

TO: Chair Beidle and members of the Senate Finance Committee

FROM: Theresa Smith

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)



I am submitting this testimony to urge a FAVORABLE report on SB 549, The H.E.R. Continuity of Care Act. As someone directly impacted by this legislation and knowing other families with similar concerns, I lead from a place of professional expertise and personal urgency. I hold a degree in patient safety and industrial engineering concepts from a highly reputable institution, alongside a professional background in policy development. I know exactly what it looks like when a system has broken down, especially for public health.

During my own child's mental health crisis, I watched firsthand as the system failed to follow basic compliance, patient safety protocols, and continuity of care standards. Therefore, the concerns are related to what happens for our mental health patients. We cannot afford to continue with systemic barriers.

The Procedural Breakdown: Even with legally executed documents in hand, I was denied access to the treatment process. My child was only offered a Release of Information (ROI) form, which serves a completely different, revocable purpose and does not equate to supported decision-making. In one instance, I stood holding my legally binding documents before an individual claiming to be a supervisor. He explicitly stated he had been instructed not to obtain documents from individuals.

The Case Manager Gap & Improper Discharge: A significant part of this operational failure is the timing of engagement. Even when a case manager is requested, that individual may not engage until the facility is already preparing for discharge. This delay drastically impacts the time needed to properly secure the resources required for a safe transition. Consequently, the continuity of care is severed before the patient even leaves the building. More than once, my child was improperly discharged because of this lack of early coordination.

The Failure of Capacity Assessments: During one crisis, a physician arbitrarily told me that my child had capacity and competency. Because of my background in patient safety, I inquired about how this clinical determination was made and requested that it be formally documented in the medical record. I later learned a formal assessment had not been conducted. Only upon challenging this failure was I introduced to the treatment team to be involved in the process. I was then able to help them help my child. Families without a background in regulatory science should not be required to know operational pathways just to get appropriate care.

Jurisdictional Burdens in Maryland: When statutory language creates operational failures or loopholes, the burden falls on the family. Seeking clarity, I engaged the Department of Health for Prince George's County and St. Mary's County. I learned that there are differences in how crises are handled, and it creates an insurmountable burden for families dealing with one crisis across multiple Maryland counties. The outcome may only be a filed complaint.

NOW The Solution: While the word "shall" may exist in current snapshots of the law, the lack of explicitly defined operational areas has created dangerous loopholes. What this legislation needs to fix is operational chaos in a defined mandate: ***facilities shall mandate meaningful consent discussions and shall honor legally executed documents.***

The clinical data supports a clear "engagement dividend" in mental health recovery. When family members or surrogates are active participants in the treatment and discharge process, the cycle of readmission is broken by higher medication adherence and more robust follow-up care.

Comparative Data Analysis

Metric	Engagement-Led Treatment	Traditional (Isolated) Care
30-Day Readmission	7.8%-16%	Up to 30.6%
Relapse (6 Months)	~30%-40%	50% to 70%
Outpatient Adherence	3x more likely to attend	High rates of "no-shows"
Medication Compliance	60% to 80% improvement	Poor adherence is the #1 predictor of relapse

Analysis of the "Readmission Cycle"

The lack of a "bridge" between the facility and the home is where most care lapses occur.

- **The Advocacy Gap:** Inpatient staff who actively contact family members see a nearly **300% increase** (Odds Ratio of 3.07) in the patient successfully attending outpatient appointments within 30 days of discharge.
- **The Exclusion Effect:** When surrogates are not engaged, the healthcare team often fails to verify if the patient truly understands their rights or post-care options. In our case, the team was not fully ensuring my child knew their rights or understood their options, resulting in a "revolving door" effect.
- **The 30-Day Window:** Data indicates that comprehensive discharge planning—which includes surrogate communication—reduces the risk of immediate readmission by roughly 27%.

Quantifying the Impact: Exclusion is incredibly expensive. Annual statewide Medicaid waste due to preventable psychiatric readmissions is currently **\$127 million**. A single "serial cycle" of readmission costs over **\$35,000 per individual**—and **\$17,500 of that is 100% preventable through family advocacy**.

When factoring in safety response, **the 60-day cumulative fiscal waste exceeds \$190 million**. We are not asking the state to take over; we are asking the state to stop cutting the safety net that families have legally and proactively put in place.

Saving lives is not only budget-neutral, but it allows the affected individual to be on a path of stabilization and recovery to full capacity.

Please support SB 549 to ensure that healing, equity, and representation finally extend to our mental health community.

Thank you,
Theresa Smith
Mother & Advocate