2011 SENATE HUMAN SERVICES

SCR 4009

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SCR 4009
1-24-2011
Job Number

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Declaring February 2011 as "American Heart Month" and Friday, February 4, 2011, "National Wear Red Day" in ND and encouraging all citizens to wear red to raise awareness of cardiovascular disease.

Minutes:

Senator Judy Lee opened the hearing on SCR 4009.

Senator Judy Lee introduced the resolution and explained that this was intended to recognize the importance of good heart health. Since the day specifically mentioned for recognition is February 4, 2011, she encouraged the committee to move on this quickly.

Senator Dick Dever moved a **Do Pass**.

Seconded by **Senator Spencer Berry**.

Roll call vote 5-0-0. **Motion passed**.

Carrier is **Senator Spencer Berry**.

Date: 1-24-2011

Roll Call Vote # _____

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 4009

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Dever Seconded By **Sen.** Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Gerald Uglem, V. Chair	✓				
Sen. Dick Dever	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent _____

Floor Assignment Sen. Berry

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

REPORT OF STANDING COMMITTEE

SCR 4009: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4009 was placed on the Eleventh order on the calendar.

2011 HOUSE HUMAN SERVICES

SCR 4009

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SCR 4009
February 2, 2011
Job # 13831

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes: See attached Testimony #1

Chairman Weisz: Opened the meeting on SCR 4009. There was a mix up at the front desk on 4009. The hearing was scheduled, but the bill was moved from the Senate to the House floor for a vote and there was not a hearing, but June is here and will have some information for us.

June Herman: Vice-President of ND Advocacy for the Heart Association. (See Testimony #1.)

Chairman Weisz: So at this stage you are just starting to look for the sources of the $2 million is that what I'm understanding?

June: Initially our discussions were the 2 million and I feel with what we are doing with our anticipated budget and the detail and I go to committee shortly to talk about that budget detail with them. We have it down to about 1.3.

Rep. Holman: Thank you for doing this. That the color would be a function of population density, but then I see Nebraska. So how is Nebraska which is at the top, different from North and South Dakota which are at the bottom?

June: You are talking about the STEMI map? It could be a reflection of our rural nature. I know Nebraska has rural aspect that they have to deal with. They certainly have a good portion of the larger population.

Rep. Kilichowski: I notice that there seems to be quite a few critical access hospitals that are not a part of this. Is it your long term goal to have everyone on it?

June: All of the facilities are being visited and there is the funding available to bring all of the facilities on. When you look at those that have not on boarded, when we assessed and the stroke system of care task force meeting last week; a lot of them are associated with a particular health care system. It may just be things are working through their hierarchy as far as coming on board and making a commitment. We certainly hope to have them on and certainly Oakes which is affiliated with that same health system. It was one of our earlier adopters. We are pleased we do have pick up from some in the system, but we certainly want to get a 100% of all of the facilities in. Most of the data in and why it shows TPA

being administered as highly as it is, is that it is the larger facilities data that is showing that. We are going to be able to start pulling data out by how often it is administered in the rural setting. I think you will see the figure drop drastically.

2011 TESTIMONY

SCR 4009

American Heart Association. | American Stroke Association.
Learn and Live.

SCR 4009 – Heart Month/Wear Red

House Human Services Committee

AHA Testimony

Chairman Weisz and members of the House Human Services Committee. For the record, I am June Herman, Vice President of Advocacy for the American Heart Association in North Dakota. I am here today to testify in support of SCR 4009.

The news is not good. In the past 30 years, obesity in this country has more than doubled among children and more than tripled among teenagers. As these rates continue to rise, we are putting an entire generation at risk for serious health conditions like type 2 diabetes, high blood pressure and even heart disease and stroke. Inactivity along with the overconsumption of unhealthy foods and sugar sweetened beverages is a leading cause.

By 2030, the direct cost of treating cardiovascular disease in the U.S. will triple, reaching a total of $818 billion. The prevalence of cardiovascular disease will also grow to the point where it affects more than four of 10 U.S. adults. These are the projections of a new AHA policy statement published in *Circulation.*

As alarming as these 2030 figures are, there's also a silver lining: They are still only projections. With effective prevention strategies, we can limit the growing burden of America's No. 1 killer. We've come a long way in our ability to treat cardiovascular disease in the past 50 years. Yet a concurrent surge in risk factors like obesity, along with an aging population, mean more people than ever before are developing cardiovascular disease and thus requiring treatment.

In 2009, the Human Resources Division included $472,700 in the Department of Health Budget for establishing a statewide stroke registry. 76% of North Dakota hospitals have joined the registry and the state is already beginning to explore the richness of data to guide interventions. (attachments A and B).

Let me put a face to stroke –

- Cristal Larsen – Valley City. 35 year old mother of two young daughters. Struck down by stroke in March 2010. Received prompt emergency treatment, including tPA. When she was discharged, her physical deficits caused her two year old to fear her, and no long give her mom hugs and kisses. But due to the quick intervention, Cristal was able to quickly gain back her abilities, and more importantly, gain back the hugs and kisses of her daughter.

- A farmer in a rural community. Family noted problems with his speech in the morning (around 8 am). He denied any need to see a physician - did his "chores" (milking cows, etc) and then walked back to the house. Had breakfast, went back outside to work, but was "dizzy" for a bit so didn't go out in the field, but worked on repairs of machinery in his shop. (full story attached). This person displayed signs and symptoms of a stroke noted by the patient himself, as well as his family for a period of time of at least 14 hours, before medical assistance was called for and he arrived for assessment and treatment.

  Medicare was utilized twice during his nursing home stay - once when he was first admitted, and a second time in 2007 after his second stroke occurred.

  Total amt. paid by Medicare: $ 38,552.36

  The cost of his nursing home care from admission to death:

  Total 325,303.84

  Total cost for his nursing home care paid (includes Medicare coverage): **$371,971.70**

- Fargo Business Owner and member of the AHA stroke care advocacy committee. In seeing a chart that I'm about to share with you on the Stroke Optional Appropriation Request, he encouraged that a portion of base funding be directed to physician awareness. Concerned over minor warnings he was experiencing , he did make several visits to his provider with his ailment undiagnosed. Then he was struck by a significant stroke. Fortunately, he received early treatment, and was able to return to his business.

This session we are pursuing a number of Optional Appropriation Requests that can help North Dakota with limiting the growing burden of cardiovascular disease

- Additional stroke funding - Go Red ND, Public Education, Stroke Standardization and Training
- Woman's Way with Heart - Adding heart screenings for Woman's Way clients

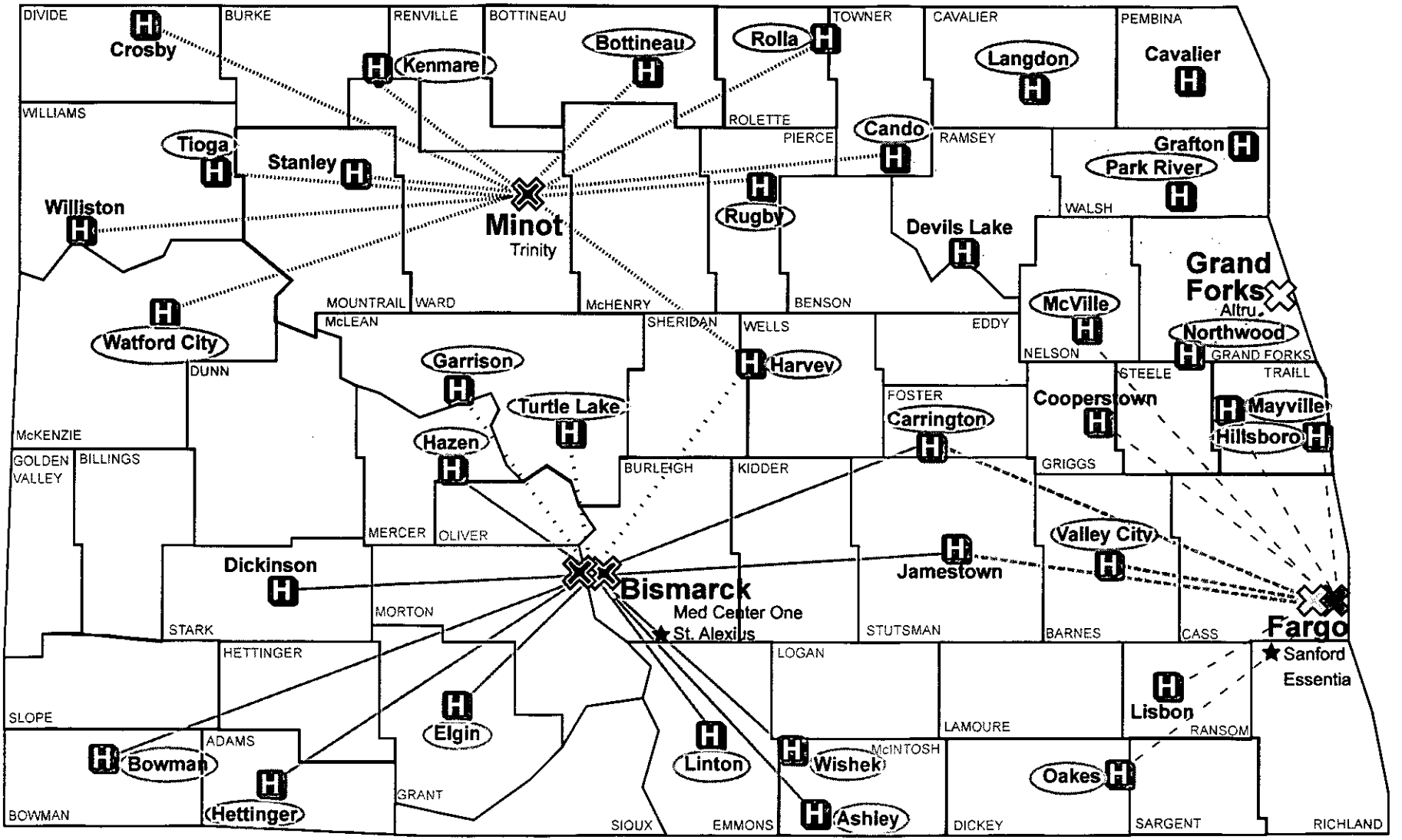
Recently, a new major heart system of care project – Mission: Lifeline, targeting ST-elevated-MIs. Attached to my testimony is a map showing North Dakota's classification as a Category 5 state for STEMI deaths, and an attachment which provides an overview of the project.

As noted, a private foundation is willing to step forward with over $4 million for the statewide project, if a match amount of 1/3 can be secured in the state. This opportunity came to us on December 9, well after the submission of the Department of Health budget. Given the scope of the project, and the impact on North Dakota lives, we are making core legislative leadership groups such as this committee aware of this opportunity. Attached is a budget overview we are finalizing for funding partners and possible submission.

AHA day at the capital is this Friday, February 4, and we appreciate the quick passage of SCR 4009 to the House floor. Friday is also wear red day, so we encourage everyone to participate.

At this time, I am available to respond to any questions you may have.

North Dakota Hospitals & Referral Centers



01/11

Referral Centers

- Trinity Hospital
- St. Alexius Medical Center
- MedCenter One & St. Alexius
- Participating in NDDoH State Stroke Program
- **Critical Access Hospitals** H
- Altru Hospital
- Sanford Health
- Sanford & Essentia Health
- Designated Primary Stroke Centers ★

Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

North Dakota State Stroke Registry (SSR)

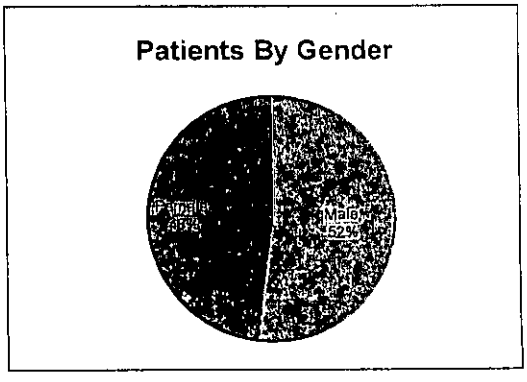
Powered by the American Heart Association's
Get With The Guidelines® – Stroke

SSR Report 1

This report includes data retrieved from the North Dakota State Stroke Registry on January 6, 2011. It reflects 1,078 records of admission that have been entered for the period January 1, 2009 through December 31, 2010. The registry data points will continue to become more robust as participating hospitals enter baseline data and new stroke cases. The following charts highlight data collected by the North Dakota State Stroke Registry:

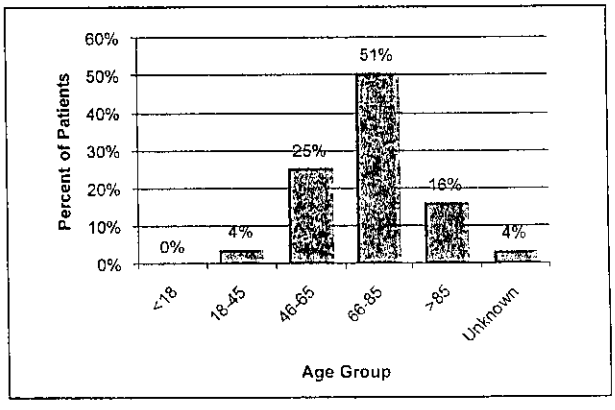
- North Dakota hospitals treated more male patients than female patients.

Gender	Number of Patients	Percent of Patients
Male	560	52%
Female	516	48%
Unknown	2	0%
Total	1,078	100%



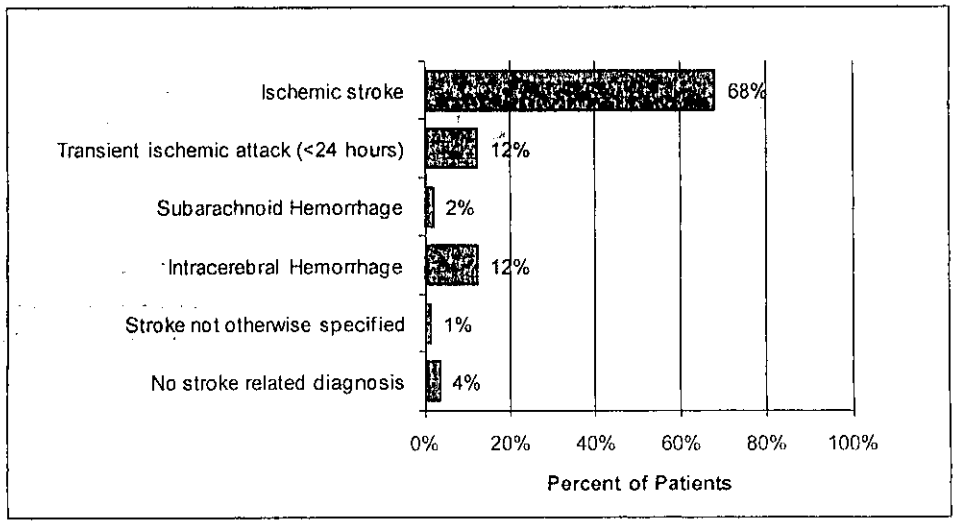
- Most stroke cases occurred in patients between age 65 and 85.

Age Group	Number of Patients	Percent of Patients
<18	0	0%
18-45	43	4%
46-65	273	25%
66-85	548	51%
>85	176	16%
Unknown	38	4%
Total	1,078	100%



- The most prevalent diagnosis was ischemic stroke which occurs as a result of an obstruction within a blood vessel supplying blood to the brain.

Diagnosis	Number of Patients	Percent of Patients
Ischemic stroke	736	68%
Transient ischemic attack (<24 hours)	133	12%
Subarachnoid Hemorrhage	23	2%
Intracerebral Hemorrhage	132	12%
Stroke not otherwise specified	16	1%
No stroke related diagnosis	38	4%
Total	**1,078**	**100%**



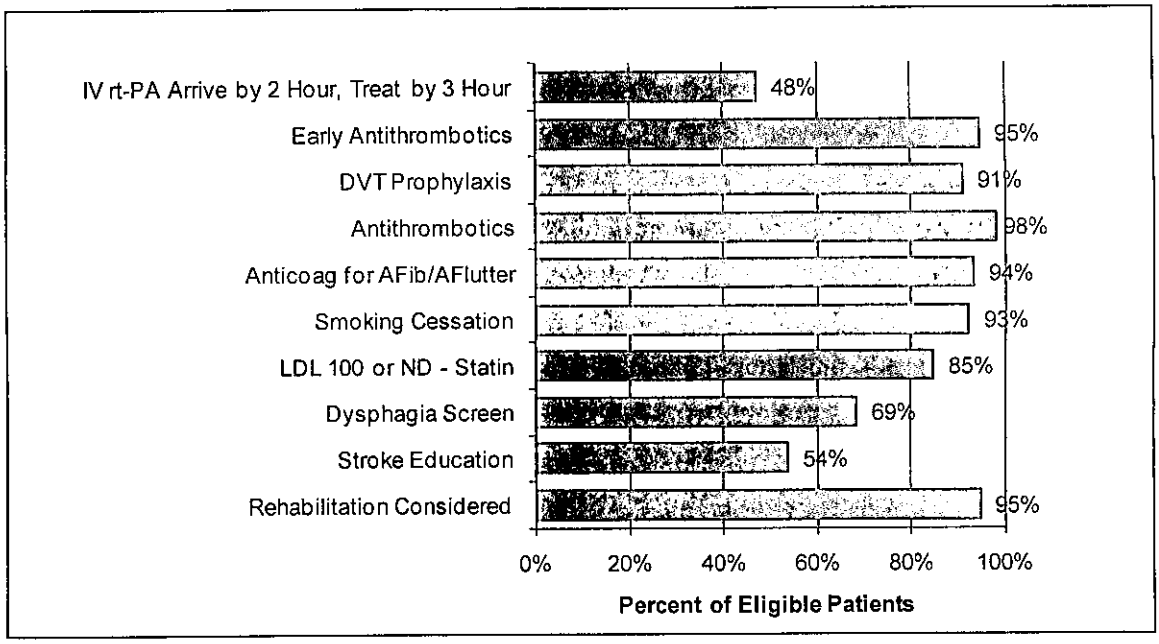
Primary stroke centers are hospitals which have been certified by the Joint Commission as centers that comply with the latest hospital guidelines for the treatment of stroke. The Department of Health designates hospitals as North Dakota Primary Stroke Centers upon verification of Joint Commission certification. To date, two of the six tertiary (general acute) hospitals have obtained Joint Commission certification.

The following data reflect the Primary Stroke Center Consensus Measures. These measures include the harmonized set of measures created by the American Stroke Association, the Joint Commission and the Centers for Disease Control and Prevention.

- Approximately half of Ischemic or hemorrhagic stroke patients or their caregivers were given education materials during the hospital stay addressing **all** of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke and warning signs and symptoms.

Consensus Measures
North Dakota Tertiary Hospitals

Consensus Measure	Percent of Eligible Patients	Numerator	Denominator
IV rt-PA Arrive by 2 Hour, Treat by 3 Hour	48%	20	42
Early Antithrombotics	95%	541	570
DVT Prophylaxis	91%	258	283
Antithrombotics	98%	640	651
Anticoag for AFib/AFlutter	94%	101	108
Smoking Cessation	93%	111	120
LDL 100 or ND - Statin	85%	262	308
Dysphagia Screen	69%	458	667
Stroke Education	54%	208	385
Rehabilitation Considered	95%	626	660



Using these data, hospitals and the State Stroke Program are able to assess the use of best practice guidelines to measure and enhance the quality of patient care and improve stroke outcomes.

- A farmer in a rural community. White male, family noted problems with his speech in the morning (around 8 am). He denied any need to see a physician - did his "chores" (milking cows, etc) and then walked back to the house. Had breakfast, went back outside to work, but was "dizzy" for a bit so didn't go out in the field, but worked on repairs of machinery in his shop. Came in once to get some "ointment" for his left hand - which he burned while welding - returned back to his shop until being called for supper. Speech hadn't improved, and he seemed to be dragging his left foot, but indicated it was nothing to worry about and ate his meal. He had some trouble holding his fork and blamed it on the burn he received earlier while welding. After completing his evening meal, he went into the living room to watch TV.

  He napped off and on in his recliner- which would be "normal" for him. His wife woke him up so that he could listen to the 10 pm news, and his speech was 100% garbled. She called the ambulance and he arrived at the hospital at 10:24 pm. He was assessed and transferred to a tertiary facility in 45 minutes - where he was hospitalized for 10 days. He returned home as he was able to "pivot" and "turn". He remained at home with his wife and two sons assisting in his cares, until it became too difficult to continue to care for him at home. He was unable to ambulate by this time, required assistance in eating, was incontinent of bowel and bladder, and had to have ground/pureed foods due to his difficulty swallowing.

  He was hospitalized for a urinary tract infection and weight loss when he was brought into the clinic. He was admitted to the hospital for antibiotics and additional testing, along with a therapy evaluation. The family agreed for him to be admitted to the nursing home in July 2005, at 78 years of age. With therapy and 24 hour care, he was able to walk short distances, feed himself, and participate in many activities -playing cards, putting puzzles together, and visiting/socialization with community friends and family. This continued

until he experienced a second stroke in 2007. Family requested comfort cares only. He remained in the nursing home, recovered minimally, and continued his stay there until his death in November 2010.

Medicare was utilized twice during his nursing home stay - once when he was first admitted, and a second time in 2007 after his second stroke occurred.

Total amt. paid by Medicare: $ 38,552.36

The cost of his nursing home care from admission to death:

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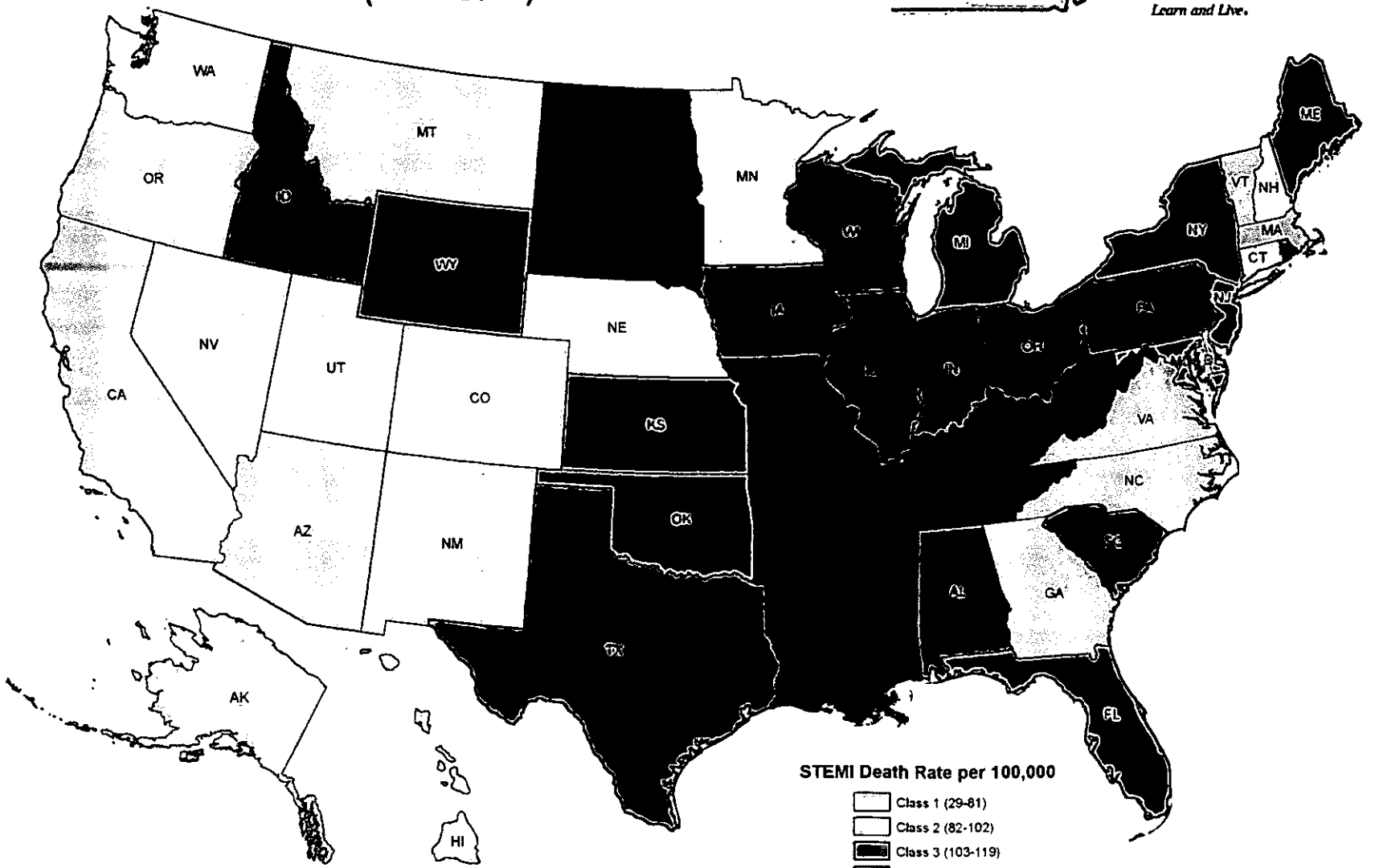
He had farmed 2 quarters of land, and milked cows for a living. He was in "good" physical shape, had no previous health problems, did not smoke, and was not overweight. His wife along with her two sons (who were married and lived more than 60 miles from their family farm), assisted in his cares and keeping him at home for 7 years. His wife rented out the farmland, sold the cattle and remained on the farm until he was admitted to the nursing home. When he was admitted to long term care, his wife had to sell their farm and tillable land. She moved into town after selling the farm at the age of 77 yrs. visiting her husband daily. He spent over 12 years in long term care and died in 2010 at the age of 93. Hi wife continues to live independently in town.

This person displayed signs and symptoms of a stroke noted by the patient himself, as well as his family for a period of time of at least 14 hours, before medical assistance was called for and he arrived for assessment and treatment.

Age 35+ STEMI Death Rate per 100,000 by State (2002-2006)



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database. ICD 10 I21 - I22.

American Heart Association
Learn and Live.

MISSION: Lifeline™

STEMI Heart Attacks

Throughout the United States each year, nearly 1,255,000 people suffer heart attacks. About 400,000 of those patients suffer the most severe type of heart attack - an ST-elevated myocardial infarction, or STEMI - caused by the total blockage of a coronary artery. To reduce risk of death or long-term disability, the STEMI must be identified quickly, the blockage cleared using balloon angioplasty or a clot-busting drug, and blood flow to the heart restored, ideally within 90-minutes of onset as recommended by American Heart Association scientific guidelines. Through Mission: Lifeline, the American Heart Association will work in collaboration with hospitals and EMS statewide to remove barriers to optimal STEMI care that will lead to lives saved and a reduction in disability. PCI procedures cost about $65,000 if provided in a timely manner. Heart surgery - $200,000.

More Lives Can Be Saved

Mission: Lifeline is the American Heart Association's initiative to improve care for STEMI patients, save lives and reduce disability. It encompasses several key activities:

- **Equip ambulances with 12-lead electrocardiograms (ECGs) in order to identify the STEMI pre-hospital, transmit ECG results to the receiving hospital, and activate the cardiac catheterization laboratory**
- **Train emergency medical providers in using the 12-lead ECG**
- **Establish protocols standardizing recommendations for treatments**
- **Train all levels of system personnel in STEMI care**
- **Document patient care to identify opportunities for improvement by adopting a standardized patient data registry**

Two Patients, Two Experiences

Ken R, 75, called 9-1-1 when severe chest pain began. Paramedics arrived within 6 minutes, used a 12-lead ECG to identify the STEMI and transmitted the ECG to the receiving hospital where the cardiac cath lab staff was prepared to perform angioplasty. Within 50 minutes of onset the blockage was cleared and Ken's life saved.

Roy F, 81, wasn't nearly as fortunate. Roy called 9-1-1 and the responding ambulance was not equipped with a 12-lead ECG. He was taken to the closest hospital where his STEMI was identified, but the hospital did not have a cath lab so Roy had to be transferred to another hospital. He finally received angioplasty but it took 3 hours and 6 minutes! Thankfully, Roy's life was saved. However, the delays resulted in serious heart muscle death and permanent disability.

EMS Response

- It's like having a cardiologist in the field with me
- SD – our 12-lead is worth more than our ambulance to us

Project Status

A national foundation, with an interest in rural health, has expressed willingness to fund approximately two-thirds of the total $6.5 million project for a STEMI response program in North Dakota, on the condition that an additional $2 million is secured. This is extraordinarily generous and has enormous implications for improving heart attack care throughout the state.