



April 2, 2024

The Honorable Delegate Joseline A. Pena-Melnyk
Chair, House Health & Government Operations Committee
241 Taylor House Office Building
Annapolis, Maryland 21401

SB 1099 – Emergency Services – Automated External Defibrillator and Naloxone Co-Location Initiative – Requirements for Public Buildings

Dear Chair Pena-Melnyk:

I am writing today to provide information that may be helpful as the Committee considers SB 1099 - Emergency Services – Automated External Defibrillator and Naloxone Co-Location Initiative – Requirements for Public Buildings.

The Maryland Institute for Emergency Medical Services Systems (MIEMSS) is an independent State agency that administers Maryland’s Public Access Automated External Defibrillator (AED) program in accordance with the Annotated Code of Maryland, Education Article § 13-517. AED Program requirements are specified by regulation (See COMAR 30.06).

The Public Access AED (PAD) Program was established in 1999 to encourage placement of AEDs in communities throughout Maryland, especially where sudden cardiac arrest is more likely or emergency medical services (EMS) response is predictably longer (e.g., high-rise office buildings). The AED Program was designed to be a voluntary program, whereby entities wishing to place AEDs on their premises could do so and, if the entities met certain requirements, would qualify for immunity from civil liability for acts or omissions in the provision of automated external defibrillation.

Since the PAD program’s creation, 17,263 AEDs have been placed at thousands of locations in the State. While having an AED and participating in the PAD Program is voluntary for the vast majority of entities that participate in the program, AEDs are required to be placed at schools and county or municipally operated pools,^[1] and by 2025 at certain restaurants and grocery stores.^[2] There is no requirement for “public buildings” to participate in the Public Access AED (PAD) Program.

Adding a requirement of naloxone placement to a largely voluntary program is potentially problematic. We worry that adding a requirement could result in entities that have been voluntarily participating in the AED Program to decide to end their voluntary participation,

^[1] HB 1200 (Chapter 203) 2006; Education-High Schools or Secondary Schools – Automated External Defibrillator Program. HB 812 (Chapter 616) 2014; Education- Middle Schools-Automated External Defibrillators. HB 364 (Chapter 107) 2013; Swimming Pools-Automated External Defibrillator Programs (Conner’s Law).

^[2] SB 299 (Chapter 305); 2023; Grocery Stores and Restaurants – Automated External Defibrillator Program (Joe Sheya Act).

especially for those who consider themselves to be at exceptionally low risk for encountering an opioid overdose victim.

At this time, we estimate that approximately 4500 PAD AEDs are at locations that would likely fall under the bill's definition of "public building." However, we do not know how many public buildings in Maryland are not currently participating in the PAD program, so we cannot estimate the practical or financial impact of implementing the Naloxone requirement among all "public buildings."

Further, we anticipate the bill would have an impact on local and county governments, but because the ultimate number of "public buildings" under the bill's definition is unknown, we cannot estimate the costs to local governments.

PAD site entities currently bear costs associated with making an AED available at their locations, including the cost of the device and of periodically (every two to three years) replacing batteries and electrode pads. Requiring naloxone would add cost. "U Intranasal" naloxone, the preferred route of administration, retails for more than \$100 per package. Naloxone also has a shorter shelf-life than AED components, and must be replaced every one to two years. Further, providing instructions to laypersons who would administer the Naloxone needs to be considered, as its application is not necessarily intuitive among the lay public.

We share interest in making naloxone promptly available at the scenes of opioid overdoses. However, we also believe that greater understanding of overdose locations is needed to best determine how to best dedicate resources. For example, in 2023 less than one percent of Maryland EMS responses for overdose were to each of most of the location types potentially qualifying as "public building." What proportion of them have AEDs is not yet known.

Our recommendation would be to conduct a study during the interim to determine how best to implement a Public Access Naloxone Program and, in so doing, identify a strategy for determining what locations would be best for Naloxone placement, how to implement the requirement of Naloxone placement, track Naloxone applications, and other factors.

I hope you and the Committee find this information helpful. Please let me know if you have any questions or if I may provide further information.

Sincerely,



Theodore R. Delbridge, MD, MPA
Executive Director

Cc: The Honorable Senator William C. Smith, Jr.