Oregon Health Authority

Measure 110 Lacks Stability, Coordination, and Clear Results

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Report 2025-29

Oregon Secretary of State

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Secretary of State **Tobias Read**
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Audit Summary

Oregon Health Authority

Measure 110 Lacks Stability, Coordination, and Clear Results

OBJECTIVE

The objective of this audit was to determine the extent to which the Oregon Health Authority (OHA) is meeting the objectives set forth by Ballot Measure 110 (2020), as amended by the Legislature in Senate Bill 755 (2021), as amended by House Bill 2513 (2023), as amended by House Bill 4002 (2024), and as amended by Senate Bill 610 (2025).

SCOPE

The audit focused on efforts made by OHA to coordinate Measure 110 (M110) to serve families and individuals affected by substance use disorder. Our audit considered the program from 2021 through July 2025 and builds upon our two prior reports on the implementation of the M110 program.

Why this audit is important

Oregon is among the highest in the nation for substance use disorder and use of illicit drugs. In 2023, more than 1,700 Oregonians died from a drug overdose.

M110 was passed by Oregon voters in 2020 to expand access to drug treatment and recovery services. It also removed criminal penalties for possession of personal quantities of drugs. In September 2024, legislation took effect that significantly changed the program by recriminalizing controlled substances. The program is funded by cannabis tax revenue.

M110 providers offer services not funded by other government programs, such as Medicaid, and are an important part of the behavioral health care continuum. The state awarded $391 million in grants to M110 providers, known as Behavioral Health Resource Networks (BHRNs), in 2025. About $800 million has been awarded since 2021.

What we found

The vision laid out in M110 — to replace criminalization of substance use disorder with a public health approach — remains unfulfilled due to persistent structural and operational weaknesses across Oregon's behavioral health system. A coordinated approach would help ensure access to care, and the chance for recovery, does not depend on where a person lives. For a problem that is decades in the making, it will likely take decades of intentional effort to correct. Instead, the pattern of annual revisions has undermined confidence in the program's direction and hindered the development of long-term strategies. Additionally, without action by OHA to address governance, integration, and accountability, the program has little to no chance to fully deliver on its promise to help Oregonians struggling with addiction. The state's efforts address only the symptoms of substance use disorder, without effectively treating the underlying disorder itself.

Governance and leadership instability have contributed to inconsistent guidance and poor grant oversight. (pg. 8)
The grant process has been inconsistent since the start of M110. A lack of consistent prioritization by OHA leadership, operational turnover, and multiple legislative changes have further complicated efforts to operate the program.

OHA has not yet strategically integrated M110 services into Oregon's broader behavioral health system. (pg. 11)
OHA did not integrate the newly created M110 provider network into the broader continuum of care supported by Medicaid and other state or federal programs. Fragmentation reduces the efficiency and effectiveness of service delivery.

Flawed data and unclear goals prevent OHA from demonstrating M110 effectiveness. (pg. 12)
OHA has not collected sufficient information to determine the number of people served or outcomes from the program.

The former M110 telephone hotline was inefficient from the beginning. (pg. 13)
As an example of OHA's dysfunctional implementation, the additional hotline for M110 was redundant and lacked strategic integration, as it duplicated existing efforts and cost the state significant resources.

Counties' implementation of deflection programs provides inequitable access to services. (pg. 15)
Deflection programs, a form of law enforcement intervention created in Oregon in 2024, are implemented inconsistently across counties. In some jurisdictions, deflection does not exist at all, raising concerns about equity of access.

Audit questions

This audit addresses questions set forth by the Legislature in ORS 430.392(5).

Question 1: **Is the current M110 system, including law enforcement, courts, and providers, functioning effectively to support a public health approach toward substance use disorder?**
Answer: No. Governance instability, fragmented coordination, poor integration, and ineffective partnerships significantly limit the ability to deliver an effective public health approach. (pg. 12)

Question 2: **Are state grant and funding systems effectively and equitably administered to support behavioral health services, particularly for communities of color?**
Answer: No. Grants have not prioritized communities of color, resulting in inequitable access to behavioral health services. (pg. 11)

Question 3: **Do investments into the M110 program contribute to measurable reductions in overdose rates and other substance use-related harms?**
Answer: Cannot determine with available data. OHA has failed to collect data to timely and reliably measure the impact of state investments into the M110 program on overdose rates or other substance use-related harms, despite prior audit recommendations. (pg. 13)

Question 4: **Has access to behavioral health, treatment, housing, and culturally specific services improved since 2020?**
Answer: Cannot determine with available data. While more services are available through the administration of BHRN funds, incomplete and unreliable data make it impossible to accurately gauge improvements in access or outcomes since 2020. (pg. 12-13)

Question 5: **Are there disparities in who is being cited or connected to services, and do these disparities reflect disproportionate effects on communities most impacted by the war on drugs?**
Answer: Yes. Available information and community testimony indicate disparities remain, reflecting continued disproportionate impacts on communities most impacted by the war on drugs, but insufficient data prevents a comprehensive understanding. (pg. 13)

Question 6: **Are people charged with drug enforcement misdemeanors being effectively connected to treatment and recovery services?**
Answer: Not always. Inconsistent access to deflection programs limits the effectiveness of connections between people and available recovery services. (pg. 15)

What we recommend

To improve M110 service delivery effectiveness and efficiency, OHA should:

1. Develop an implementation roadmap with timelines, assigned accountability, and key deliverables for program integration, evaluation, and outreach.
2. Communicate updated operational definitions for “culturally and linguistically specific services” and “culturally responsive services” to BHRN grant developers and evaluators, and M110-funded providers in future grant cycles.
3. Require all M110-funded providers to begin participating in standardized interim data reporting using established systems.
4. Complete a baseline analysis using available or proxy data. This analysis should be used to set future performance targets, identify service gaps, and address key questions in law including whether, since December 3, 2020:
    a. Overdose rates declined.
    b. The number of drug and alcohol treatment service providers increased.
    c. The number of culturally specific providers increased.
    d. Access to harm reduction services has increased.
    e. More individuals are accessing treatment than they were before December 3, 2020.
    f. Access to housing for individuals with substance use has increased.
5. Publish a yearly performance report with standardized measures of M110 program outcomes against the retrospective baseline and statutory goals.
6. Implement data-sharing infrastructure to support integrated care pathways and monitor the continuity of treatment and recovery services for people with substance use disorder engaging with the M110 program.

Agency response

OHA agreed with three of our six recommendations. The response can be found at the end of the report.

Read the full audit report

Scan the QR code to read the full audit report, including the agency response, on our website.

Oregon Secretary of State

Introduction

In November 2020, Oregon voters approved Ballot Measure 110 (M110) as a first-in-the-nation program to decriminalize small amounts of controlled substances.[1] The measure also created a new grant program, funded by cannabis tax revenue, to increase substance use disorder services by establishing Behavioral Health Resource Networks (BHRNs) in each county.[2] Since then, the Legislature has significantly changed the program to recriminalize controlled substances, alter the BHRN funding formula, and revise program governance.

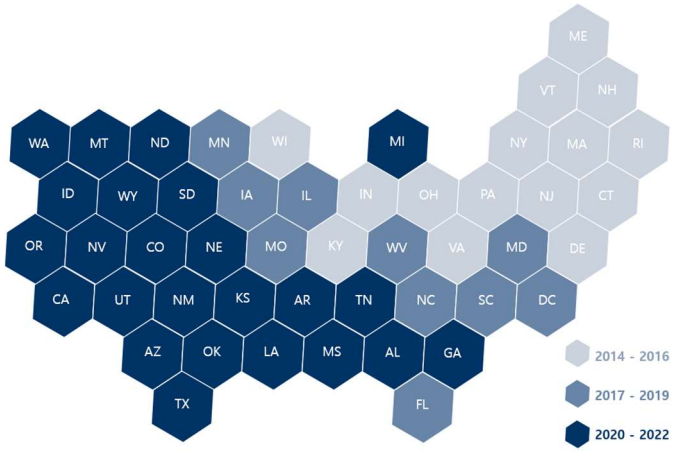
The fentanyl crisis drives the rise of overdose fatalities across Oregon

In 2023, Oregon was among the highest in the nation for substance use disorder and use of illicit drugs other than cannabis. More than 1,700 Oregonians died from a drug overdose that year.

Substance use and overdose deaths began to rise dramatically in 2019. As M110 was implemented in 2020, the rate of substance use and related deaths continued to rise. Many people blamed M110 for increased public drug use and overdose deaths; however, that does not account for other variables, such as fentanyl and COVID-19.

The COVID-19 pandemic and the increased supply of fentanyl are major contributors to the increase in overdose deaths that occurred in the wake of OHA's disorderly implementation of the M110 program. The fentanyl crisis started in the U.S. on the east coast and moved westward, hitting Oregon as the M110 program was being implemented. As fentanyl has become more prevalent, it has been added to more street drugs without users being made aware, which in combination with its extreme potency, leads to more accidental overdoses.

Figure 1: Fentanyl spread from east to west across the U.S. and reached Oregon during the COVID-19 pandemic



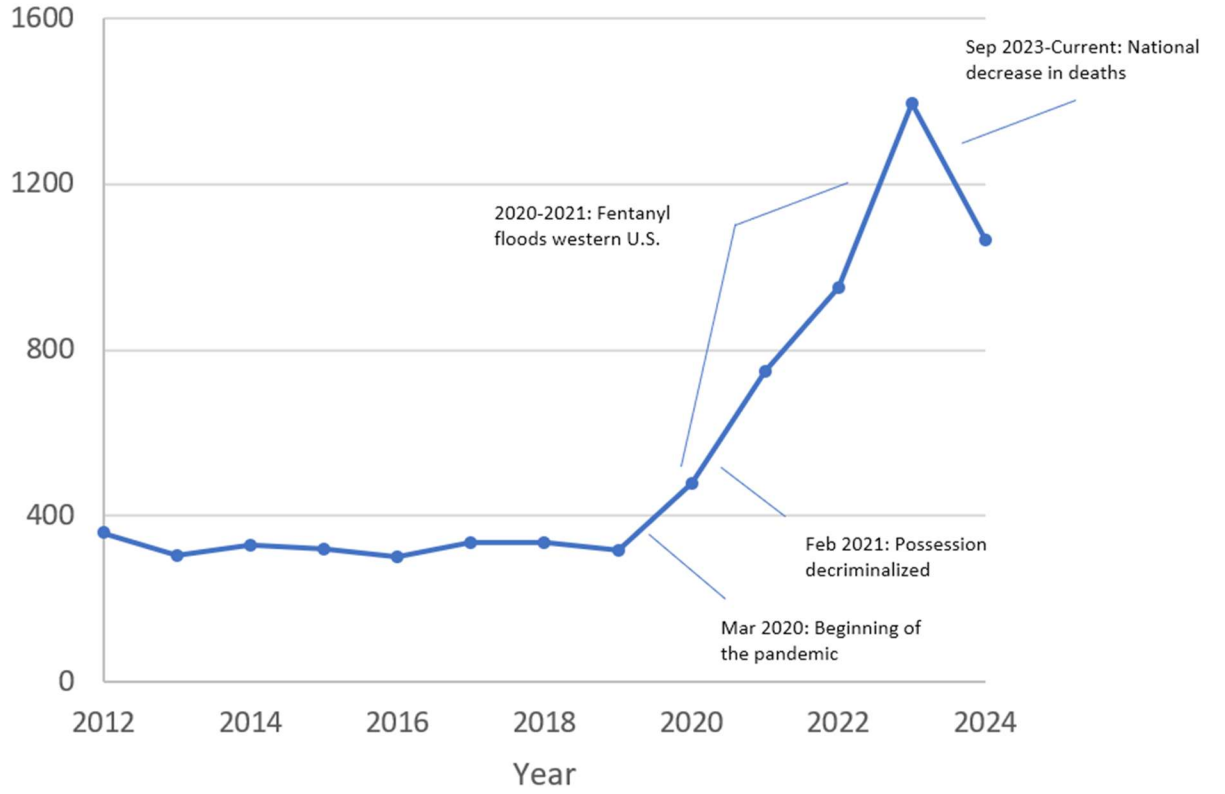
Source: Created by auditors based on data from Journal of the American Medical Association, 2024 [3]

[1] Ballot Measure 110

[2] The Oregon Health Authority notified stakeholders on October 13, 2025, that the Measure 110 program would be known as the BHRN program moving forward. This report will continue to refer to the program as M110 to be consistent with our two prior reports.

[3] The study, *Drug Decriminalization, Fentanyl, and Fatal Overdoses in Oregon*, found no link between decriminalization of drug possession and increases in fatal drug overdose rates.

Figure 2: Opioid overdose deaths spiked as fentanyl flooded Oregon's market, with the state following nationwide declines since 2024



Source: Oregon Health Authority

Oregon changed the M110 program repeatedly in the first five years

M110 was intended to treat substance use disorder from a public health approach and reduce the reliance on the legal system. Since then, legislative and operational changes have moved the program away from that public health focus and increased the involvement of the legal system.

A major component of M110 was that it decriminalized drug possession, making it a Class E violation. But in 2024, the Legislature passed House Bill 4002, which re-criminalized possession of some controlled substances as a misdemeanor.[4] This change significantly increased law enforcement engagement with people struggling with addiction. Due to the infancy of the program, it is unclear as of this report what the overall effect will be on health outcomes.

House Bill 4002 also established funding for county deflection programs. Under deflection, counties may develop a collaborative program between law enforcement and behavioral health entities to assist people struggling with addiction connect to treatment and recovery services in lieu of arrest. Funding for county deflection programs is available through grants administered by the Oregon Criminal Justice Commission.

[4] House Bill 4002

Although the terms are sometimes used interchangeably, deflection differs from diversion

According to the Oregon Criminal Justice Commission:

Deflection refers to the programs and services that are offered before the individual is formally involved in the criminal legal system but may include arrest.

Diversion refers to pre-plea options that exist through law enforcement, prosecutors, and courts before a guilty conviction has occurred. There are also post-plea diversion programs where individuals are offered options after a guilty conviction.

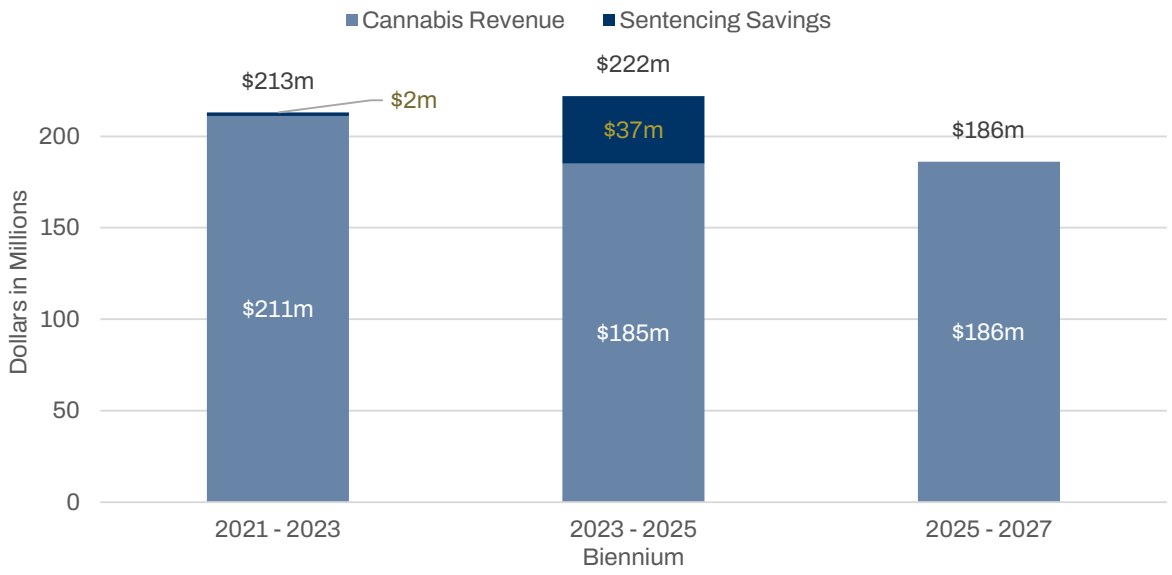
Legislative changes and declining cannabis revenue reduced program funding

When M110 went into effect, the Legislature established the Drug Treatment and Recovery Services Fund, which received money from cannabis tax revenue and savings attributed to the measure's sentencing reductions. This money was used to fund BHRN grants as well as costs to administer the program.

Savings from sentencing reductions accounted for $2.2 million in the 2021-23 biennium and $37 million in the 2023-25 biennium. However, in 2024, House Bill 4002 halted the allocation of sentencing reduction savings to the Drug Treatment and Recovery Services Fund. These savings now remain with public safety agencies.

At the same time, cannabis tax revenue has declined since the 2019-21 biennium. In May 2025, Oregon's Office of Economic Analysis reported that cannabis revenue for the Drug Treatment and Recovery Services Fund is estimated to be $185 million in the 2023-25 biennium and $192 million in the 2025-27 biennium; 2025-27 forecasted revenues have since declined. Altogether, dedicated funding for M110 and substance use disorder treatment in general has declined.

Figure 3: The pool of funds for M110 services declined in 2025-27



Source: Oregon Office of Economic Analysis

Figure 4: The M110 program has undergone significant changes in just five years

OHA's reorganization and legislative changes significantly altered M110 oversight

OHA was charged with administering the M110 program. But as the program has changed, so too has OHA's organizational structure.

Since 2021, the agency has transitioned its executive leadership, Behavioral Health Division leadership, and M110 program management. This reorganization effectively increased the visibility and communication of the Behavioral Health Division and its programs, including M110. Management reported that the M110 program had only three staff in 2021; as of this audit, the program has 18 FTE, including an executive director and a project manager. According to management, there are five vacant positions that will remain unfilled due to budget constraints. The growth in personnel demonstrates new leadership's effort to strengthen the M110 program, even as funding volatility continues to pose operational challenges.

Other legislative changes have affected who has the authority to award program grants. Voters initially gave communities the authority to decide how to spend grant funds by creating the Oversight and Accountability Council (OAC). The OAC is comprised of people with experience in substance use treatment and other addiction services, such as a physician specializing in addiction medicine, an academic researcher, and a Licensed Clinical Social Worker. Other members include people who have recovered from substance use disorder and representatives of communities disproportionately impacted by the war on drugs. The council served as the decision-making body for the M110 initiative, working closely with OHA to fund BHRNs. OHA staff provided council meeting logistics, maintained external communication, managed grants for the M110 grant recipients, and provided subject matter expertise for technical aspects of the program.

However, in 2025 and after two rounds of award funding, the Legislature passed Senate Bill 610.[5] This bill transferred the grant-awarding authority of the OAC to OHA effective January 2026. With this change, the OAC now serves in an advisory, instead of an authoritative, capacity. It remains to be seen what effect this will have on the grant-making process.

Two years later, OHA has taken action on prior audit recommendations, but risks remain

This audit reviewed relevant and available data regarding the functioning of law enforcement and the courts handling drug possession crimes, behavioral health systems providing services to people suffering from substance use disorder, and the outcomes of those services.[6] Our first audit, released in early 2023, was a real-time assessment of the relationship between the OAC, OHA, and grant recipients.[7] Later in 2023, we issued a financial review of the program.[8]

Our prior audits found deficiencies with OHA's implementation of M110. We repeatedly called attention to ill-defined strategy, inadequate data, and wasted resources on redundant hotlines. Two years after our recommendations were agreed upon by agency leadership, gaps remain unresolved and continue to undermine the will of Oregon voters to provide adequate services to people suffering from substance use disorder.

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[5] Senate Bill 610

[6] This is a high-level summary of the legislatively mandated audit requirements. See ORS 430.392(5) for detailed requirements. Although this is the last mandated audit, the Secretary of State will continue to evaluate M110 risks as part of its annual risk assessment process when developing future audit plans as required by ORS 430.392(6).

[7] Secretary of State Audits Division report 2023-03: "Too Early to Tell: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program Has Yet to Be Determined"

[8] Secretary of State Audis Division report 2023-39: "Funding and Delivery of Measure 110 Substance Use Disorder Services Shows Progress, but Significant Risks Remain"

Figure 5: OHA has fully implemented most of the prior audit recommendations

Report No.	Finding No.	Recommendation	Implemented
2023-03	1	Publish a behavioral health system integration plan by September 2023.	No ☒
2023-03	2	Address gaps that prevent implementation of detailed metrics to track the overall effectiveness and impact of M110.	Yes ☑
2023-03	3	Document policies and procedures for the M110 program.	Yes ☑
2023-03	4	Recommend the OAC expand collaboration with Department of Corrections, Oregon Housing and Community Services, and the Opioid Settlement Board.	No ☒
2023-03	5	**Legislative recommendation** to direct OHA to collect sufficient data to assess the effectiveness of the M110 program.[9]	Partially ☑
2023-03	6	**Legislative recommendation** to update statutes to eliminate the overlap and inefficiency caused by the required hotline.	Yes ☑
2023-03	7	**Legislative recommendation** to provide direction to OHA to provide proactive support to the OAC.	Yes ☑
2023-03	8	**Legislative recommendation** to stagger OAC member terms to prevent complete turnover of the council.	Yes ☑
2023-39	1	Develop a strategic plan and present it in the 2024 legislative session.[10]	Partially ☑
2023-39	2	Work with providers to better track: staffing, service expansion, and availability of culturally and linguistically specific services.[11]	Yes ☑
2023-39	3	Work with providers to improve the consistency and reliability of service expenditures and client data.	Yes ☑
2023-39	4	Work with communities and providers to identify the most critical service gaps and barriers to increasing services.	Yes ☑
2023-39	5	Make the application clear and direct and improve review process transparency and consistency.	Yes ☑
2023-39	6	Require providers to detail how they will use program funds, their experience, and their plans for serving culturally and linguistically specific clients.[12]	Partially ☑

[9] Recommendation no. 5 through no. 8 in our first audit report were directed to the Legislature and did not require OHA action.
[10] OHA provided evidence they created a draft strategic plan; however, they did not present the plan to the Legislature until September 2024, after the 2024 session ended, during which major reform legislation was considered. For this reason, we consider this recommendation partially implemented.
[11] Recommendations two and three from the 2023-39 report were implemented as of fall 2025.
[12] Recommendations from 2023-39 were originally provided to OAC and OHA. OAC made funding decisions for the first two grant cycles; however, SB 610 changed the role of OAC from a decision-making body to advisory beginning January 2026.

Audit Results

We found four areas with significant weaknesses in OHA's implementation of M110, hindering the program's ability to make substance use disorder services available to Oregonians. For the program to be successful, each of these areas — governance, strategic integration, data management, and deflection program coordination — must be addressed.

- Weak governance, characterized by leadership instability from 2020 - 2024, unclear accountability, and frequent restructuring within OHA and the OAC, has contributed to disarray.
- Because of inadequate strategic integration with Oregon's broader behavioral health system, M110 services are isolated from other state-funded programs.
- Data limitations severely restrict the state's ability to measure service delivery effectiveness, client outcomes, and demographic equity.
- Inconsistent application of deflection programs statewide limits equitable access to services.

Overall, this audit found the state's vision to replace criminalization of substance use disorder with a public health approach under M110 remains unfulfilled due to persistent structural and operational weaknesses across Oregon's behavioral health system.

Without additional action to address governance, integration, and accountability, the program has little to no chance to fully deliver on its promise to help Oregonians struggling with addiction. Without adequate access to care, people may continue to engage in behaviors that harm themselves and others, which can result in law enforcement intervention. As a result, the state's efforts address only the symptoms of substance use disorder, without effectively treating the underlying disorder itself.

Changing laws and leadership failures resulted in ineffective M110 program implementation

In 2021 OHA did not implement an effective project management framework and experienced leadership instability. The absence of continuity resulted in unclear guidance, particularly around goals to deliver culturally and linguistically specific services. Grant application reviews have struggled to maintain consistency, and funding has not demonstrably prioritized communities most impacted by the war on drugs.

Initial rollout set the program up to fail

When OHA was initially tasked with implementing the M110 program, the agency did not implement an effective project management framework. Instead, OHA hired a manager whose duties included standing up the program, making it operational, coordinating with the OAC to carry out the grant-awarding process, and managing the BHRN grants.

An effective project management framework ensures oversight of the day-to-day details of project deliverables. It ensures focus on the successful implementation of a time-bound endeavor with a specific scope, schedule, and resources. Implementation of such a framework within the M110 program could include creating standardized processes for decision-making and reporting and developing the systems to support and monitor the BHRN infrastructure.

Due to the lack of a project management approach, OHA did not effectively engage with other entities, including law enforcement or the courts; struggled to secure adequate program resources; and faced significant delays in standing up BHRNs. OAC also had decision-making authority, complicating the governance structure. This resulted in a lopsided implementation, where law enforcement had few tools to engage with people possessing small amounts of drugs, and no established treatment system to support people who needed help. As a result, there were fewer interventions for people suffering from addiction and using drugs in public spaces.

Implementing such a large-scale program requires a project management framework to stand up and coordinate the program. Since OHA did not take such an approach during the rollout, the processes were disjointed, delayed, and difficult for grant applicants to manage. The effects of the fragmented implementation continue to undermine the program's effectiveness.

Agency instability kept the program in disarray

As early as summer of 2021, staff transitions at OHA reduced institutional knowledge of M110. Because OHA did not adequately staff the program, turnover had an outsized impact. Fluctuations in staffing led to vacant roles during pivotal planning and grant-making phases. Shortly after the first BHRN grants were awarded in August 2022, OHA's director and the Behavioral Health Division director both resigned, representing instability in the agency and disrupting progress on program goals.

The departures and shifts in focus disrupted strategic guidance, delayed policy decisions, and eroded continuity of grant oversight. In the short term, this contributed to an eight-month delay in funding for substance use disorder services across the state in 2022. In the long term, this has led to a lack of defined program objectives and measures for success, incomplete and unreliable program data to assess outcomes, and inadequate program oversight.

OHA leadership's reorganization of the agency in 2024 further complicated efforts to manage the program. They dissolved the long-standing Health Systems Division and spun off separate Medicaid and Behavioral Health divisions. While leadership intended to sharpen the focus of Behavioral Health, the reorganization fragmented some shared functions such as grant management, data reporting, and policy development. Frequent changes in structure and staffing make it difficult to align strategy, operations, and oversight.

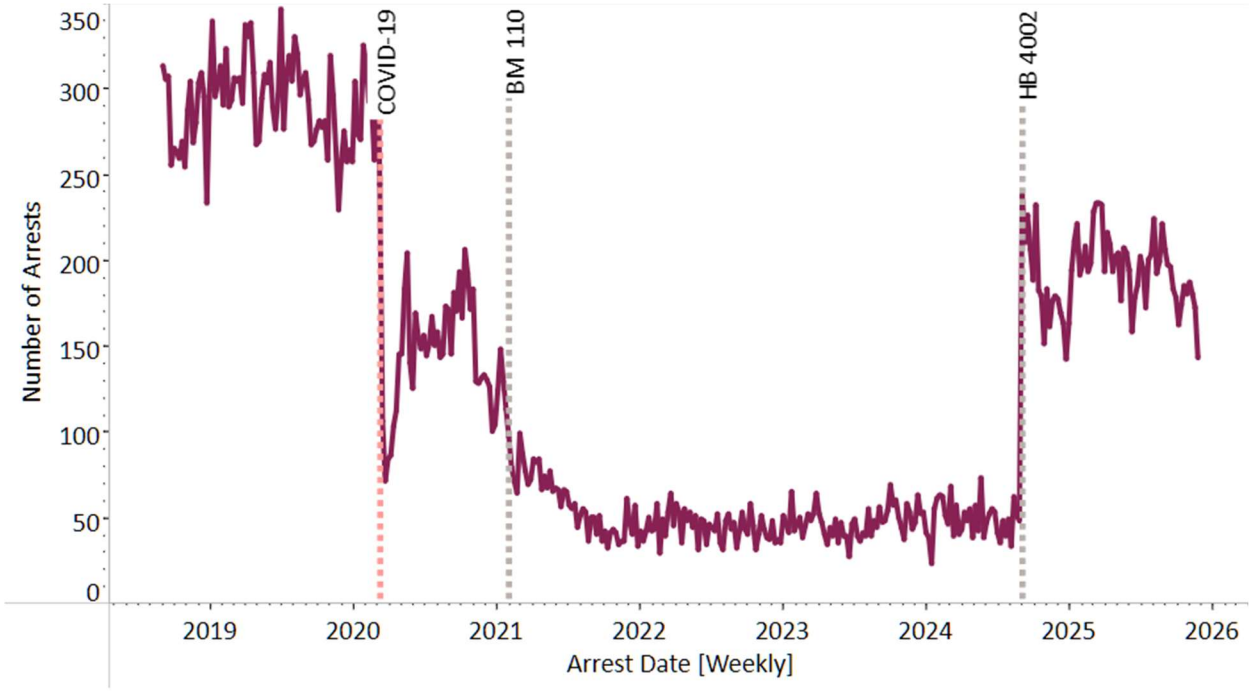
OHA staff told us that after the intense focus of the M110 grant-making process in 2022 was over, they felt agency leadership was disengaged. For the program to be successful, consistent leadership and strategic vision will be necessary. The agency should move beyond ad hoc processes and establish a project management framework grounded in industry and federal best practices. This framework should clarify authority and accountability across all levels. By formally defining roles, OHA will eliminate confusion over ownership and ensure choices are made swiftly and with transparency.

Frequent legislative changes made program implementation more difficult

Since passage in 2020, the Legislature made frequent changes to M110, altering its scope, governance, and funding. Several bills over the last five years have had major impacts to the program. In 2021, just months after the passage of M110, Senate Bill 755 amended the law by modifying provisions relating to the

program's structure, implementation, treatment services, audits, and grant mechanisms.[13] Two years after the measure was enacted, but only a year after BHRN funding was awarded, House Bill 2513 (2023) introduced new oversight provisions.[14] The following year, House Bill 4002 (2024) re-criminalized certain drug possession offenses. This resulted in a dramatic increase in arrests for drug possessions. In 2025, Senate Bill 610 changed the landscape again by shifting grant-making authority away from the OAC to OHA. SB 610 is effective January 2026.

Figure 6: Weekly drug possession arrests increased significantly after recriminalization in September 2024



Source: Oregon Criminal Justice Commission [15]

While intended to improve accountability and responsiveness, these changes disrupted continuity, delayed implementation, and created uncertainty for providers and the people who rely on the services. With timelines and responsibilities frequently shifting, the M110 program cannot achieve its objectives.

For a problem that is decades in the making, **it will likely take decades of intentional effort to correct**. Instead, the pattern of **annual revisions has undermined** confidence in the program's direction and hindered the development of long-term strategies.

The state's expectation of OHA and OAC to deliver results within four years was unrealistic. Substance use disorder in Oregon is the product of decades of systemic challenges, and stakeholders emphasized that meaningful progress requires sustained investment and stability.

[13] Senate Bill 755
[14] House Bill 2513
[15] The Criminal Justice Commission Possession of Controlled Substance Data Dashboard is available to the public.

For a problem that is decades in the making, it will likely take decades of intentional effort to correct. Instead, the pattern of constant revisions has undermined confidence in the program's direction and hindered the development of long-term strategies. If frequent legislative changes continue, it will further reduce the ability for providers, counties, and OHA to build the infrastructure necessary to reduce substance use disorder and improve outcomes across the state.

Approved grant funding doesn't prioritize communities of color

The current process to award BHRN grants doesn't align with M110's established objectives. Specifically, the process lacks mechanisms to ensure prioritization of culturally and linguistically specific services.[16] Strengthening these processes is essential for meeting the program's broader mission to improve health outcomes.

Treating substance use disorder through a law enforcement lens disproportionately impacts Black Oregonians. According to Oregon Judicial Department data from 2024, 5.8% of people cited with Class E citations for possession of a controlled substance were Black, although Black Oregonians only account for 2.4% of the state's population. The data did not reveal any disparities with other demographic groups; however, over 11% of the citations did not have demographic information needed to assess racial disparities.

In 2024, the Oregon Criminal Justice Commission presented a Racial & Ethnic Impact statement to the legislative committee considering recriminalization of drug possession. The Commission predicted racial disparities for Black/African American individuals because of the legislation, though it is too early to tell whether the new laws will exacerbate racial disparities.

Providers also expressed concerns about access to equitable care. BHRNs are required to provide culturally specific and linguistically responsive services, but OAC members told us the definition of "culturally specific and linguistically responsive services" was unclear. We tested 60 of 339 grant award applications submitted, representing over $156 million in funding awards, and found that 37 of 60 (62%) applicants didn't include clear evidence they would provide culturally or linguistically specific services. Community members told us there is a troubling disconnect in what was promised versus what is being delivered and that the program may not be prioritizing groups most impacted by the war on drugs.

To address these issues, M110 leadership should clearly communicate to providers the definitions of "culturally and linguistically specific services" and "culturally responsive services." A consistent understanding of these services will help ensure OHA achieves intended outcomes statewide to expand services to communities most impacted by the war on drugs.

[16] In 2024, the OAC voted to expand culturally and linguistically specific services. However, there were not well-defined mechanisms in the grant review process to hold themselves accountable to that goal. SB 610 transferred these funding responsibilities to OHA effective January 2026.

OHA has not strategically integrated M110 with Oregon's broader behavioral health system

Rather than operating as a strategic part of Oregon's broader behavioral health infrastructure, the M110 program operates parallel to it. It is not meaningfully integrated into the continuum of care supported by Medicaid, the Oregon Health Plan, and other state or federal programs.

Federal policy proposals to reduce Medicaid funding will severely strain Oregon's behavioral health system. According to the state's Chief Financial Office, the federal H.R. 1 (2025) will result in a $11.7 billion reduction in federal Medicaid funding over the next six years. Medicaid, which covers counseling as well as life-saving medications and treatment medications for opioid use disorder, covers one-fifth of all adults with substance use disorder. Without integration, M110 services are isolated from the infrastructure that supports long-term care continuity, leaving the system more fragile and the people it serves more vulnerable. This makes the program's structural gaps and lack of accountability mechanisms even more critical to address.

Fragmented program structure undermines program effectiveness

The Legislature's design of M110 resulted in a complex and decentralized program that lacks effective coordination between critical stakeholders, including OHA, the OAC, BHRNs, county governments, and law enforcement agencies. This complicated structure exists alongside fragmentation of the broader health care system and hampers the program's ability to achieve intended outcomes.

Multiple entities operate independently, each with distinct priorities, leading to misaligned strategies and communication breakdowns. For example, coordination between the county governments and the award process has been inconsistent and led to confusion and concerns over the nature of the M110 funding formula. This confusion culminated in a lawsuit by Washington and Clackamas counties alleging that OHA did not follow a legal process to craft the M110 funding formula, denying affected and interested parties the opportunity to weigh in on the formula. The lawsuit is ongoing as of September 2025.

Law enforcement partnerships are essential for connecting people to treatment, but these partnerships suffer from inadequate coordination and inconsistent implementation. When OHA initially rolled out the M110 program, law enforcement agencies had little involvement. While they were tasked with issuing Class E citations for possession of controlled substances, many jurisdictions didn't due to the risk of escalating an interaction that was no longer criminal. Oregon's public policy decriminalized dangerous drugs without any treatment system in place to help people suffering from serious substance use disorder.

To stabilize and strengthen the organizational structure, the state should use existing authorities to formalize responsibilities, accountability, and relationships across all program partners. Senate Bill 610, passed in 2025, will centralize authority at OHA and reduce the authority of the OAC, but doesn't take effect until January 1, 2026. By formalizing roles and responsibilities across the system, the state can better align the structure with the intent of the program.

OHA's failure to collect complete and reliable data prevents it from measuring the effectiveness of M110

Non-existent or flawed data restricts the state's ability to evaluate whether OHA's implementation of M110 is achieving the goals set forth by voters. OHA has not implemented systems to track basic metrics, such as whether the number of treatment providers or services has increased since 2020. Grant reporting lacks standardized controls or verification, meaning it's difficult to tell what effect, if any, the grant funding had. Without dependable demographic or outcome data, tying grant awards to outcomes remains unfeasible. Prior audit recommendations called for data to evaluate program performance. OHA began new data collection efforts in October 2025, but it is unclear when complete and reliable data will be available to assess program effectiveness.

OHA cannot demonstrate whether access to care has increased

OHA is required by statute to capture data to understand how many people are served by providers who receive funding through the M110 program. To do this, each BHRN partner reports data which is publicly shared through a dashboard. But this data infrastructure can't track how individuals engage with M110 programs, preventing any reliable assessment of program effectiveness. Likewise, reliable baseline data about the number of providers or people accessing services in 2020 doesn't exist to find out if access to care increased since the program started — one of the several metrics required by the Legislature. Despite this requirement, OHA has not yet taken action to leverage their existing health system data to establish baseline estimates.

While evidence suggests many people are accessing BHRN partner services, aggregated service counts reported by BHRNs obscure individual client information. For example, one provider may report 23 clients in harm reduction, 20 in peer support, and 15 in housing services, but there's no way to tell whether these are separate groups for a total of 58 individuals served, or if there is overlap among them. There is also a risk of duplicates within each category: for example, the BHRN could have reported that 23 clients were served when only one person received 23 different harm reduction services. Without unduplicated client counts, the state cannot determine program effectiveness or understand gaps in care.

Demographic data such as race, ethnicity, age, and gender are **often incomplete or inconsistently captured**, frustrating OHA's ability to measure statutory goals to focus on communities disproportionately impacted by the war on drugs.

Auditors analyzed data used to support the M110 dashboard and found demographic fields such as race, ethnicity, age, and gender are often incomplete or inconsistently captured. Clients are not required to provide detailed demographic information in exchange for receiving services. Clients may decline to provide detailed identifiable information for several reasons, including concerns over their safety, stigmatization, and the expediency of services. Although this creates barriers to data collection efforts, these challenges are not insurmountable, and this lack of data has serious consequences.

Data gaps frustrate OHA's ability to measure statutory outreach goals, which require focusing efforts on minority communities disproportionately impacted by the war on drugs. BHRN providers self-report data with minimal validation procedures. This reliance on unverified, unaudited data raises concerns about transparency and the integrity of reported outcomes.

OHA is responsible for establishing an outcomes measurement system for the M110 program; however, it has yet to do so and admitted ongoing data limitations. Both our prior audits made recommendations to prioritize data collection and outcomes measurement. In 2025, the agency implemented a new outcome tracking system that may be more useful; however, BHRNs are not required to use it. OHA is upgrading its grant management application which may provide greater insights into BHRN grant recipients. The agency should work with BHRNs to expedite their use and understanding of the new tracking system.

OHA's former M110 hotline was flawed from the beginning

When M110 was initially implemented, legislation created a hotline for people to call when they received a citation for possession of controlled substances. The former hotline would connect that person with a service provider to treat their substance use disorder. Ultimately, the hotline served as an example of the consequences of OHA's dysfunctional implementation and lack of strategic integration of the M110 program.

The idea was that people could call the hotline to avoid the $100 fine for a Class E citation. But few people with citations or substance use disorder ever contacted the hotline. Then, in 2024, House Bill 4002 eliminated the Class E citation, removing the primary incentive for people to call. Without a consistent referral mechanism, call volume continued to remain below expectations, undermining the hotline's intended role in the process.

We previously reported that, due to low call volume, the original hotline contract cost approximately $7,000 per M110 call.[17] In 2023, OHA switched to a new hotline provider. Only 6% of the 2,294 calls, texts, and chats to the second provider were specific to M110 screening and validation, as opposed to calls seeking information or in search of a program or service. Due to continued low volume, costs per interaction across calls, chats, and texts averaged $1,479 per interaction under the second contractor.

The former M110 hotline was created despite an existing network of state-funded behavioral health hotlines, some of which specifically support substance use disorder. In January 2023, we recommended OHA eliminate hotline overlap and inefficiencies. In January 2024, we recommended the Legislature remove the requirement for the hotline. The M110 hotline ended in June 2025 due to low engagement and lack of return on investment.[18]

The per-interaction cost of $1,479 far exceeds typical investments in direct care. Redirecting those funds could have paid for over 600 adults to participate in a six-month in-custody residential treatment program for about $8,000 per participant, which was highlighted in the first audit.[19] Women in custody at Coffee Creek Correctional Facility told auditors they were desperate for more access to enhanced treatment services at the time. Such a redirection would have expanded treatment services to communities most affected by the war on drugs — a key goal of voters who passed M110.

[17] The cost per call was about $3,000 when also accounting for non-M110 citation related calls to the hotline.
[18] SB 610 also removed the statutory requirement for the hotline effective January 1, 2026.
[19] Secretary of State Audits Division report 2023-03: "Too Early to Tell: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program Has Yet to Be Determined," page 21.

Redirecting hotline funds could have paid for **over 600 adults** to participate in a six-month residential treatment program.

To improve service reach, OHA should coordinate a statewide public awareness campaign that clearly directs people to existing hotlines, with culturally tailored messaging for high-need populations. OHA should also complete a service coordination review of state-funded hotlines to identify overlapping functions, streamline access points, and work to consolidate underperforming lines. These actions will ensure M110 resources deliver maximum impact for Oregonians seeking treatment.

Inconsistent county implementation of deflection programs limits equitable access to M110 services

The Legislature charged the Oregon Criminal Justice Commission with establishing the Oregon Behavioral Health Deflection Program. The deflection program was created as a direct result of M110. Deflection is a collaborative program between law enforcement agencies and behavioral health entities that assist individuals who may have substance use disorder.[20] The program makes grants available to counties to fund deflection programs in their jurisdiction. Deflection programs are intended to give law enforcement and the courts an option to redirect people with drug-related offenses into treatment services instead of jail. To apply for a deflection grant, counties were required to coordinate with BHRN providers, community mental health programs, district attorneys, and law enforcement.

The existing network of deflection services across counties lacks cohesion and consistency. Deflection services are not offered in all counties, and what services are offered and what forms they take differ widely in a disaggregated system. House Bill 4002 (2025) recriminalized drug possession and created a pathway to treatment instead of jail through a deflection program. The bill's language "encouraged," but did not require, law enforcement to refer people unlawfully possessing a controlled substance to a deflection program in lieu of arrest or prosecution. Additionally, it "encouraged," but did not require, district attorneys to divert people to assessment and treatment services in lieu of conviction.

When applied consistently, deflection programs can reduce repeat offenses, ease court and public defender caseloads, and improve health outcomes. But in Oregon, deflection hasn't been implemented evenly. Instead, programs vary by county, with some jurisdictions offering strong pathways to treatment while others provide no program at all. This uneven rollout undermines the equity and access to care goals.

Local control creates a patchwork of programs, limiting some Oregonians' access to treatment

Because counties decide whether and how to run deflection programs, Oregon has a patchwork system of different approaches. In some places, programs are working to connect people with treatment; in others, they are entirely absent. A person charged with the same offense may be deflected to treatment in one county but sent to jail in a neighboring county. Without a statewide standard, law enforcement officers and Oregonians face a confusing landscape of eligibility rules.

[20] House Bill 4002 §37(4)

This uneven system creates uncertainty, both for people needing help and for the legal systems trying to apply the law fairly. This confusion is not limited to the public. Auditors spoke with officials at various levels of government who expressed confusion regarding the differences.

The lack of consistency also adds pressure to the legal system. Recognizing the existing constraint of available attorneys and the exacerbating impacts of House Bill 4002, the Legislature appropriated $12.2 million in General Fund dollars in 2024 and established nine full-time equivalent positions to ensure eligible individuals had adequate legal representation for drug possession charges.

Since House Bill 4002 recriminalized drug possession, public defenders have seen an increase in misdemeanor cases tied to drug enforcement. Of the more than 79,000 cases appointed between September 2024 and July 2025, more than half of them were misdemeanors. Of these, about 6,400 involved drug possession charges, representing 16% of all misdemeanors and 8% of all appointed cases. Many counties already operate at or near capacity, meaning this added workload further strains public defenders and courts. A more consistent application of deflection programs statewide might offer a way to ease pressure on county courts.

Law enforcement officers are not provided with adequate training opportunities

Deflection programs only work when law enforcement officers, legal staff, and other partners know how to use them. Officers are often the first point of contact, yet may not have received consistent training on eligibility, referral processes, or program benefits. Moreover, auditors heard from multiple sources that, due to turnover and changes in the criminalization of controlled substances, many law enforcement officers had never handled a case involving possession charges. Without an understanding of how to engage individuals in possession of controlled substances and connect them with services, officers may miss opportunities to direct people into treatment or may use programs unevenly.

The lack of standardized training worsens Oregon's patchwork system. Whether someone gains access to treatment can depend on where they live and the level of training in that jurisdiction. Law enforcement officials told us that while local authority is important, the Department of Public Safety Standards and Training could help provide guidance and resources so officers have a clearer understanding of deflection options statewide. Auditors also found that OHA, although not directly responsible for deflection, could partner with law enforcement agencies to ensure training includes evidence-based practices for better health outcomes.

Evidence from other states shows that consistent training makes deflection more effective. For example, a national review of deflection and diversion programs found they reduce criminal recidivism, improve health outcomes, and lower costs.[21] The same study notes that training is a major component to successful programs and should be provided at the start and throughout the life of the program. A New York study found their judicial diversion program, which allowed judges to connect people with treatment instead of jail, saved taxpayers more than $7 million annually for five years.[22] While Oregon's structure is different, the lesson is clear: expanded training and consistent application of deflection could bring meaningful benefits to Oregonians.

[21] Guiding officers to deflect citizens to treatment: an examination of police department policies in Illinois
[22] Testing the Cost Savings of Judicial Diversion

For Oregonians, the impact of inconsistent deflection is direct and personal. People in some counties have access to treatment services that can help break cycles of addiction, while others face jail time for the same offenses. Families and communities experience the consequences of this inequity, whether through untreated addiction, repeat arrests, or limited access to needed health supports. Nationwide evidence shows that deflection programs improve health outcomes and save public funds.

Without consistent statewide application, **Oregonians remain at risk**. A coordinated approach would help ensure access to care, and the chance for recovery, does not depend on where a person lives.

Recommendations

To improve M110 service delivery effectiveness and efficiency, OHA should:

1. Develop an implementation roadmap with timelines, assigned accountability, and key deliverables for program integration, evaluation, and outreach.

2. Communicate updated operational definitions for "culturally and linguistically specific services" and "culturally responsive services" to BHRN grant developers and evaluators, and M110-funded providers in future grant cycles.

3. Require all M110-funded providers to begin participating in standardized interim data reporting using established systems.

4. Complete a baseline analysis using available or proxy data. This analysis should be used to set future performance targets and identify service gaps and should address key questions in law including whether, since December 3, 2020:

    a. Overdose rates declined.

    b. The number of drug and alcohol treatment service providers increased.

    c. The number of culturally specific providers increased.

    d. Access to harm reduction services has increased.

    e. More individuals are accessing treatment than they were before December 3, 2020.

    f. Access to housing for individuals with substance use has increased.

5. Publish a yearly performance report with standardized measures of M110 program outcomes against the retrospective baseline and statutory goals.

6. Implement data-sharing infrastructure to support integrated care pathways and monitor the continuity of treatment and recovery services for people with substance use disorder engaging with the M110 program.

Objective, Scope, and Methodology

OBJECTIVE

Determine the extent to which OHA is meeting the objectives set forth by Ballot Measure 110 (2020), as amended by the Legislature in Senate Bill 755 (2021), as amended by House Bill 2513 (2023), as amended by House Bill 4002 (2024), and as amended by Senate Bill 610 (2025).

SCOPE

The audit focused on efforts made by OHA to implement the M110 program to serve families and individuals affected by substance use disorder. Our audit considered the program from 2021 through July 2025 and builds upon our two prior reports on the implementation of the M110 program.

METHODOLOGY

To address our objective, we used a methodology that included conducting interviews, reviewing documentation, and analytical procedures. We interviewed OHA executives, managers, and staff. We also interviewed the majority of OAC members and various stakeholders from health providers, law enforcement officials, legal representatives, and community advocates. We also interviewed subject matter experts and officials from British Columbia who operate a similar decriminalization and substance use disorder treatment program. We virtually reviewed OAC and subcommittee meetings and observed legislative testimony.

We reviewed laws, administrative rules, and contracts. We examined OHA planning documents, reports, and budgets. We reviewed additional studies, reports, and data. Although we reviewed some aspects of deflection and the Behavioral Health system, we didn't audit the Criminal Justice Commission, the Court System, or the entire Behavioral Health system as it was outside the scope of our work. We performed a stratified random sample of 60 BHRN providers, out of a population of 339, to assess compliance with culturally and linguistically specific service requirements across different sizes of providers. We did not project the results to the population, but these results did inform our recommendation.

INTERNAL CONTROL REVIEW

We determined that the following internal controls were relevant to our audit objective.[23]

- Control Environment
  - We reviewed organizational charts, agency budget, and training materials to evaluate leadership stability and accountability structures.
- Risk Assessment
  - We interviewed Behavioral Health division leadership and program management to determine steps taken to identify programmatic risks.
- Control activities
  - We evaluated the M110 strategic data plan and the grant application and evaluation process.
- Information and communication

[23] Auditors relied on standards for internal controls from the U.S. Government Accountability Office, report GAO-14-704G.

    - We observed OAC meetings, interviewed stakeholders, evaluated the sufficiency and reliability of program data, and reviewed communication transmitted to BHRN partners from OHA.
- Monitoring activities
    - We interviewed OHA staff responsible for monitoring grants and evaluated program activity reports and reviewed reported data.

Deficiencies with these internal controls were documented in the results section of this report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We sincerely appreciate the courtesy and cooperation extended by officials and employees of OHA during the course of this audit.

Audit team

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ABOUT THE SECRETARY OF STATE AUDITS DIVISION

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The Secretary of State has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

OREGON HEALTH AUTHORITY

December 15, 2025

Steve Bergmann, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310

Dear Mr. Bergmann:

This letter provides a written response to the Audits Division's final draft audit report titled 'Measure 110 Lacks Stability, Coordination, and Clear Results.'

The Oregon Health Authority (OHA) appreciates the role of the Secretary of State Audits Division in providing oversight of Oregon's State funded programs on behalf of taxpayers and the people we serve. The scope of this audit was focused on efforts made by OHA to meet the evolving legislative mandates for the Behavioral Health Resource Network (BHRN) Program (previously Measure 110 Program).

The BHRN Program within the Behavioral Health Division (BHD) of OHA has reviewed the audit report and findings and has provided responses to each of the six recommendations in the report. We agree with three of the six audit recommendations and have provided planned activities and target dates to address each agreed upon recommendation. OHA has provided alternative solutions to address two of the other three audit recommendations. The remaining audit recommendation cannot be addressed because it exceeds BHRN program scope and budget and raises regulatory and technical barriers to data sharing across providers.

In response to the drug addiction and overdose rates in the state, Oregon voters passed Measure 110, which decriminalized the possession of substances for personal use and instituted a health-based approach to addiction and overdose. Since its passage in 2020, the BHRN/Measure 110 program has been impacted by several legislative amendments, including Senate Bill 755 (2021), House Bill 4002 (2024), and Senate Bill 610 (2025), which collectively reflect Oregon's shifting approach to substance use, public health, and criminal justice.

This legislation created a paradigm shift in decision-making (external partners are decision-makers and OHA is in a supporting role) that required building new relationships and developing trust with community partners and the Oversight and Accountability Council (OAC) for Measure 110. This paradigm shift, coupled with ambitious implementation timelines and stretched OHA staffing resources due to the pandemic, led to an initial delay in implementation.

BHRN services launched on July 1, 2022, and since then, OHA has continually strengthened program governance and accountability. With these foundations in place, continued focus on integration efforts present a promising opportunity to fully realize the program's potential in supporting Oregonians on their path to recovery. During the 2022-2025 grant cycle, 3 million encounters were reported. More than 80% of the funded BHRN providers performed outreach at least once per week and approximately 40% of these providers performed outreach five or more times weekly, resulting in thousands of new clients accessing critical BHRN services.

In the most recent grant cycle in 2025, the OAC funded 234 grantees (and 11 Tribal awards), which comprise the BHRN networks across the entire state. There is one BHRN in each County to ensure all funded grantees collaborate to provide care to Oregonians. In addition to completing a second complex funding process, over the last year OHA has hired new BHRN leadership and fully staffed the program with 18 FTE, an executive director, and a project manager. The BHRN leadership team (including the executive director, a manager, an implementation lead, and a project coordinator) meet with the Behavioral Health Division Director, OHA Director's Office, and Governor Kotek's Office weekly to ensure program stabilization. A project management approach has also been implemented, leading to clear roles and responsibilities, solid workstreams, and stronger grant management. The OHA BHRN Program continues to support the OAC in its current decision-making role and will pivot with the Council in its new advisory function in 2026 (per SB 610). Although these structural improvements are not acknowledged in the audit, OHA is confident that program leadership will continue to enhance the strength and impact of the BHRN Program.

Program administration has stabilized, but decreasing cannabis tax revenue continues to be a risk factor to the program's success. OHA must work within the confines of this volatile funding source, the sole revenue legislatively allocated for BHRN services. Without a legislative change, the lack of stable funding is the main ongoing risk to the health of the statewide BHRNs and the services they provide.

In 2024, OHA launched its M110 Strategic Data Plan to improve collection, synthesis, and analysis of client-level data, expenditure tracking, and refined program-level metrics (such as outreach activities) by 2026. Under this body of

work, the Submittable grant management platform was built and went live in July 2025. Submittable is designed to consolidate statewide BHRN provider expenditure tracking (which was previously conducted through spreadsheets), improve technical budget and expenditure communication between grantee and grant administrator, and collect all program non-client data. Another key element of the M110 Strategic Data Plan is requiring all BHRN grantees to enter client-level encounter data into ROADS (Resilience Outcomes Analysis and Data Submission). The ROADS data platform went live in October 2025 and includes both client demographics and encounter details. Where Submittable collects aggregate fiscal and program metrics, ROADS tracks specific client-level data.

Between now and 2026, OHA continues to train BHRN grantees on how to use ROADS, offer technical assistance and support to grantees for both Submittable and ROADS, and track Electronic Health Record systems as they work to configure their platforms to be compatible with ROADS. By July 1, 2026, all providers will be required to enter BHRN client encounters in ROADS, which enables OHA and the public to assess the specific types and impact of services provided. Using ROADS and Submittable together creates a complementary reporting infrastructure, which OHA will use to synthesize all data and report it publicly on a new BHRN data dashboard under development for the next grant cycle. As more data are submitted to OHA, the data dashboard will become more robust. As outlined in the M110 Strategic Data Plan, these new structures will also inform OHA's first comprehensive data report to the legislature on BHRN outcomes in April 2027. In the interim, the existing public facing BHRN quarterly dashboard is updated regularly with all available data and is posted on the BHRN website.

Looking forward, and using SOS audit recommendations and lessons learned, OHA is committed to ongoing improvement to the BHRN funding process. Program leadership has already begun planning for the 2029 funding cycle to ensure a transparent, thoughtful, and equitable process.

Below is our detailed response to each recommendation identified within the audit.

RECOMMENDATION 1 Develop an implementation roadmap with timelines, assigned accountability, and key deliverables for: a. program integration, and b. evaluation, and outreach.		
Agree or Disagree with Recommendation	**Target date to complete**	**Name and phone number of specific point of contact for implementation**

	implementation activities	
1a. Agree 1b. Agree	1a. Program integration: December 31, 2026 1b. BHRN evaluation and outreach: June 30, 2026	1a. Program integration: Sam Byers 1b. BHRN evaluation and outreach: Abbey Stamp

Narrative for Recommendation 1:

OHA has already implemented a project management structure to guide and track the work of the M110/BHRN team. The project manager, in collaboration with the M110/BHRN executive director, manager, and lead implementation staff, has already developed timelines, workstreams, and deliverables for primary projects, including clarified roles and responsibilities. Additionally, the project manager sits within the division strategy office as a matrix-supervised role to ensure integration across all behavioral health priorities.

Integration: Integration of the BHRN program within OHA's Behavioral Health Division's (BHD) substance use disorder (SUD) service delivery units has begun. By December 31, 2026, OHA will have established a roadmap with timelines, assigned accountability, and key deliverables for fully integrating BHRN services and providers into the state's SUD system of care.

Evaluation: OHA will continue to evaluate the impact of BHRN funding and services through regularly published program data. These data will be updated on the quarterly BHRN program dashboard, which is currently under development for the 2025-2029 grant cycle. Work on this recommendation is already underway, and a draft data dashboard with Quarter 1 (July – September 2026) data will be reviewed by OHA leadership in January 2026. The new BHRN data systems, Submittable and ROADS, allow OHA to synthesize expenditures, program metrics, and client-level data to assess program impact. Submittable is already in use, and ROADS – launched earlier this year – will be required of all BHRN grantees in 2026. OHA will create a roadmap with timelines, assigned accountability, and key deliverables to illustrate program evaluation progress by June 30, 2026. OHA has all the information required to develop a roadmap and will complete this recommendation by the end of the first year of the current funding cycle. Data and reporting are a

priority and much of this work is already underway and supported by the BHRN project manager.

Outreach: Per ORS 430.389, BHRN grantees shall conduct outreach to ensure individuals are aware of the services available and specifically conduct outreach for peer and harm reduction services. Outreach metrics are already collected and will be reported on the updated public BHRN data dashboard as soon as it is complete and posted to the BHRN website. To comply with this recommendation, OHA will create a roadmap with timelines, assigned accountability, and key deliverables to illustrate program evaluation progress by June 30, 2026, which is the end of the first year of the current funding cycle.

RECOMMENDATION 2 Communicate updated operational definitions for “culturally and linguistically specific services” and “culturally responsive services” to BHRN grant developers and evaluators, and M110-funded providers in future grant cycles.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	December 31, 2028	Abbey Stamp

Narrative for Recommendation 2:

In the 2029 BHRN-funding cycle – the next available funding cycle and the first opportunity to implement the audit recommendation – OHA will strengthen the application of its agency-wide and statutory definitions, as applicable, for “culturally and linguistically specific services” and “culturally responsive services.” This will be achieved by ensuring the definitions are clearly articulated in all funding-related materials provided to applicants and evaluators. Additionally, OHA will continue to support BHRN providers in assessing their own service delivery through the consistent and rigorous application of statutory definitions, ensuring alignment with the program’s equity and inclusion goals. Additional clarity for BHRN providers is currently documented in Submittable, which describes these definitions for M110. OHA notes the M110 Oregon Administrative Rule (944-001-0010) is narrower than the Health Systems Division Chapter 309 Oregon Administrative Rules. In the 2029 funding process, OHA will ensure consistency in rule language.

RECOMMENDATION 3 Require all M110-funded providers to begin participating in standardized interim data reporting using established systems.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	March 31, 2026	Abbey Stamp

Narrative for Recommendation 3:

OHA is actively implementing the 2024 Strategic Data Plan to strengthen data collection and reporting. As part of this effort, all BHRN-funded providers are required to report data through two systems: ROADS and Submittable.

- Submittable, which captures person-level encounter data, is currently operational and used for grant reporting, expenditure tracking, and aggregate program data.
- ROADS, which collects BHRN client-level data, was launched in October 2025. Its implementation is underway and will follow a phased timeline for use by BHRN-funded providers. The timeline is driven by configuration with Electronic Health Records and an extensive on-boarding process. All providers will be required to use ROADS by July 1, 2026, with a grace period extending to November 1, 2026, to accommodate any Electronic Health Record (EHR) configuration problems.

For interim reporting, providers not yet using ROADS are required to track and submit client counts through Submittable beginning in Quarter 2 of the 2025-2029 grant cycle, with the second reporting period concluding January 1, 2026. As data are reported, the public BHRN data dashboard will be updated on the BHRN website.

RECOMMENDATION 4

4A. Complete a baseline analysis using available or proxy data.

4B. This analysis should be used to set future performance targets, identify service gaps, and address key questions in law including whether, since December 3, 2020:

a. Overdose rates declined.
b. The number of drug and alcohol treatment service providers increased.
c. The number of culturally specific providers increased.
d. Access to harm reduction services has increased.
e. More individuals are accessing treatment than they were before December 3, 2020.
f. Access to housing for individuals with substance use has increased.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
4A. Disagree 4B. Disagree	4A. N/A 4B. N/A	4A. N/A 4B. N/A

Narrative for Recommendation 4:

OHA acknowledges the audit finding but the audit recommendation's approach is not feasible because baseline data is unavailable. As outlined in HB 4002 (2024), reporting requirements are contingent upon the availability of data. Given the absence of a valid retrospective baseline, OHA cannot accurately measure program outcomes against historical trends.

As established in the 2024 Strategic Data Plan, OHA will report quarterly on the number of BHRN-funded services, program metrics, and client-level data through a publicly available dashboard during the 2025-2029 BHRN grant cycle. This prospective approach aligns with HB 4002's recognition of data limitations and enables accurate tracking of current and future BHRN activities and client progress. This evaluative framework provides a more meaningful representation of the BHRN program's intent and impact on Oregon's behavioral health system than any proxy data.

4A – Complete a baseline analysis using available or proxy data:

The period from 2019 to 2023 is not a reliable timeframe for establishing or creating proxy baseline data in behavioral health due to the significant disruptions caused by the COVID 19 pandemic. These include a series of emergency executive orders affecting providers, as well as atypical provider rate increases and enhancements

which distort typical trends and benchmarks. This period is further complicated by the launch of multiple initiatives and programs – such as the Behavioral Health Workforce Initiative (HB 2949, passed in 2021), the Opioid Settlement Board, and the Save Lives Oregon clearinghouse – which introduced substantial changes to the behavioral health landscape, precluding the establishment of a defensible proxy baseline.

Services funded through the BHRN program are prohibited from supplanting other funding sources, such as Medicaid. As a result, BHRN-funded services are not captured in Medicaid claims data, which is the only available proxy data. Additionally, SUD treatment is typically a billable service covered by Medicaid and other payers and therefore is not generally funded or provided through BHRN resources. In short, available data is mismatched to the scope of BHRN providers, programs, and services.

4B.A – Overdose rates declined.
It is OHA's understanding HB 2513 (2023) removed the evaluation requirement related to a decrease in overdose rates. Overdose rates cannot be attributed to any single grantee or program, as they are influenced by a complex array of environmental and systemic factors. Notably, the rapid emergence of fentanyl in Oregon's drug supply – during the same timeframe as the implementation of the BHRN Program – complicates efforts to isolate program-specific outcomes.

(ii) The number of culturally specific providers increased.
[*(iii) Overdose rates have decreased.*]
[*(iv)*] **(iii)** Access to harm reduction services has increased.
[*(v)*] **(iv)** More individuals are accessing treatment than they were before December 3, 2020.
[*(vi)*] **(v)** Access to housing for individuals with substance use [*disorder*] has increased.
(B) Data on Behavioral Health Resource Networks and recipients of grants and funding under ORS 430.389, including:

Figure 1. HB 2513 Excerpt

4B.B – The number of drug and alcohol treatment service providers increased.
4B.C – The number of culturally specific providers increased.
4B.D – Access to harm reduction services has increased.
4B.E – More individuals are accessing treatment than they were before December 3, 2020.
4B.F – Access to housing for individuals with substance use has increased.

As noted for audit recommendation 4A above and discussed at length previously with the audit team, the period from 2019 to 2023 is not suitable for establishing or creating proxy baseline data in behavioral health due to pandemic-related disruptions, emergency executive orders, atypical rate adjustments, and the

introduction of major initiatives such as HB 2949, the Opioid Settlement Board, and Save Lives Oregon. These factors significantly altered the behavioral health landscape, preventing OHA from defensibly relying on this timeframe for a stable proxy baseline.

Specific to recommendation 4B.E, BHRN services are one part of a much larger SUD system of care through which individuals access treatment. This recommendation is beyond the scope of the M110 program and services.

RECOMMENDATION 5 Publish a yearly performance report with standardized measures of M110 program outcomes against the retrospective baseline and statutory goals.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Disagree	N/A	N/A

Narrative for Recommendation 5:

OHA acknowledges the audit finding but the audit recommendation's approach is not feasible. Baseline data is unavailable.

While OHA recognizes the value of annual performance reporting against a retrospective baseline and statutory goals, the unique circumstances between 2019 and 2023 – such as the COVID 19 pandemic, emergency executive orders, and significant shifts in behavioral health funding – render retrospective or proxy data unsuitable for accurately measuring program outcomes.

As described previously, through implementation of the Strategic Data Plan, OHA is already charting a forward-looking evaluative approach that emphasizes ongoing performance measures and BHRN provider-reported indicators. This method better captures program outcomes through programmatic and client-level metrics collected quarterly. These metrics will be publicly available via the BHRN program quarterly dashboard, which will provide aggregate data on program activities and service level metrics. The updated metrics introduced in the second grant cycle enable more precise tracking of BHRN activities and client progress, offering a clearer view of

program-specific outcomes and their influence on the broader behavioral healthcare system. By focusing on prospective data collection and analysis, OHA can more accurately assess the intent and impact of the BHRN program, rather than relying on a retrospective baseline that does not reflect historic realities.

RECOMMENDATION 6 Implement data-sharing infrastructure to support integrated care pathways and monitor the continuity of treatment and recovery services for people with substance use disorders engaging with the M110 program.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Disagree	N/A	N/A

Narrative for Recommendation 6:

OHA agrees with the audit finding; however, OHA respectfully disagrees with the associated recommendation.

Developing infrastructure to support integrated “care pathways” for monitoring continuity of treatment and recovery services falls outside the scope of the BHRN program. The necessary functionality and the associated costs of implementation also are not included in the program’s budget. The concept of care pathways – commonly used in medical settings or other areas to coordinate an individual’s services – relies on coordinated service delivery supported by data sharing via Electronic Health Record (EHR) systems connected via Health Information Exchange (HIE) platforms. While similar functionality and data sharing may be allowed under appropriate Federal statutes, many BHRN-funded providers do not use EHR systems or have access to HIE connectivity. Additionally, OHA does not currently have the infrastructure, staffing or legislative appropriations required for this level of data integration.

Furthermore, Recommendation 6 does not fully account for regulatory complexities involved in sharing person-level data across a diverse provider network. The BHRN-funded services encompass a combination of non-healthcare providers, healthcare providers, and substance use disorder (SUD) treatment providers. Sharing person-level data across these provider types would potentially violate the

Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2, which establish strict limitations on the disclosure of SUD treatment information.

OHA remains committed to transparency, collaboration, and continuous improvement. We appreciate the opportunity to engage in this important evaluative process and are enthusiastic about the transformative impact the BHRN program continues to have on the lives of Oregonians statewide.

Please contact Ebony Clarke with any questions via email to Behavioral Health Quality Assurance bhquality@oha.oregon.gov.

Sincerely,

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Oregon Secretary of State

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