Oregon Health Authority (OHA)
Substance Use Disorder Financial Analysis

Public Consulting Group

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PUBLIC CONSULTING GROUP

CONTENTS

EXECUTIVE SUMMARY

In a budget note in HB 5006 (2021 regular session), the Oregon State Legislature directed the Oregon Health Authority (OHA) to analyze the adequacy of behavioral health structures in the state, including conducting an analysis of behavioral health costs and financing. Following that direction, OHA contracted with Public Consulting Group LLC (PCG) for a financial study of Substance Use Disorder (SUD) services in Oregon, specifically comprised of three components: a **financial inventory of public spending on SUD services and supports**, **cost estimates to address unmet need** across the care continuum, and a review of **revenue options** to address unmet SUD needs.

Approximately **$1B of publicly-funded SUD services and supports** funded in Oregon during the 2021 – 2023 biennium were inventoried. The inventory includes a summary of **SUD spending by agency, service category, county, and fund category and type**. Dollars spent on services and supports across the care continuum are delineated across the setting categories, as determined by OHA and external agency stakeholders, who were engaged via monthly Steering Committee meetings: **primary prevention, harm reduction, treatment, recovery supports, peer-delivered services, drug courts, and other**. Several setting categories are further delineated into unique service types in the financial inventory. The "other" setting category includes administration, drug screen/collection, DUII, intoxicated driver program fund, and technical assistance/program evaluation services. A portion of funds could not be allocated into a setting category and are categorized as undetermined in the inventory. A breakdown of the allocation of dollars across the setting categories is presented below.

TABLE 1: PERCENT OF SUD SPENDING BY SETTING CATEGORY

Primary Prevention	Harm Reduction	Treatment	Peer Delivered Services	Recovery Supports	Drug Courts	Other	Can Not Determine
$58,385,114	$30,008,819	$625,112,768	$96,356,411	$90,480,860	$4,505,236	$3,625,376	$72,293,067
5.96%	**3.05%**	**65.16%**	**9.81%**	**9.21%**	**0.046%**	**0.037%**	**5.98%**

Note: Tribal funds are not included in this table as the service utilization was not identified

PCG generated cost estimates to address unmet needs based on workforce and program gaps identified in external reports and through state agency analysis. The **total annual cost for meeting identified gaps** in SUD services and supports in Oregon is estimated at **$6.85 billion**. This total estimate contains system-wide costs that may not be directly funded by the state, and it does not indicate what portion of those costs would—or should—be borne by the federal, state, or local governments, other sectors, or individuals seeking to join the workforce. The level of burden to the state for this total cost will need to be assessed in future studies.

TABLE 2: TOTAL COST OF MEETING IDENTIFIED SUD SERVICE AND SUPPORTS GAP

Service Type	Description of Cost Component	Cost Estimate
Workforce	Cost of Employing Needed Workers: Salary and Benefits (per year)	**$3,195,385,208**
	Cost to Educate, Train and Certify Needed Workers	**$1,765,241,619**
Facilities – Capital Costs	Outpatient	**$398,491,925**
	Recovery Residences	**$357,511,245**
	Recovery Community Centers	**$131,171,050**

Service Type	Description of Cost Component	Cost Estimate
	Residential Treatment	**$596,878,902**
	Withdrawal Management	**$173,866,070**
	Opioid Treatment Programs	**$18,125,000**
Other SUD Programming	Harm Reduction Programs: Program Costs	**$89,976,177**
	School-Based Primary Prevention: Statewide Planning	**$5,471,747**
	Community-Based Primary Prevention: Statewide Program	**$122,840,000**
		$6,854,958,943

The cost estimates provided in this analysis are undeniably high, but there are actions that state leaders can take to both **maximize current revenue sources** and **generate new revenue sources** to address unmet need. Oregon invests large portions of state funds into SUD services, and ensuring those investments are currently being used to the maximum benefit should be considered alongside any additional investment. **PCG recommends** that the state consider **developing a comprehensive state reporting system** that would facilitate the accurate **tracking of budget investments** all the way to the delivery of services. This system should **also measure the outcome data** for each service and begin to **assess the equity, effectiveness, and efficiency of the service and budget investment** overall.

The state should assure that all fund sources used are maximized and evaluated for efficiency alongside any potential investments in the future. The state should **evaluate the current utilization** of federal grants, Medicaid, and private sector funds **to confirm all available funding streams are being collected and spent in entirety**, as permitted by funding source specific requirements. The state should also **coordinate with other states** and advocates to **learn and develop techniques for increasing federal funding participation** for SUD services.

As **new investment opportunities** are identified the state **could consider distributing these via competitive grants for prevention or harm reduction services**, which could enhance the funding for these integral programs. A grant process would provide the opportunity for community engagement and could **support the State's efforts to identify opportunities that support equity, effectiveness, and efficiency**, through reporting requirements and closely tracked spending.

INTRODUCTION

In a budget note in HB 5006 (2021 regular session), the Oregon State Legislature directed the Oregon Health Authority (OHA) to analyze the adequacy of behavioral health structures in the state, including conducting an analysis of behavioral health costs and financing.

The Oregon Health Authority (OHA) shall study the behavioral health structures for services provided through state agencies and whether the structure adequately meets the current needs of the state as identified by the Alcohol and Drug Policy Commission strategic plan and the State Health Improvement Plan. OHA shall analyze the cost required to meet projected unmet needs, current revenue sources, and additional revenue options, including, but not limited to, taxes related to alcohol, income, and telecommunications.

To fulfill the goals of the budget note, OHA issued a competitive bid for a financial study of SUD services and supports in Oregon, specifically. The study comprises three components:

- A financial inventory of public spending on SUD services and supports, which illuminates state agency roles in addressing SUD and offer insights into the balance of spending across the care continuum and geographically.
- Cost estimates to address unmet need across the care continuum, leveraging recent methodology and findings from the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis (2022 Gap Analysis)**[i] conducted by the Oregon Health & Science University-Portland State University School of Public Health. These cost estimates provide insights on the magnitude of current public spending on SUD against the overall need.
- Revenue options to address unmet SUD needs, which can help inform executive and legislative strategies to finance SUD services and supports more equitably, effectively, and efficiently.

Public Consulting Group LLC (PCG) was contracted to provide analysis and help develop the report that will be presented to the Legislative Assembly. The report covers the following topics:

- **Financial Inventory, including:**
  - Data compilation and quality assurance methods
  - Identified data limitations
  - Summary of SUD spending by agency
  - Summary of SUD spending by service category
  - Summary of SUD spending by county
  - Summary of SUD spending by fund category and fund type
- **A cost estimate of closing the SUD workforce gap, including:**
  - Costs to build the pipeline: education, training, supervision, and certification requirements for all new positions
  - Costs to the system for adding additional workers: hourly workforce cost estimates, including fringe, and administrative support costs
  - Identification of the gaps in the prescribing workforce
- **Capital Cost estimate for gaps in treatment programs:**
  - Opioid Treatment Programs
  - Residential Treatment Programs
  - Withdrawal Management Treatment Programs
  - Outpatient Treatment Programs
- **Capital Cost estimate for gaps in recovery support programs:**
  - Recovery Residences
  - Recovery Community Centers
- **Cost estimates for gaps in harm reduction programs:**
  - Harm Reduction Programs
- **Cost estimate for gaps in primary prevention activities:**
  - School Based Prevention
  - Community Based Prevention

ACTIVITIES COMPLETED

The process of developing these estimates required data collection from and coordination between state agencies, counties, and support organizations. We are grateful for the cooperation and assistance from across the SUD service system in Oregon because this report would not be possible without it.

KICK OFF AND WEEKLY CHECK-INS

Public Consulting Group LLC (PCG) met weekly with representatives from Oregon Health Authority (OHA). These meetings were the foundation for learning more about Oregon's substance use disorder (SUD) system, establishing lines of communications with the agencies and organizations needed for the project, and establishing and planning for meetings with the Steering Committee.

DATA COLLECTED AND DOCUMENTS REVIEWED

OHA provided many background documents to assist the project team in enhancing their understanding of the Oregon SUD system. Budget data has been collected from the following organizations:

Oregon Health Authority	Oregon Department of Education	Oregon Liquor and Cannabis Commission
Criminal Justice Commission	Oregon Judicial Department	Coordinated Care Organizations
Oregon Department of Human Services	Department of Corrections	Community Mental Health Programs
Oregon State Hospital	Oregon Youth Authority	Local Public Health Authorities

The data collected for this project was limited to the 2021–2023 Biennium. Data was collected on or before Fall 2023. Some budgets in this report were not final at the time of data collection and therefore could be reported differently in another source. PCG coordinated with the Oregon Health & Science University – Portland State University School of Public Health (OHSU-PSU SPH) to adapt selected measures from the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis**, which served as a starting point for estimates of cost associated with unmet need.

STEERING COMMITTEE

Working with OHA, and with the goal of including a robust team of well-informed SUD professionals across the state, a technical Steering Committee was established for this project. The goal of the Steering Committee was to obtain input from subject matter experts during the development of PCG's research methodology and to obtain feedback on assumptions made and recommendations developed during the data collection and analysis period. Seven Steering Committee meetings occurred as of the finalization of this report and were facilitated by PCG project staff.

The Steering Committee included representatives from the following agencies or organizations:

- Alcohol and Drug Policy Commission
- Association of Oregon Community Mental Health Programs
- Coordinated Care Organizations (CCO)
- Oregon Council for Behavioral Health
- OHA – Behavioral Health
- OHA – Equity and Inclusion
- OHA – Health Policy and Analytics
- OHA – Medicaid
- OHA – Public Health Division
- OHA – Tribal Affairs
- OHSU-PSU School of Public Health

DATA REVIEW AND ANALYSIS

Data collection and analysis for this project was completed between July 2023 and March 2024. Data is subject to change as new investments are made and funding sources change in future budgets.

FINANCIAL INVENTORY

The first stage of this project was the development of a comprehensive financial inventory of substance use disorder (SUD) spending and investments across the state of Oregon during the 2021–2023 biennium. The analysis included data collection and coordination across a comprehensive stakeholder group (at least eight state agencies, all counties in Oregon, 15 Coordinated Care Organizations (CCO), and other partners) with the purpose of capturing all public SUD spending in the analysis. The following sections outline the **methodology used for the analysis** and **summary tables of SUD spending** across the state of Oregon.

METHODOLOGY

The following section provides an overview of the methodology undertaken to complete the financial inventory.

Data Collection

In June 2023, PCG began **data collection efforts** including requests for data and coordination across state agencies, counties, and coordinated care organizations. PCG submitted a data request to each agency, conducted several sets of meetings to discuss the data elements, reviewed submissions, and conducted follow-up meetings to clarify any data questions. The project team **facilitated more than 30 meetings** with program staff **to present and clarify data requests**. PCG concluded data collection efforts in the fall of 2023.

The following agencies provided SUD spending data for the financial inventory:

- OHA: Health Systems Division (HSD)
- OHA: Public Health Division (PHD)
- OHA: Health Policy and Analytics Division (HPA)
- Oregon Criminal Justice Commission (CJC)
- Oregon Liquor and Cannabis Commission (OLCC)
- Oregon Department of Human Services (ODHS)
- Oregon Department of Corrections (ODC)
- Oregon Judicial Department (OJD)
- Oregon Youth Authority (OYA)

PCG contacted Community Mental Health Programs (CMHP), CCOs, and Local Public Health Authorities (LPHAs) to **collect spending data** on the **types of services provided** and **the dollar amounts distributed** for SUD programs. The data received from **LPHAs, CMHPs, and CCOs** was used to **validate and provide additional context** to data that was received from state agencies.

The project team continued to meet with representatives from the state agencies and entities listed above, as further questions were identified about the financial data received. Several meetings were conducted with leadership from agencies **to confirm the project team's understanding of the data** received and **to update any data elements** (e.g., fund type), as requested by the agency's leadership or point of contact.

Data Compilation & Quality Assurance

Following the data collection effort, the team began **data compilation and quality assurance efforts**. All financial data received across agencies and entities was compiled into one document to support comprehensive analysis for the financial inventory. When the team identified gaps in the data received, the team reached out to the point of contact for that agency to clarify and adjust the data.

Setting Category & Service Type

Working with OHA and the Steering Committee, PCG developed a uniform list of setting categories and service types into which all spending could be categorized.

TABLE 3: FINAL SERVICE LIST

Setting Category	Service Type
Primary Prevention	Community-Based Practices
	Environmental Strategies
	Information Dissemination
	Prevention Education
	Problem Identification & Referral to Services
Harm Reduction	
Treatment	Medication Assisted Treatment
	Outpatient
	Residential
	Clinically-Managed Withdrawal Management
	Medically-Managed Withdrawal Management
	Medically-Monitored Withdrawal Management
	Problem Gambling Services
	Commercial Tobacco Smoking Cessation
Recovery Supports	Housing
	Supported Employment
	Recovery Support Centers
Peer Delivered Services	
Drug Courts	
Other	Administration
	Drug Screen/Collection
	DUII Services
	Intoxicated Driver Program Fund
	Other Medicaid Capitation Payments
	Technical Assistance / Program Evaluation

PCG categorized all spending into these service setting categories and service types. Some of the agencies and entities provided the service category for services provided, while others did not. In the case of those that did not provide that level of detail, the team leveraged other data sources (e.g., contracts) to identify the type of SUD service delivered.

Identification of County Location

The data received across state agencies and entities mostly included a county identification associated with the distribution data. For those that did not, the project team leveraged other resources (i.e., contracts, program trackers, partner meetings, and provider website information) to confirm the physical county location associated with the allocation of funds.

Quality Assurance

Several members of the PCG project team reviewed each of the data sources and accompanying documentation submitted by the state agencies and entities. Data and documentation were **reviewed for accuracy and completeness** by multiple PCG staff. Each data source submitted was **cross-checked against other applicable sources** for accuracy. An example of this process included cross-checking the OHA HSD SUD Spend Plan database with documentation and financial data received from the counties, CMHPs and CCOs.

At the final point of analysis, the project team conducted **additional quality assurance measures** by cross-checking totals and line items included in the compiled financial inventory with original documentation to confirm that all applicable elements received were included.

Data Limitations

Cost estimates are based in part on data collected for the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis** which applied the SAMSHA-developed **Calculating for an Adequate System Tool** (CAST). The CAST incorporates findings from national literature, population survey data at the national, state, and region level, and census data to estimate required capacity for a selection of prevention, treatment, recovery and harm reduction services. Predicted utilization rates for all interventions are incorporated into the CAST estimation equations and are not necessarily Oregon specific. As the CAST methodology includes only selection of services that are nationally generalizable, they that do not adequately represent the complete service landscape in Oregon.

Some state agencies and entities were **unable to provide detailed financial data** due to data system limitations.

For example, Oregon State Hospital (OSH) often serves individuals with comorbidity of mental health (MH) and SUD diagnoses. In most cases, the hospital does not delineate dollar amounts based on SUD-specific diagnoses or services. Therefore, for the purposes of this analysis, PCG did not include the OSH data, as dollars were unable to accurately demonstrate SUD-specific services.

Similarly, SUD spending data is not available for Certified Community Behavioral Health Clinics, as these clinics are paid a daily rate for services, and the costs for SUD services are not separated in any quantifiable way.

The Oregon Department of Education (ODE) does not have data detailed enough to provide insights on the financial inventory portion of this project. Therefore, school-level spending on SUD programs and activities was not included in the financial inventory.

Spending data in this report **primarily reflects state and federal funds distributed from state agencies** to providers and organizations in the community. Spending on state staff and state infrastructure are not included. This is important to note for two reasons:

1. Some state staff may engage directly in providing SUD programs and services across the continuum. Examples include OHA's Public Health Division and the Oregon Liquor and Cannabis Commission (OLCC), who employ staff that are directly engaged in primary prevention work. This includes the Public Health Division's "Rethink the Drink" campaign to reduce harms from alcohol consumption, and the OLCC Public Safety Division's work to prevent sales of alcohol and cannabis products to minors.
2. Investments to the community cannot be executed without state staff overseeing and administering grants, contracts, and programs.

Additional research may be conducted to **determine state staff and infrastructure costs** that support SUD programs and services, although it should be noted that it **can be difficult to determine SUD-specific costs**, as many staff work on both mental health and SUD-related projects.

SUMMARY TABLES

Summary tables of the financial inventory across state agencies and entities that participated in the analysis are included below. The analysis includes a review of dollars spent **by agency**, dollars spent **by service category**, spend by **service type**, spend **by county**, spend **by fund source and fund type**, and service-type **spending for M110**.

Spend by Agency

Across the State of Oregon, approximately **$1B was spent on substance use programming and services during the 2021–2023 biennium**. This represents distributed funding to support contracted partners in providing substance use programs. Further analysis is needed to provide funding analysis of infrastructure and staffing for the following agencies. **OHA – Health Systems Division spends the most** dollars on SUD, totaling around **$897M**, of which **Medicaid spending is the highest at $562M**. A breakdown of dollars spent by agency is provided in **Table 4**.

TABLE 4: SUM OF SUD SPENDING BY STATE AGENCY

State Agency	Sum of SUD Spending
Oregon Health Authority: Medicaid	$562M
Oregon Health Authority: Behavioral Health Division	$335M
Oregon Health Authority: Public Health Division	$60M
Oregon Criminal Justice Commission	$20M
Oregon Department of Human Services	$10M
Oregon Department of Corrections	$7M
Oregon Judicial Department	$5M
Oregon Youth Authority	$<1M
Grand Total	**$1B**

A breakdown of dollars spent by agency and by service category is provided below in **Table 5**. OHA HSD spent the most on treatment services for Medicaid spending, totaling $470,272,996 with the next highest of treatment services funded through non-Medicaid dollars, totaling $132,591,375. OHA PHD reported SUD spending on primary prevention which totaled $55,729,126.

Oregon CJC spent most of their money on treatment services, totaling $13,519,267. Oregon DHS spent the majority on recovery supports (e.g., housing and supported employment) with recovery supports spending totaling $8,167,423. Oregon DOC funded solely treatment services, totaling $7,046,682. OJD funded drug courts, totaling $4,505,237; and OYA funded treatment services totaling around $1,040,080.

TABLE 5: SUM OF SUD SPENDING BY STATE AGENCY AND BY SERVICE CATEGORY

State Agency by Service Category	Sum of SUD Spending
Oregon Health Authority: Medicaid	**$562,122,397**
Treatment	$470,272,996
Peer Delivered Services	$21,029,504
Recovery Supports	$402,512
Other Medicaid Capitated Payments	$70,417,386
Oregon Health Authority: Behavioral Health Division	**$322,236,190**
Primary Prevention	$2,058,987

State Agency by Service Category	Sum of SUD Spending
Harm Reduction	$29,875,449
Treatment	$132,591,375
Peer Delivered Services	$73,362,267
Recovery Supports	$79,540,766
Other	$2,931,665
Undetermined	$1,875,680
Oregon Health Authority: Public Health Division	**$55,729,126**
Primary Prevention	$55,729,126
Oregon Criminal Justice Commission	**$18,078,676**
Primary Prevention	$144,000
Harm Reduction	$56,000
Treatment	$13,519,267
Peer Delivered Services	$1,770,459
Recovery Supports	$2,370,160
Other	$218,790
Oregon Department of Human Services	**$10,009,263**
Primary Prevention	$453,001
Harm Reduction	$77,369
Treatment	$642,367
Peer Delivered Services	$194,182
Recovery Supports	$8,167,423
Other	$474,921
Oregon Department of Corrections	**$7,046,682**
Treatment	$7,046,682
Oregon Judicial Department	**$4,505,237**
Drug Courts	$4,505,237
Oregon Youth Authority	**$1,040,080**
Treatment	$1,040,080
Grand Total	**$980,767,651**

Note: Tribal funds are not included in this table as the service utilization was not identified

Oregon Health Authority: Medicaid

The largest portion of the OHA's SUD spending is on SUD treatment and services for individuals on the Oregon Health Plan, totaling around $562M funded through Medicaid and Children's Health Insurance Plan. Of this amount, $513M is paid to Oregon's coordinated care organizations (CCOs) in the form of capitated (per member, per month) payments, and $49M is directly paid to providers according to the state's Medicaid fee-for-service rate schedule. Medicaid/CHIP expenditures are primarily funded with federal dollars, with 84% ($472M) coming from federal match, and 16% ($90M) coming from state general funds. Analysis of encounter data from the Medicaid Management Information System—which tracks services rendered for Medicaid members—shows that most funds go to SUD treatment, with less than 5% of spending on other services and supports, such as peer services.

Oregon Health Authority: Behavioral Health Division

In the 2021 – 2023 biennium, OHA's Behavioral Health Division expended $322M towards a range of SUD services and supports, which can be categorized into three major buckets: services provided by

community mental health programs, behavioral health resource networks, and other programs and services supported through federal and state grants and contracts.

COMMUNITY MENTAL HEALTH PROGRAMS

Community Mental Health Programs (CMHPs) serve as the behavioral health safety net in each county. CMHPs provide a wide range of behavioral health services, some of which CMHPs are required to offer by statute or rule. Funding for behavioral health services, known as "service elements", is distributed via County Financial Assistance Agreements, which are negotiated every two years. In most cases, funding goes to Local Mental Health Authorities (county-level government bodies), which then distribute the money to CMHPs. CMHPs may be operated directly by the county, or by non-profit providers. In a small number of counties, the state directly contracts with non-profit CMHPs.

In the 2021-2023 biennium, CMHPs received $76M for SUD treatment, services and supports. About 40% of expenditures were funded with federal grant money and 60% were funded through a mixture of state funds, including general fund, lottery, alcohol and marijuana revenues, and the intoxicated driver program fund. More information on the dollars distributed by service element, which are defined in **Table 6**, can be found below in **Table 7**.

TABLE 6: SERVICE ELEMENT DESCRIPTIONS

Service Element	Service Element Description
Service Element 3:	**Local Administration - Addiction Services** Services include planning and resource development, coordination of service delivery for addiction treatment, recovery, & prevention and problem gambling services, negotiation and monitoring of contracts and subcontracts, and documentation of service delivery in compliance with state and federal requirements.
Service Element 61:	**Adult Substance Abuse Disorder Residential** Services delivered to adults eligible for and needing SUD residential treatment. Services are limited to those who are not eligible for Medicaid, who demonstrate a need for financial assistance based on an income below 200% of the current federal poverty level and currently have insufficient health coverage to obtain services.
Service Element 62:	**Housing Services** Parents in SUD Residential Treatment Supported capacity for dependent children whose parents are in adult substance use disorder residential treatment.
Service Element 63:	**Peer Delivered Services** Peer Delivered Services at Recovery Centers, agencies, or in communities, by Peer Support Specialists or Peer Wellness Specialists.
Service Element 64:	**Housing Assistance** Housing services for individuals in recovery from substance use disorders, who were previously homeless or at risk of homelessness, and who are participating in a verifiable program of recovery. Services may not exceed 24 consecutive months for any individual, unless approved by OHA.

Service Element	Service Element Description
Service Element 65:	**Intoxicated Driver Program Fund** Services for Oregon residents who have been adjudicated in an Oregon court for Driving Under the Influence of Intoxicants (DUII) or Minor in Possession (MIP). SE 65 also includes special services provided for individuals adjudicated for DUII. Services limited to Oregon residents who have a household income below 200% of the US Federal Poverty Guidelines and are not eligible for Medicaid or is underinsured.
Service Element 66:	**Continuum of Care** Community outpatient SUD services for youth and adults with substance use disorders or to youth and adults with co-occurring substance use and mental health disorders. Limited to individuals who are not eligible for the Oregon Health Plan (OHP) or who otherwise do not have a benefit that covers the A&D 66 Services.
Service Element 67:	**SUD Residential Services Capacity** Pays for housing/lodging services for indigent, underfunded, or Medicaid-eligible individuals who are enrolled in SUD adult or youth residential services or day treatment services where housing/lodging services are provided.
Service Element 80:	**Problem Gambling Prevention Services** Problem gambling services that provide education aimed at increasing public awareness of problem gambling that includes all populations of the public and prevent problem gambling.
Service Element 81:	**Problem Gambling Treatment Services** Outpatient problem gambling treatment services.
Service Element 82:	**Problem Gambling Residential Services** Problem gambling treatment in residential programs.
Service Element 84:	**Problem Gambling Prevention Services (Community)** Problem gambling community outreach services

TABLE 7: OHA BHD 21 – 23 SPENDING BY SERVICE ELEMENT

Service Element	Total State	Total Federal	2021-2023 TOTAL
Local Administration - Addiction Services.	$265,045		$265,045
Adult Substance Abuse Disorder Residential.	$1,724,068	$1,651,883	$3,375,951
Housing Services.	$2,176,369	$1,946,264	$4,122,633
Peer Delivered Services.	$6,230,267		$6,230,267
Housing Assistance.	$265,088	$1,746,377	$2,011,465
Intoxicated Driver Program Fund.	$1,656,426		$1,656,426
Continuum of Care.	$19,021,853	$18,400,336	$37,422,188
SUD Residential Services Capacity.	$2,909,923	$6,408,105	$9,318,028

Service Element	Total State	Total Federal	2021-2023 TOTAL
Problem Gambling Prevention Services.	$3,369,954		$3,369,954
Problem Gambling Treatment Services.	$5,723,778		$5,723,778
Problem Gambling Residential Services.	$1,788,501		$1,788,501
Problem Gambling Prevention Services (Community).	$286,782		$286,782
TOTAL	**$45,418,054**	**$30,152,965**	**$75,571,019**

BEHAVIORAL HEALTH RESOURCE NETWORKS

In 2020, voters approved Ballot Measure 110, which decriminalized possession of small amounts of controlled substances and reallocated marijuana tax revenue into a new fund to expand SUD services and supports, known as the Drug Treatment and Recovery Services fund. A public advisory group—the Oversight and Accountability Council (OAC), comprising those with lived experience, community partners and other members of the public—directs how the money is used. Grants are made directly to organizations participating in Behavioral Health Resource Networks (BHRNs). A BHRN is a network of organizations in each county which must collectively provide the following services, at minimum:

- Screening and referral to services
- Comprehensive behavioral health needs assessments
- Peer delivered outreach, supports, mentoring and recovery services
- Harm reduction services, information, and education
- Low-barrier SUD treatment and addiction recovery services

In the 2021-2023 biennium, the state distributed $199M to BHRNs, of which about $95M was expended by agencies, according to quarterly financial reports.

TABLE 8: BEHAVIORAL HEALTH RESOURCE NETWORKS 2022 EXPENDITURES BY SERVICE

Expenditure Type	Sum of SUD Spending
Total Distributed	**$94,663,633**
Peer Support and Mentoring	$29,880,609
Housing Services	$28,636,287
Low Barrier Substance Use Treatment	$14,774,398
Harm Reduction Intervention	$9,070,916
Screening & Assessment	$5,022,344
Supported Employment	$3,825,168
Comprehensive Behavioral Health Needs Assessment	$3,453,906

In addition, in the 2021-2023 biennium, Oregon used a mixture of state and federal funds to distribute $37M in one-time start-up funds—known as Access to Care grants—to help organizations provide services quickly.

DIRECT AWARDS FOR SUD PROGRAMS AND SERVICES

About $49M of OHA – BHD's budget went toward grants and contracts with individual organizations to offer a range of SUD-related programs, supports and services. Most of these programs are funded through two major federal grant programs, totaling about $36.1M:

Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS): $15.7M
Funds from the SUPTRS block grant are administered by the Substance Abuse and Mental Health Services Administration. Grants are awarded to states every two years, and award amounts are based on

population, rather than need. States have a great deal of flexibility with how they use their funds, but there are a few minimum requirements:

- Funds must be used to supplement—but not supplant—state funds
- A minimum of 20 percent of the award must be spent on SUD prevention
- 5% of the award must be set aside for pregnant and parenting persons
- 5% of the award may be used for administration, including research and evaluation

In the 2021-2023 biennium, the majority of SUPTRS block grant dollars funded services provided through CMHPs ($28.5M). The $15.7M in direct awards was mostly blended and braided with other funding sources to support a variety of programs and services, such as recovery programs—including Harmony Academy, Oregon's recovery high school—and workforce development (e.g. scholarships for CADCs, peer support trainings).

During the COVID pandemic, Oregon received additional SUPTRS awards through the COVID-19 enhancement funds and through the American Rescue Plan Act. These funds were used for one-time projects, including to expand peer support services, develop ECHOs (telehealth training) for older adults, and establish learning collaboratives, among many other projects.

State Opioid Response (SOR) Grants: $20.4M

The State Opioid Response Grant program is also administered by SAMHSA and is the follow-on to the State Targeted Response to the Opioid Crisis (STR) grant program. States must apply for funds every two years, and include a needs assessment and detailed plan. Funding must be used to support evidence-based programs and services across the care continuum – prevention, harm reduction, treatment, and recovery – for people who are at risk of or have opioid use disorders and/or stimulant use disorders. Funds are targeted towards grant requirements, which may change each grant cycle.

In the 2021-2023 biennium, Oregon used SOR funds—sometimes in conjunction with SUPTRS funds—to focus on regions and populations with high rates of opioid use disorder (OUD) or stimulant use disorder (StimUD), high overdose rates, and low substance use disorder (SUD) treatment participation (primarily MOUD). Activities aimed to increase access to treatment and recovery services, strengthen overdose prevention and harm reduction resources, employ a comprehensive prevention services plan, and expand the SUD workforce in the state.

The **remaining funds for direct awards to organizations ($12.7M)** came from a mix of state general funds, lottery taxes, beer and wine revenues (allocated from the Oregon Liquor and Cannabis Commission), marijuana revenues and the Intoxicated Driver Program Fund. These funds supported things like research and evaluation and individual contracts with SUD organizations. The Intoxicated Driver Program Fund specifically funded direct contracts with organizations to provide DUII services.

TRIBAL INVESTMENTS

The Oregon Health Authority respects the government-to-government relationship with the Nine Federally Recognized Tribes in Oregon. OHA recognizes the health disparities of substance use disorders and mental health issues for American Indian/Alaska Native people that have resulted from the impact of historical, intergenerational, and current-day trauma. Indian Health Care Providers are Medicaid billable providers and expenditures for services by these providers are included in the total figures for Medicaid dollars spent. Tribal Behavioral Health funding is distributed to the Tribes and Urban Indian Health Program through behavioral health contracts and is reflected in the total agency figures presented. Tribal set asides are allotted following OHA's Tribal Consultation Policy. While smaller amounts have been provided on an ongoing basis for a number of years, for substance abuse prevention and some support for outpatient SUD treatment, much of the funding in the 2021-2023 biennium was one-time funding and is included in the totals by fund type. Increased, ongoing behavioral health funding is needed to support the expansion of this work to meet the needs identified. Tribal Behavioral Health Programs provide comprehensive, culturally-responsive care across the continuum that supports prevention, treatment and

recovery, utilizing Tribal Based Practices, that best fit their own communities. The breakout of funds based on service type would not be representative of the holistic approach to service delivery. The breakout by county does not capture the fact that Tribes have service delivery areas (covering up to 11 Counties).

OTHER MAJOR INVESTMENTS (NOT SUD-SPECIFIC)

During the 2021-2023 biennium, the Oregon Legislature made historic investments in the behavioral health system. The two major buckets of investments—HB 5202, and HB 5024, allocated $230M for expanding mental health residential treatment and housing—and HB 2949, HB 4079, and HB 4004, which support workforce retention and development—are not necessarily SUD-specific, but nevertheless will make an impact on Oregonians with SUDs.

- **HB 5202/HB 5024: Behavioral Health Residential and Housing Expansion**
  - Although the focus of the HB 5202 and HB 5024 funds have been on expanding treatment and housing services for people living with serious mental illness, these investments will undoubtedly support those living with SUDs due to the high incidence of co-occurring disorders in this population.
  - All $100M in HB 5202 funds were expended by end of FY 2023. About half of this -- $47M – went to organizations that had at least one project serving SUD or COD populations in their grant agreements. This includes nearly $6M to help support Washington County's forthcoming Center for Addictions and Treatment, which will offer a comprehensive set of crisis, outpatient, residential and withdrawal management services, and is dually funded with M110 dollars.
  - The $130M in HB 5024 funds are still being rolled out, and the impact of these funds on those living with SUDs will be apparent as programs and facilities come online.

- **HB 2949, HB 4079, and HB 4004: Workforce Investments**
  - In the 2021-2023 biennium, the legislature passed HB 2949 and HB 4079, which allocated $80M in American Rescue Plan Act funds to develop and sustain the behavioral health workforce. $20M of this was earmarked specifically for supporting clinical supervision, and $60M was to be used for workforce development.
  - By end of FY 2023, OHA distributed about $14M for a variety of workforce initiatives that touch MH and SUD workers. One of these programs—funding to cover costs of testing and certification through the Mental Health and Addition Certification Board of Oregon (MHACBO)—explicitly supports CADC and CRM workforce development, as outlined in **Table 9**.
  - In addition, HB 4004 allocated about $133M in General Funds for direct payments to behavioral providers. All of this money was distributed to providers and organizations by the end of FY 2023, and was used to:
    - Increase compensation for the provider's staff;
    - Pay a retention bonus to an individual on the provider's staff if necessary to prevent the individual from leaving the provider's employ; or
    - Hire new staff and provide a hiring bonus, if necessary to recruit new staff.

TABLE 9: BEHAVIORAL HEALTH WORKFORCE INVESTMENTS

Program	Summary of Program	Total Distributed
Loan Repayment	Advancing equity by prioritizing and awarding applicants who represent or identify with the ethnicity, or culture of underserved communities, or provide services to individuals from these communities. Applications were also prioritized from	$2,490,279

Program	Summary of Program	Total Distributed
	individuals with lived experience and those who work in a rural or frontier community.	
Subsidized Certification Program	Grants to MHACBO, Oregon's certification board, for: • Activities for registration of new Qualified Mental Health Associates (QMHA) and Qualified Mental Health Professionals (QMHP); • Recertification of existing QMHAs and QMHPs in Oregon; • Maintenance, support, and further development of the certification program and behavioral health workforce in Oregon; • Registration for Certified Alcohol and Drug Counselor Registrants (CADC-R); • Initial certification costs for Certified Recovery Mentors (CRM); • Half-time staff position to provide ongoing technical support to new applicants; • Recertification of existing Certified Alcohol and Drug Counselors (CADC I, II, and III), Certified Recovery Mentors (CRM I and II) and Certified Prevention Specialists (CPS); • Initial exams for CPS, CADC I, QMHA I, QMHP-C, CRM II; • Professional development for fully certified CADC II, CADC III and QMHA I	$2,756,683
Association of SW Board (ASWB) Exam Fee Waiver Program	Waiving exam fees for all social work licensing exams for unlimited attempts.	$130,000
Bonus & Housing Stipend Program	20 organizations provided funding for housing and bonus stipends to BH staff.	$816,425
Oregon Board of Licensed SWs (BLSW) Licensing Fee Waiver Program	Contract to waive licensing fees for most initial licenses (based on success in TX, LA, CA)	$39,770
Community Mental Health Programs	Funding for CMHPs to recruit and retain their workforce	$2,363,659
Clinical Supervision Round 1	Support staff/supervisees and supervisors in obtaining Master's Level Clinician Certification	$2,151,039

Program	Summary of Program	Total Distributed
Clinical Supervision Round 2	Support staff/supervisee and supervisors in obtaining Master's Level Clinician Certification. Licensed clinicians are being trained to become clinical supervisors.	$1,281,603
Community Mental Health Programs	Funding for CMHPs to recruit and retain their workforce (clinical supervision)	$935,426

Oregon Health Authority: Public Health Division (PHD)

OHA PHD reported a total of about $60M in spending on primary prevention of substance use. The $60M spent on primary prevention by OHA PHD was spent on six different programs, described below.

- **Alcohol and Other Drugs – HS** program area totals around $2,921,531and includes the following funding streams to support the program.
    - **Comprehensive Cancer** funds provide foundational resources for partnerships, planning, coordination, leadership development and promotion of comprehensive cancer control across all cancer-related initiatives.
    - **Marijuana Tax Fund**, a portion of the state Marijuana Tax set aside for substance use prevention. Provides foundational resources for coordinated state and community efforts to address alcohol, tobacco, and drug prevention, including policy- and equity-focused data collection and analysis.
    - **SUPTRS – supplemental COVID**, grant provides foundational resources for coordinated state and community efforts to address alcohol, tobacco, and drug prevention, including data collection and analysis and implementation of the Synar Amendment.

- **Alcohol and Other Drugs – Prevention Education Program** totals around $8,875,994 and includes the following funding streams to support the program.
    - **Criminal Fines Fund** provides dollars for the establishment, operation and maintenance of alcohol and drug abuse prevention provided through a county, and related technical assistance.
    - **General Prevention Fund** provides resources for state and community efforts to address alcohol, tobacco, and drug prevention, including enforcement of state tobacco retail laws as required as a condition of receiving the Substance Abuse Prevention and Treatment Block Grant.
    - **Substance Abuse Prevention Treatment Grant**, grant provides foundational resources for coordinated state and community efforts to address alcohol, tobacco, and drug prevention, including data collection and analysis and implementation of the Synar Amendment.

- **Alcohol and Other Drugs- SE** program area totals around $452,815 and includes the following funding streams to support the program.
    - **Oregon State Cancer Registry** provides foundational resources to maintain the legislatively mandated cancer registry, including collecting and reporting cancer data. Rates of many cancers are influenced by SUD. The registry provides cancer prevalence data helpful for understanding the health impacts of SUD in Oregon.

- **Overdose Prevention** totals around $2,348,287 and includes the following funding streams to support the program.
    - **Overdose Data to Action (OD2A)**, a Centers for Disease Control and Prevention (CDC) grant, funds overdose mortality and morbidity surveillance, innovative surveillance

projects, enhance the use of the PDMP, support community prevention programs and health system interventions to reduce overdose, implement the ODMap reporting system, and empower people to make informed choices.

- **Prescription Drug Monitoring Program** (PDMP) totals around $813,799 and includes the following funding streams to support the program.
  - **Bureau of Justice Administration (BJA) FY 20 Harold Rogers Prescription Drug Monitoring Program** provides funding to enhance the PDMP. This program works to improve patient safety and clinical outcomes to reduce prescription drug overdose and misuse.

- **Tobacco- HS** program area totals around $44,977,333 and includes the following funding streams to support the program.
  - **Ballot Measure 108 Fund (Tobacco Tax)**, a state tobacco tax, provides funds directed to the Tobacco Use Reduction Account (TURA) to support a comprehensive tobacco prevention education program, including resources for policy- and equity-focused data and evaluation, health communications, state and community programs, and systemic cessation supports.
  - **Measure 44 Fund (Tobacco Tax)**
  - **Tobacco CDC** funds provide foundational resources to establish, strengthen and maintain sufficient tobacco control program capacity in state health departments to achieve the four National Tobacco Control Program goals using population-based environmental, policy, and systems interventions and strategies demonstrated to effectively impact the tobacco epidemic.

TABLE 10: OHA PHD PRIMARY PREVENTION PROGRAM TYPES BY FUND TYPE

Primary Prevention Program Type by Fund Type	Sum of SUD Spending
Alcohol and Other Drugs- HS	**$2,921,531**
Comprehensive Cancer	$50,731
MJ Tax Fund	$1,218,626
SUPTRS - Supplemental (COVID)	$1,652,174
Alcohol and Other Drugs – Prevention Education Program	**$8,875,994**
Criminal Fines Fund	$32,781
General Prevention Fund	$912,086
Substance Abuse Prevention Treatment Grant	$7,931,128
Alcohol and Other Drugs- SE	**$452,815**
Oregon State Cancer Registry	$452,815
Overdose Prevention	**$2,348,287**
Overdose Data to Action (OD2A)	$2,348,287
Prescription Drug Monitoring Program	**$813,799**
BJA FY 20 Harold Rogers Prescription Drug Monitoring Program	$813,799
Tobacco- HS	**$44,977,333**
Ballot Measure 108 Fund (Tobacco Tax)	$32,419,159
Measure 44 Fund (Tobacco Tax)	$10,421,318
Tobacco CDC	$2,136,857
Total	**$60,389,759**

Oregon Health Authority: Health Policy and Analytics

OHA Health Policy Analytics (HPA) provides funding for staff that support behavioral health programs throughout the state of Oregon. The 2017 Oregon Legislature approved HB 3261, establishing the Health Care Provider Incentive Program within the Oregon Health Authority (OHA) to support access to care for underserved communities throughout Oregon. The program offers various incentives, which include loan repayment, loan forgiveness and insurance subsidies to both students and providers who commit to serving patients in underserved areas of the state. As of December 2022, there have been 64 awards distributed for loan repayment to behavioral health professionals (including but not limited to SUD treatment professionals), totaling a little more than $1.9M.

Oregon participates in the National Health Service Corps program to address the needs of underserved populations. Through this program, certain health care providers are offered scholarships or loan repayments for providing services in federally designated Health Professional Shortage Areas. As of August 2023, there have been 48 awards distributed to substance use disorder program professionals participating in the National Health Service Corps.

Oregon Criminal Justice Commission

Oregon Criminal Justice Commission reported a total of about $19.5M in spending on SUD services, which covers three main programs: Improving People's Access to Community-Based Treatment, Supports and Services (IMPACTS); Justice Reinvestment Program (JRP); and the Specialty Courts Grant Program (SCGP). The IMPACTS program was established by SB 973 (2019) to provide funding for counties and tribal governments to develop stronger community-based supports and services available to individuals with mental health or substance use disorders that have been identified as high utilizers of the criminal justice system, emergency services, and/or institutional placements. The SCGP program was established by HB 3194 (2013) to provide funding for counties to establish processes to assess individuals charged with non-violent offenses (property, drug, and driving) and to provide a continuum of community-based services and programming to those individuals. The JRP program was established in 2007 to support the operations of Oregon's specialty courts serving adults, juveniles, and families. Specialty courts operate under a model that provides an alternative to incarceration through court-directed supervision and mandated treatment for individuals with substance use or mental health issues underlying their involvement in the criminal legal system.

Oregon Department of Human Services

Oregon Department of Human Services provided fiscal data on SUD services. This data included costs for addiction services, other medical services, and the Strengthening, Preserving, and Reunifying Families (SPRF) Program. Addiction services include statewide front end and pre-treatment services that assist caseworkers in identifying parental substance use that impacts child safety and facilitates referrals for full diagnostic assessments, SUD treatment, and ongoing support for the completion of those services. The program provides liaison services with all local treatment providers, facilitating client support through treatment and timely communication on client progress. Other behavioral health services covered by the program include a variety of services that are normally covered under the Oregon Health Plan (OHP), when the parent or child needing the service is not eligible for OHP coverage. These services allow case management and safety planning to occur, which maximize parent functioning and child safety and health. Finally, the SPRF program supports short-term supportive housing and outreach and navigation services.

Oregon Department of Corrections

In the data provided, Oregon Department of Corrections (ODOC) reported a total of about $7M spent on SUD services. These funds supported treatment services throughout the state of Oregon. In 2019, the Oregon legislature recognized SUD as a chronic disease with the passage of House Bill 2257. ODOC

began implementing elements of this chronic disease model in the last year, with expansion of Medication Assisted Treatment through a pilot across all institutions and with the addition of Peer Recovery Support service models at Coffee Creek Correctional Facility and the Oregon State Penitentiary. ODOC also funded the Columbia River Correctional Facility and the Powder River Correctional Facility with these funds.

Oregon Judicial Department

Oregon Judicial Department reported around $4.5M in funding for drug courts, including Family Treatment Courts, BJA Adult Drug Court, Substance Abuse and Mental Health Services Association Adult Drug Courts (ADC) subaward, Lincoln County Board of Commissioners HOPE Court Subaward, Umatilla Good Shepherd Hospital subaward for Adult Drug Court, Veteran's Treatment Court subaward, Clatsop County Board of Commissioners award for Adult Drug Courts, BJA Risk and Needs Triage Tool Implementation for Adult Drug Courts and the Multnomah Justice Reinvestment Program.

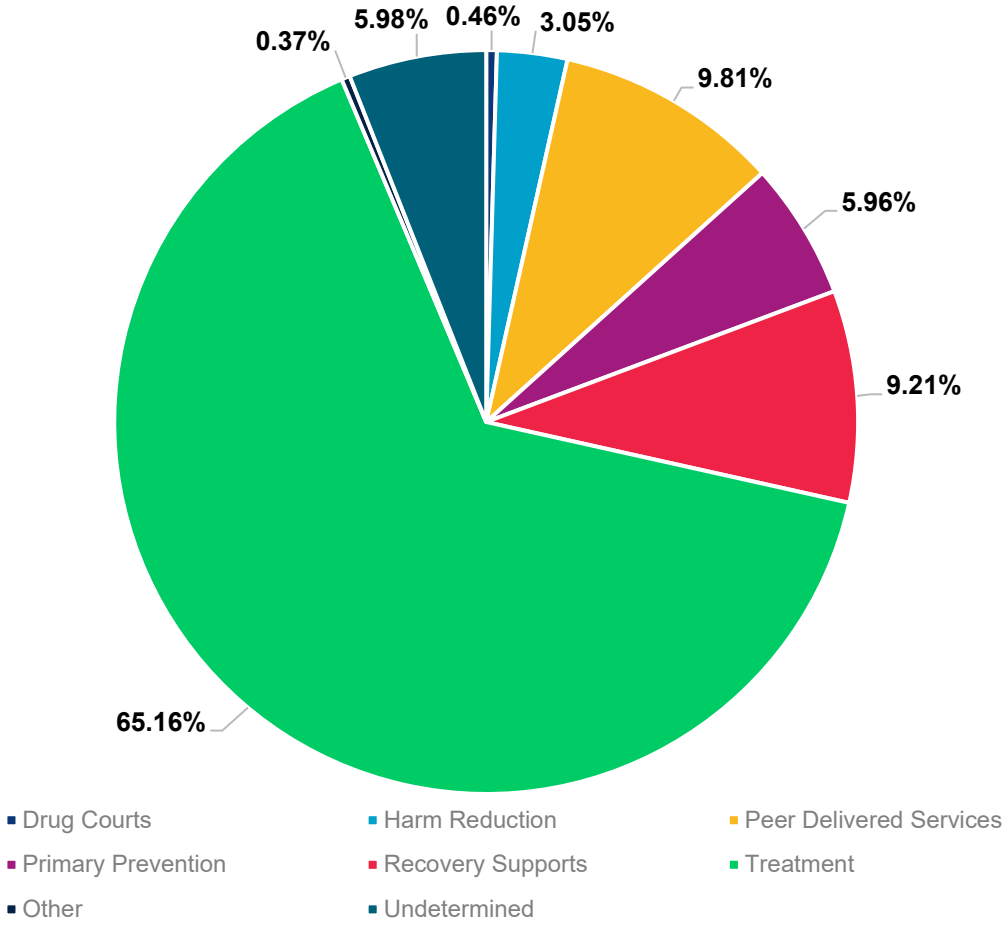
Oregon Youth Authority

OYA reported around $1M in spending on treatment services. This covers three budgeted positions, services and supplies for residential facilities providing substance use services to youth in the care of OYA.

Spend by Service Category

SUD services in Oregon span an array of setting categories and service types across the continuum. **Figure 1** displays the percentage of total spending on setting categories during the biennium. Below, **Table 12** summarizes the total dollar amount spent by **setting categories and service types** during the 2021–2023 biennium.

FIGURE 1: PERCENT OF SUD SPENDING BY SETTING CATEGORY



Oregon spends **65.16%** of SUD funding on treatment, totaling around **$625,112,768** of which, **outpatient treatment** ranks the **highest, at around $324,460,678**The next highest category of spending is SUD residential treatment, totaling around $113,774,701, and residential/residential withdrawal management comes in third at $102,314,766.

TABLE 11: SUMMARY OF SUD SPENDING BY SETTING CATEGORY AND SERVICE TYPE

Setting Category and Service Type	Total SUD Spending
Primary Prevention	**$58,385,114**
Community-Based Practices	$2,348,287
Environmental Strategies	$40,975,598
Information Dissemination	$11,591,443
Prevention Education	$1,685,913
Problem Identification & Referral to Services	$813,799
Undetermined	$970,075
Harm Reduction	**$30,008,819**
Treatment	**$625,112,768**
Outpatient	$324,460,678
Medication Assisted Treatment	$49,032,859

Setting Category and Service Type	Total SUD Spending
Residential	$113,774,701
Withdrawal Management (Residential/Residential)	$102,314,766
Problem Gambling Services	$11,518,641
Commercial Tobacco Smoking Cessation	$463,721
Undetermined	$41,387,790
Peer Delivered Services*	**$96,111,038**
Recovery Supports	**$90,257,494**
Housing	$73,158,526
Supported Employment	$8,641,035
Undetermined	$8,457,933
Drug Courts	**$4,505,236**
Other	**$3,625,376**
Administration	$310,370
Drug Screen/Collection	$696,284
DUII Services	$538,001
Intoxicated Driver Program Fund	$1,663,598
Technical Assistance / Program Evaluation	$417,120
Undetermined	**$72,793,067**
Grand Total	**$980,767,651**

*Note: Peer delivered services (PDS) are pulled out as a unique category as peers may work in a variety of settings, and setting type was not always discernable from PDS budget data.

Note: "Undetermined" contains the Medicaid Capitated Services . The remaining funds reflect data for which the category of spend is still undergoing analysis or could not be determined. This includes cost data received from agencies without a service category or description provided.

Note: Tribal funds are not included in this table as the service utilization was not identified

Spend by County

An overview of SUD spending by county in Oregon is provided in **Table 12**. This **data reflects the geographic distribution of state and federal dollars across the state**, inclusive of Medicaid and non-Medicaid treatment spending, as displayed in **Figure 2**.

TABLE 12: SUM OF SUD FUNDING DISTRIBUTION BY COUNTY (INCLUDING MEDICAID)

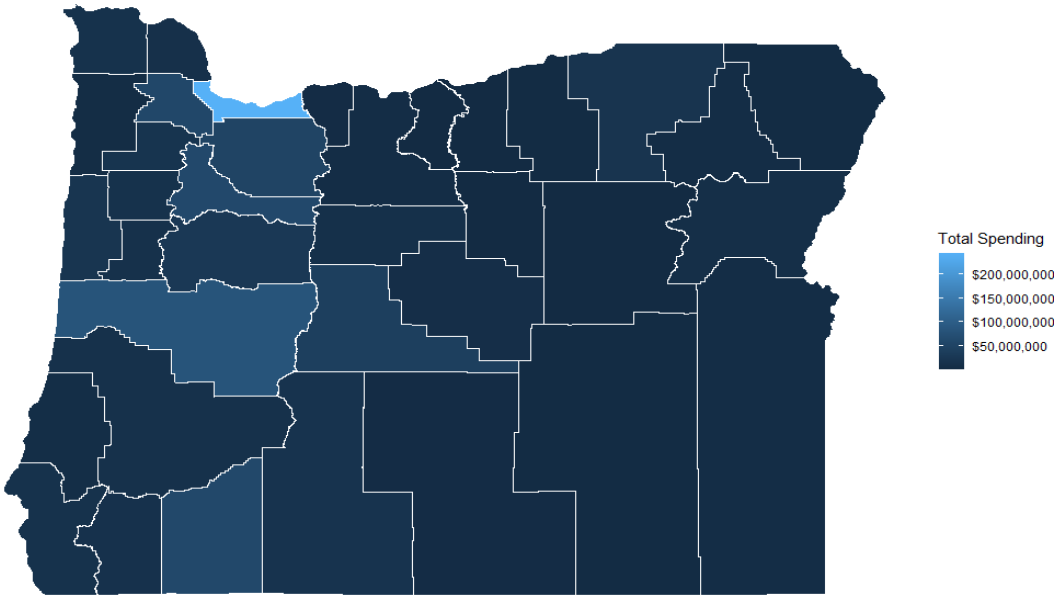
County	Funding Distributed
Multnomah	$243,136,363
Multi County	$139,495,791
Lane	$80,380,942
Marion	$58,450,108
Washington	$57,127,498
Jackson	$55,769,023
Clackamas	$49,640,166
Deschutes	$39,327,986
Linn	$27,354,601
Lincoln	$20,078,802
Umatilla	$18,659,372
Klamath	$16,824,700
Yamhill	$16,566,909

County	Funding Distributed
Clatsop	$14,408,077
Polk	$14,175,500
Curry	$14,093,199
Josephine	$13,177,939
Douglas	$12,680,687
Benton	$12,450,110
Columbia	$11,519,722
Jefferson	$10,131,012
Baker	$7,658,640
Crook	$6,944,904
Coos	$5,797,322
Malheur	$5,079,604
Union	$4,822,729
Wasco	$4,619,516
Out-of-State	$4,207,570
Tillamook	$3,574,148
Hood River	$3,368,610
Lake	$2,980,945
Wallowa	$1,495,707
Harney	$1,478,543
Morrow	$1,327,239
Grant	$1,012,350
Wheeler	$319,010
Sherman	$317,850
Gilliam	$247,079
Undetermined	$66,382
Grand Total	**$980,767,651**

*Note: Out-of-State dollars are attributable to Medicaid spending on SUD treatment.
**Note: Multi County includes Other Medicaid Capitation Payments.
***Note: Tribal funds are not included in this table as the location of services were not identified

The largest share of state and federal dollars flows into Multnomah County, with a total of **$243,136,363** spent on SUD treatment, programs, and services. The second largest share of SUD dollars goes through Lane County, at about $80,380,942. Marion, Jackson, and Washington Counties come next, with $ 58,450,108, $55,769,023, and $57,127,498 spent on SUD treatment, programs, and services respectively.

FIGURE 2: GEOGRAPHICAL DISTRIBUTION OF SUD SPENDING BY COUNTY



Spend by Fund Source and Fund Type

Of all the fund sources (i.e., Federal Funds, General Funds, Other Funds) analyzed for this report, **Federal Funds** are the **most highly utilized fund source**, totaling around **$654M. Medicaid** was the largest **federal fund expenditure**, at around **$562,122,397**. The next highest SUD services funding source is Marijuana Funds, at about $208,438,031, most of which is allocated for M110 programs (Drug Treatment and Recovery Services fund.)

Note: Due to rounding each subcategory as well as the subtotals, subcategories do not sum to the amount in each subtotal. Subtotals are rounded and sum to the accurate total.

TABLE 13: SUM OF SUD SPENDING BY FUND SOURCE AND FUND TYPE

Fund Source and Fund Type	Sum of SUD Spending
General Funds	**$85,180,890**
Federal Funds	**$654,428,152**
Comprehensive Cancer	$50,731
Harold Rogers Prescription Drug Monitoring Program	$813,799
Medicaid – Federal Match	$562,122,397
Oregon State Cancer Registry	$452,815
Overdose Data to Action (OD2A)	$2,348,287
State Opioid Response (SOR)	$21,513,580
Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRS)	$39,228,730
SUPTRS – Supplemental (ARPA)	$3,774,938
SUPTRS – Supplemental (COVID)	$10,000,462
Temporary Assistance for Needy Families (TANF)	$2,022,297
TITLE IV-B	$4,537,682
Tobacco CDC	$2,136,857
Undetermined	$5,425,578

Fund Source and Fund Type	Sum of SUD Spending
Other Funds	**$260,231,777**
Marijuana - Drug Treatment and Recovery Services (M110)	$208438,031
Marijuana - Other	$13,220,902
Lottery	$14,030,262
Alcohol – Mental Health, Alcohol and Drug Services (OHA Carveout)	$13,271,179
CW TRUST IN LIEU GRANT	$2,597
Intoxicated Drivers Program Fund	$2,232,795
Undetermined	$9,036,009
Grand Total	**$999,840,819**

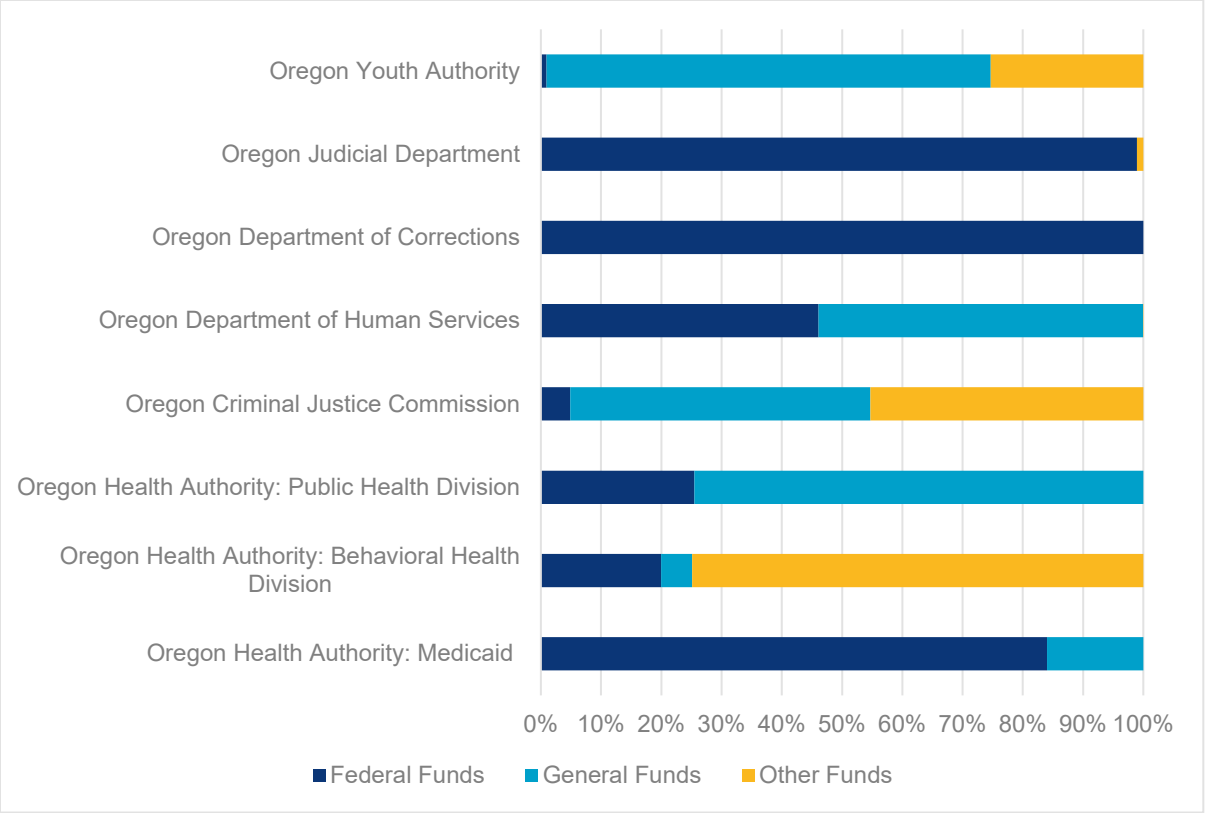
Spend by Agency by Fund Source

Included in the analysis is a breakdown of spending by state agency and by fund source. Fund sources include federal funds, general funds, and other funds. A breakdown by fund source is included below.

TABLE 14: SUM OF SUD SPENDING BY STATE AGENCY AND BY FUND SOURCE

State Agency by Fund Source	Sum of SUD Spending
Oregon Health Authority: Medicaid	**$562,122,398**
Federal Funds	$472,182,163
General Funds	$89,940,235
Oregon Health Authority: Behavioral Health Division	**$335,157,781**
Federal Funds	$66,880,672
General Funds	$17,220,787
Other Funds	$251,056,321
Oregon Health Authority: Public Health Division	**$60,389,759**
Federal Funds	$15,385,790
General Funds	$45,003,969
Oregon Criminal Justice Commission	**$19,569,619**
Federal Funds	$958,387
General Funds	$9,749,361
Other Funds	$8,861,871
Oregon Department of Human Services	**$10,009,263**
Federal Funds	$4,613,714
General Funds	$5,392,952
Other Funds	$2,597
Oregon Department of Corrections	**$7,046,682**
General Funds	$7,046,682
Oregon Judicial Department	**$4,505,237**
Federal Funds	$4,457,528
Other Funds	$47,709
Oregon Youth Authority	**$1,040,080**
Federal Funds	$9,663
General Funds	$767,139
Other Funds	$263,278
Grand Total	**$999,840,819**

FIGURE 3: SUM OF SUD SPENDING BY STATE AGENCY AND BY FUND SOURCE (%)



FINANCIAL INVENTORY – CONSIDERATIONS

State agencies, CMHPs, LPHAs and providers across the state all document data in different capacities and in different systems. This makes it difficult to collect data and compare how money is being spent on SUD programs in Oregon. **PCG recommends** considering **a state-wide data system that all community partners and members of the public can use to input financial and outcome data**. Such a system would allow interested parties to enter the amount of money budgeted, distributed, and spent from various sources for each SUD program type. Program types would be clearly defined to ensure that the definition of the service being delivered in the community is the same across all data elements. In addition, Oregon should consider requiring other data be collected in the statewide system (e.g., outcomes, location of services, etc.) to provide data connecting investments to the number of people served, geographic distribution, and outcomes.

GAP COST ESTIMATES

This section will cover the cost of filling gaps (i.e., unmet needs) in three general categories: workforce, facilities (i.e., program locations), and other SUD programming. To generate cost estimates, PCG used unmet need estimates from several sources: SUD service need estimates derived from the Substance Abuse and Mental Health Service Administration's **Calculating for an Adequate System Tool (CAST)**, as reported in the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis** and the **OHA Behavioral Health Residential+ Facility Study** (final study pending publication); original analysis from the Oregon Department of Education; and original analysis from the Oregon Health Authority.

This report does not include estimates on what portion of those costs would—or should—be borne by the federal, state, or local governments, other sectors, or individuals seeking to join the workforce. Determining the division of responsibility for these costs is an issue that leaders must grapple with as behavioral health workforce policy is advanced in Oregon.

Discussion on the reasoning for and methodology used when updating gaps for any SUD services or supports are included in each applicable program subsection within the cost estimate section of the report. Cost estimate methodology is also discussed in detail. The **total annual cost for meeting identified gaps** in SUD services and supports in Oregon is estimated at **$6.85 billion**.

TABLE 15: TOTAL COST OF MEETING IDENTIFIED SUD SERVICES AND SUPPORTS GAP

Service Type	Final Components Included in Cost Estimates in this Study	Source Used for Gap Calculation	Cost Estimate
Workforce	Salary and Benefits	2022 Gap Analysis	**$3,195,385,208**
	Building the Pipeline of Workers		**$1,765,241,619**
Facilities	Outpatient	2022 Gap Analysis	**$398,491,925**
	Recovery Residences		**$357,511,245**
	Recovery Community Centers		**$131,171,050**
	Residential	OHA Residential+ Study, (Pending Publication)	**$596,878,902**
	Withdrawal Management		**$173,866,070**
	Opioid Treatment Programs	OHA Behavioral Health Division	**$18,125,000**
Other SUD Programming	Harm Reduction Programs	2022 Gap Analysis OHA Behavioral Health Division	**$89,976,177**
	School-Based Primary Prevention	Oregon Department of Education	**$5,471,747**
	Community-Based Primary Prevention	OHA Public Health Division	**$122,840,000**
		TOTAL	**$6,854,958,943**

WORKFORCE GAP COST ESTIMATES

This section will cover the cost of employing select categories of SUD workforce based on CAST estimates reported in the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis**. These costs are estimated in two separate classifications: **cost of building the pipeline of workers** and **cost of employing the workers**.

The workforce costs provided in this study reflect the costs to the entire system. This section is intended to:

- Provide insight into the cost factors that are required to fully develop the SUD workforce. These costs can be carried by the individual or potential state and federal programs.

- Provide options for funding strategic elements listed, to encourage the development of the certified workforce.

Due to limitations in data on unmet need for workforce, PCG was unable to evaluate the need for some categories of SUD workforce. For example, PCG lacked data on unmet need for registered nurses (RNs), who are a critical component of the workforce, and, in fact, are required to serve in some SUD settings, such as withdrawal management programs. PCG recommends additional analysis on unmet workforce needs to address this knowledge gap.

Workforce Gaps

PCG used the estimates of **workforce gaps** reported in the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis** as the foundation for calculating the cost of unmet need, and updated numbers of certified workforce when updates were available.

The **number of existing SUD professionals** was determined using data acquired, collected, and distributed by the Mental Health & Addiction Certification Board of Oregon. Certifications - MHACBO[ii]

The 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis** included the CAST measure for buprenorphine prescribers, which was the number of prescribers with a buprenorphine waiver ("X waiver") in Oregon. That waiver requirement has since been eliminated by the Federal government, which substantially increased the pool of qualified prescribers in Oregon. Using Prescription Drug Monitoring Program (PDMP) data provided by the Oregon Health Authority, PCG estimated the number of providers who wrote prescriptions. Both estimates are presented in Table 16.

Table 16 provides a summary of the SUD workforce gaps based on the CAST methodology.

TABLE 16: WORKFORCE GAPS (CAST, OHSU-PSU SPH OR SUD INVENTORY AND GAP ANALYSIS)

Position	Need	Actual	Gap
Certified Prevention Specialists*	968	62	**906****
Certified Alcohol and Drug Counselors*	4,902	2,884	**2,018**
Certified Recovery Mentors*	2,177	1,565	**612**
Qualified Mental Health Associates*	20,493	2,776	**17,717**
Qualified Mental Health Professionals*	12,619	879	**11,740**
Prescribers with Buprenorphine Waiver*	3,857	1,902	**1,955**
Buprenorphine Prescribers (PCG)***	3,856	2,752	**1104********

*Source: 2022 Gap Analysis. Number of people certified in each specialty through the Metal Health & Addiction Certification Board of Oregon, within a region or county. If a person has more than one certification, they are included in the counts for each one.
**Count does not include uncertified preventionists.
***Source: Need (2022 Gap Analysis); Actual (Number of buprenorphine prescribers as estimated by PCG, using Oregon PDMP data).
****The gap identified later in this report is 1151, not subtracting region one with 47 more prescribers than needed.

Overview of Workforce Cost Estimates

To estimate the cost of closing gaps in the SUD workforce, PCG examined the total "costs to the system" to educate, train, certify and supervise new workers (Building the Pipeline) and to employ needed workers (Costs of Employment). **Total costs for closing workforce gaps,** shown in **Table 17 below,** are estimated to be about **$5.4 billion: $1.8 billion for building a new pipeline of workers** and about **$3.6**

billion in annual costs for **employing these workers.** The $1.8 billion estimated cost of building the pipeline is disproportionately weighted by post-secondary tuition costs. The portion of education-related building the pipeline costs are further delineated from the total building the pipeline costs in **Table 18**.

TABLE 17: COST ESTIMATES TO EXPAND SUD WORKFORCE (NON-PRESCRIBERS)

Position	Education, Training & Certification	Cost of Employing	Total
Certified Prevention Specialists	**$2,554,572**	**$100,313,156**	**$102,867,728**
Certified Alcohol and Drug Counselors	**$101,371,094**	**$175,096,702**	**$276,467,796**
Certified Recovery Mentors	**$734,400**	**$43,545,300**	**$44,279,700**
Qualified Mental Health Associates	**$835,594,776**	**$1,470,360,869**	**$2,305,955,645**
Qualified Mental Health Professionals	**$824,986,778**	**$1,406,069,182**	**$2,231,055,960**
TOTAL	**$1,765,241,619**	**$3,195,385,208**	**$4,960,626,827**

Educational costs (tuition and fees for post-secondary education) are the highest cost driver in the estimated $1.8 billion needed to build a new pipeline of workers and these costs are not borne directly by state government. **Table 18** delineates the costs associated with building a new pipeline of workers by education, training, supervision, and certification costs. The **educational component** of certification requirements for employment in the SUD workforce represents **96 percent of total costs for building a pipeline** of new workers, at **nearly $1.7B**. **Additional components** of certification requirements (i.e., training, supervision, and certification) account for only **four percent of total costs of building a pipeline** of new workers, at approximately **$76 million**.

TABLE 18: COST ESTIMATES TO BUILD NEW PIPELINE OF SUD WORKFORCE (NON-PRESCRIBERS) – EDUCATION VS. ALL OTHER COSTS

Position	Education	Training, Supervision & Certification	Total
Certified Prevention Specialists	N/A	$2,554,572	**$2,554,572**
Certified Alcohol and Drug Counselors	$90,890,720	$10,480,374	**$101,371,094**
Certified Recovery Mentors	N/A	$734,400	**$734,400**
Qualified Mental Health Associates	$797,973,680	$37,621,096	**$835,594,776**
Qualified Mental Health Professionals	$800,057,520	$24,929,258	**$824,986,778**
TOTAL	**$1,688,921,920**	**$76,319,700**	**$1,765,241,620**

Cost Estimate Details – Building the Pipeline

Behavioral health workforce shortages are prevalent nationwide, and so it is unlikely that Oregon would be able to fill its workforce gaps by attracting out-of-state workers with comparable licenses and/or credentials. Therefore, to calculate the cost of filling identified SUD services workforce gaps, we **must**

account for the costs related to building a pipeline of new staff who should be available to hire and onboard, including:

- Education
- Training
- Supervision
- Certification

To estimate the cost of providing the needed pool of certified workers, PCG examined **Oregon Administrative Rules (OAR), Chapter 309, Division 19**[iii] and **MHACBO**[iv] policy to determine the education, training, and supervision requirements for certification in each of the five positions identified by OHSU-PSU SPH as having gaps:

- Certified Prevention Specialist (CPS)
- Certified Alcohol and Drug Counselor (CADC)
- Certified Recovery Mentor (CRM)
- Qualified Mental Health Associate (QMHA)
- Qualified Mental Health Professional (QMHP)

In Oregon, several positions (i.e., CADC, CRM, and QMHA) are defined with multiple sets of requirements that are associated with different echelons of certification (i.e., level I, level II, and level III). To determine what investments are required to provide a pool of staff who are educated and trained at the minimal level required for certification, requirements for the **CRM I and QMHA I positions were used** to estimate costs. The **educational requirements did not vary greatly** between level I and level II for these two positions. Although, there is a non-degree and a degree pathway to meeting requirements for the QMHA I position. The **degree pathway QMHA I certification requirements were used** for cost estimates, due to **OHA's commitment to the development of a qualified workforce** who are equipped to meet clients' needs. There was a significant variance between the education requirements for the CADC I and CADC II positions, with a CADC I certification requiring no formal post-secondary education and a CADC II certification requiring a bachelor's degree. Due to that variance and OHA's commitment to developing an adept workforce, **CADC II certification requirements were used** as a baseline for determining cost estimates. To summarize, the final list of titles that were used for determining the cost of certifying the staff required to build the SUD workforce pipeline were:

- CPS
- CADC II
- CRM I
- QMHA I- degree pathway
- QMHP

Cost Estimates – Building the Pipeline

The cost of building the SUD services workforce pipeline, to support hiring the needed positions identified in 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis**, was determined based on certification requirements from the Oregon Administrative Rule (OAR) Chapter 309, division 19; OAR Chapter 415[v]; and MHACBO. Oregon Administrative Rules for behavioral health services in Oregon have been synthesized into certification regulations by OHA. These certification regulations are published, monitored, and overseen by MHACBO. Therefore, MHACBO certification resources were also utilized in determining costs associated with certifying the needed SUD services workforce.

The process for behavioral health or SUD staff certification process in Oregon is summarized in **Table 19**.

TABLE 19: OREGON BEHAVIORAL HEALTH AND SUD STAFF CERTIFICATION PROCESS

Step	Requirement
Step 1	Completion of any prerequisite formal postsecondary education, if applicable.
Step 2	MHACBO registration (i.e., become a MHACBO registrant).
Step 3*	Completion of discipline-specific training courses, if applicable.
Step 4*	Completion of a required number of client-service hours (no associated cost).
Step 5*	Completion of a regulated number of supervision hours with a certified or licensed clinical supervisor.
Step 6	Completion of any required background check(s) and successful completion (i.e., passing) of any required written or oral examination.

*Steps 3, 4, and 5 are completed simultaneously.

Once apprentice staff complete MHACBO registration, they are considered a **registrant** for the position they are seeking certification in. Throughout this section, the period between a staff becoming a MHACBO registrant and obtaining certification is referred to as the **registration-to-certification period**. **Steps Three, Four, and Five** are completed simultaneously, during the registration-to certification period. Each of the cost categories used to estimate the total cost of developing the required SUD workforce includes costs that are incurred throughout these six steps of the certification process.

Costs estimated in the **education category** include tuition for a formal postsecondary academic program, or degree. These costs are incurred in **Step One** of the certification process. Average tuition costs were considered, as determined by estimates from CollegeBoard[vi]. Room and board and other ancillary costs associated with obtaining a degree were not included. Not all positions require a formalized degree and, therefore, will not have costs included for this category.

While publicly funded college tuition in the US remains a proposition, federal, state, and local organizations have recognized the burden that postsecondary education costs place on individuals. In response, many public employers have implemented targeted educational-funding initiatives to reduce the burden[vii]. Specifically in Oregon over the last biennium, OHA – Behavioral Health Division made an $80 million investment into building the behavioral health workforce, as directed by Oregon House Bill 2949/4071. This investment included a program offering tuition-assistance and stipends for graduate-level behavioral health academics and an educational loan repayment program. Also, OHA – Health Policy and Analytics Division made a $1.929 million behavioral health workforce investment in the form of a loan-repayment program. OHA has not yet obtained outcomes data from these investments, therefore the return on the investments is unknown at this time. Thus, while the formalized postsecondary **education** required for certification in many of the positions in this study **does not directly translate to a system cost**, the **cost of the requisite educational programs is included, to demonstrate the true total cost of building** an expert, adept behavioral health **SUD workforce pipeline**.

Costs estimated in the **training category** include any discipline-specific education or training courses required to be completed during the registration-to-certification period. These costs are incurred in **Step Three** of the certification process. Required training courses may be offered by some agencies where registrants are completing supervised client-service hours throughout the registration-to-certification period, but we could not determine that any guaranteed number of training hours are absolutely provided at the employer's expense. Therefore, an assumption was made that registrants would assume the cost of all discipline-specific training courses. The cost of these required training courses was estimated based on the cost of training course package from The Center for Addiction Studies[viii] and the Mental Health & Addiction Association of Oregon Peer Training and Innovations Center[ix].

Costs estimated in the **supervision category** include a proportion of the salary costs for the certified or licensed supervisor who oversees apprentice staff and who verifies the required number of client-service hours are completed during the registration-to-certification period. These costs are incurred in **Step Five** of the certification process. Each position requires registrants to perform a specific number of client-service hours (**Step Four**) during the registration-to-certification period. There are no direct costs incurred with the completion of those client-service hours, but state standards for clinical supervision must be met while completing the hours. Two hours of face-to-face clinical supervision is the minimum requirement specified in OAR 319-19, for all behavioral health positions with clinical supervision requirements specified. That minimum of 2 hours per month was assumed for all positions requiring supervised client-service hours. The maximum registration-to-certification period allowed under the MHACBO regulations is two years. Therefore, supervision cost estimates were developed under the assumption that the supervision requirement would be met for one apprentice staff with the allocation of 48 supervisory staff hours (i.e., 2 hours per month for 24 months).

Costs estimated in the **certification category** include fees collected by MHACBO at the onset of the registration-to-certification period (i.e., registration fee) and at the conclusion of the period (i.e., background check fees and examination fees). These costs are incurred in **Steps Two and Six** of the certification process. Procurement of these registration and certification requirements are overseen by MHACBO. MHACBO 2023 schedule of registration and certification fees were used to determine the certification cost estimates. **NOTE:** During the 2021—2023 biennium, OHA made an $80 million investment into the behavioral health workforce, as directed by Oregon House Bill 2949/4071. This investment included initiatives to waive registration, background check, and examination fees associated with **Steps Two and Six** of the certification process. Without reapproval or reinvestment, these fee-waiving measures are due to expire on June 30, 2024. Certification cost estimates were made with the assumption that previous investments will expire without reinvestment.

Table 20 demonstrates the total estimated costs of supporting 32,993 registrants in the completion of all applicable six steps required for certification in the five identified deficient behavioral health or SUD service positions. Total costs are broken down by the total cost of education, training, supervision, and certification, across all positions (i.e., 32,993 staff). Aside from the **$3.4 billion** that PCG estimates is needed **to hire and pay the requisite staff** for a year, there is an **additional** estimated system cost of **$1.8 billion** required **to provide certified staff** to fill the positions.

TABLE 20: TOTAL COST OF BUILDING THE PIPELINE

All Positions: CPS, CADC II, CRM I, QMHA I, QMHP	
Number of Positions	32,993
Education	$1,688,921,920
Training	$7,667,780
Supervision	$62,747,064
Certification	$5,904,855
Total Cost	**$1,765,241,619**

In the next section, specific assumptions and information pertaining to the development of cost estimates for each individual position are provided.

Certified Prevention Specialists

A CPS is defined by OAR Chapter 309 as a behavioral health worker certified by the Division credentialing body to provide prevention specialist services. The Oregon credentialing body, MHACBO, defines the certification requirements for the CPS position as:

- 150 prevention education hours (**training**)
- 2000 supervised experience hours in the prevention domains (**supervision**)
- 120 hours of experiential learning and evaluation by a Prevention Supervisor (**supervision**)
- Ethics agreement (**certification**)
- National criminal history check (**certification**)
- International Certification Reciprocity Consortium (ICRC) Prevention Specialist examination (**certification**)

There are no prerequisite formal education or degree requirements for the CPS position. Per the MHACBO certification application[x], formal post-secondary education credits can be substituted for prevention education hours, with one college credit equaling 10 hours of prevention education. Based on that exchange rate, 15 college credits may be accepted in lieu of the required 150 hours of prevention education. For our estimates, we assumed **no costs** for formalized **education** and used the cost of prevention education training programs available in Oregon that meet the 150-hour prevention education training requirement. The cost of a prevention education **training** program from the Center for Addiction Studies (CAS) used was: **$1,350**.

There is no requirement for initial registration with MHACBO to begin the certification process, or registration-to-certification period. Therefore, the deadline to complete supervised hours within a two-year period seen in other positions does not necessarily apply for the CPS position. For consistency, we assumed a Prevention Specialist preparing for certification would still complete the requisite supervised client-service hours within a two-year period, thus estimated 48 face-to-face supervision hours (two hours per month for 24 months). The supervisory position selected, whose salary estimate was allocated to determine the cost of 48 hours of face-to-face supervision, was a Prevention Supervisor, as explicitly stated in MHACBO certification rules. A Prevention Supervisor's estimated hourly wage was obtained from Salary.com[xi]: $25.41. Therefore, the average cost of the required **supervision** was calculated at 48 hours times $25.41 per hour, or **$1,220**.

Costs associated with the certification for the CPS position are all collected by MHACBO and include an application fee of $50, a CPS examination and qualifying review fee of $130, and a national background check fee of $70. Therefore, the average cost of the required **certification** fees per CPS staff was calculated at **$250**.

The average total cost used to achieve CPS certification per individual staff is shown in **Table 21**.

TABLE 21: COST OF CPS CERTIFICATION, PER STAFF

Type of Certification Related Cost	Cost per Individual Staff
Education	N/A
Training	$1,350
Supervision	$1,220
Certification	$250
Total Cost	**$2,820**

The total cost of preparing the requisite 906 CPS staff for certification in the Oregon workforce is shown in **Table 22**.

TABLE 22: TOTAL COST OF CPS CERTIFICATION, ALL REQUISITE STAFF

Certified Prevention Specialists	
Number of Positions	906
Education	N/A
Training	$1,223,100
Supervision	$1,104,972
Certification	$226,500
Total Cost	**$2,554,572**

Certified Alcohol and Drug Counselors

A CADC is defined by OAR, Chapter 309 as a behavioral health professional who practices substance use disorder counseling pursuant to OAR 309-019-0125(9). The Oregon credentialing body, MHACBO, defines unique certification requirements for CADC I, CADC II and CADC III positions. There is a significant variance between the education requirements for certification in the CADC I and CADC II positions, with a CADC I certification requiring no formal post-secondary education and a CADC II certification requiring a bachelor's degree. Due to that variance and OHA's commitment to building an expert workforce, CADC II certification requirements were used as a baseline for determining cost estimates. MHACBO, defines the certification requirements for the CADC II position as:

- Bachelor's degree (**education**)
- 300 accredited education hours (**training**)
- 4000 supervised experience hours in the addiction counselor competencies (**supervision**)
- 120 hours of experiential learning and evaluation by a Prevention Supervisor (**supervision**)
- National Association of Alcohol and Drug Abuse Counselors, National Certification of Addiction Counselors (NCAC) examination II (**certification**)
- Written Jurisprudence Ethics examination (**certification**)

Specific to the CADC II position, there is a minimal formal education requirement of a bachelor's degree. There is an alternative pathway that allows registrants to demonstrate a minimum of an associate degree or 90 college credits plus 300 hours of alcohol and drug specialty education hours. The bachelor's degree pathway was considered for these cost estimates, due to this pathway aligning with OHA's mission to build an expert SUD workforce. Average annual in-state tuition costs, reported by CollegeBoard[xii], were used to determine the **education** cost for the requisite bachelor's degree at **$45,040.** The cost of a CAS CADC II educational training program that incorporates the 300-hour accredited hours and required coursework was used to estimate **training** costs at **$2,860**.

The maximum CADC II registration-to-certification period allowed under the MHACBO regulations is two years, or 24 months. Two hours of face-to-face clinical supervision per month during the registration-to-certification period is the minimum supervision requirement specified in OAR 319-19. Therefore, supervision cost estimates were developed under the assumption that the supervision requirement would be met for one CADC II registrant staff with the allocation of 48 supervisory staff hours. The supervisory position selected, whose salary estimate was allocated to determine the cost of 48 hours of face-to-face supervision, was a Clinical Supervisor. A Clinical Supervisor's estimated hourly wage was obtained from

Salary.com at $40.80. Therefore, the average cost of the required **supervision** was calculated at 48 hours times $40.80 per hour, or **$1,958**.

Costs associated with the certification for the CADC position are all collected by MHACBO and include a registration fee of $75, an NCAC II examination fee of $200, and a Jurisprudence Ethics examination fee of $100. Therefore, the average cost of the required **certification** fees per CADC II staff was calculated at **$375**. The average total cost used to achieve CADC II certification per individual staff is shown in **Table 23**.

TABLE 23: COST OF CADC II CERTIFICATION, PER STAFF

Type of Certification Related Cost	Cost per Individual Staff
Education	$45,040
Training	$2,860
Supervision	$1,958
Certification	$375
Total Cost	**$50,233**

The estimated total cost of preparing the requisite 2018 CADC staff for certification in the Oregon workforce is shown in **Table 24**.

TABLE 24: TOTAL COST OF CADC II CERTIFICATION, ALL REQUISITE STAFF

Certified Alcohol and Drug Counselors	
Number of Positions	2018
Education	$90,890,720
Training	$5,771,480
Supervision	$3,952,144
Certification	$756,750
Total Cost	**$101,371,094**

Certified Recovery Mentors

A CRM is defined by OAR Chapter 309 as a behavioral health care worker that has completed an approved addiction peer training program and is certified by the Division credentialing body to recovery mentor services. The Oregon credentialing body, MHACBO, defines the certification requirements for the CRM position in two levels: CRM I and CRM II. To determine the cost to provide a pool of staff who are educated and trained at the minimal level required for certification, requirements for the CRM I were used. The educational requirements did not vary greatly between level I and level II CRM requirements. MHACBO defines the certification for the CRM I position as:

- In recovery from substance use dependence, minimum period of two years (currently reduced to one year)
- Proof of attendance in OHA-approved addiction training program (**training**)
- Approved Oral Health Training (**training- no cost**)
- MHACBO CRM Ethics quiz (**certification- no cost**)

- Code of Conduct (**certification- no cost**)
- Registration and background check (**certification**)

There are no perquisite formal education or degree requirements for the CRM I position, therefore we calculated **no costs** for formalized **education** for this position. The cost of an addiction education training program from the Mental Health and Addiction Association of Oregon was used to estimate the CRM I required **training** cost of **$1,100**. There are no standardized supervisory requirements (i.e., hours of service with supervision from a supervisory staff) for the CRM I position, therefore we calculated **no costs** for **supervision**. Costs associated with certification for the CRM position are all collected by MHACBO and include a registration fee of $100 which is inclusive of costs for a required background check. Therefore, the total cost of the required **certification** fees per CRM staff was calculated at **$100**.

The average total cost to achieve CRM I certification per individual staff is shown in **Table 25**.

TABLE 25: COST OF CRM I CERTIFICATION, PER STAFF

Type of Certification Related Cost	Cost per Individual Staff
Education	N/A
Training	$1,100
Supervision	N/A
Certification	$100
Total Cost	**$1,200**

The total cost of preparing the requisite 612 CRM I staff for certification in the Oregon workforce is shown in **Table 26**.

TABLE 26: TOTAL COST OF CRM I CERTIFICATION, ALL REQUISITE STAFF

Certified Recovery Mentors	
Number of Positions	612
Education	N/A
Training	$673,200
Supervision	N/A
Certification	$61,200
Total Cost	**$734,400**

Qualified Mental Health Associates

A QMHA is defined by OAR, Chapter 309 as a behavioral health care worker who demonstrates a set of minimal competencies, who renders services and supports within their scope to individuals engaged in a Division-approved behavioral health services provider, and who meets a minimum set of qualifications. The minimum set of qualifications outlined in the OAR coincides with the MHACBO certification requirements. MHACBO defines the certification requirements for the QMHA position in two levels: QMHA I and QMHA II. To determine the cost to provide a pool of staff who are educated and trained at the minimal level required for certification, requirements for the QMHA I were used to estimate costs. The educational requirements did not vary greatly between level I and level II QMHA requirements. Although,

there are non-degree and degree pathways to meeting requirements for the QMHA I position. The degree pathway QMHA I certification requirements were used for cost estimates, due to OHA's commitment to building an expert workforce who are equipped to meet clients' needs. MHACBO defines the certification for the QMHA I, degree pathway position as:

- Bachelor's degree (**education**)
- 1000 hours supervised experience hours as a registrant (**supervision**)
- QMHA I examination (**certification**)

Specific to the QMHA I position, degree pathway, there is a minimal formal education requirement of a bachelor's degree. Average annual in-state tuition costs, reported by CollegeBoard, were used to determine the **education** cost for the requisite bachelor's degree at **$45,040.** For our estimates, we assumed **no costs** for **training**, since no additional discipline-specific training coursework is required in the registration-to-certification period for the QMHA I position. Supervision costs were estimated based on the same 24-month registration-to-certification period and required minimum time allocation of two supervisory hours per month. The supervisory position selected, whose salary estimate was allocated to determine the cost of 48 hours of face-to-face supervision, was a Clinical Supervisor. A Clinical Supervisor's estimated hourly wage was obtained from Salary.com at $40.80. Therefore, the average cost of the required **supervision** was calculated at 48 hours times $40.80 per hour, or **$1,958**.

Costs associated with the certification for the QMHA I position are all collected by MHACBO and include a registration fee of an unknown amount (currently waived and unreported) and a QMHA I examination fee of $165. Therefore, the average cost of the required **certification** fees per QMHA I staff was calculated at **$165**.

The average total cost used to achieve QMHA I certification per individual staff is shown in **Table 27**.

TABLE 27: TOTAL COST OF QMHA I CERTIFICATION, PER STAFF

Type of Certification Related Cost	Cost per Individual Staff
Education	$45,040
Training	N/A
Supervision	$1,958
Certification	$165
Total Cost	**$47,163**

The total cost of preparing the requisite 17,717 QMHA I staff for certification in the Oregon workforce is shown in **Table 28**.

TABLE 28: TOTAL COST OF QMHA I CERTIFICATION, ALL REQUISITE STAFF

Qualified Mental Health Associates	
Number of Positions	17,717
Education	$797,973,680
Training	0
Supervision	$34,697,791
Certification	$2,923,305

Qualified Mental Health Associates	
Total Cost	$835,594,776

Qualified Mental Health Professionals

A QMHP is defined by OAR, Chapter 309 as a behavioral health care worker who demonstrates a set of minimal competencies, who renders services and supports within their scope to individuals engaged in a Division-approved behavioral health services provider, document a minimum of two hours every two years of suicide risk screening, suicide risk assessment, treatment and management training, and who meets a minimum set of qualifications. The minimum set of qualifications outlined in the OAR coincides with the MHACBO certification requirements. OAR and MHACBO define the education requirement for QMHP certification as either a bachelor's degree in nursing or occupational therapy or a bachelor's degree in psychology, social work, recreational art or music therapy, or a behavioral science field. The behavioral health master's degree pathway QMHP requirements were used for cost estimates, due to OHA's commitment to building an expert workforce who are equipped to meet clients' needs. MHACBO defines the certification for the QMHP, behavioral health master's degree pathway position as:

- Master's degree in an approved behavioral health discipline (**education**)
- 1000 hours supervised experience hours as a registrant (**supervision**)
- QMHP examination (**certification**)

Specific to the QMHP master's degree pathway, there is a minimal formal education requirement of a master's degree. Average annual in-state tuition costs, reported by CollegeBoard, were used to determine the **education** cost of the prerequisite bachelor's degree at **$45,040** and the additional education cost for the requisite master's degree at **$23,108.** For our estimates, we assumed **no costs** for **training**, since no additional discipline-specific training coursework is required in the registration-to-certification period for the QMHP position, per MHACBO requirements. Supervision costs were estimated based on the same 24-month registration-to-certification period and required minimum time allocation of two supervisory hours per month. The supervisory position selected, whose salary estimate was allocated to determine the cost of 48 hours of face-to-face supervision, was a Clinical Supervisor. A Clinical Supervisor's estimated hourly wage was obtained from Salary.com as $40.80. Therefore, the average cost of the required **supervision** was calculated at 48 hours times $40.80 per hour, or **$1,958**.
Costs associated with the certification for the QMHP position are all collected by MHACBO and include a registration fee of an unknown amount (currently waived and unreported) and a QMHP examination fee that was estimated as $165. Therefore, the average cost of the required **certification** fees per QMHP staff was calculated at **$165**.

The average total cost used to achieve QMHP certification, per individual staff, is shown in **Table 29**.

TABLE 29: COST OF QMHP CERTIFICATION, PER STAFF

Type of Certification Related Cost	Cost per Individual Staff
Education- Bachelor's Degree	$45,040
Education – Master's Degree	$23,108
Training	N/A
Supervision	$1,958
Certification	$165
Total Cost	**$70,271**

The total cost of preparing the requisite 17,740 QMHP staff for certification in the Oregon workforce is shown in **Table 30**.

TABLE 30: TOTAL COST OF QMHP CERTIFICATION, ALL REQUISITE STAFF

Qualified Mental Health Professionals	
Number of Positions	11,740
Education – Bachelor's Degree	$528,769,600
Education – Master's Degree	$271,287,920
Training	N/A
Supervision	$22,992,158
Certification	$1,937,100
Total Cost	$824,986,778

Cost Estimate Details – Cost of Employment

In addition to estimating the costs for educating, training, certifying, and supervising new SUD workers, this study examined the costs to the overall health care system for employing new workers, focusing on the **cost of wages for the workforce** and the **cost for support staff**. It is important to note that costs identified in this section of the report indicate the **overall system burden**, and would be borne by all payers, including the public, private and self-payers.

To determine the total wages and support staff cost, PCG used a standard hourly wage cost model. The cost model includes a base wage assumption for the cost of each person's time. Benchmarks for the additional cost of fringe benefits are added to those costs proportionally, for each new position. The total cost per position per year is then multiplied by the number of positions to determine the total annual cost per position type.

Inflation Analysis

Because wage data was gathered from multiple sources and multiple years, PCG used Consumer Price Index for all Urban Consumers for the Western Region from Bureau of Labor Statistics (BLS) data to apply an inflationary factor commensurate with 2023. **Table 31** indicates the year-over-year change measured every year starting in November 2021.

TABLE 31: ANNUAL INFLATION

Year	Annual Change
2021	7%
2022	7%
2023	3%
21 to 23 Inflation	**17%**

Benchmarks

Due to the **lack of available data**, the project team **utilized benchmarks from another PCG study** conducted in the District of Columbia to develop rates for behavioral health services. During the study, the DC project team developed estimates of the portion of benefits for each staff and the proportion of administrative costs associated with direct service delivery.

Administrative costs were calculated by identifying the total personnel costs, broken out by category from all provider survey responses, and the total non-personnel costs, broken out by category from all the responses. The DC team then looked at the overhead personnel portion and overhead non-personnel portion of those costs and calculated how much of the overall costs were allocated to those categories.

Administrative costs include overhead personnel costs (i.e., behavioral health portion of general staff who support overall operations, such as human resources and finance) and non-personnel costs (i.e., costs related to the business, but not solely part of the administration of behavioral health services). Examples of these non-personnel costs are:

- Utilities
- Supplies
- Information Technology/Communications
- Lease and Rental
- Depreciation
- Other

The **ratio of fringe and administrative costs** to the **direct personnel costs** was applied to the wage calculations to account for the total cost of adding the required number of staff. These percentages are in alignment with many other analyses completed by PCG for a range of human service programs.

TABLE 32: SALARY AND BENEFITS BENCHMARKS

Benchmarks	Percent	Source
Fringe (Tax/Benefit)	29%	District of Columbia Behavioral Health Rate Study and Rate Development Project
Administrative + Program Support	24%	District of Columbia Behavioral Health Rate Study and Rate Development Project

Wage Analysis

Ensuring the appropriate wage assumption is vital to accurate workforce cost estimates. **Competitive wages continue to be a key factor** in implementing a **successful recruiting and retention process**. PCG collected wage estimates from several sources to provide the best perspective on the wage levels required to fill the workforce need identified in the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis**.

MHACBO WAGE SURVEY

The **primary source of wage data** for this study is the **MHACBO Wage Survey**, completed in 2022. This workforce survey is completed at regular intervals to understand wage differences over time. The most recent study compared 2021 wages to the previous study in 2017. For this study, we are using the 2021 values adjusted for inflation.

TABLE 33: IDENTIFIED GAP POSITIONS AT 2021 MHACBO-OHA WORKFORCE SURVEY WAGE LEVELS

Position	2021 Hourly Wage	2021 Annual Wage	2021 MHACBO-OHA Workforce Survey Position Identifier
Certified Prevention Specialist	$28.15	$58,552	Preventionist
Certified Alcohol and Drug Counselor	$22.06	$45,885	SUD Counselor
Certified Recovery Mentor	$18.09	$37,627	SUD Peer
Qualified Mental Health Associate	$21.10	$43,888	QMHA
Qualified Mental Health Professional	$30.45	$63,336	QMHP-C

TABLE 34: IDENTIFIED GAP POSITIONS AT 2023 MHACBO-OHA WORKFORCE SURVEY INFLATION-ADJUSTED WAGE LEVELS

Position	MHACBO Survey Hourly Wage Adjusted to 2023	MHACBO Survey Annual Wage Adjusted to 2023	MHACBO-OHA 2021 Workforce Survey Position Identifier
Certified Prevention Specialist	$32.91	$68,461	Preventionist
Certified Alcohol and Drug Counselor	$25.79	$53,650	SUD Counselor
Certified Recovery Mentor	$21.15	$43,995	SUD Peer
Qualified Mental Health Associate	$24.67	$51,315	QMHA
Qualified Mental Health Professional	$35.60	$74,054	QMHP-C

GLASSDOOR DATA

Wages in most fields across the United States **continue to change rapidly**. To confirm the inflation-adjusted wage estimates in this report are representative, PCG researched the **median wages** as reported on **Glassdoor.com**. When comparing the inflation-adjusted MHACBO-OHA survey wages to the Glassdoor wages, the MHACBO wages are slightly lower than the 2024 median wage on Glassdoor for CADCs, CRMs, and QMHAs. The MHACBO wages for CPS and QMHPs, however, are significantly higher than the Glassdoor median wage.

TABLE 35: IDENTIFIED GAP POSITIONS AT 2023 GLASSDOOR LEVELS VS MHACBO SURVEY 2023 ADJUSTED LEVELS

Position	Glassdoor Median Hourly Wage	MHACBO Survey Hourly Wage Adjusted to 2023	Glassdoor Median Annual Wage	MHACBO Survey Annual Wage Adjusted to 2023
Certified Prevention Specialist	$27.88	$32.91	$58,000	$68,461
Certified Alcohol and Drug Counselor	$27.88	$25.79	$58,000	$53,650
Certified Recovery Mentor*	$20.19	$21.15	$42,000	$43,995

Qualified Mental Health Associate	$25.96	$24.67	$54,000	$51,315
Qualified Mental Health Professional	$29.33	$35.60	$61,000	$74,054

*Glassdoor position: Peer Support Specialist, MHACBO Survey position: SUD Peer

2023 OREGON COUNCIL FOR BEHAVIORAL HEALTH (OCBH) MEMBER SURVEY DATA

Another source of reported wages is the OCBH Member Survey data. **OCBH collected data from members** to inform an analysis of current behavioral health positions across the state of Oregon. In addition to the number of positions filled and unfilled, they also collected data on the current hourly rates. Also, the survey asked, for each reported rate: is that a "**'Good Enough' hourly rate** (i.e., level needed to recruit and retain staff)"? The "Good Enough" variable, while highly subjective, can be used to compare to the inflation-adjusted MHACBO wages, to understand how well they align.

TABLE 36: IDENTIFIED GAP POSITIONS AT 2023 OCBH MEMBER SURVEY "GOOD ENOUGH" LEVELS VS MHACBO SURVEY 2023 ADJUSTED LEVELS

Position	OCBH Member Survey Position Identifier	OCBH "Good Enough" Hourly Rate	MHACBO Survey Hourly Wage Adjusted to 2023	OCBH "Good Enough" Annual Rate	MHACBO Survey Annual Wage Adjusted to 2023
Certified Alcohol and Drug Counselor	CADC 1-3	$26.77	$25.79	$55,682	$53,650
Certified Recovery Mentor*	Peer/Health Worker	$21.38	$21.15	$44,470	$43,995
Qualified Mental Health Associate	QMHA	$25.72	$24.67	$53,498	$51,315
Qualified Mental Health Professional	QMHP	$28.40	$35.60	$59,072	$74,054

*MHACBO Survey position: SUD Peer

BUREAU OF LABOR STATISTICS

While BLS is often the standard for market wages, due to the rigor of data collection and survey participation, the number of **applicable BLS positions identified is not sufficient** for this study. PCG identified the two positions that would be most applicable for this analysis to provide another comparison confirming the MHACBO data. The most recent BLS data[xiii] is May 2022, so inflation adjusted wages were calculated and are shown in **Table 37.**

TABLE 37: MATCHING BLS POSITIONS AT 2022 AND 2023 ADJUSTED LEVELS

Position	2022 Median Hourly Wage	2022 Median Annual Wage	2023 Adjusted Median Hourly Wage	2023 Adjusted Median Annual Wage
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$29.32	$60,980	$30.28	$62,983
Mental Health and Substance Abuse Social Workers	$26.14	$54,370	$27.00	$56,156

Cost Estimates – Cost of Employment

Once the components have been determined, each is calculated using the algorithm **((Annual Salary*(1.29))*1.24)*Number of Positions**. **Table 38** lists the total cost for each component and the total estimated annual cost of filling the gap of positions identified by 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis**.

TABLE 38: TOTAL ANNUAL COST OF NEEDED SUD POSITIONS

Cost Component	CPS	CADC	CRM	QMHA	QMHP
Annual Salary	$69,004	$54,076	$44,344	$51,722	$74,642
Benefits	$20,287	$15,898	$13,037	$15,206	$21,945
Total Wages	$89,291	$69,974	$57,381	$66,929	$96,587
Administrative + Program Support	$21,430	$16,794	$13,771	$16,063	$23,181
Total Cost Per Position	$110,721	$86,767	$71,152	$82,992	$119,767
Number of Positions Needed	906	2,018	612	17,717	11,740
Total Annual cost for all Positions	$100,313,156	$175,096,702	$43,545,300	$1,470,360,869	$1,406,069,182
				Total for all positions	**$3,195,385,208**

Workforce Gap Estimate Not Included in Cost Calculations – Buprenorphine Prescribers

The 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis** included an identified gap of available buprenorphine prescribers with a Drug Addiction Treatment Act (DATA) waiver (DATA-Waiver). Prior to 2023, prescribers that desired to prescribe buprenorphine for Opioid Use Disorder (OUD) were required to obtain a DATA-Waiver. To obtain a waiver, prescribers were required to complete training and submit an application to the Substance Abuse and Mental Health Services Administration (SAMHSA). The actual number from the 2022 **Oregon Substance Use Disorder Services Inventory and Gap Analysis** was determined by calculating how many prescribers obtained a DATA-Waiver, based on Comagine Health and OHA data . In that gap analysis, the OHSU-PSU SPH team determined the number of needed prescribers, based on **Calculating for an Adequate System Tool (CAST)** data, and compared that to the number of prescribers with DATA-Waivers. CAST data

regarding SUD needs in Oregon were categorized by geographical regions. The regions mirrored the National Survey on Drug Use and Health (NSDUH) substate regions. Therefore, data regarding gaps for buprenorphine are presented by NSDUH region.

TABLE 39: DATA-WAIVER PRESCRIBERS AND GAPS, BY NSDUH REGION

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Prescribers with Waiver	701	315	434	250	84	118
Needed Prescribers	763	917	1192	534	228	222
Prescriber Gap	**62**	**602**	**758**	**284**	**144**	**104**

The 2023 Consolidated Appropriations Act, Section 1262, also known as the Mainstreaming Addiction Treatment (MAT) Act removed the requirement for providers to obtain a waiver for buprenorphine prescriptions. Due to discontinuation of the DATA-Wavier requirement, OHA and PCG had to reconsider the methodology for verifying the current gap for buprenorphine prescribers in Oregon. PCG coordinated with the OHA Prescription Drug Monitoring Program staff to obtain the number of prescribers who issued at least one buprenorphine prescription in 2023. This database provides insight on actual prescribing rather than number of providers eligible to prescribe. The initial CAST data obtained by OHSU-PSU for the needed number of buprenorphine prescribers was held constant. PCG generated an updated estimate of needed prescribers using 2023 data from the PDMP (**Table 40**).

TABLE 40: 2023 BUPRENORPHINE PRESCRIBERS AND GAPS, BY NSDUH REGION

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
2023 Actual Buprenorphine Prescribers	810	513	734	368	155	172
Needed Buprenorphine Prescribers	763	917	1192	534	228	222
Prescriber Gap	**-47**	**404**	**458**	**166**	**73**	**50**

The updated methodology does indicate that there are significantly more prescribers choosing buprenorphine since the change to the DATA-Waiver, but there is still a significant gap between the CAST identified number of needed prescribers and the current number of professionals prescribing buprenorphine.

The gap in buprenorphine prescribers is not necessarily an issue with the number of prescribers available overall; it may be driven by the large number of prescribers who choose, for multiple reasons, not to prescribe buprenorphine for OUD. Disparity in medical professionals authorized to prescribe buprenorphine and the number of professionals actively prescribing is a known concern across the federal landscape. SAMHSA has made efforts to address this disparity by examining current barriers to individuals' access to buprenorphine and making recommendations to address barriers in their Policy Priority Roundtable Summary Report – Improving Buprenorphine Access in Pharmacy Settings[xiv]. While the report specifically examines pharmacy-related barriers to buprenorphine access, the same barriers may be present for professionals who prescribe buprenorphine. SAMHSA notes five key barriers:

- Stigmatization
- Patient barriers
- Classification in the same category as other opioids
- Fear of violating rules
- Pharmacies losing money on every prescription

The SAMHSA summary report also contains multiple recommendations for addressing these barriers, including removal of the X-Waiver, or Data-Waiver, which has since occurred in Oregon. Despite that advancement, updated gap calculations still show a gap in buprenorphine access for those in need. Many of the recommended steps in the summary report are still unrecognized opportunities in both the federal and state landscapes.

Inability to fill the gap of those in need of prescriptions, despite past initiatives, suggests to OHA that a lack of qualified prescribers is not the main driver creating a gap in needed medication-assisted treatment (MAT). OHA is aware of resistance from some medical professionals to prescribing buprenorphine due to the extended treatment services and requirements that accompany participation in the MAT model. The sentiment with OHA staff is that additional policy decisions must be considered to address the root cause of resistance to buprenorphine prescribing among medical professionals in Oregon.

While PCG could estimate the system cost with similar methodology used for other portions of the workforce, there would need to be more research to determine if there is a need for more prescribers, or if the need is to work with the current prescribers and support them to provide buprenorphine.

Workforce Cost Estimates – Considerations

As noted earlier, the workforce cost estimates provided for this study do not attempt to cover all approaches to strengthening and growing the SUD workforce. The State would benefit from deeper analyses on cost estimates for:

- **Retaining the current workforce**, including, but not limited to paying higher wages (including through rate increases), boosting benefits (including subsidies for childcare), and addressing workforce burnout.
- **Attracting workers to underserved areas**, which may require offering extra financial incentives and subsidies for housing in areas that lack affordable housing supply.
- **Diversifying the workforce**. It is well established that Oregon's behavioral health workforce does not reflect the cultural and linguistic diversity of the people needing services. In addition to prioritizing funding for culturally- and linguistically-specific provider training and development, additional funds may be needed to attract diverse providers to the profession.
- **Specialized training** for certain subpopulations, such as children/youth and people with co-occurring disorders.

As noted earlier, this analysis was limited to certain categories of the SUD workforce, based on available data. For example, we did not have access to information on gaps in the non-prescribing nurse workforce. These workers may be required in some settings, such as withdrawal management facilities. Future analyses of workforce gaps should consider examining a broader range of providers, and ideally, identify the number of workers who actively serve people with SUDs that are uninsured, underinsured and/or have public insurance as there are known access issues for these populations.

There are a few other important considerations to note:

- The workforce cost estimates in this study do not take into account any **offsets that could occur with improved quality in the behavioral health system**. For example, reducing provision of ineffective and/or low-quality services and increasing provision of appropriate, effective, and high-quality services could offset utilization, and thus reduce demands on the workforce.
- The cost estimates provided in this study are **not predicated on any kind of long-term implementation plan**. This study assumes a hypothetical scenario where the gap in the workforce would be closed today, based on present costs. In a real-world scenario, the expansion of the workforce would occur over a longer period of time, and all cost data would have to be adjusted accordingly.

- As described earlier, the workforce costs provided in this study **reflect the costs to the entire system**. PCG does not make any assumptions about what portion of those costs would—or should—be borne by the federal, state, or local governments, other sectors, or individuals seeking to join the workforce. To some extent, this is a policy question that leaders must grapple with—what role should the public or private sectors play in addressing workforce gaps?

PROGRAM LOCATION GAP COST ESTIMATES

The 2022 **Oregon Substance Use Disorder (SUD) Services Inventory and Gap Analysis** included CAST estimates for select SUD service program locations: outpatient, residential, withdrawal management, recovery community centers, recovery residences. Those identified gaps are listed in **Table 41**.

TABLE 41: CAST PROGRAM LOCATION GAPS (OHSU-PSU SPH, 2022)

Program Location Type	Need	Actual	Gap
Outpatient	586	383	**203**
Residential	470	187	**283**
Withdrawal Management	103	75	**28**
Recovery Residences *(beds)*	7,078	3,219	**3,859**
Recovery Community Centers	145	8	**137**

Service **gaps** identified in the 2022 Gap Analysis were estimated by **the Calculating for an Adequate System Tool (CAST)** to determine the needed number of program locations, and then comparing that number to the current number of each type of program location in the community. The **number of existing programs** used by OHSU-PSU SPH was determined using variable sources, including the Mental Health and Addiction Certification Board of Oregon (MHACBO) and Substance Use Disorder Services Survey, designed and implemented by OHSU.

In support of this study and the OHA Behavioral Health Residential+ Study, PCG and OHA coordinated with OHSU-PSU SPH staff and JG Research to generate new CAST estimates of unmet SUD residential and withdrawal management need, using updated bed data obtained through OHA's Licensing and Certification unit. PCG and OHA also worked together to conduct a novel analysis of opioid treatment program (OTP) gaps.

The final list of SUD program locations, sources of the gap determination, and the current gap values are summarized in **Table 42** below. Detailed discussion regarding updated calculations for gaps is provided in the residential, withdrawal management, and opioid treatment program sections below.

TABLE 42: SUD PROGRAM LOCATION GAPS INCLUDED IN COST ESTIMATES BY SOURCE OF GAP DETERMINATION

Program Location Type	Source of Gap	Gap Used for Cost Estimates
Outpatient	2022 Gap Analysis	**203**
Residential	PCG Residential+	**57**
Withdrawal Management	PCG Residential+	**37**
Recovery Residence	2022 Gap Analysis*	**351**

Program Location Type	Source of Gap	Gap Used for Cost Estimates
Recovery Community Center	2022 Gap Analysis	**137**
Opioid Treatment Program	OHA BHD	**52**

*The gap of 3,859 recovery residence beds determined by OHSU-PSU was maintained. PCG converted that gap to number of recovery residence program locations, based on MHACBO recovery residence capacity data.

Determination of Current Program Location Gaps

The methodology for determining the gaps in the six types of program locations varied. Gaps for outpatient facilities, recovery residences and recovery community centers are as reported in the 2022 Gap Analysis. SUD residential and withdrawal management program gaps are based on trauma system area, consistent with the scope of the OHA Behavioral Health Residential+ Facility Study. Since Opioid Treatment Programs gaps were determined through novel analysis, a unique methodology for examining program locations was used.

Outpatient Program Locations Gap

The SUD services landscape is always changing, particularly in Oregon with the recent provision of Measure 110 funds. While there have undoubtedly been changes to the level of need for and availability of outpatient program locations, there have been no new data collection or analysis efforts regarding outpatient program locations since the completion of the 2022 Gap Analysis. Therefore, the gap identified by OHSU-PSU, 203 outpatient program locations, was maintained.

TABLE 43: OUTPATIENT PROGRAM LOCATIONS GAP (CAST, OHSU-PSU SPH, 2022)

Program Location Type	Need	Actual	Gap
Outpatient	586	383	**203**

Residential Program Locations Gap

To identify the current capacity for residential program beds, the OHA Behavioral Health Residential+ Facility Study team (Residential+ team) conducted an initial statewide capacity analysis. The Residential+ team analyzed data from other projects (i.e., projects supported with funding from HB 5202, HB 5024, and Measure 110) to determine the number of new residential program beds in development and the total number of available beds throughout the state. The PCG Residential+ team, with support from OHSU-PSU SPH and JG Research and Evaluation, analyzed updated data from the **Calculating for an Adequate System Tool (CAST)** to determine an updated count of residential program beds that are needed in Oregon. More information on how the below capacity gaps were identified can be found in the OHA Behavioral Health Residential+ Facility Study report.

The capacity gaps for residential beds identified by the Residential+ are listed below in **Table 44**. The gap of residential behavior health beds in Oregon was calculated as **2,357 beds**.

TABLE 44: OHA BEHAVIORAL HEALTH RESIDENTIAL+ FACILITY STUDY RESIDENTIAL PROGRAM LOCATION GAP (BEDS)

Program Location Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Number of Beds (Current + Pending + Needed)	% Increase
Residential	1,374	44	1,418	**2,357**	3,775	162.22%

To mirror gap estimates initially provided in the 2022 Gap Analysis, this PCG team converted the updated data regarding gaps in residential bed capacity to a gap in number of residential program locations. The Residential+ team determined residential program locations accommodate, on average, 29 beds at each location. The number of program locations required to accommodate the gap of 2,357 residential beds is 81 residential program locations, based on an average accommodation of 29 beds per location. This final gap of **81 residential program locations** was used for cost estimations.

TABLE 45: FINAL RESIDENTIAL PROGRAM LOCATIONS GAP

Program Location Type	Gap (#beds)	Number of Beds per Location	Gap (# of locations)
Residential	2,357	29	**81**

Notably, recalculation of the gap for this program location represented a 71% decrease in the estimated gap for residential program locations, as summarized in **Table 46**.

TABLE 46: FINAL RESIDENTIAL PROGRAM LOCATIONS GAP COMPARED TO INITIAL OHSU-PSU GAP

Program Location Type	Initial Gap	Gap Source	Final Gap	Gap Source	Gap Change
Residential	283	2022 Gap Analysis	81	PCG Residential+	**-71%**

Withdrawal Management Program Locations Gap

To identify the current capacity for withdrawal management program locations, the PCG OHA Behavioral Health Residential+ Facility Study team (Residential+ team) conducted an initial statewide capacity analysis. The Residential+ team analyzed data from other projects (i.e., projects supported with funding from HB 5202, HB 5024, and Measure 110) to determine the number of new withdrawal management program beds in development and the total number of available beds throughout the state. The PCG Residential+ team, with support from OHSU-PSU SPH and JG Research and Evaluation, analyzed updated data from the **Calculating for an Adequate System Tool (CAST)** to determine an updated count of withdrawal management program beds that are needed in Oregon. More information on how the below capacity gaps were identified can be found in the OHA Behavioral Health Residential+ Facility Study report.

The capacity gaps for withdrawal management beds identified by the Residential+ team are listed below in **Table 47**. The gap of withdrawal management beds in Oregon was calculated as **571 beds**.

TABLE 47: OHA BEHAVIORAL HEALTH RESIDENTIAL+ FACILITY STUDY WITHDRAWAL MANAGEMENT PROGRAM LOCATION GAP (BEDS)

Program Location Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Number of Beds (Current + Pending + Needed)	% Increase
Withdrawal Management	301	16	317	**571**	888	143.29%

To mirror gap estimates initially provided in 2022 Gap Analysis, the PCG team converted the updated data regarding gaps in withdrawal management bed capacity to a gap in number of program locations. The Residential+ team determined withdrawal management program locations accommodate, on average, 14 beds at each location. The number of program locations required to accommodate the needed additional 571 withdrawal management beds is **41 withdrawal management program locations**, based on an average accommodation of 14 beds per location.

TABLE 48: FINAL WITHDRAWAL MANAGEMENT PROGRAM LOCATIONS GAP

Program Location Type	Gap (#beds)	Number of Beds per Location	Gap (# of locations)
Withdrawal Management	571	14	**41**

Notably, recalculation of the gap for this program location represented a 46% increase in the estimated gap for withdrawal management program locations, as summarized in **Table 49**.

TABLE 49: FINAL GAP WITHDRAWAL MANAGEMENT PROGRAM LOCATIONS GAP COMPARED TO INITIAL OHSU-PSU GAP

Program Location Type	Initial Gap	Gap Source	Final Gap	Gap Source	Gap Change
Withdrawal Management	28	2022 Gap Analysis	41	PCG Residential+	**+46%**

Recovery Residence Program Locations Gap

The SUD services landscape is always changing. While there have undoubtedly been changes to the level of need for and availability of recovery residence program locations, there have been no new data collection or analysis efforts regarding outpatient program locations since the completion of the 2022 Gap Analysis. Therefore, the gap identified by OHSU-PSU, 3,859 recovery residence beds, was maintained.

TABLE 50: OHSU-PSU IDENTIFIED RECOVERY RESIDENCE PROGRAM LOCATIONS GAP

Program Location Type	Need (Beds)	Actual (Beds)	Gap (Beds)
Recovery Residence	7,078	3,219	**3,859**

The 2022 Gap Analysis gap in recovery residence bed capacity was converted to a program location gap for recovery residences, based on MHACBO data. The PCG team evaluated 128 MHACBO recovery residences' data and identified 11 beds per program location, on average, in Oregon. Based on that average capacity of 11 beds per recovery residence program location, the OHSU-PSU determined gap was converted the OHSU-PSU established gap of 3,859 recovery residence beds to a gap of 351 recovery residence program locations.

TABLE 51: FINAL RECOVERY RESIDENCE PROGRAM LOCATIONS GAP

Program Location Type	Gap (#beds)	Number of Beds per Location	Gap (# of locations)
Withdrawal Management	3,859	11	**351**

Recovery Community Center Program Locations Gap

Similar to recovery residence program locations, the gap identified for recovery community center program locations in the OHSU-PSU Oregon SUD Services Inventory and Gap Analysis (137 program locations) was maintained for cost estimates provided in this study.

TABLE 52: OHSU-PSU IDENTIFIED RECOVER COMMUNITY CENTER PROGRAM LOCATIONS GAP

Program Location Type	Need	Actual	Gap
Recovery Community Center	145	8	**137**

Opioid Treatment Program Locations Gap

An Opioid Treatment Program (OTP) is defined, at Oregon Administrative Rules (OAR) 415-020-005(22), as a program that dispenses and administers opioid agonist medications in conjunction with appropriate counseling, supportive, and medical services. The requirements of an Opioid Treatment Program are outlined by OAR 415-020-0040 and include:

- Dispensing of approved opioid agonist medications;
- Individual, group, or family counseling;
- Information and training in parenting skills;
- Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), tuberculosis (TB), sexually transmitted diseases (STDs), and other infectious disease information;
- Completion of HIV, TB, and STD risk assessment within 30 days of admission;
- Relapse prevention training; and
- Opportunity for prenatal care.

While the initial scope of this project was to determine cost estimates for known gaps in SUD services and programming in Oregon, both PCG and OHA acknowledged that, amidst the ongoing opioid epidemic, novel analysis would be needed for opioid treatment programs (OTPs). OTPs are an integral component in treatment and recovery stabilization that support management of SUD and reduce the need for costly other forms of treatment, such as withdrawal management and residential services. Therefore, an assessment of the current landscape of OTPs in Oregon was added to the work completed by PCG in this study. This data was provided to OHA BHD staff, who analyzed the data and considered the following:

- The known needs of Oregonians;
- Geographical characteristics of current program locations; and
- Oregon population distribution.

These considerations were made to determine where, geographically, Oregon was missing needed OTPs. As a baseline, OHA identified any county without an OTP as in need of a program location. Beyond ensuring each county had at least one available OTP, OHA further assessed need for program locations by determining which of the following three program location types was needed to serve a county or city location:

- Mobile medication unit: a mobile satellite of a full-service unit or a non-mobile unit where the medication-assisted treatment component of the OTP framework is delivered. Extended OTP service offerings are also delivered, but may occur at the mobile, non-mobile and/or full-service locations.
- Non-mobile medication unit: a fixed location satellite of a full-service unit where the medication-assisted treatment component of the OTP treatment framework is delivered.

- Full-service medication unit: an OTP program location where all other required OTP services are offered alongside the medication-assisted treatment component.

Each non-mobile and mobile medication unit OTP location functions as a satellite of a full-service OTP location. Consumers may visit satellite locations for medication disbursement and access to some or all other OTP services. Sometimes, service offerings are limited at satellite locations, with full-service location homebases providing full-service arrays as needed. The widespread availability of satellite locations in consumers' communities supports the goal of the OTP service model: to provide viable access to opioid-agonist and partial-opioid-agonist medication on a daily or weekly basis for the promotion of ongoing treatment plan progress. When satellite locations do not have the capacity (i.e., limited size, staffing, or supplies) to provide comprehensive OTP services, they are still available to individuals at the full-service location. These comprehensive services (i.e., assessment, treatment planning, and ancillary supportive medical and human services) are typically required at a lower frequency than medication disbursement. Therefore, travelling further to access these services, less frequently, equals a reduced burden for individuals who require daily or weekly medication-assisted treatment services. Full-service OTP locations also represent a higher investment to build and maintain. Spreading the investment of OTP development across full-service and satellite locations allows Oregon to design a roadmap of interconnected program locations across the state. Ultimately, this will reduce the burden of lengthy travel for consumers who are committed to medication-assisted treatment for SUD.

OHA BHD staff considered the data regarding current OTP locations across Oregon, known regional data regarding substance use and Oregonians' needs, and known regional data regarding geographical and cultural characteristics and barriers to treatment to determine the current OTP location gaps across Oregon, by county and by program location type. The gaps, by OTP location type and county, are summarized in **Tables 53-55** below.

TABLE 53: MOBILE MEDICATION UNIT OTP GAPS BY COUNTY

County	Need	Actual	Gap
Benton	1	0	1
Clackamas	1	0	1
Columbia	1	0	1
Coos	1	0	1
Crook	1	0	1
Curry	1	0	1
Deschutes	1	0	1
Douglas	1	0	1
Harney	1	0	1
Hood River	1	0	1
Jackson	1	0	1
Jefferson	1	0	1
Josephine	1	0	1
Lane	2	0	2
Lincoln	1	0	1
Linn	1	0	1
Malheur	1	0	1
Marion	3	1	2
Morrow	1	0	1
Multnomah	4	1	3
Polk	1	0	1

County	Need	Actual	Gap
Tillamook	1	0	1
Umatilla	1	0	1
Union	1	0	1
Washington	1	0	1
Yamhill	1	0	1
TOTAL	**32**	**2**	**30**

OHA BHD staff identified a need for 32 mobile medication unit OTP locations across 26 counties throughout Oregon. Currently there are two mobile medication unit OTP locations, one based in Marion County, and one based in Multnomah County. These locations serve Tribal lands and Polk, Washington, and Yamhill Counties. For the purposes of this OTP location inventory and gap determination, the mobile medication unit OTP locations were accounted for as Marion and Multnomah County units. With two active mobile medication OTP location currently, the gap for mobile locations is 30 units.

TABLE 54: NON-MOBILE MEDICATION UNIT OPIOID TREATMENT PROGRAM GAPS BY COUNTY

County	Need	Actual	Gap
Baker	1	0	1
Benton	1	0	1
Clackamas	1	0	1
Clatsop	1	0	1
Columbia	1	0	1
Coos	1	0	1
Deschutes	1	0	1
Harney	1	0	1
Hood River	1	0	1
Josephine	1	0	1
Klamath	1	1*	0*
Lane	2	1	1
Multnomah	1	0	1
Tillamook	1	0	1
Wasco	1	0	1
Washington	2	0	2
Yamhill	1	0	1
TOTAL	**19**	**2***	**17***

*Klamath County non-mobile medication unit is planned with funding budgeted from State Opioid Response (SOR) grant. Location is not currently available but is not included in gap or cost estimates.

OHA BHD staff identified a need for 19 non-mobile medication unit OTP locations across 16 counties throughout Oregon. Currently, only Lane County has an active non-mobile medication unit OTP location, based out of a full-service unit location in Lane County. A unit is planned, using SOR grant funding, for Klamath County. This intended unit has been counted as an actual unit because funding has already been budgeted by OHA and it will not be considered a gap for cost estimation purposes. Therefore, the gap for non-mobile medication OTP locations is 17 units.

TABLE 55: FULL-SERVICE OPIOID TREATMENT PROGRAM LOCATION GAPS BY COUNTY

County	Need	Actual	Gap
Baker	1	0	1
Benton	1	1	0
Clackamas	2	1	1
Clatsop	1	1	0
Coos	1	1	0
Deschutes	1	1	0
Douglas	1	1	0
Jackson	2	2	0
Josephine	1	1	0
Lane	3	3	0
Lincoln	1	0	1
Linn	1	1	0
Malheur	1	0	1
Marion	4	4	0
Multnomah	8	8	0
Umatilla	1	1	0
Washington	2	1	1
17 counties	**32**	**27**	**5**

OHA BHD staff identified a need for 32 full-service OTP locations across 17 counties throughout Oregon. There are 27 available full-service OTP locations across those 17 counties with available units. Therefore, the gap for full-service OTP locations is five units.

Currently, there are 14 counties with full-service OTP locations, two of which (i.e., Clackamas and Washington counties) were identified as having a need beyond their current available full-service location. Three additional counties (i.e., Baker, Lincoln, and Malheur counties) do not currently have an available full-service OTP location but were identified as in need of a unit. Therefore, the gap of five full-service OTP locations represents a need in five distinct counties (i.e., Baker, Clackamas, Lincoln, Malheur, and Washington), two of which also already have one active full-service OTP location.

The statewide OTP location gaps, by program location type, are summarized in **Table 56** below. The number of counties experiencing a gap, by program location type, is also presented.

TABLE 56: FINAL OPIOID TREATMENT PROGRAM LOCATION GAPS

Opioid Treatment Program Location Type	Need	Actual	Gap	Number of Counties with Gap
Mobile Medication Unit	32	2	**30**	**26**
Non-Mobile Medication Unit	19	2*	**17***	**16***
Full-Service Unit	32	27	**5**	**5**
TOTAL	**83**	**31***	**52***	

*Klamath County actual count for non-medication OTP location includes a unit that is planned with funding budgeted from SOR grant. Unit is considered an actual unit for gap calculation purposes, as cost of this facility will not be included in gap cost estimates.

Notably, both the total gap for the full-service units and the number of counties in which there is a gap for full-service units were significantly smaller values than the gap for mobile or non-mobile medication units and the number of counties in which there is a gap for those satellite units. This disproportionate gap in units and number of counties with a satellite unit gap is representative of OHA BHD staffs' understanding of the statewide SUD service needs, the geography of Oregon, and the unique opportunity to expand the reach of OTP services with use of non-mobile and mobile medication units. OHA BHD has charted a precise prescription for each program location type, by county, to promote ease of access to the most essential service offered by OTPs, medication-assisted treatment, and to maximize the reach of OTP service offerings.

Cost Estimates – Capital Cost for Program Locations

Once final gap estimates for SUD program locations were determined, the PCG team estimated costs for building or establishing the needed outpatient, residential, withdrawal management, recovery community centers, recovery residences, and opioid treatment program locations. In total, there is a total gap of 865 program locations. The estimated total cost to build or establish the locations needed to fill the gaps is **$1,676,044,193. Table 57** below outlines the total estimated cost to fill the identified gaps at each type of program location included in this analysis and the total cost to fill all program location gaps across all program location types.

TABLE 57: COST ESTIMATES TO MEET IDENTIFIED PROGRAM LOCATION GAPS

Program Location Type	Gap	Estimated Total Cost
Outpatient	203	**$398,491,925**
Residential	81	**$596,878,902**
Withdrawal management	41	**$173,866,070**
Recovery Residences	351	**$357,511,245**
Recovery Community Center	137	**$131,171,050**
Opioid Treatment Program	52	**$18,125,000***
Total	**865**	**$1,676,044,193**

Further details for cost estimates for each of these facilities are outlined in the sections below.

Cost Estimates for Program Locations – General Methodology

To estimate the costs for outpatient, residential, withdrawal management, and recovery community center program locations, PCG used RSMeans Data Online, an internet-based software package, as a source for determining capital construction costs for building new behavioral health facilities across the state. RSMeans offers the following:

- Construction Cost Data – RSMeans collects and compiles national construction cost data for various building types.
- Cost Per Square Foot Estimates – RSMeans provides up-to-date cost per square foot estimates that consider design, materials, and labor costs specific to the building type and size.
- City Cost Indexes – RSMeans publishes a set of city cost indexes which allow for adjustments to the base cost estimates based on location-specific factors. The system provides city-specific cost estimates, so the cost estimates reflect a cost for each region compared to a statewide average. The cities included for the State of Oregon were:
    - Bend
    - Eugene
    - Klamath Falls
    - Medford
    - Pendleton
    - Portland

- Salem
- Vale

RSMeans offers location-type choices (i.e., medical office building, hospital, and community center) but requires input of size of the location in square footage. To determine appropriate size estimates for each program location type, PCG analyzed a sample of existing outpatient, residential, withdrawal management, and recovery community center program locations to determine locations' average size in square footage. Program location size data is not maintained by OHA so the data PCG could utilize was limited.

While RSMeans provides the ability to estimate capital construction costs for different regions throughout the state, there are a few limitations to the estimations. Most significantly, the exact location and cost of land for any new facility is unknown. Depending upon the specific location of a new program, land costs can vary greatly. Therefore, costs for the purchase or lease of the land required for building new program locations will be an additional cost for Oregon. Also, RSMeans does not account for the cost of anti-ligature construction in new facilities. Anti-ligature construction is crucial for individual safety, ensuring that no parts of the facility can be used for self-harm. This is an important consideration, as it would represent an additional expense for the state if anti-ligature construction is sought. In addition to the already noted limitations, these estimates do not encompass several other crucial factors: site utilities, parking, landscaping, sales tax, and other variables. Finally, costs specific to additional costs resulting from additional design requirements, prevailing wage regulations, and agency project management fees are not included in these estimates.

To estimate the total costs for building recovery residences in Oregon, the PCG team leveraged a website called Boutique Home Plans to calculate the costs per home in nine different cities in Oregon. This website houses a cost-to-build calculator derived from historical quarterly building cost data from the U.S. Census Bureau.

To estimate the total costs for establishing opioid treatment program (OTP) locations in Oregon, OHA BHD staff provided reasonable cost ranges for each program location type (i.e., mobile medication unit, non-mobile medication unit, and full-service location) based on cost data from previously established OTP locations in Oregon. The cost estimates provided for OTP locations differ from other program location cost estimates in that OHA and PCG assumed OTP locations may not require capital building costs. OHA BHD staff provided cost range estimates for establishing (i.e., start-up) OTP locations based on past location start-up costs in Oregon.

Cost Estimates – Outpatient Program Locations

To estimate the total cost for building the needed outpatient program locations in Oregon, the PCG team leveraged RSMeans to calculate the costs per facility in eight different cities in Oregon. The medical office building size of 6,000 square feet was selected with composition of brick veneer and/or reinforced concrete materials.

Table 58 outlines the RSMeans cost estimates for outpatient program locations by city and the statewide average. The statewide average cost to build an outpatient facility in Oregon is $1,963,014, with an average cost per square foot of $327. Across the city cost indexes in RSMeans, Portland ranks as the highest cost to build an outpatient program location at $2,049,822, with Vale ranking the lowest among costs per facility at $1,819,387.

TABLE 58: RS MEANS ESTIMATE OF OUTPATIENT PROGRAM LOCATION COSTS BY CITY AND STATEWIDE AVERAGE

City	Cost per Facility
Bend	$1,967,324
Eugene	$1,977,879
Klamath Falls	$1,979,331

City	Cost per Facility
Medford	$1,974,965
Pendleton	$1,928,497
Portland	$2,049,822
Salem	$2,006,910
Vale	$1,819,387
Statewide Average	**$1,963,014**

The OHSU-PSU identified gap of 203 outpatient program locations, from **Table 43** above, was maintained as the identified gap for cost estimation purposes. Based on that identified gap of 203 program locations and the average cost to build a single program location of $1,963, the estimated total costs to build the needed outpatient program locations in Oregon is $398,491,925.23.

TABLE 59: COST ESTIMATE TO FILL GAP IN OUTPATIENT PROGRAM LOCATIONS

Program Location Type	Average Cost Per Location	Gap	Gap Source	Estimated Total Cost
Outpatient	$1,963,014	203	**2022 Gap Anaysis**	**$398,491,925**

Cost Estimates – Residential Program Locations

To estimate the total cost for building new residential program locations in Oregon, the PCG team leveraged RSMeans to calculate the cost per program location in eight different cities in Oregon. A 2-3 story hospital building with an average size of 14,181 square feet and composition of brick veneer and/or wood frame was used as the location proxy in RSMeans. This location type and size, on average, accomodates 29 beds.

Table 60 below outlines the RSMeans cost estimate for residential program locations by city and the statewide average. The statewide average cost to build an residential facility in Oregon is $7,343,864, with an average cost per bed of $253,237, and an average cost per square foot of $518. Across the city cost indexes in RSMeans, Portland ranks as the highest cost to build an outpatient program location at $7,771,059, with Vale ranking the lowest cost per facility area at $6,791,737.

TABLE 60: RS MEANS ESTIMATE OF RESIDENTIAL PROGRAM LOCATION COST BY CITY AND STATEWIDE AVERAGE

City	Cost per Program Location
Bend	$7,296,686
Eugene	$7,422,710
Klamath Falls	$7,317,204
Medford	$7,399,914
Pendleton	$7,212,473
Portland	$7,771,059
Salem	$7,539,131
Vale	$6,791,737
Statewide Average	**$7,343,864**

As described in **Table 45** above, the PCG Residential+ Study team identified a gap of 2,357 residential beds in the state of Oregon. That gap of residential beds was converted to a gap in the number of residential program locations, based on the average program location capacity of 29 beds. The gap of 2,357 residential beds requires 81 residential program locations to be created to accommodate the needed beds.

The estimated total cost to fill the gap of needed residential program locations in Oregon was calculated as 81 locations times the statewide average cost per location of $7,343,864. The total cost of building residential program locations to meet the identified gap is estimated at **$596,878,902**.

TABLE 61: COST ESTIMATE TO FILL GAP IN RESIDENTIAL PROGRAM LOCATIONS

Program Location Type	Average Cost Per Location	Gap	Gap Source	Estimated Total Cost
Residential	$7,343,864	81	**OHA Residential+ Study, RSMeans for Conversion**	**$596,878,902**

Cost Estimates – Withdrawal Management Program Locations

To estimate the total cost for building new withdrawal management programs in Oregon, the PCG team leveraged RSMeans to calculate the cost per program location in eight different cities in Oregon. A two to three-story hospital building with an average size of 6,664 square feet and composition of brick veneer and/or wood frame was used as the location proxy in RSMeans. This location type and size, on average, accomodates 14 beds.

Table 62 below outlines the RS Means cost estimate for facilities for withdrawal management programs by city and the statewide average. The statewide average cost to build a facility for withdrawal management programs in Oregon is $4,262,916, with an average cost per bed of $304,494, and an average cost per square foot of $640. Across the city cost indexes in RSMeans, Portland ranks as the highest cost to build an outpatient facility at $4,511,210, with Vale ranking the lowest among costs per facility at $3,930,764.

TABLE 62: RS MEANS ESTIMATE OF WITHDRAWAL MANAGEMENT FACILITY COSTS BY CITY AND STATEWIDE AVERAGE

City	Cost per Facility
Bend	$4,256,991
Eugene	$4,291,653
Klamath Falls	$4,281,684
Medford	$4,286,448
Pendleton	$4,171,742
Portland	$4,511,210
Salem	$4,372,835
Vale	$3,930,764
Statewide Average	**$4,262,916**

As described above in **Table 48**, the PCG Residential+ Study team identified a gap of 571 withdrawal management beds in the state of Oregon. That gap of withdrawal management beds was converted to a gap in the number of program locations, based on the average withdrawal management program location capacity of 14 beds. The gap of 571 withdrawal management beds requires 41 withdrawal management program locations to be created to accommodate the needed beds.

The estimated total cost to fill the gap of needed withdrawal management program locations in Oregon was calculated as 41 locations times the statewide average cost per location of $4,262,916. The total cost of building withdrawal management program locations to meet the identified gap is estimated at **$173,866,070**.

TABLE 63: COST ESTIMATE TO FILL GAP IN WITHDRAWAL MANAGEMENT PROGRAM LOCATIONS

Program Location Type	Average Cost Per Location	Gap	Gap Source	Estimated Total Cost
Withdrawal Management	$4,262,916	41	**OHA Residential+ Study, RSMeans for Conversion**	**$173,866,070**

Cost Estimates – Recovery Residence Program Locations

Recovery residences are the only non-commercial SUD program location in the scope of this study. Therefore, cost methodology for the recovery residence program location was tailored to consider current residential housing market conditions. In Oregon, there is an initiative to build more homes to combat the current housing crisis. With this initiative in mind, the PCG team developed cost estimates for recovery residences under the assumption of building new homes, rather than purchasing existing real estate, to fill the gap for recovery residences. To develop the cost estimate of building new residences, the team leveraged a cost-to-build calculator from Boutique Home Plans. The calculator's estimates are derived from historical quarterly building cost data from the U.S. Census Bureau.

The PCG team evaluated 128 MHACBO recovery residences' data and identified 11 beds per program location on average in Oregon. To calculate the amount of square feet needed per person (i.e., per bed), the PCG team leveraged a 2017 Point 2 Homes Survey[xv] that found, Americans need, on average, 656 square feet per person. This average square feet per person includes space estimates for bedroom, bathroom, and living spaces. To estimate a cost range for recovery residences, the PCG team multiplied 11 people times 656 square feet per person. This calculated an average square foot estimate of 7,216 square feet. Therefore, we determined the costs of 11-bedroom residences with 7,216 square feet across nine cities in Oregon, using Boutique Home Plans cost calculator.

Table 64 below outlines the cost estimate for recovery residences by city and the statewide average. The statewide average cost to build a recovery residence in Oregon for an 11-bedroom, 7,216 square feet home is $1,018,551, with an average statewide cost per square foot of $141. Across the cities included in this cost estimate, Grants Pass ranks as the most expensive city to build a recovery residence, with a cost of $1,107,480. The cities of Albany/Lebanon, Euguene/Springfield, and Salem were tied for the least expensive city to build a recovery residence, with a cost of $977,188.

TABLE 64: BOUTIQUE HOME PLANS ESTIMATE OF RECOVERY RESIDENCE PROGRAM LOCATION COSTS BY CITY AND STATEWIDE AVERAGE

City	Cost per Residence
Albany/Lebanon	$977,188
Bend	$1,005,108
Corvallis	$1,014,414
Eugene/Springfield	$977,188
Grants Pass	$1,107,480
Medford	$1,070,254
Pendleton	$1,033,027
Portland	$1,005,108
Salem	$977,188
Statewide Average	**$1,018,551**

As described above in **Table 51**, the 2022 **Oregon SUD Services Inventory and Gap Analysis** identified a gap of 3,859 recovery residence beds in the state of Oregon. That gap of recovery residence

beds was converted to a gap in the number of program locations, based analysis of MHACBO data that showed the average recovery residence program location capacity of 11 beds. The gap of 3,859 beds requires 351 recovery residence program locations to be built to accommodate the needed beds.

The estimated total cost to fill the gap of needed recovery residence program locations in Oregon was calculated as 351 locations multiplied by the statewide average cost per location of $1,018,551. The total cost of building recovery residence program locations to meet the identified gap is estimated at **$357,511,245**.

TABLE 65: COST ESTIMATE TO FILL GAP IN RECOVERY RESIDENCE PROGRAM LOCATIONS

Program Location Type	Average Cost Per Location	Gap	Gap Source	Estimated Total Cost
Recovery Residence	$1,018,551	351	**2022 Gap Analysis, MHACBO Data for Conversion**	**$357,511,245**

Cost Estimates – Recovery Community Center Program Locations

To estimate the total costs for building new recovery community centers in Oregon, the PCG team leveraged RSMeans to calculate the costs per facility in eight different cities in Oregon. Program location square footage data is not maintained by OHA, therefore data available to PCG for center size estimates was limited. First, the PCG team identified a size estimate based on the average size of the last three public sales of existing recovery community centers. Size data for recently sold properties was obtained from property listings and real estate sites. The average size of those three recently sold recovery community centers was 3,400 square feet. A building with an average size of 3,400 square feet and composition of decorative concrete blocks and/or bearing walls was used as the location proxy in RSMeans.

RSMeans cost estimate for recovery community centers by city and the statewide average are provided in **Table 66** below. **The statewide average cost** to build a **recovery community center** in Oregon is **$957,452.92**, with an average cost per square foot of $281.60. Across the city cost indexes in RSMeans, Salem ranks as the highest cost to build a recovery community center at $988,877.25, with Vale ranking the lowest among costs per center at $878,828.21.

TABLE 66: RS MEANS ESTIMATE FOR RECOVERY COMMUNITY CENTERS COSTS BY CITY AND STATEWIDE AVERAGE

City	Cost of Program Location
Bend	$975,961
Eugene	$971,346
Klamath Falls	$987,954
Medford	$973,213
Pendleton	$933,116
Portland	$950,327
Salem	$988,877
Vale	$878,828
Statewide Average	**$957,453**

The OHSU-PSU identified gap of 137 recovery community centers, from **Table 52** above, was maintained as the gap for cost estimation purposes. The estimated total cost to fill the gap of needed recovery community center program locations in Oregon was calculated as 137 locations multiplied by the

statewide average cost per location of $957,453. The total cost of building recovery community center program locations to meet the identified gap is estimated at **$131,171,050**.

TABLE 67: COST ESTIMATE TO FILL GAP IN RECOVERY COMMUNITY CENTER PROGRAM LOCATIONS

Program Location Type	Average Cost Per Location	Gap	Gap Source	Estimated Total Cost
Recovery Community Center	$957,453	137	**2022 Gap Analysis**	**$131,171,050**

Cost Estimates – Opioid Treatment Program Locations

Opioid Treatment Program (OTP) location costs were calculated based on a range of costs provided by OHA BHD staff. Reasonable cost ranges for one-time start-up costs for each type of OTP location were based on cost data from previously established OTP locations in Oregon, provided by OHA BHD staff. OTP cost estimates did not include building of commercial properties for all program locations, rather it was assumed buildings could be purchased, leased, or built for full-service and non-mobile medication unit program locations. Our estimates include a blend of those start up options based on the cost for current OTPs.

Cost estimates for each unit and for the total number of units needed to fill the identified gaps, by OTP location type, are presented in **Table 68** below. The total cost of meeting the identified gap for OTP locations in Oregon ranges from **$11,750,000** to **$24,500,000**. The average cost for developing the needed 52 opioid treatment program locations in Oregon was calculated as the average of the total minimum cost and the total maximum cost. The average cost to fill the gap of needed opioid treatment program locations in Oregon is **$18,125,000**.

TABLE 68: TOTAL COST TO MEET OPIOID TREATMENT PROGRAM GAPS, BY LOCATION TYPE

Location Type	Each – Minimum	Each – Maximum	Gap	Total to Fill Gap – Minimum	Total to Fill Gap – Maximum
Mobile Medication Unit	$150,000	$350,000	30	$4,500,000	$10,500,000
Non-Mobile Medication Unit	$250,000	$500,000	17	$4,250,000	$8,500,000
Full-Service Unit	$600,000	$1,100,000	5	$3,000,000	$5,500,000
Total			**52**	**$11,750,000**	**$24,500,000**
Average Total				**$18,125,000**	

Notably, the minimum cost estimate for the 30 needed mobile medication unit OTP locations is nearly equal to the minimum cost estimate for the 17 needed non-mobile medication OTP locations. Also, the minimum cost estimate for the five needed full-service OTP locations is two thirds the minimum cost estimate for the 30 mobile medication OTP locations. These ratios demonstrate the budget flexibility that use of smaller, satellite units can provide. Increased units, spread aptly throughout the state, will provide those in need with much needed daily access to medication-assisted treatment. Implementation of hybrid OTP models will allow more units to be provided at a lower cost, which promotes widespread access to care for Oregonians.

Program Location Cost Estimates – Considerations

The methodology between the components of this project and those included in the OHA Behavioral Health Residential+ Facility Study differ in some ways due to the availability of data and the scope of

each project. The OHA Behavioral Health Residential+ Facility Study was primarily focused on costs per bed, while costs were calculated and presented based on number of program locations in this study. The costs for outpatient recovery community center program locations were based on facility-wide cost mechanisms, therefore the cost estimates were completely derived from RSMeans. Recovery residence program location cost estimations had different constraints, given the residential nature of recovery residences.

Unlike the other program location types, opioid treatment program location cost estimates did not include building costs. OTP location costs represented a range of costs to establish an opioid treatment program in an established commercial property, for full-service program locations and non-mobile medication unit program locations, or a range of costs to obtain and prepare a mobile vehicle for OTP use, for mobile medication unit program locations. Cost estimation methodology was limited, due to lack of historical data regarding costs related to opioid treatment programming. OHA BHD provided cost estimates based on knowledge of current program start-up costs. With only 30 publicly-accessible opioid treatment programs currently operating in Oregon, and only one each of mobile and non-mobile medication units, cost data is limited. OHA may consider the likeness of full-service opioid treatment program locations and outpatient program locations to test the soundness of current cost estimations for full-service opioid treatment program locations. Cost estimates for full-service OTP locations ranged from $600,000 to $1,100,000, while the average cost for an outpatient program location was nearly double the higher end of that range at $1,963,014. Although, outpatient program location cost estimates included the cost of construction of the building, which could account for much of the variance.

OTHER SUBSTANCE USE DISORDER PROGRAMMING GAP COST ESTIMATES

PCG met with agency staff to identify gaps in harm reduction, school-based primary prevention, and community-based primary prevention programs:

- Harm Reduction Programs: met with OHD BHD to develop unmet need estimates for full-service harm reduction programs, building on regional need estimates for facilities with fentanyl strip distribution, facilities with naloxone distribution and syringe exchange programs that were identified in the 2022 Gap Analysis;
- School-Based Primary Prevention Services – based on gaps identified by ODE; and
- Community-Based Primary Prevention Services – based on gaps identified by OHA PHD.

Total annual cost for providing the level of "**other SUD programming**" needed to fill Oregon's identified gaps is estimated at **approximately $218 million**. The total allocation of cost across the three other SUD programs (i.e., harm reduction, school-based primary prevention, and community-based primary prevention) as well as the source of the gap that was used for cost calculations is shown in **Table 69** below.

TABLE 69: COST ESTIMATES TO EXPAND OTHER SUD PROGRAMMING

Service Type	Final Components Included in Cost Estimates in this Study	Source Used for Gap Calculation	Cost Estimate	Percent of Total "Other Program" Cost
Other SUD Programming	Harm Reduction Programs	OHA Behavioral Health Division	**$89,976,177**	**41.22%**
	School-Based Primary Prevention	Oregon Department of Education	**$5,471,747**	**2.51%**

Service Type	Final Components Included in Cost Estimates in this Study	Source Used for Gap Calculation	Cost Estimate	Percent of Total "Other Program" Cost
	Community-Based Primary Prevention	OHA Public Health Division	**$122,840,000**	**56.27%**
		TOTAL	**$218,445,283**	**100%**

Harm Reduction Programming

The 2022 **Oregon SUD Services Inventory and Gap Analysis** included estimates for select harm reduction interventions: fentanyl test strip distribution, naloxone distribution, and syringe exchange programs. Those identified gaps are listed in **Table 70**.

TABLE 70: HARM REDUCTION INTERVENTION GAPS (CAST, OHSU-PSU SPH, 2022)

Program Type	Need	Actual	Gap
Facilities with fentanyl test strip distribution	127	83	**44**
Facilities with naloxone distribution	334	240	**94**
Syringe exchange programs	106	45	**61**

PCG and OHA BHD staff used this data to generate new estimates for full-service harm reduction programs which **concurrently offer test strip distribution**, **naloxone distribution,** and **syringe exchange** services.

Harm Reduction Programming Gap

BHD staff supported the use of the **syringe exchange program gap estimate as a baseline** to determine the gap for full-service harm reduction programs because the current syringe exchange program model can serve as a foundation for full-service harm reduction programs. Current syringe exchange programs can be transitioned to full-service harm reduction programs by adding test strip and naloxone distribution services with syringe exchange services. BHD supplied 2024 data on operational syringe exchange programs in Oregon (50 total), and this was applied to the 2022 need estimates to generate an updated estimate of the full-service harm reduction service gap.

TABLE 71: SYRINGE EXCHANGE PROGRAMS GAP ESTIMATE (2024)

Program Type	Need	Actual (2024 level)	Gap
Syringe exchange programs	106	50	**56**

BHD staff also provided need estimates for mobile harm reduction units. These units can help improve access to services for vulnerable populations, and, according to BHD staff, serve as critical components of full-service harm reduction programs. The final other SUD programming – harm reduction services gaps were identified as 56 full-service Harm Reduction Programs to include:

- A fixed location component

- A mobile location component (i.e., van)

Services provided at each of the 56 locations, whether the visit occurs at the fixed or mobile unit of the program, should include:

- Syringe exchanges
- Naloxone distribution
- Test strip distribution

Cost Estimates – Harm Reduction Programming

Full-service harm reduction program costs were calculated based on the Public Library of Science's (PLOS) Estimated Cost of Comprehensive Syringe Service Program in the United States[xvi] methodology. PLOS provides cost estimates to the following components of a comprehensive syringe service program:

- One time start-up costs unique to the fixed location component of the program:
  - Lease or rental deposit
  - Office furniture
  - Office equipment
- One time start-up costs unique to the mobile location component of the program, including first year costs:
  - Van or vehicle purchase
  - Van furniture
  - First year of gas, storage, maintenance, registration costs
- Ongoing costs (fixed location)
  - Operational costs
  - Personnel
  - Prevention services
  - Medical testing services

All costs presented below are based on estimates from the 2019 PLOS report, which was developed with 2016 and 2017 cost data. An inflationary factor has been applied to all PLOS cost estimates to update them to 2023 levels. Also, PLOS provided cost estimates in a range based on program location (i.e., rural, suburban, or urban), and program size (i.e., small [250 clients per year], medium [1,250 clients per year], and large [2,500 clients per year]). Generally, the lowest costs were found in rural-setting, small-sized program estimates and highest costs were found in urban-setting large-sized programs.

START-UP COSTS – FULL-SERVICE HARM REDUCTION PROGRAMS

One-time start-up costs for each fixed location component include lease or rent deposit, office furniture, and office equipment (e.g., items such as computers, mobile phones, office furniture, and modems). One-time start-up costs for each mobile location component include the cost to purchase a van and furniture for the van (i.e., folding table, folding chairs, and pop-out tent) plus one year's costs for registration, maintenance, gas, and storage. Although classified as a one-time cost by PLOS of a mobile location start-up, based on PLOS methodology, the mobile location values reported represent both the start-up (i.e., purchase of the vehicle and furniture) and the first year of mobile-location-specific costs.

TABLE 72: ONE TIME START-UP COSTS FOR HARM REDUCTION PROGRAMS

Program Component	Each – Minimum	Each – Maximum	56 Programs – Minimum	56 Programs – Maximum
Fixed Location Cost	$6,690	$24,132	$374,640	$1,351,392

Program Component	Each – Minimum	Each – Maximum	56 Programs – Minimum	56 Programs – Maximum
Mobile Location Cost	$29,031	$79,207	$1,625,736	$4,435,592
Total Cost	**$35,721**	**$103,339**	**$2,000,363**	**$5,787,002**

ONGOING COSTS – FULL-SERVICE HARM REDUCTION PROGRAMS

Ongoing costs related to providing services both the fixed location and mobile component of each program were calculated by PLOS based on four major cost categories:

- Personnel costs – including the cost of annual salary and administrative costs (i.e., benefits and insurance) for a program director, a part-time accountant, peer specialists, a part-time nurse, counselors, volunteer incentives, and staff training and education costs.
- Operational costs – including the cost of lease or rental payments, insurance, utilities (including internet and phone), mail services, tax preparation and audit services, bank fees, office supplies, website fees, electronic data capture systems, cleaning supplies, food items for clients, janitorial services, and indirect costs.
- Prevention services costs – including sterile syringes and needles, other injecting equipment (e.g., cotton filters, zip bags (for cotton), sterile water, alcohol swabs, tourniquets (non-latex), and cookers), naloxone, hazardous waste management, hygiene products, and sharp disposal containers.
- Onsite medical and testing services costs – including point of care testing for Hepatitis C virus and Human Immunodeficiency virus, Hepatitis A and Hepatitis B vaccinations, wound care and first aid kits, Vitamin C, condoms, and pregnancy tests.

The annual ongoing program costs for fixed and mobile location services, adjusted for inflation, are shown in **Table 73** below.

TABLE 73: ANNUAL ONGONG JOINT FIXED AND MOBILE LOCATION COSTS FOR HARM REDUCTION PROGRAMS

Combined Costs – Fixed and Mobile Locations	Each – Minimum	Each – Maximum	56 Programs – Minimum	56 Programs – Maximum
Personnel Costs	$ 256,855	$680,009	$14,383,880	$38,080,504
Operational Costs	$23,296	$274,895	$1,304,576	$15,394,120
Prevention Services Costs	$82,791	$1,575,775	$4,636,296	$88,243,400
Onsite Medical and Testing Services Costs	$9,916	$170,838	$555,296	$9,566,928
Total Cost	$372,858	$2,701,517	$20,880,039	$151,284,951

TOTAL COSTS – FULL-SERVICE HARM REDUCTION PROGRAMS

The total annual minimal and maximum cost estimates for startup and ongoing operations of an individual full-service Harm Reduction Program, including fixed and mobile services and of all recommended 56 units are summarized in **Table 74** below.

TABLE 74: TOTAL ANNUAL ONGOING COSTS FOR HARM REDUCTION PROGRAMS

Cost Component	Each – Minimum	Each – Maximum	56 Programs – Minimum	56 Programs – Maximum
Start Up Costs	$35,721	$103,339	$2,000,363	$5,787,002
Ongoing Costs	$372,858	$2,701,517	$20,880,039	$151,284,951
Total Cost	$408,579	$2,804,856	$22,880,402	$157,071,953
			Average	**$89,976,177**

The variance in cost between the minimal cost estimate for each harm reduction program location and the maximum cost estimate for each program location lends itself to the very large variance in cost between **minimal cost estimate for the total 56 programs ($22,880,402)** and the **maximum cost estimate for the total 56 programs ($157,071,953)**. Within that range, the **average annual cost** for start-up and operation of the 56 needed Harm Reduction program locations is **$89,976,177**. Minimal costs generally represent small-sized, rural-based programs. Maximum cost estimates generally represent large-sized, urban-based programs. The size of the program affected variance more than the setting, meaning large programs had substantially higher costs than small programs, while urban programs had only minimally higher costs than rural programs. For more precise estimates on the cost of implementing all needed 56 full-service Harm Reduction Programs in Oregon, OHA could calculate how many small-sized units are needed and how many large-sized units are needed. Minimum cost estimates could be used for the pool of small-sized units needed and maximum cost estimates could be used for the pool of large-sized units needed.

School-Based Primary Prevention Programming

PCG met with ODE staff to develop a methodology for estimating the cost of meeting the identified gaps in school-based prevention programming. According to ODE, "The primary opportunity for the education system to strengthen culturally relevant substance use prevention activities across schools is to establish a hub to coordinate, strengthen and align substance use prevention activities within the state agency through staffing and leadership." While Oregon Administrative Rule (OAR) 581-022-2045[xvii], or Division 22, creates the foundation for use of evidence-based prevention services in Oregon schools, a clear schema for the administrative function across the state has not been established. Considering districts' current autonomy with spending allocation and school-based prevention program planning, the establishment of a coordination hub (i.e., unit of 2.50 Full Time Equivalent (FTE) ODE staff) could serve as an anchor to outline an operational schema for substance use prevention activities across the 19 Educational Service Districts (ESDs) serving the 197 Oregon school districts. Potential goals coordination hub would be to:

- Strengthen the policy and practice infrastructure that guides prevention work in Oregon's schools
- Develop a wider set of tools, templates and supports for districts, to:
  - Support adoption of evidence-based curricula
  - Support adoption of activities that increase protective factors and reduce risk factors

Beyond offering districts a much-needed lifeline, formalization of ODE's role in statewide school-based substance use programming would support the overall success of programming statewide for another key reason: ODE's ability to coordinate with other statewide youth-serving agencies and local substance use prevention programs and preventionists. Potentially, districts could receive programming guidance and support influenced by additional state agencies (i.e., Oregon Youth Development Division (YDD), OHA, and Oregon Department of Human Services (ODHS)). There is not currently an interagency policy

aligning practice framework for youth prevention services in Oregon, however, ODE has identified the need to develop interagency policy and protocols in relation to youth substance use prevention programming and has begun work to address this need under the ODE Health in Education work. ODE's vision for this interagency work includes:

- Policy review and updates
- Development procedures to maximize students' exposure to protective factors in schools and after school programs
- Return of out of school youth to appropriate education settings
- Elimination of system barriers that inhibit success in both SUD treatment and school
- Elimination of punitive policies that remove education choices from students who use substances

According to ODE, this interagency undertaking – to further outline and formalize youth SUD prevention programming objectives and beliefs across Oregon – is needed on top of and in collaboration with the work that ESD staff do to support prevention programming in schools. ODE's coordination and alignment with other youth serving agencies and local prevention programs could produce comprehensive statewide operational mechanisms that will support ESD staff as they support districts' implementation of evidence-based, standardized prevention programming. ODE identifies the need for additional ESD staff in the form of at least one full-time equivalent staff at each of the 19 statewide districts to further support the consistent implementation of prevention programming. These ESD staff will be guided by the operational and programmatic oversight of ODE staff at the state-level coordination hub.

In summary, in relation to Division 22, ODE identified a need for:

- Coordination hub staff (i.e., 2.50 FTE ODE staff) to:
    - Update Division 22 Rule to outline administrative authority and function of ODE and to further define expectations of prevention planning and programming (1.25 FTE staff)
    - Update policies and procedures for evidence-based prevention programs (1.25 FTE staff)
- ESD staff (i.e., at least 19 FTE staff) to:
    - Convene with ODE to support crafting rule update, tools, and technical assistance materials
    - Implement updated policies and procedures re: prevention program, and
    - Oversee districts prevention planning and programming and monitor compliance with to-be-developed standards and continuous quality improvement of prevention plans and programming

Recently, the need for interagency work in the development of school-based SUD prevention has been further emphasized by Senate Bill 238[xviii] (SB 238), which requires school districts to develop and implement prevention education regarding the dangers of synthetic opioids, including fentanyl, in coordination with OHA, the State Board of Education (SBE), and the Alcohol and Drug Policy Commission (ADPC). Much like Division 22 barriers, both ODE's lack of resources and lack of administrative oversight or authority dictating the interagency coordination, prescribed in SB 238, impede SB 238 implementation. Therefore, in relation to SB 238, ODE identified a need for:

- Coordination hub staff (i.e., 1 FTE ODE staff) to:
    - Coordinate with other state agency staff, and
    - Provide guidance and tools for cohesive, evidence-based opioid prevention programs in schools.

Notably, ODE initially identified an additional SB 238 gap in the form of contract funding **($1,300,000)** to provide professional resources (i.e., modules and tools, communication resources, social media campaign funding, and curriculum supplements and resources by grade level). That gap has been removed from this report due to the most up-to-date data from ODE. Approval for these funds is now anticipated by ODE, following the conclusion of the Oregon legislation session of March 2024.

Furthermore, ODE recognizes a need for culturally relevant prevention education and intervention for elementary and secondary American Indian/Alaska Native (AI/NA) youth. ODE is directed by Oregon Senate Bill 13 (SB13) of 2017, known as Tribal History/Shared History[xix], to create and include K-12 Native American curriculum in Oregon public school and to provide requisite professional development to educators. SB 13 also directs ODE to provide funds to each of the nine federally recognized tribes of Oregon, to support their creation of individual, place-based curriculum. ODE recognizes the need includes culturally relevant SUD prevention education within this standardized, required public school Native American curriculum and tribal individual, place-based curriculum. ODE identified these key objectives for work to expand culturally relevant SUD prevention education:

- Development of public-school educators' knowledge of culturally relevant pedagogy
- Successful implementation of THSH lesson plans, achieved through creation of four additional professional development training modules
- Coordination with nine sovereign Tribes to examine current professional development modules, identify needed updates, and support for execution of updates or revisions

To achieve the key objective related to SB 13, ODE identified a need for:

- Coordination hub staff (i.e., 1 FTE ODE staff) to:
    - Continue curriculum development and directives and tools for public school implementation,
    - Offer support to the Tribes in their curriculum development
- ESD financial support (i.e., $100,000 in programmatic funding per ESD) to:
    - Support ESDs' in assisting districts implement SB 13 curricula
- Professional development resources, including:
    - Modules and training materials for public educators on SB 13 curricula
    - Funds to support Tribes' building of lesson plans and training of their educators

LEGISLATIVE FOUNDATION FOR RECOMMENDED INVESTMENTS

Oregon Administrative Rules (OAR) outline Oregon Department of Education rules within Chapter 581. Division 22 of OAR 581 establishes required standards for public elementary and secondary schools. Specifically within Division 22, 581-022-2045 establishes requirements for school-based prevention education for drugs and alcohol. 581-022-2045 requires:

- Each school district to develop a comprehensive plan for alcohol and drug abuse prevention program (to be updated annually); and
- Each program's approval by the school district board after consultation from
    - Parents
    - Teachers
    - School administrators
    - Local community agencies and
    - Persons from the health or alcohol and drug service community who are knowledgeable of the latest research information.

Beyond those two main requirements, OAR 581-022-2045 includes many specifications that outline what prevention programming should include and how they should be implemented.

While OAR 581-022-2045 requirements support statewide school-based prevention programming, it does not provide administrative authority ODE, or other Oregon public agencies, to support the achievement of those requirements. This has left 197 individual school districts implementing widespread techniques to address substance use prevention programming across Oregon. Districts currently cannot turn to a centralized support mechanism to offer prevention programming guidance. Furthermore, meeting the goals of Division 22 (i.e., implementation of expert-approved programming that incorporates the latest research information) remains the sole responsibility of individual districts. Districts, who are further

removed from other state agencies who can support an understanding and promotion of evidence-based prevention programming than ODE, are left to do the best they can to meet OAR requirements with very little state support.

Oregon Senate Bill 238 (SB 238), passed into law in 2023, assigns additional support from OHA, the State Board of Education (SBE), and the Alcohol and Drug Policy Commission (ADPC) for school districts in their development of school-based prevention curriculum. Beginning in the 2024-2025 school year, districts are required to include education regarding the dangers of synthetic opioids, including fentanyl, and regarding immunity laws and protections for those who report drug or alcohol use or overdose. Although SB 238 orders collaboration between OHA, SBE, and ADPC in support of districts' prevention programming, it remains unclear how much oversight or direction the consortium will provide in development of individual or statewide prevention programming.

Oregon SB 13, Tribal History/Shared History, passed into law in 2017, requires ODE to create and include K-12 Native American curriculum in Oregon public schools, provide requisite professional development to public school educators, and to provide funds to each of the nine federally recognized tribes of Oregon, for their creation of individual, place-based curriculum. SB 13 is built on a current recognition that a lack of accurate and complete curricula has contributed to persistent achievement and opportunity gaps between Native American and other students.

Cost Estimates – School-Based Primary Prevention Programming

ODE provided cost estimates, based on staffing and operational costs, to fill the current gaps that impede Oregon's implementation of Division 22, SB 238 and SB 13 requirements. Below, those costs are delineated into three categories, across each measure (i.e., Division 22, SB 238, and SB 13):

- ODE FTE staff, or coordination hub staff
- ESD staff
- Professional development to district educators and staff

DIVISION 22 COST ESTIMATES

To fill the identified gaps related to OAR 581-022-2045, or Division 22, ODE estimates the need for a total of 2.50 full-time equivalent (FTE) ODE staff. These FTE staff represent the development of a coordination hub, which ODE identified as the primary opportunity for school-based prevention services in Oregon. Work done by these staff would include updates to the Rule (to further define ODE's role in administration and oversight for Division 22 programming) (1.25 FTE) as well as updates to policies and procedures for Division 22 implementation and (1.25 FTE).

ODE FTE staff salary was calculated at $174,314 per year, for a total of $217,893 annual staffing costs for 1.25 FTE, or $435,785 for the total 2.50 FTE required for all Division 22 coordination hub staffing investments. Annual staffing costs for the Division 22 recommended staff are summarized in **Table 75** below.

TABLE 75: DIVISION 22 ODE COORDINATION HUB STAFF ANNUAL COST

Division 22 Function	Staff Needed (FTEs)	Annual Salary (per FTE)	Total Annual Salary
Updates to the Rule	1.25	$174,314	$217,893
Updates to policies and procedures	1.25	$174,314	$217,893
		TOTAL	**$435,785**

Related to Division 22, ODE estimates 19 FTE staff are needed to work in statewide ESDs. Their responsibilities will include implementation of state-directed Division 22 policies and procedures across districts and oversight of districts' prevention programming to ensure compliance and continuous quality improvement of districts' prevention plans.

ODE estimated the average annual salary for one ESD FTE at $160,247. Based on that estimate, the annual investment for the recommended 19 FTE staff is $3,044,693.

TABLE 76: DIVISION 22 ESD STAFF ANNUAL COST

Division 22 Function	Staff Needed (FTEs)	Annual Salary (per FTE)	Total Annual Salary
Support districts' implementation of prevention programming, monitoring districts' compliance, oversee CQI of prevention plans	19	$160,247	$3,044,693

The total costs of all recommended Division 22 investments are summarized in **Table 79** below.

TABLE 77: DIVISION 22 TOTAL ANNUAL INVESTMENT

SB 238 Function	Total Biennial Investment
ODE Coordination Hub Staffing	$435,785
ESD Staffing	$3,044,693
TOTAL	**$3,480,478**

SB 238 COST ESTIMATES

To fill the identified gaps related to SB 238, ODE estimates the need for a total of 1.0 FTE ODE staff. Work done by this staff would include coordination with other state agencies and provision of guidance and tools for development of cohesive, evidence-based opioid prevention programs. The annual FTE staffing cost is estimated at **$174,314**.

TABLE 78: SB 238 ODE COORDINATION HUB ANNUAL STAFF COST

SB 238 Function	Staff Needed (FTEs)	Annual Salary (per FTE)	Total Annual Salary
Coordinate with other state agencies, develop and implement tools and resources for implementation of cohesive, evidence-based programming	1.0	$174,314	$174,314

The coordination hub staffing cost represents the full cost of gaps identified by ODE in relation to SB 238 at this time. As mentioned, ODE initially identified a need for an additional $1,300,000 in contract funds related to SB 238 for professional development resources and communications services. Due to ODE's anticipation of approval for those funds, based on recent legislative action, these funds are not included in current cost estimates.

SB 13 – TRIBAL HISTORY/SHARED HISTORY COST ESTIMATES

To fill the identified gaps related to SB 13, or Tribal History/Shared History, ODE estimates the need for 1.0 FTE ODE staff. Work done by this staff would include continued curricula development and directives

and tools for public school implementation and coordination with Tribes for support in updating curriculum, as needed. The annual FTE staffing cost is estimated at **$174,314**.

TABLE 79: SB 13 ODE COORDINATION HUB STAFF ANNUAL COST

SB 13 Function	Staff Needed (FTEs)	Annual Salary (per FTE)	Total Annual Salary
Curricula development, Tribal support of curricula development and implementation	1.0	$174,314	$174,314

Related to SB 13 gaps, ODE estimates the cost of needed **programmatic support for ESDs** at **$800,000**. This estimate is based on an intended annual investment of $50,000 for each of the 19 ESDs. These funds would allow ESDs tools and resources to support districts' SB 13 curriculum implementation.

Also related to SB 13 gaps, ODE estimates another **$1,000,000** per year is needed for professional development resources, including modules and training materials for public educators regarding SB 13 curriculum and Tribal support for building lesson plans and training of their educators, as needed. This is a distinct cost that would be budgeted in the form of **Contracts**, as contracted providers perform this work.

The total estimated cost of recommended SB 13 investments, including ODE coordination hub staffing costs, programmatic support for ESDs, and contracted professional development are summarized in **Table 80** below.

TABLE 80: SB 13 TOTAL ANNUAL INVESTMENT

SB 238 Function	Total Biennial Investment
ODE Coordination Hub Staffing	$174,314
ESD Programmatic Support	$800,000
Contracts for Professional Development and Communications	$1,000,000
TOTAL	**$1,974,314**

TOTAL COST ESTIMATES – SCHOOL-BASED PRIMARY PREVENTION

Table 81 below summarizes the total estimated annual cost of funding needed gaps in Division 22, SB 238, and SB 13 at the state level, ESD level, and directly with districts (via contracted professional development). ODE estimates that the annual investment of **$5,629,106** is needed in each year of the next two biennia, to achieve the goal of filling these gaps in school-based prevention education and services in Oregon. Therefore, the total cost over the next two biennia would be **$22,516,424**.

TABLE 81: TOTAL ESTIMATED SCHOOL-BASED PREVENTION BIENNIAL INVESTMENT

Cost Component	ODE Hub Staff Salary	ESD Costs	Contracts	Total
Division 22 – Update Rule	$217,893	N/A	N/A	$217,893

Cost Component	ODE Hub Staff Salary	ESD Costs	Contracts	Total
Division 22 – Update Policies, Develop & Implement Curricula	$217,893	$3,044,693	N/A	$3,262,586
SB 238	$174,314	N/A	N/A	$174,314
SB 13 Tribal/Shared History	$174,314	$800,000	$1,000,000	$1,974,314
TOTAL	**$784,413**	**$3,844,693**	**$1,000,000**	**$5,629,106**

Community-Based Primary Prevention Programming

Building on the work done by PCG and OHA under the financial inventory scope of this project, OHA and PCG made efforts to assess current SUD community-based prevention service investments for gaps.

According to the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention: "Systems of prevention services work better than isolated efforts" (SAMHSA, 2017, p.9)[xx] This key principle, part of SAMHSA's Strategic Prevention Framework, means that prevention efforts are most successful when implemented collaboratively and comprehensively as systematic programs and investments, rather than individual or separate initiatives. OHA PHD staff, who oversee and implement community-based SUD prevention programming in Oregon, agree that successful prevention programming must be comprehensive, widespread, and ongoing. The interwoven, cumulative nature of prevention programming's impact is compounded by the predictive nature of prevention programming. Prevention services are implemented with the goal of preventing substance abuse or misuse. If prevention efforts are successful, substance abuse or misuse will not occur. Therefore, developing a formula to specifically calculate the needed level of prevention services is a near impossible task.

Community-Based Primary Prevention Programming Gap

How do you accurately measure the threshold for effective or acceptable levels of prevention investments when SUD persists? OHA Public Health Division (PHD) staff asked this question while developing a methodology for estimating the gap in Oregon's current community-based Alcohol and Other Drug Prevention and Education Program (ADPEP) and current community-based Other Drug Prevention and Education Program (ODPEP).

PHD developed a methodology to assess SUD prevention programming as an entire system, rather than assess individual interventions or specific initiatives. Looking at the entire program, PHD considered the **total investment in Oregon's Tobacco Prevention and Education Program (TPEP)** and **compared that investment to Oregon's investments into their ADPEP and ODPEP.**

How much prevention programming is enough is a difficult question to precisely answer but the Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control Programs[xxi] provides methodology for measuring the efficacy of states' TPEPs. The CDC has developed state-specific thresholds for recommended investments into TPEPs, based on recommended spending levels across five distinct programmatic and administrative categories:

- State and Community Interventions;
- Mass-Reach Health Communication Interventions;
- Cessation (linkages to clinical) Interventions;

- Surveillance and Evaluation; and
- Infrastructure, Administration, and Management.

CDC's most recent TPEP funding recommendations for Oregon prescribe an annual TPEP investment of at least $39,300,000.

States whose total annual TPEP investment meets or exceeds the state-specific CDC recommended spending threshold are considered adequately funded programs. According to the American Cancer Society[xxii], only two states met the CDC-recommended spending on TPEPs in fiscal year 2023: Oregon and Maine. Further, OHA determined Oregon's TPEP met the CDC's definition of an adequately funded program for the entire 2021-2023 biennium, with the state investing over $78,300,000 across the biennium, an average of $39,150,000. Comparable best practice standards or investment prescriptions for ADPEPs do not currently exist from the CDC or any other federal agency. Therefore, PHD used Oregon's TPEP as a baseline for consideration of an adequately funded primary prevention program to estimate current ADPEP and ODPEP gaps in Oregon.

The proportion of TPEP dollars spent was compared to the calculated overall societal cost of commercial tobacco in Oregon. According to the Alcohol and Drug Policy Commission's (ADPC) Strategic Plan[xxiii], and their cited study from the National Center for Addiction and Substance Abuse at Columbia University (CASA)[xxiv], the societal and economic costs of tobacco are $2.14 billion per biennium, at a minimum and excluding productivity losses, or $1.07 billion annually. **TPEP annual investments of $39.15 million represent only 3.7 percent** of the **total societal and economic costs of commercial tobacco use**.

This baseline proportion of prevention and education program cost share (i.e., 3.7 percent of total societal and economic costs) was used to calculate an estimated adequate spending level for Oregon's ADPEP and ODPEP. The ADPC Strategic Plan estimated the total societal and economic impact of all substance use in Oregon as $12.6 billion per biennium and provided the following cost allocation, with values representing minimal estimates:

- Commercial Tobacco – $2.14 billion ($1.07 billion annual)
- Alcohol – $4.0 billion ($2.0 billion annual)
- Other Substances – $500 million ($250 million annual)
- Substance Use Unattributable to a Single Substance – $5.96 billion ($2.98 billion annual)

Notably, the $250 million annual estimate for other substances was based on data collected prior to 2020 and does not reflect the societal costs of the current opioid crisis. Also, it is likely the $2.98 billion in annual costs that cannot be attributed to a single substance category would include additional costs for "other substances". Therefore, the $250 million annual estimate for other substances is on the lower end. Due to the inability to categorize the $2.98 billion of annual costs associated with more than a single substance, that portion of costs was removed. Therefore, total annual societal cost of commercial tobacco, alcohol, and other substances (minimal estimate) in Oregon was adjusted to $3.32 billion.

Cost Estimates – Community-Based Primary Prevention Programming

Using the baseline cost share proportion of 3.7 percent, ADPC estimates of societal and economic costs of commercial tobacco, alcohol, and other drugs were used to determine the recommended investment into each prevention and education program. The recommended investment for each program and the total recommended investment for all substance use prevention education programs is shown below in **Table 82**. Based on this cost estimation methodology, founded on Oregon's TPEP rating of adequately funded, it is recommended that OHA PHD **invest $122,840,000** annually **into community-based substance use prevention and education programming**. It is important to note that these figures exclude the $2.98 billion ADPC-estimated annual costs associated with substance use that cannot be attributed to a single substance.

TABLE 82: ESTIMATED COMMUNITY-BASED PREVENTION BIENNIAL INVESTMENT

Prevention and Education Program Type	Societal and Economic Costs	Cost Share for Prevention Program Investment	Recommended PEP Investment
Commercial Tobacco	$1,070,000,000	**3.7%**	$39,590,000
Alcohol	$2,000,000,000		$74,000,000
Other Drugs	$250,000,000		$9,250,000
TOTAL	**$3,320,000,000**		**$122,840,000**

REVENUE SOURCES TO MEET NEED

The cost estimates provided in this analysis are undeniably high, but **there are actions that state leaders can take to both maximize current revenue sources and generate new revenue sources** to address unmet need. Oregon invests large portions of state funds into SUD services, and ensuring those investments are currently being used to the maximum benefit should be considered alongside any additional investment.

MAXIMIZING CURRENT REVENUE SOURCES

As evidenced in the financial inventory, SUD financing is highly complex in Oregon, involving many different revenue streams. Each revenue stream has their own requirements and conditions, and with so many different actors (i.e., state agencies, counties, Coordinated Care Organizations (CCOs), Community Mental Health Programs (CMHPs) and community partners), identifying the data source and utility can be very difficult, if even possible.

To remedy this, Oregon could undertake a multi-agency process to **examine how current revenue sources** can be **used as equitably, effectively, and efficiently as possible**.

Equity

In 2019, Oregon Health Authority (OHA) adopted The OHA Health Equity Goal: "Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

- **Achieving health equity** requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
- The **equitable distribution** or redistribution of **resources and power**; and
- Recognizing, reconciling, and **rectifying historical and contemporary injustices**."

To accomplish this goal, **state agencies** could **start by working together** to identify policies and practices **that ensure community voices and voices of lived experience are represented** in conversations about behavioral health financing and funding strategies. Financing and funding strategies perform best when they reflect the needs and preferences of the people state agencies serve. While

agencies are likely advancing this work individually, **inter-agency coordination and planning is essential** to accomplishing the full benefit of this work.

Even prior to program planning and execution, equity can be encouraged on the budgetary level. In the February 2021 edition of Government Finance Review, The Basics of Equity in Budgeting[xxv], Shayne Kavanagh and Jake Kowalski align the budgeting process with the goals of equity in local or municipal governance. These lessons can be applied to statewide efforts. Kavanagh and Kowalski explain that governments exist, at the foundation level, to support **Health, Safety**, and **Welfare**. These goals can be applied to almost any government entity and should be the foundation for any budget alignment. These goals require coordination between state agencies and the legislature to ensure the budget is achieving those goals. The budget principles that can be applied to achieve these goals are:

- **Cost Effectiveness:** Evaluate **program effectiveness in comparison to the cost of the program** to identify the outcomes and how that varies by communities and sub-populations.
- **Equitability:** Understand if the program benefits are equitable for all residents of the state. Ensure marginalized groups are obtaining the benefit at the same rate as other groups. This will **support the state's move from equality to equity** by evaluating the investment as it relates to the outcome.
- **Cross cutting themes:** Evaluate the **benefit of the programs across agencies** and service delivery systems. SUD services impact many other state programs across the state, such as child welfare, corrections, and healthcare. **Understanding** how **investments in SUD programs** and services **impact those other systems** will **allow the state to evaluate efficacy, equity, and return on investment more comprehensively**.

Consistent with OHA's health equity goals, **funds should be prioritized for populations who experience the greatest health inequities**. One group identified as in need of more comprehensive supports is **Oregon youth**. Youth and young adults are facing significant challenges accessing services across the state. In Oregon Council on Behavioral Health's (OCBH) Statement and Recommendations; on the current collapse and needed modernization of the Oregon youth and family SUD system of care[xxvi], OCBH note that **Oregon youth are not provided the appropriate healthcare continuum necessary to ensure the necessary SUD services are accessible and comprehensive**. OCBH note that, "Youth referred to care today in OCBH member's remaining services, both outpatient and residential, arrive often with little to no early intervention and severe co-occurring acuity and often intergenerational ACES impacts, regardless of income levels, and a lack of equitable referral," (p. 2). The statement also notes that there are so few resources for youth, that they are often driven to receive services outside of the state**. Out of state travel** for services places an **undue burden on the youth of Oregon** and their families at a time when youth and families are already facing unprecedented difficulties, in the shadow of the COVID 19 pandemic. The distance and separation from their families can exacerbate the issues these youth are facing. The **shortage of children's behavioral health services** is not unique to Oregon and is **a nationwide issue** caused by many **contributing factors** including **workforce shortages** that severely limit the community-based service capacity. Rarely are funds available to immediately expand community-based capacity in a significant way. Rather, funds must be generated by incrementally moving children from very expensive services to less expensive services earlier in continuum and reinvesting that savings to add more community capacity over time, as depicted in Figure 4 below.

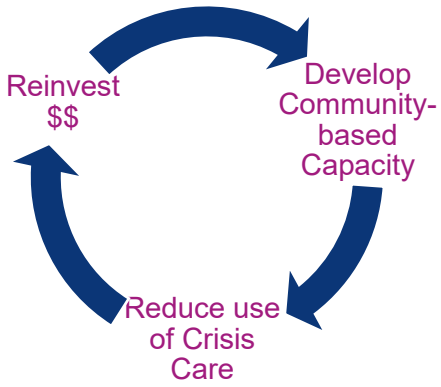


FIGURE 4: INCREMENTALLY INCREASING COMMUNITY-BASED CAPACITY

One **example of the model of cost savings over time**, with investment into community-based capacity, is **Wrap Around Milwaukee**, which utilized a system of care grant from Substance Abuse and Mental Health Services Administration (SAMHSA) to help support the initial cost of setting up a care management entity. The care management entity was designed to manage children with complex needs and then phase in enrollment, over 18 months, with a focus on youth in out-of-home residential treatment and those at risk of such placement. The **goal was to generate funds to re-invest into building more service capacity and community-based services**. **Key to the success** of this approach is the ability to **maximize existing funding sources** (e.g.: Medicaid, Title IV-E, and grants) **and funding flexibility** to pool funds from the agencies involved in the system of care. **Oregon** already **has a system of care framework** that **could be leveraged to develop enhanced services for children** and young people.

Tribal communities are also historically marginalized and underfunded for SUD services. The **historical success of tribal communities with disproportionately little funding should not dissuade decision makers from further investments** and participation. To ensure inter-governmental equity, State agencies should **conduct Tribal consultations** whenever they receive funding for SUD services and supports. Services provided with the full knowledge and support of Tribal decision makers will be most effective to tribal members, and the most appropriate proportion of services can be determined more sustainably. State agencies should be able to identify where investments are being provided and understand the impact of those investments, and communicating and working with Tribal leaders will support that vision through coordinated support.

In addition to supporting tribal communities, the **State should ensure that all marginalized communities receive adequate and equitable services**. To achieve this, state agencies should **track and understand the impact of investments**, to the best of their ability, on all service users with a special focus on communities that have been disproportionately impacted by health inequities.

One way to increase community involvement in the resource allocation process is to allocate a portion of funds (e.g., Opioid Settlement funds) via a competitive grant process. This can help organizations serving populations disproportionately impacted by health inequities grow and thrive and to test the impact of innovative or new programs. The Biden-Harris Administration has identified several guidelines for equitable grantmaking in their Advancing Equity and Racial Justice Through the Federal Government report[xxvii]:

- **Helping underserved communities** learn about and navigate federal funding opportunities, providing technical assistance throughout the application process, and making federal funding applications simpler and easier to navigate.
- **Reducing administrative burdens** in grants applications and in compliance activities

- Ensuring that **application reviews are equitable** by using evidence-informed decision-making processes.
- Including **consideration of equity impacts in Notices of Funding Opportunity** and tracking the extent to which financial activities as budgeted advance equitable outcomes.

The Stanford Social Innovation Review published the Five Accelerators of Equitable Grantmaking and How to Harness Them[xxviii]. Those accelerators are:

- Getting clear on values
- Listening to feedback from grantees
- Adopting an equity lens on grantmaking
- Responding to group or peer influence
- Reacting to global and political crises

These **accelerators are aligned** with **much of what Oregon is already doing** to support equity in SUD services. **Tracking these investments will require a more robust reporting system and greater participation between agencies.** To ensure equity, the state should **consider a data reporting system that tracks investments through service delivery** and should track those investments by geography and demographic indicators to ensure funds are being spent in alignment with the most significant need. The **greatest limitation to an equitable budget** is the **lack of clear data regarding service delivery outcomes** across the state. The data gathered and analyzed in this study is a solid foundation, but consistent data on the demographics and effectiveness of service delivery would be significantly more equitable.

Effectiveness

Tracking budgeted funds to the service expenditure is key to ensuring budgets are effectively allocated. To accomplish this, **Oregon must establish a more robust data infrastructure** to **track the impact of dollars**. Once these data systems are established, the State can **collect outcomes and measure the effectiveness of any given program**. This data infrastructure is critical for making evidence-based funding decisions. In addition to effective budgeting, a **robust data reporting** system would **facilitate inter-agency cooperation** through the development of consistent definitions and service metrics that would also provide the Governor's office and State Legislature with a consistent understanding of how the budget is spent by state agencies, providing data on the "who" and "what" SUD funding serves. This **data** could also be **used to compare relative impact of investments** across the entire portfolio of SUD investments and, as noted above, can support equitable grant making processes. Consistent data and metric definitions would allow agencies to examine the factors that lead to better or worse outcomes in their investments. While some poor outcomes can be identified as waste, other outcomes can lead agency staff to identify organizations that may lack the infrastructure to successfully implement a program or service, and more money may be needed for capacity building. **When effectiveness is paired with the principles of equity** noted above, **state decision makers** will be better positioned to **identify where poor outcomes are tied to historical underfunding** of services and which are simply ineffective. Agencies should also not shy away from disinvesting in programs that are not making an impact or are making a relatively weak impact compared with other investments when controlled for equity.

As reporting requirements increase to support the data goals of the state, **funding for program reporting** and evaluation **should be built into grants**, especially for small organizations and/or newer entrants to the field, who may lack the administrative infrastructure needed to conduct robust analysis of outcomes. **These supports are essential to ensuring grantees have the capacity** to effectively participate and provide accurate and useful data.

The OCBH Statement includes options for effectiveness as well, OCBH proposes:

- **Provide access to modern technology** for client care, data, and referral.

- **Create a system workflow** that reduces redundancy placing the right job in the right place from oversite, payment, care coordination, through service delivery and follow up.
- **Provide a full continuum of health-focused services** for families including prevention through treatment (Oregon Council on Behavioral Health, 2021, pg. 4).

The **OCBH proposed actions** are aligned with the other sources provided in the report. When distilled they **all state that clear data, fully supported systems, and strategic investments will help** ensure equitable and effective service delivery. The State has already demonstrated a desire to provide such a system and needs only to continue to develop a more robust data system with strategic investments in the coming years.

Efficiency

As funding and service delivery are fully tracked, State agencies should align funding strategies and goals. This includes **identifying funding areas that may be duplicative**, and, conversely, **identifying areas where agencies can pool money and resources** to achieve greater impact. Agencies may also **consider working with external partners**, such as counties, philanthropies and CCOs, to **develop aligned strategies and streamline operating procedures**. Agencies should, also, **examine how the practice of blending and braiding funding sources may be impacting the efficiency of grant and contract administration**. Each funding stream has its own set of reporting requirements and parameters, and this can create a **great deal of administrative burden for state grant administrators and for the organizations receiving funds**. Agencies could explore using a single, dedicated funding source for a whole program, versus blending sources. For example, OHA could consider funding service elements to CMHPs through general funds and using federal grant money towards other programs. Lastly, agencies should ensure that **grant requirements have the minimum possible administrative burden on organizations receiving funds**. This frees up organizations to execute their core services and programs.

The state should consider using the Center for Health Care Strategies (CHCS) **State Principles for Financing Substance Use Care, Treatment, and Support Services**[xxix] as a framework for state agencies to coordinate on SUD funding in the coming years. In the September 2023 report, CHCS describes 10 principles and policy steps that would provide state policy makers the ability to improve the SUD system. Those ten principles are outlined in **Table 83** below:

TABLE 83: CHCS 10 PRINCIPLES FOR FINANCING SUBSTANCE USE CARE, TREATMENT, & SUPPORT SERVICES

Principle	Definition (Overview)
Principle 1	Use Medicaid funds strategically to expand and sustain access to evidence-based substance use prevention, treatment, and recovery support services
Principle 2	Direct flexible federal funds — to the fullest extent allowable — toward boosting infrastructure, prevention, harm reduction, and recovery support services
Principle 3	Conduct an inclusive decision-making process for allocating opioid settlement funds and prioritize funds for investments in services and infrastructure needs not covered by Medicaid and other existing state/federal funding streams
Principle 4	Incentivize and sustain “no wrong door” approaches to substance use care, treatment, and support services
Principle 5	Ensure patients are placed in the most appropriate level of care, including non-residential, community-based substance use treatment, and recovery support services
Principle 6	Address substance use treatment disparities for historically marginalized groups and communities

Principle	Definition (Overview)
Principle 7	Advance equitable access and outcomes for substance use care, treatment, and recovery support services among populations with multiple system involvement
Principle 8	Use data to drive effective, equitable care and outcomes
Principle 9	Require specialty substance use treatment providers to offer evidence-based treatments, particularly medications for opioid use disorder
Principle 10	Bolster the substance use prevention, treatment, and recovery support service network for children and youth

National Academy for State Health Policy[xxx] released a report in February of 2021 detailing the importance of data in SUD service delivery. In this study, the Academy describes the ways current **data can be used to inform decision making**. Chief among them is the **ability to identify at risk or underserved populations**. **Policy makers can ensure that new investments are effective when they can identify the impact of those specific investments**. Oregon has many data sources with a significant amount of data, but those **sources would be far more powerful** for statewide planning **if** they were able to be **linked and widely available for analysis** by state agencies, legislators, and the public.

NEW REVENUE

It is clear to the project team that Oregon invests a significant amount of money into SUD services and has taken advantage of all the most common revenue sources. The following considerations can help guide the state to maximize current investments in the future.

Federal Funds

Oregon currently receives funding from two of the largest SUD federal grant programs in the U.S. – the **SUPTRS block grant** and the **State Opioid Response grant**. These are the **steadiest sources of federal grant funding** available to states (at this time), and thus the **most impactful funds** Oregon can continue to leverage to meet SUD needs. Other federal funding opportunities are unpredictable and typically much smaller; however, **agencies should consider establishing a point person or team that exclusively identifies federal funding opportunities** and determines the return on investment of pursuing additional opportunities. This latter point is critical to note, because pursuing any particular grant program has an opportunity cost to the state, and to the organizations receiving funds. This office could also have a community outreach function to help spread awareness of opportunities directly available to individual providers and community organizations, such as loan repayment programs and federal grants open to non-governmental organizations.

Opioid Settlement Funds

There will likely be **more Opioid Settlement Funds** being **distributed in the future**. The state could consider distributing these via competitive grants for prevention or harm reduction services that could enhance the funding already in the system. A **grant process** would provide the opportunity for **community engagement** and could **support the State's efforts to** identify opportunities that **support equity, effectiveness, and efficiency** through reporting requirements and closely tracked spending. These funds are the **ideal opportunity for the state to try new things** and develop reporting structures in coordination with other agencies. This work can be supported internally or through an experienced contractor that will support the grant process.

Medicaid

The financial inventory revealed that **federal dollars in the Medicaid program are the single largest revenue source** for SUD services and supports in Oregon. It follows that Oregon should **continue work to pursue waivers and state plan amendments** that enable the state to **leverage the federal match**. Most recently, the state legislature passed **HB 4002**, which directs OHA to pursue a state plan amendment to expand Certified Community Behavioral Health Clinics (CCBHCs) statewide. Some states that have passed similar legislation are pursuing full conversion of their community mental health organizations into CCBHCs. As **Oregon pursues plans to bring Certified Community Behavioral Health Clinics statewide**, it should **consider analyzing the potential cost savings to the state of converting CMHPs into CCBHCs**, provided that it would not compromise overall funding available to CMHPs.

Private Sector Funds

Currently, the **public sector is the largest payer of behavioral health services and supports in Oregon and nationwide,** according to The Commonwealth Fund[xxxi]. Data collected by OHA's Health Care Cost Target Committee Program, for example, shows that in the year 2021, public payers covered about three-quarters of all behavioral health expenditures ($861M out of $1.14B) in the state.

TABLE 84: PROFESSIONAL BEHAVIORAL HEALTH SPENDING, CALENDAR YEAR 2021[xxxii]

Market	Amount
Medicaid (Including Medicare/Medicaid Dual Eligibles)	$504,759,170
Commercial	$281,373,930
Medicare Advantage + Medicare Advantage Dually Eligible	$16,742,806
State Contracts (e.g. Service Elements)	$339,630,521
TOTAL	**$1,142,506,427**

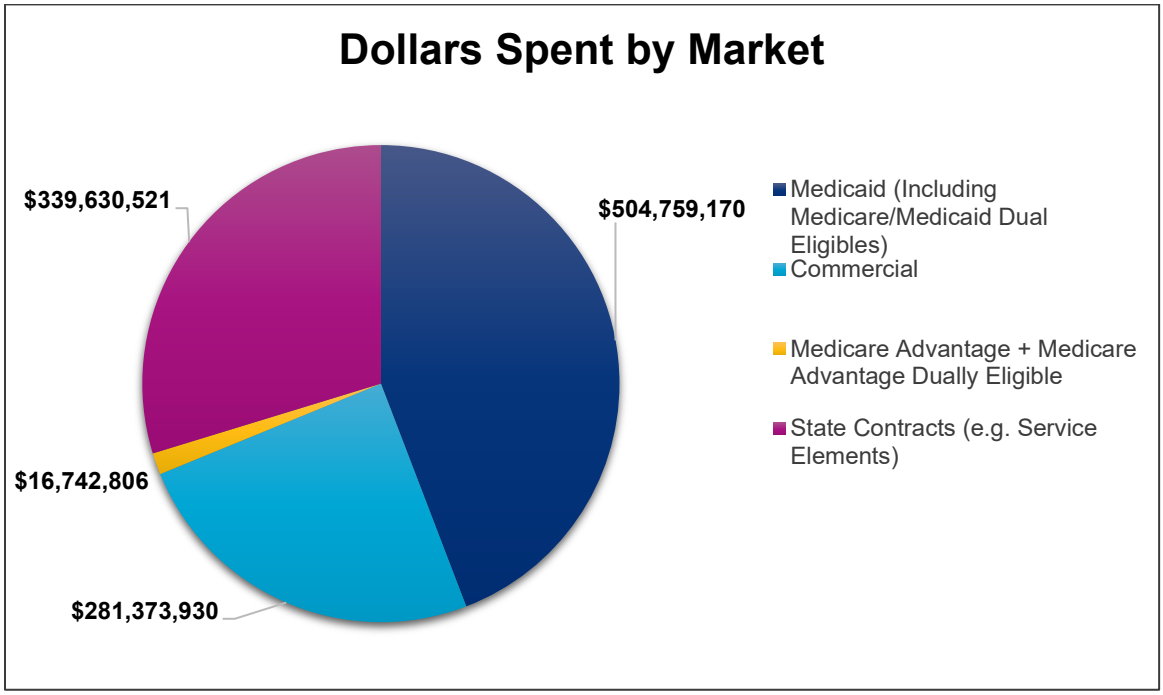


FIGURE 5: PROFESSIONAL BEHAVIORAL HEALTH SPENDING, CALENDAR YEAR 2021 – DOLLARS PER MARKET

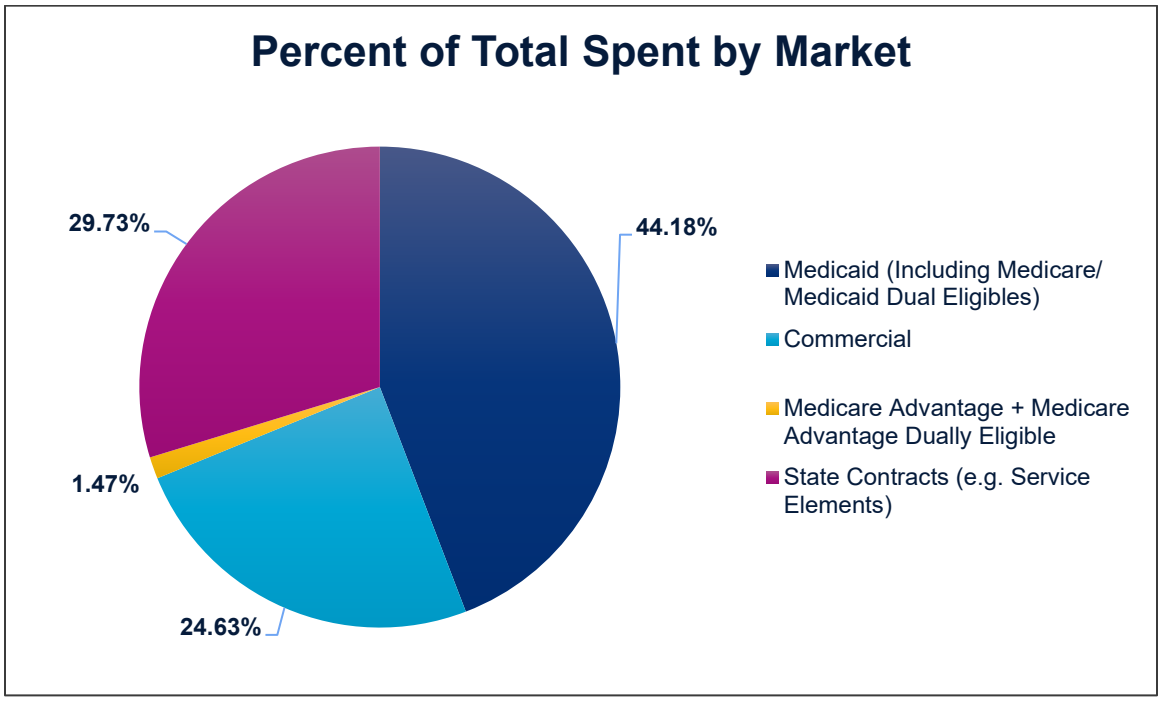


FIGURE 6: PROFESSIONAL BEHAVIORAL HEALTH SPENDING, CALENDAR YEAR 2021 – PERCENT OF TOTAL SPEND PER MARKET

Some of this spending differential may reflect the higher prevalence and/or acuity of behavioral health conditions among low-income people and people with disabilities, who are more likely to be publicly insured and/or receiving services from publicly-funding programs. Benefit design could also be a factor, and additional analysis should be conducted to examine **parity between commercial and public coverage** in Oregon, which has one of the most comprehensive behavioral health Medicaid plans in the country.

The **private sector's role** in **addressing the behavioral health workforce shortages** should also **be examined**, as Oregon does not have nearly enough funds in its state budget to cover the costs for expanding the SUD workforce, as estimated in this study.

State Funds

Absent significant inflows of money from federal or private resources, **Oregon will need to use additional state funds if it wishes to cover the costs of unmet SUD needs**. Oregon has two fundamental options to do this, each carrying advantages, disadvantages, and varying levels of political feasibility:

- **Divert more revenue towards financing SUD services.** Some argue that a higher proportion of revenue generated from substance consumption (e.g. alcohol) should be used to address SUDs. M110 did just that by diverting marijuana revenue to the Drug Treatment and Recovery Services Fund. The state could consider similar moves for other revenue sources, such as putting more conditions on how cities and counties spend alcohol and marijuana revenue. The state should consider though, while this would ensure more money for SUD services, it could also be highly disruptive to county budgets.

- **Generate new revenue.** The main alternative to transferring funds away from one priority area to another—or from local government to state government—is to generate new revenue, either by raising taxes or increasing revenue from fees (e.g., licensing fees). The implications of this approach vary based on which revenue source is under consideration. As of April 2024, an external workgroup—the Task Force on Alcohol Pricing and Addiction Services, created by HB 3610 (2023 session)—is meeting to discuss the benefits and drawbacks of a potential alcohol price tax increase in Oregon, with a report due to the Legislature in September 2024. Another alternative is to make a constitutional amendment to the surplus kicker, either to reduce tax rebates in kicker years, or to eliminate them altogether.

The state should also consider reviewing its overall budget strategically, identifying where investments upstream could reduce prevalence and acuity of SUDs, and thus reduce strain on the behavioral health system.

NEXT STEPS

As mentioned in the previous sections, a robust data system that would capture all the reporting that is already being provided to the state would be invaluable to future research and system evaluation. This report is simply a first look at the SUD system, and the state would do well to assess the funds as they are spent on the county and CCO level. If the data is collected in a format that is consistent across all organizations, future studies can more accurately and efficiently evaluate the systems.

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