HB1396 - Drug and Alcohol Treatment Programs - Discharge of Patients and Referral Services – Standards

QUESTIONS AND ANSWERS

1. Q: Will this bill require Maryland Department of Health (MDH) to establish specific standards that are not already established under COMAR 10.47.01.04, 10.47.02.07, and 10.47.02.08?

   A: No. This bill only requires discharge planners in Treatment Programs to provide referrals to a lower level of care (often residential) within the substance use disorder (SUD) Continuum of Care (CoC) as well as wrap-around services –based on a patient's Assessment and Treatment Plan.

2. Q: Will all SUD patients need to be referred to a lower level of residential care in the SUD CoC?

   A: No. Only A patient who has been assessed as needing or benefitting from a residential program –based on a medical ASSESSMENT, and who has identified a willingness and desire to enter a residential program, as noted in their TREATMENT PLAN, should be referred to a residential program –where they continue to receive the care and support required for them to recover.

3. Q: Does this bill require any additional standards for the discharge and transfer of an SUD patient from a higher level of care to a lower level of care?

   A: No. These standards already exist under COMAR 10.47.01.04, 10.47.02.07, and 10.47.02.08.

4. Q: If existing regulations and standards already provide for appropriate discharge planning for patients from treatment programs, then why is this bill necessary?

   A: There are no provisions for enforcing compliance. These perfectly crafted and well intentioned "regulations and standards" definitely do provide provisions for "planning" a discharge (via a Treatment Plan), but not for ACTUALLY IMPLEMENTING the discharge. Without any accountability or enforcement, SOME treatment providers ARE completing a treatment plan, but failing to execute it.

5. Q: If "SOME" treatment providers are failing to execute a discharge plan, based on the treatment plan, are there "SOME" providers who successfully discharge patients into a "next-level-of care"?

   A: Yes. Currently, some treatment providers begin "planning" a patient's discharge upon entry, giving them plenty of time to assess the patient, develop a treatment plan with the patient, and facilitate a smooth bed-to-bed transfer to a lower level of care within the SUD CoC, thereby facilitating their patient's recovery. On the other hand, some treatment

providers begin planning a patient's discharge within days of the date when their Medicaid / insurance will no longer pay for the higher level of care. They fail to ensure that there is sufficient time to plan the patient's discharge according to their treatment plan. These patients find themselves in a homeless shelter, or back "on the streets," when they could have and should have been transferred to a residential program had their discharge planner been competent and cared for their well-being.

6. Q: Will this bill result in patients being 'stuck in a holding pattern' in higher level treatment facilities without legitimate medical and treatment reasons while awaiting a bed placement at a lower level of care?

   A: It should not. If this happens, it is because the discharge planner within the higher level of care is failing to do his/her job in a timely manner.

7. Q: Might this lead to a burden placed upon the treatment provider?

   A: If one treatment provider effectively discharges their patients to a lower level of care, while another provider is incapable of doing so, then the burden must be placed upon the ineffective and incompetent provider, and not the patient.

8. Q: Might this create a backlog and cause other patients waiting for a bed at the higher level of care to have longer wait times on existing waitlists?

   A: Again, it is because the discharge planner failed to sufficiently coordinate a timely discharge. It is unfair to place the patient awaiting an appropriate discharge at high risk of relapse when he/she fails to get the services that he/she needs in order to recover –as outlined in their ASSESSMENT and TREATMENT PLAN, because the discharge planner failed to do his/her job.

9. Q: Are treatment providers still responsible for discharging patients to a lower level of care within the SUD Continuum if they relapse while in a residential treatment program or wish to discontinue participation in SUD treatment?

   A: No. A relapse changes the Assessment, and if a patient does not wish to be transferred to a lower level of care within the Continuum, then he/she will not add it to their Treatment Plan –which is a reflection of the patient's willingness and desires for their own personal recovery journey.

10. Q: Current regulations and standards provide that an individual is only discharged from the most intensive programs after they are assessed to no longer need this intensive care –so why isn't a discharge to an outpatient program and a homeless shelter ideal?

    A: To assume that an outpatient program in combination with a homeless shelter is the same level of care that a halfway house or recovery residence provides, disregards the American Society of Addiction Medicine (ASAM) medical necessity criteria for

determining the appropriate level of substance use service an individual may need, and that MDH purportedly relies upon, since the ASAM Continuum includes step-down from high intensity medically supervised treatment to a lower level of residential care, often in conjunction with outpatient treatment –but a homeless shelter is nowhere on the ASAM Continuum of Care for SUD.

11. Q: Will this bill provide any additional criteria, beyond what is already in place to protect patients under COMAR 10.47.01.04, 10.47.02.07, and 10.47.02.08?

    A: No. It does the following:
    - **a. Codifies statutes already passed into law under chapter 580 (house bill 869) – Recovery Residence Residential Rights Protection Act (2017).**
    - **b. Better enforces requirements already implied under COMAR 10.47.01.04, 10.47.02.07, and 10.47.02.08.**
    - **c. Strengthens COMAR regarding residential treatment for substance use disorder in an effort to lower Maryland's death rate for preventable overdoses.**
    - **d. Changes vague and ambiguous directives in COMAR to become clearer and more effective.**
    - **e. Saves lives by enhancing and strengthening Maryland's Continuum of Care for substance use disorder.**

12. Q: Will this bill only make it extremely difficult to discharge some patients despite their readiness for discharge?

    A: Only in those treatment programs with ineffective and incompetent discharge planners who fail to provide appropriate and adequate discharge planning in a timely manner on behalf of their patients. Hopefully, this bill will bring about better trained and more conscientious discharge planners.

13. Q: Will the requirement to prohibit discharges into homeless shelters elongate patient stays at an institution for mental disease (IMD), thereby impacting a provider's 'average length of stay' (ALOS)?

    A: No, provided the discharge planner begins coordinating a patient's discharge within a few days of entering treatment. Good discharge planning operates under the premise that "Discharge Planning begins on Day 1" (the day that the patient enters treatment).

14. Q: What if the higher-level treatment provider cannot locate a bed in a lower level of care?

    A: Maryland has a network of more than 400 recovery residences across the state –and navigators, often working for free when they are unable to access state or local funding, NEVER fail to locate a bed for a client. It is a misconception that "there are no beds available" as long as a navigator spends a sufficient amount of time searching for a bed and faxing discharge paperwork in a timely manner –well in advance of the patient's discharge.

15. Q: How would we change the habit of some providers who wait until a couple days before the patient is due to be discharged to begin discharge planning –when they have not allowed a sufficient amount of time to locate a bed into a step-down program to effectively transfer their patient bed-to-bed?

    A: By rewarding treatment providers who maintain patients within the CoC, and sanctioning providers who cannot seem to locate a bed anywhere within it and have a high rate of discharges to homeless shelters or 'back to the streets' –what peer navigators call "discharges to nowhere".

16. Q: If patients are ready for discharge, but then remain in a higher level of care longer, awaiting a lower level of care bed, then isn't the patient at risk for adverse events and potentially diluting the effectiveness of the treatment by commingling active treatment participants with residents who no longer require this level of care?

    A: Commingling a vulnerable patient in 'early recovery' with people who are actively using drugs in homeless shelters with little or no support, or back into coping with the stress of living 'on the street', is a much more dangerous and harmful environment than commingling patients with a week or two or three of recovery with patients with a couple days of recovery.

17. Q: Why focus on discharge planning when the patient has already participated in treatment?

    A: Good discharge planning saves lives! Patients desiring a residential program, consistent with the ASAM Continuum, <u>deserve</u> an effective and capable discharge planner, who will ensure that they get the support they need to recover. Recovery does not happen overnight. It is a process that requires time and support.

18. Q: Are there any benefits for all Marylanders –most of whom do not have a substance use disorder?

    A: Yes. Every Maryland taxpayer is already paying for discharge planning. Maryland taxpayers <u>expect</u> to get what they are paying for –and that is a smooth transition within the Continuum of Care –one that helps individuals, rather than harms them.