HOSPICE
RED RIVER VALLEY

Senate Bill 2332
Senate Human Services Committee
Senator Judy Lee, Chairman
January 25, 2023

Good morning, Chairman Lee and members of the Senate Human Services Committee. My name is Dr. Tracie Mallberg Sylvester, and I am here today to testify in favor of SB 2332.

I have been the medical director for Hospice of the Red River Valley for nearly 6 years and more recently, for Red River Healthcare, which provides home-based primary and palliative care services for patients who struggle with the mobility to seek healthcare. My testimony today is not only from the perspective of a medical director, but also that of a farm-kid, born and raised in Cogswell, ND. Growing up feeding chickens and pigs, throwing bales and splitting wood. I was blessed with that ND work ethic and ND values. I completed my entire education in ND, including graduating from the UND School of Medicine. Over the past 20 years I have been proud to raise my children here, and to provide healthcare to the people of our state.

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Early in my career I stumbled upon the opportunity to provide primary care and ER coverage on a locums basis, for communities all over North Dakota. Communities who either did not have a permanent physician, or who required temporary physician services, like Cando, Devils Lake, Fort Yates, Fort Totten, Garrison, Jamestown, Langdon, Valley City and Watford City. I was able to see patients and develop relationships with healthcare professionals all over the state. If there is one thing that I learned during the last 2 decades, it is that the residents of our state, especially in the rural areas, do not expect anything excessive or unreasonable, but most do hope to remain in their homes during the later years of their life.

After 15 years of medicine, I thought I knew what hospice was, but it was not until my own father passed away that I was able to really understand, the support and comfort that hospice care can bring to families, during some of the most difficult times in life. While I wholeheartedly love the mission and service we provide, shortly after joining HRRV I came to realize that the need for support in the home, starts long before people are eligible for hospice. I was asked to evaluate a woman with advanced dementia, who's family requested Hospice. She was being cared for, in her home, by her elderly husband, with as much assistance as their daughter could provide. When explaining to the family that she did not qualify for hospice services as she clearly had a life expectancy of more than six-months, her family

asked me “Well then, what do we do? We can’t even get her to the clinic for appointments anymore.”

The sad reality was that I did not have an answer for them. Not long after that, our team began to provide primary care services, on a very limited basis, for patients with dementia. It quickly became clear that a structured, program to bring primary care into the home, could fill a huge gap in healthcare for many patients and families. Keeping with the mission of providing the right care, in the right place, at the right time, we moved forward, in 2019, with the development of Red River Valley Healthcare and our House Calls program.

The idea of house calls is not new, and in fact, more than a few of my older patients remember a time when their doctor routinely made house calls. In the 1930s, 40% of all physician visits took place in the home, but by 1996 this had declined to only 0.5%. Driven by financial pressures to increase revenue by seeing more patients, more quickly. Unfortunately, 1/3 of the current Medicare budget is spent caring for those who have a chronic illness, during the last two years of their life. This is frequently very high-cost healthcare, resulting from crisis situations that often, could have been prevented. These patients frequently receive procedures, tests, and hospitalizations, which, when asked, the patient may not have wanted. The beauty of home-based care is that its goal is to engage those patients who are not connecting

to the healthcare community, helping them to identify goals for their care, and teaching them to appropriately utilize the services available in the community.

North Dakota's geography creates unique challenges in that approximately 50% of our population lives in rural areas, and 38 of 53 counties are frontier counties, with population densities of <7 people/sq. mile. Transportation, mobility issues and even feeling overwhelmed by the complexity of the healthcare system limit the ability and willingness to access primary care. Rural ND ranks near the bottom of the country in obtaining Annual Wellness Exams, often indicating inconsistent and inadequate preventative care and rural residents are significantly less likely to pursue any specialty care, compared to their counterparts in an urban area if it requires traveling over an hour from their home.

By bringing primary care into the patient's home, we have not only been able to forge strong physician-patient relationships and greater trust, but we often gain a unique perspective, not available in a typical clinic setting. Providers must often assume that their patients are taking the medications they've been prescribed and frequently have no reason to question a patient who reports doing "just fine" at home because they fear having to leave their home. As I've served patients in the home, I have found unopened boxes of medication stacked in the corner and

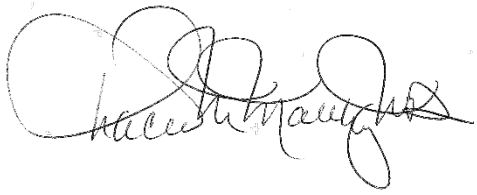
when I asked, I found that the patient did not know how to use the medication in the nebulizer they received, to manage his breathing. I found another patient had been sleeping on her couch for months because she could no longer manage the stairs to her bedroom. I am also given the opportunity to observe the interaction with their caregiver, who is all too often an elderly spouse and can identify ways to support them both.

Home-based primary care is not a replacement for healthcare currently provided in rural communities, but an opportunity to augment care for those at the highest risk. The days when rural healthcare survived on the back of one rural provider are gone. I'll admit that early in my training, I saw myself becoming that doctor, but years of practicing medicine in North Dakota have shown me that no one person, team, or healthcare group can take on a project of this size and importance alone. It will require an investment in a proven method of providing care, which is not only reproducible but self-sustaining. This is not a project to profit off the healthcare of North Dakota, but an investment in care for the people of our state.

In the words of our 26th president, "In any moment, the best thing you can do is the right thing. The worst thing you can do is nothing."

Thank you for the opportunity to testify in support of what will undoubtedly change healthcare in rural North Dakota. I am asking for your support in passing Senate Bill 2332.

Respectfully submitted,



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