Oregon Public Health Institute and Bridge Center Testimony in Support of HB 2506

1. Introduction

Co-Chair Prozanski, Co-Chair Kropf, and Members of the Committee,

The Oregon Public Health Institute and the Bridge Center jointly provide this testimony in support of HB 2506, with some suggested adjustments to the bill.

Who we are:

Emily Henke, MPH: I am the Executive Director of the Oregon Public Health Institute (OPHI, www.ophi.org). **Founded in 1999, OPHI is a nonprofit organization dedicated to advancing health equity and improving public health outcomes across Oregon.** We work with healthcare providers, community-based organizations, government agencies, policymakers, and other partners to strengthen public health infrastructure, expand access to care, and create an Oregon where everyone has a chance to live a healthy and fulfilling life.

Arianna Campbell, DMSc, MPH, PA-C: I am a co-founder, Senior Director and a Principle Investigator at the Bridge Center at the Public Health Institute (www.bridgetotreatment.org). Founded in 2018 by a team of experienced emergency clinicians, Bridge is a national program that has led the largest and fastest expansion of ED-based medication of addiction treatment in the country. Through our ED- and EMS-provider led program, we are currently implementing our nationally-renowned model in 18 states and more than 300 hospitals.

We have partnered together to support Oregon's efforts to transform EMS- and hospital-initiated MOUD. We are jointly writing to express our general support for HB 2506, with recommendations for adjustments to language and scope.

Both the **scientific literature and our direct experience in a current OPHI-led pilot program** tell us that expanding **medications for opioid use disorder** (MOUD) access in emergency settings is one of the **most effective strategies** to reduce opioid-related deaths. HB 2506 offers a crucial opportunity to **apply both research-backed solutions and real-world lessons** to ensure a statewide approach that works for Oregonians.

As such, OPHI and Bridge are submitting this testimony in support of HB 2506. However, we propose adjustments to the bill's language that we believe will increase the efficiency and impact of this work at the statewide level. HB 2506 acknowledges that patient encounters in emergency settings are critical opportunities to address the opioid crisis and health equity. **We want to underscore that leadership of emergency department (ED) and Emergency Medical Services (EMS) providers is essential for this to have the impact we need. Efforts that target EDs and EMS should be led by ED and EMS champions who work daily in the very specific context of emergency medicine.** This is backed up by the Bridge Center's experience in 17 states and is essential if we hope to create a shared, statewide vision of ED- and EMS-based MOUD and make meaningful change that saves lives.

With refinements, HB 2506 provides a pathway for an Oregon where anyone can walk into an ED or call EMS and expect to receive high-quality, evidence-based, dignified MOUD care. The implementation of this bill cannot happen without simultaneous movement building, shared vision, and the leadership of the people who do this work every day. **This calls for mobilizing the existing healthcare system to respond to the opioid crisis**: **with a focus on EDs, EMS, and first responders, we can activate local leaders who can transform addiction care and reduce overdose deaths**.

2. The Research Case for MOUD in Emergency Settings

Extensive research supports the **integration of MOUD in emergency settings** as a key intervention to reduce overdose deaths, improve long-term treatment engagement, and lower healthcare costs.

Key Findings:

- **Emergency care is the only form of healthcare guaranteed to all individuals, regardless of ability to pay**—making it a crucial access point for evidence-based addiction treatment (Englander & Davis, 2022).
- **Nationally, 28% of adult ED patients screen positive for SUD** (Elder et al., 2020).
- **MOUD is proven to reduce overdoses, opioid-related hospitalizations, and mortality** (Wakeman et al., 2020; Santo et al., 2021).
- **When paired with navigation in emergency departments (EDs), MOUD doubles the likelihood that patients will remain in treatment** (D'Onofrio et al., 2015).
- **Expanding MOUD in emergency settings improves health system efficiency**—ED-based buprenorphine induction **saves nearly $18,000 per patient** compared to standard care (Orme et al., 2022).
- **Despite its effectiveness, MOUD remains inconsistently available in EDs and EMS across the country**, weakening overdose response strategies and disproportionately impacting vulnerable populations (Crane, 2013; Rockett et al., 2006; Cherpitel & Ye, 2008).
- **Efforts to expand MOUD access have often excluded hospital settings**, leaving critical gaps in emergency response (Stopka et al., 2024).

Together, these studies make one thing clear—expanding access to MOUD in emergency settings saves lives. HB 2506 is a crucial step in ensuring that every Oregonian experiencing an opioid crisis has access to proven, life-saving treatment at the moment they need it most.

3. The Oregon Bridge Pilot: A Real-World Model for MOUD Expansion

While research provides the foundation, OPHI and the Bridge Center are putting this knowledge into **action in Oregon today**. With funding from the Oregon Health Authority, our **Oregon Bridge pilot program** is demonstrating how **EMS and ED-based MOUD access can be successfully implemented**, reinforcing the urgency of **scaling these efforts statewide through HB 2506**.

So far, results from just the first 6 weeks of our Oregon Bridge pilot project include:

- **25 EMS leaders from six agencies across three counties trained to provide pre-hospital buprenorphine** and better integrate patient navigation with local EDs.
- **EMS agencies [report immediate changes] in practice**, including **increased identification of opioid withdrawal, patient education, and advocacy for MOUD treatment upon ED arrival**.
- **Increased EMS-ED collaboration**—Pilot participants in Marion and Multnomah Counties are now working to ensure patients receive **continuous care after transport**, reducing treatment drop-offs.

4. Our Recommendations and Proposed Changes to HB 2506

A. **Invest in the ED- and EMS-led movement to support a shared vision and statewide impact:** The early success of our pilot indicates that MOUD can be successfully integrated into emergency settings in Oregon. However, scaling this work statewide requires best practices, dedicated coordination of implementation efforts, and technical support for EMS providers, ED clinicians, healthcare systems, navigators and community-based treatment providers. **The formation of a community of practice housed in a neutral, non-governmental, statewide nonprofit organization will provide the critical staffing and administrative (**and more) **support for coordination**. This forum would allow these health champions to move beyond their own individual organizational policies and contribute to a broader statewide movement. The Bridge Center's successful implementation of the California Bridge program is evidence of what it takes to build a movement: more than 2,000 medical providers, navigators, and hospital staff in California are trained and onboarded to a shared approach for universal access to addiction treatment.

B. **Avoid legislating the practice of medicine.** We support the creation of standards but recommend a revision to the language used in Section 1.2 of the bill. Instead of using "standards of care," we propose language along the lines of "guidelines for care." This is a rapidly-evolving area of practice, and (as in other areas of medicine) standards of care are not static. The bill's current "standards of care" language makes providers unnecessarily vulnerable to legal action in the event that recognized best practices outpace the ADPC's ability to update its "standards of care." **"Proposed guidelines for care" (or similar language) provides a more adaptable framework and removes the potential for conflict when clinicians need to decide between doing what is best for the patient in front of them and meeting a standard of care that may not be advisable or even feasible given their local or operational realities**. **We need to avoid legislating the practice of medicine in order to allow the practice of medicine to evolve with new scientific research.**

5. Call to Action

The research is clear—MOUD access in emergency settings **saves lives, reduces costs, and improves long-term health outcomes**. Early learnings from our MOUD pilot support this.

However, **pilot programs alone are not enough**. Without dedicated **policy, funding mechanisms, and statewide coordination to support the sustainability of MOUD access** these efforts will remain fragmented. We respectfully urge the committee to **support HB 2506 with key changes** to ensure that every Oregonian in need of treatment can access it **without unnecessary delays or barriers**.

OPHI is **ready to collaborate with policymakers, EMS, healthcare agencies, and community partners** to ensure successful statewide implementation.

6. Conclusion & Contact Information

Thank you for your time and attention to this critical issue. Please feel free to reach out with any questions or for further discussion.

Sincerely,
Emily Henke
Executive Director
Oregon Public Health Institute
emily@ophi.org

Arianna Campbell, DMSc, MPH, PA-C
Senior Director, M-PI,
The BRIDGE Center at PHI
Arianna@bridgetotreatment.org

References

Cherpitel, C. J., & Ye, Y. (2008). Drug use and problem drinking associated with primary care and emergency room utilization in the US general population: Data from the 2005 national alcohol survey. *Drug and Alcohol Dependence, 97*(3), 226–230. https://doi.org/10.1016/j.drugalcdep.2008.03.033

Crane, E. H. (2013). Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. *The CBHSQ Report,* Substance Abuse and Mental Health Services Administration (US). http://www.ncbi.nlm.nih.gov/books/NBK384680/

D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA, 313*(16), 1636–1644. https://doi.org/10.1001/jama.2015.3474

Elder, J. W., Wu, E. F., Chenoweth, J. A., Holmes, J. F., Parikh, A. K., Moulin, A. K., Trevino, T. G., & Richards, J. R. (2020). Emergency Department Screening for Unhealthy Alcohol and

Drug Use with a Brief Tablet-Based Questionnaire. Emergency Medicine International, 2020, 1–7. https://doi.org/10.1155/2020/8275386

Englander, H., & Davis, C. S. (2022). Hospital standards of care for people with substance use disorder. *New England Journal of Medicine, NEJMp2204687.* https://doi.org/10.1056/NEJMp2204687

Stopka, T. J., et al. (2024). Barriers to integrating medications for opioid use disorder in hospital settings. [Pending Publication]

Orme, S. R., et al. (2022). Economic evaluation of emergency department-initiated buprenorphine with peer navigation for opioid use disorder: A cost-benefit analysis. *Health Economics Review.*

Wakeman, S. E., et al. (2020). Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Network Open.*

Santo, T., et al. (2021). Association of opioid agonist treatment with all-cause mortality in opioid dependence: A systematic review and meta-analysis. *JAMA Psychiatry.*