To whom it may concern,

I am writing in strong support of measure 2506. We need statewide systems that set standards and expectations for health care systems in the treatment of patients with substance use disorders (SUDs), and this bill helps ensure that. This bill is also part of a care standard that can work toward assuring increased identification of SUDs, increase access to and initiation of treatment, leverage of community partnerships to streamline care, and to ensure smooth transitions of care. Increasing health care competence in delivering care, supporting systems that enable this care, and working with community partners to deliver the full spectrum of care, are all essential elements in combating the opioid epidemic.

I began working as a hospitalist physician (Internal medicine boarded) over 2 decades ago, the last 18 years of which have been in Oregon. As the opioid epidemic worsened, so did my realization that I was not educated in, and able to adequately treat, the increasing number of patients I was seeing in the hospital who had untreated SUDs. Subsequently, around 2017, I began self educating in the treatment of SUDs, and ultimately became a board certified addiction medicine specialist, now working in both hospital and addiction medicine capacities. During these past 8 years of focusing on the treatment of patients with SUDs I have seen how lack of access to care and transitions of care remain barriers to effective treatment for patients with SUDs.

One example comes to mind of a 27 year old man with a 10 + year history of opioid (heroin and fentanyl) use disorder (OUD) who had been hospitalized many times with drug related medical complications, including 2 overdoses requiring life saving ICU care, as well as various blood infections leading to prolonged hospital stays. I met him after he was admitted yet again for a bloodborne infection related to his OUD, offered him medication (buprenorphine), and started medical treatment for his use disorder while he was hospitalized. We set up care for him post discharge, using our community partners. He told me I was the first doctor after all these times of being hospitalized to offer him MOUD (medications for OUD), and that I was the first doctor who actually seemed to know how to adequately treat his disease. I point this out not to toot my horn but to demonstrate the treatment gap that still exists for patients with SUDs despite highly effective treatments. He discharged to a community partner on the Oregon Coast near where he lived. He remains drug free and on life saving MOUD to this day. While I celebrate this victory, I am also aware that 99% of patients entering Oregon hospitals are still not cared for by physicians and care teams competent in the treatment of OUD, and thus too many patients will not receive such life saving care.

The seeds of my addiction medicine education began at OHSU based Project IMPACT ECHO educational sessions. This is where myself and many other physicians (ED, hospital, primary care) are offered training and technical assistance in weekly online classes hosted by local experts from various levels of the addiction medicine care continuum,, all contributing their experience and knowledge. There is also critical interactive dialogue in these groups, where ideas and experiences are shared. In addition to receiving excellent medical training for addiction medicine care, these ECHO's, through collaboration with other members, enabled me

to build essential community partnerships. These colleagues turned out to be instrumental in assisting me in my efforts to become board certified in addiction medicine. More importantly, the relationships I made there, and have built on since, have been critical in forging the necessary community partnerships required of addiction medicine care. At this point, I run a hospital based addiction medicine service at SHS (Samaritan Health Services 5 hospital system). Due to these partnerships, I am able to leverage community resources to ensure comprehensive treatment of patients with SUDs across the care continuum. While there are ongoing efforts and gains in Oregon with increasing access to addiction medicine care, there still exists a huge treatment gap. Resources like Project ECHO have been instrumental for hundreds of providers like me who have attended them, to start providing addiction med care, and build on local partnerships to provide the complete spectrum of care.

Lastly, the bill supports ADPC and OHA to work toward development of funding models to increase access of MOUD care for patients with OUD seen in the emergency department (ED) and even in EMS. Patients with opioid overdoses have the same 12 month mortality as someone with a STEMI (heart attack) yet those overdoses often leave the ambulance or ED with nothing or a narcan at best. Surely this bill is one step in working towards ensuring all patients with OUDs get the immediate care they deserve.

Issues like these discussed above, make the need for statewide standards of care for treatment of patients with SUDs essential. This bill will standardize the expectation for providers across the state for level of care, encourage health systems to put resources toward meeting these expectations, and help ensure that all people with SUDs seen in health care will be offered the comprehensive life saving treatment for their disease.

Thank you for your consideration,

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