MADC Hospital Opioid Overdose MAT SB 1071 Favorabl

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Position: FAV

Maryland Addiction Directors Council

Hospitals – Opioid Overdose – Medication Assisted Treatment (SB 1071)
Senate Finance Committee
March 14, 2024
FAVORABLE

Maryland Addiction Directors Council (MADC) represents SUD and Dual Recovery outpatient and residential providers in Maryland. MADC members provide over 2,000 residential beds across the State and advocate for quality SUD and Dual Recovery outpatient and residential treatment as well as evidence-based practices in treatment. MADC providers are at the forefront of the opioid overdose crisis.

MADC is writing in support of SB 1071. With the fentanyl epidemic, lethality has soared, and residential clients come to treatment in tremendous need. Approximately 2,400 people a year die from overdose in Maryland with most of these deaths due to fentanyl overdose. Access to Medication-Assisted Treatment for patients presenting at the hospital due to overdose will save lives.

Recent studies conclude that Medication-Assisted Treatment as part of an effective care model is key to client treatment engagement (Stewart, Daily et. al., *Expanding Access to Medication Treatment for Opioid Use Disorders: Findings from the Washington State Hub and Spoke Effort,* 2024) (Hawkins, Malte et. al., *Buprenorphine Receipt and Retention for Opioid Use Disorder following an Initiative to Increase Access in Primary Care,* 2023). MADC strongly supports referral to treatment from hospital care as a key part of an effective care model. MADC providers work with Peer Specialists, Social Workers, and other hospital staff to provide immediate access to treatment and continuation of medication.

The behavioral healthcare system needs every tool available to save lives in the opioid overdose crisis. MADC supports SB 1071 as an important part of this life-saving care. Thank you for considering our views.

Testimony Drew Fuller SB 1071.pdf

Uploaded by: Drew Fuller

Position: FAV

Drew Fuller, MD, MPH, FASAM, FACEP
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.

Legal Action Center Testimony SB1071_FAV_Hospital_

Uploaded by: Ellen Weber
Position: FAV

Hospitals – Opioid Overdose – Medication-Assisted Treatment (SB 1071)
Finance Committee
March 14, 2024
FAVORABLE

Thank you for the opportunity to submit testimony in support of SB 1071, which would require hospital emergency departments to develop protocols and deliver evidence-based care to patients who present with an opioid overdose. This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. The Center issued a report in 2021, which I co-authored, on a hospital emergency department's (ED) legal obligations to deliver specific care to individuals who present with substance-use related conditions: Emergency: Hospitals are Violating Federal Law by Denying Required Care for Substance Use Disorders in Emergency Departments.

SB 1071 would align Maryland's hospital ED practices with those that have been recommended by multiple federal agencies, the Surgeon General, the American College of Emergency Physicians (ACEP) and medical experts across the country. With the amendments offered by the sponsor, it would require all hospital EDs to (1) screen and diagnose patients for opioid use disorders based on standardized criteria; (2) offer to administer buprenorphine to treat an ED patient's opioid-related overdose and other opioid-related medical emergency conditions, including injuries and infections; and (3) make facilitated/warm hand-off referrals to community-based treatment services post-discharge. Under SB 1071, some Maryland hospitals would be required to update their protocols for patients with opioid use disorder and those treated for overdose, which had been required by the General Assembly in 2017 (HB 1329/SB 967).

I. Need for Evidence-Based Care for Patients with Opioid Use Disorder in Maryland's Emergency Departments

Hospital EDs play a crucial role in addressing Maryland's opioid epidemic, which claimed nearly 2,100 lives in the year ending October 2023. The ED is a point of access for medical care for many Marylanders with opioid use disorders, and the need for emergency care has escalated. Non-fatal opioid-related hospital ED visits increased by 10.5% (8,679 to 9,594 visits) from October 2022 to October 2023, and emergency medical service (EMS) naloxone administrations increased by 1.4% (from 8,836 to 8,963). Opioid-related ED visits increased in all but 2 counties during that period. The overdose epidemic has disparately harmed Black individuals, who suffered 48% of all overdose deaths in 2022 while making up 31% of Maryland's population, while remaining relatively constant among non-Hispanic white Marylanders since 2016.

The deadly and unabated threat posed by fentanyl demands uniform, evidence-based practices by all Maryland hospital EDs. While the Maryland Hospital Association's 2018 recommendations for ED protocols, issued in response to HB 1329/SB 967, established important standards – universal SUD screening, naloxone dispensing, facilitated referral to treatment and peer

recovery services — they no longer align with the extensive research and clinical adoption of evidence-based ED practices for opioid use disorder care. The Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department, issued by an ACEP-convened group of emergency physicians in June 2021, recommends that emergency physicians "offer to initiate opioid use disorder treatment with buprenorphine in appropriate patients and provide direct linkage to ongoing treatment for patients with opioid use disorder."

While many Maryland hospitals have adopted these practices, others have not – even in the face of uncontroverted evidence that opioid agonist medications effectively address acute opioid withdrawal and reduce mortality by 50 percent. Buprenorphine treatment for patients in the ED also improves engagement in follow-up addiction care post discharge. Newly-released data from the CA Bridge Patient Outcomes Study found a very high uptake of buprenorphine treatment among ED patients (86%), and those who received buprenorphine in the ED were almost 2 times more likely to be engaged in treatment 30 days after discharge than patients who were not treated with buprenorphine. These positive treatment outcomes are particularly important to ensure that Black individuals, who access buprenorphine at a disparately lower rate than white individuals, gain access to life-saving care.

States and local jurisdictions have taken varied steps to incentivize and require hospitals to adopt evidence-based practices. For example, the Baltimore Health Department issued Guidelines in 2018 that include three graduated levels of care, the most basic of which requires screening for substance use disorders, capacity to initiate medication for opioid use disorder, naloxone prescriptions and discharge protocols with a referral to community-based treatment. New York adopted legislation that requires general hospital EDs to develop treatment protocols for the appropriate use of medications, including buprenorphine, prior to discharge. N.Y. PUB. HEALTH LAW § 2803-U(1) (2019). Massachusetts adopted legislation that requires acute care hospitals to maintain protocols for and the ability to provide evidence-based practices, including buprenorphine, for individuals who have overdosed. (H4742/2018). SB 1074 would require these same life-saving practices across Maryland.

II. Hospital Legal Exposure for Failing to Provide Evidence-Based Services

Hospitals resist the implementation of these life-saving practices for various reasons, many of which can be addressed through education and training or additional support for the ED team. For example, some practitioners do not have the knowledge or comfort required to prescribe opioid agonist medications for patients with opioid use disorder, and some ED staff are unfamiliar with community-based services to which a patient can be referred. Other resistance, however, is based on stigmatizing and negative, yet long-refuted, stereotypical attitudes about patients with opioid use disorders that influence care decisions. All Marylanders should be able to rely on their hospital ED to fulfill its role to treat emergency medical conditions, such as lethal opioid-related overdoses, and link patients to definitive care in the community – the same care individuals receive for other chronic health conditions like cardiac disease, asthma and diabetes.

When hospitals fail to provide required emergency medical services or deny medical services based on stereotypes related to drug use, they risk legal sanctions under several federal laws. The Emergency Medical Treatment and Labor Act (EMTALA) requires an ED to screen all patients for medical emergency conditions, including opioid use disorder, and then stabilize the individual's condition to reasonably ensure that it does not materially deteriorate at discharge.

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When an ED does not provide effective relief for opioid withdrawal (i.e. administer an opioid agonist medication) or link a patient to on-going treatment, it is quite predictable that the patient's condition will deteriorate post-discharge. The patient will continue to use drugs to address cravings, placing their lives at risk.

The Americans with Disabilities Act bars hospitals from denying health services to individuals solely on the basis of their use of illegal drugs, administering services in a way that discriminates on the basis of disability or failing to provide a reasonable accommodation. By failing to offer buprenorphine based on stereotypical attitudes, such as the belief that a person who uses drugs will continue to do so, is taking time that could be devoted to patients with medical emergencies, or will sell a buprenorphine prescription, the hospital risks a lawsuit for disability-based discrimination. Hospitals that refuse a patient's request for buprenorphine to treat their overdose or for an effective referral to a community-based program likely violate their obligation to provide a reasonable accommodation. And a hospital ED that refuses to stock buprenorphine for opioid use disorder care may be liable for administering its services in a way that discriminates against individuals with disabilities.

All hospital EDs can effectively care for patients with opioid use disorders by implementing well-established protocols for screening and diagnosis, initiation of medication for opioid use disorder and facilitated referrals to care. Maryland has model programs that should be adopted by hospitals across the state.

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Thank you for considering our views. We urge the Committee to issue a favorable report on SB 1071 to ensure that all hospital EDs are delivering life-saving care for patients with opioid use disorder.

Ellen M. Weber, J.D.
Sr. Vice President for Health Initiatives
Legal Action Center
eweber@lac.org

SB1071.pdf
Uploaded by: Mike McKay
Position: FAV

Mike McKay
Legislative District 1
Garrett, Allegany, and Washington Counties

Judicial Proceedings Committee

Executive Nominations Committee

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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Senate Bill 1071 – Hospitals – Opioid Overdose – Medication-Assisted Treatment

March 8, 2024

Dear Chair Beidle, Vice Chair Klausmeier, and Members of the Committee

The purpose of Senate Bill 1071 is to require hospitals to establish and maintain protocols in order to provide appropriate interventions that help in the treatment of opioid-related overdoses. The bill will also require that hospitals possess, dispense, administer, and prescribe medication-assisted treatment as needed and specified and finally treat the patient. It requires for Fiscal Year 2026, the Governor of Maryland must include in the annual budget, $500,000 from the Opioid Restitution Fund.

I thank you all for your time and ask for a favorable report.

Sincerely,

Senator Mike McKay

Representing the Appalachia Region of Maryland

Serving Garrett, Allegany, and Washington Counties

NCADD-MD - 2024 SB 1071 FAV - Overdose Protocol in

Uploaded by: Nancy Rosen-Cohen

Position: FAV

Senate Finance Committee
March 14, 2024

Senate Bill 1071 – Hospitals - Opioid Overdose - Medication-Assisted Treatment

Support

NCADD-Maryland supports Senate Bill 1071 with the sponsor's amendments. The evidence is clear that additional interventions in many hospitals are needed to ensure that people who enter emergency departments due to opioid overdoses receive effective help. While it is common for hospitals to provide people with naloxone, and more and more hospitals employ peers to work with individuals, there are many hospitals that do not initiate medications used in the treatment of opioid use disorders (OUDs) and also facilitate connection to community-based services upon discharge.

Many studies in numerous countries point to these best practices. As far back as 2015, research indicated that medication induction in emergency departments resulted in greater engagement in treatment in the community. The Baltimore City Health Department, in 2018, launched the Levels of Care initiative to rank the capacity of area hospitals to provide effective interventions with the highest level including medication initiation.

Just last month, additional research showed yet again that implementing low-threshold access to medications for OUD in emergency departments was associated with a substantially higher likelihood of follow-up treatment engagement one month later.

Senate Bill 1071, with the sponsor's amendments, requires all hospitals to implement protocols that offer medication to people with opioid use disorders in emergency departments. Community-based treatment programs providing treatment with buprenorphine and/or methadone have long partnered with many hospitals and desire to develop new relationships where they do not exist. In areas of the state where community-based programs are scarce, primary care providers who prescribe buprenorphine can be connected to hospitals to receive referrals.

(over)

National Council on Alcoholism & Drug Dependence – Maryland Chapter
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www.ncaddmaryland.org

In all jurisdictions in the state, peers and recovery community organizations stand willing and able to assist with these connections. The provision of medication while in the emergency department can be used to manage withdrawal symptoms and allow for the time needed for facilitated connection to ongoing treatment outside the hospital.

The number of overdose deaths in Maryland in August of 2023 increased by nearly 3% compared to August of 2022. The tens of millions of dollars coming to the state from the opioid manufacturers must be spent on activities that provide intervention, treatment and recovery support services.

We believe it is time for all hospitals to provide these services in order to address the overdose crisis and we urge a favorable report with the sponsor's amendments.

SB1071-FIN-SUPP.pdf
Uploaded by: Nina Themelis
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB1071

March 14, 2024

TO: Members of the Senate Finance Committee

FROM: Nina Themelis, Interim Director of Mayor's Office of Government Relations

RE: Senate Bill 1071 – Hospitals - Opioid Overdose - Medication-Assisted Treatment

POSITION: FAVORABLE

Chair Beidle, Vice Chair Klausmeier, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 1071.

Senate Bill 1071 will mandate hospitals to establish and maintain certain protocols and capacities related to the treatment of patients who are being treated for an opioid-related overdose, require hospitals to connect patients who are administered or prescribed medication-assisted treatment (MAT) to an appropriate provider to voluntarily continue treatment under certain circumstances, and urge the Governor to include an appropriation of $500,000 in the annual budget bill for fiscal year 2026 from the Opioid Restitution Fund to fund training for healthcare professionals and provide resources to hospitals to implement the requirements of this Act.

Hospitals play a critical role in addressing the opioid crisis, serving as hubs for comprehensive care and essential treatment resources. In Maryland, nearly 9,000 residents who received care through the state's hospital system – either in an inpatient or ED facility – from 2016 through 2021 subsequently lost their lives to an overdose. Of those individuals, 41% had received care for an overdose-related encounter during the same time period.[i] **Had this 41% (nearly 4,000 people) received the care and referrals mandated under this bill, they might still be with us today. These statistics highlight a crucial opportunity for hospitals to serve as a conduit to sustained treatment and recovery.**

Implementing the protocols and procedures required by this bill will help ensure people receive evidence-based, high-quality care, thereby increasing the likelihood of successful recovery and reducing the risk of recurring overdose incidents. The bill's inclusion of MAT is also critical to this mission. MAT combines medications (such as methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies. It is proven to be safe and effective in managing opioid use disorders (OUD) and can help people stay in recovery.[ii] Research indicates that engagement in long-term MAT significantly reduces the risk of overdose among individuals with OUD by up to 50%.[iii] By connecting patients to MAT providers and other resources for sustained recovery, hospitals can serve as lifelines for those in need, offering not only immediate medical intervention but also a pathway to long-term recovery.

Furthermore, the inclusion of a $500,000 appropriation in the annual budget bill for fiscal year 2026 from the Opioid Restitution Fund is a strategic investment in the health and well-being of communities across Maryland. These funds will allow hospitals to implement the requirements of SB 1071, supporting the work needed to carry out our state's commitment to saving lives and improving the well-being of our communities.

Overdose deaths are preventable. By establishing standardized protocols, promoting continuity of care, and allocating necessary funds, we can strengthen our healthcare system's response to overdose and substance use disorder.

For these reasons, the BCA respectfully requests a **favorable** report on SB 1071.

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[i] Maryland Department of Health. (2023, August 15). *2022 Annual Report Data-Informed Overdose Risk Mitigation.* Retrieved from Stop Overdose: https://stopoverdose.maryland.gov/wp-content/uploads/sites/34/2023/08/8-15-2023-2022-DORM-Annual-Report-Final.pdf
[ii] US Food and Drug Administration. (2023). Information about Medication-Assisted Treatment (MAT). Retrieved from https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat
[iii] National Academies of Science. (2019, March 30). *The Effectiveness of Medication-Based Treatment for Opioid Use Disorder.* Washingotn, DC: National Academies Press.

MD SB1071 Legislative Testimony.pdf
Uploaded by: Peter Treitler
Position: FAV

Hospitals – Opioid Overdose – Medication-Assisted Treatment (SB 1071)
Senate Finance Committee
March 14, 2024
FAVORABLE

Thank you for the opportunity to submit testimony in support of SB 1071, which would require hospital emergency departments (EDs) to develop protocols and deliver evidence-based care to patients who present with an opioid overdose. My endorsement of this bill is based on nearly a decade of research on ED-based interventions for opioid use disorder, my past role as a clinical social worker in the addiction field, and my lived experience as someone in long-term recovery from opioid use disorder (OUD). The views and opinions expressed in this testimony are my own and do not reflect the official policy or position of Boston University.

Extensive research underscores the central role of EDs in addressing OUD, particularly as many people with OUD forego routine health care services and only engage with the health care system during acute care visits. Life-threatening events like overdose can also serve as pivotal "teachable moments" when individuals may be more receptive to services. Notably, a seminal study in 2015 demonstrated that administering buprenorphine, an OUD medication that is highly effective in reducing overdose risk, in EDs resulted in improved treatment adherence post-discharge, with subsequent studies corroborating these findings. Other ED-based interventions, such as addiction medicine consultation, screening, brief intervention, and referral to treatment, and peer navigation have also been shown to help link patients to treatment from EDs. Based on the emerging evidence, the American College of Emergency Physicians issued consensus recommendations in 2021, stating that ED physicians should initiate OUD medications and provide direct linkage to treatment for patients with OUD.

Despite these recommendations and growing evidence of effectiveness, OUD services remain underutilized in EDs. SB 1071 offers a pathway to enhance ED-based OUD care by mandating the provision of specific services to individuals treated for opioid overdose. Critically, the bill gives hospitals the flexibility to tailor the implementation of services based on their resources and unique circumstances. Further, SB 1071 allocates funding and resources to support implementation, addressing a significant barrier – lack of expertise – that has prevented greater uptake of ED-based OUD services.

In closing, I urge the Committee to support SB 1071 as a means to improve the delivery of evidence-based OUD services in Maryland's EDs. Thank you for considering my perspective.

Sincerely,

Peter Treitler, PhD
Assistant Professor
Boston University School of Social Work
treitler@bu.edu

SB 1071 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

March 13, 2024

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building – 3 East
Annapolis, MD 21401

RE: Support – Senate Bill 1071: Hospitals - Opioid Overdose - Medication-Assisted Treatment

Dear Chairman Beidle and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support Senate Bill 1071: Hospitals - Opioid Overdose - Medication-Assisted Treatment (SB 1071). The Maryland Office of Overdose Response reports that 2,513 fatal overdoses occurred in Maryland from October 2022 to September 2023. In the previous twelve months to that, 2,549 fatal overdoses occurred in Maryland. Opioids were by far and away the primary driver of said overdoses. Also worth noting is that in the twelve months ending in September 2023, compared to the twelve months ending in September 2022, there were 1.2% fewer emergency medical services (EMS) naloxone administrations in Maryland, decreasing from 9,018 to 8,909. However, in the twelve months ending in September 2023, compared to the twelve months ending in September 2022, there were 6.5% more non-fatal, opioid-related hospital emergency department visits, increasing from 8,864 to 9,437.

The numbers are clear, opioid overdoses continue to be a significant public health concern for Maryland, with thousands of deaths still occurring each year. SB 1071 adds steps in the emergency treatment of opioid overdose to help prevent future overdoses, including outpatient treatment referrals that would get patients on suboxone or other medication-assisted treatment rather than being sent back out on the street to simply overdose again.

However, MPS/WPS will note that this Honorable Committee should be aware of the reality of the treatment tableau. While an admirable goal, SB 1071 is trying to mandate that hospitals do something that is not in their full control. Access to outpatient medications for opioid use disorder clinics is difficult, and frequently, clinics require an admission interview prior to

accepting the patient. So, patients may be started on medications that outpatient providers will refuse to continue, or outpatient providers will provide with significant delay. Furthermore, SB 1071 may have some unintended consequences, such as ERs becoming even more de facto treatment centers than they already are.

Therefore, for all the reasons above and with the aforementioned warnings acknowledged, MPS/WPS ask the committee for a favorable report on SB 1071. If you have any questions regarding this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

5 - SB 1071 - FIN - MDH - LOSWA (1) (1).pdf
Uploaded by: Jason Caplan
Position: FWA

DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

March 14, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 1071 – Hospitals - Opioid Overdose - Medication-Assisted Treatment – Letter of Support with Amendments

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of support with amendments for SB 1071 - Hospitals - Opioid Overdose - Medication-Assisted Treatment.

This bill requires hospitals to establish and maintain protocols and capacity to treat patients for opioid-related overdose and connect patients that are administered or prescribed Medication-Assisted Treatment (MAT) to an appropriate provider to continue treatment and requires the Department to appropriate funds from the Opioid Restitution Fund for hospitals to provide training and resources to implement the requirements of §19–308.10 of the Health-General Article.

There are many studies showing hospital-based clinicians lack knowledge and comfort treating substance use disorder.[1][2][3][4] The Department currently coordinates with the Maryland Hospital Administration and the Mosaic Group to build the capacity of hospitals in Maryland to better respond to patients that present with high-risk substance use through the integration of universal screening, the employment of teams of peer recovery coaches to help with linkage to care and the introduction of MAT initiation. Over the last two years, the Department funded Mosaic Group to re-engage with twenty-one (21) hospitals to help them enhance their programming and start this work with the remaining hospitals that implemented the Reverse the Cycle program previously.

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[1] Jakubowski A, Singh-Tan S, Torres-Lockhart K, Nahvi S, Stein M, Fox AD, Lu T. Hospital-based clinicians lack knowledge and comfort in initiating medications for opioid use disorder: opportunities for training innovation. Addict Sci Clin Pract. 2023 May 18;18(1):31. doi: 10.1186/s13722-023-00386-x. PMID: 37198707; PMCID: PMC10193697.

[2] O'Rourke BP, Hogan TH, Teater J, Fried M, Williams M, Miller A, Clark AD, Huynh P, Kauffman E, Hefner JL. Initiation of medication for opioid use disorder across a health system: A retrospective analysis of patient characteristics and inpatient outcomes. Drug Alcohol Depend Rep. 2022 Nov 12;5:100114. doi: 10.1016/j.dadr.2022.100114. PMID: 36844164; PMCID: PMC9948916.

[3] Stewart MT, Coulibaly N, Schwartz D, Dey J, Thomas CP. Emergency department-based efforts to offer medication treatment for opioid use disorder: What can we learn from current approaches? J Subst Abuse Treat. 2021 Oct;129:108479. doi: 10.1016/j.jsat.2021.108479. Epub 2021 May 15. PMID: 34080563; PMCID: PMC8380665.

[4] Cindy Parks Thomas, Maureen T. Stewart, Cynthia Tschampl, Kumba Sennaar, Daniel Schwartz, Judith Dey, Emergency department interventions for opioid use disorder: A synthesis of emerging models, Journal of Substance Abuse Treatment, Volume 141, 2022, 108837, ISSN 0740-5472, https://doi.org/10.1016/j.jsat.2022.108837. (https://www.sciencedirect.com/science/article/pii/S0740547222001192)

Given the work currently underway, the Department had offered amendments on the cross file of this bill, but supports the general intentions of the sponsors. Our main concern with the current language is the required appropriation of $500,000 from the Opioid Restitution Fund for implementation of SB 1071. Appropriations from the Opioid Restitution Fund must follow strict requirements based on the master settlement agreements. Therefore, we request that this language be struck from the bill.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

testimony SB 1071 MOUD in hospitals.pdf

Uploaded by: Joseph Hobelmann

Position: FWA

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 1071 Hospitals - Opioid Overdose - Medication-Assisted Treatment
Finance Committee March 14, 2024

FAVORABLE WITH AMENDMENTS

Dear Chair Beidle and members of the committee,

This bill can significantly improve opioid use disorder (OUD) treatment, reduce emergency department and hospital admissions, reduce healthcare costs, and **significantly reduce fatal overdoses.**

Regarding House Bill 1155 as amended by HB1155/973521/1 (03/11/24)
We support the amendments offered by the Legal Action Center with the following additions:

> **Rationale: Individuals with OUD may often present for care with miscellaneous problems that are not obviously or definitely "opioid-related,"** e.g., minor trauma, motor vehicle crash, pneumonia, other medical illnesses, vomiting, dehydration, feeling poorly etc. Also, those who present with "opioid-related" problems are already known to likely have OUD.

MDDCSAM RECOMMENDED AMENDMENTS (in bold):

In Subsection (B) paragraph (1):

In addition to amendments from the Legal Action Center, MDDCSAM recommends that hospitals and emergency departments shall establish and maintain protocols and capacity to provide, before discharging a patient, appropriate, evidence-based interventions that reduce the subsequent harm following an opioid-related overdose, a visit for an opioid-related emergency medical condition, **or opioid use disorder.**

In Subsection (C) paragraphs (2):
In addition, MDDCSAM recommends that hospital and emergency department protocols include uniform practices for screening for and diagnosing **opioid use disorder (OUD)** not limited just to individuals who present with an opioid-related overdose or opioid-related emergency medical condition.

In Subsection (B) paragraph (2):
In addition, MDDCSAM recommends that hospital shall establish and maintain emergency services protocols and capacity to provide appropriate evidence-based interventions … following an opioid-related overdose, a visit for an opioid related emergency medical condition, **and for opioid use disorder.**

In subsection (C) paragraph (3):

In addition, MDDCSAM recommends that hospitals and emergency department protocols include offering and administering opioid agonist medication for treatment of patients **who are diagnosed with an opioid use disorder,** not limited just to those presenting with an opioid-related overdose, or an opioid-related emergency medical condition … (as recommended by the treating health care practitioner and agreed to by the patient).

In subsection (D) and new subsection (E):
In addition to suggested amendments, MDDCSAM recommends the following:

(D): BEFORE DISCHARGING A PATIENT WHO IS **DIAGNOSED WITH AN OPIOID USE DISORDER OR** ADMINISTERED OR PRESCRIBED MEDICATION **FOR OPIOID USE DISORDER,** A HOSPITAL SHALL:

(1) MAKE A REFERRAL OF THE PATIENT TO AN APPROPRIATE PROVIDER OR FACILITY FOR A TIMELY APPOINTMENT, WHERE POSSIBLE, TO VOLUNTARILY CONTINUE TREATMENT IN THE COMMUNITY; AND

(2) WORK WITH PEER SUPPORT PROFESSIONALS, AS AVAILABLE, OR OTHER RESOURCES TO ASSIST THE PATIENT IN ACCESSING THE IDENTIFIED TREATMENT SERVICES.

(E): USING ELECTRONIC HEALTH DATA, A HOSPITAL SHALL:

(1) QUANTIFY PATIENTS WITH:

(I) AN OPIOID USE DISORDER, AND

(II) AN OPIOID-RELATED OVERDOSE, AND

(2) OF PATIENTS WITH AN OPIOID USE DISORDER AND WITH AN OPIOID-RELATED OVERDOSE, CALCULATE:

(I) ADMINISTERED OR DISPENSED A MEDICATION FOR OPIOID USE DISORDER, AND/OR

(II) PRESCRIBED A MEDICATION FOR OPIOID USE DISORDER.

Rationale: Change is relatively unlikely to occur on the basis of establishing a protocol only. According to the Institute for Healthcare Improvement (IHI), "Measurement lies at the heart of quality improvement."

Multiple published studies have demonstrated the effectiveness of initiating buprenorphine specifically in the emergency department (ED). Most recently, Herring and colleagues showed that 86**% of ED patients with opioid use disorder (OUD) agreed to receive buprenorphine treatment, and 50% of these remained engaged in OUD treatment 1 month later, double the likelihood vs. those who did not receive buprenorphine.** This compares favorably with buprenorphine initiation in office settings. (Herring)

Nationally, only 20% of people with OUD are receiving treatment, often attributed to the notion that they are not interested in treatment with medications. But this study shows the vast majority will accept treatment when it is easy to access.

According to Dr. Herring, the system of EDs in the U.S. is one of the most valuable components of our public health infrastructure, providing 24-7 access for all. **EDs are the ideal setting to successfully reach and initiate treatment for people suffering from OUD.**

More than 5% of overdose patients seen at an emergency department (ED) die within the year, many in the first 2 days after discharge. There is an **urgent need** to roll out large-scale interventions to reduce opioid-related overdose deaths. In 2021, opioid use disorder (OUD) contributed to more than 80 000 overdose deaths in the US, up 24% from 2020.

The Standard of Care:

Whether in the ED or elsewhere, initiating treatment with medication is the standard of care for OUD, reducing fatal overdose by half. **OUD is unique** among substance use disorders in that **medications are the primary effective treatment** for the great majority of those affected, particularly opioid agonists treatments (OAT: methadone or buprenorphine). **Treatments without medication are ineffective** on their own, except possibly for mild or recent-onset OUD. *When combined with medication treatment*, evidence of effectiveness of concomitant counseling or psychotherapy on abstinence rates or retention in treatment is mixed. However, "buprenorphine without concomitant counseling is vastly superior to no treatment" according to the Director of the National Institute of Drug Abuse (NIDA) in a 2021 review. (Volkow)

According to NIDA, "Decades of research have shown beyond doubt the overwhelming benefit of medication for opioid use disorder (MOUD): … proven to be life-savers, keeping patients from illicitly using opioids, enabling them to live healthy and successful lives, and facilitating recovery. . . The efficacy of MOUD has been supported in clinical trial after clinical trial…". (NIDA) (SSN). Psychosocial interventions are an important part of comprehensive treatment whenever possible. The use of MOUD **is endorsed by every major health organization world-wide** that has addressed this issue.

The California Bridge program has established the initiation of medication treatment for OUD (MOUD) as **a standard of care in emergency departments**. Launched in 2018 by the California Department of Health Care Services, **it now operates in 85 percent of the state's E.D**s. (CA-Bridge)

"MOUD," not "MAT"

Note that the older term 'Medication Assisted Treatment' (MAT) has been replaced by Medication for Opioid Use Disorder (MOUD) by the Substance Abuse and Mental Health Services Administration (SAMHSA), NIDA, the Centers for Disease Control and Prevention (CDC), and the Drug Enforcement Administration (DEA), since 'MAT' promotes harmful medication stigma by inaccurately implying that medication for OUD is only a secondary part of treatment without medications. (Saitz))(Adams)

With these amendments, we urge a favorable report.

Respectfully,
Joseph A. Adams, MD, FASAM, board certified in internal medicine and addiction medicine

REFERENCES:

- IHI: Institute for Healthcare Improvement - Better Quality Through Better Measurement" https://www.ihi.org/education/training/better-quality-through-better-measurement

- Herring, AA, et. al. Emergency Department Access to Buprenorphine for Opioid Use Disorder. JAMA Network Open. 2024;7(1):e2353771. free: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2814325

- Volkow 2021: Volkow, ND & Blanco, C. The Changing Opioid Crisis: development, challenges and opportunities Mol Psychiatry. 2021 January ; 26(1): 218–233. free: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7398847/

- NIDA: Five Areas Where "More Research" Isn't Needed to Curb the Overdose Crisis. August 31, 2022 https://nida.nih.gov/about-nida/noras-blog/2022/08/five-areas-where-more-research-isnt-needed-to-curb-overdose-crisis

- (SSN) https://www.stopstigmanow.org/research-articles

- CA-Bridge: https://bridgetotreatment.org/addiction-treatment/ca-bridge/

- Saitz R, et. al. Recommended Use of Terminology in Addiction Medicine Journal of Addiction Medicine: J Addict Med , May 29, 2020 https://facesandvoicesofrecovery.org/wp-content/uploads/2020/06/Saitz-2020-JAM-Editorial Terminology_in_Addiction4.pdf

- Adams JA. Stigma: The Greatest Barrier to Effective of Opioid Use Disorder. Maryland Medical Journal. March 2023; Volume 24 (1):7 https://www.stopstigmanow.org/wp-content/uploads/2023/03/article-MMJ-Adams-stigma-3-2023.pdf

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SB1071 - Medication Assisted Treatment SWA.pdf

Uploaded by: Leslie Weber
Position: FWA

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.**

SB 1071-Hospitals - Opioid Overdose - Medication-A
Uploaded by: Jake Whitaker
Position: INFO

Maryland
Hospital Association

March 14, 2024

To: The Honorable Pamela Beidle, Chair, Senate Finance Committee

Re: Letter of Information- Senate Bill 1071- Hospitals - Opioid Overdose - Medication-Assisted Treatment

Dear Chair Beidle:

On behalf of the Maryland Hospital Association's (MHA) 62 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 1071. Maryland continues to cope with an opioid crisis, and our hospitals are on its front lines.

While we appreciate the intent behind SB 1071, in general, we do not believe clinical practice should be legislated. Science often moves faster than the legislative process. Given that advances happen regularly, codifying these practices may harm hospitals' ability to offer evidence-based standards of care.

Current evidence indicates that offering buprenorphine in emergency departments reduces morbidity and mortality[1]. Thus, procedures to start medication-assisted treatment (MAT) at emergency departments for individuals who suffered an overdose have already been widely adopted. We ask the Committee to ensure flexibility so that hospitals can quickly pivot as standards of care evolve.

We hope that you find this information useful as you deliberate this legislation.

For more information, please contact:
Jake Whitaker, Director, Government Affairs
Jwhitaker@mhaonline.org

[1]Evidence-Based Resource Guide Series: Use of Medication-Assisted Treatment in Emergency Departments."
Substance Abuse and Mental Health Services Administration (SAMHSA).
https://store.samhsa.gov/sites/default/files/pep21-pl-guide-5.pdf