff to establish process protocols, increase knowledge and understanding of research, and using fidelity tools /scales. Additionally, participants assisted by creating the forms to be used during the fidelity review and throughout the process. Teams were allowed three months to complete the reviews. Note, some of the reviews have not been completed but the project will continue until all have been reviewed and the final report with recommendations is complete and presented to the AMH management team, the EBP Steering Committee and the EBP stakeholder group.

Samples of the substance abuse programs reviewed and review findings:
(The programs were assured that this would not be public information so we are not listing the particular programs in this public document)

Drug Court
This program had implemented Drug Court for approximately eight years. The fidelity status of the program is rated as moderate. The strengths of the program are the team member's commitment to the participants, the process and those participants are positively recognized for their progress, including graduation and staff is knowledgeable about criteria for moving from phase to phase. Challenges related to implementing the program are limited resources, full participation from other agencies involved with the process, and lack of options for treatment and wraparound services due to the geographic location and size of county.

Matrix Model
This small rural program has been implementing the Matrix Model for approximately seven months. The program is implementing the model to 75% fidelity. Clients like the components of the model and it appears to be effective. Strengths of the program from the client's perspective are that the counselors "really care". The staff would like to learn more on how to improve

fidelity. Challenges of implementing the program were lack of personnel, difficulty in getting families involved and facilitation of social support groups.

(Matrix Model)-Motivational Interviewing
This corrections program has been implementing the Matrix Model for approximately fifteen months. The program is implementing the model to fidelity 80%. The program received over six months in training on Motivational Interviewing (MO) provided by AMH support prior to the fidelity review. Strengths of the program are staff committed to the model and seeking ways to improve their services. The biggest challenge is the on going involvement of co-leaders.

When most of the programs had been reviewed and reports written, the ten "peer" reviewers and AMH staff met to discuss what they experienced, learned and would recommend improving and sustaining the effort. The reviewers received official AMH certificates stating they were AMH approved fidelity reviewers. Though the report is not yet completed, the pilot was a success, the "peer" reviewers will continue to participate in fidelity reviews and AMH will continue to train providers in how to conduct their own fidelity reviews. AMH plans to continue to develop a cadre of "peer' provider fidelity reviewers.

Oregon

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. Part 2).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Goal #16: FY 2005 (Compliance):

Objective: Oregon will include a review of confidentiality compliance as a component of all alcohol and drug treatment provider license reviews.

The Oregon administrative rule standards require that providers of alcohol and drug treatment services comply with 42 CFR Part 2, the federal confidentiality regulations. As part of the site review process, staff from the AMH reviews a sample of clinical records to evaluate program compliance with the confidentiality regulation as well as other Oregon administrative rules. Licensing staff continues to provide ongoing training and technical assistance to assure providers understand and are in compliance with these regulations.

Goal #16: FY 2007 (Progress):

Oregon continues to maintain its requirements for compliance with federal and state confidentiality regulations and continues to monitor compliance through onsite reviews. With the addition of the HIPAA laws, the site review process found many providers remain confused around their responsibilities in complying with both HIPAA and 42 CFR Part 2. The division continues to work with providers to help clarify the differences and similarities within each of the requirements.

Goal #16: FY 2008 (Intended Use):

Oregon will continue to maintain and enforce its administrative rule standards protecting patient records from inappropriate disclosure. Trainings and technical assistance will continue to be provided as needed based on provider requests and site review outcomes.

Oregon

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions and Regulations).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Goal #17: An agreement to ensure that the State has in effect a system to comply with 42 C.F.R. part 54, Charitable Choice Provisions and Regulations.

FY 2005 (Compliance):

AMH did not contract with any faith-based prevention, treatment, or recovery support service providers in 2005.

Goal 17
FY 2007 (Progress):

AMH currently does not contract with any faith-based prevention, treatment, or recovery support service providers. If AMH did contract with faith-based providers, there would be requirements explicitly detailed in the contract(s) to provide notice, referral, and alternative services as outlined in the federal regulations.

The division established a partnership relationship with EMO in 2006, co-sponsoring two events designed to engage the faith communities in substance abuse prevention and recovery services. An initial, statewide "Faith Partners" meeting was held on May 23, 2006 and included representatives from multiple faith organizations from various denominations. Trish Merrill, Director for the Rush Center of the Johnson Institute, facilitated the meeting providing an overview of the Faith Partners in Prevention and Recovery model and national efforts to implement this model in other states. This meeting included a brief overview of the charitable choice provisions and regulations.

A follow up event focused on training teams from congregations was held in November 2006. This event provided "hands on" skill building for teams to implement prevention or recovery support services within their congregations. Teams also learned how to conduct a congregational assessment to determine what the perceived needs and strengths are in terms of addressing addiction issues and how to identify resources that exist within the congregation to apply to these needs.

Follow up work continues to be done throughout 2007 between AMH and EMO monitoring the progress of congregations who participated in the training events. AMH is scheduled to meet with the EMO board of directors and some of the congregation representatives who participated in the training described above in September 2007.

Goal 17
FY 2008 (Intended Use):

If AMH contracts with any faith-based providers in 2008, there will be requirements explicitly detailed in the contract(s) to provide notice, referral, and alternative services as outlined in the federal regulations.

The division will provide charitable choice information to potential faith-based providers who express an interest in providing substance abuse services during 2008. A formal letter describing the charitable choice provisions and regulations will be sent to any faith-based organization that contacts the division regarding interest in providing services governed by the division including substance abuse prevention or treatment.

State:
Oregon

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2007) to the fiscal year for which the State is applying for funds provide a description of the State’s procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☐ Use model notice provided in final regulations.
- ☐ Use notice developed by State (attached copy).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☐ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☐ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA’s Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

State:
Oregon

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Oregon

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Oregon

Dates of State Expenditure Period:
From 7/1/2006 to 6/30/2007

Activity	A. SAPT Block Grant FY 2005 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention* and Treatment	$12,286,254	$9,999,165	$1,160,492	$11,529,020	$	$
2. Primary Prevention	$3,276,334		$2,776,172	$1,292,710	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. Administration (excluding program/provider level)	$819,084		$	$	$	$
6. Column Total	$16,381,672	$9,999,165	$3,936,664	$12,821,730	$	$

*** Prevention other than Primary Prevention**

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Form 4ab

State:
Oregon

Form 4a. Primary Prevention Expenditures Checklist

	Block Grant FY 2005	Other Federal	State	Local	Other
Information Dissemination	**$327,633**	**$27,484**	**$12,927**	**$**	**$**
Education	**$655,267**	**$551,348**	**$258,542**	**$**	**$**
Alternatives	**$360,397**	**$110,214**	**$51,708**	**$**	**$**
Problem Identification & Referral	**$1,015,664**	**$1,397,803**	**$646,355**	**$**	**$**
Community-Based Process	**$458,687**	**$441,134**	**$206,834**	**$**	**$**
Environmental	**$458,687**	**$248,190**	**$116,344**	**$**	**$**
Other	**$**	**$**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$**	**$**	**$**
TOTAL	**$3,276,335**	**$2,776,173**	**$1,292,710**	**$**	**$**

Form 4b. Primary Prevention Expenditures Checklist

	Block Grant FY 2005	Other Federal	State	Local	Other
Universal Indirect	**$**	**$**	**$**	**$**	**$**
Universal Direct	**$**	**$**	**$**	**$**	**$**
Selective	**$**	**$**	**$**	**$**	**$**
Indicated	**$**	**$**	**$**	**$**	**$**
TOTAL	**$**	**$**	**$**	**$**	**$**

Form 4c

Resource Development Expenditure Checklist

State:
Oregon

Did your State fund resource development activities from the FY 2005 block grant?

☒ Yes ☐ No

	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	**$157,954**	**$129,234**	**$**	**$287,188**
Quality Assurance	**$39,341**	**$**	**$**	**$39,341**
Training (post-employment)	**$133,964**	**$14,884**	**$**	**$148,848**
Education (pre-employment)	**$**	**$15,733**	**$**	**$15,733**
Program Development	**$**	**$31,472**	**$**	**$31,472**
Research and Evaluation	**$19,670**	**$**	**$**	**$19,670**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$350,929**	**$191,323**	**$**	**$542,252**

Expenditures on Resource Development Activities are:

☐ **Actual** ☒ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:
Oregon

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
000001	OR100462	Region 1	$353,195		$261,332	$39,069	$	$
000002	OR301201	Region 5	$184,413		$147,851	$22,104	$185,330	$
000003	OR101032	Region 5	$51,036		$73,633	$11,008	$43,636	$
000004	OR104175	Region 5	$433,483		$264,358	$39,522	$	$
000005	OR900648	Region 5	$18,600		$7,584	$1,134	$43,636	$
000006	OR901562	Region 4	$553,425		$375,859	$56,191	$81,078	$
000007	OR750415	Region 5	$14,875		$	$	$43,636	$
000008	OR100900	Region 4	$66,686		$37,457	$5,600	$	$
000009	OR000361	Region 1	$109,062		$108,626	$16,240	$	$
000010	OR101502	Region 3	$54,970		$21,205	$3,170	$43,637	$
000011	OR104175	Region 5	$		$51,577	$7,711	$37,706	$
000012	OR101026	Region 1	$84,801		$	$	$264,139	$

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State:
Oregon

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
000014	OR100579	Region 3	$16,161		$2,620	$392	$43,636	$
000015	OR102526	Region 4	$14,875		$	$	$43,636	$
000016	OR101163	Region 5	$122,229		$112,317	$16,791	$	$
000017	OR102534	Region 4	$14,875		$	$	$43,636	$
000018	OR100538	Region 3	$198,864		$162,800	$24,339	$	$
000019	OR301367	Region 5	$31,414		$33,678	$5,035	$43,636	$
000020	OR101025	Region 3	$14,186		$31,772	$4,750	$	$
000021	OR100648	Region 4	$249,211		$164,439	$24,584	$	$
000023	OR900507	Region 5	$299,905		$251,184	$37,552	$43,636	$
000024	OR101034	Region 1	$5,950		$	$	$17,455	$
000025	OR900192	Region 5	$86,228		$144,960	$21,672	$61,091	$
000026	OR750126	Region 3	$183,099		$122,554	$18,322	$61,091	$

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State:
Oregon

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
000027	OR101874	Region 2	$365,471		$322,567	$48,224	$150,580	$
000028	OR000381	Region 3	$42,862		$56,989	$8,520	$43,636	$
000029	OR900796	Region 3	$359,109		$163,768	$24,483	$43,636	$
000030	OR000261	Region 4	$70,729		$53,132	$7,943	$61,091	$
000031	OR750530	Region 5	$33,585		$38,098	$5,696	$43,636	$
000032	OR750761	Region 4	$44,242		$59,800	$8,940	$33,664	$
000033	OR900556	Region 5	$82,412		$114,807	$17,164	$76,363	$
000034	OR750803	Region 5	$30,299		$31,409	$4,696	$43,636	$
000035	OR750092	Region 5	$30,499		$31,815	$4,756	$43,636	$
000036	OR900077	Region 4	$878,254		$527,421	$78,849	$76,363	$
000037	OR103540	Region 5	$34,614		$40,194	$6,009	$43,636	$
000038	OR102609	Region 4	$525,411		$293,689	$43,907	$132,068	$

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State:
Oregon

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
000039	OR103888	Region 4	$360,186		$351,316	$52,522	$61,091	$
000040	OR104035	Region 5	$33,504		$30,361	$4,539	$51,818	$
000041	OR301375	Region 3	$896,598		$856,797	$128,091	$150,580	$
000042	OR900739	Region 3	$101,394		$92,747	$13,866	$43,636	$
000043	OR900549	Region 3	$179,491		$120,203	$17,970	$76,363	$
000044	OR100090	Region 3	$599,367		$706,532	$105,627	$150,580	$
000045	OR102450	Region 5	$61,045		$63,725	$9,527	$92,665	$
000046	OR102096	Region 1	$3,284,656		$4,803,503	$718,124	$299,835	$
000047	OR900267	Region 3	$43,438		$46,046	$6,884	$61,091	$
000048	OR301391	Region 3	$33,257		$37,429	$5,596	$24,222	$
000049	OR750167	Region 5	$30,072		$30,944	$4,626	$43,636	$
000050	OR901331	Region 2	$1,079,840		$769,335	$115,016	$149,017	$

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Oregon

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
000051	OR100587	Region 3	$236,079		$157,580	$23,558	$61,091	$
000052	OR100926	Region 4	$14,875		$	$	$43,636	$
000053	OR101351	Region 2	$40,276		$	$	$30,877	$
000054	OR750407	Region 5	$147,079		$76,650	$11,459	$	$
000055	OR102567	Region 4	$21,543		$33,591	$5,022	$43,636	$
TOTAL			$12,821,730		$12,286,254	$1,836,800	$3,276,334	$

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PROVIDER ADDRESS TABLE

State:
Oregon

NO PROVIDER ADDRESSES LISTED

Prevention Strategy Report

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Student Assistance Programs [32]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Pregnant Women/Teens [2]	Multi-agency coordination and collaboration/coalition [43]	0
Drop-Outs [3]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Ongoing classroom and/or small group sessions [12]	0
	Mentors [15]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Violent and Delinquent Behavior [4]	Multi-agency coordination and collaboration/coalition [43]	0
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Mentors [15]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Information lines/Hot lines [8]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Student Assistance Programs [32]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
Physically Disabled [7]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Information lines/Hot lines [8]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Physically Disabled [7]	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
Abuse Victims [8]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Youth/adult leadership activities [22]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
Already Using Substances [9]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Already Using Substances [9]	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Student Assistance Programs [32]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	0
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0

Form 6a: Risk - Strategies (...continued)

State:
Oregon

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Homeless and/or Run away Youth [10]	Speaking engagements [6]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Mentors [15]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Recreation activities [26]	0
	Employee Assistance Programs [31]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Accessing services and funding [45]	0

TREATMENT UTILIZATION MATRIX

State:
Oregon

Dates of State Expenditure Period:
From 7/1/2006 to 6/30/2007 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**5,441**	**4,184**	**$392.00**	**$1,638,856.00**	**$100.00**
Rehabilitation / Residential					
3. Hospital Inpatient			**$.00**	**$.00**	**$.00**
4. Short-term (up to 30 days)	**5,389**	**5,025**	**$3,168.00**	**$15,918,501.00**	**$100.00**
5. Long-term (over 30 days)			**$.00**	**$.00**	**$.00**
Ambulatory (Outpatient)					
6. Outpatient			**$.00**	**$.00**	**$.00**
7. Intensive Outpatient	**40,581**	**30,989**	**$216.00**	**$6,707,864.00**	**$65.53**
8. Detoxification	**7,575**	**7,095**	**$433.00**	**$3,071,561.00**	**$30.00**
9. Opioid Replacement Therapy	**1,562**	**1,409**	**$325.00**	**$457,487.00**	**$4.47**

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Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Oregon

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AGE GROUP	A. TOTAL	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	5,031	2,503	1,654	178	70	20	4	30	22	212	188			85	65	3,028	2,003	603	237
2. 18-24	10,915	6,336	3,196	235	99	53	17	151	47	309	262			137	73	7,221	3,694	1,542	265
3. 25-44	28,053	15,284	9,109	844	418	112	40	264	73	801	704			256	148	17,561	10,492	3,404	485
4. 45-64	12,488	7,482	3,503	480	209	21	7	102	22	317	198			103	44	8,505	3,983	582	102
5. 65 and over	570	390	117	24	1			5	2	15	11			4	1	438	132	21	1
6. Total	57,057	31,995	17,579	1,761	797	206	68	552	166	1,654	1,363			585	331	36,753	20,304	6,152	1,090
7. Pregnant Women	1,228		1,051		49		2		9		89				28		1,041		93

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 20,022

Oregon

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations:

a) **Base rate for services to pregnant women and women with dependent children**

Oregon understands that money spent each year since 1994 must be equal to or greater than the 1994 amount. The 1994 cost for services women and women with dependent children was determined by using the block grant expenditures for 1992 and increasing this amount by adding 5% of the grant award for 1993 and 5% of the grant award for 1994. The resulting number was Oregon's base line MOE for women's services.

Since February of 1994, Oregon has transitioned many women to the Oregon Health Plan, whose contracted providers deliver, or make available, the full array of services as mandated in the CFR. The State's share of costs for these services is reported as part of the MOE.

Oregon counts women in five different program areas, compares the counts to total usage in each area, and develops percentages of women's services. Since 1999, Oregon has applied the percentage against the block grant expenditures as recorded in the State's accounting system (SFMS).

Oregon's MOE is reported on Table IV.

b) Base rate for TB services

Oregon uses data from the Public Health Office, Department of Human Services, which provides all services for TB.

To establish the baseline, the percentage of substance abusers was applied against total TB expenditure data for 1991 and 1992. The resulting amounts were averaged to give the MOE baseline. Since 1999, Oregon has used Health Division Data for total TB expenditures and percentages provided for substance abusers.

Oregon's MOE is reported on Table II.

State:
Oregon

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2005) + B2(2006) / 2 (C)
SFY 2005 (1)	$12,906,550	
SFY 2006 (2)	$12,821,730	$12,864,140
SFY 2007 (3)	$12,864,450	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2005 ☒ **Yes** ☐ **No**

FY 2006 ☐ **Yes** ☒ **No**

FY 2007 ☐ **Yes** ☒ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy): 1/31/2008

The MOE for State fiscal year(SFY) 2007 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount and the State fiscal year:** $0 | 0

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

TB (MOE Table II)

State:
Oregon

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$372,841	10%	$37,284	
SFY 1992 (2)	$399,239	10%	$39,924	$38,604

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2007 (3)	$212,285	24.06%	$51,076

HIV (MOE Table III)

State:
Oregon

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1993 (1)	$2,063,612	
SFY1994 (2)	$2,237,148	$2,150,380

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2007 (3)	$0

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

Womens (MOE TABLE IV)

State:
Oregon

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$1,872,018	
2005		$2,640,795
2006		$2,496,225
2007		$2,636,643

Enter the amount the State plans to expend in FY 2008 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $3,268,130

Oregon

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2008 application for SAPT Block Grant funds.

The Planning Process
Under the guidance of the Governor's Council on Alcohol and Drug Abuse Programs (GCADAP), AMH initiates and facilitates state and local level planning for alcohol and drug prevention and treatment services. Planning commences with AMH's county profiles document developed by AMH. The document provides county specific needs for alcohol and drug prevention and treatment services and describes prevention and treatment strategies consistent with the Institute of Medicine (IOM) spectrum of services model.

The planning process involves meetings and discussions among state social service agencies (Children, Adults and Family Services, Oregon Youth Authority, Department of Corrections, Children's Commission, and Department of Education), county level social service committees, local advisory councils, contractors, and advocates. These meetings discuss planning parameters and tools including the AMH's county profiles. The meetings develop strategies; set priorities, and establish criteria for delivering alcohol and drug prevention and treatment services to those who need them the most. As a lead agency, the AMH facilitates the planning process, provides technical assistance, and develops reports to share with all participants and the GCADAP. Specific plans are then developed by local councils and submitted to AMH for review and approval. Working both with the local councils and the GCADAP, AMH ensures that plans meet policy and financing requirements. Final plans are reviewed and approved by the GCADAP acting on behalf of the Governor.

AMH uses different data sources in developing the county profile document. Prevention and treatment needs for the adult (18+) population are assessed from the 1999 household survey funded by CSAT under the State Treatment Needs Assessment Program (STNAP). Prevention and treatment service needs for the youth (12-17) are based on the Oregon healthy teens school survey data. This survey is designed based on the Hawkins and Catalano's risk/protective factors model. The Public Health Agency in collaboration with others including the AMH administers the healthy teens survey annually. AMH also uses social indicator data from the CPMS and the statewide LEDS. Management makes decisions based on treatment needs prevalence information.

AMH developed its SEOW consisting of representatives of stakeholders, service providers, state administrators, and private/public researchers to fully functional status. The SEOW compiled three epidemiological profiles on substance use and consequences in Oregon -- one on alcohol, one on illicit drugs and another on tobacco use. These profiles provide extensive information for identifying problem spots and prioritizing services in the planning process. The SEOW will also assist AMH build capacity to report the prevention National Outcome Measures and conform to SAMHSA's Strategic Prevention Framework.

Sub-State Planning Regions
Oregon is divided into five sub-state planning regions. The first region consists of Multnomah County. Nineteen percent of Oregonians reside in this region, yet the region is the most populated one at 1,491 residents per square mile. At this rate, the region is 38 times denser than the state average. In 2006, this region accounted for 56%, 34%, and 40% of reported AIDS, HEP B and TB cases respectively. About two-fifth of intravenous drug users reside in this region.

The second region includes Clackamas and Washington counties.[1] About twenty four percent of Oregonians live in this region at 328 persons per square mile. In 2006, seventeen percent of AIDS cases and 14% of TB cases are reported in this region. The region also accounts for about 20% of Hepatitis B and 13% of intravenous drug users.

The third region consists of ten counties (Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, and Yamhill). This region has mixed frontier and rural characteristics. About 31% of Oregonians live in this region at a density of 82 residents per square mile. About a third of treatment recipients come from this region. About 15% of AIDS, 29% of HB and 27% of TB cases in 2006 were reported in this region. One-third criminal activities and about 29% of intravenous drug users come from this region.

The fourth region includes six counties (Coos, Curry, Douglas, Jackson, Josephine, and Klamath). The region has both rural and frontier characteristics. About fourteen percent of Oregonians reside in this region at a density of 28 persons per square mile. Seven percent of AIDS and 11% of HB cases were reported in this region in 2006. Tuberculosis prevalence is low at only 6% of reported cases in 2006. The region accounts for about 13% of those in need of treatment and 11% of intravenous drug users.

The fifth region consists of 17 counties (Baker, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Lake, Malheur, Morrow, Sherman, Umatila, Union, Wallowa, Wasco, and Wheeler). This is a rural region accounting only for 11.8% of the population at a density of 8 residents per square mile. Only 5.5% of AIDS and 13.6% of TB cases were reported in this region in 2006. Hepatitis B is low at only 6% cases reported in 2006. The region also accounts for 7% of intravenous drug users and 10% of those in need of treatment.

State and Local Level Advisory Councils

Oregon has both state and local level advisory councils. The GCADAP is a state level 11-member body designed intentionally to represent geographic regions of the State; at risk populations such as women, minorities, youth and the elderly; categories of alcohol and drug related professions; and non-professional alcohol and drug social advocacy groups. The Governor appoints members for a term of 4-years. To ensure public accountability, only individuals without conflict of interest are appointed and each member is eligible only for one re-appointment.

The major function of the GCADAP is to advise the Governor on the economic and social impact of alcohol and drug abuse; setting goals, priorities, and strategies for addressing alcohol and drug abuse issues effectively; developing and implementing alcohol and drug abuse prevention and treatment capacity; and monitoring alcohol and drug treatment and prevention programs.

Specifically, the Council oversees and coordinates the following activities.

- The assessment and description of alcohol and drug treatment and prevention needs,

[1] Clackamas and Washington counties along with Multnomah are collectively referred to as tri-counties. These are frontier and the most populated counties accounting for about 43% of the population, 72.5% of AIDS cases, 53% of TB cases, and 54% of hepatitis B cases reported in 2006.

- Development and implementation of statewide alcohol and drug prevention and treatment plans,
- The assimilation of priorities and recommendations contained in locally developed alcohol and drug related plans,
- Design and implementation of organizational capacity, and
- Setting criteria for the purchase and delivery of treatment and prevention services.

The Council receives all technical and financial support from the AMH.

Each county has a LADPC. Membership to these councils reflects the geographic and social diversity of the local community. These councils play vital role in the effort to develop and implement comprehensive and realistic alcohol and drug prevention and treatment plans. The councils are responsible to assist the GCADAP, AMH and other local planning committees to identify needs and set priorities for alcohol and drug prevention and treatment services.

Monitoring Process
AMH develops quarterly performance measures at county and provider levels. These indicators are designed to measure access to services, retention, and treatment outcomes relative to levels of need for those services. Observations are shared quarterly with local committees and contractors. Contractors with less than satisfactory performance are put on notice to take corrective actions. AMH provides technical assistance as necessary to contractors to ensure that those in need of treatment are adequately served.

AMH estimates the number of adults and youth who need alcohol and other drug treatment annually. The 1999 Oregon Household Survey of Adults provides the percentage of adults (18 and older) who are abusing or are dependent on alcohol and other drugs. This prevalence rate is applied to the current year's population estimates of adults by county to calculate the number of individuals in need of treatment. The youth estimates are derived by determining what percentage of the students surveyed have used alcohol and/or other drugs. This percentage is applied to county youth population to obtain the number of youth in need of treatment. Twenty percent of those in need of treatment are expected to actually participate in treatment.

AMH produces reports using data from the CPMS, quarterly Treatment Outcome Improvement Report (TOIR) and shares with county Mental Health Program Directors. The TOIR summarizes each county's performance measures including access to treatment. AMH measures access by the number of unduplicated individuals who received treatment during the year. This number is compared for each county to the annual demand for treatment services. Other performance measures the AMH shares with counties include Engagement, Completion, Retention, and Length of Stay.

AMH uses this performance related information to make recommendations to counties regarding County Biennial Implementation Plans. If a county does not appear to address access issues adequately, the AMH may reject or request amendments in county plans. Based on observations, AMH may also require changes that redirect funding from a specific service to another or from one group of population to another or from one county to another county. AMH monitors the

data continuously and may make changes in funding levels or categories at any point in the biennium.

AMH monitors prevention activities through three primary methods. First, each county/tribe is required to provide the Office with a biennial prevention plan and track activities and services through the use of the Minimum Data Set (MDS) for Prevention system. This allows the office to monitor activities and insure that populations identified in the county/tribal needs assessment are being served. Second, the office requires each county/tribe to complete an annual report on the services that have been provided. This report is compared to the original implementation plan to ensure that services are being provided to the intended populations. Third, a site review is conducted with county/tribe every two years. The purpose of the site review is to ensure that services are provided consistent with the relevant laws and administrative rules and identify problem areas and training needs. The OAHA then provides recommendations to address problem areas as well as training and technical assistance to enhance counties' capability to serve the needs of identified populations.

Public Comment

GCADAP and AMH are required by the Oregon Legislature to ensure citizen participation at both state and local levels in the development and execution of alcohol and drug prevention and treatment plans (ORS 430.255(2)(e)). The GCADAP and AMH use two constitutional tools to ensure public participation in planning for alcohol and drug abuse prevention and treatment services and developing annual block grant applications.

First, the GCADAP and AMH are required (ORS 430.250(2)(a)) to reflect local priorities and recommendations in their statewide plan for alcohol and drug abuse prevention and treatment services. Local plans are developed with broad citizen involvement (see planning process) and technical assistance from AMH.

Second, state social service agencies (Children, Adults and Family Services, Oregon Youth Authority, Department of Corrections, Children's Commission, and Department of Education) are required by the Oregon legislature as condition of budget approval (ORS 430.250(3)) to work with the GCADAP and AMH in preparing statewide alcohol and drug abuse prevention and treatment services plans.

Senate Bill 555 enacted in 1999 cemented this cooperative approach to planning by requiring agencies to work through the GCADAP and AMH with each other and local committees, councils, providers and advocates in developing a comprehensive statewide alcohol and drug abuse prevention and treatment services plans.

The AMH working with the Governor's Council on Alcohol and Drug Abuse Programs received inputs from several state and county level stakeholder meetings and public discussion forums. These expert and public opinions were used in developing both the State's biennial service plan and 2008 SAPT Block Grant application.

At state level, AMH and the Governor's Council on Alcohol and Drug Abuse Programs conducted a series of open public hearings at diverse locations throughout the state. In addition,

AMH regularly arranged and facilitated meetings between individual council members and representatives of local planning committees, including Local Alcohol and Drug Planning committees. AMH also coordinated the council's monthly meeting to synthesize and develop planning ideas. The council routinely received feedback and reports from alcohol and drug prevention and treatment providers, other state agencies, communities, and medical groups.

At the county level, Local Alcohol and Drug Planning Committees held several public hearings and facilitated public comments and crafted local service plans. The committees conducted regular meetings, at which public participation was encouraged and insightful inputs were received. The committees also participated in a varying array of public functions, such as open planning forums and meetings with local civic and service organizations to further enrich the outcome of the planning process.

Acronyms

AMH -	Addictions and Mental Health Division
CPMS -	Client Processing and Monitoring System
GCADAP -	Governor's Council on Alcohol and Drug Abuse Programs
IOM -	Institute of Medicine
LADPC -	Local Alcohol and Drug Planning Council
TOIR -	Treatment Outcome Improvement Report

State:
Oregon

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2008 block grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

_ Population levels, Specify formula:

_ Incidence and prevalence levels

_ Problem levels as estimated by alcohol/drug-related crime statistics

_ Problem levels as estimated by alcohol/drug-related health statistics

_ Problem levels as estimated by social indicator data

_ Problem levels as estimated by expert opinion

0 Resource levels as determined by (specific method)

_ Size of gaps between resources (as measured by)

and needs (as estimated by)

_ Other (specify):

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Oregon	2005

		3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 1	701,545	114,774	22,955	26,630	5,326	38,380	7,676	3,209	6,329	0	25.7	8.7	4.6

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 2	867,625	107,344	21,469	10,128	2,026	34,029	6,806	5,965	3,053	0	12.7	2.1	1.3

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 3	1,151,185	151,306	30,261	20,196	4,039	52,672	10,534	7,607	9,591	0	13.6	1.4	1.9

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 4	533,280	63,981	12,796	8,049	1,610	18,315	3,663	3,504	5,308	0	10.9	1.5	.9

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Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Oregon	2005

		3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 5	**436,870**	**49,500**	**9,900**	**5,316**	**1,063**	**16,070**	**3,214**	**3,170**	**4,019**	**0**	**7.8**	**1.4**	**2.5**

1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	**3,690,505**	**486,905**	**97,381**	**70,319**	**14,064**	**159,467**	**31,893**	**23,455**	**28,300**	**0**	**14.6**	**3**	**2.2**

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Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Oregon	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	42,649	0	0	0	0	0	0	0	0	0	0	0	0	42,649	0	0	0	0	0
2. 18 - 24	83,235	42,347	25,527	767	132	176	31	2,355	1,856	585	113	1,897	1,161	4,604	1,684	44,492	27,158	8,239	3,345
3. 25 - 44	231,295	120,953	68,288	3,046	1,128	380	128	9,283	8,233	2,046	635	3,731	2,160	8,113	3,171	128,482	75,855	19,070	7,889
4. 45 - 64	104,769	65,094	27,296	1,161	499	180	36	3,958	1,009	1,404	595	1,321	526	1,279	411	71,348	29,286	3,048	1,086
5. 65 and over	24,957	9,053	13,496	276	174	24	5	380	914	217	56	102	130	59	71	9,960	14,654	150	193
6. Total	486,905	237,447	134,607	5,250	1,933	760	200	15,976	12,012	4,252	1,399	7,051	3,977	56,704	5,337	254,282	146,953	30,507	12,513

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Form 9 Footnotes
In the 17 and Under category there is no gender breakdown, so the number in the male category is for both male and female.

Oregon

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

State and regional level estimated treatment needs are provided in Form 8. Form 9 shows the distribution of estimated treatment needs by age group, race and sex.

Adult (18 or older) treatment needs are estimated using prevalence rates from CSAT funded household survey administered in 1999. Youth (12 – 17 years old) treatment needs are estimated using prevalence rates from the 2006 Oregon Healthy Teens school survey data. The number of substance related criminal activities are obtained from the 2005 annual report of criminal offenses and arrests. The Oregon State Police publishes this report annually. Incidence rates of communicable diseases (AIDS, Hepatitis B, and TB) are obtained from the State's Communicable Diseases Reporting and Monitoring program data.

The household survey was administered over a period of ten months (March through December 1999) using computer assisted telephone interview (CATI) to minimize non-sampling bias. The sample was generated using a Random Digit Dialing (RDD) technology. At the end of the survey, 12,017 completed questionnaires were returned yielding a response rate of 56.6%.

The survey asked respondents about their general use of alcohol, marijuana, cocaine, methamphetamine, heroin, hallucinogen, and any other substance. Survey questions were developed to generate responses that indicate substance abuse and dependence based on the Diagnostic and Statistics Manual (DSM-IV) criteria of the American Psychiatric Association. Final prevalence rates were derived from statistically adjusted (weighted) survey data.

Adult (18 or older) treatment needs were estimated by applying race, sex, and age group specific regional prevalence rates to the corresponding 2006-estimated population. For example, for a population of group "X" defined by race, sex and age group with a prevalence rate of 'p_x', treatment needs were obtained as '$p_x n_x$' where 'n_x' is the corresponding population size. Prevalence rates for the Asian race group were applied to the Native Hawaiian/Other Pacific Islander race because the latter were not represented in the sample. Similarly, average prevalence rates across race groups were used to estimate treatment needs by other and two or more race categories. When a particular group in any region is not represented in the Survey population, the statewide average prevalence rate for that particular group is used.

Youth (12 – 17 years old) treatment needs were estimated by applying prevalence rates from the 2006 Oregon Healthy Teens school survey to the 2006 youth population. Prevalence rates among the youth population are defined as the proportion of those using alcohol or drugs at a high frequency in the sample. Youth treatment needs were not assessed by race, sex, and age due to low sample sizes.

Intravenous Drug Users

We estimated the number of intravenous drug users in need of treatment by applying the proportions of intravenous drug users in the treatment recipient population to those in need of treatment at the general population level. Intravenous drug use prevalence rates are the proportions of those who reported to the CPMS administering their drugs by injection to the total treatment population in SFY 2005/2006. One-fifth of those in need are expected to seek treatment.

Prevalence of Substance Related Criminal Activities
We estimated prevalence of alcohol and drug related criminal activities from the LEDS, which is instituted and maintained by the Oregon State Police (OSP). The Oregon State Police analyze and disseminate criminal justice information as authorized by the Oregon Legislature (ORS 181.730). The Office develops standards and procedures (ORS 181.715) for reporting criminal justice data and all law enforcement agencies in the State are required to report criminal activities to LEDS (ORS 181.550). The database is also part of the national network of criminal justice information. The reported numbers in this application are taken from the 2005 (the most recent year available) report.

Incidences of Communicable Diseases
We reported incidence rates (# of persons per 100,000 residents) of communicable diseases (Hb, AIDS, & Tb) for CY 2006 as indicators of communicable disease prevalence. The Oregon Public Health Office (formerly known as Oregon Health Division) is charged to develop and institute reportable disease (e.g., tuberculosis, hepatitis B and AIDS) reporting procedures and enforce the rules governing the reporting process (ORS 433.004). The Public Health Office requires all licensed health professionals to report upon encountering any reportable disease to county public health offices. Other agencies required by law to report any reportable disease to county public health offices include law enforcement officers (ORS 433.009, ORS 433.085), paramedics (ORS 433.085) and magistrates (ORS 433.130). County public health offices subsequently report such data to the Public Health Office using standardized forms. The Public Health Office documents, maintains, analyzes and disseminates the information for intervention and prevention service planning. Compliance with reporting requirements is fairly high and the division ensures that the data are valid and reliable.

REFERENCES:

1. Feyerherm, William; Goff, Clinton; and Campbell, Caitlin. Oregon Household Treatment Need Survey, Portland Survey Research Laboratory, Portland State University, May 2001.
2. State of Oregon Report of Criminal Offenses and Arrests, February 2007.
3. Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. American Psychiatric Association, Washington, DC, 1994

Form 11

State:
Oregon

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

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SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2008 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$12,160,805	$25,664,827	$1,696,751	$42,268,645	$0	$0
2. Primary Prevention	$3,242,881		$3,706,802	$3,621,257	$0	$0
3. Tuberculosis Services	$0	$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0	$0	$0	$0	$0	$0
5. Administration (excluding program/provider level)	$810,720		$0	$0	$0	$0
6. Column Total	$16,214,406	$25,664,827	$5,403,553	$45,889,902	$	$

Form 11ab

State:
Oregon

Form 11a: Primary Prevention Planned Expenditures Checklist

	Block Grant FY 2008	Other Federal	State	Local	Other
Information Dissemination	**$324,288**	**$36,697**	**$36,213**	**$**	**$**
Education	**$648,576**	**$736,171**	**$724,251**	**$**	**$**
Alternatives	**$356,717**	**$147,160**	**$144,850**	**$**	**$**
Problem Identification & Referral	**$1,005,293**	**$1,866,375**	**$1,810,629**	**$**	**$**
Community-Based Process	**$454,003**	**$589,011**	**$579,401**	**$**	**$**
Environmental	**$454,003**	**$331,388**	**$325,913**	**$**	**$**
Other	**$**	**$**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$**	**$**	**$**
TOTAL	**$3,242,880**	**$3,706,802**	**$3,621,257**	**$**	**$**

Form 11b: Primary Prevention Planned Expenditures Checklist

	Block Grant FY 2008	Other Federal	State	Local	Other
Universal Direct	**$**	**$**	**$**	**$**	**$**
Universal Indirect	**$**	**$**	**$**	**$**	**$**
Selective	**$**	**$**	**$**	**$**	**$**
Indicated	**$**	**$**	**$**	**$**	**$**
TOTAL	**$**	**$**	**$**	**$**	**$**

Form 11c

State:
Oregon

Resource Development Planned Expenditure Checklist

Does your State plan to fund resource development activities with FY 2008 funds?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$162,693**	**$133,110**	**$**	**$295,803**
Quality Assurance	**$40,521**	**$**	**$**	**$40,521**
Training (post-employment)	**$137,983**	**$15,331**	**$**	**$153,314**
Education (pre-employment)	**$**	**$16,205**	**$**	**$16,205**
Program Development	**$**	**$32,416**	**$**	**$32,416**
Research and Evaluation	**$20,260**	**$**	**$**	**$20,260**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$361,457**	**$197,062**	**$**	**$558,519**

Form 12

State:
Oregon

TREATMENT CAPACITY MATRIX

This form contains data covering a 24-month projection for the period during which your principal agency of the State is permitted to spend the FY 2008 block grant award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**10,882**	**8,368**
Rehabilitation / Residential		
3. Hospital Inpatient		
4. Short-term (up to 30 days)		
5. Long-term (over to 30 days)	**10,778**	**10,050**
Ambulatory (Outpatient)		
6. Outpatient	**81,162**	**61,978**
7. Intensive Outpatient	**15,150**	**14,190**
8. Detoxification		
9. Opioid Replacement Therapy	**3,124**	**2,818**

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Oregon

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2008 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐	Competitive grants	Percent of Expense: %
☒	Competitive contracts	Percent of Expense: 17%
☐	Non-competitive grants	Percent of Expense: %
☐	Non-competitive contracts	Percent of Expense: %
☒	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: 83%
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☒	According to county or regional priorities	Percent of Expense: 100%

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐	Line item program budget	Percent of Clients Served: % Percent of Expenditures: %
☐	Price per slot	Percent of Clients Served: % Percent of Expenditures: %

Rate:	Type of slot:
Rate:	Type of slot:
Rate:	Type of slot:

☒	Price per unit of service	Percent of Clients Served: % Percent of Expenditures: 48%
	Unit: Youth residential bed/day	Rate: 160
	Unit: Adult residential bed/day	Rate: 102
	Unit: Dependent bed/day	Rate: 30

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

State:
Oregon

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) Every two years

(Frequency for prevention:)

☐ Activity Reports

(Frequency for treatment:)

(Frequency for prevention:)

☐ Management information System

☐ Patient/participant data reporting system

(Frequency for treatment:)

(Frequency for prevention:)

☐ Performance Contracts

☐ Cost reports

☐ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) Every two years

(Frequency for prevention:)

☐ Licensure standards - personnel

(Frequency for treatment:)

(Frequency for prevention:)

☐ Other (Specify):

Form T1 was pre-populated with the following Data Source: Discharges in CY 2006

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment status [denominator]		
Percent of clients employed (full-time and part-time) or student		
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]	**1,126**	**1,014**
Total number of clients with non-missing values on employment status [denominator]	**4,218**	**4,218**
Percent of clients employed (full-time and part-time) or student	**26.7%**	**24.0%**
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$] **-2.7%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**3,367**
Number of CY 2006 discharges submitted:	**4,497**
Number of CY 2006 discharges linked to an admission:	**4,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**4,318**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**4,218**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Intensive Outpatient (IO)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment status [denominator]		
Percent of clients employed (full-time and part-time) or student		
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Outpatient (OP)

Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients employed (full-time and part-time) or student [numerator]	**17,469**	**17,937**
Total number of clients with non-missing values on employment status [denominator]	**28,389**	**28,389**
Percent of clients employed (full-time and part-time) or student	**61.5%**	**63.2%**
Percent of clients employed (full-time and part-time) or student at discharge minus percent of clients employed or student at admission.	Absolute Change [$\%T_2 - \%T_1$] **1.7%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**35,207**
Number of CY 2006 discharges submitted:	**34,624**
Number of CY 2006 discharges linked to an admission:	**32,934**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**31,184**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**28,389**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Form T1 Footnotes
These fields are pre-populated by SAMSHA.

Form T2 was pre-populated with the following Data Source: Discharges in CY 2006

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]	**3,573**	**3,881**
Total number of clients with non-missing values on living arrangements [denominator]	**4,096**	**4,096**
Percent of clients with stable housing	**87.2%**	**94.8%**
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$] **7.6%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**3,367**
Number of CY 2006 discharges submitted:	**4,497**
Number of CY 2006 discharges linked to an admission:	**4,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**4,318**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**4,096**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Intensive Outpatient (IO)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Outpatient (OP)

Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with stable housing [numerator]	**26,409**	**26,585**
Total number of clients with non-missing values on living arrangements [denominator]	**27,577**	**27,577**
Percent of clients with stable housing	**95.8%**	**96.4%**
Percent of clients with stable housing at discharge minus percent of clients with stable housing at admission.	Absolute Change [$\%T_2 - \%T_1$] **0.6%**	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**35,207**
Number of CY 2006 discharges submitted:	**34,624**
Number of CY 2006 discharges linked to an admission:	**32,934**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**31,184**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**27,577**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Form T2 Footnotes
These fields are pre-populated by SAMSHA.

Form T3 was pre-populated with the following Data Source: Discharges in CY 2006

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]	

Long-term Residential(LR)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**3,367**
Number of CY 2006 discharges submitted:	**4,497**
Number of CY 2006 discharges linked to an admission:	**4,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**4,331**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Intensive Outpatient (IO)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Outpatient (OP)

Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T_1)	At Discharge (T_2)
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		
Percent of clients with no arrests at discharge minus percent of clients with no arrests at admission.	Absolute Change [$\%T_2 - \%T_1$]	

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**35,207**
Number of CY 2006 discharges submitted:	**34,624**
Number of CY 2006 discharges linked to an admission:	**32,934**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**31,782**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Form T3 Footnotes
These fields are pre-populated by SAMSHA.

Form T4 was pre-populated with the following Data Source: Discharges in CY 2006

ALCOHOL ABSTINENCE

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$]	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol [numerator]	**2,076**	**4,079**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**4,331**	**4,331**
Percent of clients abstinent from alcohol	**47.9%**	**94.2%**
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$] **46.3%**	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**2,008**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**2,255**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**89.0%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**2,071**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**2,076**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**99.8%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**3,367**
Number of CY 2006 discharges submitted:	**4,497**
Number of CY 2006 discharges linked to an admission:	**4,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**4,331**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**4,331**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$]	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol [numerator]	**10,597**	**23,445**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**31,782**	**31,782**
Percent of clients abstinent from alcohol	**33.3%**	**73.8%**
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission.	Absolute Change [$\%T_2 - \%T_1$] **40.5%**	

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**13,200**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**21,185**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**62.3%**

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**10,245**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**10,597**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**96.7%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**35,207**
Number of CY 2006 discharges submitted:	**34,624**
Number of CY 2006 discharges linked to an admission:	**32,934**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**31,782**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**31,782**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Form T4 Footnotes
These fields are pre-populated by SAMSHA.

Form T5 was pre-populated with the following Data Source: Discharges in CY 2006

DRUG ABSTINENCE

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$]	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge (T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**0**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**889**	**3,890**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**4,331**	**4,331**
Percent of clients abstinent from drugs	**20.5%**	**89.8%**
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$] **69.3%**	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**3,006**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**3,442**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**87.3%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**884**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**889**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**99.4%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**3,367**
Number of CY 2006 discharges submitted:	**4,497**
Number of CY 2006 discharges linked to an admission:	**4,356**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**4,331**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**4,331**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$]	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**0**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**0**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**0**
Number of CY 2006 discharges submitted:	**0**
Number of CY 2006 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**0**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file
[Records received through 5/14/2007]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs [numerator]	**15,606**	**23,690**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**31,782**	**31,782**
Percent of clients abstinent from drugs	**49.1%**	**74.5%**
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission.	Absolute Change [$\%T_2 - \%T_1$] **25.4%**	

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**8,532**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**16,176**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**52.7%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge (T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**15,158**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**15,606**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**97.1%**

Notes (for this level of care):	
Number of CY 2006 admissions submitted:	**35,207**
Number of CY 2006 discharges submitted:	**34,624**
Number of CY 2006 discharges linked to an admission:	**32,934**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**31,782**

Number of CY 2006 linked discharges eligible for this calculation (non-missing values):	**31,782**

Source: SAMHSA/OAS TEDS CY 2006 admissions file and CY 2006 linked discharge file [Records received through 5/14/2007]

Form T5 Footnotes
These fields are pre-populated by SAMSHA.

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

Most recent year for which data are available	From:	To:

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]		
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]		
Percent of clients participating in social support activities		
Percent of clients participating in social support of recovery activities in prior 30 days at discharge minus percent of clients participating in social support of recovery activities in prior 30 days at admission. (Positive percent change values indicate increased participation in social support of recovery activities.)	Absolute Change [$\%T_2$-$\%T_1$] /	

State Description of Employment Status Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T6? (Select all that apply)** ☐ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T6? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T6? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T6? (Select all that apply)** ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data on all clients, if data is not currently available. Plans should also discuss barriers, resource**

	needs and estimates of cost.

Form T6 Footnotes
We do not have data to complete this form. The form is not mandatory yet.

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 7/1/2005	To: 6/30/2006

Length of Stay			
Level of Care	**Average**	**Median**	**Standard Deviation**
Detoxification (24-Hour Care)			
1. Hospital Inpatient	0	0	0
2. Free-standing Residential	5	4	0
Rehabilitation / Residential			
3. Hospital Inpatient	0	0	0
4. Short-term (up to 30 days)	0	0	0
5. Long-term (over 30 days)	74	49	0
Ambulatory (Outpatient)			
6. Outpatient	134	106	0
7. Intensive Outpatient	0	0	0
8. Detoxification	80	30	0
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement Therapy	183	118	0
10. ORT Outpatient (optional)	359	189	0

Form T7 Footnotes
These fields are pre-populated by SAMSHA.

Oregon

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

State Performance Management and Leadership

Describe the single state authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the state and identify to whom they are distributed.

AMH is making significant progress in terms of using data to inform decisions. The SEOW, supported by the SAMHSA, Center for Substance Abuse Prevention through a subcontract with Synectics, has provided Oregon with new analytical capacity for deriving important insights from consequence, consumption, and prevalence data concerning tobacco, alcohol, and illicit drug use. This information has been documented in profiles as consistent with the work product requirements based on the Synectics subcontract. The profile are posted on the AMH web site and fact sheets are currently under development that will summarize the information into more concise formats for diverse stakeholders such as community coalitions, business leaders, legislators, and other private citizens.

AMH is currently in the process of reviewing our methodology for reporting prevalence for alcohol and drug abuse and dependence for youth and adult populations and estimating the need for publicly supported prevention and treatment services. We have historically relied on data from a 1999 Oregon Household Survey conducted by the division with support from SAMHSA, however, this data is quite outdated and we feel the need to update our methodology considering options for new approaches. We are exploring using the National Survey on Drug Use and Health (NSDUH) as a data source to derive prevalence for a variety of reasons including the fact that this survey is updated annually. For youth populations, we do have the Oregon Healthy Teen Survey which is updated annually and can still be used as a valid data source.

AMH is embarking on a new needs assessment and capacity building initiative for addiction services which will result in a clearly documented statement of need and capacity building strategy for the next six years. Oregon builds state budgets biennially so the strategy will encompass three biennia, 2009 – 11; 2011 – 13; and 2013 – 15. The epidemiological data and prevalence data will assist Oregon as we generate community insights and capacity needs for budget development over the next six years.

AMH routinely monitors system performance for outpatient addictions treatment. Each quarter, AMH publishes a report called the Treatment Improvement Report (TIR) and distributes the report to all of the intermediaries, known as CMHP, managing these services. The report is also reviewed by the Governor's Council on Alcohol and Drug Abuse Programs and AMH management. The TIR consists of five measures; Engagement in Treatment, Retention in Treatment, Placement in Appropriate Level of Care at admission, Completion of Treatment, and Reduced Use. This report focuses on non-DUII chemical dependency outpatient treatment services for adults and adolescents. AMH routinely monitor utilization for all publicly funded residential services. Residential bed days are contracted with providers or through intermediaries with a 100% utilization requirement and Medicaid match is used to support a portion of clinical services. Therefore, monitoring utilization is an important function for the division. Quarterly utilization reports are generated by the Program Analysis and Evaluation Unit and distributed to AMH managers and staff members who have responsibilities for monitoring utilization standards.

Periodically, AMH develops fact sheets on a variety of prevention, treatment and recovery topics. These fact sheets have been distributed to many different stakeholders including service providers, legislators, state agency partners, the general public through the web site, task forces and committees, and special interest groups. Data from the Oregon Healthy Teen Survey, CPMS, Oregon's TEDS data set, Minimum Data Set for Prevention (MDS) and other data sets are used to gather information for these fact sheets. Over the past three years, AMH has produced fact sheets on the following topics: Methamphetamine; Drug Courts; Underage Drinking; Prescription Drug Abuse; Synthetic Opiate Replacement Therapy and Successful Outcomes; Older Adults; Performance Measures and Outcomes in Addiction Treatment; and Oregon's Progress in meeting National Outcome Measures. The fact sheets on outcomes in addiction treatment were instrumental during the 2007 legislative session in securing additional investments for addiction services. Fact sheets may be viewed and downloaded from the AMH web site at:

http://www.oregon.gov/DHS/addiction/resource_center.shtml

AMH developed its first annual report on Substance Abuse Prevention services supported by the Division in 2007. The report was designed to be primarily read by professionals in the prevention field and key stakeholders. AMH is hearing from private citizens and other groups that they have read the report and found it to be very informative as well. The report summarizes expenditure information and data reported from the 36 Oregon Counties and nine federally recognized Indian Tribes on the impact of substance abuse prevention efforts supported by the Division and can be found at: http://www.oregon.gov/DHS/addiction/publications/sub-abuse-prevention-report.pdf

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

The Oregon Legislature adopts Key Performance Measures (KPM) for DHS including AMH. The following KPMs were included in the Legislatively Adopted 2007 – 09 Key Performance Measures report from the 2007 Legislature for addiction services:

#19 – Completion of alcohol and drug treatment – The percentage of engaged clients who complete alcohol and other drug abuse treatment and are not abusing alcohol and other drugs. Target for 2008 is 75.1%.

#20 – Alcohol and drug treatment effectiveness – The percentage of adults employed after receiving alcohol and drug treatment. Target for 2008 is 52%.

#21 – Alcohol and drug treatment effectiveness – The percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment. Target for 2008 is 52%. (AMH received additional investments from the legislature specifically to address this target population during the 2007 0- 09 beinnium. For these investments, contracts will specify a higher standard with a target of 60%.)

#22 – 8th grader risk for alcohol and drug use – Percentage of 8th graders at high risk for alcohol and other drug use. Target for 2008 is 30%.

#23 – Alcohol and drug treatment effectiveness – The percentage of children whose school performance improves after receiving alcohol and drug treatment. Target for 2008 is 60%.

Another related measure to addiction services is a TANF measure, #7 – TANF family stability – The percentage of children entering foster care who had received TANF cash assistance within the prior two months. Target for 2008 is 24%. AMH is engaged in an initiative known as the "Family Success and Recovery Initiative" to improve treatment access, engagement, and family stability with TANF families working closely with partners from the TANF program and early childhood systems. This new KPM will help us gage our effectiveness in meeting the initiative goals and objectives.

The KPMs are generated by the legislature using historical performance data measured against benchmarks that were generated as part of "Oregon Shines," Oregon's long-range strategic plan, measuring the economic, social, and environmental climate. More information and a full, current report on Oregon's progress toward its goals can be found at: http://www.oregon.gov/DAS/OPB/docs/2007Report/2007_Benchmark_Highlights.pdf

What actions does the State take as a result of analyzing performance management data?

AMH uses performance data to direct technical assistance and training initiatives, monitoring regional trends and needs in the areas comprising the TIR. Oregon is one of the five states along with New York, Michigan, Washington, and Massachusetts, participating in NIATx 200. AMH has developed an electronic data reporting system to capture data that is consistent with the NIATx aims and is gearing up for data training in September with all of the providers who have signed on to participate in this project. AMH will be exploring ways to use data generated from the NIATx 200 project to monitor performance and build a more performance-based system of accountability in future years based on the lessons learned.

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Has the State developed EBPs or programs and, if so, does the state require that providers use these EBPs?

AMH is required by Oregon Law to report to the legislature, an increasing proportion of funds that support EBPs. By the 2009-11 biennium, 75% of AMH funds for those populations at risk of emergency psychiatric services and/or criminal or juvenile justice involvement are to support EBPs. AMH believes all of its clinical and prevention services are subject to the law and developed its plans accordingly.
AMH adopted a definition, established policies for identifying, evaluating, approving and listing evidence-based practices and programs, established a baseline percentage of expenditures by conducting surveys of providers and continues to do provider surveys to document the number and name of EBPs used in Oregon.

The expectation is that programs will increasingly use approved EBPs but there are not administrative rules mandating that or contract stipulations currently. The results of the surveys indicate that is the case. AMH plans to amend existing rules and contracts to incorporate key elements for successful EBP delivery including quality assurance/quality improvement processes and well defined clinical supervision. AMH plans to develop contract, policy, reimbursement changes which will provide incentives for the adoption of EBPs.

Provider Involvement

What actions does the state expect the provider or intermediary to take as a result of analyzing the performance management data?

Intermediaries, CMHPs, use the performance data to gage system effectiveness, reporting information to their county boards and commissions and making more specific data requests of AMH for provider specific performance on an ad hoc basis. AMH is in the process of strengthening the addictions provider capacity to use data to improve performance through the NIATx 200 project.

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

AMH staff conduct regular CPMS trainings for alcohol and drug abuse treatment providers (see attached schedule). These trainings are a day-long and help providers submit accurate client information. In 2007 we conducted 20 trainings, with over 300 in attendance.

We also send out a CPMS Messenger newsletter to all providers. This newsletter reminds them of the importance of accurate, timely and complete data submitted to the State.

An electronic version (E-form) of the paper CPMS form is also used statewide. There are built-in edits that prohibit inaccurate responses. This tool is available to treatment providers and is free of charge.

Do workforce development plans address NOMS implementation and performance-based management practices?

The NIATx 200 project is a major emphasis under Oregon's workforce development plan with regard to data reporting and performance management. This was discussed above. Oregon has also applied for a Robert Woods Johnson Advancing Recovery grant with the provider association, OPERA and the AOCMHP based on the NIATx principles. If Oregon is successful, this initiative will also be blended into the workforce development plan in order to build performance management capacity at the state and local levels and to strengthen the continuum of recovery oriented addiction services.

Does the State require providers to supply information about the intensity or number of services received?

Currently, only the MMIS captures encounter data in alcohol and drug services covered under the OHP chemical dependency benefit. However, AMH is working diligently toward the goal of implementing a new statewide integrated behavioral health data collection and reporting system in Oregon. To that end, AMH secured the services of a contractor through a competitive bidding process to take the lead in the documentation of system requirements, researching the available options and assisting the State in its efforts to obtain adequate funding for a new hospital and community-based behavioral health client data collection and reporting system. The system is referred to as the B-HIP. The use of the term "behavioral health" means mental health and addiction services. B-HIP will capture encounter data on intensity of services provided for addiction clients.

Form P1

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - FFY 2005 (Baseline)	18.40	
		Ages 18+ - FFY 2005 (Baseline)	62.30	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]	Ages 12–17 - FFY 2005 (Baseline)	10.90	
		Ages 18+ - FFY 2005 (Baseline)	25.90	
3. 30-day Use of Other Tobacco Product	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days,	Ages 12–17 - FFY 2005 (Baseline)	6.20	
		Ages 18+ - FFY 2005 (Baseline)	8.10	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2005 (Baseline)	10.30	
		Ages 18+ - FFY 2005 (Baseline)	8.60	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2005 (Baseline)	4.50	
		Ages 18+ - FFY 2005 (Baseline)	3.10	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	75.90	
		Ages 18+ - FFY 2005 (Baseline)	83.10	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	95.20	
		Ages 18+ - FFY 2005 (Baseline)	96	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	79.60	
		Ages 18+ - FFY 2005 (Baseline)	73.30	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P3

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2005 (Baseline)	12.80	
		Ages 18+ - FFY 2005 (Baseline)	16.70	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2005 (Baseline)	12.40	
		Ages 18+ - FFY 2005 (Baseline)	15.40	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2005 (Baseline)	13.20	
		Ages 18+ - FFY 2005 (Baseline)	18.70	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2005 (Baseline)	13.50	
		Ages 18+ - FFY 2005 (Baseline)	18.90	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2005 (Baseline)	13.40	
		Ages 18+ - FFY 2005 (Baseline)	19.90	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	91.20	
2. Perception of Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2005 (Baseline)	86.90	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	78	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	77.60	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	88.60	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P5

NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 15–17 - FFY 2005 (Baseline)	((s))	
		Ages 18+ - FFY 2005 (Baseline)	37.20	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P7

NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2005 (Baseline)	88.20	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P7 Footnotes
These fields are pre-populated by SAMSHA

Form P8

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2005 (Baseline)	36	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P9

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2005 (Baseline)	108	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P10

NOMs Domain: Social Connectedness

Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2005 (Baseline)	63.20	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2005 (Baseline)	((s))	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2005 (Baseline)	92.80	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Oregon collects Prevention NOMs data using MDS. However the data are collected for population-based prevention activities. Thus Form 12A, wich requires individual-based data is not completed.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Oregon records particpant' race for population-based activities using the following designations: white, Black or African American, Native Hawiaiian/Other Pacific Islander, Asian, American Indian/Alaskan Native, and More than one race. The latter compriese those who reported more than one race are reported in Form P12B as 'Race Unknown or Other' subcategory.

Category	Description	Total Served
A. Age	1. 0-4	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	
	10. Age Not Known	
B. Gender	Male	
	Female	
	Gender Unknown	

C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	Race Unknown or Other (not OMB required)	
D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	

Form P12B

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	2127
	2. 5-11	30047
	3. 12-14	49518
	4. 15-17	23417
	5. 18-20	22853
	6. 21-24	21527
	7.25-44	37691
	8. 45-64	33165
	9. 65 And Over	20413
	10. Age Not Known	
B. Gender	Male	111658
	Female	129100
	Gender Unknown	
C. Race	White	202829
	Black or African American	16355
	Native Hawaiian/Other Pacific Islander	869
	Asian	7605
	American indian/Alaska Native	14342
	Race Unknown or Other (not OMB required)	3277

	Hispanic or Latino	40764
	Not Hispanic or Latino	199834

Form P13

Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total		

Form P13 Footnotes
This table is not applicable to our system

Form P14

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Oregon accepts all programs on the National Registry of Effective Programs (NREP) as evidence based. In addition, Oregon has adopted its own definition of evidence-based practices which closely mirrors the definition set forth in this application. If a practice is not on NREP, an application can be submitted to have it recognized as evidence based by Oregon. The information collected through the application process is reviewed by internal and external reviewers against criteria outlined in Oregon's definition. Based on the evaluation a rating is made and approved by the Assistant Director of the Addiction and Mental Health Division.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Programs report their names addresses and activities to our MDS system.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	26	0	26	10	12	22
2. Total number of Programs and Strategies Funded	47	0	47	35	24	59
3. Percent of Evidence-Based Programs and Strategies	55.32%	NaN	55.32%	28.57%	50.00%	37.29%

Form P15

Services Provided Within Cost Bands

Type of Intervention	A. Number of Programs and Strategies	B. Number of Programs and Strategies Falling Within Cost Bands	C. Percent of Programs and Strategies Falling Within Cost Bands
1. Universal Direct Programs and Strategies	47		%
2. Universal Indirect Programs and Strategies	0		%
3. Subtotal Universal Programs	47	0	0.00%
4. Selective Programs and Strategies	35		%
5. Indicated Programs and Strategies	24		%
6. Total All Programs	106	0	0.00%

Form P15 Footnotes
Oregon does not collect cost data by type of intervention.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet

Subrecipient Name:_____

Date Form Completed:_____

Name of Contact Person:_____

Phone:_____ **E-mail Address:**_____

Table 1: Progam Detail

1	2	3	4	5	6
Program Name	**Number of Participants**	**Number of Program Hours Received**	**Total Cost of the Program**	**Average Cost Per Participant (Col 4/Col 2)**	**Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0)**
Universal Direct Programs					**Universal Direct: $58.01–$693.98**
1.					
2.					
3.					
4.					
Universal Indirect Programs					**Universal Indirect $1.05–$82.26**
1.					
2.					
3.					
4.					
Selective Programs					**Selective $151.88–$6,409.29**
1.					
2.					
3.					
4.					
Indicated Programs					**Indicated $510.47–$4,888.44**
1.					
2.					
3.					
4.					

Table 2: Subrecipient Cost Band Summary

	1	2
Program Type	**Number of Programs**	**Number of Programs Falling Within Cost Bands**
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Total		

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- ***Universal.*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
    - ***Universal Direct.*** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
    - ***Universal Indirect***. Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- ***Selective.*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- ***Indicated.*** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participant s served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a "1" in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded "1" in Table 1, column 5).

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Oregon

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)
No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.