JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Pamela Beidle
Chair, Finance Committee

FROM: Leslie Ford Weber
Associate Director, Maryland Government Affairs

SB1071
Support with Amendment

DATE: March 13, 2024

RE: **SB1071: Hospitals – Opioid Overdose – Medication-Assisted Treatment**

Johns Hopkins supports with amendments **SB1071: Hospitals – Opioid Overdose – Medication-Assisted Treatment.** This bill specifies a course of treatment that must be made available to overdose patients who present to hospital emergency rooms for treatment. Johns Hopkins appreciates the intent to ensure that Maryland's hospitals are providing the highest quality care to patients experiencing opioid use disorder.

Clinicians from Johns Hopkins' behavioral health, psychiatric and emergency medicine teams reviewed the text of the bill as introduced and expressed concern about the following matters. We understand that the sponsor of the House crossfile of this bill is working on amendments that will address most of these issues and hope that the Senate will consider the same as your deliberations move forward.

- "Medication-assisted treatment" as a term of art to describe holistic approaches to treating this substance use disorder is falling out of favor, and holistic approaches are not logistically feasible in an emergency room setting. The preferred term is "Medications for opioid use disorder (MOUD)" and indicate pharmacotherapy only.

- Johns Hopkins is also concerned about the requirement in (B)(2) that each hospital in Maryland possess, dispense, administer and prescribe at least one formulation of three different pharmaceuticals: a full agonist, a partial agonist and a long-acting antagonist. However, use of a long-acting antagonist (Vivitrol) is not appropriate in the acute care setting, and certainly not after an opioid overdose. It requires 1-2 weeks of abstinence of all opioids in order to safely administer, which would not be the case after overdose.

- Johns Hopkins suggests that the wording in (C)(1) referencing the federal drug enforcement is outdated; DEA no longer provides waivers. Instead, this section could be reworded to reference "Applicable training and other standards as permitted by federal and state law."

- In (C)(2), the word "opioid agonist treatment" should be replaced with MOUD.

- Johns Hopkins also suggests that the use of the word "connect" in (D) is ambiguous and should be defined. While it would be appropriate for hospital emergency departments to offer transition to crisis centers when geographically feasible, and/or provide information about available community resources that would be appropriate for patients to pursue, and/or to counsel patients verbally after treatment in the acute setting for an overdose, it may not possible to definitively link a patient to a provider or facility. While making a definitive appointment or physical transition is ideal, most community facilities do not have staff and processes in place to provide assessment and intake services on nights and weekends, for instance. The hours of operation and available space for treatment in community-based providers is outside the control of Maryland's hospital emergency departments. It would be inappropriate to keep a patient in the hospital after the acute crisis has been addressed and would further exacerbate the state's challenges with transitions to post-acute care and long wait times in emergency departments.

Accordingly, Johns Hopkins respectfully requests a **FAVORABLE WITH AMENDMENTS** committee report on **SB1071.**