HB 1131 Buprenorphine Training Grant and Work Group

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FAVORABLE

Greetings Madam Chair Beidle and Vice-Chair Hayes and thank you to Del. Joe Vogel for sponsoring the House version of this legislation.

As background, I am Patrick Chaulk MD, ACPM, a board certified Preventive Medicine Physician. I am a clinician with PCARE a nonprofit Baltimore-based program that provides free, low barrier care for people struggling with opioid use disorder. I am a member of the Maryland Department of Health's Standing Advisory Committee on Opioid-Associated Disease Prevention and Outreach Programs and a member of BCHD's Syringe Services Oversight Committee, where I was Assistant Commissioner until 2018. These experiences have allowed me to interact with thousands of people suffering from opioid use disorder (OUD).

I delivered testimony on the House bill and am submitting written testimony today as an individual only and not on behalf of any organizations.

Maryland saw a decline in overdose deaths in 2024. However, **the decade-long trend has been increasing: from 8.9/100,000 in 2003 to 31.3 in 2023.** Clearly there is still much more that we need to, and can do, to reduce these preventable deaths.

The public is becoming increasingly aware of the value of naloxone in resuscitating someone experiencing an opioid overdose. **But naloxone is just the first step** in successful overdose treatment.

Naloxone rapidly displaces opioids prompting return of respiration - **but it can also result in painful opioid withdrawal**. Symptoms include: agitation, abdominal pain and vomiting, muscle pain, cramping and irritability. These symptoms contribute to an existing chaotic and confusing experience for patients.

Since naloxone's effect lasts only 60-90 minutes overdose can reoccur if the patient consumed one of the wide-spread newer and longer acting synthetic opioids. **Between 5% and 10% of those resuscitated will overdose again. The greatest risk for this relapse is in the first 24-48 hours after initial resuscitation.** T**reatment to prevent relapse as well as withdrawal is administration of buprenorphine** which will reduce symptoms, stabilize and calm the patient and reduce the probability of overdose relapse.

Administration of buprenorphine has traditionally been administered after the patient has been transported to the hospital. Increasingly its **administration is delivered by paramedics in the field as part of standard of care with resuscitation management. This has been adopted, in part, because up to 45% of revived patients refuse hospital transport for a variety of reasons, such as long wait times once at the hospital.** Paramedic-lead field administration of buprenorphine is standard practice in such diverse jurisdiction as: Burlington, Vermont; Oakland CA, San Francisco CA and many California Counties; Madison, Wisconsin; Seattle, Washington; Trenton, New Jersey.

Another advantage of field administration of buprenorphine is that it produces a high rate – up to 78% - of engagement in further care and addiction treatment. This occurs most when peer recovery specialists

are included on the EMS team. With lived-recovery these peers bring knowledge, trust and connection to the EMS encounter.

To achieve the advantages of EMS field administration of buprenorphine the bill authorizes establishment of a workgroup to guide and disseminate this program in the State. Using the lessons learned from other state experiences, it will be possible for the Work Group to design a model consistent with the best interests of the State and local governments.

As naloxone is but the first step in opioid overdose treatment, buprenorphine is only the second step. **The final step is linking patients to effective recovery, something a patient who dies from an overdose will never have the opportunity to experience.**

Maryland in creating a training workgroup as a center piece of opioid overdose treatment has a chance to demonstrate great leadership in the field by linking effective opioid overdose resuscitation and withdrawal management to effective non-stigmatizing addiction treatment. A thoughtful work group is strategically positioned to achieve this goal.

I strongly recommend passage of this important bill for Marylanders. Thank you Madam Chair and committee members for this opportunity to submit this testimony in support of this bill.

1. Prehospital Buprenorphine Treatment for Opioid Use Disorder by Paramedics: First Year Results of the EMS Buprenorphine Use Pilot. HG Hern, et. al. Prehosp Emerg Care. 2023;27(3):334-342.
2. Buprenorphine Field Initiation of ReScue Treatment by Emergency Medical Services (Bupe FIRST EMS): A Case Series. GG Carroll et. al. Prehosp Emerg Care. 2021 Mar-Apr;25(2):289-293.
3. Glenn MJ, Rice AD, Primeau K, et al. Refusals After Prehospital Administration of Naloxone during the COVID-19 Pandemic. Prehosp Emerg Care. 2021;25(1):46-54.
4. Carroll G, Solomon KT, Heil J, et al. Impact of Administering Buprenorphine to Overdose Survivors Using Emergency Medical Services. Ann Emerg Med. Published online October 1, 2022.