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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO HEALTH AND SAFETY - COMPREHENSIVE DISCHARGE PLANNING

Introduced By: Representatives Canario, Lima, McLaughlin, Fellela, and Bennett

Date Introduced: June 08, 2017

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

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

23-17.26-3. Comprehensive discharge planning.

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

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

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

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

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

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

notification of emergency contacts, such refusal shall be noted in the patient's medical record;

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

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

(vi) Coordinating and improving communication with outpatient providers.

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

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

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

(iii) That, with patient consent, pursuant to 21 C.F.R. § 1306.07, a physician in a hospital or freestanding, emergency-care facility, who is not specifically registered to conduct a narcotic treatment program, may administer narcotic drugs, including buprenorphine, to a person for the purpose of relieving acute, opioid-withdrawal symptoms, when necessary, while arrangements are being made for referral for treatment. Not more than one day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days and may not be renewed or extended;

(iv) That each patient presenting to a hospital or freestanding, emergency-care facility with indication of a substance-use disorder, opioid overdose, or chronic addiction, shall receive

information, made available to the hospital or freestanding, emergency-care facility in accordance with subsection (a)(4)(v), about the availability of clinically appropriate inpatient and outpatient services for the treatment of substance-use disorders, opioid overdose, or chronic addiction, including:

(A) Detoxification;

(B) Stabilization;

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

(D) Inpatient and residential treatment;

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

(F) Certified recovery coaches; and

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

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

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

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

(iii) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities, pre-admission, admission, and discharge regulatory standards, a recovery plan, and voluntary transition process for patients with substance-use disorders, opioid overdose, or chronic addiction. Recommendations from the 2015 Rhode Island governor's overdose prevention and intervention task force strategic plan may be incorporated into the standards as a guide, but may be amended and modified to meet the specific needs of each hospital and freestanding, emergency-care facility;

(iv) Develop and disseminate best practices standards for health care clinics, urgent-care

centers, and emergency-diversion facilities regarding protocols for patient screening, transfer, and referral to clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv);

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

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

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

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

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

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This act would require medical treatment facilities to provide discharge plans for patients with nonsubstance abuse related mental health disorders.

This act would take effect upon passage.

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