

2015 HOUSE HUMAN SERVICES

HB 1279

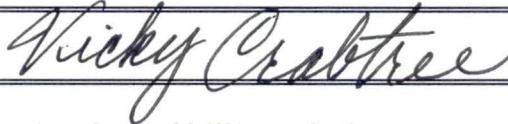
2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1279
1/20/2015
Job #22212

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to a hospital patient's designation of a caretaker to assist with after-care.

Minutes:

Testimonies 1-7

Chairman Weisz opened the hearing on HB 1279.

Rep. Fehr: Introduced and support HB 1279. (See Testimony #1)

3:15

Chairman Weisz: On page 4 on the top you added the section where you are now bringing the state health council in so they can expand this criteria. Is that your intent?

Rep. Fehr: This falls under the Health Dept. and my understanding is that the health council with the Health Dept. will create the administrative rules.

Mooney: Is the intent to make an effort for hospitals to try and establish a care giver in the aftercare aspects?

Rep. Fehr: You will hear others following me. AARP is concerned about elderly folks who are routinely needing someone else there to hear instructions. My interest is in behavioral health and there are some language on page 1, line 9 that specifically includes behavioral health support. If the hospital asks the patient being discharged if they would like to designate a caregiver, it is more likely to happen than not.

Josh Askvig: Director of Advocacy for AARP of ND testified in support of the bill. (Testimony #2) Chairman Weisz to answer your question about the health council, they license hospitals. If they were not to follow these provisions is there a penalty and what would that be? That would be spelled out in the rule making provision. Rep. Mooney if you have a loved one and you are involved in their care as a patient, they are included in that care taking team so. Today you see more cycle of hospitalization which is home, back in hospital and then home again. We are trying to break that cycle by including and improving the transitions.

14:09

Rep. Porter: On page 2, at the top sub 1, explain why it is important to do this twice?

Askvig: Within 24 hours of a patient entry into the hospital it is to make sure a person is involved in that care. Second, as an example, you have a child in the hospital and the caretakers were the parents and they had to go back to work the next day so they could designate another person to be the caretaker.

Rep. Porter: In your example isn't it the parent's responsibility to notify the change of the caretaker rather than the hospital having to ask you again?

Askvig: I believe that is exactly what the language states. I'm looking at page 2, line 26, subsection d. I read that as if they elect to change it, they need to notify the hospital and then the hospital has 24 hours to make that change in the medical record.

Rep. Porter: I understand that, but I'm looking at line 2 where it says they have to do it twice.

Askvig: Ok. Again on the release part, that would be the scenario I described for you. We are happy to clarify the language and make it simple.

Rep. Porter: On line 3, if the patient's condition requires transfer to another hospital, why should the sending hospital have to worry about this provision?

Askvig: If they had documented the name of the caregiver within in 24 hours we ask that the information be transferred to the designated hospital. To my knowledge this would only apply to North Dakota facilities. North Dakota would have to send that information to another hospital, but Minnesota would not have to send it to us.

Rep. Porter: I don't see the importance on the front end of the designation as I would on the back end when they are being discharge to home.

Askvig: We are happy to work on this language.

21:30

Barbara Handy-Marchello: Testified in support of the bill. (See Testimony #3)

Shelle Aberle: Testified in support of the bill. (See Testimony #4)

30:00

Opposition

Dan Hannaher: Director of Legislative Affairs for Sanford Health introduced Dr. Craig Lamber.t

Dr. Craig Lambrecht: Sanford Health Bismarck President testified in opposition of the bill. (See Testimony #5)

32:51

Rep. Oversen: If Sanford Health already does a care plan upon the release of a patient, how does this change on how you handle the care plan, specifically designating a caregiver?

Dr. Lambrecht: What additional cost, oversight and compliance issues would be responsible for? This will cost us more and we are at capacity everyday in mental health, ICU and we try to figure out who has beds and who doesn't throughout the state.

Rep. Rich Becker: Are you saying Sanford Health is already doing the notifications and working with the caregivers?

Dr. Lambrecht: Yes. We have to bare the responsibility of every discharge and make sure we have their medications right. We are scrambling for primary care providers. Every patient should have a primary care provider. That is the individual who should be responsible for you when you are discharged. Patients that come back after being discharged we don't get paid for that anymore. That is a bad day for us.

Rep. Rich Becker: How do answer some of the people here that testified that upon discharged their loved ones and the caregivers were not adequately prepared to administer meds?

Dr. Lambrecht: That is on us to bare that responsibility to integrate the post care delivery with the patient and caregiver. We could do that better. The HIPPA requirements that we have for confidentiality and compliance to them makes it difficult for us. and I'm afraid I'll be wearing orange someday

Rep. Dick Anderson: Can you expound on the liability issues?

Dr. Lambrecht: We know if there is going to be additional compliance issues that we are faced with, along with compliance comes liability. Everybody does the best job they can, but in the end who is responsible?

Rep. Fehr: Could you point to something in the bill that Sanford doesn't do?

Dr. Lambrecht: When we looked at the bill, question was, what additional services are we going to have to provide and what responsibilities are we going to have that will be demands on us? We already are tasked with discharge planning and putting together teams and staffing and dealing with wage issues in this environment. It will cost us, but I don't know how much.

Rep. Mooney: As an identified caregiver can I be held liable for the caregiving if it was done improperly?

Dr. Lambrecht: If there is a bad outcome who bares the responsibility for that? If the care plan was all in place I think it would be a discussion that would be very difficult to have.

Rep. Oversen: We don't want to increase healthcare costs. One section of the bill says we do not obligate the caretaker to do these tasks. It also requires that the hospital makes a brief record of what they did task the caregiver with and finally it says, we aren't creating private right of action against any hospital for these designations. Is there something we can do to clarify this better?

Dr. Lambrecht: We could come have 3 different lawyers and they will come out with 3 different opinions. I think those opinions at the end of the day will suggest we don't know the answer to this as it is uncharted territory and there will be risks and it will take time, money and staffing that will distract from patient care.

Rep. Damschen: Would there be any liability in not informing a patient or caregiver properly on how to administer that care?

Dr. Lambrecht: Absolutely. It is our responsibility to shoulder the discharge plan and then follow-up.

Rep. Rich Becker: Are there any other non-intended consequences?

Dr. Lambrecht: We struggle to do the things we are doing now and adding more for us to do is difficult for us.

Rep. Porter: I understand the good intentions of this legislation. Maybe you can give us some information. We have many critical access hospitals that are understaffed, adding this mandate on top of that how does the whole system work?

Dr. Lambrecht: I will defer that question to my college. It would delay care.

Rep. Fehr: There are other states that implemented legislation like this. Are you familiar with what the hospitals in those states did to formulizing caregivers into their system?

Dr. Lambrecht: I'm not familiar with what is happening in other states. We are willing to familiarize ourselves with that.

54:00

Jerry Jurena: President of the ND Hospital Association testified in opposition of the bill. (See Testimony #6)

55:24

Rep. Oversen: If something doesn't go right with the patient in aftercare, who does the liability fall on? Does this bill change how the fall out would be?

Jurena: Yes. Right now there is no documentation in the medical records designating that the hospital told you to take care of your mother. With a discharge plan they sit down and go over the plan. It is not documented anywhere. Once it is put in the hospital record it becomes the hospitals responsibility.

Rep. Oversen: If the hospital is documenting what they told the caregiver, doesn't that shift the burden?

Jurena: I don't have any control over that caregiver. Once we put it into the chart, the hospital shall do this and I put in there the caregiver shall do this, I'm responsible for what you are doing.

Rep. Oversen: If we do need to clarify that this is not intended to shift liability back and forth, maybe we can do that.

Jurena: Being a part of numerous law suits. I don't think that will hold water.

Dan Hannaher: Sanford Health handed out Testimony for Dr. Volk. (See Testimony #7) At the end of this testimony, Dr. Volk states we are already struggling to meet our present needs. This bill should be opposed.

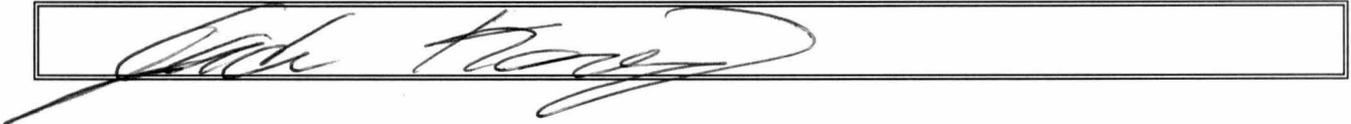
Chairman Weisz closed the hearing.

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1279
2/23/2015
24250

- Subcommittee
 Conference Committee



Minutes:

Attachment #1

Chairman Weisz: Let's take up 1279.

Rep. Mooney: I have some amendments that I would like to suggest. (Attachment 1) Since we visited on 1279 last I have heard from my hospitals back in my district who have expressed discomfort with the language as it was presented. Having been a caregiver myself I have the sympathy and empathy for why it is that we would want to provide support for them, but as I listened, reread the bill and testimony, and visited with my hospitals and administrators what kept coming in true in my mind was home and community based services. In the 2013 session we passed forward a study resolution that was picked up by the human services committee and it was one of our study points. We have 3 that we studied: behavioral health, traumatic brain injury, and home and community based services. The home and community based services simply out of default of time constraints got the least amount of attention in committee. It is a huge topic and important to look at. Having supports is vital for us to be sure that we have the confidence and the needed resources to be sure that what we are doing is appropriate. I felt that we should have study that is based similarly what we did with the behavioral health study. It was very comprehensive, incorporated all the stake holders that could be identified, and the results were resounding. I pulled the study from that bill to see how it was phrased. The language you see is modeled directly from the behavioral health study. It is a comprehensive study of home and community based services that would include that piece of rehabilitation and recovery. In my mind that is one part of the whole comprehensive study plan.

Rep. Porter: The fourth paragraph down puts the fiscal note out of the bill I think. It is a contracted study and not a Legislative Management study. You either fund it and do it or take that language out.

Chairman Weisz: I am not so sure. Legislative council does have a fund for doing studies that they are given that can be consulted in the interim process, but I am not sure the way it is worded now. Maybe it should say Legislative Management because then they would have the decision not Legislative Council. Legislative Management is the elected group. If you gave them the decision, it would have to come out of the fund for Legislative Council

that is already there. Then it wouldn't rest within the council and it would have to rest within the Legislative Management.

Rep. Porter: We would still have to check and make sure it falls into this budget or change the wording so they may contract within the budget.

Chairman Weisz: Why don't we just eliminate the word consulted?

Rep. Porter: Maybe Representative Mooney wants to kind of explain what that would be doing. The coordination belongs to the interim committee so that doesn't have to be in there. Is what's the intent of that paragraph, inside of the study resolution and how it fits, are we thinking that it is not a Legislative Management study going to an interim committee that it is something being RFPed to an independent consultant and then coming back and reporting to the Legislative Management interim committee.

Rep. Mooney: Based off of the way that we constructed it from the behavioral health and much of the conversation I heard was a lot of what we talked about in the behavioral health when we were moving that forward, is should we have the contract for consulting or not have the contract. Ultimately we ended up moving it forward with the may contract for consulting because by allowing that to be decided between Legislative Council and Legislative Management then it could be determined if it was appropriate or not, and if it was appropriate to have the consulting then they wouldn't have; ultimately the study piece was so large and it was early on when we had the interim period that if we were going to do it justice that we would have to have a third entity come in and help us build the comprehensive study piece to it. Drawing from how successful it was I left it how it was. I have no objection if there is a sense that we need to adapt it in a different way but I thought for discussion we should start with this.

Chairman Weisz: It is a shall consider so I guess whatever we do in the language it wouldn't need a fiscal note.

Rep. Damschen: I think the way it is worded is probably the way it was in the behavioral health one last year.

Chairman Weisz: Is that the same language?

Rep. Damschen: I think so. You put in the request and it has to be approved by the chairman of the Legislative Management and then there is a pool of money available for studies. That is the way it worked last time.

Chairman Weisz: So the language should at least say Legislative Management then?

Rep. Damschen: It may be that Legislative Council does the contracting.

Rep. Mooney: I'm perfectly fine with changing that to management.

Rep. Fehr: I am no objections to a Legislative Management study. If this is a hog house of a bill I would object to that. This is a good bill, it would save some lives, and I don't want to lose the intent of the care giver.

Rep. Oversen: I agree with Representative Fehr, and I resist motion to amend the bill.

Rep. Mooney: I guess this would be my first hog house but that would have been my intent with this amendment. I make that a motion to amend.

Representative Anderson: Second

Rep. Porter: In that motion do you want to change "council" to "management"?

Rep. Mooney: Yes.

Rep. Fehr: I resist the motion. The existing bill would require a little extra work on the hospitals part and incidentally there are other states where medical groups have been supportive of the care act. It is unfortunate that in this state the medical folks have come out against it. I believe it would be minimal but once they implemented it would make a big difference.

A Roll Call Vote Was Taken: Yes 8, No 5, Absent 0

Carries

Representative Mooney: Motion a do pass as amended

Representative Anderson: Second

A Roll Call Vote Was Taken: Yes 10, No 3, Absent 0

Motion carries

Representative Mooney will carry the bill

8/2/23/15

February 23, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1279

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of home and community-based services in North Dakota.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying home and community-based services in this state. The study must include consideration of home and community-based services and support systems that relate to chronic injury or illness, rehabilitation and recovery, aged or disabled individuals, and the scope of the study must include consideration of access, availability, and delivery of services. The study must include input from stakeholders, including representatives of law enforcement, social and clinical service providers, advocacy organizations, tribal government, state and local agencies and institutions, and representatives of caregivers in this state. The legislative management may contract for consulting and coordination of study services to assist the legislative management in conducting the home and community-based study. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly."

Renumber accordingly

Date: 2-23-15
 Roll Call Vote #: /

**2015 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 1279**

House Human Services Committee

Subcommittee

Amendment LC# or Description: See attachment #1

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By Rep. Mooney Seconded By Rep. D. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen		✓
Rep. Dick Anderson	✓				
Rep. Rich S. Becker		✓			
Rep. Damschen	✓				
Rep. Fehr		✓			
Rep. Kiefert	✓				
Rep. Porter		✓			
Rep. Seibel		✓			

Total (Yes) 8 No 5
 Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:
Change Council to management a hoghouse bill.

Date: 2-23-15
 Roll Call Vote #: 2

**2015 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 1279**

House Human Services Committee

Subcommittee

Amendment LC# or Description: _____

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By Rep. Mooney Seconded By Rep. D. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen		✓
Rep. Dick Anderson	✓				
Rep. Rich S. Becker		✓			
Rep. Damschen	✓				
Rep. Fehr		✓			
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep. Mooney

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1279: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1279 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of home and community-based services in North Dakota.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying home and community-based services in this state. The study must include consideration of home and community-based services and support systems that relate to chronic injury or illness, rehabilitation and recovery, aged or disabled individuals, and the scope of the study must include consideration of access, availability, and delivery of services. The study must include input from stakeholders, including representatives of law enforcement, social and clinical service providers, advocacy organizations, tribal government, state and local agencies and institutions, and representatives of caregivers in this state. The legislative management may contract for consulting and coordination of study services to assist the legislative management in conducting the home and community-based study. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly."

Renumber accordingly

2015 SENATE HUMAN SERVICES

HB 1279

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1279
3/17/2015
24952

- Subcommittee
 Conference Committee

Committee Clerk Signature

Ramonson Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill to provide for a legislative management study of home and community-based services in North Dakota

Minutes:

Attach #1- #2 Rep. Alan Fehr
Attach #3 Rep. Gail Mooney
Attach #4 Josh Askvig, AARP
Attach #5 Kim Jacobson, Traill County Soc. Services
Attach #6 HB 1279
Attach #7 Barbara Handy-Marchello
Attach #8 Mike Tomasko
Attach #9 Jerry E. Jurena, ND Hospital Assoc.

Vice Chairman Oley Larsen opened the hearing on HB 1279.

Representative Alan Fehr, District 36, introduced HB 1279 to the Senate Human Services Committee. (Attachment #1) (Attachment #2)(Ends 3:25)

Senator Warner asked if this would be a hog house amendment.

Rep. Fehr replied that from the original bill it was hog housed into this study and what he handed out as suggested language would be a study for caregiving. It would be up to the committee as to what to do with this.

Representative Gail Mooney, District 20, testified IN FAVOR OF HB 1279.
(Attachment #3) (4:35-8:48)

Senator Howard Anderson, Jr. asked if there is any information specific to North Dakota about whether this is done or in how many cases it's not, or if those are the things we need to study.

Rep. Mooney replied that it's definitely something we need to study. We have gaps, we have lacking connectivity and there's no one place to make a phone call to get help.

Senator Dever's first thought when he was initially exposed to this was that health care providers do this anyway. He found out that most do, but not necessarily. He understood the uniformity and that it might be a good thing to study but he didn't recall a fiscal note. He wanted to know why the House changed it from its original bill to a study.

Rep. Mooney explained that there was no fiscal note. The complicating factors came from the liability factors and then implementation - an unfunded mandate going to the private hospital providers to require one more level of training and documentation of their intent to support not only the patients but caregivers. Possible complications include the hospital not being able to determine who the caregiver would be or what the level of their capabilities might be. The hospitals would become pseudo trainers without really being able to weigh in on who might be appropriate in that capacity. Further issues went into the potential for liability. There was a clause at the end of the original bill that would take hospitals out of the liability equation, but there are other statutes of concern. What caregivers and patients need always goes back to resources and support. They need someone who can say what to do in the home environment, so it was services through the home environment as well as the hospital environment. It's more complicated than simply a singular mandate. That's how it ended up becoming a study.

Chairman Judy Lee stated that this committee has heard a bill about community paramedics. At least one hospital is using community paramedics as part of this discharge plan to follow up on folks. This seems like part of the whole picture as well. They work for the hospital in a case like that so liability isn't an issue for them.

Rep. Mooney agreed. There are numerable services available in communities, even in rural areas, that are associated with the hospital. She provided examples: nursing coaches, paramedics, home based providers, pharmacies, public health districts, hospice, and senior citizen centers. They are all a piece of the puzzle but no where do we identify what we have, what liability is covered through which organization, and how we piece it together to benefit more of the people across the state, not just those being discharged from a hospital setting.

Chairman Judy Lee pointed out that the Department of Human Services has a toll free number in which services are available and that is now available through 211.

Josh Askvig, Associate State Director of Advocacy for AARP North Dakota, testified IN FAVOR of HB 1279 (Attachment #4) (16:49-23:25)

Senator Axness discussed aftercare costs. He cited a personal case relating to lower back surgery where after care instruction was not provided. Complications resulted and wound care was an issue. Only after the fact was the information provided. If this is already being done, who is liable in a situation like this? How would this bill change who is liable?

Mr. Askvig said it should have no effect on liability. In the .03000 version of the bill the last 4 lines of the last section, lines 11-14, says that the hospital is not liable. In other states we heard the concern about liability with hospitals. We wanted to mitigate and eliminate that

as much as possible. Mr. Askvig discussed examples in other states. It shouldn't change liability. He understands there are still concerns.

Senator Axness pointed out that with his personal example every time he went to the hospital it utilized staff time and resources. Some of the complaints against this are that it will be an unfunded mandate. So is what's freeing up staff time also the intent of the original bill?

Mr. Askvig answered that if you take additional time upfront with instructions for care at home, it sometimes will eliminate the likelihood that they will need care later. So it could eliminate hospital staffing later. The key is trying to prevent them from going back.

Chairman Judy Lee said that federal healthcare reform has a big component talking about readmissions and thought hospitals are pretty tuned into that concept.

Senator Dever stated that his perception of his healthcare and that of his family is his responsibility, but the purpose of the bill is to provide a tool for that.

Mr. Askvig agreed.

Senator Howard Anderson, Jr. pointed out that when you do surveys, everyone states their support. What do you perceive is the barrier to a hospital doing this now? For example, the people who were taking care of him irritated him when they would ask the same question over and over again. Why don't you feel the hospital now doesn't provide the proper care? Under current reimbursement rates, they don't want you back.

Mr. Askvig indicated that caregivers have stated that they didn't get a good understanding until they got home, and they had to figure it out. Nothing prevents it being done today, but this bill would ensure that it gets done.

Chairman Judy Lee asked why the person who felt they didn't have enough information when they got home didn't call back for further information.

Mr. Askvig answered that in many instances they do, but then they are chasing afterwards rather than being on the front end.

Chairman Judy Lee pointed out that if it is something a lay person is going to be doing at home, it probably doesn't require the highest level of instructor. Why would that kind of question be in there as to whether they got instructions from the doctor or nurse?

Mr. Askvig indicated that is from the national standards. There is nothing in the bill that dictates who would provide that demonstration, but just that they received the aftercare instruction. In many instances, they are going home without instruction today. We are simply asking that there be a standard, that if a caregiver is designated and present at discharge, they be instructed.

Chairman Judy Lee asked if he would agree that, when asking for feedback, you are more likely to get information back from people who are unhappy than those who are happy.

Mr. Askvig hesitantly agreed.

Mr. Askvig added that Rep. Fehr handed out a study on caregivers rather than home and community based services. The preference would be to restore the original version of the bill, but if not, maybe narrow the focus to the caregivers which would make sense to them and be more in line with the original intent of the bill.

Mr. Askvig confirmed that .03000 is the original version the house saw. (Attachment #6)

Kim Jacobson, Director of Traill County Social Services, testified IN FAVOR of HB 1279. (Attachment #5) (34:22-40:00)

Senator Howard Anderson, Jr. said that the original intent of the care act was not so much assessing the HCBS, but how the information gets from the hospital to the HCBS provider. I don't see much of that in the study.

Ms. Jacobson was speaking mostly to the amended version. Certainly we need to partner with HCBS to have that discussion to ensure good care is provided to our citizens and keep their condition from progressing prematurely. Under the study, if we could involve family caregivers and look at the system as a whole to see how each piece works, there could be benefit to that as a whole.

Chairman Judy Lee appreciated Ms. Jacobson's thorough review of what could be included in the study.

Senator Dever asked if observations of legislators and confusion are in both chambers.

Ms. Jacobson responded that when talking about the different guardianships, different type of waivers, adult protective services, home and community based services, etc., it gets very confusing.

Senator Dever acknowledged that she was speaking to the amended version of the bill and asked if she preferred that to the original bill or in addition to it.

Ms. Jacobson responded that if the original version did not impact county social services directly, they did not track the bill real close prior to it being hog housed. When it changed, it impacted them more. However she understood the need for caregivers as stated originally.

Marnie Walth, representing Sanford Health, testified in support of HB 1279 as it is currently. She said they would also support **Rep. Fehr's** amended version to do a study of that unpaid care. They testified against the bill as it was originally heard in the House. (43:17) She reported that they have intricate processes in place to take care of their patients and when they go home. In their determination the bill as originally written would require unfunded mandate, duplication of processes, and more bureaucracy to a process they are trying to streamline and for what they are already doing well.

Senator Howard Anderson, Jr. used the example of ACA and the movement toward accountable care organizations and the issues of cutting down on readmissions to hospitals etc. From his own profession sometimes he gets the sense that we don't do things unless we are told to do them and this an example of that. He said that we seriously started working on readmission controls when we were told to do that.

Ms. Walth didn't disagree with what Senator Howard Anderson, Jr. said. Often they are told to follow where the revenue services come from. That business model is changing to quality patient care. And quality care includes not having a patient come back in their doors after they care for them and send them home. They are now paying on quality of care.

Senator Dever asked if he was in error when he earlier said that the initial response was that facilities already did this. He also asked if they saw a way to amend the original bill to address their concerns and then implementing it or if they saw a study coming that they could live with.

Ms. Walth answered that they have elaborate processes in place called discharge planning. With the original bill, their take on it was that it was unnecessary because these are processes they are already doing. In listening to the conversation, she can't say that there aren't issues elsewhere. If the study documents those issues, it may identify best practices that others could learn from.

Senator Axness pointed to the readmission rates and said that he was never readmitted but had to go back to the hospital numerous times. He wondered if that can be taken into account - that it's not just based on readmissions.

Ms. Walth explained that the ACA is not just readmission; it is also the patient satisfaction survey.

Senator Axness stated that other states have enacted this and thought Minnesota had. Sanford practices in Minnesota and he wondered if it has created a barrier?

Josh Askvig offered information that it hasn't been enacted in Minnesota.

V. Chairman Oley Larsen asked for clarification on giving information to a caregiver.

Ms. Walth gave a personal example. Because of HIPAA, the patient needs to sign a release so the information can be shared with the caregiver. If the patient has had a surgery, they will include the caregiver in the discussion. The patient can't leave the facility unless someone is there to drive and they have home instructions.

Chairman Judy Lee you have to authorize non-relative caregivers.

Barbara Handy-Marchello testified IN FAVOR of HB 1279 in its original form.
(Attachment #7) (53:05-55:50)

Senator Howard Anderson, Jr. referred to Ms. Marchello's description of the situation with her mother and that generally she got good information but sometimes she may have had questions. He wondered how the bill would help her get the answers more easily than what she did. He didn't see in the bill that the hospital has to provide information.

Ms. Marchello replied that the process of communication is not always clear. There were times she didn't think she was going to get any information from whomever she was trying to talk to, and felt she needed to demand answers. It is a matter of insuring the communication takes place. She felt she is capable of asking the questions, but there are many who do not know what questions to ask. She sees this bill as addressing the issue of communication.

OPPOSITION TO HB 1279

There was no opposing testimony.

Chairman Judy Lee referred to the electronic testimony handed out.
(Attachment #8 and Attachment #9)

NEUTRAL TESTIMONY ON HB 1279

There was no neutral testimony.

Chairman Judy Lee closed public hearing on HB 1279.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1279
3/24/2015
25338

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill to provide for a legislative management study of home and community-based services in North Dakota

Minutes:

No attachments

The Senate Human Services Committee met on March 24, 2015 on HB 1279 for committee work.

Senator Howard Anderson, Jr. expressed the study should be the caregivers rather than the home and community based care services. Representative Fehr had provided a proposed amendment. We have studied home and community based care services enough. This is how the information gets from the hospital to the home and community based care services.

Senator Dever added this is information getting to family caregivers.

Chairman Judy Lee indicated that we just spent a lot of money on a Long Term Care study that included home and community based care services. There is no need to do this again.

Senator Howard Anderson, Jr. moved to ADOPT AMENDMENT as proposed by Representative Fehr. The motion was seconded by **Senator Axness**.

Discussion

Senator Dever likes this. When we discussed in HB 1046 about an additional facilitator, that is about working with family caregivers. A few sessions ago, we put money in the Alzheimer's Association for the same purpose, and those are very good ways of providing services. That is more about helping the caregiver give care.

Chairman Judy Lee stated the thing that is different is that it requires hospitals to do something they are already doing. Federal healthcare reform is going to seriously ding any hospital with their reimbursement if they have readmissions for somebody after the

fact. You have all received emails from physicians or hospital administrators saying this is an onerous requirement to have more documentation when they are already doing it. She is not sure it is really needed.

Senator Howard Anderson, Jr. indicated that he has talked to hospitals. They are not opposed to the study that is suggested here because they are looking at it all the time anyways, and it may help them.

Chairman Judy Lee indicated they would resist putting it back to the original language.

Senator Axness discussed his personal experience. He wasn't readmitted so this will not show up on the statistics. The study is worthy of looking at.

Roll Call Vote to ADOPT AMENDMENT

6 Yes, 0 No, 0 Absent. Motion passes.

Senator Dever moved DO PASS HB 1279 AS AMENDED. The motion was seconded by **V. Chairman Oley Larsen**. No discussion.

Roll Call Vote to DO PASS AS AMENDED

6 Yes, 0 No, 0 Absent. Motion passes.

Senator Dever will carry HB 1279 to the floor.

March 24, 2015

TD
3/24/15

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1279

Page 1, line 1, remove "home and community-based"

Page 1, line 2, replace "services in North Dakota" with "family caregiver supports and services"

Page 1, line 5, remove "home and community-based services in this"

Page 1, remove lines 6 through 13

Page 1, line 14, replace "community-based study." with "family caregiver supports and services. The study must identify policies, resources, and programs available for family caregivers and encourage additional innovative and creative means to support family caregivers so that they are able to continue to provide in-home support for older adults. The study must include input from stakeholders, including representatives of hospitals, social and clinical providers, advocacy organizations, tribal government, state and local agencies and institutions, and caregivers in this state. The study committee may receive testimony on the needs of family caregivers, including designation of caregivers, training, respite services, medical leave policies, and delegation of tasks to non-medical aides. The study must include an inventory of the resources available to family caregivers and may make any recommendations for administrative actions to support family caregivers. The legislative management may contract for consulting and coordination of study services."

Renumber accordingly

**2015 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. HB1279**

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: Rep. Zehr Amendment 15.0349.04001 Title 05000

- Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By Sen. Anderson Seconded By Sen Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

**2015 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. HB1279**

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: 15.0349.04001 Title 05000

- Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
- Other Actions: Reconsider _____

Motion Made By Sen. Dever Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1279, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1279 was placed on the Sixth order on the calendar.

Page 1, line 1, remove "home and community-based"

Page 1, line 2, replace "services in North Dakota" with "family caregiver supports and services"

Page 1, line 5, remove "home and community-based services in this"

Page 1, remove lines 6 through 13

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Renumber accordingly

2015 TESTIMONY

HB 1279

#1

Testimony on HB 1279
Rep Alan Fehr, District 36
January 20, 2015

Mr Chairman and members of the Human Services Committee, I am Representative Alan Fehr of District 36.

I am here to introduce HB 1279, which relates to the designation of a caregiver by a hospitalized patient and the hospital's communication with that designated caregiver.

HB 1279 encourages the best possible care of loved ones after they are discharged from a hospital.

Under HB 1279, if someone is admitted to a hospital, the hospital will be required to ask the patient or legal guardian if they would like to designate a caregiver.

A caregiver is generally a trusted family member or friend. The patient is not required to designate a caregiver but, if one is designated, the hospital would be required to record that in the medical record and notify the caregiver when the patient is being released to home or transferred to another facility.

Furthermore, if the patient is being released to home, the hospital is required to inform the caregiver of the discharge plan and complete aftercare instructions.

On page 3 of the bill, starting on line 11, the hospital is required to provide the designated caregiver with a complete description of the patient's aftercare needs that are necessary to support the patient to live at home, including information about community resources and instruction about aftercare tasks that need to be performed. As necessary, this could include a demonstration of tasks that need to be performed and an opportunity for the caregiver and patient to have questions answered.

This bill is intended to support hospitalized patients, especially those who are most vulnerable and need additional help from family and friends. It is not intended to interfere with good clinical care or any emergency needs. You will notice that on page 4, starting on line 4, there are limitations on this bill. Subsection 2 starting on line 7 acknowledges that there may be circumstances that make it difficult for a hospital to fully comply with these requirements. In that case, they will need to document their efforts.

In conclusion, this bill sets a requirement for hospitals to involve designated caregivers to improve patient care and wellbeing following release from a hospital.

Thank you. I urge you to support HB 1279. I welcome your questions.



Real Possibilities in

#2

North Dakota

HB 1279 - SUPPORT

January 20, 2015

House Human Services Committee

Josh Askvig - AARP North Dakota

jaskvig@aarp.org or 701-989-0129

Chairman Weisz, members of the House Human Services Committee, I am Josh Askvig, Associate State Director of Advocacy for AARP North Dakota. Thank you for the opportunity to appear before you today and share AARP's strong support of HB 1279.

Dr. Ethel Percy Andrus, a retired educator and AARP's founder, became an activist in the 1940s when she found a retired teacher living in a chicken coop because she could afford nothing else. Dr. Andrus couldn't ignore the need for health and financial security in America and set the wheels in motion for what would become AARP. We are a nonprofit, nonpartisan membership organization with 85,000 members in North Dakota and 38 million nationwide. We understand the priorities and dreams of people 50-plus and are committed to helping them live life to the fullest, including here in North Dakota.

Over the past few years, AARP has raised its attention on family caregivers — spouses, partners, relatives, friends, or neighbors who provide unpaid care for a loved one. We have watched the situation facing caregivers evolve — longer lifespans and an increase in the number of persons with complex medical conditions that have stressed current support systems; the growth in the number of Baby Boomers who find themselves squarely in the sandwich generation, caring for both children and parents, that has created demand for new models of care and greater access to information; and the increase in complex conditions requiring coordination that has left "caregivers trying to tie together the fragmented pieces of their family member's care with several different clinicians, hospital stays, and transitions

between settings."¹ As such, we have intensified our efforts to ensure that family caregivers have the support they need to care for their loved ones.

In North Dakota, these efforts are particularly important. AARP Public Policy Institute's 2014 Long Term Scorecard showed that North Dakota ranked 33rd out of 50 states with respect to support that family caregivers receive.² Obviously, we can do more for the 109,000 individuals across the state who are caregivers for a loved one during the year and contribute \$830 million in unpaid care.³

HB 1279 recognizes the critical role family caregivers play in keeping their loved ones out of costly institutions. It puts in place some small, but meaningful supports for caregivers during hospital transitions, a difficult and stressful time for both patients and caregivers. Specifically, the bill takes several common sense steps that ensure a designated caregiver is seen as a partner in a patient's care.

1. Designation of the Caregiver in the Medical Record — The bill provides a patient or his/her legal guardian an opportunity to designate a caregiver upon admission into the hospital and if the patient does designate a caregiver, it requires that the hospital simply include this designation in the medical record with other patient information. This designation allows the family caregiver to receive timely information that can allow him/her to better provide post-discharge care. Including the designation in the medical record shows that the caregiver is valued and establishes another avenue by which the hospital can share important information.

2. Notification to the Caregiver of Discharge — This legislation calls on the hospital to alert the family caregiver, in a timely fashion, if his/her loved one is

¹ Susan Reinhard, *Home Alone: Family Caregivers providing Complex Chronic Care*, AARP http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf

² Susan Reinhard, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* <http://www.longtermscorecard.org/>

³ Susan Reinhard, et.al., *Valuing the Invaluable: The Growing Contribution and Cost of Caregiving* <http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf>

being discharged home or transferred to another facility. By providing the caregiver with information well before discharge, the caregiver can better manage the transition from one care setting to another.

3. Instruction of After-care Tasks — Most importantly, the legislation creates a framework through which a caregiver can receive instruction in the tasks that they will be asked to provide upon discharge. In a survey of North Dakota voters age 45 and older, a high number of North Dakota caregivers are responsible for overseeing medication management (66 percent) and medical or nursing tasks (56 percent) such as administering injections, operating specialized medical equipment, doing wound care and performing other complex health maintenance tasks.

This November telephone survey of 800 North Dakota voters age 45 and older showed strong support for provisions in the legislation. Summaries of the survey data are attached to my testimony.

Specifically, 92 percent of the survey respondents support requiring hospitals and health care facilities to explain and demonstrate medical and nursing tasks that family caregivers will need to perform after the patient returns home; 91 percent support keeping a family member informed of major decisions, like transferring or discharging the patient; and 82 percent support recording the name of a patient's family caregiver in the medical record upon admission.

Again, the strong support for these proposals is even more relevant because of the high number of North Dakota caregivers who are responsible for overseeing increasingly complex medical tasks.

As caregivers are better informed, notified, and instructed in after-care tasks, they have a better chance to keep their loved ones safely at home. AARP asks you to support House Bill 1279. Thank you for the opportunity to testify today and I am happy to take any questions you might have.

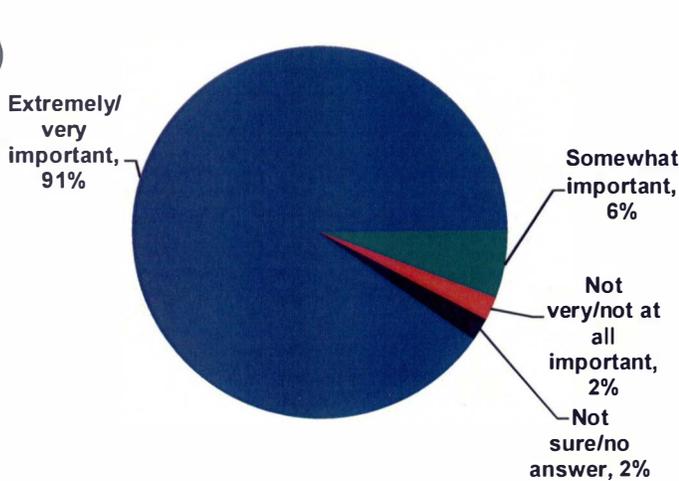
**2014 AARP Caregiving Survey of North Dakota Voters Age 45 and Older:
Family Caregivers**

There are approximately 109,000 caregivers over the course of the year in North Dakota. North Dakota caregivers provide 71 million hours of care per year with an estimated economic value of \$830 million dollars.¹

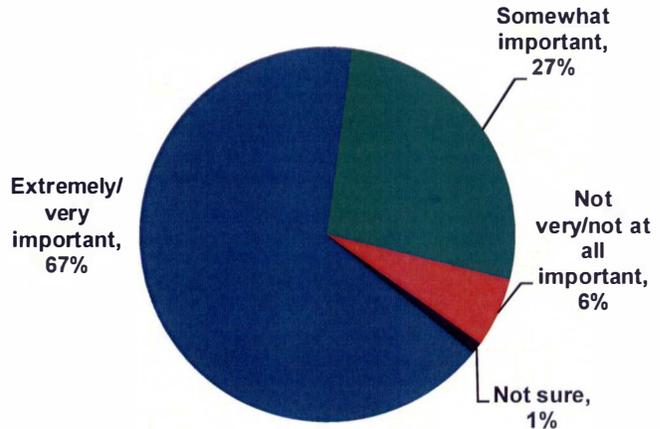
Most (70%) North Dakota voters age 45 and older believe that being cared for at home with caregiver assistance is the ideal situation when the basic tasks of life become more difficult due to aging or illness. Moreover, more than half (56%) of North Dakota voters age 45 and older say it is extremely, very, or somewhat likely they will provide care on an unpaid basis for an adult loved one who is ill, frail, elderly or who has a disability.

Most North Dakota caregivers are helping or have helped their loved ones with shopping (90%), transportation (84%), household chores (82%), meal preparation (74%) as well as more complex care like managing medications (66%) and other nursing and medical tasks (56%). The majority (72%) of these caregivers says it is likely that they will need to provide this type of care in the future. As such, nearly all (91%) of these caregivers believe it is important to be able to provide care so that their loved ones can keep living independently in their own home and two-thirds (67%) believe it is important to have more caregiver resources and training that allows family caregivers to continue to provide in-home care.

Importance of Providing Care to Adult Loved Ones Among North Dakota Caregivers
(n=383, Respondents Who Are Current or Past Caregivers)



Importance of Having More Resources and Training for Caregivers Among North Dakota Caregivers
(n=383, Respondents Who Are Current or Past Caregivers)



The average age of North Dakota caregivers is 63 years old and the majority is female (60%), married (71%), has a two year college degree or higher (64%), working either full or part-time (54%) and has an annual household income of less than \$100,000 (56%).

AARP North Dakota commissioned a telephone survey of 800 North Dakota voters age 45 and older to learn about their experiences with family caregiving, as well as their opinions on proposals to support family caregivers in the state. This report highlights results from voters interviewed between November 6 and November 16, 2014. The data in this report has been weighted by age, gender and geographic county of residence to reflect the North Dakota population of voters age 45 and older. The survey has a margin of error of ±3.5 percent.

¹Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving, Lynn Fein, Susan C. Reinhard, Ari Houser, and Rita Choula, AARP Public Policy Institute

4

AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We advocate for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name as well as help our members obtain discounts on a wide range of products, travel, and services. A trusted source for lifestyle tips, news and educational information, AARP produces AARP The Magazine, the world's largest circulation magazine; AARP Bulletin; www.aarp.org; AARP TV & Radio; AARP Books; and AARP en Español, a Spanish-language website addressing the interests and needs of Hispanics. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org.

State Research brings the right knowledge at the right time to our state and national partners in support of their efforts to improve the lives of people age 50+. State Research consultants provide strategic insights and actionable research to attain measurable state and national outcomes. The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

AARP staff from the North Dakota State Office, Campaigns, State Advocacy and Strategy Integration (SASI), and State Research contributed to the design, implementation and reporting of this study. Special thanks go to AARP staff including Janis Cheney, State Director in North Dakota, Joshua Askvig, Associate State Director of Advocacy in North Dakota; Chryste Hall, Reshma Mehta, Lani Kawamura, William Brown, and Jodi Sakol, Campaigns; Kristina Moorhead and Sarah Mysiewicz, SASI; and Joanne Binette, Rachelle Cummins, and Darlene Matthews, State Research. Please contact Aisha Bonner at 202-434-3531 for more information regarding this survey.



AARP Research

For more information about this survey, please contact Aisha Bonner at:

202.434.3531 or e-mail abonner@aarp.org

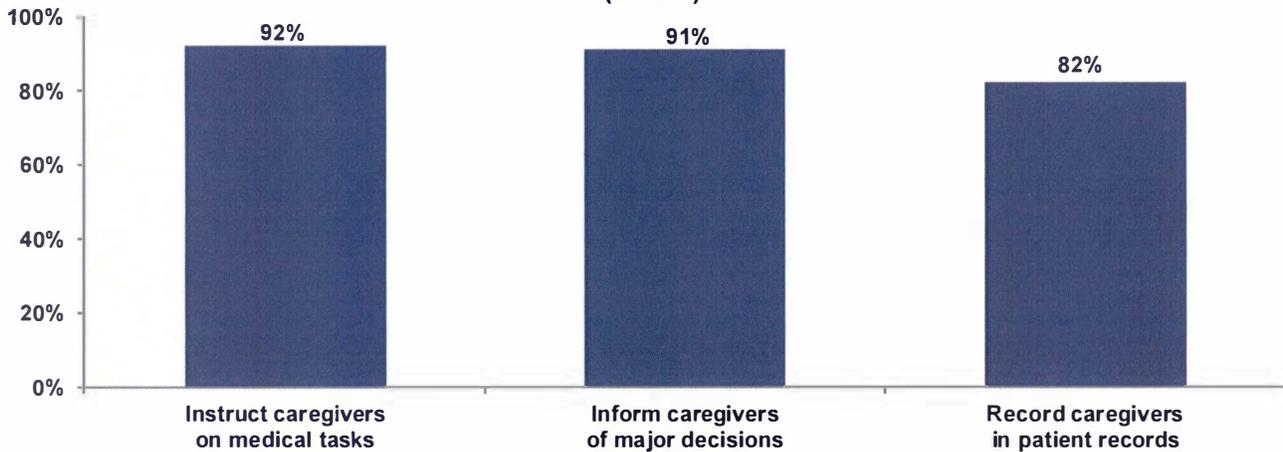


2014 AARP Caregiving Survey of North Dakota Voters Age 45 and Older: Support for Family Caregivers When Loved Ones Are Hospitalized

North Dakota voters age 45 and older strongly support proposals to help family caregivers navigate the health care system on behalf of their loved ones. Specifically, respondents support requiring hospitals and health care facilities to explain and demonstrate medical and nursing tasks that family caregivers will need to perform after the patient returns home; keeping a family caregiver informed of major decisions, like transferring or discharging the patient; and recording the name of a patient's family caregiver in the medical record upon admission.

The strong support for these proposals is even more relevant due to the high numbers of North Dakota caregivers who are responsible for overseeing medication management (66%) and medical or nursing tasks (56%).

Support for Proposals to Ensure Hospitals Engage with Family Caregivers
(n=800)



The average age of North Dakota caregivers is 63 years old and the majority is female (60%), married (71%), has a two year college degree or higher (64%), working either full or part-time (54%) and has an annual household income of less than \$100,000 (56%).

AARP North Dakota commissioned a telephone survey of 800 North Dakota voters age 45 and older to learn about their experiences with family caregiving, as well as their opinions on proposals to support family caregivers in the state. This report highlights results from voters interviewed between November 6 and November 16, 2014. The data in this report has been weighted by age, gender and geographic county of residence to reflect the North Dakota population of voters age 45 and older. The survey has a margin of error of ±3.5 percent.

6

AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We advocate for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name as well as help our members obtain discounts on a wide range of products, travel, and services. A trusted source for lifestyle tips, news and educational information, AARP produces AARP The Magazine, the world's largest circulation magazine; AARP Bulletin; www.aarp.org; AARP TV & Radio; AARP Books; and AARP en Español, a Spanish-language website addressing the interests and needs of Hispanics. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org.

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AARP Research

For more information about this survey, please contact Aisha Bonner at:

202.434.3531 or e-mail abonner@aarp.org

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#3

House Bill 1279
House Human Services Committee
January 20, 2015
Barbara Handy-Marchello, Bismarck, North Dakota

Chairman Weisz and members of the House Human Services Committee, I am Barbara Handy-Marchello from Bismarck. I am speaking in favor of House Bill 1279.

I am entering into a new phase of life as the caregiver to my mother. Though my mother is in pretty good health, there have been times when it was necessary for me to assume the role of caregiver while she recovered from surgery or illness. I have found that there is no way to adequately prepare for the various medical problems and emergencies that we all face as we age.

So far, our experience with the doctors, nurses, and other medical professionals has been very good. Bismarck hospitals and doctors achieve a high standard of care. However, I have more than once faced rising panic over my ability to get the information I need. Though I have probably annoyed medical staff with my questions, I don't always know that I am asking the right question of the right person. This bill will create a sound system of communication between medical staff and caregivers.

In my family, we are fortunate in that my mother and I agree that I am her caregiver when necessary, but I know of families where the role of caregiver has been confused by family tensions. This bill will help families clarify this role which can only improve the quality of care.

I also know of caregivers who have felt that they did not receive adequate information about the patient's care or instructions for at-home care. At-home care, especially for someone with no experience in human healthcare, can be very frightening. It is very easy to arrive at home and find that you don't know or can't remember when or how to administer medication or other treatments. You may not know what to expect in the normal healing process. More information, including proper demonstration of after-care tasks, is extremely important in providing the best possible options for recovery and a return to independence for the patient.

While it is unlikely that this bill will cover every possible healthcare situation, it will go a long way toward helping a family or a caregiver manage patient care and promote communication between medical professionals and caregivers.

Thank you for your attention to the needs of families who have to provide care to a loved one. The CARE Act will help to remove some of the worry and difficulty for both the caregiver and the patient and promote better health for the patient.

1

#4

House Human Services Committee
January 20, 2015
House Bill 1279

Mr. Chairman and members of the House Human Services Committee, I, Shelle Aberle wish to go on record in support for HB 1279 (The Caregiver, Advise, Record, Enable (CARE) Act as introduced.

As Representative Fehr noted, on any given day, 75,000 North Dakotans perform a great labor of love by caring for aging parents, spouses, or other family members and friends. They help with many different tasks so their loved ones can remain independent and safe in their own homes.

A majority of family caregivers also perform medical or nursing tasks like complex medication management, wound care and injections. Yet, most of these unpaid family caregivers receive little or no training for these duties.

My mother in law died the summer of 2013 at age 76. She was a double kidney transplant recipient with diabetes and lifetime medical diagnosis that included breast and skin cancer (in remission) and intestinal failure leaving her with an ileostomy. Through decades of doctoring, she was able minded and active in her own care. My father in law had little hands on with her medical processes as she was able to care for herself. This changed the summer of 2013 when she was in and out of the hospitals and assisted living facilities. Since she had most of her medical issues for decades, it was assumed upon her release from the institutions that my father in law (age 77) was knowledgeable in her care. He was too proud to ask the doctors questions, and as a family we not always at the hospital when she was released to ask questions. He did not want family help as he felt it showcased he was not fit to care for his spouse. Yes, a bit of a stubborn German, as is our North Dakotan culture not to ask for help.

We offered advice, assistance, and we visited often. We saw how ragged and tired he was becoming. We started to look for home health care to come in for them, and then she would end up back in the hospital.

When she left the hospital for the final time, my father in law was given a list of her medications and a bag of a few new meds to take home. He was not given information about home health options or hospice care, he was not given any check sheet for her medications, nor given any information on her wound care and injections for her diabetes. I was talking to him on the phone shortly after her discharge and heard the

HB 1279
January 20, 2015

desperation in his voice. I called my husband and we went to their house to help design a care plan for her.

First was to figure out her medication schedule. I gathered all the pill bottles she had scattered around the house. I counted at least 150 different bottles with meds laying all over the place. My husband and I compared all the bottles to the list of meds she was given at the hospital --- she had 35 prescribed medications to juggle through her day. The initial process took my husband and I both 4 hours to set up her meds, but it was done correctly. We set up all the meds for the week. We had 115 prescriptions to destroy -- and that included large bottles with over 6000 pain pills in the house. Not everyone has a family member that can step up to take care of this.

I continue to look back and see how a few simple steps upon release would have eliminated the angst for my father in law. Had we not been there to help sort through all her medications, she would have easily over or under dosed. A simple check sheet could have solved this process. She also had injections with her diabetes and wound care for her ileostomy that we also helped my father in law learn as he did not know how to do this either as he did not have any training upon her discharge.

Watching his frantic pace in trying to keep up, we thought we were going to bury them both last summer.

My husband retired last summer from the North Dakota National Guard as a Colonel after serving for 35 years. He has the kidney disease that his mother had and is facing a transplant in the near future. Although he is perfectly capable of taking care of himself right now, I am his caregiver already as we search for a donor and start planning the future of the transplant. My husband is on peritoneal dialysis and I have learned that process through a week long training provided by the hospital. This elevated my apprehension on aiding in his care and assuring that he gets the proper medical care.

The provisions in House Bill 1279 would ensure that family caregivers are kept informed and are provided with an explanation and a demonstration of the medical tasks they will perform at home after discharge from a hospital.

I, Shelle Aberle respectfully requests a Pass on House Bill 1279.

This testimony provided by Shelle Aberle, North Dakota citizen.

2

#5

House Human Services Committee

Rep. Robin Weisz, Chair

Jan. 20, 2015

HB 1279

Testimony presented by:

Dr. Craig Lambrecht, Sanford Health Bismarck President

Good morning, Chairman Weisz and members of the House Human Services Committee. For the record, I am Dr. Craig Lambrecht, Sanford Health Bismarck President, and I represent Sanford Health.

Sanford Health, an integrated health system headquartered in the Dakotas, is the largest, rural, not-for-profit health care system in the nation. The Sanford West division is headquartered in Bismarck and features clinic locations in Bismarck, Mandan, Dickinson and Minot.

Thank you for the opportunity to share my concerns regarding the unintended consequences of House Bill 1279. As an emergency department physician and longtime North Dakota health care leader, I appreciate the bill's honorable intent in that it is clearly aimed at helping patients. However, creating blanket mandates targeting expertly-trained hospital teams working in an already highly-regulated environment is misaimed.

Please know providing excellent patient care is at the core of every decision I make as president of Sanford Health Bismarck—affordable, quality services are top priority throughout the continuum of care including individualized hospital discharge planning for every patient. Led by a physician, each patient's discharge planning team includes specialized care providers, a case worker and, when applicable, a social worker collaborating with the patient and their designated caregiver. We work diligently and intentionally to maximize the patient's wellness, to expedite recovery and eliminate the possibility of avoidable readmission.

1

HB1279
January 20, 2015

This bill requires undue burden to invest additional staff resources to duplicate education and documentation processes already integrated into our processes. Furthermore, the timing requirements will create increased capacity challenges in that discharge planning will be delayed thus increasing patients' length of stay and reducing the number of available hospital beds.

Finally, the bill subjects hospitals to significant risk by mandating training and education take into account a caregiver's capabilities and limitations as well as the patient's home environment. I am concerned about the enormous liability this places on my team and suspect it may violate scope of professional licensing practice in some situations.

Simply put, the bill creates an unfunded mandate to document and duplicate processes already in place for our patients. We welcome the opportunity to work together with the bill's authors to help them learn more about existing processes and identify opportunities for continued improvement.

Thank you for your leadership and commitment to supporting North Dakota's health care system.

Craig Lambrecht, M.D.

Craig.lambrecht@sanfordhealth.org

701-323-6104

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Our Mission:
Dedicated to the work of
health and healing

#6



North Dakota Hospital Association

Vision

The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission

The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

**Testimony: HB 1279
Hospital Designation of a Caretaker for After Care
House Human Service Committee
January 20, 2015**

Good morning Chairman Weisz and Members of the Human Service Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am unable to be present at this hearing as I am testifying in Senate Appropriations on the Department of Human Services Appropriation bill.

We have surveyed our membership regarding this bill and the consensus is they oppose this bill and ask that you give this bill a **Do Not Pass**.

The hospitals oppose this bill for the following:

- It creates additional expense in the cost of care by requiring additional documentation of care to be provided by non-hospital staff in a non-hospital setting after leaving the hospital.
- The bill will in effect require hospitals to hire additional staff. The hospitals already have a shortage of professional staff and hiring additional people will be difficult.
- There are no funds allocated to provide this service. Basically this bill is creating an unfunded mandate imposed on the hospitals.
- It creates additional liability for the hospitals beyond our control. We have no control of the care that would be documented in a hospital chart after the patient leaves the hospital; however, because it would be in the patient's chart the hospitals would be liable.
- We are not aware of any problems or issues regarding the current method of discharge planning hospitals now offer. Hospitals do work with referring facilities and families on the coordination of care upon discharge.

HB 1279

January 20, 2015

If you have questions I would be willing to address them at a later time or in writing.

We oppose this bill and ask that you give this bill a **Do Not Pass**.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "J E Jurena". The signature is stylized with a large initial "J" and "E".

Jerry E. Jurena, President
North Dakota Hospital Association

Sanford
801 Broadway N
PO Box 2010
Fargo, ND 58122
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sanfordhealth.org



January 19, 2015

North Dakota House of Representatives
Human Services Committee
State Capitol
Bismarck, ND

RE: HB 1279

Chairman Weisz and Members of the Committee:

I am Dr. James Volk, Chief Medical Officer at Sanford Health in Fargo, North Dakota. My apologies for not being able to appear before you in person, a work commitment keeps me in Fargo. However, I do wish to express deep concern over the impacts that House Bill 1279 would have on Sanford Health and other providers around the state.

This is bad legislation, with good intent. We agree with the bills author's that proper care and treatment of patients after their discharge is vital to their healing, and that avoiding readmissions wherever possible is desirable. These are issues we face every day and deal with effectively in our management of patient care.

The bill would require that before a patient is discharged from a hospital and no later than 24 hours after a patient enters a hospital, the hospital shall provide the patient or the patient's legal guardian with the opportunity to designate a caregiver. The hospital would have to document the patient's designation of a caregiver and provide instruction regarding after-care tasks to the caregiver. The hospital would be required to notify the patient's caregiver at least four hours before the patient is discharged.

No funding is provided for these added requirements of informing and training, creating a burdensome unfunded mandate. And while there is a vague liability clause included, in the instance of a patient's negative experience with a caregivers tasks not having been performed properly, we believe liability risks for our health system would still be significant.

We want to assist our patients in getting the proper after-care needed to recover from a hospital stay. And we do it every day, counseling, educating, and training our patients and their caretakers when requested. But to mandate requirements, establish rigid timelines, and legislate protocols will be costly and restrictive.

Our Mission:
Dedicated to the work of
health and healing

HB 1279
January 20, 2015

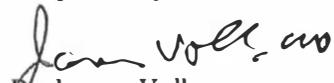
The health care industry is already highly regulated. We closely monitor patient readmissions, and we are constantly under scrutiny from CMS, the Center for Medicare and Medicaid Services, and other federal regulators. Likewise, our industry accreditation through the Joint Commission closely inspects our processes and provides for improvement plans. And we at Sanford, and frankly all North Dakota providers, take pride in our national reputation as a high quality provider state.

Our paramount concern with this legislation relates to the impacts it would have on our workforce. If there is a crisis in North Dakota health care today, it is our workforce needs. Before this legislature you will find numerous bills attempting to boost access to a workforce of qualified and educated individuals. Nursing in particular continues to woefully lack the stream of employee applicants to properly fill all our position needs. And this bill would exacerbate the problem by mandating the education and instruction of caretakers. We have not precisely calculated the FTE impact on our institutions, but it would be real. And the reality is, today, we cannot fill those additional positions. We are already struggling to meet our present needs.

Until the workforce needs of the health care community are effectively addressed, mandating the increased workload of providers is folly, and should be opposed.

Mr. Chairman and members of the committee please know the health and healing of our patients is fundamental to everything we do at Sanford Health. Our patient focused integrated system continues to evolve and we take pride in the ongoing improvements provided in a complex environment. We appreciate the bill's authors for their concern for patients in their after-care and successful recovery processes. The best way to achieve results, however, is not through legislative unfunded state mandates. Rather those results are best found in the coordinated patient care of the health care environment.

Respectfully submitted,


Dr. James Volk
Chief Medical Officer
Sanford Health
Fargo, ND

HB 1279 2-23-15 #1

During the 2015-16 interim, the legislative management shall consider studying home and community based services in North Dakota.

The study must include consideration of home and community based services and support systems that relate to chronic injury or illness, rehabilitation and recovery, aged or disabled individuals, and the scope of the study must include consideration of access, availability, and delivery of services.

The study must include input from stakeholders, including representatives of law enforcement, social and clinical service providers, advocacy organizations, tribal government, state and local agencies and institutions, and representatives of caregivers in North Dakota.

The legislative council may contract for consulting and coordination of study services to assist the legislative management in conducting the home and community based study.

The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.

**Testimony on HB 1279
Rep Alan Fehr, District 36**

*Attachment #1
HB 1279
03/17/2015
J# 24952*

Madam Chair and members of the Senate Human Services Committee, I am Representative Alan Fehr of District 36.

I am here to introduce HB 1279. HB 1279 in its current form requests a legislative management study of home and community-based services, specifically relating to support systems, access, availability, and delivery of services.

This amended bill is a hog-house of the original bill, which was modeled after a national initiative known as the Care Act.

The Care Act relates to the designation of a caregiver by a hospitalized patient and the hospital's communication with that designated caregiver to encourage the best possible care of loved ones after they are discharged from a hospital. If someone is admitted to a hospital, the hospital would be required to ask the patient or legal guardian if they would like to designate a caregiver.

A caregiver is generally a trusted family member or friend. The patient is not required to designate a caregiver but, if one is designated, the hospital would be required to record that in the medical record and notify the caregiver when the patient is being released to home or transferred to another facility.

Furthermore, if the patient is being released to home, the hospital is required to inform the caregiver of the discharge plan and complete aftercare instructions.

The Care Act is intended to support hospitalized patients, especially those who are most vulnerable and need additional help from family and friends. It is not intended to interfere with good clinical care or any emergency needs. The Care Act includes protection from liability for hospitals and their workers.

You will hear further testimony on the Care Act and the importance of promoting communication with caregivers. Since this bill was turned into a study, I am requesting this Committee to consider the value of the Care Act, either to consider the original version of the bill or to include the Care Act in the study. A draft of suggested language has been prepared.

I welcome your questions.

Attachment #2
HB 1279
03/17/2015
J# 24952

SECTION 1. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, legislative management shall consider studying family caregiver supports and services. The study committee must identify policies, resources, and programs available for family caregivers and encourage additional innovative and creative means to support family caregivers so that they are able to continue to provide in-home support for older adults. The study must include input from stakeholders, including representatives of hospitals, social and clinical providers, advocacy organizations, tribal government, state and local agencies and institutions, and representatives of caregivers in this state. The study committee may receive testimony on the needs of family caregivers, including designation of caregivers, training, respite services, medical leave policies, delegation of tasks to non-medical aides and other policies. The study committee must compile an inventory of the resources available to family caregivers. Legislative management may contract for consulting and coordination of study services to assist legislative management in conducting the family caregiving study. Legislative management shall report its findings and recommendations for legislative and administrative action to support family caregivers, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.

HB 1279 – CARE/HCBS Study
Representative Gail Mooney
Senate Human Services Committee
March 17, 2015

Attach #3
HB 1279
03/17/2015
J# 24952

Chairman Lee, and Senate Human Services Committee, thank you for the opportunity to speak on HB 1279.

In its original form, HB 1279 was intended to serve as a means to identify, train and record caregiver(s) instructions through hospital discharge plans. The House Human Services hearing provided numerous testimonies in support of the bill, which clearly demonstrated a need for consistent resources and support systems for caregivers for in-home patient recovery and care upon hospital discharge. However, opposition came in the form of the implementation - logistics, qualifiers, staffing and liabilities were all points of concern. Both sides had valid and decidedly important points.

The differences between caregiver/patient needs, and the practical points of implementation were never reconciled, yet in the interest of quality continuum of care, it seemed counterproductive to not arrive at a viable solution going forward from this session.

What you see before you, in HB 1279, is a Hog House Amendment that would ask Legislative Management to consider an interim study of Home and Community Based Services that includes the relevant points of recovery and rehabilitation from the original bill.

**Examples of Potential
Home & Community
Based Service Partners**

Hospitals, Long Term Care, Social Services, Pharmacies, Paramedics, Advanced Emergency Medical Technicians, Physicians, Nurses, Physicians Assistants, Public Health Districts, Hospice, Senior Citizens Centers, Meals on Wheels... plus others to identify, develop or connect.

Why Home and Community Based Services?

To answer that, we can step back to the original goals, as heard in the House Human Services Committee: *resources and supports*. To provide patients and their designated caregivers with the necessary systems to ensure appropriate and quality care is provided in the in-home setting, once discharged from a hospital. A simple mandate of one more discharge form - or the directive of minimal requirements in a discharge plan may sound good - but in practicality would do little to provide the actual outcomes of resources and supports.

To provide consistent and meaningful outcomes, we need to take a concerted effort to look at the full spectrum of community systems (both private and public sectors) to identify available resources, supports, and services – and where there are gaps - to arrive at a systematic approach to the needs. The goal of helping people to remain in their homes longer – and with safe and healthy support systems – is key to the overall wellness of people across the state.

The study language was derived from the Behavioral Health Interim Study initiated from the 2013 Legislative Assembly. The framework of that study was deliberate in the objective of outcomes for the 2015 Legislative Session, and as a result was resoundingly successful. It made sense to model a Home and Community Based Services Study off this language.

I would welcome, and encourage, this committee to consider any adjustments of language that might strengthen the construct of a Home and Community Based Services study for the assurances of best outcomes for the 2017 Session. In doing so, we can expect to take in to account not only the needs of patients and caregivers in a recovery and rehabilitation situation, but also in the preventative continuum of healthy living needs for a broader spectrum of North Dakota citizens of all ages.



Attch#4
HB 1279
03/17/2015
J# 24952

North Dakota

HB 1279 – AMEND to SUPPORT FAMILY CAREGIVERS
March 17, 2015

House Human Services Committee
Josh Askvig - AARP North Dakota
jaskvig@aar.org or 701-989-0129

Chair Lee, members of the Senate Human Services Committee, I am Josh Askvig, Associate State Director of Advocacy for AARP North Dakota. Thank you for the opportunity to appear before you today and share AARP's strong support for North Dakota's family caregivers.

Dr. Ethel Percy Andrus, a retired educator and AARP's founder, became an activist in the 1940s when she found a retired teacher living in a chicken coop because she could afford nothing else. Dr. Andrus couldn't ignore the need for health and financial security in America and set the wheels in motion for what would become AARP. We are a nonprofit, nonpartisan membership organization with 85,000 members in North Dakota and 37 million nationwide. We understand the priorities and dreams of people 50-plus and are committed to helping them live life to the fullest, including here in North Dakota.

Let me be clear, we support home- and community-based services and efforts to improve those supports. However, HB 1279 was originally introduced to provide support and recognition to the unpaid backbone of home care in North Dakota – family caregivers. We want to state up front our ask is that you restore the bill to its original version, taking into account the potential need for amendments that hospital advocates may have to make this bill workable for them.

Why do we support the original version? Over the past few years, AARP has raised its attention on family caregivers — spouses, partners, relatives, friends, or neighbors who provide unpaid care for a loved one. We have watched the situation

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facing caregivers evolve: longer lifespans and an increase in the number of persons with complex medical conditions that have stressed current support systems; the growth in the number of Baby Boomers who find themselves squarely in the sandwich generation, caring for both children and parents, that has created demand for new models of care and greater access to information; and the increase in complex conditions requiring coordination that has, to quote the report *Home Alone: Family Caregivers providing Complex Chronic Care*, left "caregivers trying to tie together the fragmented pieces of their family member's care with several different clinicians, hospital stays, and transitions between settings."¹ As such, we have intensified our efforts to ensure that family caregivers have the support they need to care for their loved ones.

In North Dakota, these efforts are particularly important. AARP Public Policy Institute's 2014 Long Term Scorecard showed that North Dakota ranked 33rd out of 50 states with respect to the legal system and supports that family caregivers receive.² Obviously, we can do more for the 109,000 individuals across the state who are caregivers for a loved one during the year and contribute \$830 million in unpaid care.³

HB 1279 originally was drafted to recognize the critical role family caregivers play in keeping their loved ones out of costly institutions. It would put in place some small, but meaningful, supports for caregivers during hospital transitions, a difficult and stressful time for both patients and caregivers. Specifically, the original bill took several common sense steps that ensure a designated caregiver is seen as a partner in a patient's care.

¹ Susan Reinhard, *Home Alone: Family Caregivers providing Complex Chronic Care*, AARP http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf

² Susan Reinhard, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* <http://www.longtermscorecard.org/>

³ Susan Reinhard, et al., *Valuing the Invaluable: The Growing Contribution and Cost of Caregiving* <http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf>

1. *Designation of the Caregiver in the Medical Record* — The bill as introduced provides a patient or his/her legal guardian an opportunity to designate a caregiver upon admission into the hospital. If the patient does designate a caregiver, it requires that the hospital simply include this designation in the medical record with other patient information. This designation allows the family caregiver to receive timely information that can allow him/her to better provide post-discharge care. Including the designation in the medical record shows that the caregiver is valued and establishes another avenue by which the hospital can share important information.

2. *Notification to the Caregiver of Discharge* — This legislation calls on the hospital to alert the family caregiver, in a timely fashion, if his/her loved one is being discharged home or transferred to another facility. By providing the caregiver with information well before discharge, the caregiver can better manage the transition from one care setting to another.

3. *Instruction of After-care Tasks* — Most importantly, the legislation creates a framework through which a caregiver can receive instruction in the tasks that they will be asked to provide upon discharge. In a survey of North Dakota voters age 45 and older, a high number of North Dakota caregivers are responsible for overseeing medication management (66 percent) and medical or nursing tasks (56 percent) such as administering injections, operating specialized medical equipment, doing wound care and performing other complex health maintenance tasks.

This November telephone survey of 800 North Dakota voters age 45 and older showed strong support for provisions in the legislation. Summaries of the survey data are attached to my testimony.

Specifically, 92 percent of the survey respondents support requiring hospitals and health care facilities to explain and demonstrate medical and nursing tasks that family caregivers will need to perform after the patient returns home; 91 percent support keeping a family member informed of major decisions, like transferring or

4.4

discharging the patient; and 82 percent support recording the name of a patient's family caregiver in the medical record upon admission.

The strong support for these proposals is even more relevant due to the high numbers of North Dakota caregivers who are responsible for overseeing medication management (66 percent) and complex medical or nursing tasks (56 percent). Couple this with the information we know from the *Home Alone* report that “The majority of these medication caregivers (more than 60 percent) learned how to manage at least some of the medications on their own...” Almost half (47 percent) said they received no training. Thirty-two percent received training in an outpatient setting. And critically, only 16 percent received training from a hospital nurse or doctor.⁴

AARP asks you to restore House Bill 1279 to its original version as the CARE Act. As caregivers are better informed, notified, and instructed in after-care tasks, they have a better chance to keep their loved ones safely at home and prevent hospital readmissions.

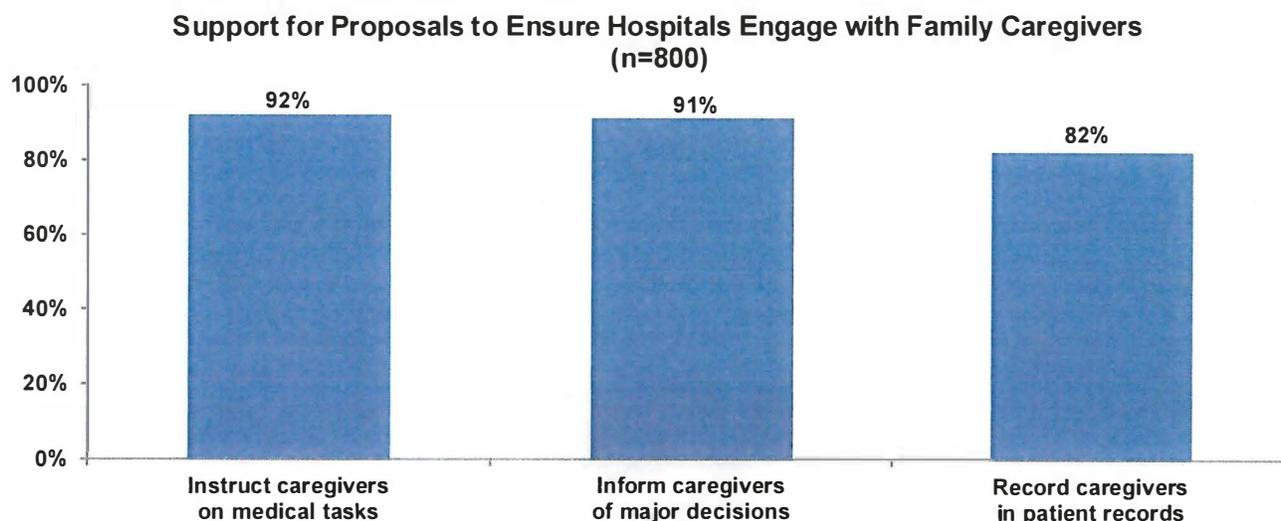
Thank you for the opportunity to testify today. I am happy to take any questions you might have.

⁴ Susan Reinhard, *Home Alone: Family Caregivers providing Complex Chronic Care*, AARP http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf

2014 AARP Caregiving Survey of North Dakota Voters Age 45 and Older: Support for Family Caregivers When Loved Ones Are Hospitalized

North Dakota voters age 45 and older strongly support proposals to help family caregivers navigate the health care system on behalf of their loved ones. Specifically, respondents support requiring hospitals and health care facilities to explain and demonstrate medical and nursing tasks that family caregivers will need to perform after the patient returns home; keeping a family caregiver informed of major decisions, like transferring or discharging the patient; and recording the name of a patient's family caregiver in the medical record upon admission.

The strong support for these proposals is even more relevant due to the high numbers of North Dakota caregivers who are responsible for overseeing medication management (66%) and medical or nursing tasks (56%).



The average age of North Dakota caregivers is 63 years old and the majority is female (60%), married (71%), has a two year college degree or higher (64%), working either full or part-time (54%) and has an annual household income of less than \$100,000 (56%).

AARP North Dakota commissioned a telephone survey of 800 North Dakota voters age 45 and older to learn about their experiences with family caregiving, as well as their opinions on proposals to support family caregivers in the state. This report highlights results from voters interviewed between November 6 and November 16, 2014. The data in this report has been weighted by age, gender and geographic county of residence to reflect the North Dakota population of voters age 45 and older. The survey has a margin of error of ± 3.5 percent.

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AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We advocate for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name as well as help our members obtain discounts on a wide range of products, travel, and services. A trusted source for lifestyle tips, news and educational information, AARP produces AARP The Magazine, the world's largest circulation magazine; AARP Bulletin; www.aarp.org; AARP TV & Radio; AARP Books; and AARP en Español, a Spanish-language website addressing the interests and needs of Hispanics. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org.

State Research brings the right knowledge at the right time to our state and national partners in support of their efforts to improve the lives of people age 50+. State Research consultants provide strategic insights and actionable research to attain measurable state and national outcomes. The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

AARP staff from the North Dakota State Office, Campaigns, State Advocacy and Strategy Integration (SASI), and State Research contributed to the design, implementation and reporting of this study. Special thanks go to AARP staff including Janis Cheney, State Director in North Dakota, Joshua Askvig, Associate State Director of Advocacy in North Dakota; Chryste Hall, Reshma Mehta, Lani Kawamura, William Brown, and Jodi Sakol, Campaigns; Kristina Moorhead and Sarah Mysiewicz, SASI; and Joanne Binette, Rachelle Cummins, and Darlene Matthews, State Research. Please contact Aisha Bonner at 202-434-3531 for more information regarding this survey.



AARP Research

For more information about this survey, please contact Aisha Bonner at:

202.434.3531 or e-mail abonner@aarp.org

**2014 AARP Caregiving Survey of North Dakota Voters Age 45 and Older:
Family Caregivers**

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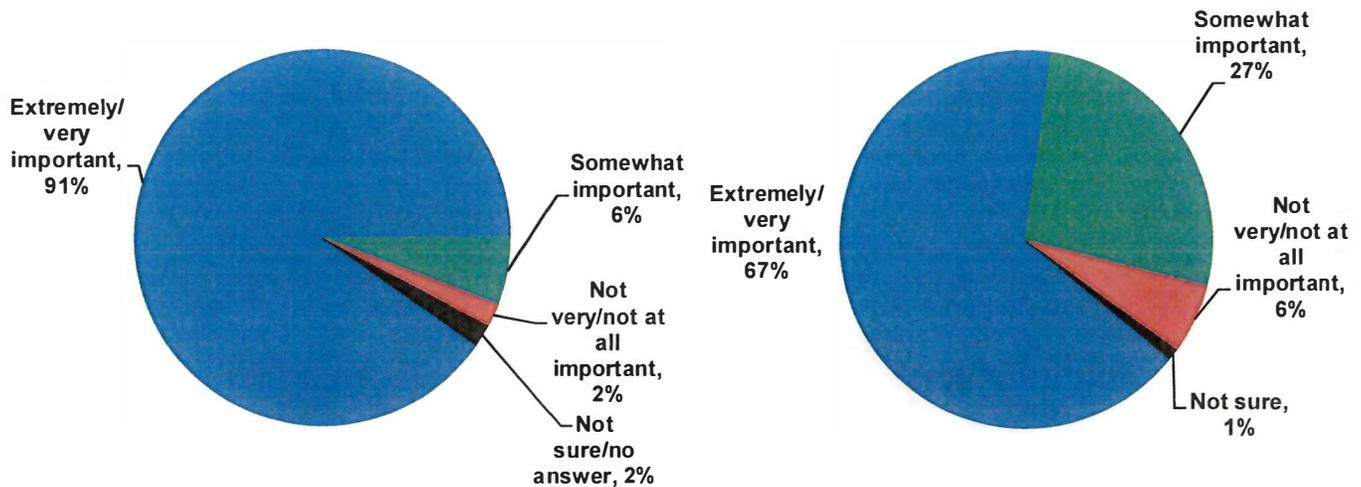
There are approximately 109,000 caregivers over the course of the year in North Dakota. North Dakota caregivers provide 71 million hours of care per year with an estimated economic value of \$830 million dollars.¹

Most (70%) North Dakota voters age 45 and older believe that being cared for at home with caregiver assistance is the ideal situation when the basic tasks of life become more difficult due to aging or illness. Moreover, more than half (56%) of North Dakota voters age 45 and older say it is extremely, very, or somewhat likely they will provide care on an unpaid basis for an adult loved one who is ill, frail, elderly or who has a disability.

Most North Dakota caregivers are helping or have helped their loved ones with shopping (90%), transportation (84%), household chores (82%), meal preparation (74%) as well as more complex care like managing medications (66%) and other nursing and medical tasks (56%). The majority (72%) of these caregivers says it is likely that they will need to provide this type of care in the future. As such, nearly all (91%) of these caregivers believe it is important to be able to provide care so that their loved ones can keep living independently in their own home and two-thirds (67%) believe it is important to have more caregiver resources and training that allows family caregivers to continue to provide in-home care.

**Importance of Providing Care to Adult Loved Ones
Among North Dakota Caregivers
(n=383, Respondents Who Are Current or Past Caregivers)**

**Importance of Having More Resources and Training for Caregivers
Among North Dakota Caregivers
(n=383, Respondents Who Are Current or Past Caregivers)**



The average age of North Dakota caregivers is 63 years old and the majority is female (60%), married (71%), has a two year college degree or higher (64%), working either full or part-time (54%) and has an annual household income of less than \$100,000 (56%).

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¹ Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving, Lynn Fein, Susan C. Reinhard, Ari Houser, and Rita Choula, AARP Public Policy Institute

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AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We advocate for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name as well as help our members obtain discounts on a wide range of products, travel, and services. A trusted source for lifestyle tips, news and educational information, AARP produces AARP The Magazine, the world's largest circulation magazine; AARP Bulletin; www.aarp.org; AARP TV & Radio; AARP Books; and AARP en Español, a Spanish-language website addressing the interests and needs of Hispanics. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org.

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AARP Research

For more information about this survey, please contact Aisha Bonner at:

202.434.3531 or e-mail abonner@aarp.org

Attach#15
HB 1279
03/17/2015
J#24952

Senate Human Services Committee
March 17, 2015
House Bill 1279
Kim Jacobson, Director – Traill County Social Services

Chairman Lee and members of the Senate Human Service Committee, for the record my name is Kim Jacobson. I am the Director of Traill County Social Services located in Hillsboro, North Dakota. I am also a member of the North Dakota County Social Service Director's Association. I speak today in support of House Bill 1279.

Home and Community Based Services (HCBS) are very important service in North Dakota. They help elderly and disabled individuals live safely, ideally in their home communities and in the least restrictive environment. For the purposes of my testimony, my definition of HCBS services is very inclusive including the full spectrum of services provided to the aged and disabled ranging but not limited to family caregivers, qualified service providers, assisted living, basic care, and skilled nursing care. This is also be referred to by some as the long-term care continuum.

North Dakota HCBS services, policy and structure has been implemented piece by piece over a period of time. Many factors including federal program funding and rules, waiver approvals, state legislative action, policy development, interpretations, etc. all impact our current system. From my perspective as a County Social Service Director, the current structure is a tangled matrix which is very cumbersome, fractured, and non-cohesive. In actuality, the focus of the program is system-centered (silos) vs. client-centered service. Additionally, as a local agency we see how the system is confusing for clients, their families, providers, and even ourselves. Based on my discussion and observations of legislators, I often their hear comments about their confusion and questions as they face important decisions regarding policy, service, and funding.

From my understanding, HB 1279 is crafted to mirror the process of the Behavioral Health Study. Such study would allow a birds-eye view of the system as a whole, while helping educate all individuals on the system strengths, needs, barriers, and opportunities. Through independent study including a wide variety of stakeholders partnering with officials, we could yield information that could effectively shape future decisions regarding funding, needs, and refine current programs. This will allow a reference point for legislators and other decision-makers to make sound decisions and to spend valuable tax-payer dollars wisely through highly informed decision-making.

County Social Services recommend the following items to be considered as potential areas of study:

- Identify the various services on the full spectrum by defining services and developing common vernacular (vs. jargon and acronyms) to ensure understanding.
- Identify the gaps and barriers for people needing service, those receiving service and compare with services available throughout the state.
- Obtain cost effectiveness statistics of serving individuals at each level of care.
- Include the entire continuum of care in the study (such as long-term care, assisted living, basic care, PACE, Money Follows the Person, Options services, individual/agency QSPs, family caregivers, home health, DD providers, Public Health, advocacy groups, etc.)
- Provide an opportunity to engage service providers, family members, individuals, organizations, state and local officials, advocacy groups, and legislators, etc. to learn and problem-solve together while strategizing for the future of service in North Dakota.
- Identify potential options to early intervention/prevention/cost-savings to skilled nursing home care such as innovative alternate services (ex. limited SPED).
- Most importantly, examine and make program improvement recommendations using the client's perspective with the goal of enhancing a seamless program by wrapping services around a client to support them during their continuum of care history.

Prior to closing my testimony, I would like to share with you the importance and relationship between HB 1279 and SB 2206 – Social Service Funding. It would be ideal for an HCBS study to be performed during the same time as the Governor's Social Service Funding Committee work. Thirty-eight counties, including Traill County, operate a county-funded HCBS program. These programs are county programs and are funded and defined by each participating county. If work on both items could be completed during the same interim, we could be prepared for informed decision-making as the 65th Legislative Assembly approaches with the goal of preventing any unintended consequences that could potentially harm our elderly and disabled citizens served at the county social service level.

For these reasons, I urge you to support passage of House Bill 1279 with a "Do PASS" recommendation. Thank you for your consideration. I welcome questions from the committee.

15.0349.03000

Sixty-fourth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1279

Attach #6
HB 1279
03/17/2015
J# 24952

Introduced by

Representatives Fehr, D. Anderson, Bellew, Hofstad, Seibel

1 A BILL for an Act to create and enact chapter 23-48 of the North Dakota Century Code, relating
2 to a hospital patient's designation of a caretaker to assist with after-care.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1.** Chapter 23-48 of the North Dakota Century Code is created and enacted as
5 follows:

6 **23-48-01. Definitions.**

7 As used in this chapter:

- 8 1. "After-care" means assistance provided by a caregiver to a patient after the patient's
9 release from a hospital. The term may include assisting with behavioral health support
10 services, basic activities of daily living, instrumental activities of daily living, and
11 carrying out medical or nursing tasks, such as managing wound care, assisting in
12 administering medications, and operating medical equipment.
- 13 2. "Caregiver" means an individual duly designated as a caregiver by a patient under this
14 chapter, who provides after-care assistance to a patient in the patient's residence. The
15 term may include a relative, partner, friend, or neighbor or any individual who has a
16 significant relationship with the patient.
- 17 3. "Entry" means a patient's admission to a hospital for the purposes of medical care or
18 behavioral health care.
- 19 4. "Hospital" means a facility licensed under chapter 23-16.
- 20 5. "Release" means a patient's exit or discharge from a hospital to the patient's residence
21 following an inpatient admission.
- 22 6. "Residence" means a dwelling the patient considers to be the patient's home or
23 temporary home. The term does not include a rehabilitation facility, hospital, nursing
24 home, assisted living facility, or group home.

1 **23-48-02. Designation of caregiver.**

2 1. Within twenty-four hours following a patient's entry to a hospital and again before the
3 patient's release or transfer to another hospital or facility, the hospital shall provide
4 each patient or the patient's legal guardian with at least one opportunity to designate
5 at least one caregiver for purposes of this chapter.

6 a. If the patient is unconscious or otherwise incapacitated upon entry to a hospital,
7 within twenty-four hours following the patient's recovery of consciousness or
8 capacity the hospital shall provide such patient or the patient's legal guardian with
9 an opportunity to designate a caregiver for purposes of this chapter.

10 b. If the patient or the patient's legal guardian declines to designate a caregiver
11 under this section, the hospital shall document this in the patient's medical
12 record.

13 c. If the patient or the patient's legal guardian designates an individual as a
14 caregiver:

15 (1) The hospital shall request the written consent of the patient or the patient's
16 legal guardian to release medical information to the patient's caregiver,
17 following the hospital's established procedures for releasing personal health
18 information and in compliance with all federal and state laws. If the patient
19 or the patient's legal guardian declines to consent to release medical
20 information to the patient's caregiver, the hospital is not required under
21 section 23-48-03 to provide notice to the caregiver or to provide information
22 contained in the patient's discharge plan.

23 (2) The hospital shall record in the patient's record the patient's or legal
24 guardian's designation of caregiver; the relationship of the caregiver to the
25 patient; and the name, telephone number, and address of the caregiver.

26 d. A patient or legal guardian may elect to change a caregiver designation at any
27 time. If a patient or legal guardian notifies the hospital of a change in caretaker
28 designation, within twenty-four hours of such notification the hospital shall record
29 this change in the patient's medical record.

30 2. A designation of a caregiver by a patient or a patient's legal guardian under this
31 section does not obligate an individual to perform any after-care tasks for a patient.

1 3. This section may not be construed to require a patient or a patient's legal guardian to
2 designate a caregiver.

3 **23-48-03. Caregiver notice and instruction - Rules.**

4 1. A hospital shall notify the patient's caregiver of the patient's release or transfer to
5 another hospital or facility. This notice may be provided after the patient's physician
6 issues a discharge order and may not be less than four hours before the patient's
7 actual release or transfer to such hospital or facility.

8 2. Before a hospital transfers a patient to another hospital or facility, the transferring
9 hospital shall include in the patient's discharge plan the name and contact information
10 of the caregiver.

11 3. Before a patient's release from a hospital, the hospital shall consult with the caregiver
12 and the patient regarding the caregiver's capabilities and limitations and shall issue a
13 discharge plan that describes a patient's after-care needs at the patient's residence.

14 a. At a minimum, the discharge plan must include:

15 (1) The name and contact information of the caregiver;

16 (2) A description of all after-care tasks necessary to maintain the patient's
17 ability to live at the patient's residence, taking into account the capabilities
18 and limitations of the caregiver; and

19 (3) Contact information for any health care, community resources, and
20 long-term services and supports necessary to successfully carry out the
21 patient's discharge plan.

22 b. The hospital issuing the discharge plan shall provide a caregiver with instruction
23 in all after-care tasks described in the discharge plan.

24 (1) At a minimum, the instruction must include a demonstration of the after-care
25 tasks performed and at the time of the demonstration an opportunity for the
26 caregiver and patient to have questions answered about the after-care
27 tasks.

28 (2) The hospital shall document in the patient's medical record the instruction
29 required under this subsection, including, at a minimum, the date, time, and
30 contents of the instruction.

Sixty-fourth
Legislative Assembly

1 4. The state health council may adopt rules to implement the provisions of this chapter,
2 including rules to further define the content and scope of any instruction provided to a
3 caregiver under this chapter.

4 **23-48-04. Limitations.**

- 5 1. This chapter may not be construed to interfere with the rights of an agent operating
6 under a valid health care directive under chapter 23-06.5.
- 7 2. To the extent the unique circumstances of a patient's care require the hospital to vary
8 from complying with provisions of this chapter, that hospital shall document the
9 variance and the efforts made by the hospital to comply with the provisions of this
10 chapter.
- 11 3. This chapter does not create a private right of action against a hospital, a hospital
12 employee, or an individual with whom a hospital has a contractual relationship and
13 does not supersede or replace exiting rights or remedies under any other provision of
14 law.

House Bill 1279
Senate Human Services Committee
March 17, 2015
Barbara Handy-Marchello, Bismarck, North Dakota

Attach # 7
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Chair Lee and members of the Senate Human Services Committee, I am Barbara Handy-Marchello from Bismarck. I am speaking in favor of restoring House Bill 1279 to the CARE Act.

I am entering into a new phase of life as the caregiver to my mother. Though my mother is in pretty good health, there have been times when it was necessary for me to assume the role of caregiver while she recovered from surgery or illness. I have found that there is no way to adequately prepare for the various medical problems and emergencies that we all face as we age.

So far, our experience with the doctors, nurses, and other medical professionals has been very good. Bismarck hospitals and doctors achieve a high standard of care. However, I have more than once faced rising panic over my ability to get the information I need. Though I have probably annoyed medical staff with my questions, I don't always know that I am asking the right question of the right person. This bill will create a sound system of communication between medical staff and caregivers.

In my family, we are fortunate in that my mother and I agree that I am her caregiver when necessary, but I know of families where the role of caregiver has been confused by family tensions. This bill will help families clarify this role which can only improve the quality of care.

I also know of caregivers who have felt that they did not receive adequate information about the patient's care or instructions for at-home care. At-home care, especially for someone with no experience in human healthcare, can be very frightening. It is very easy to arrive at home and find that you don't know or can't remember when or how to administer medication or other treatments. You may not know what to expect in the normal healing process. More information, including proper demonstration of after-care tasks, is extremely important in providing the best possible options for recovery and a return to independence for the patient.

I encourage you to reinstate the original version of HB1279 that would implement the CARE Act. While it is unlikely that this bill will cover every possible healthcare situation, it will go a long way toward helping a family or a caregiver manage patient care and promote communication between medical professionals and caregivers.

Thank you for your attention to the needs of families who have to provide care to a loved one. The CARE Act will help to remove some of the worry and difficulty for both the caregiver and the patient and promote better health for the patient.

HB1279

From: AARP [mailto:aarpwebact@action.aarp.org]
Sent: Friday, March 06, 2015 6:51 PM
To: Lee, Judy E.
Subject: Restore the CARE Act (HB1279)

Attach #8
J# 24952
03/17/2015

Mar 6, 2015

email: Tomasko
AARP

Senator Judy Lee
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Dear Senator Lee,

I am contacting you about HB 1279.

The bill as originally introduced was to provide additional support and instruction for family caregivers when loved ones are released from the hospital. Unfortunately, the House "hoghoused" the bill and turned it into a study on home care services. This was NOT the intent of the original bill.

Turning this bill into a study on an unrelated issue is a slap in the face to family caregivers across North Dakota. Over 2,000 of my fellow North Dakotans sent messages in support of this bill. Additionally, a November 2014 AARP survey of 800 North Dakotans showed an overwhelming majority supported each of the three key provisions of the CARE Act (see percentages below).

That's why I am asking you to remove the House amendments and restore the CARE Act to its original language.

The CARE Act is a simple bill that has three important provisions:

- 1) The name of the family caregiver is recorded when a loved one is admitted into a hospital (82% ND's surveyed support);
- 2) The family caregiver is notified if the loved one is to be discharged to another facility or back home (91% of ND's surveyed support); and,
- 3) The facility must provide an explanation and a demonstration of the medical tasks such as medication management, injections, and wound care that the family caregiver will perform at home (92% of ND's surveyed support).

In North Dakota, 56 percent of family caregivers in North Dakota perform medical or nursing tasks for their loved ones. Two out of three North Dakota caregivers (66 percent) perform complex medical or nursing tasks like managing medications, including administering intravenous fluids and injections. And most family caregivers report that they receive little or no instruction to perform these tasks. That's why the CARE Act is so important.

North Dakota family caregivers provide unpaid care valued at an estimated \$830 million annually. For our state, their contribution runs even deeper. By helping their older loved ones remain at home and

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out of costly nursing homes, usually paid for by Medicaid, family caregivers are, in essence, saving the state money.

I encourage you to restore HB 1279 to its original version. After restoring the bill, vote YES on the original HB 1279 - the CARE Act - to ensure that the North Dakota value of families being engaged in healing is honored and continued.

Sincerely,

Mr. Mike Tomasko
1839 CYPRESS WAY
WEST FARGO, ND 58078-4297
(701) 205-4583



Vision

The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission

The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Attach #9
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**Testimony: HB 1279
Study of Home and Community-based Services
Senate Human Services Committee
March 17, 2015**

Good morning Chairman Lee and Members of the Senate Human Service Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am unable to be present at this hearing as I am testifying in House Appropriations on the Department of Human Services Appropriation bill SB 2012.

The original bill HB 1279 mandated that hospitals within 24 hours of a patient's admission and again before discharge provide the patient an opportunity to designate at least one caregiver. We are still opposed to this mandate as each hospital currently has a discharge planning process in place. I am not aware of any complaints that have been reregistered regarding the current process.

Hospitals nationwide have been working with the American Hospital Association (AHA) and the Centers for Medicare and Medicaid Services (CMS) to reduce re-admissions nationwide. CMS through the Hospital Engagement Network (HEN) program, which the North Dakota Hospital Association has been a part of, has been monitoring and reporting on a monthly basis ten quality initiatives set by CMS over the last three years in addition to reporting on reducing re-admissions.

We can live with a study; however, a study would show this mandate to be a duplication of discharge planning efforts.

In a survey that NDHA completed the hospitals listed the following reasons in opposition to the original bill:

- It creates additional expense in the cost of care by requiring additional documentation of care to be provided by non-hospital staff in a non-hospital setting after leaving the hospital.
- The bill will in effect require hospitals to hire additional staff. The hospitals already have a shortage of professional staff and hiring additional people will be difficult.
- There are no funds allocated to provide this service. Basically this bill creates an unfunded mandate imposed on the hospitals.
- It creates additional liability for the hospitals beyond our control. We have no control of the care that would be documented in a patient's chart after the patient leaves the hospital. Again because it would be in the patient's chart the hospitals would be liable for any adverse outcomes.
- We are not aware of any problems or issues regarding the current method of discharge planning hospitals now provide. Hospitals will continue to work with referring facilities and families on the coordination of care upon discharge.
- We can live with a study. Currently hospitals are still required to report to CMS on re-admissions and quality initiatives.

We are opposed to the duplication in the discharge planning process.

We can live with a study but find it unnecessary and we oppose any and all efforts to return to the original bill. I ask that you give this bill a **Do Not Pass**.

If you have questions I would be willing to address them at a later time or in writing.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Jerry E. Jurena", with a stylized flourish extending to the right.

Jerry E. Jurena, President
North Dakota Hospital Association