SB 1547 -2 STAFF MEASURE SUMMARY

Senate Committee On Human Services

Prepared By:	Iva Sokolovska, LPRO Analyst
Sub-Referral To:	Joint Committee On Ways and Means
Meeting Dates:	2/14

WHAT THE MEASURE DOES:

The measure allows a treatment center for substance use disorder to admit a minor who doesn't want to be admitted for up to 14 days only if: the minor has a substance use problem and can't control their drug or alcohol use; there's no better way to treat the minor; treatment is likely to help the minor, or their condition will get worse without it, the minor meets any other rules set by the Oregon Health Authority. The measure requires health plans to cover inpatient treatment for cannabis use for minors if their mental health provider says it's needed because the minor's use is a habit and could lead to using illegal drugs. The measure directs the Oregon Health Authority (OHA) to create a program where people with opioid addiction can get help through the suicide prevention hotline and access health providers. The measure creates an advisory committee that will make recommendations to OHA on how to make it easier for emergency medical workers and military medics to get licensed to provide emergency medical services.

Detailed Summary:

Parental Admission of Minor for Inpatient Substance Use Disorder Treatment (Sections 1 and 2)

Permits the director of a treatment facility to admit a minor for inpatient diagnosis, evaluation, and treatment of a substance use disorder over the the minor's objection if:

- An application for admission of a minor to a treatment facility is made by a parent or guardian of the minor; and
- There is reason to believe that the minor's substance use disorder could be improved by the recommended course of treatment or would deteriorate further if left untreated and the period for inpatient treatment does not exceed 14 days; and
- The director believes the minor has a substance use disorder, and
  - has lost the ability to control personal use; or
  - the minor uses a substance to the extent that the health of the minor is substantially impaired or endangered or the social or economic functioning of the minor is substantially disrupted;
- there is no less restrictive alternative available for the minor's treatment.

Mandates the release of a minor admitted to treatment to be discharged within 72 hours if the facility receives notice, in writing, from the minor's parent or guardian requesting discharge, or if the director of the treatment facility determines that the minor will no longer benefit from continued treatment and the minor is not dangerous to self or others. Permits the treatment facility to disclose information regarding the minor's treatment the parent or guardian, without the consent of the minor, to the extent permitted under federal law. Allows OHA to establish other criteria for admission by rule.

Insurance Coverage of Treatment for Cannabis Use by Minors (Sections 3-5)

- Requires health benefit plans to reimburse the cost of inpatient treatment for cannabis use for an enrollee who is a minor if prescribed by the enrollee's mental health care provider based on a determination that the enrollee's use is habitual and likely to lead to the unlawful use of controlled substances.

Virtual Opioid Dependency Program (Sections 6 and 7)

- Directs OHA to establish a virtual opioid dependency pilot program to provide on-demand intervention and treatment for individuals with opioid use disorder through the 9-8-8 suicide prevention and behavioral health crisis hotline.
- Requires the pilot program to allow individuals to call the hotline 24 hours a day, seven days a week, and speak to a health care provider with prescribing privileges. Permits providers to immediately start the caller on an opioid agonist therapy, refer the caller immediately to treatment, transition services and ongoing dependency care; or take other appropriate steps to intervene and provide a pathway to treatment for the caller.
- Releases providers participating in the pilot program from civil liability for any actions taken in good faith.
- Directs OHA to report to the Legislative Assembly on the operation and outcomes of the pilot program by September 15, 2025.
- Repeals provisions on January 2, 2026.
- Appropriates $5,000,000 to OHA to establish and maintain the pilot virtual opioid dependency program.

Emergency Medical Services Reciprocal Licensing(Section 8)

- Requires OHA to convene an advisory committee to provide recommendations for a reciprocal license program emergency medical services (EMS) providers, including members of the Armed Forces of the United States who are trained to provide emergency medical care.
- Specifies membership and duties of advisory committee.
- Directs the advisory committee to report to the Legislative Assembly by September 15, 2024, with recommendations for rules to establish the reciprocal license program.
- Directs OHA to establish and begin issuing licenses under the reciprocal license program by January 1, 2025.
- Repeals provisions on January 2, 2026.

ISSUES DISCUSSED:

EFFECT OF AMENDMENT:

-2 Modifies definition of "health benefit plan" as used in the measure's provisions and modifies the requirement for a health benefit plans to reimburse the cost of inpatient treatment for cannabis use for an enrollee who is a minor if the enrollee’s use is habitual and likely to lead to use of other addictive controlled substances.

BACKGROUND:

The persistent worry over substance use among youth necessitates tailored approaches distinct from those for adults. Studies indicate that a significant portion of substance use disorders emerge during adolescence or young adulthood, underscoring the urgency of intervention to prevent persistent issues into later life stages. Proactive measures aimed at prevention and treatment among youth are crucial to combat Oregon's substance abuse crisis effectively. Alongside current support systems, there exist multiple initiatives geared towards addressing substance misuse among youth and young adults in the forthcoming years. In Oregon, rates of youth with a documented substance use disorder have remained above the national average and increased in 2019 (Youth and Young Adult SUD Treatment and Recovery Report 2023). Substance use disorder cases among young adults aged 18 to 25 have seen a slight decrease, yet Oregon's rates still surpass the national average within this demographic. As of 2022, a substantial 59% of emergency department visits for youth and young adults requiring substance use treatment were covered by the Oregon Health Plan (Medicaid). Individuals encountering substance use-related emergencies may undergo treatment and discharge, be transferred to other hospital units, or find themselves "boarded" within the emergency department. Boarding typically arises when a patient remains in the emergency department for more than 24 hours due to a lack of alternative care options and their insufficient stability for hospital discharge.

According to current legislation, Oregon allows minors aged 14 and above to consent to specific treatments provided by designated healthcare professionals without parental approval. Moreover, Oregon law safeguards the

confidentiality of records related to such treatments but permits exceptions for disclosure to the minor's parents and other third parties under specified conditions. Since 1985, Oregon has granted minors aged 14 and above the authority to consent, without parental consent, to outpatient treatment offered by designated healthcare professionals for mental or emotional health conditions or certain substance dependencies, excluding methadone maintenance (ORS 109.675). Although minors are empowered under Oregon law to initiate treatment for mental or emotional health conditions or substance dependencies without parental consent, the healthcare provider, with limited exceptions, must involve the minor's parents before concluding the minor's treatment. Additionally, the healthcare provider may, without the minor's consent, disclose information concerning the minor's treatment in specific situations (ORS 109.680). In instances where the minor is at a serious and immediate risk of attempting suicide, but inpatient treatment is neither necessary nor practical, the healthcare provider is obligated to collaborate on safety planning with the minor's parents and any other individuals whom the provider reasonably believes can help diminish the likelihood of the minor's suicide attempt.

Using marijuana can result in the development of problematic use, referred to as marijuana use disorder, which can manifest as addiction in severe cases. Statistics indicate that approximately 30% of marijuana users may experience some level of marijuana use disorder. Individuals who initiate marijuana use before the age of 18 are four to seven times more likely to develop a marijuana use disorder compared to adults. Marijuana use disorders frequently involve dependence, characterized by withdrawal symptoms when the drug is not consumed. Commonly reported symptoms among frequent marijuana users include irritability, mood swings, sleep disturbances, decreased appetite, cravings, restlessness, and physical discomfort, typically peaking within the first week after cessation and lasting up to two weeks. Marijuana use disorder escalates to addiction when an individual cannot cease using the drug despite its interference with various aspects of their life. Estimates of marijuana addiction are contentious, partly because epidemiological studies on substance use often utilize dependence as a measure of addiction, although dependence can exist without addiction. Studies indicate that approximately 9% of marijuana users will develop dependence, with this figure rising to about 17% among those who initiate use during adolescence. In 2015, around 4.0 million individuals in the United States met the diagnostic criteria for marijuana use disorder, with 138,000 voluntarily seeking treatment for their marijuana use.

Opioid Use Disorder (OUD) is a chronic health issue demanding sustained supportive care. Those grappling with OUD confront various obstacles hindering their access to care, such as societal stigma, the availability of trained clinicians, and the financial burdens associated with therapy. A systematic review of telemedicine-delivered interventions for Substance Use Disorders highlighted studies investigating the efficacy of real-time telehealth approaches, including several focusing on individuals with OUDs. The majority of these studies indicated consistently high levels of client satisfaction with telemedicine interventions, especially in areas with limited care accessibility. Notably, the Alberta Virtual Opioid Dependency Program model showcased remarkable client satisfaction levels, marked increases in utilization, and promising initial clinical outcomes, according to a 2022 study involving 440 clients.

Emergency Medical Services, commonly referred to as EMS, constitutes a vital system dedicated to delivering immediate medical care during emergencies. Typically initiated through a call for assistance, such as dialing 911, EMS responds promptly to instances of severe illness or injury, prioritizing the provision of emergency medical attention to patients. Prehospital EMS is readily identifiable when emergency vehicles like ambulances or helicopters are observed responding to emergencies or transporting patients to and from medical facilities. Highly trained and licensed EMS personnel, including Emergency Medical Technicians (EMTs) and Paramedics, specialize in providing prehospital emergency medical care. In addition to their roles in emergency response, EMTs and Paramedics may also work in diverse settings such as private industry, clinics, hospital emergency departments, community health centers, or other medical facilities. Licensing requirements for EMS personnel vary by state, with each state holding the legal authority and obligation to regulate EMS operations within its jurisdiction and

define the scope of practice for state-licensed EMS professionals. Many active-duty military personnel, equipped with specialized training in emergency medical fields, pursue national EMS certification through the National Registry of EMTs (NREMTs). This national certification can streamline the process of obtaining individual state EMS licensure for uniformed military personnel transitioning into civilian EMS roles.