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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

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A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING

Introduced By: Senators Miller, Goodwin, McCaffrey, Goldin, and Satchell

Date Introduced: January 24, 2019

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 23-17.26-3 of the General Laws in Chapter 23-17.26 entitled
2 "Comprehensive Discharge Planning" is hereby amended to read as follows:

3 **23-17.26-3. Comprehensive discharge planning.**

4 (a) On or before January 1, 2017, each hospital and freestanding, emergency-care facility
5 operating in the state of Rhode Island shall submit to the director a comprehensive discharge plan
6 that includes:

7 (1) Evidence of participation in a high-quality, comprehensive discharge-planning and
8 transitions-improvement project operated by a nonprofit organization in this state; or

9 (2) A plan for the provision of comprehensive discharge planning and information to be
10 shared with patients transitioning from the hospital's or freestanding, emergency-care facility's
11 care. Such plan shall contain the adoption of evidence-based practices including, but not limited
12 to:

13 (i) Providing education in the hospital or freestanding, emergency-care facility prior to
14 discharge;

15 (ii) Ensuring patient involvement such that, at discharge, patients and caregivers
16 understand the patient's conditions and medications and have a point of contact for follow-up
17 questions;

18 (iii) ~~With patient consent, attempting to notify the person(s) listed as the patient's~~
19 ~~emergency contacts and recovery coach before discharge. If the patient refuses to consent to the~~

1 ~~notification of emergency contacts, such refusal shall be noted in the patient's medical record~~
2 Attempting to notify the person(s) listed as the patient's emergency contacts and recovery coach,
3 consistent with the provisions of the Federal Health Insurance Portability and Accountability Act
4 of 1996, HIPAA, sections 261 through 264 (29 U.S.C. § 1181 et seq.). All such attempts at
5 notification shall be noted in the patient's medical record;

6 (iv) Attempting to identify patients' primary care providers and assisting with scheduling
7 post-discharge follow-up appointments prior to patient discharge;

8 (v) Expanding the transmission of the department of health's continuity-of-care form, or
9 successor program, to include primary care providers' receipt of information at patient discharge
10 when the primary care provider is identified by the patient; and

11 (vi) Coordinating and improving communication with outpatient providers.

12 (3) The discharge plan and transition process shall include recovery planning tools for
13 patients with substance-use disorders, opioid overdoses, and chronic addiction, which plan and
14 transition process shall include the elements contained in subsections (a)(1) or (a)(2), as
15 applicable. In addition, such discharge plan and transition process shall also include:

16 (i) That, with patient consent, each patient presenting to a hospital or freestanding,
17 emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic
18 addiction shall receive a substance-~~abuse~~ use evaluation, in accordance with the standards in
19 subsection (a)(4)(ii), before discharge. Prior to the dissemination of the standards in subsection
20 (a)(4)(ii), with patient consent, each patient presenting to a hospital or freestanding, emergency-
21 care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction
22 shall receive a substance-~~abuse~~ use evaluation, in accordance with best practices standards, before
23 discharge;

24 (ii) That if, after the completion of a substance-~~abuse~~ use evaluation, in accordance with
25 the standards in subsection (a)(4)(ii), the clinically appropriate inpatient and outpatient services
26 for the treatment of substance-use disorders, opioid overdose, or chronic addiction contained in
27 subsection (a)(3)(iv) are not immediately available, the hospital or freestanding, emergency-care
28 facility shall provide medically necessary and appropriate services with patient consent, until the
29 appropriate transfer of care is completed;

30 (iii) That, with patient consent, pursuant to 21 C.F.R. § 1306.07, a physician in a hospital
31 or freestanding, emergency-care facility, who is not specifically registered to conduct a narcotic
32 treatment program, may administer narcotic drugs, including buprenorphine, to a person for the
33 purpose of relieving acute, opioid-withdrawal symptoms, when necessary, while arrangements
34 are being made for referral for treatment. Not more than one day's medication may be

1 administered to the person or for the person's use at one time. Such emergency treatment may be
2 carried out for not more than three (3) days and may not be renewed or extended;

3 (iv) That each patient presenting to a hospital or freestanding, emergency-care facility
4 with indication of a substance-use disorder, opioid overdose, or chronic addiction, shall receive
5 information, made available to the hospital or freestanding, emergency-care facility in accordance
6 with subsection (a)(4)(v), about the availability of clinically appropriate inpatient and outpatient
7 services for the treatment of substance-use disorders, opioid overdose, or chronic addiction,
8 including:

9 (A) Detoxification;

10 (B) Stabilization;

11 (C) Medication-assisted treatment or medication-assisted maintenance services, including
12 methadone, buprenorphine, naltrexone, or other clinically appropriate medications;

13 (D) Inpatient and residential treatment;

14 (E) Licensed clinicians with expertise in the treatment of substance-use disorders, opioid
15 overdoses, and chronic addiction;

16 (F) Certified recovery coaches; and

17 (v) That, when the real-time patient-services database outlined in subsection (a)(4)(vi)
18 becomes available, each patient shall receive real-time information from the hospital or
19 freestanding, emergency-care facility about the availability of clinically appropriate inpatient and
20 outpatient services.

21 (4) On or before January 1, 2017, the director of the department of health, with the
22 director of the department of behavioral healthcare, developmental disabilities and hospitals,
23 shall:

24 (i) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities, a
25 regulatory standard for the early introduction of a recovery coach during the pre-admission and/or
26 admission process for patients with substance-use disorders, opioid overdose, or chronic
27 addiction;

28 (ii) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities,
29 substance-~~abuse~~ use evaluation standards for patients with substance-use disorders, opioid
30 overdose, or chronic addiction;

31 (iii) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities,
32 pre-admission, admission, and discharge regulatory standards, a recovery plan, and voluntary
33 transition process for patients with substance-use disorders, opioid overdose, or chronic addiction.
34 Recommendations from the 2015 Rhode Island governor's overdose prevention and intervention

1 task force strategic plan may be incorporated into the standards as a guide, but may be amended
2 and modified to meet the specific needs of each hospital and freestanding, emergency-care
3 facility;

4 (iv) Develop and disseminate best practices standards for health care clinics, urgent-care
5 centers, and emergency-diversion facilities regarding protocols for patient screening, transfer, and
6 referral to clinically appropriate inpatient and outpatient services contained in subsection
7 (a)(3)(iv);

8 (v) Develop regulations for patients presenting to hospitals and freestanding, emergency-
9 care facilities with indication of a substance-use disorder, opioid overdose, or chronic addiction to
10 ensure prompt, voluntary access to clinically appropriate inpatient and outpatient services
11 contained in subsection (a)(3)(iv);

12 (vi) Develop a strategy to assess, create, implement, and maintain a database of real-time
13 availability of clinically appropriate inpatient and outpatient services contained in subsection
14 (a)(3)(iv) of this section on or before January 1, 2018.

15 (5) On or before September 1, 2017, each hospital and freestanding, emergency-care
16 facility operating in the state of Rhode Island shall submit to the director a discharge plan and
17 transition process that shall include provisions for patients with a primary diagnosis of a mental
18 health disorder without a co-occurring substance use disorder.

19 (6) On or before January 1, 2018, the director of the department of health, with the
20 director of the department of behavioral healthcare, developmental disabilities and hospitals, shall
21 develop and disseminate mental health best practices standards for health care clinics, urgent care
22 centers, and emergency diversion facilities regarding protocols for patient screening, transfer, and
23 referral to clinically appropriate inpatient and outpatient services. The best practice standards
24 shall include information and strategies to facilitate clinically appropriate prompt transfers and
25 referrals from hospitals and freestanding, emergency-care facilities to less intensive settings.

26 SECTION 2. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
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RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING

1 This act would amend the current law so that, as part of a comprehensive discharge plan,
2 a hospital or an emergency care facility would be allowed to attempt to contact the patient's
3 emergency contact and the recovery coach, in accordance with federal law.

4 This act would take effect upon passage.

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