ACP Oregon Chapter State Advocacy Day – February 10th, 2022

ACP - What's it all about?

Background

The American College of Physicians (ACP) is a national organization of internists - specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internists are major practitioners of primary care in the United States. They are especially well-trained in the diagnosis of puzzling medical problems, in the ongoing care of complicated illnesses, and in caring for patients with more than one disease. Internists not only treat disease but also coordinate health care and play a critical role in preventing disease and promoting health and well-being.

Internists and Subspecialists

An M.D. or D.O. who completes a three-year internal medicine residency program is an internist. The general internist is an expert in the general care of the adult but also may have special areas of expertise like hospital medicine. A subspecialty internist is an internist with one to three years of additional training in a particular organ (nephrology/kidney), system (endocrinology/glands), or age group (geriatrics). Some internists practice a combination of both general and subspecialty medicine.

Mission and History

The ACP's mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine. ACP was founded in 1915 to promote the science and practice of medicine. In 1998, ACP merged with the American Society of Internal Medicine (ASIM) which was established in 1956 to study economic aspects of medicine.

Membership

With 161,000 members, ACP is the largest medical specialty society in the world. ACP provides education and advocacy for its members in their practice of internal medicine and related subspecialties such as cardiology and gastroenterology. ACP members lead the profession in education, standard-setting, and sharing of knowledge to advance the science and practice of internal medicine.

Levels of ACP membership are Medical Student, Resident/Fellow-in-Training, Member, Fellow (FACP), Honorary Fellow, and Master (MACP). Fellowship and mastership recognize achievements in internal medicine. Masters are selected for outstanding contributions to medicine.

ACP Oregon Chapter

The Oregon Chapter of ACP – currently led by Chapter Governor Jenny Silberger, MD, FACP, a practicing Internist in Portland, OR – represents over 1800 student, resident/fellow-in-training, and clinician members across the state. Having been the recipients of the National ACP Chapter Excellence Award every year since 1997, our Chapter has a long track record of excellence in member engagement and education. In keeping with our goal to improve the quality and effectiveness of health care, we are visiting Salem to meet with policy makers to share our perspectives on issues that we believe warrant attention.

Our Health & Public Policy (HPP) committee, composed of dedicated trainees and practicing internists, seeks to promote the health and wellness of Oregonians by advocating for key policy issues in the state. For the upcoming legislative sessions, a survey of our state-wide membership identified the following issues as key priority issues for our members. Thus, we thank the members of the Oregon Legislature and their staff for their time and consideration on the following issues.

Summary of Key Issues

1. Universal Health Care and a Publicly-Funded Coverage Option
2. Addressing Houselessness
3. Carbon Emissions, Climate Change, and Public Health
4. Treatment for Substance Use Disorder

ACP Oregon Chapter State Advocacy Day – February 10th, 2022

Addressing Houselessness

ACP recognizes that houselessness is a public health crisis and that the provision of housing is a key solution.

What's it all about?

An intersectional issue

Houselessness has been increasing in the United States for the last four consecutive years and Oregon is no exception to the trend. Our state has the fourth highest rate of per capita houselessness and the rate of chronic houselessness has increased at twice the national rate.[1] Furthermore, data from the Department of Housing and Urban Development (HUD) demonstrates that vulnerable populations such as veterans, historically marginalized groups, and the chronically houseless are disproportionately impacted.[2] For instance, racial and ethnic minority groups are at an increased risk of becoming houseless at both the national and the local level. African American Oregonians are twice as likely, and Indigenous people are five times as likely to experience houselessness.[3] Nationally, Black and Latinx groups are overrepresented in poverty rates relative to their representation in the overall population,[4] and extreme poverty is the strongest predictor of houselessness for families.[5] Taken together, these statistics show that houselessness culminates at the intersection of race and poverty.

The implications

Multnomah County has been tracking morbidity and mortality data for the houselessness population for more than a decade and the results are striking. In 2020 alone, 126 houseless people died in Multnomah County. None of these deaths were related to COVID-19 and 90% of them were associated with substance use. The average age of those that died while experiencing houselessness was 46 years old as compared with 76 years of age for the general population.[6] Houselessness increases the risk of acquiring communicable diseases, injuries from improper wound care, malnutrition, and complications from chronic conditions such as diabetes, asthma, and hypertension as life on the streets makes medication adherence challenging, if not impossible.

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[1] https://www.tprojects.org/our-impact/about-homelessness

[2] https://www.hud.gov/press/press_releases_media_advisories/hud_no_21_041

[3] https://www.pdx.edu/homelessness/mythbusters

[4] https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/inequality/#_ftn1

[5] https://www.apa.org/pi/families/poverty

[6] https://www.multco.us/multnomah-county/news/multnomah-county-street-roots-release-2020-domicile-unknown-report-homeless

Additionally, houselessness increases the risk of depression, alcohol and substance use disorders.[7] These statistics demonstrate the fundamental link between access to stable housing and physical and mental health.

Another important implication of houselessness is its impact on healthcare costs. Poor health is both an antecedent and consequence of houselessness. Individuals experiencing houselessness are high cost users of health care services. In a 2019 survey of 646 unsheltered houseless people living in Portland, over 40% stated that they visited the hospital at least three times in the last three months. This same group had a total of $1 million in unpaid medical bills.[8] Nationally, the result of inpatient medical stays for homeless individuals is estimated to be between $863,889,793 and $165,004,417, while costs from Emergency Department utilization is estimated to be between $337,589,529 and $64,480,173.[9] In this way, the healthcare system functions as a final safety net system for the houseless population at great cost to society. Solving houselessness thus has the potential to improve the health of affected individuals which will reduce the need for tertiary care and allow for a reinvestment of the savings to the healthcare system back into communities, social services, education, and other opportunities to address social determinants of health.

The Solution - Housing

While there are many factors that influence health, stable housing is a key "social determinant of health" that directly impacts health outcomes.[7] Evidence shows that models like Housing First cost $23,000 less than shelters, increase housing retention, and reduce emergency department usage without preconditions like sobriety.[10]

What's the current status?

Oregon received federal funding from the COVID-19 relief act of 2021 and has plans to build "Streets to Stability: Safe Rest Villages" in six different locations. Portland City Council also approved a measure, which will take effect in 2022, that expands where shelters can be built in the city. However, both initiatives have met significant resistance and the latter is well behind schedule. In addition, starting on January 1st Senate Bill 850 will require death reports to identify if an individual was houseless. Prior to this, Multnomah County was the only county in Oregon engaging in this practice (as of 2011).[11] This will be extremely useful for advocates and policymakers in making informed decisions.

Oregon also has a wide range of more traditional services to support the houseless. These include shelters, residential treatment centers, and subsidized housing though there are many barriers to accessing these resources including long wait times and restrictive rules.

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7 https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf

8 https://www.oregonlive.com/health/2009/03/portlands_posthospital_care_fo.html

9 https://www.pdx.edu/homelessness/sites/g/files/znldhr1791/files/2021-06/Report.pdf

10 http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf

11 https://www.opb.org/article/2022/01/03/oregon-begins-tracking-homeless-deaths-with-new-law-2021/

Some creative solutions are villages, such as the Women's Village in Kenton or the AfroVillage. The cost of eviction for Oregon could be between $720 million - $4.7 billion with racial minorities at the highest risk for evictions. In an effort to curb the risk of rising houselessness in Oregon, the state Legislature approved more than $400 million for rental assistance and eviction prevention in January of 2022.[12]

As discussed above, houselessness is a key driver of much of the substance use in our society. Previous legislative efforts to direct the Oregon Health Authority to develop housing have done so with the requirement they be drug and alcohol "free" (ORS 430.335). Given the intersectionality of houselessness and substance use disorders (SUD), addressing either alone may limit success compared to addressing them together. In 2021, SB69 was introduced but was in committee upon adjournment. This would have appropriated funding to the Oregon Health Authority to expand the range of housing for individuals with substance use disorders.[13] This is notable as the legislative language SB69 sought to amend ORS 430.335 and allow OHA to develop housing that could support people who were still actively using substances but undergoing SUD treatment.

Ultimately, houselessness continues to grow in our state being driven by a complex multitude of issues. Evidence-based approaches or novel pilots to address the negative impacts of houselessness in Oregon are needed to preserve the health & economic vitality of our state.

What is ACP asking of our legislators?

The Oregon ACP asks that legislators support policy efforts to solve houselessness that are rooted in evidence-based solutions. And we support the following bill:

HB4123	**Sponsors** -Chief: Rep Kropf, Rep Williams, Sen Patterson, Rep Evans, Rep Gomberg, Rep Hoy, Rep Smith G, Rep Zika, Sen Anderson, Sen Gelser Blouin, Sen Hansell, Sen Knopp, Sen Thomsen -Regular: Rep Grayber, Rep Levy, Rep Marsh **Committees** -Ways & Means (Joint) -Housing (House)	-Requires Oregon Department of Administrative Services to provide grants for certain coordinated homeless response systems. Appropriates moneys for specified response system grants. -Requires response systems to report annually to Housing and Community Services Department, Oregon Housing Stability Council and interim committee of Legislative Assembly. -Sunsets January 2, 2025.

[12] https://www.oregon.gov/ohcs/about-us/Documents/press/12-13-2021-Special-Session-PR.pdf
[13] https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB69

ACP Oregon Chapter State Advocacy Day – February 10th, 2022

Carbon Emissions, Climate Change, and Public Health

ACP recognizes that climate change is a critical public health issue and asks legislators to support common sense measures to curtail carbon emissions and mitigate the harmful effects of climate change on health.

What's it all about?

Climate change is a rapidly escalating public health crisis. While all Oregonians are imperiled by its health impacts, our most marginalized communities will be disproportionately harmed.[1] The record-breaking wildfires of 2020 and heatwave of 2021 were a testament to our unequal vulnerability. People who were financially obligated to work outdoors, incarcerated in close proximity to the wildfires, or living outdoors were exposed to toxic air and extreme temperatures without refuge. These groups are largely composed of economically and socially disenfranchised people who are disproportionately people of color. As climate change intensifies, these same groups are most likely to suffer severe health impacts.[2] If the State of Oregon hopes to protect these vulnerable populations and prioritize climate justice, it must lead the transition toward a sustainable economy by urgently transitioning away from the combustion of fossil fuels. This will require a multifaceted approach, requiring legislative leadership.

What's the current status?

Efforts by the Oregon legislature to mitigate greenhouse gas emissions have produced mixed results - some approaches have failed to achieve broad support.

In 2019, HB 2020 (Clean Energy Jobs Initiative) was introduced. The bill aimed to lower emissions to 80% below 1990 levels by 2025 and use revenues to adapt to the impacts of climate change and transition to a lower carbon future. Most opponents of the bill were people from rural areas who felt the bill would disproportionately affect their livelihood given that industries that emit greenhouse gasses tend to be concentrated in rural areas. Ultimately, HB2020 passed in the House but remained in the Senate committee at adjournment and was not brought back during subsequent sessions.

Other approaches such as proposals for a "cap and trade regulatory programs" have also been politically controversial. Under a cap and trade regulatory program, greenhouse gas emitting industries are given a permit for the amount of such gasses that they can release into the atmosphere.

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[1] York EA, Braun MJF, Goldfarb GG, Sifuentes JE. Climate and health in Oregon: 2020 report. Oregon Health Authority. December 2020: Portland, OR. https://www.oregon.gov/oha/PH/HEALTHYENVIRONMENTS/CLIMATECHANGE/Pages/profile-report.aspx

[2] Davies IP, Haugo RD, Robertson JC et al. The unequal vulnerability of communities of color to wildfire. PLoS One. 2018;13(11):e0205825.

If they exceed this amount, they can purchase extra permits from industries that have not met their regulatory limit for emissions. Otherwise, they face substantial fines.[3,4,5] The amount of permits would decline over time, therefore making it more costly for industries to continue to emit greenhouse gasses. Cap and trade programs therefore create a financial incentive for industries to reduce their greenhouse gas emissions. In the 2020 legislative session, a revised Senate bill (SB 1530) shifted the focus to *"Cap and Invest"*.[4] This new proposal addressed some of the concerns related to HB 2020 but had not received a vote at adjournment.

Gov Kate Brown took some initial action in March 2020 through Executive Order 20-04 which took steps to establish goals for greenhouse gas emission reduction.

In 2021 HB 2479 was introduced which proposes a modified definition of global warming which would broaden the definition to include aerosol air contaminants like black carbon (or "soot", the result of combustion engines burning coal, diesel and fossil fuels, and burning of biomass like wood and debris[5]) which contribute to global warming. This bill would also require The Department of Environmental Quality to estimate, track and report emissions of black carbon. HB2479 remained in committee on adjournment.

Progress toward the development of renewable energy in Oregon was made in September 2021 when HB 3375 was passed leading to the establishment of a task force with a "goal of planning for the development of up to three gigawatts of floating offshore wind energy project within federal waters off Oregon Coast by 2030" according to the bill summary.

Also in the 2021 session, HB 2488 was introduced which aimed to make changes to statewide land use planning goals by the end of 2026 to, "…address climate justice by addressing climate change adaptation and mitigation and environmental justice for disadvantaged communities." This legislation calls for creating targets and processes for reducing and sequestering greenhouse gas emissions and mapping the potential impacts of climate change on resources in local Oregon communities. This includes quantifying "the cumulative health risks to disadvantaged communities caused by land uses," including health risks due to pollution exposure, climate-related hazards and decreased access to public facilities and resources such as housing, food, water and healthcare. Notably, HB 2488 calls for evaluating all proposed changes through an environmental justice lens, specifically by focusing on impacts to "disadvantaged communities," defined as persons with low income or persons of color and requiring the inclusion of these communities in land use and resources decision-making. Under HB 2488, an Environmental Justice advisory committee would be appointed to advise the Department of Land Conservation and Development on changes to statewide land use.

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[3] Wolf J. Oregon's cap-and-trade bill explained. Mail Tribune. Published July 2, 2019. Accessed January 12, 2020.

[4] Jackson A. Oregon Poised (Again) to Cap Carbon Pollution. NRDC.

[5] https://www.nrdc.org/experts/alex-jackson/oregon-poised-again-cap-carbon-pollution. Accessed January 12, 2020

Why and how should the legislature address this issue?

Climate change has major consequences for the health of all Oregonians. Warming temperatures and the subsequent environmental impacts will negatively affect all organ systems.[6,7] Some of these effects include:

**Cardiovascular (Heart health):* Extreme heat events and drought are associated with cardiovascular disease. In addition, particulate matter released from fossil fuel combustion is also associated with cardiovascular disease and death.
**Infectious Disease:* A warming climate and change in rainfall patterns will lead to the spread of many vector-borne and waterborne diseases, including malaria, dengue, West Nile virus, Lyme disease, cholera, and cryptosporidium.
**Pulmonary (Lung Health):* Extreme heat, increased ozone, and wildfires can all exacerbate respiratory disease. In addition, a warmer climate can lead to an increase in pollen production and a longer pollen season, which may further exacerbate allergies and lung disease.
**Nephrology (Kidney Health):* Increased temperatures are linked with renal failure and kidney stones.
**Gastroenterology (Digestive health):* Warmer temperatures will increase the risk of infectious gastroenteritis illness as vector-borne and waterborne disease expand their geographic distribution.
**Geriatrics:* Elderly individuals are much more susceptible to extreme heat events and other major weather events.

[6] Salas RN, Solomon CG. The Climate Crisis - Health and Care Delivery. N Engl J Med. 2019;381(8):e13.

[7] https://www.acponline.org/acp_policy/testimony/acp_statement_to_house_resources_committee_climate_change_2019.pdf

What is ACP asking of our legislators?

ACP asks legislators to support legislative measures that seek to curtail greenhouse gas contributions to climate change, and efforts to mitigate the negative health impacts climate change imposes on Oregonians. We support the following bills:

HB4058	**Sponsors:** (at the request of House Interim Committee on Environment and Natural Resources for Representative Pam Marsh) **Committees:** -Ways & Means (Joint) -Housing & Development (Senate)	-Directs Oregon Health Authority to create program to acquire and distribute air conditioners and air purifiers on emergency basis to individuals eligible for medical assistance. -Establishes Heat Pump Deployment Program within State Department of Energy to provide grants to entities to provide financial assistance to cover purchase and installation of heat pumps and related upgrades. -Establishes Heat Pump Deployment Advisory Council & Heat Pump Deployment Fund. -Directs Public Utility Commission to explore measures to address differentiated rates or energy assistance for ratepayers with higher utility bills during periods of extreme temperatures or poor air quality.
SB 1536	**Sponsors:** (at the request of Senate Interim Committee on Housing and Development) **Committees:** -Ways & Means (Joint) -Housing & Development (Senate)	-Limits restrictions on portable cooling devices in residences by landlords, homeowner's associations, condominium associations and local governments. -Requires landlords to make reasonable accommodations to allow certain tenants access to cooling. -Requires new and certain rehabilitated residential dwelling units to provide adequate cooling including to provide adequate electrical service for tenant's reasonable heating and cooling. -Authorizes State Department of Energy to make available for rental housing loans for upgrades to support cooling facilities and rebates for heat pump purchases and installations. -Establishes Residential Energy Upgrade Loan Fund and Residential Heat Pump Rebate Fund (sunset January 2, 2025.) -Requires certain residential landlords to submit to Housing and Community Services Department proposals for implementing cooling strategies by December 31, 2024. -Requires department to report on proposals to interim committee of Legislative Assembly no later than September 15, 2025. -Requires department to provide technical assistance to residential landlords on acquiring cooling technologies and devices. Appropriates moneys to department. -Expands Department of Human Services grant program for clean air shelters to include warming and cooling shelters and facilities.

ACP Oregon Chapter State Advocacy Day – February 10th, 2022

Treatment for Substance Use Disorder

ACP supports legislative efforts that improve access to medications for substance use disorder.

What's it all about?

Substance Use Disorder (SUD)

Drug overdose is a leading cause of unintentional death and injury in the United States,[1] and the substance use crisis continues to be an ongoing source of mortality and morbidity in Oregon.[2-3] In 2019, 35,770 Oregonians who sought medical care from July to December had a documented opioid use disorder (OUD) diagnosis,[11] and during the COVID-19 pandemic, there has been a seventy percent increase in opioid related deaths.[2] Furthermore, polysubstance use is common and requires additional care coordination and clinical expertise.[4] In the pacific northwest, the rates of methamphetamine use are disproportionately higher than other regions of the country.[4-5] Among Oregonians with an OUD diagnosis, 34 percent also had a diagnosis of stimulant use disorder.[11]

Hospitalizations and associated costs due to SUD are also rising across Oregon and the United States.[6-7] Patients with OUD are seven times more likely to be hospitalized than the general population,[8] and patients at risk of overdose and death are often seen in healthcare settings the year prior to their death.[9] Compared to patients hospitalized with similar conditions, hospitalized patients with OUD have higher mortality rates.[2,10]

Medication for Opioid Use Disorder (MOUD)

Medications are available for the treatment of OUD, including methadone, buprenorphine, and naltrexone.[11] While these medications are effective, access remains a barrier to treatment. In order to prescribe buprenorphine, a provider must obtain a DEA-approved X waiver. In Oregon, there were only 1,360 certified practitioners in 2019 who were able to prescribe buprenorphine, and the majority of waivered practitioners were located in urban areas.[11] Likewise, methadone must be dispensed from an opioid treatment program, which further restricts access to this evidence-based medication.

While efforts have been made to increase access to MOUD in outpatient offices and inpatient treatment facilities, hospitalization provides a key opportunity to start medication for OUD to prevent further morbidity and mortality. Patients who withdraw from opioids without starting MOUD have a lower tolerance for opioids and a resulting higher risk of overdose upon hospital discharge.[12-14] Hospital-based addictions care can provide evidence-based, comprehensive, peer-supported, trust-building, and trauma-informed care for patients with SUD.[19-21] This model of treatment has been further shown to destigmatize addiction, change hospital culture, and increase providers' understanding of addiction and SUD treatment.[22] In addition, hospital-based addiction care can decrease post-discharge substance use and increase post-discharge engagement in SUD treatment.[19,23]

In the event of an overdose, naloxone is a safe and effective drug used for reversing opioid overdoses [15-16], and this medication will not harm an individual if they do not have opioids in their system.[15] Unfortunately, the presence of illicitly manufactured fentanyl is increasing in drug supply chains[17], and multiple doses of naloxone may be required to reverse an overdose when fentanyl is present.[18] In addition to increasing access and availability of naloxone, other harm reduction measures should be implemented. Increasing access to clean syringes and fentanyl testing strips can help reduce complications associated with SUD and help reduce overdose deaths.

What's the current status?

In 2017, The American College of Physicians released a position paper "*Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs.*" Several main tenants of this paper are:

- the ACP recognizes substance use disorder as a public health problem, the resulting cost of substance use disorder and related complications on the healthcare system, and that an emphasis on prevention and treatment measures is needed[19], and
- the ACP recognize the need to expand access to medication for addiction treatment of opioid use disorders, improve training on the treatment of substance use disorders, address stigma surrounding substance use disorders, continue harm reduction efforts, and support continued research on programs and treatments[19]

Oregonians have been working hard to expand resources for substance use disorder, including access to MOUD, naloxone, and clean syringes. Recently, Oregon has reduced barriers for patient access to naloxone without a prescription[25] and despite this progress, more effort is needed to improve access to MOUD.

What is ACP asking of our legislators?

Oregon ACP asks legislative members to support legislation that works to increase access to medications for the treatment of substance use disorder. We would welcome seeing a future bill similar to 2021 SB 69 be re-introduced. And we support the following bill:

HB 4081	**Sponsors** -Chief: Rep Prusak, Sen Kennemer -Regular: Rep Dexter, Rep Grayber, Rep Hoy, Rep Marsh, Rep Neron, Rep Reynolds, Rep Schouten, Rep Smith Warner, Rep Williams, Sen Golden, Sen Gorsek, Sen Steiner Hayward **Committees** -Health Care (House)	Requires pharmacist who dispenses opioid prescription to offer prescription for naloxone, or similar drug, and information about naloxone under specified circumstances. Creates exceptions to requirement to offer prescription for naloxone or similar drug. Requires health benefit plan to provide payment or reimbursement for naloxone prescription and dispensation by pharmacist. Becomes operative January 1, 2023.

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ACP Oregon Chapter State Advocacy Day – February 10th, 2022

Universal Health Care and a Publicly-Funded Coverage Option

ACP supports legislative efforts that achieve universal coverage with essential benefits and lower administrative costs; is not dependent on residence, employment, health status, or income; and is pursued through a single-payer financing approach, or a publicly-financed coverage option to be offered along with regulated private insurance. For the 2022 legislative session, ACP Oregon supports legislative efforts to establish a state-based health insurance marketplace.

What's it all about?

Universal Health Care: Single-Payer v. Public Option

The United States remains the only wealthy industrialized country yet to achieve universal health care coverage. Instead, our unsustainable health care system is plagued by inefficiencies and is unaffordable and inaccessible to many.[1] As of 2019, there were 248,000 Oregonians without health care coverage.[2] And within this large uninsured population, there are clear disparities. In 2019, only 5.4% of White Oregonians were uninsured compared to 11.6% of the Hispanic or Latino population, 10.6% of American Indian or Alaska Natives, and 8.2% of Black or African Americans.[3] Furthermore, as a result of the COVID-19 pandemic and rising unemployment, many of our neighbors and citizens have lost their income and employer-sponsored health insurance, leaving them uninsured or underinsured. As of January 10th, 2022, there has been a 26.82% increase in Oregon Health Plan coverage since the State of Emergency in March of 2020.[4] And despite this incredible demand for federally-funded health insurance, many Oregonians continue to remain uninsured. In this crisis, we have an opportunity: to reset how Oregon approaches providing fundamental access to not only emergency care but also preventative and chronic health care to ensure the health and livelihood of all Oregonians for generations to come. Oregon has historically been a leader in health system innovation.

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[1] Crowley, R., Daniel, H., Cooney, T. G., Engel, L. S., & for the Health and Public Policy Committee of the American College of Physicians. (2020). Envisioning a better U.S. Health care system for all: Coverage and cost of care. *Annals of Internal Medicine*, *172*(2_Supplement), S7. https://doi.org/10.7326/M19-2415

[2] "Oregon Health Insurance Survey (OHIS), Early Release Results, 2019," Oregon Health Authority (OHA). Available here: https://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2019-OHIS-Early-Release-Results.pdf.

[3] OHIS 2019 Data, by Types of Uninsurance. Available here: https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonUninsuranceRates/Uninsurance?%3Aiid=2&%3AisGuestRedirectFromVizportal=y&%3Aembed=y.

[4] Oregon Health Authority. (2022, January 10). *OHP data and reports*. Oregon Health Plan. Retrieved January 12, 2022, from https://www.oregon.gov/oha/hsd/ohp/pages/reports.aspx

For example, after the state's 2008 Medicaid expansion, studies have shown that gaining health insurance increased access, utilization, and self-reported health.[5] We can once again lead the nation by transitioning Oregon to an evidence-based, universal health care program that promotes health equity and lowers the costs of our healthcare system. While a single-payer system remains the goal for many, implementation of a government-created public option, akin to Medicare for those under age 65,[6] is an incremental and more immediately viable next step to achieve expanded health coverage for Oregon's most in-need populations.[7]

What's the current status?

In 2020, The American College of Physicians released a position paper "Envisioning a Better U.S. Health Care System for All" [1], that supports state and federal initiatives to pursue universal healthcare coverage. Several main tenants of this paper are:

- The United States should transition to a healthcare system that achieves universal coverage with essential benefits and lower administrative costs
- That coverage should not be dependent on a person's place of residence, employment, health status, or income
- That two options could achieve these objectives: a single-payer financing approach, or a public financed coverage option to be offered along with regulated private insurance.

Oregonians have been working toward the goal of universal health care for decades, and the movement toward a single-payer system has been bolstered by data and growing public support in recent years. For instance, in Oregon an economic feasibility study was completed in 2017 which illustrated the financial benefits of a single-payer plan.[8] Nevertheless, a public option is still seen as a more viable next step towards expanding health coverage. In pursuing this route, Oregon would be joining Washington, Nevada, and Colorado as states at the forefront of passing public option legislation.[9] In 2019, the Oregon Legislative Assembly passed SB 770, which established the Task Force on Universal Health Care to work toward providing all Oregonians with high quality and publicly funded health care.[10,11] This task force is focused on

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[5] Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP, Schneider EC, Wright BJ, Zaslavsky AM, Finkelstein AN; Oregon Health Study Group. The Oregon experiment--effects of Medicaid on clinical outcomes. N Engl J Med. 2013 May 2;368(18):1713-22. doi: 10.1056/NEJMsa1212321. PMID: 23635051; PMCID: PMC3701298.

[6] Robertson, L. (2009, December 18). *Public option vs. single payer*. FactCheck.org. Retrieved January 11, 2022, from https://www.factcheck.org/2009/12/public-option-vs-single-payer/

[7] Guarino, M. (2021). (rep.). *A public option for Oregon: Health care policy lessons from other states*. Oregon State Public Interest Research Group.

[8] White, Chapin, Christine Eibner, Jodi L. Liu, Carter C. Price, Nora Leibowitz, Gretchen Morley, Jeanene Smith, Tina Edlund, and Jack Meyer, A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR1662.html.

[9] Guarino, M. (2021). (rep.). *A public option for Oregon: Health care policy lessons from other states*. Oregon State Public Interest Research Group.

[10] *Oregon health authority: Task force on universal health care: Office of health policy: State of Oregon*. (n.d.). Retrieved from https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx

[11] *SB770 2019 regular session—Oregon legislative information system*. (n.d.). Retrieved from https://olis.leg.state.or.us/liz/2019R1/Measures/Overview/SB770

researching models for a public option in Oregon, and they released their first report in December 2020, outlining three models for consideration: a coordinated care organization-led model, a carrier-led model, and a state-led model in partnership with a third-party administrator (TPA).[12] A follow-up report commissioned by the OHA released in December 2021 outlines potential avenues to move the plan forward and recommends pursuing a coordinated care model with proposals for legislatively mandated premium cuts and capping growth targets[13]. Any avenues forward to rein in healthcare costs will certainly include cutting provider reimbursements, however Oregon ACP still has some reservations on certain particular matters related to how the plan will meet cost-saving goals.

ACP believes in strong primary care as a backbone for the US health system. The OHA commissioned[13] report proposes legislative mandates on setting premiums caps, yet expects to offer higher services compared to similarly tiered plans. We believe that providing rich benefits while containing costs can only be achieved by broad cost-containment mechanisms including controlling administrative overhead, the costs of medications, and costs of hospital care. While physicians may share in some payment reduction, significant changes on this front are likely to result in serious access issues in the state, and changes in this arena alone are unlikely to achieve the proposed capped growth targets. Having a requirement for physicians without a matching requirement for participation in the public option by the pharmaceutical industry and the hospitals with a presence in the state would appear to create a mismatch in negotiating power.

Thus, Oregon ACP is worried how such proposals may lead to cutting reimbursements to primary care and lead to unintended consequences in the healthcare workforce and access to care. Nonetheless, Oregon ACP is committed to partnering with legislators & stakeholders to explore how to increase access and reign in healthcare costs in our state, and would encourage further exploration on how a plan to pursue a public-funded health insurance plan can apply to all aspects of healthcare costs in our health delivery system.

Given the short session, it is unlikely widely-accepted solutions to the proposed OHA public options will be found on short order. As an intermediary step, there is a proposed action to set up a State-based Health Insurance Market. This is a requisite infrastructure step needed for ***any*** public option to be viable. Thus, to continue progress as more details on how the public option will look, ACP Oregon supports legislative efforts to establish a state-based health insurance marketplace.

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[12] Brooks-LaSure, C., Ellis, K., Polk, E., & Ario, J. (2020). (rep.). *Oregon Public Option Report: An Evaluation and Comparison of Proposed Delivery Models*. Manatt Health Strategies.

[13] Ario, J., Karl, A., & Zhan, A. (2021). (rep.). *Oregon Health Authority Public Option Implementation Report*. Manatt Health Strategies.

What is ACP asking of our legislators?

Oregon ACP asks legislative members to collaboratively work with stakeholders, including Oregon ACP, to pursue initiation of a publicly-funded health insurance option. Moreover, we ask for support in establishing a state-based health insurance marketplace (HB-4035).

HB 4035	**Sponsors:** (at the request of House Interim Committee on Health Care for Representative Rachel Prusak) **Committees:** -Health Care (House)	-Requires Oregon Health Authority to study and make recommendations for options to improve access to or lower cost of health care in Oregon. -Requires authority to implement recommendations to extent of agency's existing statutory authority and report to interim committees of Legislative Assembly related to health any legislative changes necessary to fully implement recommendations.