LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Hospitals – Opioid Overdose – Medication-Assisted Treatment (HB 1155)
Health and Government Operations Committee
March 1, 2024
FAVORABLE

Thank you for the opportunity to submit testimony in support of HB 1155, 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.

HB 1155 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 HB 1155, 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

810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.57 www.lac.org

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, 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). HB 1155 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.

810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.57 www.lac.org

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.

****

Thank you for considering our views. We urge the Committee to issue a favorable report on HB 1155 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