

2019 -- H 5383

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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: Representatives Edwards, Bennett, Chippendale, Canario, and Mendez

Date Introduced: February 14, 2019

Referred To: House Finance

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 Encouraging notification of the person(s) listed as the patient's emergency contacts and certified  
3 peer recovery specialist to the extent permitted by lawful patient consent or applicable law,  
4 including but not limited to the Federal Health Insurance Portability and Accountability Act of  
5 1996, as amended and 42 CFR Part 2, as amended. The policy shall also require all such attempts  
6 at notification to be noted in the patient's medical record;

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

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

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

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

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

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

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

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

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

10 (A) Detoxification;

11 (B) Stabilization;

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

14 (D) Inpatient and residential treatment;

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

17 (F) Certified [peer](#) recovery ~~coaches~~ [specialists](#); and

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

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

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

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

32 (iii) Develop and disseminate, to all hospitals and freestanding, emergency-care facilities,  
33 pre-admission, admission, and discharge regulatory standards, a recovery plan, and voluntary  
34 transition process for patients with substance-use disorders, opioid overdose, or chronic addiction.

1 Recommendations from the 2015 Rhode Island governor's overdose prevention and intervention  
2 task force strategic plan may be incorporated into the standards as a guide, but may be amended  
3 and modified to meet the specific needs of each hospital and freestanding, emergency-care  
4 facility;

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

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

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

16 [\(b\) Nothing contained in this chapter shall be construed to limit the permitted disclosure](#)  
17 [of confidential health care information and communications permitted in § 5-37.3-4\(b\)\(4\)\(i\) of](#)  
18 [the Confidentiality of Health Care Communications Act.](#)

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

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

30 SECTION 2. Section 5-37.3-4 of the General Laws in Chapter 5-37.3 entitled  
31 "Confidentiality of Health Care Communications and Information Act" is hereby amended to read  
32 as follows:

33 **5-37.3-4. Limitations on and permitted disclosures.**

34 (a)(1) Except as provided in subsection (b) of this section, or as specifically provided by

1 the law, a patient's confidential health care information shall not be released or transferred  
2 without the written consent of the patient, or his or her authorized representative, on a consent  
3 form meeting the requirements of subsection (d) of this section. A copy of any notice used  
4 pursuant to subsection (d) of this section, and of any signed consent shall, upon request, be  
5 provided to the patient prior to his or her signing a consent form. Any and all managed care  
6 entities and managed care contractors writing policies in the state shall be prohibited from  
7 providing any information related to enrollees that is personal in nature and could reasonably lead  
8 to identification of an individual and is not essential for the compilation of statistical data related  
9 to enrollees, to any international, national, regional, or local medical information database. This  
10 provision shall not restrict or prohibit the transfer of information to the department of health to  
11 carry out its statutory duties and responsibilities.

12 (2) Any person who violates the provisions of this section may be liable for actual and  
13 punitive damages.

14 (3) The court may award a reasonable attorney's fee at its discretion to the prevailing  
15 party in any civil action under this section.

16 (4) Any person who knowingly and intentionally violates the provisions of this section  
17 shall, upon conviction, be fined not more than five thousand (\$5,000) dollars for each violation,  
18 or imprisoned not more than six (6) months for each violation, or both.

19 (5) Any contract or agreement that purports to waive the provisions of this section shall  
20 be declared null and void as against public policy.

21 (b) No consent for release or transfer of confidential health care information shall be  
22 required in the following situations:

23 (1) To a physician, dentist, or other medical personnel who believes, in good faith, that  
24 the information is necessary for diagnosis or treatment of that individual in a medical or dental  
25 emergency;

26 (2) To medical and dental peer review boards, or the board of medical licensure and  
27 discipline, or board of examiners in dentistry;

28 (3) To qualified personnel for the purpose of conducting scientific research, management  
29 audits, financial audits, program evaluations, actuarial, insurance underwriting, or similar studies;  
30 provided, that personnel shall not identify, directly or indirectly, any individual patient in any  
31 report of that research, audit, or evaluation, or otherwise disclose patient identities in any manner;

32 (4)(i) By a health care provider to appropriate law enforcement personnel, or to a person  
33 if the health care provider believes that person, or his or her family, is in danger from a patient; or  
34 to appropriate law enforcement personnel if the patient has, or is attempting to obtain, narcotic

1 drugs from the health care provider illegally; or to appropriate law enforcement personnel, or  
2 appropriate child protective agencies, if the patient is a minor child or the parent or guardian of  
3 said child and/or the health care provider believes, after providing health care services to the  
4 patient, that the child is, or has been, physically, psychologically, or sexually abused and  
5 neglected as reportable pursuant to § 40-11-3; or to appropriate law enforcement personnel or the  
6 division of elderly affairs if the patient is an elder person and the healthcare provider believes,  
7 after providing healthcare services to the patient, that the elder person is, or has been, abused,  
8 neglected, or exploited as reportable pursuant to § 42-66-8; or to law enforcement personnel in  
9 the case of a gunshot wound reportable under § 11-47-48, [or to patient emergency contacts and](#)  
10 [certified peer recovery specialists notified in the case of an opioid overdose reportable under §](#)  
11 [23-17.26-3](#);

12 (ii) A health care provider may disclose protected health information in response to a law  
13 enforcement official's request for such information for the purpose of identifying or locating a  
14 suspect, fugitive, material witness, or missing person, provided that the health care provider may  
15 disclose only the following information:

- 16 (A) Name and address;
- 17 (B) Date and place of birth;
- 18 (C) Social security number;
- 19 (D) ABO blood type and rh factor;
- 20 (E) Type of injury;
- 21 (F) Date and time of treatment;
- 22 (G) Date and time of death, if applicable; and
- 23 (H) A description of distinguishing physical characteristics, including height, weight,  
24 gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars,  
25 and tattoos.

26 (I) Except as permitted by this subsection, the health care provider may not disclose for  
27 the purposes of identification or location under this subsection any protected health information  
28 related to the patient's DNA or DNA analysis, dental records, or typing, samples, or analysis of  
29 body fluids or tissue.

30 (iii) A health care provider may disclose protected health information in response to a law  
31 enforcement official's request for such information about a patient who is, or is suspected to be, a  
32 victim of a crime, other than disclosures that are subject to subsection (b)(4)(vii) of this section,  
33 if:

- 34 (A) The patient agrees to the disclosure; or

1 (B) The health care provider is unable to obtain the patient's agreement because of  
2 incapacity or other emergency circumstances provided that:

3 (1) The law enforcement official represents that such information is needed to determine  
4 whether a violation of law by a person other than the victim has occurred, and such information is  
5 not intended to be used against the victim;

6 (2) The law enforcement official represents that immediate law enforcement activity that  
7 depends upon the disclosure would be materially and adversely affected by waiting until the  
8 patient is able to agree to the disclosure; and

9 (3) The disclosure is in the best interests of the patient as determined by the health care  
10 provider in the exercise of professional judgment.

11 (iv) A health care provider may disclose protected health information about a patient who  
12 has died to a law enforcement official for the purpose of alerting law enforcement of the death of  
13 the patient if the health care provider has a suspicion that such death may have resulted from  
14 criminal conduct.

15 (v) A health care provider may disclose to a law enforcement official protected health  
16 information that the health care provider believes in good faith constitutes evidence of criminal  
17 conduct that occurred on the premises of the health care provider.

18 (vi)(A) A health care provider providing emergency health care in response to a medical  
19 emergency, other than such emergency on the premises of the covered health care provider, may  
20 disclose protected health information to a law enforcement official if such disclosure appears  
21 necessary to alert law enforcement to:

22 (1) The commission and nature of a crime;

23 (2) The location of such crime or of the victim(s) of such crime; and

24 (3) The identity, description, and location of the perpetrator of such crime.

25 (B) If a health care provider believes that the medical emergency described in subsection  
26 (b)(4)(vi)(A) of this section is the result of abuse, neglect, or domestic violence of the individual  
27 in need of emergency health care, subsection (b)(4)(vi)(A) of this section does not apply and any  
28 disclosure to a law enforcement official for law enforcement purposes is subject to subsection  
29 (b)(4)(vii) of this section.

30 (vii)(A) Except for reports permitted by subsection (b)(4)(i) of this section, a health care  
31 provider may disclose protected health information about a patient the health care provider  
32 reasonably believes to be a victim of abuse, neglect, or domestic violence to law enforcement or a  
33 government authority, including a social service or protective services agency, authorized by law  
34 to receive reports of such abuse, neglect, or domestic violence:

1 (1) To the extent the disclosure is required by law and the disclosure complies with, and  
2 is limited to, the relevant requirements of such law;

3 (2) If the patient agrees to the disclosure; or

4 (3) To the extent the disclosure is expressly authorized by statute or regulation and:

5 (i) The health care provider, in the exercise of professional judgment, believes the  
6 disclosure is necessary to prevent serious harm to the patient or other potential victims; or

7 (ii) If the patient is unable to agree because of incapacity, a law enforcement or other  
8 public official authorized to receive the report represents that the protected health information for  
9 which disclosure is sought is not intended to be used against the patient and that an immediate  
10 enforcement activity that depends upon the disclosure would be materially and adversely affected  
11 by waiting until the patient is able to agree to the disclosure.

12 (B) A health care provider that makes a disclosure permitted by subsection (b)(4)(vii)(A)  
13 of this section must promptly inform the patient that such a report has been, or will be, made,  
14 except if:

15 (1) The health care facility, in the exercise of professional judgment, believes informing  
16 the patient would place the individual at risk of serious harm; or

17 (2) The health care provider would be informing a personal representative, and the health  
18 care provider reasonably believes the personal representative is responsible for the abuse, neglect,  
19 or other injury, and that informing such person would not be in the best interests of the individual  
20 as determined by the covered entity in the exercise of professional judgment.

21 (viii) The disclosures authorized by this subsection shall be limited to the minimum  
22 amount of information necessary to accomplish the intended purpose of the release of  
23 information.

24 (5) Between, or among, qualified personnel and health care providers within the health  
25 care system for purposes of coordination of health care services given to the patient and for  
26 purposes of education and training within the same health care facility; or

27 (6) To third party health insurers, including to utilization review agents as provided by §  
28 23-17.12-9(c)(4), third party administrators licensed pursuant to chapter 20.7 of title 27, and other  
29 entities that provide operational support to adjudicate health insurance claims or administer health  
30 benefits;

31 (7) To a malpractice insurance carrier or lawyer if the health care provider has reason to  
32 anticipate a medical liability action; or

33 (8)(i) To the health care provider's own lawyer or medical liability insurance carrier if the  
34 patient whose information is at issue brings a medical liability action against a health care



1 provider.

2 (ii) Disclosure by a health care provider of a patient's health care information that is  
3 relevant to a civil action brought by the patient against any person or persons other than that  
4 health care provider may occur only under the discovery methods provided by the applicable  
5 rules of civil procedure (federal or state). This disclosure shall not be through ex parte contacts  
6 and not through informal ex parte contacts with the provider by persons other than the patient or  
7 his or her legal representative.

8 Nothing in this section shall limit the right of a patient, or his or her attorney, to consult  
9 with that patient's own physician and to obtain that patient's own health care information;

10 (9) To public health authorities in order to carry out their functions as described in this  
11 title and titles 21 and 23 and rules promulgated under those titles. These functions include, but are  
12 not restricted to, investigations into the causes of disease, the control of public health hazards,  
13 enforcement of sanitary laws, investigation of reportable diseases, certification and licensure of  
14 health professionals and facilities, review of health care such as that required by the federal  
15 government and other governmental agencies;

16 (10) To the state medical examiner in the event of a fatality that comes under his or her  
17 jurisdiction;

18 (11) In relation to information that is directly related to a current claim for workers'  
19 compensation benefits or to any proceeding before the workers' compensation commission or  
20 before any court proceeding relating to workers' compensation;

21 (12) To the attorneys for a health care provider whenever that provider considers that  
22 release of information to be necessary in order to receive adequate legal representation;

23 (13) By a health care provider to appropriate school authorities of disease, health  
24 screening, and/or immunization information required by the school; or when a school-age child  
25 transfers from one school or school district to another school or school district;

26 (14) To a law enforcement authority to protect the legal interest of an insurance  
27 institution, agent, or insurance-support organization in preventing and prosecuting the  
28 perpetration of fraud upon them;

29 (15) To a grand jury, or to a court of competent jurisdiction, pursuant to a subpoena or  
30 subpoena duces tecum when that information is required for the investigation or prosecution of  
31 criminal wrongdoing by a health care provider relating to his, her or its provisions of health care  
32 services and that information is unavailable from any other source; provided, that any information  
33 so obtained, is not admissible in any criminal proceeding against the patient to whom that  
34 information pertains;

1 (16) To the state board of elections pursuant to a subpoena or subpoena duces tecum  
2 when that information is required to determine the eligibility of a person to vote by mail ballot  
3 and/or the legitimacy of a certification by a physician attesting to a voter's illness or disability;

4 (17) To certify, pursuant to chapter 20 of title 17, the nature and permanency of a  
5 person's illness or disability, the date when that person was last examined and that it would be an  
6 undue hardship for the person to vote at the polls so that the person may obtain a mail ballot;

7 (18) To the central cancer registry;

8 (19) To the Medicaid fraud control unit of the attorney general's office for the  
9 investigation or prosecution of criminal or civil wrongdoing by a health care provider relating to  
10 his, her or its provision of health care services to then-Medicaid-eligible recipients or patients,  
11 residents, or former patients or residents of long-term residential care facilities; provided, that any  
12 information obtained shall not be admissible in any criminal proceeding against the patient to  
13 whom that information pertains;

14 (20) To the state department of children, youth and families pertaining to the disclosure  
15 of health care records of children in the custody of the department;

16 (21) To the foster parent, or parents, pertaining to the disclosure of health care records of  
17 children in the custody of the foster parent, or parents; provided, that the foster parent or parents  
18 receive appropriate training and have ongoing availability of supervisory assistance in the use of  
19 sensitive information that may be the source of distress to these children;

20 (22) A hospital may release the fact of a patient's admission and a general description of a  
21 patient's condition to persons representing themselves as relatives or friends of the patient or as a  
22 representative of the news media. The access to confidential health care information to persons in  
23 accredited educational programs under appropriate provider supervision shall not be deemed  
24 subject to release or transfer of that information under subsection (a) of this section; or

25 (23) To the workers' compensation fraud prevention unit for purposes of investigation  
26 under §§ 42-16.1-12 -- 42-16.1-16. The release or transfer of confidential health care information  
27 under any of the above exceptions is not the basis for any legal liability, civil or criminal, nor  
28 considered a violation of this chapter; or

29 (24) To a probate court of competent jurisdiction, petitioner, respondent, and/or their  
30 attorneys, when the information is contained within a decision-making assessment tool that  
31 conforms to the provisions of § 33-15-47.

32 (c) Third parties receiving, and retaining, a patient's confidential health care information  
33 must establish at least the following security procedures:

34 (1) Limit authorized access to personally identifiable, confidential health care

1 information to persons having a "need to know" that information; additional employees or agents  
2 may have access to that information that does not contain information from which an individual  
3 can be identified;

4 (2) Identify an individual, or individuals, who have responsibility for maintaining  
5 security procedures for confidential health care information;

6 (3) Provide a written statement to each employee or agent as to the necessity of  
7 maintaining the security and confidentiality of confidential health care information, and of the  
8 penalties provided for in this chapter for the unauthorized release, use, or disclosure of this  
9 information. The receipt of that statement shall be acknowledged by the employee or agent, who  
10 signs and returns the statement to his or her employer or principal, who retains the signed  
11 original. The employee or agent shall be furnished with a copy of the signed statement; and

12 (4) Take no disciplinary or punitive action against any employee or agent solely for  
13 bringing evidence of violation of this chapter to the attention of any person.

14 (d) Consent forms for the release or transfer of confidential health care information shall  
15 contain, or in the course of an application or claim for insurance be accompanied by a notice  
16 containing, the following information in a clear and conspicuous manner:

17 (1) A statement of the need for and proposed uses of that information;

18 (2) A statement that all information is to be released or clearly indicating the extent of the  
19 information to be released; and

20 (3) A statement that the consent for release or transfer of information may be withdrawn  
21 at any future time and is subject to revocation, except where an authorization is executed in  
22 connection with an application for a life or health insurance policy in which case the  
23 authorization expires two (2) years from the issue date of the insurance policy, and when signed  
24 in connection with a claim for benefits under any insurance policy, the authorization shall be  
25 valid during the pendency of that claim. Any revocation shall be transmitted in writing.

26 (e) Except as specifically provided by law, an individual's confidential health care  
27 information shall not be given, sold, transferred, or in any way relayed to any other person not  
28 specified in the consent form or notice meeting the requirements of subsection (d) of this section  
29 without first obtaining the individual's additional written consent on a form stating the need for  
30 the proposed new use of this information or the need for its transfer to another person.

31 (f) Nothing contained in this chapter shall be construed to limit the permitted disclosure  
32 of confidential health care information and communications described in subsection (b) of this  
33 section.

1 SECTION 3. This act shall take effect upon passage.

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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING

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- 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 certified peer recovery specialist, in accordance with federal law.
- 4           This act would take effect upon passage.

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