Department of Legislative Services

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2017 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 519 (Delegate Morhaim, *et al.*)
Health and Government Operations

Public Health - Overdose and Infectious Disease Prevention Safer Drug Consumption Facility Program

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This bill authorizes a community-based organization (CBO) to establish an Overdose and Infectious Disease Prevention Safer Drug Consumption Facility Program in one or more jurisdictions. A program must, among other requirements, provide a location supervised by health care professionals or other trained staff where drug users can consume preobtained drugs, as well as receive other services, education, and referrals. A CBO must receive approval from the Department of Health and Mental Hygiene (DHMH) or a local health department (LHD) to establish a program. The bill specifies program requirements, establishes program reporting requirements, and establishes legal protections for a person acting in accordance with the bill's provisions.

Fiscal Summary

State Effect: Assuming a small number of CBOs apply to DHMH, the department can likely approve or deny program applications with existing budgeted resources. To the extent that a significant number of CBOs apply to DHMH, the department may require additional staff, as discussed below. Revenues are not affected.

Local Effect: Significant operational and fiscal impact for those LHDs that choose to implement a program. Local expenditures may be offset by authorized funding sources established under the bill. LHDs may also incur minimal costs associated with approving programs that apply to them instead of to DHMH.

Small Business Effect: Meaningful for any small business CBO that elects to operate a program as authorized under the bill.

Analysis

Bill Summary: "Community-based organization" means a public or private organization that is representative of a community or significant segments of a community and that provides educational, health, or social services to individuals in the community. The definition includes hospitals, clinics, substance abuse treatment centers, medical offices, federally qualified health centers, mental health facilities, and LHDs.

A CBO may apply to DHMH or a LHD for program approval at any time, regardless of previous applications. DHMH or the LHD must (1) make its decision to approve or deny an application based on whether the CBO can satisfy the bill's program requirements; (2) make a decision within 45 days of receiving an application; and (3) provide a written explanation of its decision to the CBO.

A program must, among other requirements, (1) provide secure sterile needle exchange; (2) answer questions about safe injection practices; (3) administer first aid, if needed, monitor for potential overdose, and administer rescue medications; (4) provide referrals; (5) educate participants on the risks of contracting HIV and viral hepatitis; and (6) provide overdose prevention education and access to or referrals to obtain naloxone. A program may, with permission, bill a participant's health insurance; accept specified outside financial assistance; apply for grants; and coordinate with any opioid-associated disease prevention and outreach program or CBO.

A program must collect a range of data about its operations, including (1) the number of participants served and the frequency with which they utilize program services; (2) specified demographic information; (3) the number of hypodermic needles and syringes distributed for use on-site; (4) the number of overdoses experienced on-site and overdoses reversed on-site; (5) the number of individuals who received overdose care and the type and number of rescue drugs used; and (6) the number of individuals referred to other services and the types of services to which they were referred. Each program must report this data to DHMH or the LHD that approved the program, and the Joint Committee on Behavioral Health and Opioid Use Disorders, by December 1 of each year.

Program participants, staff members, and program property owners are not subject to arrest, prosecution, or any civil or administrative penalty, including action by a professional licensing board, and may not be denied any right or privilege because of their involvement in the program. Further, a property owner, manager, employee, volunteer, or program participant who is acting in accordance with the bill's provisions is not subject to the seizure or forfeiture of any real or personal property used in connection with a program in accordance with State or local law. However, these individuals are not immune from criminal prosecution for any activities not authorized or approved by the program.

Current Law: In February 2015, the Governor issued two executive orders establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council and the Heroin and Opioid Emergency Task Force to establish a coordinated statewide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse. Additionally, Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders. The joint committee is required to monitor the activities of the coordinating council and the effectiveness of the State Overdose Prevention Plan; local overdose prevention plans and fatality review teams; strategic planning practices to reduce prescription drug abuse; and efforts to enhance overdose response laws, regulations, and training. In January 2017, the Governor issued another executive order establishing an Opioid Operational Command Center within the coordinating council to facilitate coordination and sharing of data among State and local agencies.

The Heroin and Opioid Emergency Task Force issued its final report in December 2015, which included a recommendation for legislation authorizing any county in Maryland to establish an opioid-associated disease prevention and outreach program to provide outreach, education, and linkage to treatment services, including the exchange of sterile syringes to people who inject drugs. Chapter 348 of 2016 implemented this recommendation.

Chapter 348 authorizes a LHD or CBO, with the approval of DHMH and the appropriate local health officer, to establish an opioid-associated disease prevention and outreach program. A LHD or CBO must apply to DHMH and a local health officer for authorization to operate a program. DHMH and the local health officer must jointly authorize the program.

An opioid-associated disease prevention and outreach program must:

- provide security of program locations and equipment;
- allow participants to obtain and return hypodermic needles and syringes at any program location, if more than one location is available;
- have appropriate staff expertise in working with individuals who inject drugs;
- include adequate staff training;
- disseminate other means for curtailing the spread of HIV and viral hepatitis;
- link individuals to additional services, including substance-related disorder counseling, treatment, and recovery services; testing for specified diseases; reproductive health education and services; wound care; and overdose response program services;
- educate participants on the dangers of contracting HIV and viral hepatitis;
- provide overdose prevention education and access to naloxone or a referral to obtain naloxone;

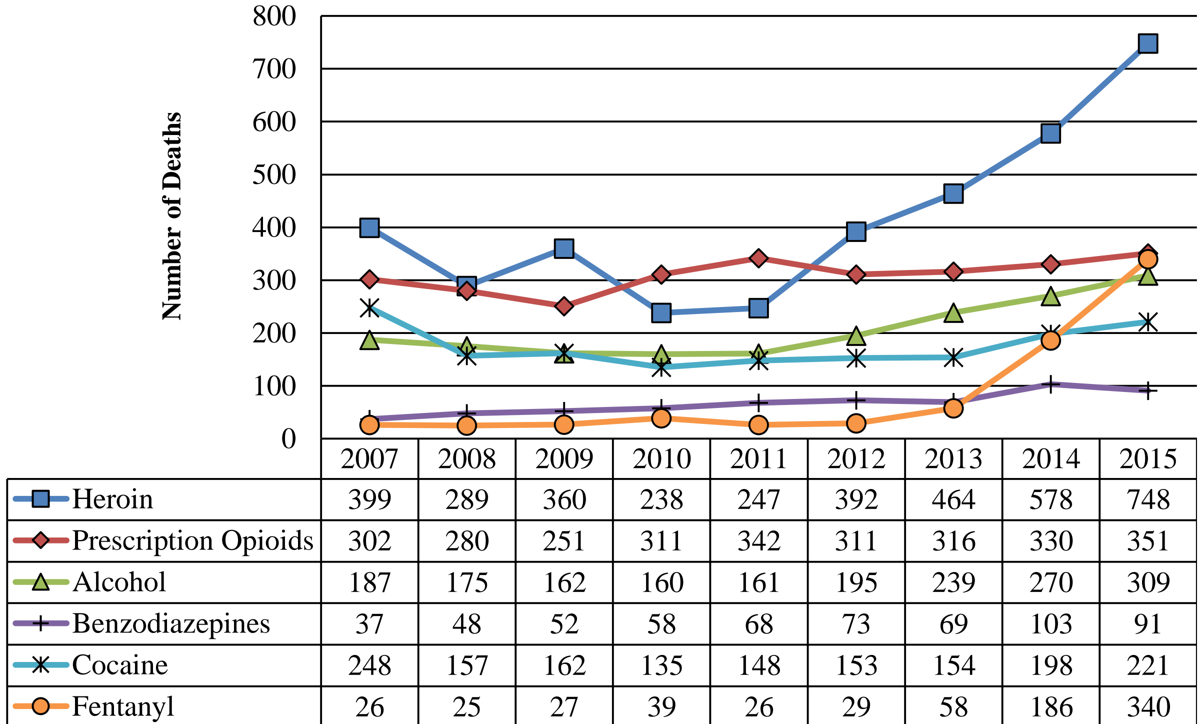
- establish procedures for identifying program participants in accordance with specified confidentiality provisions;
- establish methods for identifying and authorizing staff members and volunteers who have access to hypodermic needles, syringes, and program records;
- develop a plan for data collection and program evaluation; and
- collect and report specified information to DHMH at least annually.

Background: According to a 2011 study published in *The Lancet*, internationally, more than 65 supervised injecting facilities (SIFs), sites where drug users can inject preobtained illicit drugs, have been opened as part of various strategies to reduce the harms associated with drug use. The study, which reviewed the reduction in overdose mortality after the opening of a SIF in Vancouver, found that SIFs are an effective intervention to reduce community overdose mortality and should be considered for assessment, particularly in communities with high levels of injection drug use.

According to DHMH's 2016 report, *Drug and Alcohol-Related Intoxication Deaths in Maryland*, drug- and alcohol-related intoxication deaths in Maryland increased for the fifth year in a row, totaling 1,259 deaths in 2015 – a 21% increase since 2014 and an all-time high. Of all intoxication deaths, 1,089 deaths (86%) were opioid-related, including deaths related to heroin, prescription opioids, and nonpharmaceutical fentanyl. Opioid-related deaths increased by 23% between 2014 and 2015 and have more than doubled since 2010. Heroin- and fentanyl-related deaths have risen particularly sharply. The number of heroin-related deaths increased by 29% between 2014 and 2015 and has more than tripled between 2010 and 2015. The number of fentanyl-related deaths increased by 83% between 2014 and 2015 and has increased nearly twelvefold since 2012. **Exhibit 1** shows trends in drug- and alcohol-related intoxication deaths in Maryland from 2007 through 2015.

Preliminary data from DHMH indicates that the number of intoxication deaths increased at an even steeper rate in 2016, with 1,468 deaths from January through September 2016 compared to 904 deaths during the same period in 2015 (a 62% increase). Additionally, for January through September 2016, the number of heroin-related deaths increased 72% and the number of fentanyl-related deaths increased nearly fourfold compared to the same period in 2015.

Exhibit 1
Total Number of Drug- and Alcohol-related Intoxication Deaths By Selected Substances in Maryland
2007-2015



	2007	2008	2009	2010	2011	2012	2013	2014	2015
Heroin	399	289	360	238	247	392	464	578	748
Prescription Opioids	302	280	251	311	342	311	316	330	351
Alcohol	187	175	162	160	161	195	239	270	309
Benzodiazepines	37	48	52	58	68	73	69	103	91
Cocaine	248	157	162	135	148	153	154	198	221
Fentanyl	26	25	27	39	26	29	58	186	340

Source: Department of Health and Mental Hygiene

State Expenditures: DHMH or a LHD is required to provide initial approval (or denial) of applications from CBOs and written justification for the decision. The bill establishes no enforcement or ongoing requirements for DHMH or the LHD. DHMH advises, however, that site inspections for such facilities should be conducted as a matter of best practice. Although DHMH advises that two full-time employees are needed to implement the bill, the Department of Legislative Services (DLS) disagrees. Based on the assumption that a small number of CBOs are likely to apply, and that either DHMH *or* a LHD must review applications, DLS advises that DHMH can likely implement the bill's requirements with existing resources and staffing levels. To the extent that a significant number of CBOs apply to the department, DHMH may need additional staff assistance to review and respond to these applications and to possibly conduct site visits.

Local Fiscal Effect: Expenditures increase significantly for any LHD that chooses to implement a program as authorized under the bill. It is unknown how much such a program will cost, and there would likely be significant variations among programs depending on the size, number of health care professionals, hours, variety of services, and population

served. DHMH advises, for comparison, that implementing a syringe exchange program for an average-sized LHD costs approximately $400,000. Thus, establishing a program under the bill likely costs at least $400,000. DLS notes that LHDs are *not* mandated to establish a program under the bill. These expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

The Maryland Association of County Health Officers (MACHO) advises that it may also cost LHDs approximately $1,500 to $2,000 annually to review CBO applications and reports, although depending on the number of programs that apply to LHDs rather than DHMH, some LHDs may be able to absorb these costs with existing resources. MACHO additionally notes that it is unclear if LHDs have any ongoing enforcement or monitoring role in overseeing these programs.

Small Business Effect: To the extent that a CBO is a small business and successfully applies to establish a program under the bill, expenditures increase significantly, as discussed under the local fiscal effect. These expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Additional Information

Prior Introductions: HB 1212 of 2016, a similar bill, was withdrawn after a hearing in the House Health and Government Operations Committee.

Cross File: None.

Information Source(s): Maryland Association of County Health Officers; Department of Health and Mental Hygiene; Maryland Insurance Administration; *The Lancet*; Department of Legislative Services

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