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Hospitals Opioid Overdose – Medically Assisted Treatment (HB 1155)
Health and Government Operations, March 1, 2024
Favorable

Thank you for the opportunity to submit testimony in support of HB 1155. This testimony is submitted on behalf of my current and future patients, their families and many of my emergency medicine and addiction medicine colleagues throughout the state.

As a patient safety specialist, I would state that the opioid overdose crisis is one of the greatest patient safety issues of our day. One that requires highly reliable systems of care and accurate reporting.

Please allow me to share some background to best add the testimony already provided.

Clinical and Policy Experience in Emergency Medicine, Addiction Medicine, and Patient Safety

- Practiced medicine in Maryland for over 28 years –23 years in emergency medicine in a variety of settings within the Johns Hopkins health system and community practices in Baltimore and Calvert Counties.

- Patient Safety Specialist for 10 years - **Chief Safety Officer** for the largest EM group in the Mid-Atlantic region.

- Transitioned full time to Addiction Medicine and helped launch the **Opioid Crisis Response Program** for the Calvert County Health Department and served as medical director for 3 years.

- Currently, I am a board-certified Addiction Medicine specialist practicing in Glen Burnie with patients seen throughout the state as far as Frederick County, Southern Maryland, and the Eastern shore.

- I privileged to serve several Anne Arundel County health department committees focused on addressing the opioid overdose crisis and harm reduction.

- I serve on the **Fatal Overdose Review Team (FORT)** for Anne Arundel County and did so for Calvert County. For nearly 5 years, I have reviewed overdose fatality cases and events related to their care.

Existence of a Protocol and Stocking of Medication Does NOT Assure Successful Treatment – Quality Measures Must Be a Part of the Process

- In 2019, the leadership of my EM group initiated buprenorphine treatment protocols in 23 hospitals located in Maryland, Virginia, West Virginia and Washington DC. We did so with senior leadership commitment and close physician buy-in. Unfortunately, at that time it was not clear of the importance of providing buprenorphine treatment following an overdose. There was no mandate and no measures. Thus, we could not report the impact or compliance of the protocols. Most clinicians were interested in providing care for OUD.

Access to Care and Close Collaboration Can Make a Difference

- Calvert County observed a nearly 50% decrease in overdose deaths at the peak of the COVID crisis where many counties were experiencing increases. We believe it was a result of providing highly reliable, low barrier, easy access care with close collaboration with the Calvert Memorial Emergency Department and other regional hospitals and providers.

MOUD with Buprenorphine is a Standard of Care and the Treatment Most Fitting for Emergency Providers

- Chronic treatment can decrease the death rate but up to 80% and possibly even greater.
- Death rates have reported to be 2-5% and up to 10% in the 12 months following OD.
- The medication is safe and effective and can even be provided in the back of an ambulance without IV access or continuous cardiac monitoring.

Few Patients Report Receiving Buprenorphine in the ED following an Opioid Overdose

- I have cared for well over a thousand patients with opioid use disorder in the last 5 years. Many had experienced an overdose as some point in the course of their disease. Unfortunately, I can't recall of a single case where one of my patients reported going to an emergency department post OD and receiving buprenorphine. Many of my addiction medicine colleagues report the same experience. I believe this is due more to lack of knowledge or lack of specificity within protocols

- Several patients do report getting a dose of buprenorphine and/or bridge prescriptions when needed, but not post overdose.

Hospitals and Emergency Physicians Are Currently Ready and Able to Provide this Care

- National tools, protocols, professional endorsements, and clinical evidence are available to support the provision of care.

- We have all the components to make this a reality. Most hospitals have some protocols in place. Most ED physicians and willing and able to provide this care. Post opioid OD is a medical crisis and they are medical crisis specialists. Adjustments to protocols can be made to assure provision of medication treatment to qualified patients after an overdose.

- Hospitals already have "Code Stroke", and "Code MI" protocols in their emergency departments where a team rapidly descends upon the patient, coordinates care, initiates time sensitive treatment, and then refers on to the next level of care. All the care is measured, timed, and reported.

- We need that same level of excellence post opioid overdose. Treating opioid overdose could conceivably have a greater impact on Years of Life Saved.

- Senior hospital leaders are sometimes overwhelmed with all the demands of care and reporting requirements. The initial response is that they are not already doing this or that they don't support mandates. This does not have to be the case.

- We the appropriate impetus, success can be achieved. A legislative mandate can be that impetus.

Live Handoffs are Not Required but Reliable Referral Systems are Needed

- 24/7 "warm handoffs" are not practical or required for success. Reliable systems of referral with reporting and follow up can work well. Asynchronous communications systems can be used to relay patient information. Reporting should be done to demonstrate follow up success rates.

High Risks Demand High Reliability (not Hope)

- Safety Science does not rely on "Hope" as a method for high reliability. The airlines, the military and other high-risk industries rely on assertive deployment of reliable systems and practices and closely measure and report the outcomes. The same expectations should be applied for the healthcare response to opioid overdose crisis.

- We can't just HOPE that a hospital will have an appropriate and reliable protocol in place. We can't just HOPE that all clinicians can or will follow it. WE can't just HOPE the patient won't die without providing the gold standard treatment. We can't just hand

patients list of possible treatment providers (no matter how well curated) and HOPE they get the treatment they need in a timely and reliable fashion.

- Extending on the DEA's public relations campaign of "One Pill Can Kill" we now operate in the era of high potency synthetic opioids where "The Next Pill Can Kill" and time matters.

- My apologies for understating the problem at the beginning of my statement. This is not just one of the most important patient safety issues of our day; this is **one of the greatest "public safety" issues our citizens are experiencing**…. And we all have a responsibility to assure success.