

>> Opioids and the Ongoing Drug Overdose Crisis in Oregon

This report summarizes the burden of opioids and other drug overdoses among Oregonians as required by ORS 432.141. It describes progress in reducing fatal and nonfatal overdose events in Oregon. As the situation in Oregon has changed since the house bill was enacted in 2017, other substance-related overdose events, such as stimulants and polysubstance are included in this report.



Acknowledgments

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Executive summary

Substance use disorder and overdoses are widely recognized as health threats of increasing urgency throughout the United States, including Oregon. Opioids and stimulants continue to be the types of substances most associated with fatal and non-fatal overdoses in the state. Opioids include a wide range of substances, such as prescription painkillers, illicitly manufactured fentanyl (IMF) and heroin. Fentanyl is a potent synthetic opioid approved to treat severe pain but is also manufactured and sold illicitly. Common stimulants include methamphetamine and cocaine.

The state has continued its trajectory of notable progress over the last decade in reducing substance use and overdoses related to prescription opioids. However, significant and sustained increases in the supply of IMF and non-opioid drugs such as methamphetamine, which are often used with opioids, are continuing to drive unprecedented increases in fatal and non-fatal overdoses, making Oregon's fentanyl overdose death rate one of the fastest growing in the country from 2019 to 2023.¹ Unfair, unjust and avoidable health inequities resulting from systemic racism continue to cause a disproportionate burden of overdose among the state's Black and Native American communities. Both the availability and potency of fentanyl are important factors in the increase of overdoses in Oregon, as in other states. The Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) program seized more than 62 million dosage units of fentanyl in 2023, up from less than 125,000 fentanyl dosage units seized in 2019.

Mixing IMF with alcohol or other drugs increases the likelihood of an overdose. Continuing a trend that began in 2021, more than half of overdose deaths were classified as polysubstance, where more than one substance (drug or alcohol) was identified as a contributing cause of death in 2022.

Oregon's illicit drug market is continuing to rapidly evolve as the state faces a new threat from fentanyl adulterated with xylazine (FAX), a potent veterinary tranquilizer not approved for human use that can cause serious skin and soft tissue infections and other complications. OHA is tracking FAX-related overdoses and severe skin and soft tissue infections (SSTIs) as a proxy measure, as well as preparing diagnosis and treatment guidance in anticipation of increasing FAX use in the state. As of 2022 there was no substantial increase in SSTI-related hospitalizations or Emergency Department (ED) visits, but trends are challenging to track because people may try to

¹ National Vital Statistics System, Provisional Drug Overdose Death Counts <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

treat wounds on their own or seek help from wound care clinics outside of emergency departments or hospitals. In 2022, the presence of xylazine was noted in toxicology results for 10 people who died from overdoses, up from two in 2020.

The Oregon Health Authority (OHA) draws upon information from multiple sources to collect information on overdoses in Oregon. While some provide near real-time data, other datasets have a three-month to one-year lag between data collection and reporting as the data are processed and analyzed. These delays include time for data cleaning and processing, which improve data quality. This report focuses on data for calendar year 2022; more recent data are included when available.

Key takeaways - Drug overdose deaths in 2022

- The number of people in Oregon dying from unintentional and undetermined overdoses continues to increase at an alarming pace, from 1,083 people in 2021 to 1,289 people in 2022.
- Unintentional overdoses represented a large majority (89%) of all overdose deaths.
- Fentanyl surpassed methamphetamine as the most common substance identified as the cause of death in unintentional and undetermined drug overdoses. Nine out of ten (90%) of unintentional and undetermined drug overdose deaths were attributed to methamphetamine and/or fentanyl.
- Twelve percent of people who died from an unintentional and undetermined drug overdose death had experienced a previous overdose.
- Only 4.5 percent of people who died from an unintentional and undetermined drug overdose were being treated for substance use disorder at the time of their death.
- Those at higher risk for unintentionally dying from a drug overdose continued to include non-Hispanic American Indians and Alaska Natives, non-Hispanic Blacks, and males. As in previous years, those at lower risk were people of Hispanic ethnicity and non-Hispanic Asians and Pacific Islanders. When interpreting demographic data, it is important to remember that communities have been disproportionately affected by systemic racism, social-economic-political injustices, and systemic bias. These inequities can worsen health outcomes and increase the risk of experiencing a drug overdose. Furthermore, there remains more limited access to culturally appropriate resources and services.

Key takeaways - Nonfatal overdoses in 2022

- Nonfatal drug overdoses continue to increase and are underestimated in available data. For example, there were 2,794 opioid overdose ED visits in 2021 compared to 3,480 opioid overdose ED visits in 2022. Many people who experience a drug overdose do not seek health care and the overdose is reversed by bystanders, friends, or family members administering naloxone, a drug that rapidly reverses an opioid overdose. An increasing number of overdoses require multiple doses of naloxone.
- Emergency medical services (EMS) personnel administered naloxone during 6,797 EMS encounters compared to 5,612 in 2021. Naloxone may be administered to an unconscious patient to determine if they are experiencing an opioid overdose.
- Non-Hispanic Black and non-Hispanic American Indian and Alaskan Native people continued to experience the highest rates of drug overdose-related hospitalization and ED visits.
- The number of people hospitalized as inpatients and treated in emergency departments for causes related to an opioid overdose continued to increase in 2022. Drug related overdose hospitalizations added up to \$187 million in total charges, and 48% of those charges listed Medicaid as the primary payer. Total charges for overdose emergency room visits related to drug overdose were \$51 million, and 52% of those charges listed Medicaid as the primary payer.
- 45,197 hospitalizations and 66,208 emergency department visits involved a substance use disorder diagnosis but not an overdose diagnosis. These health care interactions are opportunities to connect patients to treatment, provide naloxone, refer as needed for other services, and provide additional support to reduce their risk for experiencing future overdoses.

The Oregon Health Authority continues to coordinate a broad array of programs and works with organizations across the state to reduce the burden of substance use disorder and overdose-related harms. This work spans a continuum from prevention to harm reduction, treatment, recovery support, and is focused on health equity and trauma informed.

In summary, the overdose crisis in Oregon continues to expand as the counts of fatal and nonfatal overdoses increase year by year. The primary contributors these trends are the increasing supply of fentanyl in the illicit drug market and increasing use of fentanyl, methamphetamine and multiple other substances. Non-Hispanic American Indian and Alaskan Native and non-Hispanic Black populations are disproportionately affected and have higher rates of both fatal and nonfatal overdose events. These populations have been subjected to long-term systemic racism and health inequities and need to be meaningfully engaged when developing strategies to reduce overdose risk.

Introduction

2017 Oregon House Bill 3440 introduced a requirement for OHA to produce an annual report on opioid- and opiate-related overdoses and deaths due to overdose. This report fulfills that requirement. Because patterns of substance use and overdose in Oregon have changed dramatically in the intervening years, this report also provides additional data about the context and causes of the current crisis, some of its human and financial impacts, and the Oregon Health Authority's role in tracking, responding to, and preventing overdoses from opioids and other drugs.

The magnitude of Oregon's overdose crisis has increased significantly in recent years. Fatal drug overdoses are now the leading cause of injury-related death in Oregon and across the country, since surpassing motor vehicle traffic and firearm deaths in 2008.² The number of people experiencing nonfatal drug overdoses receiving treatment in emergency departments (EDs) or via inpatient hospitalizations has increased in the last 5 years, primarily due to increased amounts of fentanyl and other newly arriving illicit substances in the drug supply.³ However, many individuals who experience a nonfatal overdose do not seek medical treatment and these events are not included in the following analyses.

Overdose deaths, substance use, and dependency are all preventable and have a profound effect upon individuals, families, and communities across the state. In 2021, the combined medical costs and value of statistical life, a monetary estimate of life expectancy based on the decedent's age, was estimated at \$11.9 billion for unintentional drug poisoning deaths in Oregon.⁴ While monetary costs can be calculated, social and community impacts of an overdose are much harder to define. In addition to the person experiencing an overdose, family, friends, and the surrounding community are all affected. This report presents the information OHA has available about people experiencing drug overdose but cannot estimate the larger and radiating impacts of overdose.

2 All Injuries Fast Stats <https://www.cdc.gov/nchs/fastats/injury/htm>

3 Centers for Disease Control and Prevention. Drug Overdose Surveillance and Epidemiology (DOSE) System: Nonfatal Overdose Emergency Department and Inpatient Hospitalization Discharge Data. Atlanta, GA: US Department of Health and Human Services, CDC; [2023, June, 14]. Access at: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/dose-dashboard-nonfatal-discharge-data.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/nonfatal/dose/discharge/dashboard/index.html

4 Centers for Disease Control and Prevention. WISQARS Cost of Injury Data. Atlanta, GA: US Department of Health and Human Services, CDC; [2023 December 21]. Access at: <https://wisqars.cdc.gov/cost/>.

Xylazine

Xylazine, also known as “tranq,” is an animal tranquilizer not approved for use in humans. Side effects of xylazine-adulterated drugs include lower than normal blood pressure (hypotension), slower than normal heart rate (bradycardia) and heavy sedation.⁵ Use of xylazine-adulterated drugs in any way (not only by injection) can increase the risk of severe wounds and skin and soft tissue infections (SSTI), especially on the arms and legs, which can worsen quickly and are challenging to heal.

In April 2023, the White House declared fentanyl adulterated with xylazine as an emerging threat to the United States.⁶ Xylazine can cause severe skin and soft tissue infections that can originate in areas associated and not associated with injection drug use. The combined use of fentanyl and xylazine increases the risk of an unintentional drug overdose event. Opioid antagonist medications, such as naloxone, are useful in reversing the effects of a fentanyl overdose, but they do not reduce or reverse the side effects associated with xylazine use. This may result in situations where people experiencing overdoses can remain sedated and be a higher risk for an unintentional fatal overdose even after receiving naloxone.

First seen in Puerto Rico in the early 2000s, xylazine was mixed into a variety of substances and used as a cutting agent. Philadelphia, PA was heavily impacted by the introduction of xylazine adulterated fentanyl in the early 2020s. The Philadelphia Department of Public Health noticed an increase in SSTIs and associated it with the increase of xylazine in the local illicit drug supply.⁷ Across the country, the number of people with an SSTI seen in the hospital or ED has increased as xylazine has adulterated the illicit drug supply.

Oregon medical examiner data identified xylazine as a drug involved in two unintentional and undetermined drug overdose deaths in 2020, nine in 2021 and 10 in 2022. In coordination with public health emergency response systems, OHA has developed new informational materials about fentanyl adulterated with xylazine (FAX) health care and community social service providers. The agency has also adapted its internal overdose response protocol to better reflect the growing complexity of polypharmacy overdoses. OHA is continuing to track FAX status in partnership with the federal Oregon-Idaho High Intensity Drug Trafficking Area program.

5 Johnson J, Pizzicato L, Johnson C, Viner K. Increasing presence of xylazine in heroin and/or fentanyl deaths, Philadelphia, Pennsylvania, 2010–2019. *Injury Prevention*. 2021 Aug 1;27(4):395–8.

6 Biden-Harris Administration Designates Fentanyl Combined with Xylazine as an Emerging Threat to the United States <https://www.whitehouse.gov/ondcp/briefing-room/2023/04/12/biden-harris-administration-designates-fentanyl-combined-with-xylazine-as-an-emerging-threat-to-the-united-states/>

7 Philadelphia Department of Public Health, Health Update – Xylazine (tranq) exposure among people who use substances in Philadelphia. Published December 8th, 2022. https://hip.phila.gov/document/3154/PDPH-HAN_Update_13_Xylazine_12.08.2022.pdf/

Data sources and limitations

Data from a variety of sources add to our understanding of the overdose crisis in Oregon. OHA analyzes data from emergency medical services encounters; ED chief complaint(s), diagnosis and accompanying triage notes; emergency department and hospital inpatient discharges; and death certificates to support enhanced understanding of overdoses throughout the medical care continuum. OHA and some local public health authorities track ED visit chief complaint information via the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) system to identify possible increases in the number of people experiencing overdoses in near-real time, and this information can support timelier responses to the ever-evolving overdose crisis. Other information that takes longer to receive and process, such as data from hospital inpatient and ED discharges, postmortem toxicology reports, and circumstantial information about unintentional overdose deaths, provides more detail about overdoses and can inform statewide and population-specific prevention and response strategies. While the data OHA has available are useful in understanding the overdose crisis across the state, this information does not tell the entire story. Some people do not seek or receive medical care after an overdose, and these incidents are not collected in the available data. Furthermore, qualitative data, such as the stories from people affected by overdoses, are not consistently collected.

Information on fatal overdoses

The Oregon Health Authority (OHA) Center for Health Statistics is the repository for **death certificate** data in Oregon, which includes information on overdose-related deaths, including suicide, homicide, unintentional overdoses, and overdoses of undetermined intent. This data only includes information about people with established residence in Oregon who died in the state. Deaths are identified as overdose-related if the death investigator or certifier has reason to believe drugs were involved (such as drug paraphernalia found near the person who died, or if the person had a history of substance use). This limitation can lead to underestimation of the number of fatal overdoses.

Supported by the U.S. Centers for Disease Control and Prevention (CDC),⁸ the **Oregon State Unintentional Drug Overdose Reporting System (SUDORS)**

⁸ Overdose Data to Action. For more information visit https://www.cdc.gov/overdose-prevention/php/od2a/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/od2a/index.html

collects information on unintentional and undetermined drug overdose deaths from a variety of data sources, including death certificates, medical examiner reports, and toxicology reports. It provides detailed contextual information about overdose deaths that can inform prevention and treatment interventions. SUDORS collects toxicology information to identify specific substances, such as methamphetamine, alcohol, morphine and fentanyl or chemically similar drugs (fentanyl analogs).⁹

Information on nonfatal overdoses

Information on nonfatal overdoses and substance use can be collected by a variety of sources, such as emergency medical services (EMS), emergency department (ED) and hospital inpatient visits. Public health agencies can use nonfatal overdose data to detect potential overdose cluster/spike events, improve understanding of overdose and substance use trends, and focus interventions to support people at high risk.

Some of the earliest information available on emergency department and urgent care clinic visits comes from first impression data. The **Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE)** collects information about visits to non-federal Oregon emergency departments and urgent care centers that currently share their data with the Oregon Health Authority (OHA). Funding from the U.S. Centers for Disease Control and Prevention (CDC)¹⁰ has enabled OHA to access and report ESSENCE data to identify trends in emergency department and urgent care center visits related to opioid overdoses.

ESSENCE data offers an advantage for identifying notable increases in the number of people seen for opioid overdoses as it is reported daily. Although data completeness and quality differ by facility, ESSENCE is a timely and powerful information source for near real-time information, allowing communities to respond quickly to potential clusters of overdoses. A monthly Opioid Overdose Data report, which contains ESSENCE data, is available monthly by [subscription](#).¹¹

The **Oregon Emergency Medical Services Information System (OR-EMSIS)** collects information on the emergency medical services provided, the context of the situation the EMS has responded to and patient information. The encounter information is entered into the OR-EMSIS system shortly after the encounter has finished, usually within 48 hours.

EMS data includes information on administration of the drug **naloxone** to people potentially having an overdose. As naloxone only interacts with opioids, it can be

9 Fentanyl analogs are synthetic opioids that are alterations of the medical drug fentanyl.

10 Overdose Data to Action. For more information visit https://www.cdc.gov/overdose-prevention/php/od2a/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/od2a/index.html

11 Opioid Overdose Data Reports based on information from ESSENCE are updated monthly at <https://www.oregon.gov/oha/ph/preventionwellness/substanceuse/opioids/pages/index.aspx>.

provided to an individual who is unconscious to determine if they are experiencing an opioid overdose. Naloxone has no effect on stimulants or xylazine. Many overdose events are treated by bystanders who administer naloxone, and do not result in a 911 call or EMS response. These events are not included in the available data. Although Oregon's Good Samaritan law protects the caller and the person who has overdosed against drug possession and paraphernalia charges, many people who use drugs avoid calling 911 or accessing health care due to stigma, a previous negative experience in the healthcare system such as long wait times, or fear of arrest. Therefore, OR-EMSIS data underestimate the amount of naloxone used in the community.

Discharge data include hospital and emergency department (ED) visit information. Non-federal hospitals and EDs report data on visits and stays when there is a charge for services (the Portland Veterans Affairs Medical Center is not included in this data). This information includes diagnosis(es), medical care received, primary payers for the charges, disposition at discharge and demographic information (e.g., age, sex, race, and ethnicity). Hospital and ED discharge data do not overlap. If a patient goes to an ED first and then is admitted to the hospital, their information will appear in the hospital discharge data only. Hospital discharge data include information for visits that were at least 24 hours long. This information does not include outpatient and ED visits. While the discharge data is reliable and consistent, especially for injury reporting, it takes four to six months for data to become available after the last day of the quarter. Another limitation is that a substance use diagnosis can be included in the visit's summary, but "substance use" may not be listed as the primary reason for the visit. Including all the available diagnosis information allows for a more accurate count of the patients with substance use. Some patients with a substance use problem may not be counted if substance use diagnoses are not included in the discharge visit summary.

A person may have several visits related to an overdose, but only the first encounter for that overdose is included. For example, if someone returns to the ED for follow-up care associated with an opioid overdose, that visit would not be counted. If the same person had another overdose event in the same year they would be counted again as the overdoses are separate events.

Hospital and emergency department discharge data, ESSENCE and OR-EMSIS data all share an additional limitation: if health care providers do not suspect a drug overdose as the main reason for the visit, then an overdose or substance use diagnosis code is not recorded. While these and other limitations do exist for the available data, the information OHA has available does provide valuable perspectives to our understanding of the polysubstance use and overdose crises.

Demographic data

Race and ethnicity data are collected on the death certificate and organized into several categories based on national standards: Hispanic, non-Hispanic Asian and Pacific Islander, non-Hispanic American Indian and Alaska Native, non-Hispanic Black, non-Hispanic white, and non-Hispanic other.¹² It is important to note that race and ethnicity data were reported as “other” or “unknown” on death certificates for approximately 3% of all fatal unintentional and undetermined overdose deaths. Deaths of people whose race or ethnicity were categorized as other and unknown were not included in the demographic rate calculations noted below.

Due to limitations of current statewide information systems and systemic reporting processes, deaths of transgender, gay, lesbian, bisexual and queer people are more likely to be under-counted. Implementation of 2023 House Bill 3259 (also known as the Data Justice Act) will support enhanced collection of sexual orientation and gender identity data in the future.

It is important to note that race, ethnicity, sex, gender, and other demographic categorizations may not reflect the way individuals and communities identify themselves. Also, while broad categorizations create larger groupings of people and yield data with higher statistical reliability, smaller communities within these categories may show different trends. As part of OHA’s commitment to data justice,¹³ programs are working to make more meaningful information available that is more reflective of diverse communities in Oregon and useful for addressing specific community needs.

¹² Please see the Endnotes section for additional information on how the race and ethnicity categories were defined.

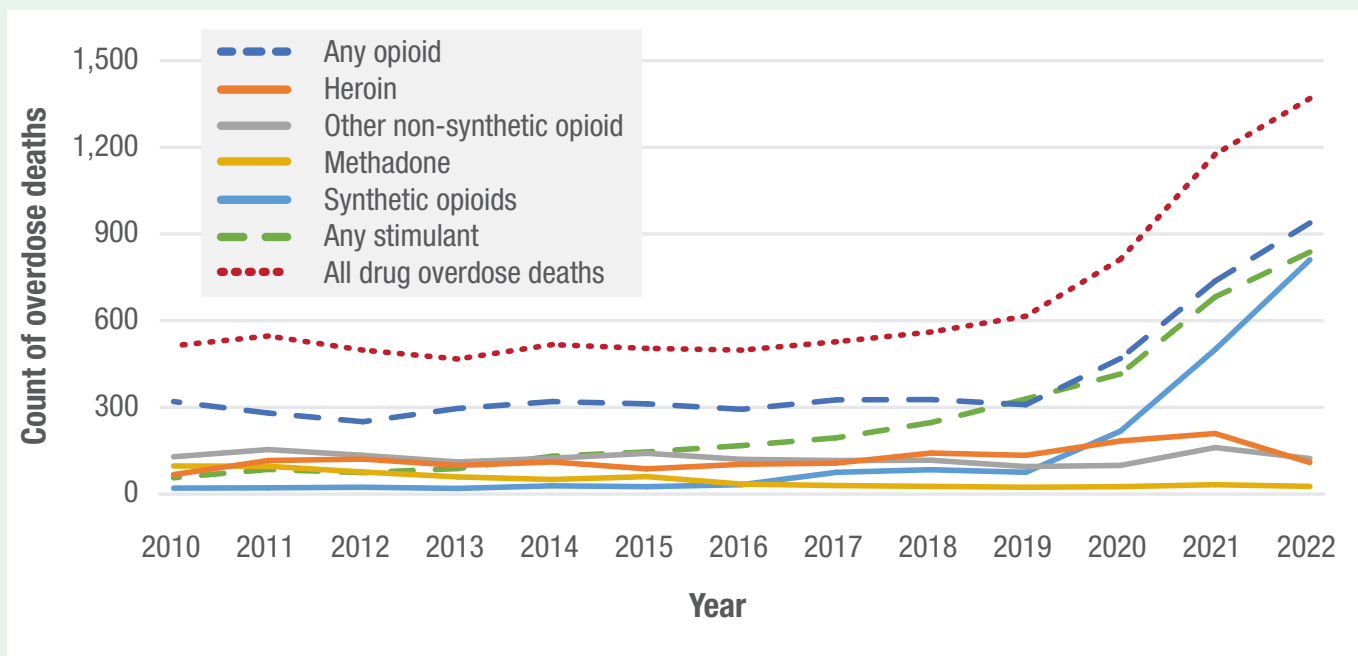
¹³ <https://www.oregon.gov/oha/EI/REALD%20Documents/Data-Justice-Fact-Sheet.pdf>

Overdose deaths

The number of Oregonians who have died from all types of overdoses, regardless of intent, increased more than 172% during the last decade (508 in 2012 to 1,383 in 2022) (Figure 1). This includes an increase of more than 100% between 2019 (626 overdose deaths) and 2022 and an increase of 16% between 2021 (1,189 overdose deaths) and 2022. In 2022, almost nine out of ten of these deaths were unintentional.

Illicitly manufactured varieties of the **synthetic opioid fentanyl** (IMF) have primarily contributed to the increase in overdoses since 2019. IMF is a highly potent opioid, up to 50 times stronger than heroin, and a very small dose of fentanyl can be lethal.¹⁴ Furthermore, as IMF is not standardized, the strength can vary by source and by batch. The number of people who died of an overdose related to synthetic opioids, such as fentanyl, increased 61% from 2021 to 2022. While current toxicology

Figure 1. Oregon drug overdose deaths associated with synthetic opioids continued to rise in 2022



Source: 2010-2022 Oregon Vital Records (Deaths) – Center for Health Statistics – OHA

Note: The opioid category includes deaths classified as heroin, methadone, other non-synthetic opioids (excludes heroin), and synthetic opioids. See endnotes for additional information on overdose death classifications based on the ICD-10 system.

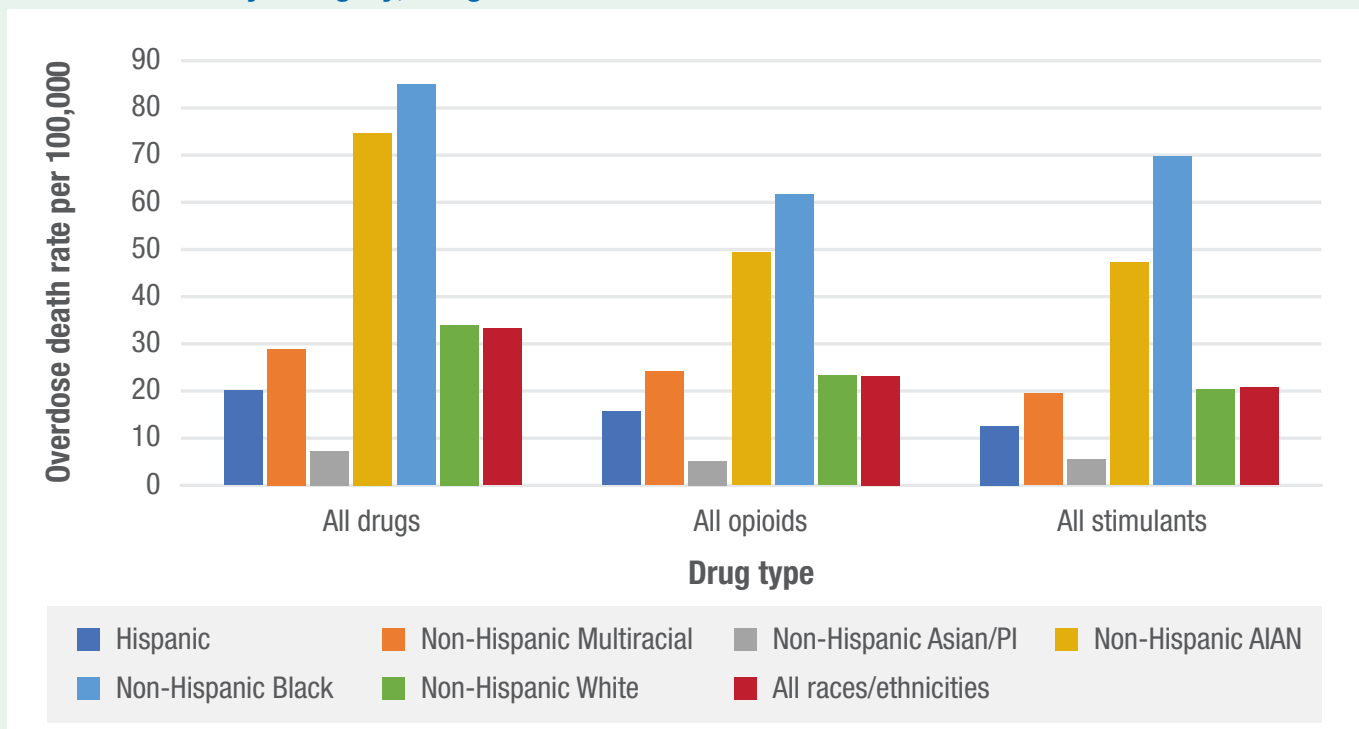
14 Fentanyl Facts. https://www.cdc.gov/stop-overdose/caring/fentanyl-facts.html?CDC_AAref_Val=https://www.cdc.gov/stopoverdose/fentanyl/index.html

information about fentanyl-related overdose deaths cannot identify whether an overdose was caused by prescription or IMF, anecdotal information from law enforcement and people who use drugs indicates that IMF is a contributor in most of these deaths.

Stimulant-related overdose deaths contribute substantially to the overdose epidemic in Oregon. The number of people dying from overdoses involving stimulants has more than tripled (increased 232%) in recent years, from 256 in 2018 to 849 in 2022. Although cocaine-related deaths have increased gradually over time (not shown in Figure 1), the most notable increase within the stimulant drug classification has been associated with amphetamine-related drugs, such as methamphetamine.

Since 2016, people identifying as non-Hispanic Black and non-Hispanic American Indian and Alaskan Native have consistently been at higher risk of death from a drug overdose compared to all other races and ethnicities (Figure 2). While overdoses related to opioids and stimulants showed a similar pattern across most race and ethnicity categories for 2022, stimulant-related overdose deaths stood out as most heavily affecting the non-Hispanic Black community.

Figure 2. All intents of drug overdose death rates differed by drug type and race and ethnicity category, Oregon 2022



Source: 2022 Oregon Vital Records (Deaths) – Center for Health Statistics - OHA

AIAN - American Indian and Alaska Native populations. PI - Pacific Islander.

Note: All rates per 100,000 population. See endnotes for additional information on race and ethnicity classifications.

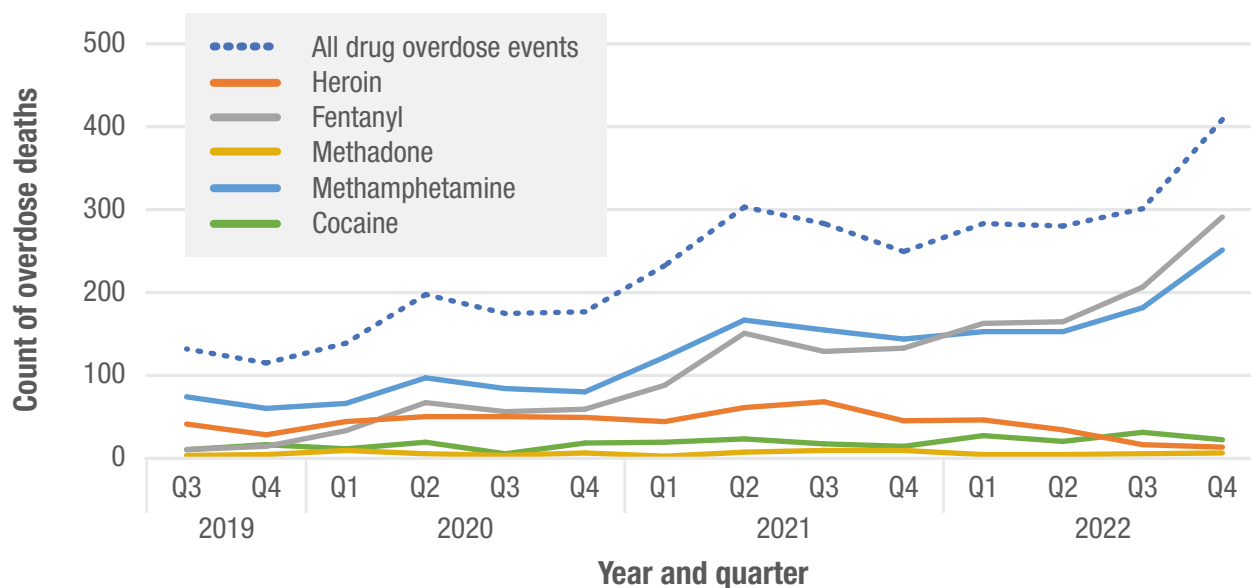
The number of people dying from drug overdose-related suicide increased from 81 in 2020 to 111 in 2022 and involved a wide variety of substances, from over-the-counter medications (e.g., acetaminophen), prescribed medications (e.g., insulin) and illicit substances (e.g., methamphetamine).

SUDORS unintentional and undetermined drug overdose deaths¹⁵

A vast majority (89%) of people who died of a drug overdose in 2022 did so unintentionally. As shown in Figure 3 below:

- The number of people who died from unintentional and undetermined overdoses related to **fentanyl** and **methamphetamine** increased notably in the second quarter (April through June) of 2020 and increased again in early 2021, possibly due to increased adulteration of the illicit drug supply by fentanyl.

Figure 3. Fentanyl surpassed methamphetamine as the most common cause of drug overdose death in 2022



Source: 2019-2022 Oregon SUDORS

Note: When two or more drugs are attributed to a death, the death is included in all the drug categories. Therefore, the sum of all the drug categories will be greater than the total number of fatal overdose events. Drug type definitions may differ between SUDORS and death certificate data due to how the data are structured and should not be directly compared. See endnotes for additional information.

¹⁵ The way drug overdose-related deaths are defined in the death certificate data and the SUDORS data differ, so these counts cannot be compared. The key difference between the two data sources is that the SUDORS data only includes information on drug overdose deaths of unintentional or undetermined intent.

- In the first quarter of 2022 (January through March), fentanyl surpassed methamphetamine as the most common substance identified as a cause of overdose deaths.
- The fourth quarter (October through December) of 2022 reported a new high of 413 people who died from unintentional and undetermined drug overdoses within a 3-month period.

The Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) program has declared fentanyl and methamphetamine as the most serious drug threats in the Oregon-Idaho region.¹⁶

The number of people dying from unintentional and undetermined overdoses related to cocaine has remained relatively consistent since SUDORS data became available in July of 2019. The number of people dying from overdoses related to heroin began decreasing in the third quarter (July through September) of 2021 and continued to decrease throughout 2022, which reflects a shift in the local illicit drug supply from heroin to fentanyl.

SUDORS data for 2022 indicate that:

- More than half (58%) of the people in Oregon who died from an unintentional or undetermined intent overdose in 2022 had more than one drug type (e.g., opioid and stimulant) in their system at the time of death. Of all deaths involving multiple substances (polysubstance deaths) that occurred during that time, 92% involved any opioid, 80% involved fentanyl, and 70% involved methamphetamine. In comparison, alcohol and cocaine were involved in 22% and 13% of all polysubstance deaths, respectively.
- Methamphetamine was involved in 58% of unintentional and undetermined drug overdose deaths and fentanyl or fentanyl analogs were involved in 65% of overdose deaths.
- Ninety percent of all unintentional and undetermined drug overdose deaths in 2022 involved methamphetamine and/or fentanyl or fentanyl analogs.

Unintentional and undetermined overdose death demographics

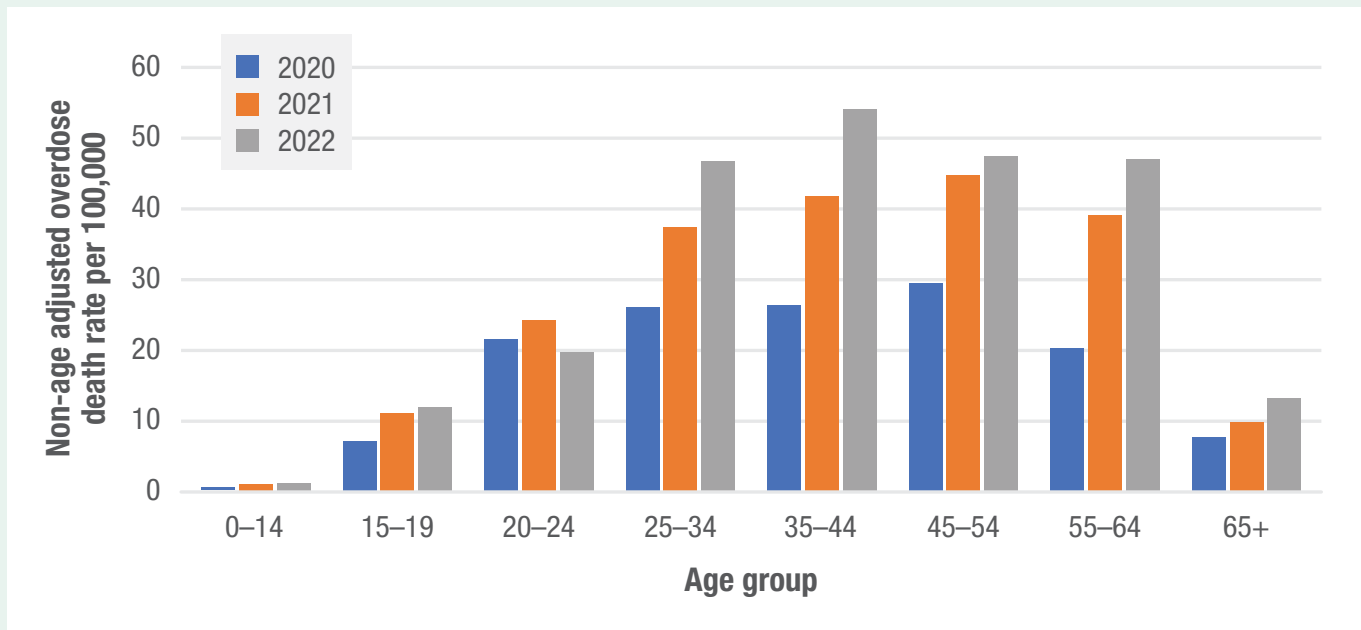
Compared to 2021, the unintentional or undetermined intent overdose-related non-age-adjusted¹⁷ **death rate** (number of deaths per 100,000 population) increased in 2022 for most age groups (see Figure 4). The age groups with the largest growth between 2021 and 2022 were: 65 and older (38%), 35-44 (30%), 25-34 (25%), and 55-64

¹⁶ Oregon-Idaho HIDTA 2023 Drug Threat Assessment: https://static1.squarespace.com/static/579bd717c534a564c72ea7bf/t/62acea7b18bb1f1d6c6d8eb7/1655499393650/OR+ID+HIDTA+2023+TA_FINAL.pdf

¹⁷ See endnotes for additional information.

(21%). The 20-24 age group's rate decreased 19% between 2021 and 2022. Please note that the overdose death rates for the 0-14 age group noted in Figure 4 below are considered statistically unreliable because they are based on counts of less than 20.

Figure 4. Non-age adjusted overdose death rates increased for most age groups between 2021 and 2022.

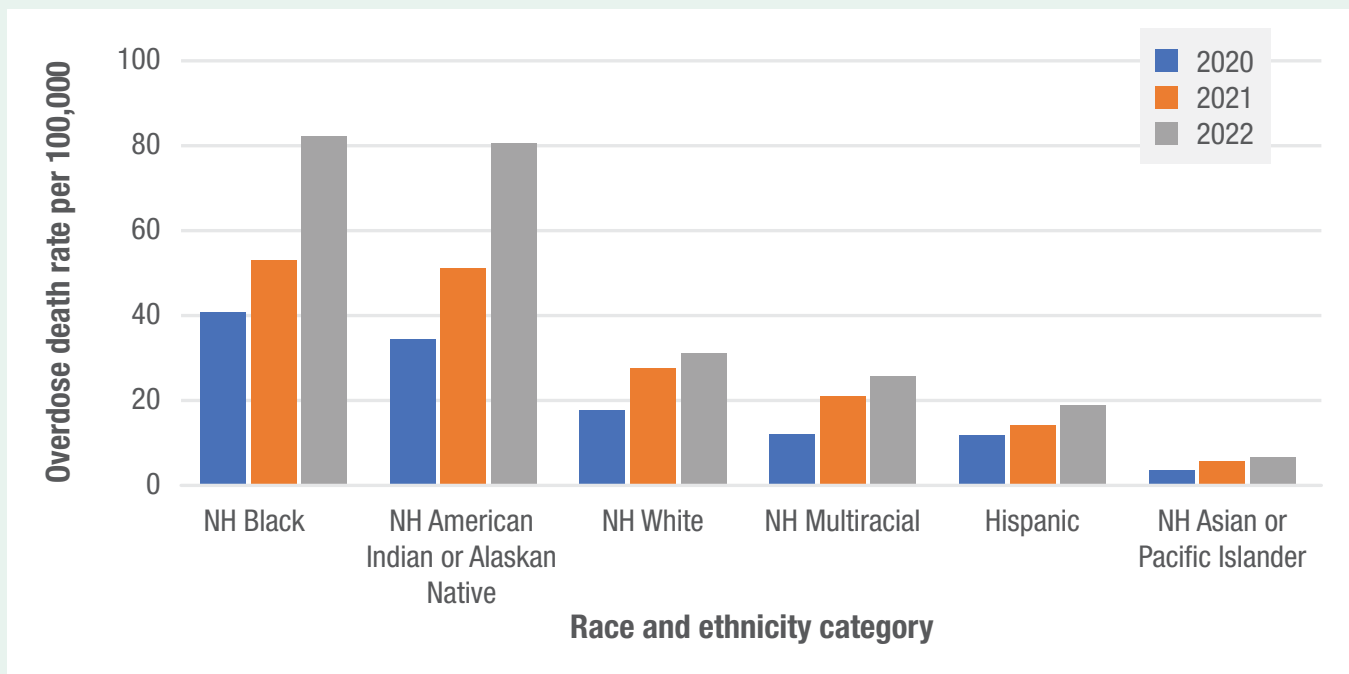


Source: 2020-2022 Oregon SUDORS

Note: The rate for the 0-14 age group is statistically unreliable as the counts are lower than 20.

As shown in Figure 5 below, the racial and ethnic groups that had a higher risk of dying from an unintentional and undetermined intent drug overdose in 2022 were non-Hispanic Black and non-Hispanic American Indians and Alaska Native people. People with Hispanic ethnicity and non-Hispanic Asians and Pacific Islanders had a lower rate of unintentional and undetermined drug overdose death compared to people identified in other race and ethnicity categories. Unintentional and undetermined overdose death rates for all racial and ethnic categories in this data source (Hispanic, non-Hispanic Black, non-Hispanic American Indian and Alaskan Native, non-Hispanic Asian and Pacific Islander, and non-Hispanic White) increased between 2021 and 2022. The largest increases during that period were among the non-Hispanic American Indian and Alaskan Native population (58%) and the non-Hispanic Black population (56%). When interpreting demographic data, it is important to remember that many of these populations have been disproportionately affected by systemic racism, social-economic-political injustices, and systemic biases. These inequities can worsen health outcomes, inhibit access to services and may increase the risk of experiencing a drug overdose.

Figure 5. People identified as Non-Hispanic Black and non-Hispanic American Indian or Alaskan Native had the highest unintentional and undetermined drug overdose death rates per 100,000 population.



Source: 2020-2022 Oregon SUDORS

Note: Multiple race/ethnicity categories may be recorded for a single death. The “least common race” methodology was used to assign a single race and ethnicity category. For example, if any Hispanic ethnicity was recorded, then the individual was categorized as Hispanic. Then the non-Hispanic race category was assigned based on the following order: Multiracial, Black, American Indian or Alaskan Native, Asian or Pacific Islander, White, and other. People with other or unknown race or ethnicity were not included in the rate calculations for the race and ethnicity categories shown here.

Note: NH - Non-Hispanic

Note: Non-Hispanic Asian or Pacific Islander rates are statistically unreliable due to counts less than 20.

In 2022, people who identified as male were more likely to die of an unintentional or undetermined overdose than those who identified as female. Among both groups, those aged 35-44 had the highest non-age-adjusted rate of death from unintentional or undetermined drug overdose. This information is based on the designation of gender on death certificates. Individuals are included in the death data reported by sex based on their gender identity as noted on their death certificate. While overdose deaths among this diverse group of people are not broken out into gender orientation subgroups per agency guidelines that protect privacy and confidentiality, these populations have been disproportionately affected by biases and inequities that have influenced their risk for experiencing overdoses.

Other risk factors for unintentional or undetermined overdose death in 2022 included non-alcohol related substance use issues (69.4% of deaths), diagnosed mental illness (36.1%), and alcohol use issues (16.9%). However, only 8.1% of Oregonians who died

from an unintentional or undetermined drug overdose in 2022 were receiving current treatment for substance use disorder. Homelessness and a lack of stable housing also emerged as risk factors; 19.9% of unintentional and undetermined overdose deaths that occurred in 2022 were homeless and 2.5% occurred among people who were experiencing housing instability. The proportion of individuals who died from an unintentional or undetermined drug overdose and were homeless increased from 13.8% in 2020 to almost 20% in 2022, but these risk factors are often underreported.

In 2022, eight out of ten (83%) unintentional and undetermined fatal overdose incidents in Oregon occurred in urban counties¹⁸: Multnomah (451), Lane (168), Marion (86), Jackson (76), Clackamas (76), Washington (67), and Josephine (33). While most overdoses in Oregon occurred in urban counties, rural counties are also heavily affected by the overdose crisis.

Fentanyl and xylazine-related unintentional and undetermined overdose deaths

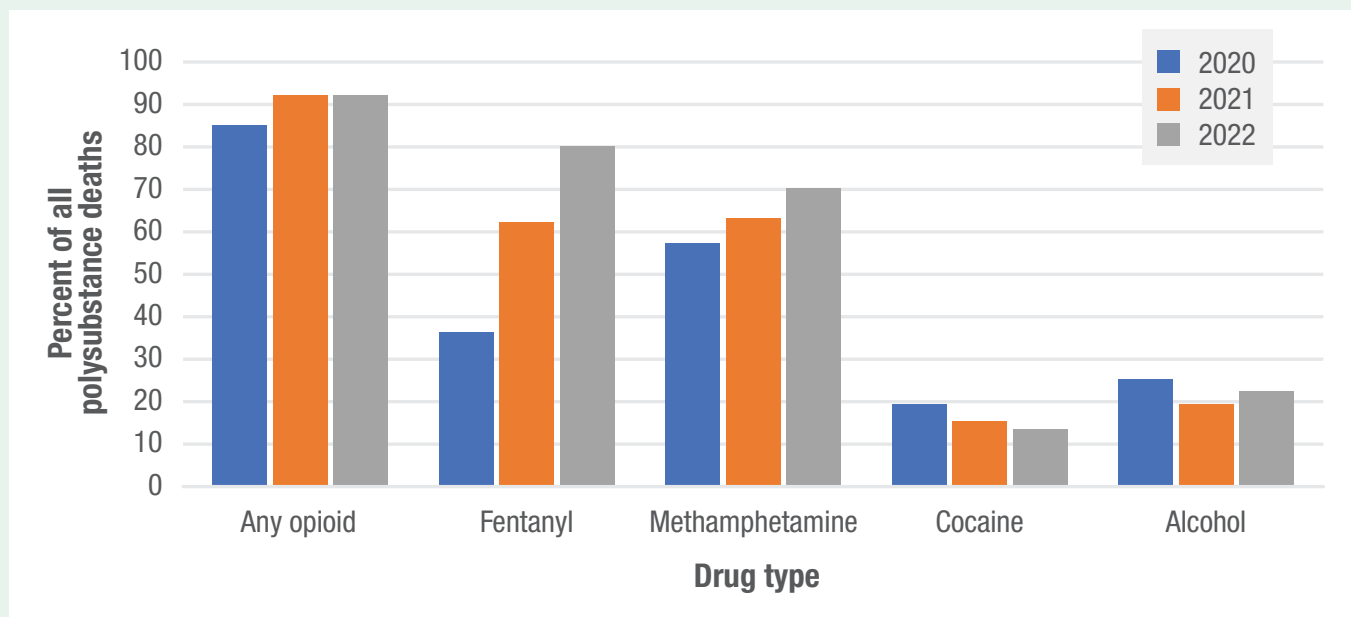
In July 2020, toxicology reports providing drug-related information for SUDORS began including tests for xylazine. Several unintentional and undetermined drug overdose deaths have identified xylazine in the toxicology report (not necessarily a substance that caused the death) in Oregon. While they account for about 1% of the overdose deaths examined, the number of people dying from overdose who had xylazine in their systems has increased since 2020. In 2022, there were 10 unintentional and undetermined drug overdose deaths where xylazine was identified in the toxicology report, up from two xylazine-related overdose deaths in 2020.

Polysubstance unintentional and undetermined overdose deaths

A person who had more than one drug class, such as stimulants and opioids, identified in the toxicology analysis as causing the death is considered a **polysubstance overdose death**. These substances may be illicitly or legally obtained, and the interaction of multiple drugs may cause unintended outcomes, including overdose.

¹⁸ Urban is defined as within a metropolitan/micropolitan statistical area using 2013 US Census Bureau information. The Oregon Office of Rural Health has additional information here: <https://www.ohsu.edu/media/866>.

Figure 6. Fentanyl involvement in polysubstance overdose deaths have increased significantly since 2020



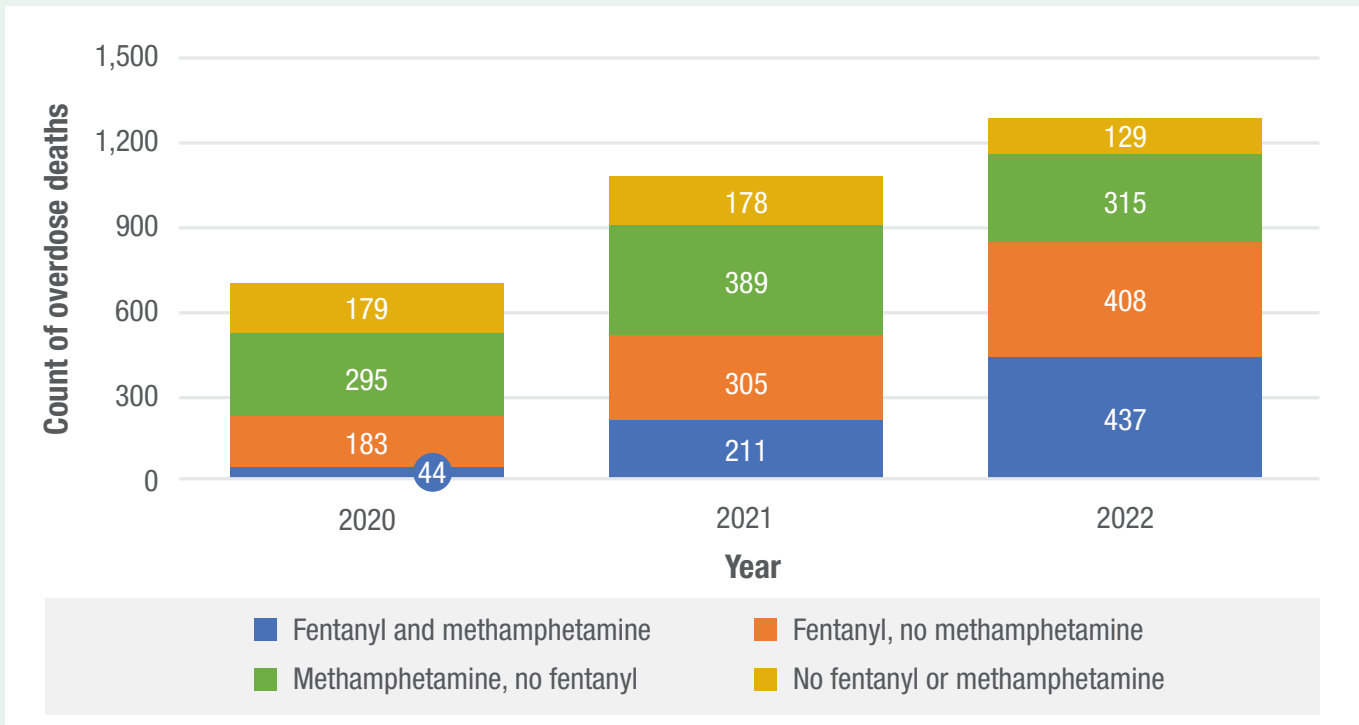
Source: 2020-2022 Oregon SUDORS

In 2020, 45% of people who died of an unintentional and undetermined overdose death were identified as polysubstance, which rose to 51% (536) in 2021 and 58% (744) in 2022. Ninety-two percent of polysubstance overdose deaths in 2022 involved an opioid of any kind (see Figure 6), and 80% involved fentanyl (compared with 36% in 2020 and 62% in 2021). In 2021, 103 unintentional or undetermined drug overdose deaths included both opioids and alcohol; in 2022 this number climbed to 167, an increase of 62%.

In 2022, methamphetamine and fentanyl remained the most common drugs identified as a cause of death in unintentional and undetermined overdoses in Oregon. Fentanyl includes both pharmaceutical fentanyl and IMF as toxicology tests cannot differentiate between prescribed and illicitly manufactured fentanyl. As shown in Figure 7, there was a 107% increase in the number of people who died of an unintentional or undetermined drug overdose where fentanyl and methamphetamine were both identified as a cause of death in 2022 (437 overdose deaths) compared to 2021 (211 overdose deaths).¹⁹

¹⁹ Additional information can be found in the Oregon State Medical Examiner annual report. At the time of writing, the Medical Examiner reports are not listed on their website but are publicly available upon request.

Figure 7. Fentanyl and methamphetamine were the cause of death in a third of all unintentional and undetermined drug overdose deaths in 2022



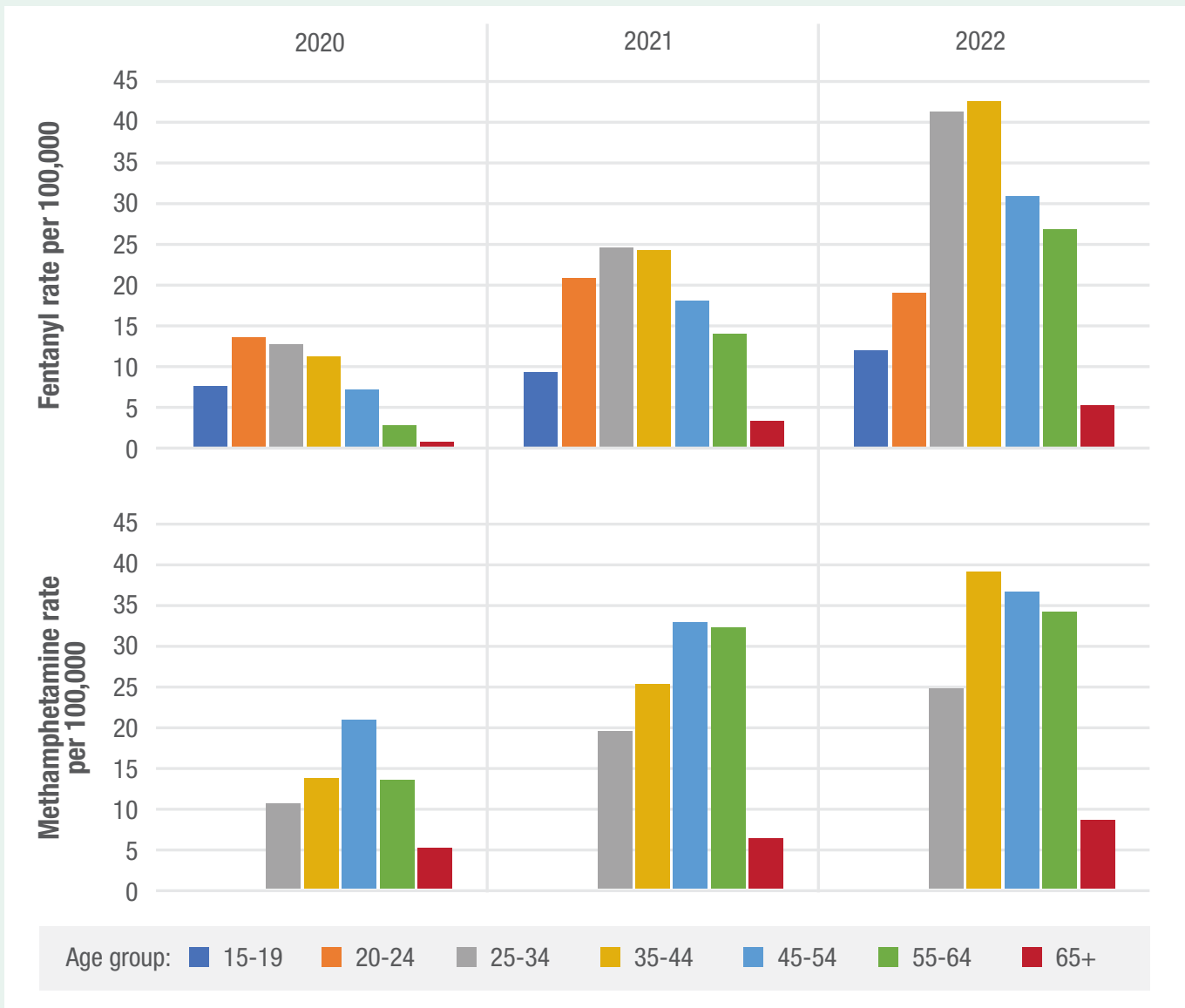
Source: 2020-2022 Oregon SUDORS

Note: Only fentanyl and methamphetamine were examined in this graph, other substances may have been involved but were not taken into account for this analysis.

More people died of an unintentional or undetermined fentanyl drug overdose in 2022 compared to previous years. Individuals of all ages were affected by this increase. As shown in Figure 8, 35–44-year-old people had the highest rate of fentanyl drug overdose deaths, but the largest increase between 2021 and 2022 was noted among 55-64-year-olds. Fentanyl overdose death rates of unintentional and undetermined intent decreased in the 0-9 and 10-14 age groups between 2021 and 2022, but these rates are considered statistically unreliable as the counts are less than 20.

All age groups had an increase in **methamphetamine-related unintentional and undetermined drug overdose deaths** between 2020 and 2022. The highest rate of methamphetamine overdose deaths was in the 35-44 age group category (see Figure 8). The number of people who died from a methamphetamine unintentional or undetermined drug overdose for the 0-9, 10-14, 15-19 and 20-24 age groups were below 20, so the rates are considered statistically unreliable and not shown in Figure 8. Overall, individuals identified as male had a higher rate of methamphetamine overdose compared to individuals identified as female, 25.7 and 9.8 per 100,000 population, respectively.

Figure 8. Fentanyl and methamphetamine unintentional and undetermined overdose deaths have increased for most age groups in 2022



Source: 2020-2022 Oregon SUDORS

Substance use and nonfatal overdoses

Visits to emergency departments and hospitalizations related to nonfatal overdoses and substance use can be an opportunity for medical personnel to provide information and resources to people who use drugs. Individuals who experience a nonfatal overdose are at a higher risk of experiencing a fatal overdose in the future. The following section focuses on nonfatal overdose and substance use visit data.

Non-overdose substance use ED visits and hospitalizations

Non-overdose substance use related visits can include a wide range of reasons, such as substance use treatment or wound care for sores potentially associated with drug use. Substance use, including intoxication, can be included in the hospitalization or ED discharge data. People who use drugs have a wide variety of health needs, and the inclusion of a substance use diagnosis can still allow for education and other resources to be provided. Trends over time can provide important information about the community.

Emergency department visits include people who were seen in the ED and were not admitted in a hospital for continued care. In 2022, 66,208 people who visited the ED had a diagnosis reported related to substance use with no associated overdose code. Fewer people (18,645) were seen for intoxication-related reasons and had no mention of an overdose diagnosis in 2022. This information indicates that many people with substance use and people who use drugs and alcohol are visiting emergency departments for a variety of medical issues other than an overdose. The costs associated with these visits are significant; total reported charges for ED visits in 2022 with a substance use disorder diagnosis code and no associated overdose reported in the discharge database was over \$361 million. In comparison, total charges associated with ED visits related to motor vehicle injuries were \$164 million in 2022.

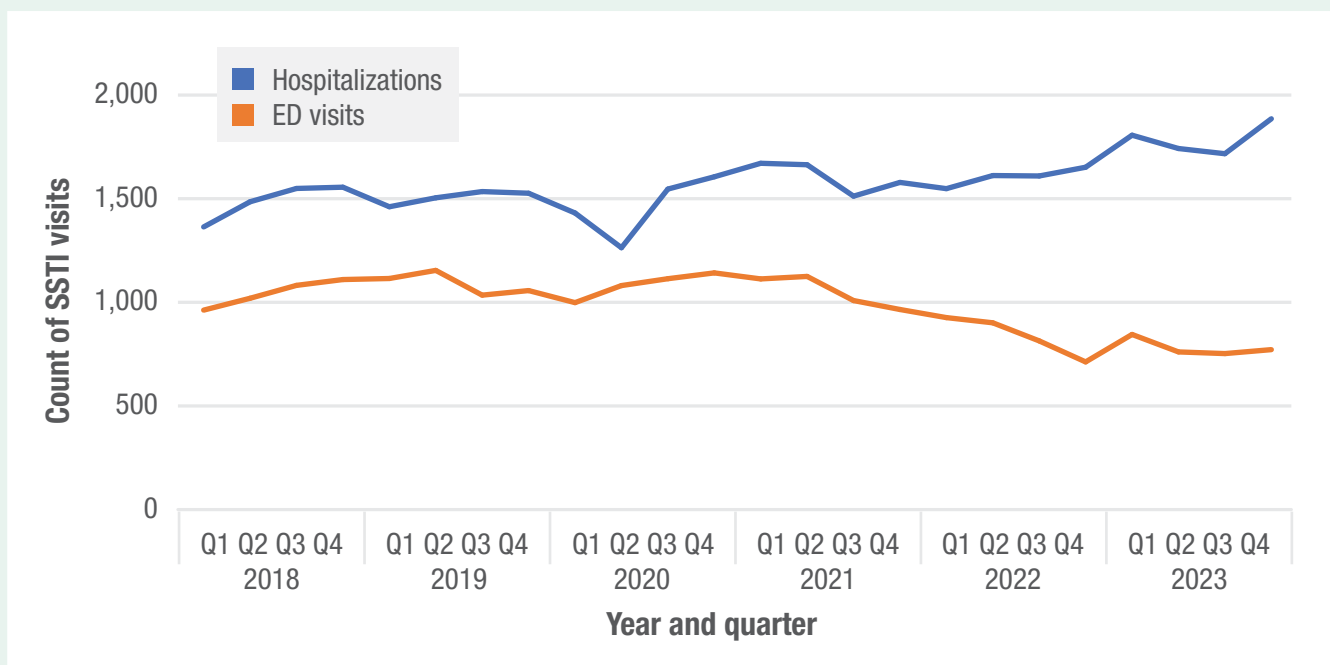
People with substance use and intoxication-related diagnoses recorded in ED visits decreased from 2018 to 2022. Five percent of ED visits in 2022 included a substance use diagnosis with no reported overdose, compared to 5.5% in 2018. This decrease in emergency department substance use visits may reflect changing patterns of interactions with the health care system due to a variety of reasons, including the COVID-19 pandemic.

Hospitalizations include people admitted to a medical facility for more than 24 hours of care. In 2022, 45,197 hospitalizations in Oregon-based facilities included a substance use disorder diagnosis and no indication of an overdose. In the same year, there were 3,270 hospitalizations with a specific mention of an intoxication-related diagnosis with no overdose diagnosis code. In 2018, substance use disorder-related diagnoses were included in 12.4% of non-overdose hospitalizations each year; this increased to 13.7% in 2022. This trend indicates a continued need for substance use treatment as well as a need for stronger supports for people who use drugs to help them avoid future overdose events.

Skin and soft tissue infections with associated overdose or substance use diagnoses in inpatient hospitalizations or ED visits

Wounds associated with drug use have been a consistent concern in the population of people who use drugs. Drug use, especially when using a needle for administration, can increase the risk of developing a severe skin and soft tissue infection (SSTI), such as an abscess, ulcer, or cellulitis. The issue has become more urgent with the introduction of xylazine into the local illicit drug supply. Temporal trends of visits that include a substance use and a wound or SSTI diagnosis in a hospitalization or ED visit can serve as a proxy for identifying xylazine in the local illicit drug supply.

Figure 9. The number of hospitalizations for SSTIs have increased since 2020



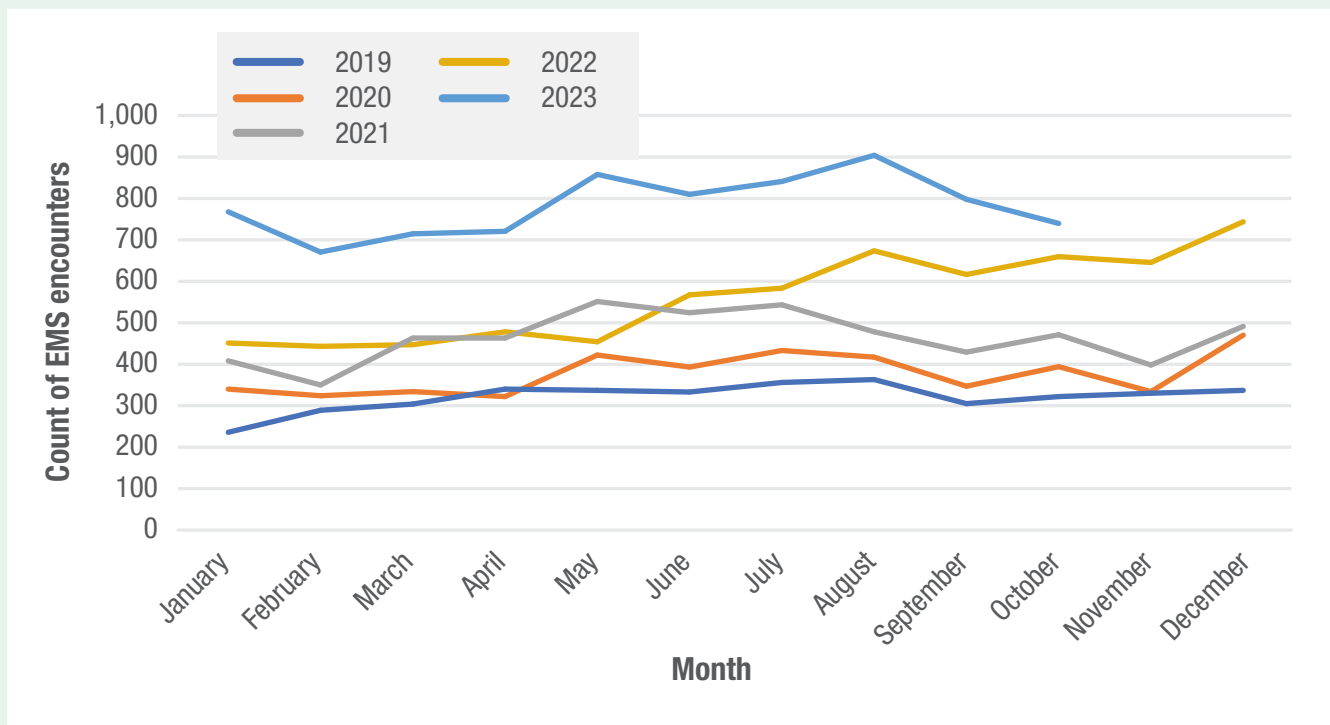
Source: Oregon Hospitalization and Emergency Department Discharge database, 2018-2023

In response to reports from Philadelphia, which has recently experienced a notable increase in xylazine use, the OHA has begun examining the trends of people seen for a SSTIs who also have an overdose or substance use diagnosis mentioned in the hospitalization and ED visit encounter data. As xylazine becomes more common in the Oregon drug supply, the number of people seeking care for SSTIs is likely to increase. In 2023, there has been an increase in SSTI-related hospitalizations while ED visits stayed relatively stable (Figure 9). However, it is important to keep in mind that available data only include individuals who seek care at an Oregon based hospital or ED. Individuals may try to treat wounds on their own or seek help from wound care clinics outside of ED or inpatient settings.

Overdose-related Emergency Medical Services encounters

EMS personnel are often the first responders for health care during a drug overdose. EMS personnel administered naloxone to people more frequently in 2022 than 2021: 5,612 people in 2021 and 6,797 people in 2022 (a 21% increase). Partial data available for 2023 are higher than any previous year (Figure 10). Naloxone was primarily administered by paramedics (67% in 2022), but some encounters (18%) do not have this information available. Bystanders and laypeople administered naloxone to 192 people (3%) where EMS responded to the scene and naloxone administration was recorded.

Figure 10. Naloxone was administered in more encounters in 2023 than previous years



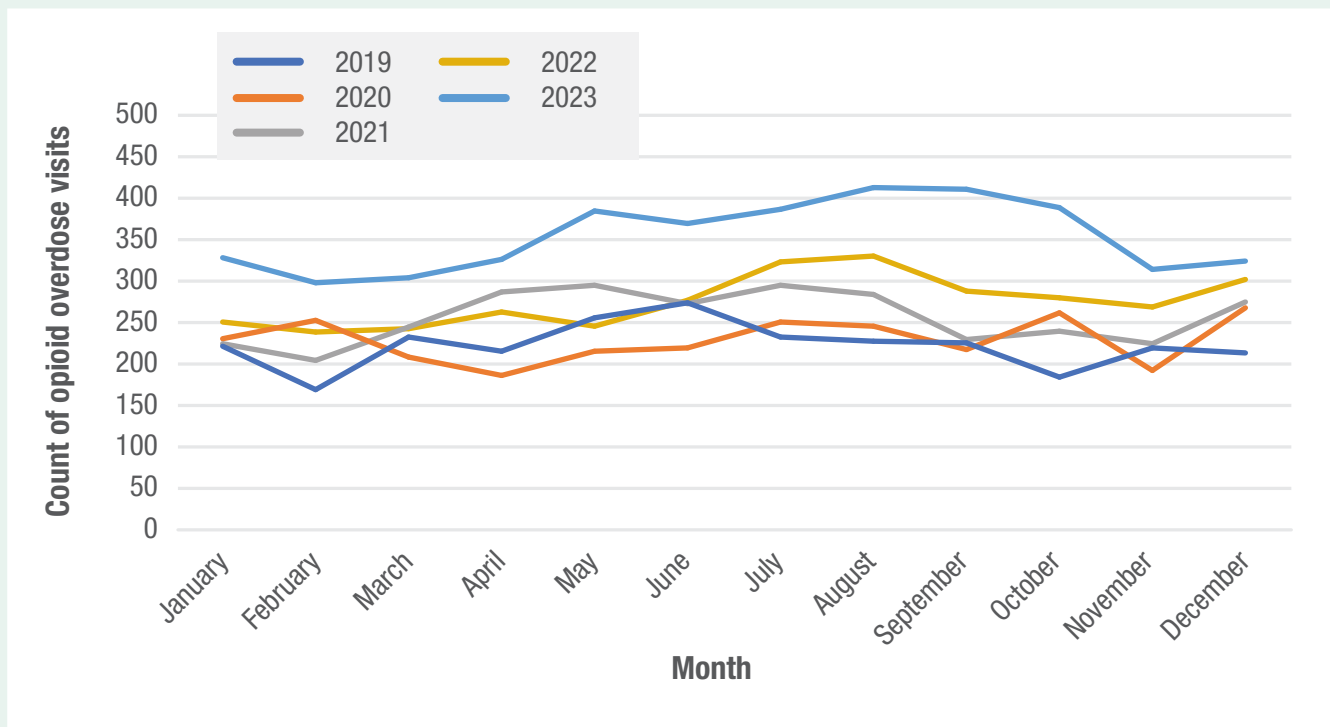
Source: Oregon Emergency Medical Services Information System, 2019-2023

EMS can be called to almost any location to provide aid. The most common type of location EMS recorded naloxone administration was a private residence in 2021 and 2022. More than 70% of the encounters where naloxone was administered ended with the patient being treated by the responding EMS unit and transferred to an ED.

Overdose-related emergency department and urgent care visits

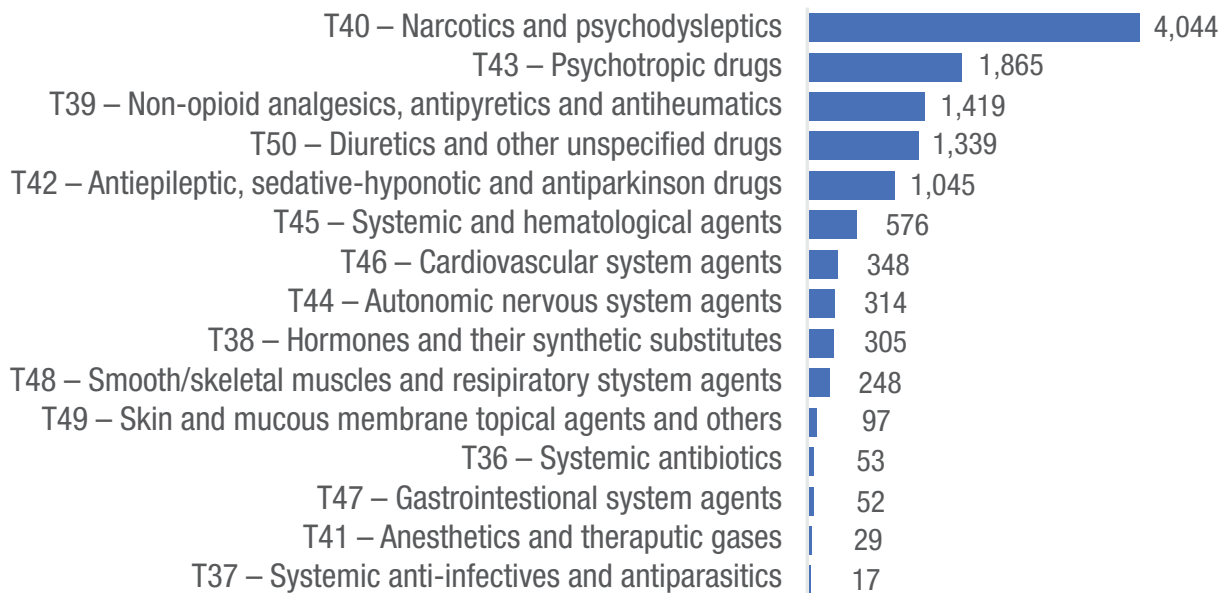
The number of people who had an **opioid-related overdose visit to EDs** and urgent care centers in 2023, the most recent available data, was higher than any previous year (Figure 11). Overall, people with a first impression (quick, initial assessment of why a person is needing care) for an opioid overdose accounted for less than 0.2% of all ED and urgent care center visits in 2023.

Figure 11. Opioid overdose emergency department visits increased further in 2023



Source: Oregon ESSENCE data, 2019-2023

Figure 12. Opioids and hallucinogens (narcotics and psychodysleptics) were the most common substances involved in an overdose ED visit in 2022



Source: Oregon Emergency Department Discharge Database, 2022

Emergency department discharge visits

In 2022, a total of 10,545 ED visits occurring in Oregon non-federal facilities²⁰ involved an overdose or poisoning from any type of drug.²¹ The most common overdose or poisoning related diagnosis ICD-10-CM code is T40, associated with narcotics and psychodysleptics (hallucinogens), such as opioids, cocaine, cannabis and LSD (Figure 12). –

Opioid-related overdoses accounted for 2,794 total emergency department visits in 2022. The yearly number of **people who visited the ED for opioid-related overdoses** has increased over the last few years. Counts increased 24.6% from 2021 (2,794) to 2022 (3,480) and continued to increase in the first half of 2023. The number of people seen for **heroin-related ED visits** continued to decrease from 2018 to 2021 and decreased even more rapidly after June 2021 (Figure 13). A fentanyl-specific ICD-10-CM diagnosis was introduced in October 2020 and is a subset of the synthetic opioid ICD-10 diagnosis category. As the health care community became accustomed to this new diagnosis code and the testing for synthetic opioids began to increase, the number people who visited the ED for a **fentanyl-related overdose**

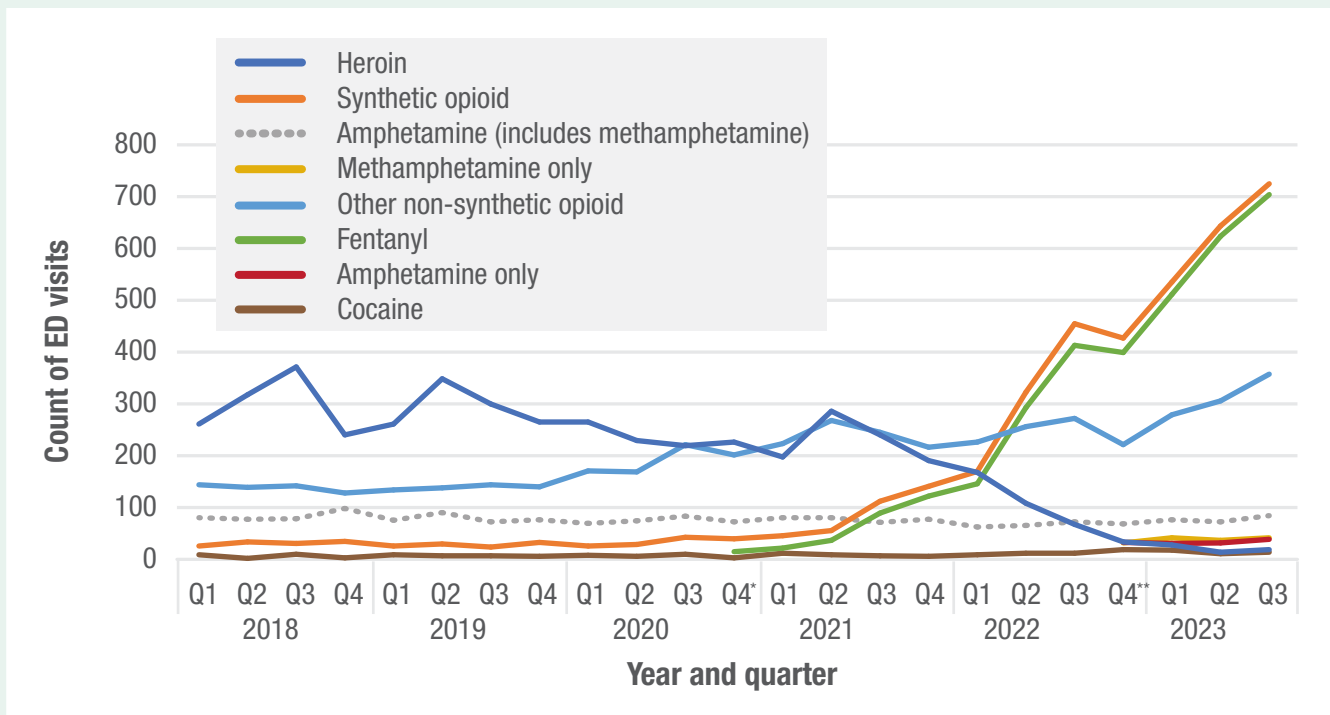
20 A non-federal facility is a hospital that is not fully funded by the federal government. In Oregon, the only federal facility is the Veterans Affairs Medical Center located in Portland.

21 ICD-10-CM diagnosis codes in this category include T36-T50. Not all these diagnosis codes pertain to illicit substances, such as methamphetamine or heroin.

increased. As fentanyl is included in the larger synthetic opioid diagnosis category, this suggests that fentanyl is the primary contributor to the 886% increase in synthetic opioid overdose ED visits between 2018 and 2022 in Oregon.

The number of ED visits for a **stimulant overdose** increased 3.5% from 471 in 2021 to 488 in 2022. In the fourth quarter of 2022, a new ICD-10-CM code specific to methamphetamine-related poisoning was introduced. The dashed gray line in Figure 13 represents any ED visit that had either an amphetamine or methamphetamine-related diagnosis code, which is consistent with how the amphetamine category was defined prior to the fourth quarter of 2022. Half of the amphetamine-related ED visits in 2022 are attributed to methamphetamine, and that is now visible with these two substances separated in their own categories. These two lines are hard to visualize in Figure 13 as they overlap; there were 37 people seen in the ED for an amphetamine overdose and 36 people seen for a methamphetamine overdose in the fourth quarter of 2022. Methamphetamine specific overdose diagnosis reporting is expected to increase in the future as health care professionals become more acquainted with the new code.

Figure 13. Heroin overdose-related ED visits began to sharply decrease after June of 2021



Source: Oregon Emergency Department Discharge Database, 2018-2023

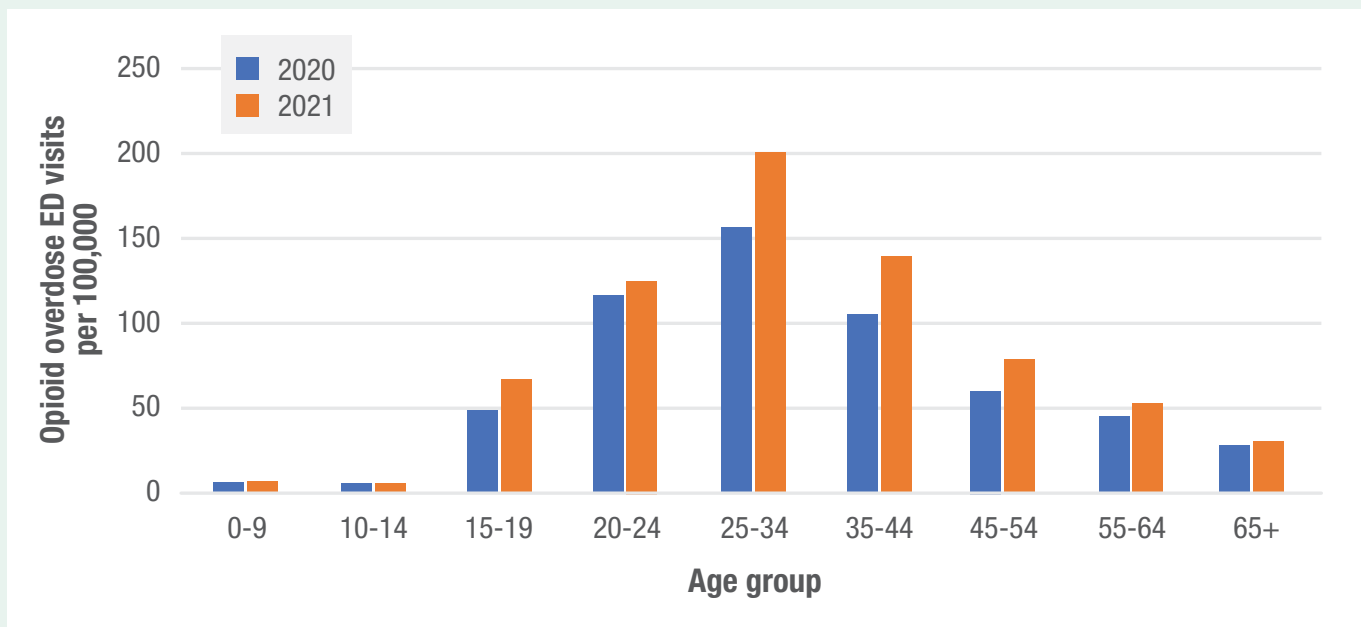
* Fentanyl ICD-10-CM code introduced. Note the synthetic opioid and fentanyl trends are similar, indicating that the synthetic opioid trend is primarily caused by fentanyl. Fentanyl is still included in the synthetic opioid category.

** Methamphetamine ICD-10-CM code introduced. Prior to 2022 Q4 methamphetamine was included in the amphetamine category. In 2022 Q4 the methamphetamine and amphetamine categories were separated.

Overdose-related expenses for ED visits are significant and have increased in recent years. In 2022, reported charges on drug-related overdose visits to EDs totaled \$50.8 million. Medicaid was listed as the primary payer for 52% of these overdose ED visits in 2022. There were \$14.2 million in total charges for opioid-related overdose ED visits in 2022, an increase of 17% compared to 2021. Total stimulant-related overdose ED visit reported charges decreased slightly from 2021 (\$2.6 million) to 2022 (\$2.9 million).

Figure 14 shows the **age breakdown of people who visited the ED for an opioid-related overdose**. Young adults (age group 25-34) had the highest non-age adjusted rate and experienced a 28% increase from 2021 to 2022. The number of opioid-related ED visits for 2022 increased in every age group when compared to 2021. The number of people in the 10-14 age group who were seen remained the same between these two years. Please note that the rate for the 0-9 and 10-14 age categories are unreliable as the counts are less than 20. Male-identified individuals had more opioid and stimulant overdose-related ED visits than female-identified people in all five years of data examined.

Figure 14. Patients 25-34 years had the highest rate of opioid overdose-related ED visits in 2021 and 2022



Source: Oregon Emergency Department Discharge Database, 2021-2022

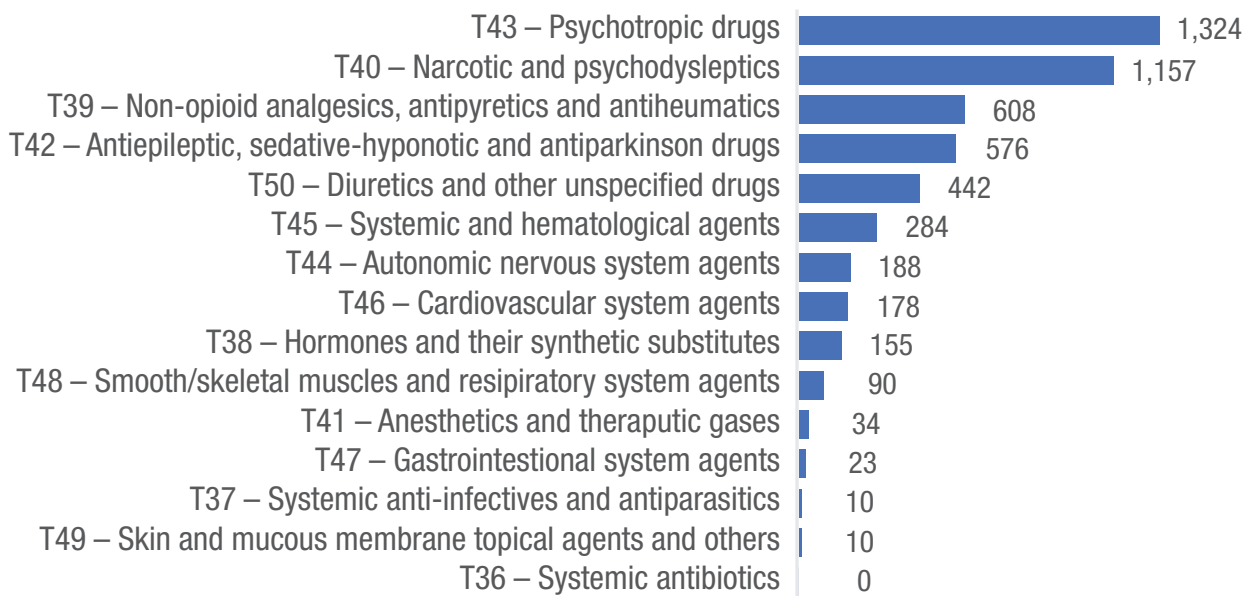
Demographic analysis shows that people identified as non-Hispanic American Indian and Alaska Native and non-Hispanic Black had the highest rates for any drug overdose-related ED visit that did not involve hospitalization. Individuals identified as Hispanic and non-Hispanic Asian and Pacific Islander had lower drug overdose-

related ED visit rates compared to other race and ethnicity categories. All race and ethnicity categories had an increase in opioid overdose-related ED visits between 2021 and 2022, with the non-Hispanic White population increasing 60% during these two years.

Inpatient hospitalization discharge visits

Some people need medical care that involves an inpatient hospitalization following a drug overdose. Individuals can experience an overdose from a wide range of substances, many of which are prescription or over-the-counter medications. In 2022, 3,893 people were hospitalized in Oregon non-federal medical facilities for an overdose or poisoning of a drug of any kind.²² The most common overdose or poisoning related diagnosis ICD-10-CM code for inpatient hospitalizations is T43, associated with psychotropic substances, such as psychostimulants like methamphetamine, ecstasy, and methylphenidate (Figure 15).

Figure 15. Opioids and stimulants were not the only substances that required hospitalization for an overdose or poisoning event in 2022

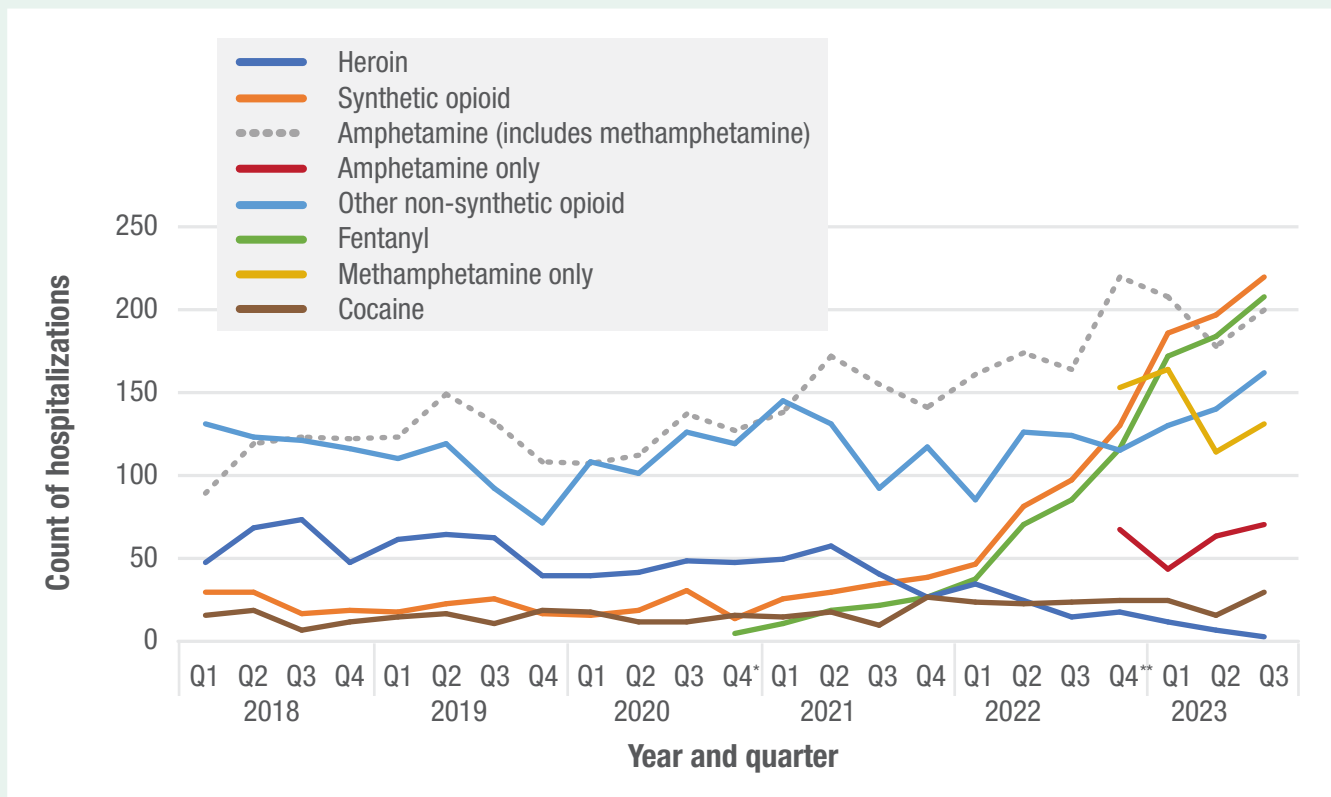


Source: Oregon Hospital Discharge Database, 2022

²² ICD-10-CM diagnosis codes in this category include T36-T50. Not all these diagnosis codes pertain to illicit substances, such as methamphetamine or heroin.

The **number of hospitalizations for an opioid-related drug overdose** increased 5% from 962 in 2021 to 1,010 in 2022. Beginning in the second quarter of 2021, hospitalizations for synthetic opioid-related overdoses began to drastically increase (Figure 16). Synthetic opioids increased 170% from 2021 (134 hospitalizations) to 2022 (362 hospitalizations) and 260% from 2018 (100 hospitalizations) to 2022. The Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) 2024 Threat Assessment report²³ indicated a declining local supply of heroin, which is reflected in a 26% decrease in heroin-related overdose hospitalizations in Oregon from 2018 to 2021. Hospitalizations related to heroin overdoses continued to decrease by 46% in 2022. In the first half of 2023, the number of hospitalizations for synthetic opioid overdoses continued to increase.

Figure 16. Synthetic opioid and fentanyl overdose hospitalizations have increased throughout 2022



Source: Oregon Hospital Discharge Database, 2018-2023

* Fentanyl ICD-10-CM code introduced. Note the synthetic opioid and fentanyl trends are similar, indicating that the synthetic opioid trend is primarily caused by fentanyl. Fentanyl is still included in the synthetic opioid category.

** Methamphetamine ICD-10-CM code introduced. Prior to 2022 Q4 methamphetamine was included in the amphetamine category. In 2022 Q4 the methamphetamine and amphetamine categories were separated.

23 Oregon-Idaho HIDTA 2024 Threat Assessment. <https://static1.squarespace.com/static/579bd717c534a564c72ea7bf/t/6480bc59dd714268468921ff/1686158433887/%28U%29+Oregon-Idaho+HIDTA+2024+Threat+Assessment+-+FINAL+060623.pdf>

A fentanyl-specific ICD-10-CM diagnosis code was introduced in October 2020. As the health care community became accustomed to this new diagnosis code and the testing for synthetic opioids began to increase, the documentation of fentanyl hospitalizations increased. Fentanyl is still included in the synthetic opioid category shown in Figure 16. This trend indicates that fentanyl is most likely the main driving factor for the increase in synthetic opioid overdose hospitalizations in Oregon.

Stimulant-related hospitalizations increased 18% from 2021 (704) to 2022 (831). The most common substance identified in the stimulant class from 2018 to the third quarter of 2022 was amphetamine, which included methamphetamine. In the fourth quarter of 2022, a new ICD-10-CM code specifically for methamphetamine-related poisoning was introduced. The dashed gray line in Figure 16 represents any patient that was hospitalized for either an amphetamine or methamphetamine-related diagnosis, which is consistent to how the amphetamine category was defined prior to the fourth quarter of 2022. Most of the amphetamine-related hospitalizations are attributed to methamphetamine, and that is now visible with these two substances separated in their own categories (yellow and red lines in Figure 16). As familiarity with this new diagnosis code increases, the reports of methamphetamine-specific overdoses are expected to increase.

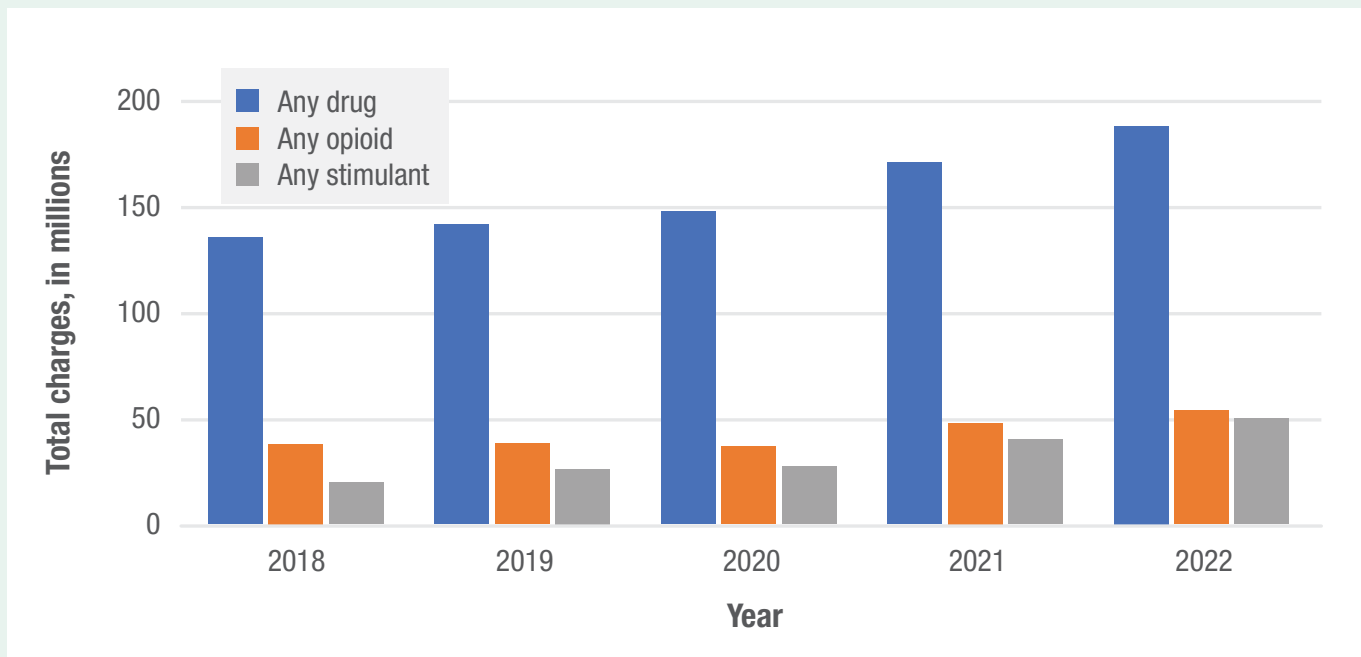
The number of people **hospitalized for cocaine overdoses** increased 78% in 2022 when compared to 2018. The HIDTA 2024 Threat Assessment reports an increase in cocaine seizure, an indication that there is an increase in cocaine in the local illicit drug supply and that fatal and nonfatal cocaine overdoses might increase in the future.²⁴

The COVID-19 pandemic influenced how people interacted with the health care system, especially during the second and third quarters of 2020. Yet the counts of opioid and stimulant-related overdose hospitalizations increased during this period, which suggests that the need for overdose-related health care continued to be in demand during and after the pandemic.

24 Oregon-Idaho HIDTA 2024 Threat Assessment. <https://static1.squarespace.com/static/579bd717c534a564c72ea7bf/t/6480bc59dd714268468921ff/1686158433887/%28U%29+Oregon-Idaho+HIDTA+2024+Threat+Assessment+--+FINAL+060623.pdf>

In 2022, people hospitalized for a drug overdose tallied in over \$186 million in reported charges (Figure 17). Medicaid was listed as the primary payer for 48% of these visits and Medicare was the primary payer in 31%. A total of \$53 million in charges for opioid-related overdose hospitalization was reported in 2022, an increase of 12% compared to 2021. Total stimulant-related overdose hospitalization charges increased 24% from 2021 (\$39 million) to 2022 (\$49 million).

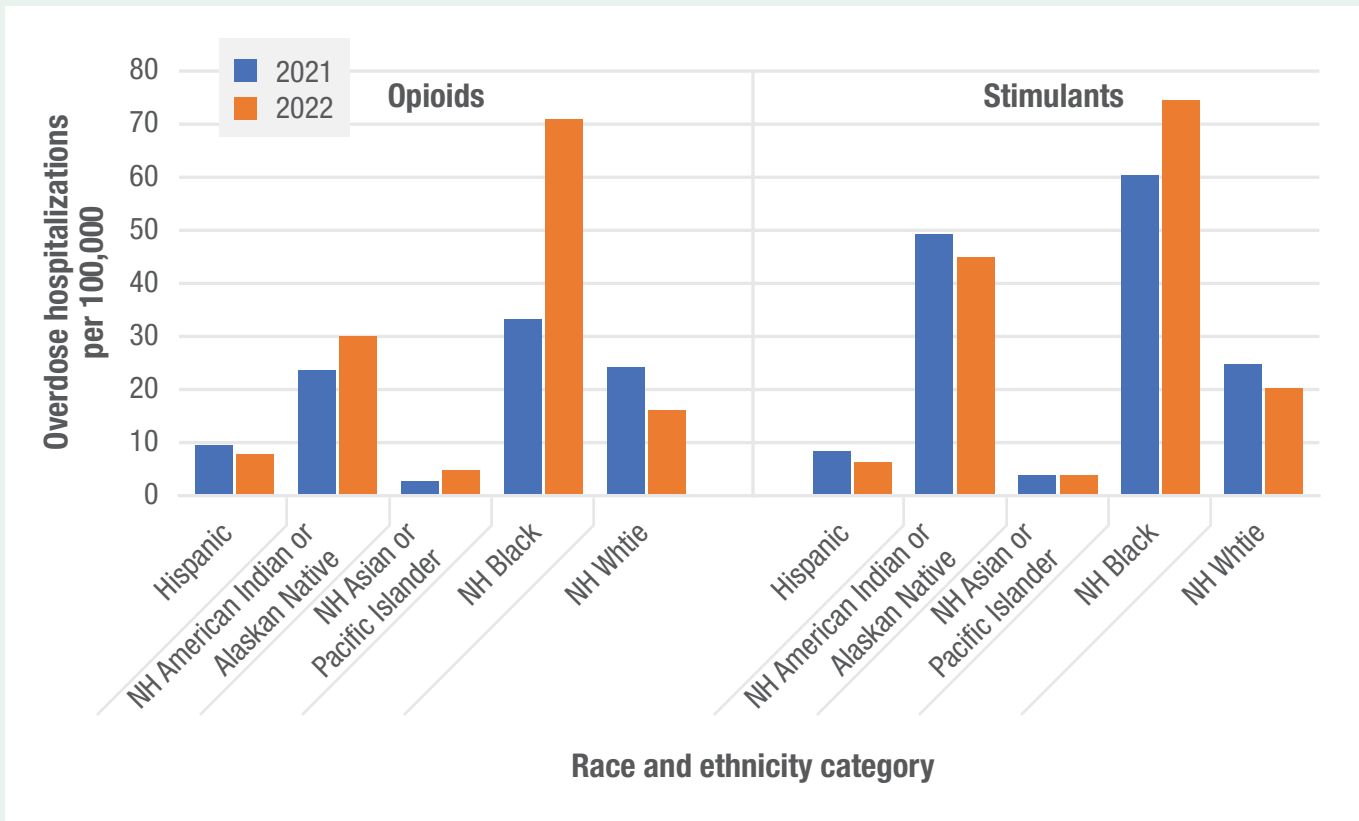
Figure 17. Total charges from any drug overdose related hospitalizations continue to increase.



Source: Oregon Hospital Discharge Database, 2018-2022

Individuals identified as non-Hispanic Black and non-Hispanic American Indian and Alaskan Native had higher rates of an opioid-related overdose hospitalization than other races and ethnicities in 2022 (Figure 18). These populations have been disproportionately affected by historical and contemporary systemic racism, socio-economic-political injustices, and biases. These generational traumas and inequities can worsen health outcomes, including increasing the risk of a drug overdose. People who were identified as Hispanic and non-Hispanic Asian and Pacific Islander had lower rates of opioid-related overdose hospitalization compared to other race and ethnicity categories.

Figure 18. Drug overdose hospitalization rates by race and ethnicity differ between opioids and stimulants.



Source: Oregon Hospital Discharge Database, 2021-2022

Note: Only one racial category and one ethnicity category are reported in the Oregon Hospital Discharge Database. Therefore, if an individual was reported with a Hispanic ethnicity, they are included in the Hispanic category. People of non-Hispanic ethnicity are represented in the various race categories. See endnote for more information about rate calculation. NH stands for non-Hispanic.

People who identified as non-Hispanic American Indian or Alaskan Native and non-Hispanic Black had the highest overdose hospitalization rates for both opioids and stimulants (Figure 18). People who identified as Hispanic and non-Hispanic White tend to have a higher rate for opioid overdose-related hospitalizations than with stimulants, while people who identified as non-Hispanic Black had a higher rate of stimulant overdose-related hospitalizations than with opioids.

In 2022, people who identified as female were more often hospitalized for overdoses involving any type of drug (non-age-adjusted rate of 94 per 100,000), compared to people who identified as male (non-age adjusted rate of 89.2 per 100,000 population). Individuals who self-identify as male (27.6 per 100,000 population) were more often admitted for stimulant-involved overdoses than those who identify as female (11.6 per 100,000 population). Male individuals also experienced a higher rate of opioid-related overdose hospitalizations than female individuals, 27.5 and 20.1 per 100,000 population respectively.

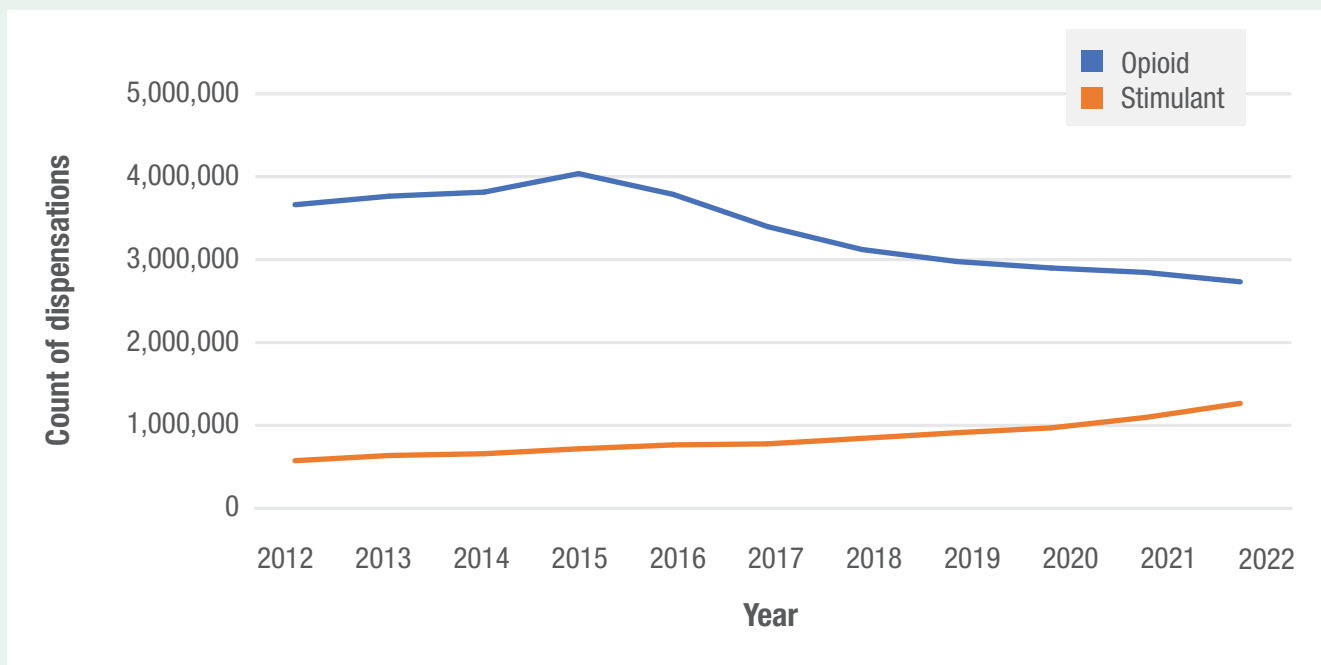
Oregon Prescription Drug Monitoring Program dispensation data

In 2009, the Oregon Legislature passed Senate Bill 355 mandating the Oregon Health Authority to develop the Prescription Drug Monitoring Program (PDMP). The PDMP is a tool that Oregon healthcare providers can use when prescribing Schedule II through IV controlled substances and additional Oregon-specific listed substances such as gabapentin and naloxone. The PDMP collects Oregon resident patient data on controlled prescription medications dispensed by retail pharmacies. Prescribers can use PDMP data to prescribe controlled substances more safely and effectively by reviewing the patient's recent scheduled medication dispensations. While there has been an overall decrease in prescription opioid overdose deaths since implementation of the PDMP, there is still much work to be done to educate prescribers about safer prescribing practices. Opioid medication dispensations have decreased since 2015, mostly due to the efforts to educate prescribers on risky prescribing practices, both at the state and federal level (Figure 19). Between 2015 and 2022, stimulant medications, such as those used to treat attention deficit hyperactive disorder (ADHD), have increased 74%, from 737,000 in 2015 to 1,283,000 dispensations in 2022.

The PDMP remains an important resource for Oregon due to high rates of substance use in the state. The Substance Abuse and Mental Health Services Administration (SAMHSA) conducted the National Survey on Drug Use and Health in 2021. SAMHSA reported that Oregon ranked in the top quintile (20%) for substance use disorder in the past year for people 12 years and older, including alcohol use disorder in the past year.²⁵ Oregon was ranked in the top 20 states for opioid use disorder. Prescription opioid dispensing from retail pharmacies has decreased from a high of 4 million prescriptions in 2015 to a low of 2.7 million in 2022, the most recent full year of available data.

25 2021 National survey on drug use and health national maps of prevalence estimates, by state. <https://www.samhsa.gov/data/sites/default/files/reports/rpt39463/2021NSDUHsaeMaps110122/2021NSDUHsaeMaps110122.pdf>

Figure 19. Opioid medication dispensations have decreased since 2015.



Source: Oregon Prescription Drug Monitoring Program (PDMP), 2012-2022

As part of 2017 House Bill 3440, the Prescribing Practice Review Subcommittee²⁶ of the Prescription Drug Monitoring Program Advisory Commission was created to provide input on safe prescribing practices. Since 2018, this PDMP subcommittee has notified prescribers engaged in potentially risky prescribing practices and provided them information about the most current prescribing guidelines. Based on these guidelines, the subcommittee created measures to identify prescribers who could benefit from additional education on safer prescribing practices using agreed-upon standards:

- **Co-prescribing:** prescribing co-occurring (overlapping prescriptions) opioids and a sedative (benzodiazepines, non-benzodiazepine sedatives or gabapentin) to the same patient (these types of medications can combine to cause serious side effects, including overdose).
- **Opioid naïve:** prescribing more than a seven-day supply of opioids to patients who have not been prescribed opioids before (opioid-naïve patients).
- **MED 200+:** prescribing high dosages of opioids (daily morphine equivalent dose (MED) 200mg or more).²⁷

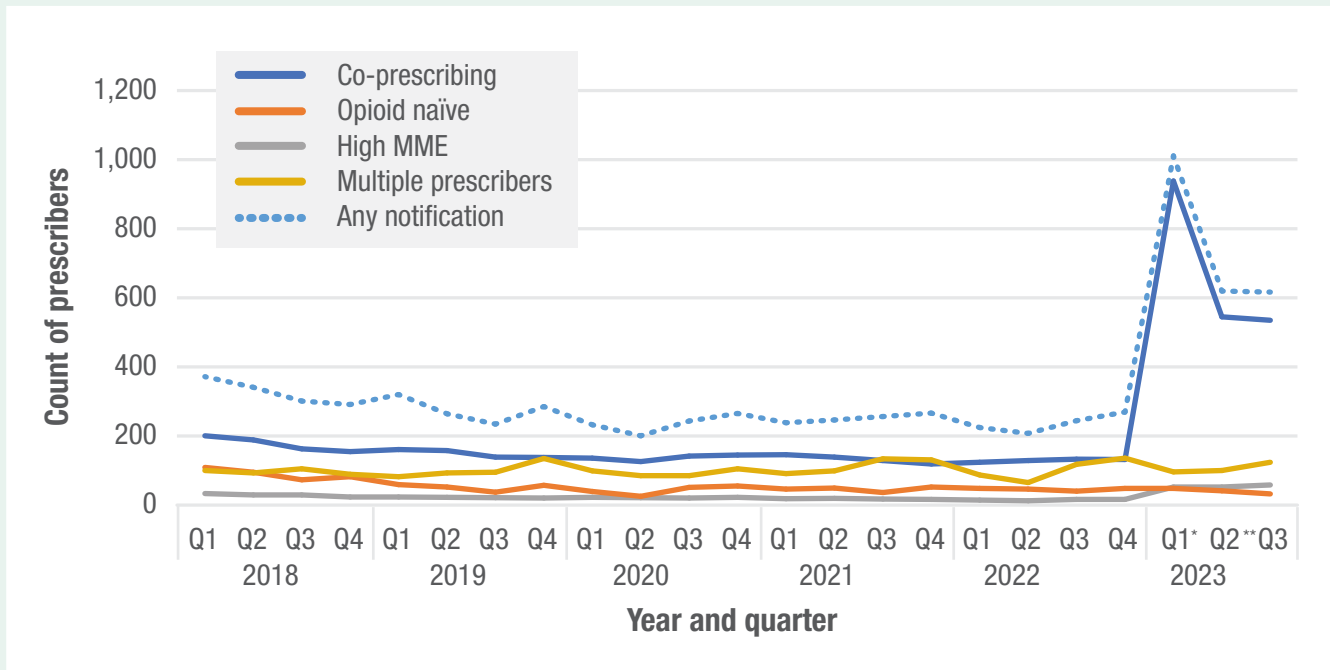
²⁶ Risky prescribing criteria are set by the PDMP Advisory Commission Prescribing Practice Review Subcommittee as established by ORS 431A.896.

²⁷ Current prescribing guidelines recommend a daily Morphine Equivalent Dose at or below 90mg is the standard of care. The 200+ MME category shown in Figure 20 indicates prescribing practice that carries the highest level of risk to patient safety.

- **Multiple prescribers:** prescribing opioids to patients receiving opioids from four or more prescribers in a six-month period.

As shown in Figure 20, the number of prescribers identified by a risky prescribing practice measure per quarter decreased 28.3% from 2018 Q1 (January – March) to the fourth quarter of 2022. This indicates that the PDMP has been successful in identifying and educating prescribers engaged in potentially risky prescribing practices. Starting in the first quarter of 2023, the co-prescribing opioid and sedative measure was updated by the subcommittee to reflect current evidence-based research on opioid prescribing practices. The new measure examines opioid dispensation that overlap with a sedative (benzodiazepine, non-benzodiazepine sedative or gabapentin) dispensation. Prescribers are notified for this measure when they prescribe 15 or more patients an opioid and a sedative within the quarter. This change in the co-prescribing measure increased the total number of prescribers that are notified of potentially risky prescribing practices 285% in the first quarter of 2023 when compared to the fourth quarter of 2022. Several prescribers provided feedback about the new measure, including the removal of single-event co-prescribing (ex. a benzodiazepine pre-procedure and an opioid post-procedure). Thanks to this

Figure 20. Number of prescribers notified of potentially risky prescribing practices increased in Q1 2023 due to updating the co-prescribing measure.



Source: Oregon Prescription Drug Monitoring Program (PDMP), 2018-2023

* Co-prescribing opioid and sedative measure updated by the PDMP Prescribing Practice Review Subcommittee. This change in definition increased the number of prescribers that are notified of potentially risky prescribing practices.

** Co-prescribing opioid and sedative measure was further updated by the PDMP Prescribing Practice Review Subcommittee following prescriber feedback to remove single-procedure related dispensations.

feedback, the Prescribing Practice Review Subcommittee was able to refine the co-prescribing opioid and sedative measure further in the second quarter of 2023.

The three remaining measures are currently under review and may have additional changes made based on subcommittee recommendations. Additional measures for stimulant prescribing practices are also in development in collaboration with Comagine Health analysts as a part of the Harold Rogers grant.

Healthcare providers, pharmacists, and their appropriate delegates have the ability and responsibility to check the drug dispensation history of patients to which they are prescribing a scheduled drug. Dispensing history can be viewed through the PDMP web portal or through a display within the patient's electronic medical record. While a searcher must enter patient information when using the web portal, information integrated within a patient medical record is automated. To view PDMP information in the patient's medical record, a provider must click into an embedded report. Since many health systems have integrated PDMP data into patient medical records, web portal queries have been on the decline.

Despite the increased ease of querying the PDMP within the patient's electronic medical record, healthcare providers do not always fully utilize this tool. Of the 6.6 million automated queries generated by the PDMP between January and March 2023, only 21% resulted in a healthcare provider actively clicking to view a patient's dispensation history integrated in their health record.²⁸ Compared to the previous quarter's data, the proportion of health care providers that review the embedded report in the patient's medical records has increased.

28 Oregon Prescription Drug Monitoring Program 1st Quarter 2023 Report (January-March). <https://www.oregon.gov/oha/PH/PreventionWellness/SafeLiving/PDMP/Pages/reports.aspx>

Discussion

Current challenges

The U.S. overdose crisis originated in the 1990s due to increased injudicious opioid prescribing to address chronic pain, which eventually led to illegal distribution and nonmedical use of prescription opioids. States, including Oregon, responded by implementing prescription drug monitoring programs (PDMPs) to decrease opioid misuse and diversion by tracking the prescribing and dispensing of controlled substances. However, this inadvertently led to clinicians under-prescribing for pain and terminating care for patients who had developed opioid use disorders.²⁹ Many patients who developed opioid use disorders and had their prescriptions revoked sought illicit opioids, including heroin. Substance use disorder and heroin overdoses rapidly increased in the early 2010s, but the illicit opioid market began to shift from heroin to fentanyl in the mid-2010s. Fentanyl is stronger, cheaper to produce, and easier to traffic. These factors make fentanyl more profitable for drug cartels to illegally manufacture and distribute. Fentanyl is now the primary contributor to the national overdose crisis.

Oregon's overdose landscape is distinct from national trends due to the state's historically high rates of methamphetamine use. Methamphetamine overdoses represented an increasing proportion of Oregon's overdose deaths until 2020, when illicitly manufactured fentanyl began to flood the illicit drug market in both counterfeit pill and powdered form. It is becoming increasingly common for other illicit substances to be adulterated with fentanyl, often without the knowledge of the person using the drugs. Polysubstance use, whether intentional or unintentional, is especially risky because the effects from combining drugs may be stronger and more unpredictable than using one drug alone.³⁰ Polysubstance use involving fentanyl and methamphetamine now contributes to more than half of Oregon's unintentional overdose deaths.

Substance use disorder is a complex but treatable medical condition caused by a wide variety of individual, social, and environmental factors. These factors may include but are not limited to adverse childhood experiences, intergenerational trauma, and co-occurring mental health and alcohol use disorders. Social determinants of health such

29 Dickson-Gomez J, Christenson E, Weeks M, Galletly C, Wogen J, Spector A, McDonald M, Ohlrich J. Effects of implementation and enforcement differences in prescription drug monitoring programs in 3 states: Connecticut, Kentucky, and Wisconsin. *Substance Abuse: Research and Treatment*. 2021 Mar 25. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8013627/>

30 Polysubstance Use Facts https://www.cdc.gov/stop-overdose/caring/polysubstance-use.html?CDC_AAref_Val=https://www.cdc.gov/stopoverdose/polysubstance-use/index.html

as housing insecurity, financial insecurity, low educational attainment, neighborhood violence, and limited access to healthcare can also contribute to the risk of developing a substance use disorder. American Indian/Alaska Native and Black/African American communities in Oregon are disproportionately impacted by substance use disorder and overdose. These disparities are closely related to the systemic racism and centuries-long inequities these communities have historically experienced.

Mental health disorders, substance misuse, and suicide are interrelated population health issues that deeply impact individuals, families, communities, and society at large. Prevention strategies that focus on reducing the shared risk factors and promoting the shared protective factors associated with these issues can positively impact multiple quality of life outcomes. However, health promotion and primary prevention initiatives have historically been siloed and chronically underfunded.

There are substantial gaps in Oregon's substance use disorder treatment services, where the demand and need for these services significantly outweigh the availability of resources.³¹ Furthermore, the extremely limited access to culturally and linguistically appropriate services in Oregon perpetuates the state's substance use disorder and overdose-related inequities among communities that have been systemically marginalized. Oregon's limited capacity to serve individuals with serious and complex behavioral health conditions has contributed to over-utilization of emergency departments and unnecessary incarceration. People who use drugs experience high rates of incarceration, particularly in communities of color and rural communities. Inadequate access to substance use disorder treatment while in custody and inadequate transitions of care between carceral and community settings puts these individuals at extreme risk of overdose upon release. People who use drugs also commonly face discrimination and stigma that impact their well-being and discourage them from seeking treatment, thereby increasing their risk for overdose and other substance use-related harms.

Oregon's overdose crisis is part of a *syndemic* of multiple co-occurring health outcomes created by complex social, economic, and systemic factors. There is no single policy, initiative, or intervention that one agency, sector, or system of the state could implement to fix what has been decades in the making. Addressing this syndemic will require a cross-agency, multisector response to simultaneously address the multiple factors contributing to substance use and overdose, including racism, stigma, affordable housing, transportation accessibility, healthcare access, economic opportunity, climate change, and other forms of community-level trauma. Implementing a population health approach that includes both upstream and downstream initiatives can decrease substance use initiation, regular use, and harmful use and promote improved quality of life and well-being among Oregonians.

31 Supplement to the Oregon Substance Use Disorder Services Inventory and Gap Analysis: County Directory of Substance Use Disorder Prevention, Treatment and Recovery Services. <https://www.oregon.gov/adpc/pages/gap-analysis.aspx>

Response strategies

OHA's strategic approaches for overdose prevention are outlined in the 2020-25 Alcohol and Drug Policy Commission Strategic Plan, the 2019-2024 Oregon Tribal Behavioral Health Strategic Plan and the OHA Overdose Prevention and Response Alignment Work Plan. The 2020-2024 State Health Improvement Plan, *Healthier Together Oregon*, endorses the approaches laid out in the ADPC Strategic Plan. The common aims of the various strategic plans include comprehensive, coordinated statewide and Tribal health systems that 1) effectively address the substance use continuum through policies and investments in practices and strategies informed by data that save lives now, advance prevention and promote health, address risk and protective factors, decrease harms related to substance use, and expand treatment and recovery services; 2) center equity in policies and investments; and 3) support healing, healthy, and thriving individuals, families, and communities.

OHA's response to the overdose crisis has involved multiple initiatives touching every division of the agency. OHA divisions are collaborating closely with state and local partners to combat the substance misuse crisis and advance health equity. One of OHA's top priorities is to increase culturally specific services and resources for communities experiencing the highest substance misuse and overdose disparities.

Statewide initiatives

Over the past two years, OHA has distributed nearly 90% of the \$1.3 billion in new Measure 110 behavioral health investments allocated by the Oregon State Legislature in 2021. These range from workforce restoration and supportive housing and services to funding community-based behavioral health networks throughout the state. The agency has disbursed more than \$300 million to establish behavioral health service networks under Measure 110. These networks now operate in every Oregon county to provide comprehensive treatment and supports for people seeking treatment for substance use disorders. Measure 110 has successfully expanded accessible, community-based services to highly vulnerable people. The Measure 110 Oversight and Accountability Council prioritized cultural competence among grantees, and this focus is expected to improve service access statewide and help address inequities in substance use and treatment outcomes.

OHA's Save Lives Oregon program works to provide people who use drugs with access to programs and resources that support their health and dignity. Save Lives Oregon prioritizes serving individuals impacted by injustice, oppression, and trauma. The Save Lives Oregon Harm Reduction Clearinghouse launched in 2020 to provide life-saving supplies such as naloxone to organizations and Tribal communities on the front lines of harm reduction. The Clearinghouse has continued to distribute lifesaving supplies to more than 250 organizations statewide. The Clearinghouse

distributed over 200,000 doses of naloxone in 2022, and Clearinghouse partners have reported more than 5,000 opioid reversals since 2020. Following legalization of drug testing strips with passage of HB 2395, the Clearinghouse also added these to their supply distribution list.

Passage of 2022 HB 4098 established the [Oregon Opioid Settlement Prevention, Treatment and Recovery \(OSPTR\) Fund](#) and Board to administer the 45% State of Oregon portion of settlement funds received from opioid manufacturers, distributors, and pharmacies for their role in creating and fueling the opioid epidemic. Approximately \$272 million will be paid to the state fund in multiple payments through the year 2038. All allocation decisions are made by the OSPTR Board and OHA provides administrative support. This funding source holds promise for supporting substance use and overdose prevention, harm reduction, treatment, and recovery strategies allowed by the terms of Oregon's intrastate allocation agreements and in alignment with the Alcohol and Drug Policy Commission's Statewide Strategic Plan. OHA has dedicated a full-time project coordinator to support the OSPTR Fund and Board with planning, implementation, coordination, evaluation, fiscal and contract management, community engagement, and communications. Throughout the current fiscal biennium, which ends in June 2025, approximately \$89 million will be deposited into the OSPTR Fund. To date, the OSPTR Board has allocated the following:

- \$26.7 million to the nine Federally Recognized Tribes in Oregon – this is equivalent to 30% of all funds anticipated this biennium. This 30% set-aside will continue throughout the life of the fund as additional settlement payments are deposited.
- \$13 million to the Save Lives Oregon Harm Reduction Clearinghouse to distribute naloxone and other life-saving supplies to qualified organizations.
- \$4 million to develop a unified and evidence-based state system for collecting, analyzing and publishing data about the availability and efficacy of substance use prevention, treatment and recovery services in Oregon as required by [ORS Chapter 63, Section 6](#).
- \$13.7 million to counties, community-based organizations, Regional Health Equity Coalitions, and the Oregon Council for Behavioral Health to increase and strengthen Oregon's substance use disorder prevention workforce.
- \$13.08 million to establish Recovery Community Centers in counties with the greatest need, support personnel at Oxford House Recovery Housing, and expand culturally specific and youth recovery services in Recovery Community Centers.

- \$14.3 million to add mobile and non-mobile medication units to existing Oregon Opioid Treatment Programs (OTPs) and for Oregon Health & Sciences University (OHSU) to provide training and technical assistance to jails to improve access to medications for opioid use disorder and foster collaboration with OTP providers.

New polysubstance use primary prevention initiative

In September 2023, the SAMSHA awarded OHA's Public Health Division (PHD) a competitive 5-year, \$1.2 million annual Alcohol/Overdose Strategic Prevention-Partnership for Success (SPF-PFS) grant. Polysubstance use, involving more than one drug and/or alcohol, accounted for more than half (54.6%) of overdose deaths in 2021 (2020 Oregon Death Certificate Data). This new initiative seeks to 1) strengthen state capacity to identify and address alcohol misuse and overdose as a polysubstance use crisis impacting overlapping priority populations in Oregon; and 2) prioritize and co-develop strategies to build capacity with communities experiencing the highest inequitable impacts of overdose and alcohol misuse in the state. OHA-PHD will fund up to four grantees through a request for proposal process in Fall 2024.

Mobilizing a rapid response to prevent and reduce fentanyl related overdoses

In early 2023, the Interim OHA Director convened a Behavioral Health Cabinet to enhance collaboration and coordination across the agency. This group led development of an equity-focused overdose response “sprint plan” with 30-, 60-, and 90-day strategies to guide and focus the agency’s response to increases in fentanyl related overdoses. Primary goals included: 1) engaging communities for action, 2) better aligning naloxone distribution systems with community needs, 3) enhancing public awareness and education, and 4) scaling up same-day access to overdose prevention and medication for opioid use disorder. By mid-December 2023, the agency had hosted multiple regional listening sessions in both urban and rural communities and initiated a needs assessment among local public health authorities serving high burden counties that are not currently funded by OHA to conduct overdose prevention. Findings from these sessions will inform a broader overdose prevention and response plan in 2024 and beyond.

In anticipation of increasing amounts of xylazine within Oregon’s illicit drug supply, the agency convened a cross-divisional fentanyl/xylazine workgroup in May 2023. This public health/behavioral health collaboration developed a xylazine data tracking protocol, which uses existing surveillance systems to monitor the prevalence and spread of xylazine-related overdoses. OHA also prepared xylazine educational materials for health systems and social service partners. These materials use trauma-informed, anti-stigma messaging to educate healthcare providers and people who use

drugs on how to identify and properly care for the serious wounds that commonly result from xylazine use.

Collaboration with local partners

Supported by a fourth year of overdose prevention funding from the Centers for Disease Control and Prevention, OHA's Public Health Division funded 11 overdose prevention coordinators to implement local overdose prevention initiatives in 23 counties across the state. The overdose prevention coordinators collaborate with multi-disciplinary partners to develop, plan, and implement culturally relevant interventions using tailored prevention strategies that emphasize reaching groups disproportionately affected by substance use disorder and overdose.

From April 2022 to June 2023, the Public Health Division funded seven community-based organizations (CBOs) to implement culturally specific overdose prevention projects with communities experiencing high overdose burdens, including people who were recently incarcerated, rural communities, and Tribal members.³² The Public Health Division has allocated additional funding for CBOs in 2025 to support projects targeting populations experiencing high substance misuse and overdose burdens.

The Oregon Public Health Division collaborated with local public health authorities to finalize an overdose response protocol. This data monitoring and communication procedure supports efficient and effective information sharing when community partners share alerts of unusually high numbers of overdoses within a particular time, location and/or population, or when state or local data systems identify similar trends. The agency has also provided preliminary guidance to local mental health authorities to guide sharing of data about overdose deaths among Oregonians ages 24 and under, as required by the 2023 Opioid Omnibus Bill (HB 2395).

Support for Tribal partners

The Oregon Public Health Division provided funds to support scholarships for members of Oregon's Nine Federally Recognized Tribes to attend the 2023 National Tribal Opioid Summit, where attendees shared their knowledge, experiences, and commitment to ending the Tribal opioid crisis. Additionally, the Oregon Health Systems Division provides the Nine Federally Recognized Tribes and the Urban Indian Health Program with funding to strengthen Tribal behavioral health programs and expand service delivery. Tribes may use these funds to participate in cultural conferences and workshops that build resilience, integrate practices that improve emotional well-being, coordinate activities that promote community involvement, and more.

32 OHA Overdose Response Team Listening Session Summary: <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/ORT-Listening-Session-Summary-Report-0724.pdf>.

Youth initiatives

OHA is working closely with the Oregon Department of Education to implement a variety of school-based youth overdose prevention initiatives, including developing new curriculum supplements related to the dangers of synthetic opioids (per Senate Bill 238), updating the Fentanyl and Opioid Response Toolkit for Schools, revising Oregon Health Education Standards, and creating pathways for school districts to obtain opioid reversal kits free of cost through the Save Lives Oregon Harm Reduction Supply Clearinghouse. OHA also supported the launch and implementation of Harmony Academy, Oregon's first recovery high school.

OHA convenes a 26-member statewide Youth Advisory Council (YAC) comprising youth with diverse lived experiences and cultural identities to support public health efforts in schools and communities to address the secondary impacts of the COVID-19 pandemic, including topics related to youth substance misuse and overdose. OHA also administers the System of Care Advisory Council, whose primary duty is to develop and maintain System of Care-related policy and a comprehensive, long-range plan that encompasses health systems, child welfare, education, juvenile justice, public health, and services and supports for young people (age 0-25) with mental health disorders, substance use disorders, and/or intellectual and developmental disabilities.

Workforce development

OHA established the Behavioral Health Workforce Initiative (BHWi) in 2021 to address the behavioral health workforce crisis that was further exacerbated by the COVID-19 pandemic. The BHWi is tasked with equitably increasing the capacity of the behavioral health workforce. This includes increasing diversity to improve equitable access to culturally responsive, linguistically specific, and culturally specific behavioral health professionals and paraprofessionals. The BHWi's Workforce development strategy thus far has included reducing barriers to education and certification leading to positions that provide direct services to those in need of mental health and substance abuse services.

The Mental Health and Addiction Certification Board of Oregon (MHACBO) has received \$3.7 million of BHWi funding since November 2022 to pay for registration fees of new Certified Alcohol and Drug Counselor Registrants (CADC-R), certification exam fees, and initial certification fees for Certified Recovery Mentors (CRM). The funding also pays recertification fees for existing Certified Alcohol and Drug Counselors (CADC I, II, and III), Certified Recovery Mentors (CRM I and II), and Certified Prevention Specialists. This grant also funded similar incentives for the mental health (QMHA and QMHP) certifications that MHACBO oversees.

The BHWi has also worked to increase the clinical supervision of individual SUD providers by expanding the Oregon Administrative Rules (OAR) that guide the Clinical Supervision Expansion Grant. CADCs and Certified Gambling Addiction Counselors (CGAC) were added to the list of credentials that could be supported by the grant to increase access to quality clinical supervision that either assists individuals in obtaining certification or advancing their certification (e.g., CADC I to CADC II).

Future direction

Addressing Oregon’s overdose crisis will continue to require significant resources, broad partnerships, and data-driven policies and investments across the substance use disorder continuum. OHA will continue to implement a coordinated, collaborative approach to prevent overdoses and substance use-related harms in alignment with the State’s strategic plans. OHA is committed to engaging local partners and the Nine Federally Recognized Tribes in Oregon to implement community-led approaches that reduce stigma, advance equity, center community voice, and address rapidly evolving substance use overdose trends.

In 2024, OHA will host culturally specific listening sessions with communities disproportionately impacted by substance misuse and overdose. OHA will also conduct additional listening sessions with local public health authorities who are not currently receiving overdose prevention funding. The Behavioral Health Cabinet will apply findings from OHA’s 2023 and 2024 community engagement activities to inform a long-term overdose response that:

1. Decreases overdoses and death from substance use (including alcohol);
2. Increases access to naloxone and medication for opioid use disorder;
3. Improves coordination across system partners; and
4. Increases primary prevention to build education and awareness.

OHA is committed to employing a multifaceted approach across the substance use disorder care continuum that centers equity, reduces stigma towards people who use drugs, and addresses polysubstance use, including alcohol. This approach aligns with the [Transforming Behavioral Health pillar of OHA’s 2024-2027 strategic plan](#) and the Alcohol and Drug Policy Commission’s 14 Recommendations for Immediate Action to Reduce the Number of People Who Die of Overdose in Oregon (December 2023). Furthermore, this approach supports Oregon’s progress towards a modernized public health system.

Oregon launched the first licensing and regulatory framework for psilocybin services in the nation in January 2023. Research suggests that psilocybin may help address depression, anxiety, trauma, and addiction.³³ Some of Oregon’s licensed service centers and licensed facilitators have partnered with substance use disorder providers to offer psilocybin services as part of a comprehensive treatment model, but additional research is needed to better understand the efficacy of this practice. Psilocybin services offer an innovative and promising new approach for treating addiction and increasing well-being for individuals with substance use disorder.

Oregon is well-positioned to build on existing infrastructure by applying lessons learned from the state’s COVID-19 response to leverage resources, break down silos, and align strategic plans and funding streams to implement integrated, comprehensive overdose prevention, harm reduction, substance use treatment and recovery strategies. As this work moves the state towards OHA’s 2030 strategic goal to eliminate health inequities, Oregon can continue to be a national leader, demonstrating how cross-sector partnerships, rooted in equity, can improve behavioral health outcomes for all.

33 Oregon Psilocybin Services – Scientific Literature Review and Cultural Anthropological Information. <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/Pages/Psilocybin-Scientific-Literature-Review.aspx>

Endnotes

Population estimates: The Census Bureau population estimates were used for all rate calculations. For 2022 rates, the 2021 population estimate was used as 2022 data was unavailable.

Rates: Non-age-adjusted rates are calculated as the count divided by the subpopulation of interest. For example, the number of deaths of 25–34-year-old divided by the total 25–34-year-old population. This allows interpretation at a population level and cross-comparison among subpopulations.

Unreliable rates: In situations where the count is less than 20, the rate is considered unreliable. With low counts, changes in rates can appear to vary widely but the changes may result from random variations rather than a true trend.

Hospital and ED discharge race and ethnicity rates: Due to a known data limitation, only one racial category and one ethnicity is reported. For example, if an individual identifies as multiple races, only one race category is available in the discharge data. Therefore, the race categories were treated as “alone” and “not in combination” and the population estimate used for the rate denominator was for the reported racial category.

Overdose death ICD-10 classification: The Oregon Health Authority, Public Health Division uses data from state death certificates and the State Medical Examiner to describe drug overdose deaths in Oregon. 2021 is the latest complete year for reporting. The data include codes from the International Classification of Diseases, Tenth Revision (ICD-10), a system used by healthcare providers to classify diagnoses. The other non-synthetic opioid category includes deaths due to natural and semi-synthetic opioids (T40.2) and methadone (T40.3). The synthetic opioids category (T40.4) includes deaths due to fentanyl. The stimulants category includes all amphetamine-based stimulants (T43.6) and cocaine (T40.5). ICD-10 codes do not differentiate between the source of these drugs (legal vs. illicit) or whether the deceased person was taking the drugs as intended.



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