

**Alcohol and Drug Counselor Program  
Program Review  
2017**

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1. 2012 Vital Signs Report – 145 page report available at [www.nattc.org/files/VitalSignsReport.pdf](http://www.nattc.org/files/VitalSignsReport.pdf)
2. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Report to Congress on the Nation’s Substance Abuse and Mental Health Workforce Issues January 24, 2013 - 62 page report available at <https://store.samhsa.gov/shin/content/PEP13-RTC.../PEP13-RTC-BHWORk.pdf>
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# ***Alcohol and Drug Counseling Program Review***

## ***Final Draft***

***Prepared by Jonny Gieber 11/13/2017***

1. Program/Discipline Overview:

- a. *What are the educational goals or objectives of this program/discipline? How do these compare with national or professional program/discipline trends or guidelines? Have they changed since the last review, or are they expected to change in the next five years?*

**Educational Objectives** - The Alcohol and Drug Counseling Programs primary goal is to prepare students to work in the addiction counseling field and become Certified Addiction Counselors (CADC) via the certifying body, the Addiction Counselor Certification Board of Oregon (ACCBO). ACCBO is an affiliate of the National Association of Alcohol & Drug Abuse Counselors, the National Certification Commission and is a Prevention Member Board of the International Certification Reciprocity Consortium on Alcohol and other Drug Abuse.

The program is designed to serve students who do not have degrees by offering the Associate of Applied Science: Alcohol and Drug Counselor. Students who already have degrees are best served to seek the Addiction Studies Certificate. Our program works closely with our advisory board, representatives of ACCBO and of the Oregon Health Authority to insure we are current with the trends and changes in the addiction-counseling arena. The addiction counseling arena is going through a period of rapid and significant change due to health care reform and the development of the Peer Mentor Movement. According to the 2012 Vital Signs Report (contained in its entirety in Appendix One) we can anticipate an ongoing need for addiction counselors:

“More SUD treatment professionals will be needed in the next five years. While there is limited data to track the projected growth, retraction, and composition of the SUD workforce over the next five years, it is anticipated that the implementation of the Affordable Care Act in 2014 will result in a significant increase in the need for professionals who are able to care for individuals with SUDs in

a variety of managed healthcare settings.” □

“Applicants for open positions in SUD treatment facilities need to be better qualified. Clinical directors reported that their facilities face significant challenges in filling open positions due to a lack of qualified applicants.” □

“The workforce needs to be diversified. The current workforce is predominantly white, female, and over the age of 45. Younger professionals from diverse racial/ethnic backgrounds who are able to work in integrated settings will be needed.”

Another part of the data collected for this review is from the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Report to Congress on the Nation’s Substance Abuse and Mental Health Workforce Issues January 24, 2013 and is listed in its entirety in Appendix Two.

“In addition, the shift to a recovery-oriented paradigm has resulted in an increased use of peers, recovery support workers, care managers, patient navigators, and health educators. The role of peer specialists is to provide ongoing recovery support for people with mental or substance use disorders. As of September 2011, 23 states have developed certification programs for peer specialists. Certified Peer Specialists/Recovery Coaches may work in many settings including independent recovery community organizations, partial hospitalization or day programs, inpatient or crisis centers, vocational rehabilitation or drop-in centers, residential programs, and medication assisted programs. Peer support activities include self-determination and personal responsibility, providing hope, recovery coaching, life skills, training, communication with providers, health and wellness, illness management, addressing discrimination and promoting full inclusion in the community, assistance with housing, education/employment, and positive social activities (Center for Substance Abuse Treatment [CSAT], 2009; Daniels et al., 2011).”

#### **Data from Oregon.**

Several attempts to secure data from Oregon sources regarding the need for addiction counseling service providers failed. We tried to locate sources of data specific to our field at the Oregon Health Authority and it was simply not available. We created an instrument to obtain the data from Portland area providers and could not find a way to motivate folks to complete the

questionnaire. We heard from multiple sources that finding enough qualified individuals to fill the current job openings is very challenging. In our own practicum agencies, we have seen a dramatic increase in the number of our students getting hired prior to completing their placements and a significant decrease in students enrolling in practicum due to their success in finding employment. As a result of a serendipitous discovery that students could be awarded credit for prior learning for their jobs as addiction counseling service providers we hope to be able to help these students complete their academic goals without incurring more financial burden (See Appendix Three for the CPL document for A&D Students).

**Drug Addiction Statistics: Do we still have a need for addiction counseling service providers?**

Excerpts from <https://www.drugabuse.gov/publications/drugfacts/nationwide-trends>

**Illicit drug use in the United States has been increasing.** In 2013, an estimated 24.6 million Americans aged 12 or older—9.4 percent of the population—had used an illicit drug in the past month. This number is up from 8.3 percent in 2002. The increase mostly reflects a recent rise in use of marijuana, the most commonly used illicit drug.

**Binge and heavy drinking are more widespread among men than women.** In 2013, 30.2 percent of men and 16.0 percent of women 12 and older reported binge drinking in the past month. And 9.5 percent of men and 3.3 percent of women reported heavy alcohol use.

**Driving under the influence of alcohol has also declined slightly.** In 2013, an estimated 28.7 million people, or 10.9 percent of persons aged 12 or older, had driven under the influence of alcohol at least once in the past year, down from 14.2 percent in 2002. Although this decline is encouraging, any driving under the influence remains a cause for concern.

**Fewer Americans are smoking.** In 2013, an estimated 55.8 million Americans aged 12 or older, or 21.3 percent of the population, were current cigarette smokers. This reflects a continual but slow downward trend from 2002, when the rate was 26 percent.

**Rates of alcohol dependence/abuse declined from 2002 to 2013.** In 2013, 17.3 million Americans (6.6 percent of the population) were dependent on alcohol or had problems related to their alcohol use (abuse). This is a decline from 18.1 million (or 7.7 percent) in 2002.

**After alcohol, marijuana has the highest rate of dependence or abuse among all drugs.** In 2013, 4.2 million Americans met clinical criteria for dependence or abuse of marijuana in the past year—more than twice the number for dependence/abuse of prescription pain relievers (1.9 million) and

nearly five times the number for dependence/abuse of cocaine (855,000).

**There continues to be a large "treatment gap" in this country.** In 2013, an estimated 22.7 million Americans (8.6 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (0.9 percent) received treatment at a specialty facility.

### **Opiate Addiction is Growing**

Excerpts from <http://www.cdc.gov/drugoverdose/data/overdose.html>

Overdose deaths involving prescription opioids have quadrupled since 1999,<sup>1</sup> and so have sales of these prescription drugs.<sup>2</sup> From 1999 to 2014, more than 165,000 people have died in the U.S. from overdoses related to prescription opioids.<sup>1</sup>

Opioid prescribing continues to fuel the epidemic. Today, at least half of all U.S. opioid overdose deaths involve a prescription opioid.<sup>1</sup> In 2014, more than 14,000 people died from overdoses involving prescription opioids.

### **Overdose Deaths**

Among those who died from prescription opioid overdose between 1999 and 2014:

- Overdose rates were highest among people aged 25 to 54 years.
- Overdose rates were higher among non-Hispanic whites and American Indian or Alaskan Natives, compared to non-Hispanic blacks and Hispanics.
- Men were more likely to die from overdose, but the mortality gap between men and women is closing.<sup>4</sup>

### **Additional Risks**

Overdose is not the only risk related to prescription opioids. Misuse, abuse, and opioid use disorder (addiction) are also potential dangers.

- In 2014, almost 2 million Americans abused or were dependent on prescription opioids.<sup>5</sup>
- As many as 1 in 4 people who receive prescription opioids long term for noncancer pain in primary care settings struggles with addiction.<sup>6</sup>
- Every day, over 1,000 people are treated in emergency departments for misusing prescription opioids.<sup>7</sup>

**In Washington** state and across the nation, overdoses have surpassed traffic accidents as the No. 1 cause of accidental death. From <http://www.seattletimes.com/seattle-news/crime/as-opioid-epidemic-hits-home-what-officials-are-doing-about-it/>

**What effect will the election of Donald Trump have on Addiction Treatment?** From <http://www.QUITALCOHOL.com/treatment/addiction-treatment-policy-president-trump.html> (full article can be found in Appendix 3).

**What effect will the election of Donald Trump have on people receiving Medicaid?** From <http://khn.org/news/millions-could-lose-medicaid-coverage-under-trump-plan/> (full article can be found in Appendix 4) (In Oregon, the Oregon Health Plan, is entirely dependent on Medicaid dollars)?

**What will be the Oregon Health Authorities Response to changes in health care coverage and how will it effect addiction treatment services?** From the Oregon Health Authority website on Nov. 13<sup>th</sup>, 2016.

“The U.S. Election and OHA’s Commitment to Health Care Transformation

The state remains committed to ensuring all Oregonians have access to high-quality, affordable health care. OHA is committed to working with our federal partners to is greater access, better outcomes and lower costs for Oregonians.

Oregon has a long history of commitment to health system transformation and we are already working with stakeholders and policymakers to maintain our focus. We look forward to continuing those discussions in the coming months and will post updates on this page.”

#### **New Federal Legislation passed in December of 2016:**

On December 7th, the U.S. Senate passed the 21st Century Cures Act in a bipartisan vote of 94-to-5. Now the bill is headed to the President's desk to be signed into law. This bill includes \$1 billion to address the opioid epidemic through grants to states and territories.

The \$1 billion designated for grants to states to supplement opioid abuse prevention and treatment activities, over the next two years, must also go through Congress. But the money is authorized from \$3.5 billion in cuts from the Prevention and Public Health Fund and the sale of some of the Strategic Petroleum Reserve.

Summary of the Addiction Counseling Program response to the recent election results. It certainly is too soon to tell how the change in our political atmosphere is going to affect the delivery of addiction counseling services. We will remain engaged in monitoring the progress at the national and state level and be as responsive as we can to any emerging shifts in funding and the consequent changes to the need for and role of the addiction counseling service provider.

B. Briefly describe curricular, instructional, or other changes that were made as a result of SAC recommendations and/or administrative responses from the last program review?

As a result of the 2012 review process, we made several changes in the AD Program:

- We made WR 121 a pre-requisite for the program (instead of a required class for the degree).
- We added MP 201 (changed to MP 150) Introduction to Electronic Health Records a required course for the program.
- We added Lib 101 Research and Beyond a pre-requisite for the program.
- We eliminated AD 201 Families and Addiction and replaced it with AD 202 Trauma and Recovery.
- We created an Elective track where students choose two classes from the following list:

AD 105 Aging and Addiction AD 105 (used existing course)

AD 107 Addiction Recovery Mentor

AD 109 Criminality and Addiction

AD 108 Adolescents and Addiction

AD 110 Substance Use Prevention

AD 111 Gambling and Addiction I

AD 112 Gambling and Addiction II

2. Outcomes and Assessment: Reflect on learning outcomes and assessment, teaching methodologies, and content in order to improve the quality of teaching, learning and student

success.

A. Course-Level Outcomes: The college has an expectation that course outcomes, as listed in the CCOG, are both assessable and assessed, with the intent that SACs will collaborate to develop a shared vision for course-level learning outcomes

i. What is the SAC process for review of course outcomes in your CCOGs to ensure that they are assessable?

The AD SAC has used three approaches to assess course outcomes:

The First Approach we use is the quadrennial course review process. Any course under review for any reason has its outcomes automatically reviewed and how assessable they are and the methods used to assess them are discussed.

The Second Approach involved targeting a specific course (AD 270 A Practicum) and by completing an assessment of every student in practicum over the last several years using the following instrument:

Alcohol and Drug Counseling Program Practicum Supervisor Faculty members will administer this tool. This tool will be used each term as part of the practicum evaluation process starting Fall Term 2012. Practicum is designed to have students be given the opportunity to functioning at the entry level case manager status by the 2<sup>nd</sup> term at a given practicum site. This instrument is developed to measure the ability of students who are in their 2<sup>nd</sup> term 3<sup>rd</sup> or 4<sup>th</sup> term of any given practicum site. Students who are in their first term at a given site go through an orientation process and are not expected to be able to meet the targeted outcomes during the first term of a placement. Each instructor will collect this data each term, for each applicable student. A term-by-term aggregate summary will be created and a year-long (fall to summer) summary document will be created by the Department Chair.

**Inter-rater Reliability.** Every practicum site is different in some way from every other practicum site. Variability in agencies mission and scope of practice make finding a common scale for evaluation highly problematic. While these realities make establishing inter-rater reliability



difficult there is one standard that while subjective is universal and therefore contributory to establishing a baseline assessment. That standard is simply to determine if the supervisor would allow the student to perform the task in question in the same manner they would let an employee who is hired at the case manager level.

The following describes the A&D Programs targeted outcomes and what questions/approaches were created to measure the given outcome.

**Outcome 1. Meet the Addiction Counselor Certification of Oregon (ACCBO) educational requirements for the Certified Alcohol and Drug Counselor Level II (CADC II) including having a minimum of 720\* hours of the 1000 work experience hours required by ACCBO to be eligible for the CADC I exam.**

\*due to a change in credit to work hour computation current students will earn 648 hours instead of 720. This change needs to be tracked and included in the next catalog.

The “educational requirements” aspect of this outcome is not measured because it is by definition and design obtained by the students when they earn the degree or the newly revised certificate. The certifying body has for over two decades accepted the designated courses we provide for students to meet their educational requirements.

**For Outcomes 2, 3 and 4 a survey will be used to collect data each term from agency supervisors.**

**Outcome 2. Follow established professional addiction counseling standards and clinical procedures to conduct intake assessments and evaluations and co-facilitate addiction treatment groups in a clinical setting.**

1. Would you allow this practicum student to conduct an intake/evaluation assessment independently? (yes or no)

2. Would you allow this practicum student to conduct a group independently? (yes or no)

**Outcome 3. Complete record keeping obligations, deliver educational presentations, and participate in staff meetings in accordance with professional standards.**

3. Would you allow this practicum students documentation become a part of the permanent client record? (yes or no)

4. Would you allow this practicum student to conduct educational presentation without supervision? (yes or no)

5. Does this practicum student function as a contributory member at their staff meetings? (yes or no)

If no, what did the supervisor report would help make this outcome more attainable?

**Outcome 4. Effectively utilize clinical supervision to hone and further develop their addiction specific counseling skills.**

6. Does this practicum student effectively use clinical supervision (yes or no)

The results of this survey are overwhelmingly positive and we almost never receive anything but affirmative responses. What we have learned is that students who are not going to do well in practicum usually don't make it past the first term of practicum. The reasons students don't do well is almost always due to personal/developmental issues and not due to lack of academic preparation. We do not have a mechanism to screen student's personal readiness for practicum other than their ability to pass the prerequisite courses.

The Third Approach involved a targeted attempt to measure a specific outcome that was relevant to three linked classes: AD 150/151 (Basic Counseling and Addiction), AD 155/AD 157 (Motivational Interviewing), AD 250/251 Advanced Counseling. This project involved training instructors in a basic measurement of empathy in order to be able to assess student's ability to demonstrate acquisition of this skill set by the conclusion of the class (AD 150/151). The plan was then to measure this same skill set at the conclusion of the two other courses in the sequence (AD 150/151 is a pre-requisite for both) to determine if students had retained or improved the original skill set. As a result of rating the students counseling transcripts for the final class project for AD 150/151 it was determined that students were generally not meeting the targeted base line empathy score. Instead of continuing with this project it was decided that the AD 150/151 course would be redeveloped and then students would be assessed after the course was updated. One of our most senior adjunct faculty members, Dennis Morrow, wrote a manual for this class and agreed to teach this class to implement the improvements. After a committee review of the students empathy scores it was demonstrated that a marked and acceptable level of empathy was now being demonstrated by students at the conclusion of the course.

- ii. Identify and give examples of changes made in instruction (on-campus and online as appropriate), to improve students' attainment of course outcomes, or outcomes of requisite course sequences (such as are found in in MTH, WR, ESOL, BI, etc.) that were made as a result of assessment of student learning.

Since the last review the AD program has all but eliminated the distance learning classes. It was discovered that many of our students could not successfully navigate distance learning modalities. It also became very difficult to recruit and retain instructors who were able and qualified to teach these courses. The only distance learning class that we still offer is AD 105 Aging and Addiction. We have continued to offer this class as a service to the Gerontology program which has specifically requested that this class be taught online.

B. Addressing College Core Outcomes

- i. Update the Core Outcomes Mapping Matrix.

<http://www.pcc.edu/resources/academic/core-outcomes/mapping-index.html>

For each course, choose the appropriate Mapping Level Indicator (0-4) to match **faculty expectations for the Core Outcome for passing students**. (You can copy from the website and paste into either a Word or Excel document to do this update, and provide as an Appendix).

Updated Core Outcome Mapping Matrix can be found in Appendix Five.

C. For Career and Technical Education Programs: Degree and Certificate Outcomes

- i. Briefly describe the evidence you have that students are meeting your Degree and/or Certificate outcomes.

This process was described in detail starting on page 5. In summary, we ask every practicum supervisor for every practicum student completing a practicum rotation if they consider the student able to operate at the employ level for specified tasks and responsibilities. With rare exception our students are rated as employment ready and able to complete the targeted tasks and responsibilities.

ii. Reflecting on the last five years of assessment, provide a brief summary of one or two of your best assessment projects, highlighting efforts made to improve students' attainment of your Degree and Certificate outcomes.

As previously discussed, we have redesigned a course (AD 150/151) directly as a result of our assessment process. It may be interesting to note that when we discovered that we had a problem and it needed to be fixed that this created confusion and lack of direction in the ongoing assessment oversight process and in fact no actual assistance has been offered despite several requests.

iii. Do you have evidence that the changes made were effective (by having reassessed the same outcome)? If so, please describe briefly.

Yes. We re-assessed the targeted outcome as previously discussed and we were very pleased to discover that at the conclusion of the AD 150/151 class students were now demonstrating the desired level of empathy.

iv. Evaluate your SAC's assessment cycle processes. What have you learned to improve your assessment practices and strategies?

The biggest challenge we have in the A&D Program is that there are only two full time faculty members. Any project that requires instructor participation is made very difficult by the simple reality that there are very few dollars or resources to pay adjunct faculty to participate in this process. With only a few exceptions, most of our adjunct faculty members can only attend SAC meetings a few times a year and very few can attend additional committee meetings. We need help in this area but it appears to be very difficult to obtain.

v. Are any of PCC's Core Outcomes difficult to align and assess within your program? If yes, please identify which ones and the challenges that exist.

No.

### 3. Other Curricular Issues

A. Which of your courses are offered in a distance modality (online, hybrid, interactive television, etc.), and what is the proportion of on-campus and online?

For courses offered both via DL and on campus, are there differences in student success? If yes, describe the differences and how your SAC is addressing them. What significant revelations, concerns, or questions arise in the area of online delivery? (Contact the Office of Institutional Effectiveness for course-level data.)

Online courses increase failure rates significantly for our students. As previously noted, we only offer one course in an online format, AD 105 Aging and Addiction. This course is part of our elective choices for the students and they only select it if they are comfortable with this modality. Until recently we offered a simple, one credit, AD 278 Practicum Preparation Class in an online format. After many terms of dropout rates that were sometimes as much as 50% we moved this to a face to face class. There has been a dramatic improvement in pass rates for students.

B. Has the SAC made any curricular changes as a result of exploring/adopting educational initiatives (e.g., Community-Based Learning, Internationalization of the Curriculum, Inquiry-Based Learning, Honors, etc.)? If so, please describe.

No.

C. Are there any courses in the program that are offered as Dual Credit at area High Schools? If so, describe how the SAC develops and maintains relationships with the HS faculty in support of quality instruction.

No

D. Please describe the use of Course Evaluations by the SAC. Have you developed SAC-specific questions? Has the information you have received been of use at the course/program/discipline level?

We have not developed SAC specific questions. The evaluations are used as part of instructor assessments. On a few occasions the evaluations were very helpful identifying classroom issues that resulted in instructors either being reassigned to another class or no longer given teaching assignments.

E. Identify and explain any other significant curricular changes that have been made since the last review.

The Alcohol and Drug Counseling Program is in the midst of significant change. The Addiction

Counseling arena is currently undergoing a major shift in how services are delivered and who delivers those services. While these changes are very evident via reports from agency supervisors, human resources personnel and from the Oregon Health Authority there exists very little data or outcome studies to support these shifts but never the less they are happening and all indications are that they are here to stay (unless of course the new political reality has other plans). Here is a summary of the changes in the Addiction Counseling arena:

- There is an increasing demand for Certified Recovery Mentors.
- There is an increasing demand for Master Level Qualified Mental Health Professionals (QMHPs) but there are very few of these individuals who have been prepared as Addiction Counseling Professionals.
- Paradoxically, the percentage of our practicum students who get employed while in practicum has dramatically risen from less than 10% to as high as 40%.
- Nationally student debt has continued to rise. Wages in the addiction counseling arena are not significantly changing.
- Co-ordinated Care Organizations and Medicare changes has created more opportunities for reimbursement for addiction services while at the same time providing confusion and uncertainty on how to obtain that very reimbursement. At one point during the last year, one of our largest practicum sites suspended taking in practicum students because of this issue. This agency has now re-opened practicum training opportunities.
- The Addiction Counselor Certification Board of Oregon (ACCBO) is reported to be preparing a new certification (a pre-CADC credential) that would allow our practicum students to obtain the required National Provider Identification Number needed to make reimbursement more efficient.
- The Oregon Health Authority offers an educational path to obtain a Peer Wellness Specialist Certificate. Negotiations with them are ongoing but it appears that in addition to the current Certified Recovery Mentor Course (AD 107) we could create another course that students could take that when combined with the proposed course would allow students to earn the PWS. There is an increasing demand for PWS and for dual certifications (CRM and PWS) and with the soon to open 150 bed psychiatric facility (Unity) we expect this demand to increase in the Portland Metro area.

- There is a current project underway to create a Human Service Degree at PCC. It appears that if this effort is successful then several of our courses may be included: AD 101 Addiction (note name change), AD 160 Basic Counseling (reformulated AD 150/151) and AD 104 Multicultural Counseling.

After considering the aforementioned issues and after analyzing the true cost of our program for students we are currently in the process of redesigning the program. This redesign is going to be heavily influenced by two guiding questions: What do students have to have to become certified with ACCBO? How can we reduce the cost and time students need to complete the program? We have submitted the following changes to the Curriculum Committee and to Degrees and Certificates:

**#1 Eliminate Wr. 122.** No other human service or addiction counseling program requires WR. 122. ACCBO does not require WR. 122.

**#2 - Eliminate the prerequisites for Abnormal Psychology 239.** The Psychology SAC has agreed to change the prerequisites for Psych 239. Students will be allowed into the class if they have taken AD 102 Drug Use and Addiction.

**#3 – Eliminate MP 150 Electronic Medical Records.** This class has not proven to be enough of a benefit to students to justify requiring it.

**#4 – Remove AD 104 Multicultural Counseling from the certificate.** In order to return the certificate to 44 credits and avoid the very difficult issues that arise with related instruction and embedded math we have chosen to return the certificate to its original 44 credits. The original reasons for developing a 50 credit or more certificate was primarily based on the belief that we needed to do so to be able to keep our Perkins funded advisor. It turns out that this information was erroneous.

**#5 – Make application for a new Addiction Studies Certificate to include the following:**

<a href="#"><u>AD 101</u></a> §	Alcohol Use and Addiction	3
<a href="#"><u>AD 102</u></a> §	Drug Use and Addiction	3
<del><a href="#"><u>AD 104</u></a></del>	<del>Multicultural Counseling</del>	<del>3</del>
<a href="#"><u>AD 106</u></a>	Smoking Cessation	1
<a href="#"><u>AD 150</u></a> §	Basic Counseling and Addiction	3
<a href="#"><u>AD 151</u></a>	Basic Counseling Skills Mastery	1
<a href="#"><u>AD 152</u></a>	Group Counseling and Addiction	3
<a href="#"><u>AD 153</u></a>	Theories of Counseling	3

<a href="#">AD 154</a>	Client Record Management and Addiction	3
<a href="#">AD 155</a> §	Motivational Interviewing & Addiction	3
<a href="#">AD 156</a>	Ethical and Professional Issues	3
<a href="#">AD 157</a>	Motivational Interviewing Skills Mastery	1
<a href="#">AD 255</a> §	Multiple Diagnoses	3
<a href="#">AD 270A</a>	Practicum: Addiction	9
<a href="#">AD 270B</a> <sup>1</sup>	Practicum: Addiction - Seminar	4
<a href="#">AD 278</a>	Practicum Preparation	1
<a href="#">MP 150</a>	<del>Introduction to Electronic Health Records</del>	<del>3</del>
Total Credits		50
		<b>44</b>

**#6 Eliminate AD 150 Basic Counseling and AD 151 Basic Counseling Lab and replace with a 4 credit AD 160 Basic Counseling.** This addresses a concern that the “lab” class did not fall with the established parameters for this designation.

**#7 Eliminate AD 155 Motivational Interviewing and AD 157 Motivational Interviewing and replace with a 4 credit AD 161 Motivational Interviewing and Addiction.** This addresses a concern that the “lab” class did not fall with the established parameters for this designation.

**#8 Eliminate AD 250 Advanced Counseling and AD 251 Advanced Counseling Lab and replace with a 4 credit AD 256 Advanced Counseling.** This addresses a concern that the “lab” class did not fall with the established parameters for this designation.

**#9 Move AD 256 Advanced Counseling to Program Electives List.** As part of the effort to streamline the program to reduce time and cost for students.

**#10 Rename the Program to the Addiction Counseling Program.** Modernizes the name and eliminates the continued artificial distinction between Alcohol and Drugs as presented in the current name.

**#11 – Dramatically reduce the number of prerequisites for the program.** To reduce the amount of time and money needed to complete the program we have made dramatic cuts to the prerequisites needed to get into the program.

Current Prerequisites: 20-24 credits

1. WR 121 - English Composition 4 credits
2. WR 122 - English Composition 4 credits



3. AD 101 - Alcohol Use and Addiction 3 credits
4. LIB 101 - Library Research and Beyond 1 credit
5. PSY 239 - Abnormal Psychology 4 credits
  - a. (PSY 201A or equivalent is a prerequisite for this course) 4 credits
  - b. May also include Math 20 is a prerequisite for this course) 4 credits

Proposed Prerequisites: 5 credits

1. WR 121 - English Composition I
2. LIB 101 - Library Research and Beyond
- 3.

**#12 – Reduce AAS Degree to 90ish Credits and make the required courses more transparent.**

Add back into certificate

<b>AD 101</b>	<b>Addiction</b>	<b>3</b>
<a href="#"><u>AD 102</u></a>	Drug Use and Addiction	3
<a href="#"><u>AD 103</u></a>	Women and Addiction	3
<a href="#"><u>AD 104</u></a>	Multicultural Counseling	3
<a href="#"><u>AD 106</u></a>	Smoking Cessation	1
<a href="#"><u>AD 150</u></a>	Basic Counseling and Addiction	3
<a href="#"><u>AD 151</u></a>	Basic Counseling Skills Mastery	1
<a href="#"><u>AD 152</u></a>	Group Counseling and Addiction	3
<a href="#"><u>AD 153</u></a>	Theories of Counseling	3
<a href="#"><u>AD 154</u></a>	Client Record Management and Addiction	3
<a href="#"><u>AD 155</u></a>	Motivational Interviewing & Addiction	3
<a href="#"><u>AD 156</u></a>	Ethical and Professional Issues	3
<a href="#"><u>AD 157</u></a>	Motivational Interviewing Skills Mastery	1
<a href="#"><u>AD 184</u></a>	Men & Addiction	3
<a href="#"><u>AD 202</u></a>	Trauma and Recovery	3
<a href="#"><u>AD 250</u></a>	<del>Advanced Counseling and Addiction</del>	<del>3</del>
<a href="#"><u>AD 251</u></a>	<del>Advanced Counseling Skills Mastery</del>	<del>1</del>
<a href="#"><u>AD 255</u></a>	Multiple Diagnoses	3
<a href="#"><u>AD 270A</u></a>	Practicum: Addiction	18
<a href="#"><u>AD 270B</u></a> <sup>1</sup>	Practicum: Addiction - Seminar	8

<a href="#">AD 278</a>	Practicum Preparation	1
<a href="#">MP 150</a>	<del>Introduction to Electronic Health Records</del>	3
	Alcohol and Drug Counselor Degree Electives	6
	General Education	16
	Total Credits	95
		91

**#13 - Reformulate Cohort Structure Proposal.** Reduces the time to complete the program by at least a term.

1. AD 160 Basic Counseling (formerly AD 150/151) remove it from cohort. Allow students to take it prior to cohort. Prerequisite AD 101. AD 160 is a prerequisite for AD 161 Motivational Interviewing.
2. AD 153 Theories of Counseling remove it from cohort. Allow students to take it prior to cohort. Prerequisite AD 101.
3. First term of cohort: AD 154 Client Records Management, AD 160 Motivational Interviewing (formerly AD 155/157), AD 156 Ethic and Addiction.
4. Second term of cohort: AD 152 Group Counseling and Addiction is taken with the first term of practicum. Students may elect to delay their movement into practicum but they must take AD 152 when they do elect to move into practicum.

**#14 - Changes to AD 106 Smoking Cessation.** Modernizes the title and content to focus on Nicotine Use instead of the more limited scope of “smoking”

1. Change the name from AD 106 Smoking Cessation to AD 106 Nicotine Cessation.
2. Rewrite course content guide replacing in reference to smoking cessation with nicotine cessation.

**#15 Deactivate Gambling Classes :** AD 111 Gambling and Addiction I, AD 112 Gambling and Addiction II. These classes are under enrolled consistently and if AD 111 is offered then AD 112 has to be offered to meet needs of students seeking gambling certificate.

F. Needs of Students and the Community:

The need for an Addiction Counseling Program remains significant. Opiate addiction has now reached epidemic proportions and novel approaches and increased funding are being sought to

help address not only the opiate addiction but other addictions as well. Behavioral addictions (gambling, technology use, etc) continue to be a significant and under addressed issue.

G. Have there been any notable changes in instruction due to changes in the student populations served?

No.

H. What strategies are used within the program/discipline to facilitate success for students with disabilities? What does the SAC see as particularly challenging in serving these students?

The faculty in the A&D Program are very responsive to request to make accommodations to students with disabilities. We do notice that a sense of entitlement has deeply permeated our student population on all levels and when working with students with disabilities request the possible list of accommodations seems to be growing exponentially. This places instructors in a very difficult position to sort out what do they need to do and what is optional when students interpret optional accommodations as required accommodations.

I. What strategies are used within the program/discipline to facilitate success for online students? What does the SAC see as particularly challenging in serving online students?

We have eliminated all of the online courses from the program except for one.

J. Has feedback from students, community groups, transfer institutions, business, industry or government been used to make curriculum or instructional changes (if this has not been addressed elsewhere in this document)? If so, describe.

Yes. We have sought out and received input from many sources including our Advisory Board, Representatives of the Oregon Health Authority, Representatives of Co-ordinated Care Organizations, the Addiction Counselor Certification Board of Oregon (ACCBO) and the Oregon Prevention Education and Recovery Association (OPERA). We have also met with a number of representatives from Human Resource Departments from various addiction counseling agencies. We have attempted to pursue articulation agreements with Warner Pacific, Portland State University and Concordia. We appear to be very close to finalizing an agreement with Concordia.

4. Faculty: reflect on the composition, qualifications and development of the faculty

- A. Provide information on how the faculty composition, professional development, and teaching reflect the [Diversity, Equity and Inclusion goals](#) of the institution (from PCC's Strategic Plan, Theme 5). What have you done to further your faculty's knowledge and creation of a shared understanding about diversity, equity and inclusion?

The Alcohol and Drug Counseling Program is deeply committed to the Diversity, Equity and Inclusion Goals. We recently filled an opening for a full time faculty position with an excellent candidate who has been working with and serving a diverse population for many years. In addition, she herself is African American. She has also done a great job serving as a coordinator/advisor for students who were recipients of the Oregon Health Authority African American Grant. This grant has served 9 students since spring term 2014.

The Alcohol and Drug Counseling Program is the only program of its kind with a strong emphasis on gender studies (AD 103 Women and Addiction, AD 184 Men and Addiction). Dennis Morrow, the instructor for AD 184, has taught this class in several other venues and states and has a growing national reputation in this regard.

The Alcohol and Drug Counseling Program has supported the development of the Queer Resource Center and we work hard to serve our student population which is one, if not the most, diverse population of any group at PCC.

- B. Report any changes the SAC has made to instructor qualifications since the last review and the reason for the changes. (Current Instructor Qualifications at: <http://www.pcc.edu/resources/academic/instructor-qualifications/index.html> )

We have not made changes to our instructor qualifications since 2012.

All new instructors will have one of the following:

1. A Bachelors degree in counseling, psychology, human service, human development, sociology, social work or related discipline and be a current Certified Addiction Counselor Level II (or equivalent) or a current Certified Prevention Specialist (or equivalent) and have a minimum of five years of experience working with chemically or behaviorally addicted or at risk populations, or
2. A Masters degree in counseling, psychology, human service, human development, sociology, social work or related discipline and have a minimum of five years working with chemically or behaviorally addicted or at risk populations, or
3. A Doctoral degree in counseling, psychology, human service, human development, sociology, social work or related discipline or a clinical doctorate degree (MD or DO only) and at least one year of

working with the chemically or behaviorally addicted or at risk populations or as a researcher in the arena of behavior and/or neuroscience.

Approved November 2012

- C. How have professional development activities of the faculty contributed to the strength of the program/discipline? If such activities have resulted in instructional or curricular changes, please describe.

The majority of our instructors also work in the counseling arena and they either present community level professional trainings or are required to maintain their own credentials with a specified number of continuing education credits. Most of our faculty are industry leaders who bring current and ongoing updates to their classrooms.

## 5. Facilities and Academic Support

- A. Describe how classroom space, classroom technology, laboratory space, and equipment impact student success.

We are very satisfied in the A&D Department with the classroom technology available. The new library space has rooms that our students can use to create counseling videos as prescribed in three separate classes. With the current availability of smart phones most students do not need video recording equipment and therefore we no longer provide it.

- b. Describe how students are using the library or other outside-the-classroom information resources. If courses are offered online, do students have online access to the same resources?

Students commonly use online resources to create presentations and reports. The LIB 101 class seems to be sufficiently preparing most students for this.

- B. Does the SAC have any insights on students' use of Advising, Counseling, Disability Services, Veterans Services, and other important supports for students? Please describe as appropriate.

We are very fortunate in the AD Program to have Amanda Gallo serve as our Admissions Specialist and Karen Henry serve as our Program Advisor. They are both very competent and do a great job working with students. Additionally, we have Corinne Hiebert and Jeri Reed who not only do a

fantastic job with all their behind the scenes administrative work but they will help students whenever possible. This is a great team to work with! Our students are also significant consumers of Disability Services and Counseling Services and they seem to really benefit from these services.

6. Career and Technical Education (CTE) Programs only. To ensure that the curriculum keeps pace with changing employer needs and continues to successfully prepare students to enter a career field:

A. Evaluate the impact of the Advisory Committee on curriculum and instructional content methods, and/or outcomes. Please include the minutes from the last three Advisory Committee meetings in the appendix.

Our Advisory Board is comprised of representatives from a cross section of the addiction counseling services arena. We are very fortunate to have this group give us real world perspective and advice for the Alcohol and Drug Counseling Program. During the last several years the rapidly evolving addiction counseling world has been hard to track and keep current with and the Advisory Committee has played an integral part in helping us sort out the emerging trends and employer needs. The minutes from the last three meetings are in Appendix Six.

B. Describe current and projected demand and enrollment patterns. Include discussion of any impact this will have on the program/discipline.

While competition for enrollment in our program remains strong, enrollment in practicum is decreasing. It appears this is due to an increasing number of students who are employed during their first practicum placement. We have also recently discovered that our students who successfully get employed as addiction counselors may be eligible for Credits for Prior Learning. For certificate seeking students this could save them as many as 13 credits (9 practicum AD 270 A and 4 seminar AD 270 B) and degree seeking students could save as many as 26 credits (9 practicum AD 270 A and 4 seminar AD 270 B). See Credit for Prior Learning in Appendix Seven.

C. How are students selected and/or prepared (e.g., prerequisites) for program entry?

We use a point system based on classes students have taken in order to select students for program admission. We will be making adjustments to this given that we are changing the number of prerequisites classes and we are in the process of streamlining the time it takes to complete the degree and the certificate.

D. Review job placement data for students over the last five years, including salary information where available. Forecast future employment opportunities for students, including national or state forecasts if appropriate.

Alcohol and Drug Counseling Program Student Survey (September 2015 - 2016)

1. Number of Respondents: 29
2. Are you currently working in the Addiction Counseling arena?
  - a. Yes 78.57% No 21.43%
3. If no, what are you currently doing?
  - a. Attending School? 16.67%
  - b. Working in another field? 50.00%
  - c. Other? 33.33%
4. How much do you earn per hour?
  - a. Under \$12? 3
  - b. \$12 - \$15? 6
  - c. \$15 - \$18? 1
  - d. \$18 - \$20? 2
  - e. \$20 + ? 1
5. Were you hired at your practicum site?
  - a. Yes – 77.78%
  - b. No – 22.22%

**Future need for addiction counselors?** According to the 2012 Vital Signs Report (contained in its entirety in Appendix One) we can anticipate an ongoing need for addiction counselors: “More SUD treatment professionals will be needed in the next five years. While there is limited data to track the projected growth, retraction, and composition of the SUD workforce over the next five years, it is anticipated that the implementation of the Affordable Care Act in 2014 will result in a significant increase in the need for professionals who are able to care for individuals with SUDs in a variety of managed healthcare settings.”

E. Please present data on the number of students completing Degree(s) and/or Certificate (s) in your program. Analyze any barriers to degree or certificate

completion that your students face, and identify common reasons why students may leave before completion. If the program is available 100% online, please include relevant completion data and analysis.

In 2013 we had 25 students earn the AAS degree and 24 students earn the Addiction Studies Certificate.

In 2014 we had 20 students earn the AAS degree and 32 students earn the Addiction Studies Certificate.

In 2015 we had 21 students earn the AAS degree and 52 students earn the Addiction Studies Certificate.

In 2016 without the fall data we have had 18 students earn the AAS degree and 42 students earn the Addiction Studies Certificate.

Analysis: Students are increasingly pursuing the Addiction Studies Certificate. The trend is for students to report that they wish to find employment in the addiction counseling arena with the least amount of time and resources needed. Important to note that every student receiving the AAS degree have also earned the ASC and therefore these statistics involve duplicate counts. We have a Perkins funded dedicated advisor (Karen Henry) for the A&D students who is an integral part of helping students obtain their academic goals and indubitably has made a significant contribution to increasing student success over her tenure.

F. Describe opportunities that exist or are in development for graduates of this program to continue their education in this career area or profession.

Our students have successfully transferred to Portland State University, Concordia and Warner Pacific. Portland State University offers a 4 year Bachelor's of Science Degree that is very popular with our students. This degree can be used to apply for the Masters of Social Work degree and it allows the student to complete the MSW in one year instead of two. Repeated attempts to get firm articulation agreements with each of these schools has been started several times. Once lower level personnel have forwarded the necessary documents to the upper level folks for required sign-off the process stops without feedback or requests for clarifications. It just stops.

## 7. Recommendations



A. What is the SAC planning to do to improve teaching and learning, student success, and degree or certificate completion, for on-campus and online students as appropriate?

As described in previous pages we are currently attempting to streamline the program by reducing pre-requisites, changing how the cohort aspect of the program is offered and reducing the overall number of credits needed for the certificate and the degree. We have also been attempting to reduce textbook cost.

B. What support do you need from administration in order to carry out your planned improvements? (For recommendations asking for financial resources, please present them in priority order. Understand that resources are limited and asking is not an assurance of immediate forthcoming support, but making administration aware of your needs may help them look for outside resources or alternative strategies for support.)

Significant administrative participation will be needed if the proposed Human Services Degree is going to materialize. Budget implications, staffing implications, and across the district co-operation will be essential to the success of this endeavor. Specifically, it is projected that more several more sections per term involving AD 101 Addiction, AD 104 Multicultural Counseling and AD 160 Basic Counseling would be needed for roughly 30 to 40 more credits per year. See Appendix Eight for a letter from the author of the proposed Human Services Degree

- For more information about the program review go to:  
<http://www.pcc.edu/resources/academic/program-review/index.html>

## Addiction Treatment Policy Under President Trump

<http://www.quitalcohol.com/treatment/addiction-treatment-policy-president-trump.html>

Published November 9<sup>th</sup>, 2016

It's the day after Election Day as this article is being written, and Donald Trump has won the American presidency. Some believe he will make America great again and others believe he is evil incarnate. There almost seems to be no in-between. Regardless of how you feel, the presidency is in the hands of Donald Trump. Among the many influences Trump will have on American policy, addiction treatment is one of them. Up until October 28<sup>th</sup>, eleven days before being elected, Trump had only one outlook on drug policy: build a wall along our southern border.

Trump's stance on curbing drug addiction is centered almost exclusively on stopping the flow of drugs from entering the country through Mexico. Then in late October, Trump released a four-point plan to fight the American drug epidemic.

1. Create a wall along the US-Mexico border to prevent illegal drug smuggling. This point also includes aggressive prosecution of both drug dealers and traffickers, including deportation if applicable. Drug smugglers are already creating tunnels in anticipation.
2. Shut down all shipping of fentanyl and related chemicals from China. There are numerous Chinese factories that sell unregulated amounts of fentanyl, and the chemicals needed to make fentanyl, to any buyer. Cartels from Mexico are ordering fentanyl from China and bringing it into the US. Currently there is a fentanyl epidemic in America as death rates from the powerful opioid are skyrocketing.
3. Increase access to drugs used in addiction recovery. Limit the amount of Schedule II drugs manufactured. (This includes most opioid medications.) This could be great. However, the DEA already sets limits on manufacturing, and from 2014 to 2015, most limits increased.
4. Continue to help recovering addicts with the Comprehensive Addiction and Recovery Act (CARA). Also, provide more access to naloxone, a drug that can reverse the effects of an opioid overdose. This is the big one. CARA has the capability to make some real, positive changes in the world of addiction recovery. However, the Republican party has recently removed some funding.

Building a wall, stopping international drug shipping, being harder on drug dealers, increasing access to recovery drugs, manufacturing less opioid medication, and providing more anti-overdose drugs are all straightforward means of fighting the drug epidemic. Only time can tell if these policies will be effective. However, regarding CARA, the situation is a little more complicated.

Let's take a deeper look at CARA and how Trump may affect it. Then let's compare the drug policies of Trump and Democratic nominee Hillary Clinton, to see what will be versus what could have been. Last, let's evaluate Trump's drug policies and stances to see where we will be in the world of addiction recovery for the next four (or eight) years.

## CARA (and Trump's Effects)

[The Comprehensive Addiction & Recovery Act, CARA](#), is the most expansive federal, bipartisan legislation designed to ensure the devotion of federal resources toward evidence-based education, treatment and recovery programs for addiction. First introduced in March, CARA passed through the Senate with a 94-1 vote, and has since been put into law. The reason for CARA is a sad one.

“...according to the most recent estimates, nearly 9 out of 10 people who need drug treatment don't get it,” says Senator Whitehouse of Rhode Island in a discussion published here. He continues, saying, “The idea that we are still letting 9 out of 10 people who need treatment not even get it, not have access to it, is a terrible failing.” Like Trump's proposed drug policies, CARA comes in four parts:

- Prevention efforts and drug education, particularly for children, parents, and the elderly.
- Make [naloxone](#) more available to law enforcement and first responders.
- Identify and treat those who are incarcerated and afflicted with substance addiction with evidence-based treatment.
- Fortify prescription drug monitoring and eventually significantly decrease the amount of opioid medications in the hands of Americans.

CARA was made into law by the Obama administration but the Republican party prevented Democratic efforts to maximize funding for CARA. He said, “I am deeply disappointed that Republicans failed to provide any real resources for those seeking addiction treatment to get the care that they need. In fact, they blocked efforts by Democrats to include \$920 million in treatment funding.” Still, many millions of dollars have already been used in CARA's name. However, the debate regarding future funding will be held in 2017, which means the debate will be held during the presidency of Trump.

Seeing as much of the points laid out by CARA are also points laid out by Trump's drug policy, one can only assume that Trump will support the funding of CARA. However, he is after all Republican and therefore part of the political party that cut funding for CARA. Only time will tell. Regardless, though, of your political stance, it is inarguable that Hillary Clinton had much more concise of a plan regarding addiction recovery and drug policy in America.

## Drug & Addiction Treatment Policy Comparison: Trump & Clinton

Had Clinton been elected yesterday; things would be a lot different. Drug policy is included here. Not to say that Trump doesn't care about the drug epidemic, because surely he does, but Clinton offered a much more detailed plan than Trump. Outside of support for CARA, Trump “has not proposed any specific spending,” as stated in an article on the topic published by ABC. Clinton,

however, proposed spending \$10 billion in five specific areas of drug policy: prevention, treatment, aiding first responders, reforming prescription, and reforming applicable criminal justice.

Funding is just one of the four major differences between Trump's and Clinton's drug policies. Aside from the money, both differ on how to stop the drug supply, how to increase prevention and treatment, and how to crack down harder on the drug criminals.

### **The Money**

As stated, Trump offers no clear plan as to how to fund his policies. Although he supports many facets of the war on drugs, he does not have a clear funding process.

Clinton proposes spending \$10 billion, three-quarters of it on the individual states and the remaining \$2.5 billion on the Substance Abuse Prevention and Treatment Block Grant program, which provides funding for addiction recovery research and centers.

### **The Supply**

Trump says the wall he's going to build will prevent drugs from entering America from Mexico. The DEA has said that 79% of heroin analyzed in 2014 came from Mexico. Also, Trump notes that he will attempt to end the Chinese shipping of fentanyl and related chemicals. Lastly, he believes "the DEA should limit production of Schedule II opioid painkillers," as said in the ABC article. They already do, but perhaps not as stringently as they should.

Clinton does not focus at all at stopping the drug supply, but rather on the other aspects of drug policy.

### **Prevention & Treatment**

Trump wishes to expand the reach of naloxone and "make it easier for doctors to prescribe 'abuse-detering drugs.'" He believed the process of approval for such drugs is too slow. As part of this section on drug policy, Trump also mentioned while campaigning in New Hampshire that he wants to establish drug courts.

Clinton's policies are focused almost entirely on this section of drug policy. She wants to improve the existing treatment facilities and build new ones. She wants more health care providers, and to reduce childcare costs for those in addiction recovery treatment. She wants insurance companies to cover the costs of addiction recovery treatment.

Clinton's \$10 billion plan would also include the promotion of medically-assisted treatment, stricter laws regarding drug prescriptions, making naloxone more widely available, and funding educational programs regarding drug prevention for schools.

### **Stopping the Criminals**

Trump, in a speech delivered October 15<sup>th</sup>, pledged to “aggressively prosecute traffickers of illegal drugs.” Also, Trump wants to follow in the footsteps of his Vice President, Mike Pence, who created mandatory minimum sentences for drug offenses in Indiana.

Clinton wants to “prioritize treatment over incarceration for low-level offenders.” She supports drug courts, and wants to use them an alternative for prison when it comes to low-level drug offenders who need help.

Again, no matter how you feel about Trump or Clinton, it’s hard not to see how Clinton’s proposed drug policies are much more clear and evidence-based than Trump’s. However, with China and Mexico combining to provide the US with an overload of fentanyl, maybe Trump’s wall will be effective. Also, Trump clearly will get behind drug policy. With CARA, addiction treatment will only get better from here, right?

## **A Review of Trump’s Policy**

The 45<sup>th</sup> president is focusing on the supply of drugs more than any other aspect. This method is known as interdiction, and per Theodore Cicero, substance abuse expert and psychiatry professor at Washington University in St. Louis, it doesn’t work.

“All interdiction attempts have failed,” said Cicero. “It is hard to see how re-emphasizing attempts to reduce supply will make much of dent in an important problem. We need to reduce demand, not simply the supply of these drugs.” While Clinton offered a 1,500 page paper outlining her drug policies to be, Trump “apparently has no position paper at all.” In fact, what he does have is a video less than one minute long.

Here is an exact-word transcript of Trump’s words in the short video:

“New Hampshire has a tremendous drug epidemic. Every time I go there, people come up to me and say, ‘Mr. Trump, what are we gonna do?’ Drugs are pouring in. I’m gonna create borders. No drugs are coming in. We’re gonna build a wall. You know what I’m talking about. You have confidence in me. Believe me, I will solve the problem. They will stop coming to New Hampshire. They’ll stop coming to our country. And the people that are in trouble, the people that are addicted, we’re going to work with them and try and make them better. And we will make them better.”

All we can do is wait, and pray that Trump truly does make them better.

- See more at: <http://www.quitalcohol.com/treatment/addiction-treatment-policy-president-trump.html#sthash.TSz09wWe.dpuf>

## **Millions Could Lose Medicaid Coverage Under Trump Plan**

By [Phil Galewitz](#) November 9, 2016

<http://khn.org/news/millions-could-lose-medicaid-coverage-under-trump-plan/>

Millions of low-income Americans on Medicaid could lose their health coverage if President-elect Donald Trump and a Republican-controlled Congress follow through on GOP proposals to cut spending in the state-federal insurance program.

The biggest risk for Medicaid beneficiaries comes from pledges by Trump and other Republicans to repeal the Affordable Care Act, which provided federal funding to states to expand Medicaid eligibility starting in 2014. Thirty-one states and Washington, D.C. [did so](#), adding [15.7 million](#) people to the program, according to the government. About 73 million are now enrolled in Medicaid — about half are children.

Reducing the number of people in Medicaid while ensuring that only the most needy — such as children and pregnant women — remain eligible will be a goal for Trump and the new Congress, said Brian Blase, senior research fellow at the conservative Mercatus Center at George Mason University in Virginia.

This KHN story also ran in [The Daily Beast](#). It can be republished for free ([details](#)).

**THE DAILY BEAST**

“If we do not have fewer people in Medicaid in four years, then we have not reformed health policy in a good direction,” he said.

But there are obstacles to the Republicans’ plans. Medicaid, one of President Lyndon Johnson’s “Great Society” domestic programs that was created in 1965, is the nation’s main health insurance program for low-income people.

Overhauling it is politically difficult because of the potential harm to recipients as well as the financial consequences to states, hospitals, doctors and other health providers, who might not get paid for their services if patients don’t have coverage. [Total Medicaid spending](#) was \$532 billion in fiscal 2015, with about 62 percent funded by the federal government.

One major change endorsed by both Trump and House Speaker Paul Ryan (R-Wis.) would transform Medicaid from an entitlement program into a block grant program.

Here’s the difference. In an entitlement program, coverage is guaranteed for everyone who’s eligible. The federal government’s commitment to help states cover costs is open-ended. The states’ obligation is to cover certain groups of people and to provide specific benefits. Children and pregnant women who meet specific income criteria must be covered, for example.

That formula would change if federal funds flow to states through block grants. States would have more flexibility to run their Medicaid programs as they wish — including cutting benefits and eligibility. And proponents say it would allow the federal government to spend less on Medicaid and make states responsible for covering costs beyond their federal allotments.

Turning Medicaid into a block grant program has been discussed for more than 25 years, but the idea has always met resistance from some states, health providers, health care advocates and Democrats. Even with a Republican majority in Congress and Trump in the White House, the plan would still face an uphill legislative battle.

The federal government rarely shifts power to the states and not all states want to be at increased financial risk for the program.

“Medicaid block grants face a very uncertain future,” said Joel Cantor, director of the Center for State Health Policy at Rutgers University in New Jersey.

Another option to redefine Medicaid funding, similar to a block grant, is known as a per capita cap. States would be given a set amount of money per enrollee, which would increase each year but critics fear likely not keep up with rising health expenses. That method would help states better deal with growing enrollment because funding would rise, too.

Even without help from Congress, Trump’s administration could change Medicaid using the executive branch’s power to approve states’ requests for waivers from federal rules. That could allow Trump to approve changes proposed by Republican governors that the Obama administration has rejected, including work requirements for Medicaid enrollees and monthly premiums and other cost-sharing.

Trump could also end some waivers that expanded Medicaid and sent billions in new federal funding to some states that transformed care.

Any congressional changes to Medicaid next year would likely include negotiations about the Children’s Health Insurance Program, another federal-state program that provides coverage to youngsters whose families are slightly over the Medicaid eligibility. The program expires if not reauthorized by Sept. 30, 2017. According to the Kaiser Family Foundation, about 8 million children get coverage through CHIP, which has had Republican and Democratic support.

After Trump is in office, he may find it’s harder than he realized to repeal Obamacare and tinker with Medicaid because cutting off coverage for millions of people could bring plenty of political fallout, said Joan Alker, executive director of the Center for Children and Families at Georgetown University.

Republican Gov. Matt Bevin of Kentucky took a similar tack last year, she observed, running against Obamacare and vowing in his campaign to eliminate the expansion. He has since proposed major changes to Medicaid, but he has not yet moved to kill the expansion.

Still, Alker said Trump’s win puts the block grant idea front and center in January. And an agreement to do it could give states flexibility to make cuts in federally required benefits, such as health screenings for infants and children.

“I would be very concerned about what could happen,” Alker said.

AD Core Outcomes Mapping Matrix							
Course	Course Name	CO1	CO2	CO3	CO4	CO5	CO6
AD 101	Alcohol Use and Addiction	1	2	4	1	4	4
AD 102	Drug Use and Addiction	1	2	4	1	4	4
AD 103	Women and Addiction	2	3	3	3	4	4
AD 104	Multicultural Counseling	4	4	2	4	4	4
AD 105	Aging and Addiction	1	2	4	1	4	4
AD 106	Smoking Cessation	1	2	4	1	4	4
AD 150	Basic Counseling and Addiction	4	1	2	2	4	4
AD 151	Basic Counseling Skills Mastery	4	1	2	2	4	4
AD 152	Group Counseling and Addiction	4	1	4	3	4	4
AD 153	Theories of Counseling	3	1	4	2	4	2
AD 154	Case Management and Addiction	4	0	3	2	4	0
AD 155	Motivational Interviewing	4	1	2	2	4	4
AD 156	Ethics and Professional Issues	2	4	4	2	4	2
AD 184	Men and Addiction	2	3	3	3	4	4
AD 202	Trauma and Recovery	3	2	3	2	4	4
AD 250	Advanced Counseling and Addiction	4	1	2	2	4	4
AD 251	Advanced Counseling Skills Mastery	4	1	2	2	4	4
AD 255	Multiple Diagnosis	4	3	4	2	4	1
AD 280A	Practicum: Addiction	4	2	4	4	4	4
AD 280B	Practicum: Addiction - Seminar	4	2	4	4	4	4
Revised 10/25/2016							



**Alcohol and Drug Counseling Program  
Advisory Meeting  
Feb. 29<sup>th</sup>, 2016**

**1. Introductions and Announcements**

**2. A&D Program Review Process – presented by Jonny Gieber**

a. Steps of Process

- i. Attend training on review process. (completed)
  1. Guidelines for Review (see attached)
  2. Susan Wilson can provide consultation for Review.
- ii. Examine 2012 A&D Program Review (see attached)
  1. Determine if any data presented needs to be updated and submitted with this review.
  2. Identify issues raised in previous review that are important to update.
- iii. Establish critical questions for review
  1. Addiction Studies Certificate - The current Addiction Studies Certificate has many problems: embedded math needs to be identified, the previous belief that the certificate needed to be more than 44 credits to allow participation by a Perkins funded advisor has now been shown to be in error and the suggestion has been made to return the certificate to its original 44 credits, it appears that more students are applying for the certificate than for the degree and the reasons for this are uncertain. The content of the certificate also needs to be re-examined to determine if the needs of the new addiction counseling specialist is being met via this course work.
    - a. *The Advisory Board agreed with this proposal.*
  2. Lab Courses - Three current courses are listed as labs, AD 151, AD 157 and AD 251. The current formatting of the ‘labs’ is not consistent with PCC policy and needs to be changed. Should an actual skills lab be created? Should these 1 credit courses be changed to lecture credits? Should this issue be addressed in a different fashion?
    - a. *The Advisory Board suggested that while an actual lab may be useful this is a longer term project and perhaps rolling the one credit class into the three credit class is the best approach.*
  3. Human Services Degree Proposal (see attached). There appears to be an increasing demand for QMHAs (see attached) in the State of Oregon. There has been some consideration if the A&D program should expand and include a Human Service degree track. While this consideration has not been formalized another department has been developing a proposal. Should the A&D Department support this proposal? What implications are there for the A&D

Department if it is approved? Should we be developing our own proposal even if it is at odds with the current proposal?

- a. *It was suggested that the A&D Department stand in support of this effort and await more developments before determining what choices, if any, are at hand for the program.*

4. Career Pathways Development (see attached). Would it be in the best interest of our students to develop Career Pathways within the A&D Program? How would this be effected by the considerations of the Human Service Degree Proposal? The Addiction Counselor Certification Board of Oregon has expanded its certifications to include the Certified Recovery Mentor (CRM) and the Certified Addiction Peer Recovery Counselor (PRC). It appears that there are increasing employment opportunities for the CRM and it is believed that the PRC will also be in demand by employers. It is unclear if the single elective class offered in the A&D Program (AD 107 Addiction Recovery Mentor) is sufficient and/or should there be a clear Career Pathway established. On the mental health side, there is also a Peer Wellness Specialist, which only requires the recipient of the receiver of this to have 80 hours of training. Should we pursue an agreement with the Oregon Health Authority where we could offer an additional class that would allow the CRM class plus this new class to result in the PWS certificate?

Additionally, many Bachelor of Social Work programs have been developed in the Portland area. Students who choose this avenue can then potentially earn their MSW in one year instead of two. Would it be advantageous to develop a career pathway for these students?

*The Advisory Board was very mixed on this issue and believed more information needs to be gathered before these issues could be decided.*

5. Creation of a new certificate and/or change the cohort system?  
The Addiction Counseling employers appear to be moving toward hiring Qualified Mental Health Professionals (QMHPs) and away from hiring Certified Addiction Counselors (CADC I, II). The QMHP requires a person hold a Masters degree. A study is currently underway to determine the reality of this belief in the Portland Metro area. Related to this issue is the need to provide trainings to the QMHPs regarding addiction. Due to the cohort process currently used by the A&D Program it is very difficult to provide the education in a format that works for current QMHPs. The continuing education folks at PCC are exploring the

possibility of offering some courses to help QMHPs. Should we develop a track for QMHPs?

a. *This should be explored.*

6. Redesign of course offerings - The program currently has two gender specific classes AD 103 Women and Addiction and AD 184 Men and Addiction. It also has an elective course AD 105 Aging and Addiction and AD 108 Adolescence and Addiction. Perhaps it is time to modernize these courses and reformat them into a developmental sequence.

a. *It was proposed that all of the electives be examined as part of a potential program redesign with an emphasis on CADC required classes.*

7. Practicum process examination - The practicum process currently used is labor intensive and very expensive in terms of instructional dollars. It also is not particularly environmentally friendly as it involves significant gasoline consumption for face to face appointments that tend to be very routine. What is the current academic standard for practicums that involve onsite supervisors provided by the agencies and academic supervisors who do not directly observe students?

a. *The Advisory Board did not support a change regarding the practicum system.*

8. Cohort System - Is the current approach of the cohort model working? Is this model meeting the needs of our students? What are the down sides of the cohort model? Since we decreased the number of cohorts to 3 (down from 4) how has this effected enrollments? What are the advantages/disadvantages of a lock step start in the fall type of program and have all the classes predetermined?

a. *This inquiry was supported with no firm suggestions made.*

iv. Identify data collection processes

1. Kate Kinder has offered to assist with the employer survey (see attached).
2. Karen Henry and Amanda Gallo are compiling student questionnaires (see attached).
3. Jonny Gieber will look for external sources of data and when appropriate updates from the 2012 review.

a. *No additional sources of data were identified.*

v. Create review team

1. Jonny Gieber will be lead on this project.
2. Felesia Otis will contribute Spring and Summer term as a temporary full time faculty, future participation will in part depend on the completion of the hiring process for the permanent full time faculty position.

3. The Advisory Committee and SAC will be consulted at each regularly scheduled meeting. Any member from either of these groups can participate.
  4. Community members who have volunteered to assist with this review:
    - a. Shawn Clark – Oregon Health Authority
    - b. Devarshi Bajpai – Multnomah County
    - c. Anthony Jordan – Inact and a member of the African American Addiction Counseling and Behavioral Health Coalition.
    - d. Frederick Staten – Cascadia
    - e. Greta Coe – Problem Gambling Services Manager
    - f. John Morgan – former student, Depaul
  5. Page Kalkowski – former student, Ph.D Stanford Educational Evaluation and Design will be hired on a limited basis to help with the process.
- vi. Establish time line for review
1. Feb. 29<sup>th</sup>, 2016 Overview of Process and Initial Feedback Advisory Committee.
  2. Spring Term SAC – Assessment Process Proposal Presented
  3. End of Spring Term 2016 – Research Project with with Kate Kinder launched.
  4. Summer and Fall 2016 – all data collected.
  5. Winter 2017 – report written and finalized.
  6. Spring 2017 – report submitted for administrative review.
    - a. *No additional input offered.*

Alcohol and Drug Counselor Program  
 Advisory Board  
 May 11<sup>th</sup>, 2015  
 Minutes

1. Introductions and Announcements.
2. The Research Group had initial meeting - update and presentation of current inquiry. (This was the group formed to look at what appears to be changes in the Alcohol and Drug Counseling Program).

*Brief report given. Appears that the future program review will likely be used to take a deeper look at these issues. Difficult to get at data.*

3. Is it time to reconsider adding back the Certified Prevention Specialist to the program?

*No indication that significant funding is coming "down the pike" to justify activating this certificate.*

4. Is it time to consider expanding the "Traditional WorkForce" course offerings?

*At this time the Certified Recovery Mentor course AD 107 is a very popular course and many jobs are available for CRMs. Less clear is*

*future of Peer Wellness Specialist and if we need to develop a class that will allow people to earn this Oregon Health Authority Certifi*

5. Program Update - process to hire temporary full-time person getting ready to be launched.

6. *A discussion of addressing diversity issues in the addiction counseling transpired and a strong encouragement for the program to continue to focus on addressing these issues. The number of addiction counseling providers from diverse groups remains very low.*

Jonny Gieber MS, CADC II  
Department Chair  
Alcohol and Drug Counseling Program  
503 740 9478  
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Alcohol and Drug Counselor Program  
November 2, 2016  
Advisory Meeting  
Minutes

1. Introductions and Announcements
2. Certificate Problems
  - a. How to fix it? (SAC did not want to pursue justifying the embedded math requirement).

*Division Dean John Saito proposed that special funds be used to investigate with the aid of a math instructor if there is indeed ample content to justify an embedded instruction allowance. Jonny will follow up.*

3. ACCBO - Peer Recovery Counselor Certification
  - a. Should we develop a course to meet the second 40 hour requirement?  
(Current students can meet this requirement by simply taking the cohort classes.)
  - b. Should we develop a certificate for this (SAC did not think so).

*Frederick offered that PSU offers a PWS, Meghan Cohey senior director at Cascadia would be contact person for this. Jonny will follow up.*

Questions to address in the future:

Should we offer a Peer Wellness Specialist Training class?

Should we offer a course to follow up the CRM course that results in meeting the educational requirement for the Peer Recovery Counselor (ACCBO credential).

4. The Green Monster: Marijuana and Recovery
  - a. How should we counsel students who may be using medical marijuana?
  - b. Can non-recovering students use recreational marijuana (or medical)?
  - c. What are ACCBO's standards concerning marijuana?
  - d. How is marijuana handled on pre-employment drug screens?
  - e. Can marijuana use be considered a harm reduction strategy?
  - f. What is the current legal status in Oregon regarding these questions?
  - g. If a person is in DUI treatment do they need to have marijuana free urine's?
  - h. Is a recovering person wise or unwise to consider medical marijuana especially for conditions that typically would involve treatment?

of opiates?

i. Is there such a thing as medical marijuana?

*A robust discussion with only one clear outcome: Federal money is the core issue regarding marijuana use. Any treatment area that receives federal dollars must have a marijuana free policy.*

5. Research Project

a. Tool is ready. Challenging to get HRs to complete it. Ideas?

*Suggested that a meeting of HRs that regularly meets may be a way to collect this data.*

6. African American Scholarship Program Report – *Update presented by Felesia*

7. Full time faculty permanent position targeted to be filled by April, 2016.

8. Clark College Addictions Program potentially closing.

### **A&D Certificate Troubles**

In a land not so far away some mysterious person looked at the Alcohol and Drug Counselor Program Certificate and proclaimed that in order to use advising services provided by our Perkins Funded Program Advisor we needed to increase the number of credits of the certificate.

Upon this winding path it turns out that to increase the number of credits of the certificate required that we address math as part of the certificate. The math monster needed to rise (a fearsome beast indeed for much of our village). What to do? The governess of the land proclaimed that anyone wishing to hold the certificate would not only take math but would do so at the Math 105 level. The villagers moaned, "but to hold the sacred degree only requires Math 65, what madness is this?" The governess shook her head and simply said, "the book says it is so. No reason to offer, all arguments will falter. Move on.".... But wait. With a sly look upon her face she said, "there is another path, weave a tale of embedded math". So we weaved, the governess approved, certificate in hand, down the path we marched.

One day, between the unicorns and rainbows and all the happy villagers it came to be that a cloaked figure stood ringing a bell. As silence fell the festivities a voice cried out, "embedded math you now must show, line by line is how it will go, another obstacle to overcome must now focus and get it done".

That night the village elders meet to decide how to remove this obstacle blocking their path. After much clinching of jaws and wringing hands this is the choices that would govern their land:

1. Return the certificate to its former state, not enough credits for Perkins advisor to participate.
2. Add the Math monster of Math 105, not sure how many seekers this will leave alive.
3. Eliminate the certificate in all of its forms let it be devoured by the rule worn worms.

What of embedded math? The elders said let it go, let it go, no more madness for us to hold.

Jonny Gieber

Credit for Prior Learning – Fall 2016

As a service to students, starting in Fall Term 2016, the Alcohol and Drug Counseling Program now has the option to award credit for Practicum (AD 270A) for AD students who have worked or are currently working in the Alcohol and Drug Counseling field in a position that meets the requirements for work experience as described by the Addiction Counselor Certification Board of Oregon (ACCBO) for the CADC I application including being supervised by a CADC II or CADC III.

Students should be aware that getting an ACCBO work experience approved position in the Alcohol and Drug counseling field without having already completed Practicum is very challenging. Students should plan for and expect to complete Practicum in order to be employable. For those students who are an exception and are able to gain ACCBO work experience approved positions in the field without having already completed Practicum, Credit for Prior Learning (CPL) is now an option.

In order to be eligible to receive CPL, follow the steps below:

1. Individuals who complete requirements for work experience as described by the Addiction Counselor Certification Board of Oregon (ACCBO) for the CADC I application, and submit documentation from ACCBO that demonstrates those hours have been accepted for application to the CADC I or II, can apply for Credit for Prior Learning (CPL) for AD 270 A Practicum. Credits must be submitted in increments of 108 hours (3 credits), 144 hours (4 credits), 180 hours (5 credits) or 216 hours (6 credits).
2. Individuals requesting CPL credit must be enrolled at PCC and have an established transcript.
3. Individuals requesting CPL credit for the Alcohol and Drug Program Addiction Studies Certificate and/or AAS Degree must schedule an appointment with Jonny Gieber, Department Chair of the Alcohol and Drug Counseling Program (503.740.9478) and have the following documents to submit:
  - a. A copy of the ACCBO Checkoff List that contains the number of accepted hours that is signed and dated by ACCBO (page 5 here [http://accbo.com/general\\_images/pdf\\_files/cadc2016app\(fillable\).pdf](http://accbo.com/general_images/pdf_files/cadc2016app(fillable).pdf))
  - b. A copy of a completed Non-Traditional Credit Request Form (<http://www.pcc.edu/resources/graduation/documents/request-non-trad-credit.pdf>)
4. The Department Chair will retain a copy of submitted documentation per #3.
5. The Student will submit the signed form(s) to the business office and will be responsible for the \$10 per form fee.

CPL will not be available for Practicum Seminar (AD 270 B). Students must schedule an appointment with Jonny Gieber, the Department Chair of the Alcohol and Drug Counseling Program, to discuss the most appropriate way to address the AD 270 B requirement. One of three solutions will be made available:

1. The student attends AD 270 B.
2. The student challenges AD 270 B (and will earn a C grade.)
3. AD 270 B is substituted with another class (if possible.)

Students planning to complete Practicum (AD 270A) through CPL have two options to complete Practicum Preparation (AD 278):

1. The student attends AD 278
2. AD 278 is substituted with another class (if possible.)

Students planning to complete Practicum by taking AD 270A must take AD 278 prior to starting Practicum.

Dear Jonny,

First, I want to thank both you and Sue for meeting with me the other day. I always walk away from our interactions learning a bit more about your program and PCC.

Equally, I wanted to express my appreciation for your willingness to work across institutional silos to support the development of the new Family and Human Services (HUS) degree. As we discussed, we anticipate a "soft" roll out of the degree program in the 2017-2018 academic year, with an official launch in Fall 2018. That said, we will begin to advise those students who are interested in the HUS credential next year. Specifically, we will help them develop a program of study, with the potential for students to complete a few core program classes even before the degree "sunrises."

As you know, we will be using Addictions (AD) courses in two ways: (1) as a part of the degree's core interdisciplinary requirements, and (2) as part of the 12 credits worth of Concentration Area Elective that students must take in order to complete the degree. AD is one of five concentration areas that students may select, including Gerontology, Family Life/Parenting Education, Early Childhood Education, and Human Service Generalist.

AD core degree requirements for HUS will include the following 10 credits: **AD 104 (Multicultural Counseling), AD 101 (Addictions), and AD 160 (Basic Counseling)**. These courses are the most frequently offered (each term) in your program and are most flexible for students. We do hope these particular classes will continue to be offered on a quarterly basis for HUS students.

AD concentration area electives will include **AD 110 (Substance Use), AD 102 (Drug Use and Addiction), AD 107 (Addiction and Recovery), and AD 105 (Aging and Addictions)**. If students wish to "concentrate" in Addictions for the HUS degree, these particular courses will need to be taken before they graduate. We hope these classes can be offered frequently enough in a 2-year cycle for students to access. These courses, combined with the AD core requirements may provide a pathway for those students interested in a peer wellness certification (per our conversation), providing additional credentialing for those moving into wellness work.

At this point, we are not sure of anticipated enrollment numbers. However, we should have a better idea during the 2017-2018 academic year when we begin to pilot a few core HUS classes. Also, we will also be advising students to complete their concentration area and core degree requirements while we wait for the HUS courses to go "live" in Fall 2018. Based on anecdotal response, we believe this will be a popular program. Additionally, the cooperation of your program will provide an additional pathway for students who wish to focus more in addiction studies than human services. We definitely anticipate a reciprocal relationship with AD as we help guide students toward a pathway that best suits their needs and goals.

Finally, I want to again reiterate my gratitude that you are so willing to collaborate with our department and this new degree program. We look forward to many creative conversations and curricular exchanges as we head into the future.

As always, please do not hesitate to reach out and let me know if you have questions and concerns. We look forward to working with you.

Respectfully,

Andrew

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Pronouns: he/him/his/himself