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SB 1071 - Hospitals-Opioid Overdose - Medication Assisted Treatment
In Favor
March 14, 2024

My name is Drew Fuller, MD and I am speaking in favor of the bill on behalf of myself, many of my patients and colleagues.

I have practiced medicine in Maryland for 28 years and I am currently board certified in both emergency medicine and addiction medicine but I come here today to speak as a **patient safety specialist**. I had the honor of being the Chief Safety Officer for the largest emergency medicine group in the Mid-Atlantic – Staffing 23 hospitals in Maryland, Virginia, and DC.

I transitioned from emergency medicine to addiction medicine in 2019 to help start an opioid crisis response program in Calvert County. I was moved to do so because I witnessed that too many of our patients were not getting access to the most effective treatment both in our hospitals and in our communities.

Preventable Deaths – Preventable Injury – (Patient safety perspective)

In Maryland, the mean age of opioid OD Death – **44 years old – many with dependent children**. Thus, tremendous "Years of Life Lost" (YLL) as well as a multi-generational impact.

- Too many OD deaths have been seen in our EDs prior to the event or in the course of their disease
- A single dose in the ED can double the chance of successful follow up and retention in care and reduce mortality
- Mortality in highest in the 1st 48 hours after discharge from ED for opioid OD.
- ED initiated treatment is safe, effective, and frankly quite easy to administer – all you need is a finger and tongue. – No IV. No Labs. No Urine Drug Screen – and likely, no Monitor – after all in can be given in the back of a truck (EMS initiated treatment) – patients give it to themselves unmonitored at home and even in the woods.

- It is one of the most effective treatments/interventions that I could provide as an emergency physician – on the level of expediting care for an angioplasty for heart attack or antibiotics for septic shock.

The Challenge is that we are not there yet –

- Many patients report not being offered the treatment in the ED.
- None of my patients nor several of my colleagues' patients have ever reported receiving a dose of buprenorphine after an overdose. This is a critical gap in care.
- Many hospitals have some form of a protocol in place but there are no mandates to follow the protocols or provide treatment.
- We are still battling stigma and ignorance within our professional ranks
    - Editorial in March 2024 - Emergency Medicine News (32,000 subscribers) Dr. Mark Collins, MD *" …..I wonder if we are just replacing one drug for another."*
- Better linkage to care is still needed. Accountable referral partners are needed.

- Having practiced as a patient safety specialist in hospitals for 10 years I can tell you it takes **many years and even decades for obvious solutions to trickle down.**

- in an era when the **"Next Pill Can Kill"** - **Our citizens don't have years**

The Good News

- Many of the pieces are already in place. Some form of protocols are already exist. Adjustments can easily be made.
- Many physicians, nurses and administrators are already on board.
- Hospitals are used to mandates. That is how they succeed.
- Maryland has excellent resources for education and program development with groups such as Mosaic and the Maryland Patient Safety Center
- **Accountable Referral Systems** can be created in which community partners also take responsibility on seeing the patients in a timely manner with a low threshold care model and report back to the hospital.

- We need a mandate, a catalyst.
- This legislation will help get us there more quickly and save more lives
    - One death, one orphan is too many

Hope is essential but it is not a reliable strategy for safety and high reliability. Just like any other high-risk industry, we need mandates, methodologies, and measures.

This should be framed as one of the most important **PUBLIC SAFETY** issues of our day and we all have a duty for urgent action.