2009 HOUSE HUMAN SERVICES

HB 1339

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **HB 1339**

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **January 19, 2009**

Recorder Job Number: 7197

Committee Clerk Signature Jane Prindle

Minutes:

Chairman Weisz opened the hearing of HB 1339.

Representative Lois Delmore, District 43, was not able to be present, but provided the Committee with written testimony. **(Attachment 1)**

Representative Todd Porter, District 34, introduced the bill. This bill relates back to trauma and where if you don't have a surgeon in the emergency room, the outcomes are less favorable for the patient. This bill relates to being able to transfer patients quickly to a primary stroke center. We basically are putting into Century Code the definition of what stroke centers are. We are utilizing the health department to create a task force to start looking at what we can do as a state to move forward with the care of patients having a stroke. There is a component about emergency medical services—the same thing we do with trauma patients. If you have a patient that you think is having a stroke, should you be transporting that patient to a facility that doesn't have a cat scanner? It is already proven that transferring patients to the proper facility saves lives.

Chairman Weisz: How will this affect the hospitals that aren't designated as stroke centers?

Representative Porter: It really wouldn't. It would be more focused on primary stroke centers, on transfer protocols, and how to handle and deal with patients having a stroke. On

page 2 it talks about the task force coming back with recommendations to establish the stroke system in the rural areas. To start with this would put in place the mechanism the State of ND and the Health Department would be looking at—a stroke system across ND. You would still have to come back and make the final recommendations to the 2011 Assembly.

Representative Holman: Is "stroke" a widely recognized medical term.

Representative Porter: Yes, it is.

Representative Uglem: How many of the smaller rural hospitals would have the scans necessary to identify what type of stroke it is?

Representative Porter: I don't have that information. You see a lot of MRIs and CAT scanners going down the road so just depending on the given day a facility could have one and the next day they don't.

June Herman, senior Director of Government Relations for the American Heart Association in ND, testified in favor of the bill: **(Attachment 2)**

Representative Holman: Who makes the transport decision?

Herman: We can develop triage procedures, work with directors for EMS services, and take a look at some training needs. Just as with trauma there are processes put in place but you still rely on the basic decision making out there in the field.

Representative Frantsvog: On page 2 of your testimony, it says only 6 hospitals have the potential 24/7. . . What are those 6 hospitals?

Herman: If you look at the map (attached to her testimony), it is the best indication. (Further discussion of locations and capacities of medical centers on map.)

Chairman Weisz: You indicated you are going to $1.4 million from CDC, yet the Department of Health needs $150,000 beyond that. What's that $1.4 million being used for now.

Herman: $150,000 per year will provide for a director and program. There is also stroke month education provided by the grant.

Representative Conrad: Would it be reasonable to say that the distance people are coming to get that service would affect the number of deaths.

Herman: It could be a matter of risk factors in the area. We cannot explain the higher stroke incidence in some of the areas. We are talking here of people that are in treatable stages of the stroke. Some people may present themselves and all you do is keep them at the hospital and address the post-event and rehabilitation.

Representative Hofstad: The bill directs the establishment of a task force. Is that task force made up primarily people from the health department or are there other stakeholders involved?

Herman: It is outlined in the bill—the parties we would want to have at the table, I don't think it's exclusive of others; we are not listed but plan to participate in the process. We certainly know we need the participation of rural EMS, rural hospitals, larger hospitals and the major EMS centers to be develop the system.

Representative Frantsvog: The proposed study on the first page of your testimony, you are talking about the ability of those who are transporting an individual having the capability a closer facility in lieu of another facility at a greater distance. Who makes that decision and how would you establish guidelines? If I'm driving the ambulance do I make that decision or is someone in a medical facility going to make that decision?

Herman: The stakeholders will work through that. I think you will see the work being done by the various quadrants of state looking at where EMS currently transfer patients and work through having the assessment tools to identify how the patient should be transported. There will be directives that will indicate basic directions. Those are all the pieces we still have to

work through. That's the purpose of every one coming to the table to work out how we put the system in place.

Representative Kathy Hawken, District 46, testified in favor of the bill. I think this is something that needs timely and good care. We can do some really positive things working in this direction. The bill does a number of things that makes care of a stroke patient quicker and better. I hope you will consider it positively.

Mona Thompson, representing the ND EMS Association, provided testimony on the bill. She had several concerns. **(Testimony 3)** She volunteered to work with the Committee to work out some amendments.

Chairman Weisz: Suppose you are near Jamestown and the decision was made to transport to Fargo. As far as Medicaid, you would have an issue of bypassing the Jamestown hospital.

Thompson: That's right.

Representative Holman: The assumption is that there will be four of these centers.

Thompson: There will be the assumption that there will be just four centers at this time and most likely that is because they are designated stroke centers. It is usually designated in larger cities.

Herman: They may go to a nearby hospital where they work out the protocol and then transfer to the hub hospital. It doesn't mean every stroke victim will go directly to the hub. You will have a system developed based on what are the skills and resources of all the hospitals within that region determining how to provide the best stroke care for that patient.

Representative Conrad: You referred to an amendment? Would that address the reimbursement issue?

Thompson: The ND EMS Association is looking to draft that amendment working with Representative Porter and the American Heart Association. What we would like is to stop at

smaller hospitals to stabilize the patient and taking an advanced life support ambulance to transport the patient to the centers. Yes, it would address the reimbursement issue.

Doctor Hyder, director of the Stroke Center at St. Alexius, testified in favor of the bill. Stroke is sad and tragic. It is the leading cause of disability in the USA. It's a very serious disease. Stroke affects one patient every 45 seconds in the USA. By the time this hearing is ended about 40 patients in the US will have suffered a stroke. Ten of them will end up in a nursing home and ten of them will have died. The financial impact of stroke is tremendous. The average cost in a nursing home for life time care in a nursing home costs about $150,000. That does not count the social burden on the family. It is now treatable and curable. You can reverse the affect of a stroke. You can remove the clot and the patient can walk out of the hospital. All it takes is a good EMS system, a trained EMS who can triage a patient, the small hospitals staying in contact with the main stroke centers to make a coordinated decision to determine which patients would get better care in the stroke center. We can make that decision over the phone in five minutes. We are talking about saving the life of a patient. North Dakotans are very stoic and do not come to the hospitals. We need education and public awareness and it needs to be repeated often.

Representative Potter: Would you go over the symptoms of stroke.

Hyder: Numbness or weakness on one side of the body, difficulty in speech, loss of vision, unsteadiness or dizziness, or unexplained headaches. It is not painful. We need to provide education and information on where to go for care. There is about a three hour window from when the symptoms start. The task force will come up for the criteria for best treatment.

Doctor Brent Herbel, St. Alexius Stroke Center: We have one of the best stroke centers in the nation. . . discussed a patient and effective treatment. . . By having this technology we are looking at a 6 – 8 hour window before the brain cells start to die.

Representative Uglem: Do you have an idea of the average time wasted would be if the patient went to the wrong hospital?

Herbel: It's not necessarily a time factor but more on the education of the hospital. The time to transfer could be very precious time.

Chairman Weisz: Once you get beyond that 6 to 8 hour window, are you able to do anything for that patient?

Herbel: It depends upon if they have a bleed in the brain. If there is a clot, we are looking at putting them on an intravenous blood thinner and just have to let the stroke take its course.

Arnold Thomas, president of the ND Healthcare Association, testified in favor of the bill. **(Attachment 4).**

There was no opposing testimony.

Chairman Weisz closed the hearing of HB 1339.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **HB 1339**

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **February 2, 2009**

Recorder Job Number: 8341

Committee Clerk Signature Jan Pruden

Minutes:

Chairman Weisz opened discussion of HB 1339. If you remember it has a fiscal of $143,300. We have requested a new fiscal note. I have been assured by the Department of Health that there will be $0 fiscal note on the bill. There really isn't anything for them to do as the players are doing all the work. We could take action on this.

Representative Porter: If you remember the EMS Association was talking about the verbiage on page 3, subsection 2. That needs to stay in there as it is. It tells the Department needs to work with the stroke task force and the EMS Association to develop protocols. If you take the language out, then EMS is basically out of the picture and the discussion. **I move a Do Pass.**

Representative Holman: Second.

Representative Pietsch: There was some concern also on Section 1.

Representative Porter: There is nothing on this bill that is mandatory except for a task force getting together and establishing future criteria that would have to come back either to the State Health Council or to the Legislature to work it out.

Representative Hofstad: I talked to Chip Thomas about the criteria set for these 6 hospitals. Is the bill specific in who sets the criteria or how it is set? He said that we could set the criteria or it could be set with the Association and that would clearly define the parameters from which

those hospitals were set. We wouldn't be faced with the possibility of are we going to have 6? 8? 10? Is the bill exclusive on which those 6 hospitals would be?

Representative Porter: The one thing that sets the number is that there is national accreditation that goes along with this. It is really limited as to who could be nationally accredited. The system will be set up similarly as the trauma system. We are not going to reinvent the wheel.

Representative Conrad: Line 2 says in the law the State will not be setting up the criteria.

Chairman Weisz: The main thing is not the setting up the centers themselves; it is the coordination of the other players. The key will be how the rural and not-so-rural hospitals and EMS work with those centers to have the highest level of care possible.

A roll call vote was taken: Yes: 12, No: 0 Absent: 1 (Damschen)

Representative Potter will carry the bill.

Later in the day, this bill was brought back for reconsideration.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1339

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 2, 2009

Recorder Job Number: 8405 1 min. 33 sec. & 8406 12 sec.

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: We kicked out 1339 this morning on stroke centers. I ask that we bring this back to committee. Health Department says that there will be an FTE needed.

Rep. Porter made motion to bring back to committee.

Rep. Kilichowski seconded.

Voice Vote: 13 yeas 0 nays 0 absent

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1339

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 16, 2009

Recorder Job Number: 9544

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's look at HB 1339. Stroke center bill. There is an updated fiscal note. Reason FN changed it from general fund to other funds, but it added almost $30,000 to it. Had a long conversation with the Health Dept. on this. The reason the fiscal note has changed there is a (inaudible) grant they can access. The still either have to contract his out (inaudible) FTE to write the rules the people are going to come up with.

Rep. Porter: I still question department with players all coming to the table and wanting to do this.

Chairman Weisz: Page 2 line 23 where it says the Dept. of Health shall adopt a nationally recognized standardized stroke-triage assessment tool. And they will have to post it to the website.

Rep. Conrad: If money gone from general fund and money coming from a grant, then the FTE is gone, right?

Chairman Weisz: Not necessarily. From the FN they can contract out for service. We did get rid of the general fund.

Rep. Porter: If we added a Section 2 to the bill that said something like, the department either shall or may contract with a third party to provide administrative duties using federal funds and

then go on to say that the department is not authorized any additional FTEs because of this act, then they have to do it from within, or it would make them contract it out.

Chairman Weisz: Rep. Porter, what additional oversight would be required by the Health Dept.

Rep. Porter: Not a thing, the way the bill is written, the only way you could do, that the hospital would have all the expenses of going to either the joint commissioner and accreditation meeting their requirements to be a designated stroke center or some other nationally recognized group that is designating stroke centers. As far as a hospital is concerned, they wouldn't do anything, because they have to go to the federal. It's in line with what the trauma system is. The Health Dept. has nothing to do with a level 2 trauma center, that's done by a national organization. All they do is rubber stamp it and say, you've met the requirements. In order to be a primary stroke center they must show they have met the requirements by joint commission by accreditation for health care organizations or a similar accrediting or certifying organization. The Health Dept. has nothing to do.

Chairman Weisz: If the Harvey hospital wants to be a stroke center, they have to go in there and basically say they are not a stroke center because you don't meet the standards.

Rep. Porter: I guess, I don't know if anybody would ever do that. You need to put together a taskforce so all the interested parties would need to sit down and set up, potentially there can only be 6 stroke centers across the state at this federal level. But, that doesn't mean that some other hospitals would be a stroke center level 3 where they have an arrangement with a neurologist at a facility with a stroke center that has telemedicine capabilities and transfer agreements. The groups get together and design the system and coming back to the next legislative assembly and going back to the health council and putting in administrative rules to

do it. I don't see where it would take $10,000 to have meetings, figure out how you're going to do it and come back and do it.

Rep. Conrad: There is no appropriation in here, in this bill. If there is no appropriation in the department's budget. So, I don't know why we even have to consider it (inaudible). This is just to set up the cost (inaudible).

Chairman Weisz: It's not in the department's budget, I never did get an answer from them, what they were spending the $180,000 on.

Rep. Porter: Motion a DO PASS

Rep. Conklin: Second.

Rep. Frantsvog: I'm still trying to understand what we are doing. That if there is no appropriation, what are we changing? We aren't changing anything?

Chairman Weisz: On the issue of appropriations, are they going to want to look at it separately on that grant money or are they going to let the Health Dept. figure out what they are going to do with it. Even if we pass it as is, nothing prohibits the Health Dept. to go into appropriations and ask them for an FTE to help them.

Rep. Porter: From the time we had the hearing and we passed it out, the Health Dept. changed the corporation on the first FN from general funds to the (inaudible) funds.

Roll Call Vote for a DO PASS: 13 yes, 0 no, 0 absent.

MOTION CARRIED DO PASS.

BILL CARRIER: Rep. Potter Chairman Weisz:

FISCAL NOTE

Requested by Legislative Council
02/05/2009

REVISION

Bill/Resolution No.: HB 1339

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures				$180,000		$180,000
Appropriations				$180,000		$180,000

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill relates to hospital designation as a primary stroke center. It would create a complex program requiring expertise in stroke care. It would also require time to organize the various groups identified in the bill and provide regulatory oversight of the designated stroke center hospitals.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The program would require substantial time to organize the various groups identified in the bill and provide regulatory oversight of the designated stroke center hospitals. If this project is completed by an FTE of the Health Department the total cost of the project would be $132,000. If the project is contracted out to another entity the estimated cost of the project would be $180,000.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

During the 2009-11 biennium it is estimated that it will take 1.0 FTE ($107,000) of staff time and associated operating costs of $25,000 to organize the various groups identified in the bill and provide regulatory oversight of the designated stroke center hospitals. If this project is contracted out rather than an FTE the cost of a contractor would be approximately $180,000.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The appropriation for this project is included in the operating line item as a contractual expense in the department's

appropriation bill (SB 2004). If an FTE is the preferred method of delivery, an FTE will need to be appropriated and a transfer of $107,000 from the operating line item to the salaries and wages line item will be needed.

Name:	Kathy J. Albin	**Agency:**	Health Dept.
Phone Number:	328.4542	**Date Prepared:**	02/09/2009

FISCAL NOTE

Requested by Legislative Council
01/13/2009

Bill/Resolution No.: HB 1339

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$143,300		$154,000	
Appropriations			$143,300		$154,000	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill relates to hospital designation as a primary stroke center. It would create a complex program requiring expertise in stroke care. It would also require time to organize the various groups identified in the bill and provide regulatory oversight of the designated stroke center hospitals.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The program would require substantial time to organize the various groups identified in the bill and provide regulatory oversight of the designated stroke center hospitals. We estimate a requirement of 1.0 FTE to complete the work. The Health Department would require $143,300 from the general fund to fund 1.0 FTE and associated operating costs to accomplish the requirements outlined in the bill.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

During the 2009-11 biennium it is estimated that it will take 1.0 FTE ($107,000) of staff time and associated operating costs of $34,300 to organize the various groups identified in the bill and provide regulatory oversight of the designated stroke center hospitals. The only increase in costs for the 2011-13 biennium is for salary costs.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Funds for this project are not included in the Department's appropriation bill (SB 2004). The Department will need these funds appropriated to carry out this project.

Name:	Kathy J. Albin	**Agency:**	Health Dept.
Phone Number:	328.4542	**Date Prepared:**	01/16/2008

Date: 2-2-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1339

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Porter Seconded By Rep. Kilichowski

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) 13 No 0

Absent 0

Bill Carrier _____

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

motion to have HB1339 go back to Committee

Date: 2-2-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1339

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Porter Seconded By Rep. Holman

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	√		REP. TOM CONKLIN	√	
VICE-CHAIR VONNIE PIETSCH	√		REP. KARI L CONRAD	√	
REP. CHUCK DAMSCHEN	A		REP. RICHARD HOLMAN	√	
REP. ROBERT FRANTSVOG	√		REP. ROBERT KILICHOWSKI	√	
REP. CURT HOFSTAD	√		REP. LOUISE POTTER	√	
REP. MICHAEL R. NATHE	√				
REP. TODD PORTER	√				
REP. GERRY UGLEM	√				

Total (Yes) 12 No 0

Absent 1 Rep Damschen

Bill Carrier Rep. Potter

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

Committee Work Session Afternoon

REPORT OF STANDING COMMITTEE

HB 1339: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (12 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1339 was placed on the Eleventh order on the calendar.

Date: 2/16-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1339

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Porter Seconded By Rep. Conklin

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	✓		REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	✓	
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN	✓	
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI	✓	
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	✓				
REP. GERRY UGLEM	✓				

Total (Yes) 13 No 0

Absent 0

Bill Carrier Rep Potter

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

REPORT OF STANDING COMMITTEE

HB 1339: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1339 was placed on the Eleventh order on the calendar.

2009 SENATE HUMAN SERVICES

HB 1339

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1339

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 03/04/2009

Recorder Job Number: 10146

Committee Clerk Signature Mary K Morson

Minutes:

Chairman J. Lee Opened the hearing on HB 1339.

Representative Todd Porter District #34. Introduced HB 1339. He has been working with hospitals to develop protocol for stroke centers. There is definite advantage to having a system in place particularly when dealing with strokes caused by blood clots. He is highlighting them because they are a smaller percentage of strokes that take place but they are also the ones where the new technology can reverse the symptoms and help the patient. Patients who have been treated in this manner can be sent home and not to a long term facility. Spoke about the technologies and medicines used in the treatment of these strokes. Everything is dependent on timing as blood clot strokes are time sensitive and usually allow an 8 hour window to access treatment. This is a similar case to heart attack patient protocol. This bill is creating a trauma system for strokes. There are only going to be 6 trauma certified centers in ND due to the level of technology and resources needed; the same holds true for stroke centers. Smaller towns do have cat scanners and MRIs as well as transfer protocols—spoke about the process of transfer and communication. Nothing on this bill would go into effect until 1/1/2010. The committee will approach this much as they did when they certified trauma centers in 1990. Spoke about the process of implementing the bill. The appropriation originally started out

coming from general funds but was then switched to the CDC budget as there is grant money available.

Senator Dever Would those 6 level 2 trauma centers qualify with what you expect to come out of this or would this raise the standards?

Porter There would definitely have to be some adjustments made. Spoke about those adjustments.

Senator Heckaman Are EMS already trained in this area or will there need to be additional training for our rural emergency services?

Porter They are already trained. Spoke about the protocol for stroke victims.

Senator Heckaman The reason I was asking that is because the bill says that they do not have to comply until 2012 and I thought that was because they needed more training.

Porter The 2012 date is to get communication and regional transport up to speed.

Senator Dever Are there other hospitals than those 6 trauma centers that could qualify?

Porter There is nothing that says they cannot but the likelihood of those hospitals having the right specialists is slim.

Senator Dever Provided a personal comment about his brother's stroke story.

June Herman Senior Director of Government Relations for the American Heart Association. Spoke in support of 1339. See attachment #1.

Dr. Hyder Spoke in support of 1339. See attachment #2. Provided some statistics about strokes, they are common. Also described warning signs of strokes. Described the need for a stroke system similar to the trauma system and the process of treating stroke patients

Senator Erbele Can you clarify how the EMS portion will work? Diagnosing and transport, etc...

Hyder The task force will be looking at which hospitals are equipped and mapping out routes for the EMS which will help them decide where to take the patient based on the expertise of the physicians at the hospitals.

Senator Dever In the process of certifying stroke centers, smaller rural hospitals will raise their level of expertise as well?

Hyder That is correct. I also see them coming to the level of stroke center as well. The can treat the patient well before moving them to a specialist in case of complications.

Senator Dever So they may not need to immediately ship the patient but they may be in a position to do provide preliminary care.

Hyder Yes.

Chairman J. Lee It seems that part of the public education may be to convince these smaller facilities that they are partners in this and are not threatened by being bypassed to go to another facility. Sometimes the hardest sell is to the professionals.

Hyder You are correct, and we will be working with all of the hospitals. Spoke about the purpose of the program—not related to bed numbers or money for hospitals.

Tom Kloster Stroke victim. Spoke in support of 1339. See attachment number #3.

Robert Beattie Chair of Community and Family Medicine at UND. Spoke in support of 1339. Gave his personal history of practicing medicine in rural areas. Having a stroke center to call is extremely helpful and reassuring to those that provide stroke care.

Chairman J. Lee Do you think that having these types of connections would be helpful for physicians making decisions on where to treat?

Beattie Yes

There was no opposition testimony submitted.

Senator Dever Is Dr. Herbal available to both hospitals?

Hyder He is available to both.

Tim Meyer State Director of EMS/Trauma NDDOH. Neutral. Supportive of making inroads into stroke care.

Senator Dever I see in the fiscal note there is an appropriation for the health department to hire an FTE to do this or contract it out, is that covered in this bill or do we need to address it?

Meyer I think Representative Porter discussed that it would come from a CDC grant. If it were not covered we would have to hire out.

Discussion about the fiscal note

Chairman J. Lee Closed the hearing on HB 1339.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1339

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 03/09/2009

Recorder Job Number: 10521

Committee Clerk Signature Mary K Monson

Minutes:

Chairman J. Lee Opened the discussion on HB 1339

Senator Heckaman I move **Do Pass and Rerefer to Appropriations**

Senator Pomeroy Second

The Clerk called the role on the motion to **Do Pass and Rerefer to Appropriations.**

Yes: 5, No: 0, Absent: 1 (Senator Marcellais).

Senator Heckaman will carry the bill.

Date: 3/9/09

Roll Call Vote #: _____

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1339

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Pomeroy

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment Senator Heckaman

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

REPORT OF STANDING COMMITTEE

HB 1339: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1339 was rereferred to the **Appropriations Committee.**

2009 SENATE APPROPRIATIONS

HB 1339

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1339

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-16-09

Recorder Job Number: 11028

Committee Clerk Signature Alice Delzer

Minutes:

V. Chair Grindberg: Called the committee hearing to order at 2:30 pm in reference to HB 1339 in regards to Relating to hospital designation as a primary stroke center and related services offered by emergency medical services operations.

Representative Todd Porter: District 34, Mandan, introduced and testified in support of HB 1339. The end result of a stroke usually isn't death but requires long term care in a facility. What this bill would do would to start a primary stroke center. (02.37) You can dissolve that clot and patients can sometimes? Those types of facilities will only be very similar how we started the trauma care center. They are taken to a place that has a cat scanning machine. The window of opportunity to remove the clot is somewhere around 6-8 hours; in order for this system to work you have to be sure the patient is transported to the right level of care.

V. Chair Grindberg: is more intended for rural based.

Representative Todd Porter: It is both. The two facilities in Bismarck if one wants to have 24/7 coverage, all the things if they want to do that they would have to go through the certification.

V. Chair Grindberg: this bill they already do anyway. Only 1 of the two hospitals can do the corkscrew procedure. The only other one is in Fargo.

V. Chair Grindberg: you have a stroke in southwest ND; EMS community would know who has the expertise.

Representative Todd Porter:, you could end up at Elgin, Bowman, there are more than the bigger ones you mentioned. You could end up in Elgin, the cat scan is not there everyday, the ambulance would pick you up, their decision might be not to stop at Elgin, and go directly to the bigger facility that could help the patient . the patient having stoke systems. The new component would be a little bit of training.

V. Chair Bowman: In Bowman we bought a cat scan we are hooked up with Med Center One, it takes 23 seconds. Is that something they would use for strokes?

Representative Todd Porter: yes. And through that agreement they can read the results back in Bismarck get back with the diagnosis and make arrangements to get the patient into the proper place to get rid of that clot.

Senator Krauter: What role is the Department of Health doing here?

Representative Todd Porter: Their role, they are responsible for the organization and putting together the stroke task force. The other is to start the data base and the statistical analysis, just like we did with trauma. The other role is that through the task force, in order for some place to be a designated stroke center.

Senator Krauter: If the dept does it is one price. If we contract it out it's different.

Representative Todd Porter: no idea. Apparently if you do it through a private contract, it will be more money.

Senator Kilzer: does this bill is their model legislation some place, I don't' think the primary concern, the primary concern should be with the people who pick up the patient and the emergency doctors, they can make the diag. 90% of these are thrombosis, take appropriate

history, and proceed with the TPA or whatever they use. Very few of these come to surgery. The morality is too high. Is this model legislation from someplace?

Representative Todd Porter: It is a collage of model legislation. There were 3 or 4 different states. Going all the way from spelling it completely out to this kind of model where it enacts the stroke and turns it back to health care. While there were different states out there that had the complete law, we felt that in order to work for both the rural and urban settings

Senator Wardner: on the task force.

Representative Todd Porter: the task force on page 2 line 5 talks about who the members would be. That task force deals with the ? transfers of prodicals to move that patient.

Senator Wardner: there could be a couple of them representing rural officers, whatever the health dept deems as nec.

Yes.

Senator Krebsbach: trying to meld what the dept of health and jacco they are the standard they go by, yet the dept may suspend who is the lead agency in this fase.

Representative Todd Porter: the state dept of health. Jacco has the criteria and all set up for Stroke center system. The health dept listen totape. Here.

Senator Wardner: on page 2 line 14 are we looking at making a distinction between em room phy and the ambulance people. In other words asking the amb people what the decision should be.

Representative Todd Porter: no we wouldn't be. Part of the process in training would allow them to, using the triage from the heart association, inside of that, EMS service all have medical director, you should be transferring this patient, it would be the proper redirection of patients based on the assessment of EMS individuals. It is what goes on today with trauma. In the current law the ambulance cannot transport that patient.

Senator Krebsbach: my idea for ambulance service to get them to the nearest hospital for stabilization. When you look at metro areas, this theory may work, but in rural ND is it the best?

Representative Todd Porter: Statistically it is the best. The protocol right now is to transport to the best facility that can handle the patient? You stop at a facility with a patient who is bleeding internally and the facility doesn't have a surgeon, what care is the patient actually going to get?

June Herman: Senior Director Heart Association testified in favor of HB 1339 and provided written testimony # 1. What makes sense in the different sections of the state? What is the best interest for the stroke patient? We did feel it was important in the rural state of ND, to look at the triage tool. And then to look at capabilities of hospitals, what are the barriers, so if there are some? It is just the starting point; we are using the certification process. It protects the hospital. When you look at the geographical challenges we have in the state.

V. Chair Grindberg: It is needed to access the fed funds do you envision when this grant runs out the request will be made for the state to fund this ongoing.

June Herman: the funds are avail. Take a look at stroke being the catastrophic. If there are barriers out there, health tech, trying to take a look at how can we better set up? But the only time we have to convene a work study is the next 2 years because of the federal funding.

Chair Grindberg: How many strokes in ND on annual basis.

June Herman: Get that to you.

V. Chair Grindberg: I would presume the bill would if it passes, it would create an environment in the larger communities that no hospital that would not want to designated a stroke center because of the competitive nature.

June Herman: I am pleased to say by the virtue of sitting down with those large facilities and also the rural hospitals, there is a high interest in developing and building this. There are teams. We have been doing a lot of work, there certainly some work there it is an opportunity to sit down and develop the system further.

Senator Wardner: Other than the FTE would you be able to work in partnership with the health dept.

June Herman: When we entered this whole process the vision was that would be through the CDC funds. I don't have a physician.

Senator Krauter: I relate this to Dementias, Alzheimer's units. You start talking strokes; there are many different types of strokes and to diagnose a stroke; it's a lot.

June Herman: I wish we had our neurologist who has been involved in this bill? It is a small percentage that needs to be transported to another hospital. That is occurring some today. There are some patients that won't do any good for because of the severity of the stroke.

Senator Kilzer: Actually strokes are pretty common, cancer, heart disease and stroke. Senator Krauter is right about many different types of strokes. Why are you focusing on early treatment and transfer? Why not focus on prevention and give attention to more people at risk. People have a lot of TIA's. If you focus on treating those, and blood pressure, you would take care of over half the mortality. I don't understand the focus not being on education and prevention rather than early treatment. The early treatment is pretty well established. A good ER doctor or cardiologist intern can do as well as a highly specialized hospital that may or may not be certified. I think the focus is misdirected.

June Herman: We have a lot of info we are looking at all aspects this is just one particular piece of it. We are trying to take a shot here and set up a system of care aimed towards our aging population, this is not the only way we are trying to address stroke in the state.

Senator Krauter: Have health dept explain fiscal note. If contracted out potentially less.

V. Chair Grindberg: someone from health dept comment on that.

Susan Morman: Director of heart and stroke disease for dept of health, at the time it was written I was on medical leave, the as a contract. There was some discussion; it is my understanding why it was done in that matter. Currently it is in the contract line.

Senator Wardner: why the difference in the amount. (36.)

Susan Morman: get that info and get it to the committee. Yes.

Senator Christmann: I am wondering is this something the hospitals are all in favor of, or some against and some for.

Arnold Thomas: Pres ND Health care assoc. the vision is a clear vision. In this case it's stroke. We also know time is very important for diagnosis and appropriate care and that's the clear mission. There are issues here that are broader than just the stroke. My understanding with both and large and small moved to the most appropriate level of care and medically there is no opposition from the hospitals.

Senator Krebsbach: I notice on page 3, there is a semiannual report required by the hospital. Is it necessary?

Arnold Thomas: the whole reporting within the emergency system, this particular aspect is not as strong as what it needs to be. Are we doing the best we can do? It is highly suspect of this whole area of? When I think when the volume of stroke is reported to you, the reporting would be based on what kind of volume you would have. In order to make the vision work you have to know what is going on in the network. Stroke is a broad category and so if you are talking about getting an individual to a facility.

V. Chair Grindberg: Does the Dept of health role seems to me strokes have been around a long time?

Arnold Thomas: They need to be part partial of the discussion. The primary came from the American Heart Association. There is not a neutrality urban issues are urban, rural are rural. This measure before you will allow.

V. Chair Grindberg: If this measure fails, it could still happen.

Arnold Thomas: It will continue and drive them as well.

Closed the hearing

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1339

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 2, 2009

Recorder Job Number: 11695

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg opened discussion on HB 1339.

Senator Fischer moved Do Pass.

Senator Wardner seconded.

A Roll Call vote was taken. Yea: 14 Nay: 0 Absent: 0

The bill goes back to Human Services and Senator Heckaman will carry the bill.

Chairman Holmberg closed the hearing on HB 1339.

Date: 4-2-09
Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1339

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Fischer Seconded By Wardner

Representatives	Yes	No	Representatives	Yes	No
Senator Fischer	✓		Senator Warner	✓	
Senator Christmann	✓		Senator Robinson	✓	
Senator Krebsbach	✓		Senator Krauter	✓	
Senator Bowman	✓		Senator Lindaas	✓	
Senator Kilzer	✓		Senator Mathern	✓	
Senator Grindberg	✓		Senator Seymour	✓	
Senator Wardner	✓				
Chairman Holmberg	✓				

Total Yes 14 No 0

Absent 0

Floor Assignment Human Services Heckaman

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

REPORT OF STANDING COMMITTEE

HB 1339: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1339 was placed on the Fourteenth order on the calendar.

2009 TESTIMONY

HB 1339

#1

Testimony
House Bill 1339

House Human Services Committee
Monday, January 19, 2009

Chairman Weisz and members of the House Human Services Committee. I am Representative Lois Delmore, District 43, which serves the Grand Forks Community. I am here today to testify in support of House Bill 1339, and ask for a "do pass" recommendation from this committee.

My district is fortunate to have a large hospital facility within its community with the capacity to address acute stroke events. Time to treatment is a critical aspect as to potential outcome for a stroke victim. While outcomes can't be guaranteed, chances can be improved through timely care to help keep productive members of my community and yours.

Good stroke care in my home community is important. It is also important to know that as we travel through other areas of the state for business, family gatherings or enjoying North Dakotas rural areas, we have provided for the best possible system of response to a stroke emergency in any area of the state.

HB 1339 provides the starting point for hospitals and EMS stakeholders to look to the geographic challenges and needs in each of the quadrants of patient services in our state. Thank you for the opportunity to address your committee today. As I have other bills up today, I will excuse myself, as I know others here can respond to specifics of HB 1339.

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House Bill 1339

American Heart Association Testimony

House Human Services Committee
Monday, January 19, 2009

Chairman Weisz and members of the House Human Services Committee. I am June Herman, Senior Director of Government Relations for the American Heart Association in North Dakota. I am here today to testify in support of House Bill 1339, and ask for a "do pass" recommendation from this committee.

In 2007, this committee recommended a study of the North Dakota trauma system, with the inclusion of the American Heart Association at the table, given that stroke response issues are also time dependent and had potential to improve as EMS trauma system recommendations moved forward. We appreciate this committee's support in that regard.

In addition to participating in overviews to learn more about the challenges faced by the ND trauma system, AHA was also engaged in working through the administrative rules process that resulted in consensus rule language enacted in 2008. Those rules outlined the following:

> 2. In the following specific instances transport must be made to a licensed health care facility with specific capabilities or designations. This may result in bypassing a closer licensed health care facility for another located farther away. An ambulance service may deviate from these rules contained in this section on a case-by-case basis if online medical control is consulted and concurs.
>
> a. Major trauma patients must be transported to a designated trauma center as per article 33-38.
>
> b. A patient suffering acute chest pain that is believed to be cardiac in nature or an acute myocardial infarction determined by a twelve-lead electrocardiograph must be transported to a licensed health care facility capable of performing percutaneous catheter insertion or thrombolytic therapy.
>
> c. In cities with multiple hospitals an ambulance service may bypass one hospital to go to another hospital with equal or greater services if the additional transport time does not exceed ten minutes.

Such language recognizes that hospital by-pass for acute event interventions can benefit the patient if hospital by-pass occurs. Section c of the language reflected the situation of transport for acute stroke victims and was as far as we could proceed until further stakeholder engagement could occur regarding stroke systems of care.

Also since last session, the North Dakota Healthcare Association assisted us greatly in obtaining participation of all 45 hospitals that would serve an acute stroke victim. The data showed a patient referral pattern of acute stroke patient transfer to facilities that could provide intervention. This data was invaluable for us as we look at the next stage of addressing acute stroke events in North Dakota.

In spring of 2008, I invited various stakeholders to work with us on AHA model legislation addressing stroke response. The model legislation was based on a national AHA medical science document titled "Implementation Strategies for Emergency Medical Services within Stroke Systems of Care". As with any model legislation, it needed input and dialogue to fit the needs of the state. Department of Health, Division of EMS, ND EMS Association, ND Medical Association, ND Healthcare Association and several others were able to provide initial response and receive follow-up from me as we worked through this bill. In addition, ND Rural Health Association, stroke system leaders of the large hospitals, also had opportunities to discuss and view the model language.

With input, we adapted the model language for how the state could accomplish the Primary Stroke Center certification task, through agreement that the Joint Commission certification process and expertise could be utilized. As only six hospitals have the potential for 24 – 7 neurology consult, the scope of certification was narrow to begin with for North Dakota.

In addition, North Dakota has received a four year, $350,000 per year Heart Disease and Stroke capacity building grant from Centers of Disease Control and Prevention (CDC). Through use of the funds, the Heart Disease and Stroke Prevention Program is directed to improve acute stroke care through the establishment of primary stroke centers, planning groups to develop recommendations to establish statewide systems of care and a standardized stroke-triage assessment tool.

These strategies are key to improving stroke outcomes and are strongly encouraged by CDC Heart Disease & Stroke Prevention grantors. These strategies are also included in North Dakota's state plan, so it could make sense that the Department's Heart and Stroke program oversees HB1339 staffing directives.

Attached to my testimony is a map of North Dakota reflecting the impact of stroke on each of our counties. The large red dots reflect the location of the hospitals that serve as hubs for acute stroke response. Each quadrant reflects unique challenges and work towards establishing the best possible outcomes we can for acute stroke victims. I've heard from individuals in some of the counties with the greatest toll (darker purple areas), who see this bill as an important start in the process towards building that system.

At this time, I would be happy to respond to any questions you may have on the bill, the process to get here today. Thank you.

State Stroke Systems Hospital Mapping Initiative

North Dakota: Age 35+ Stroke Death Rate per 100,000 by County

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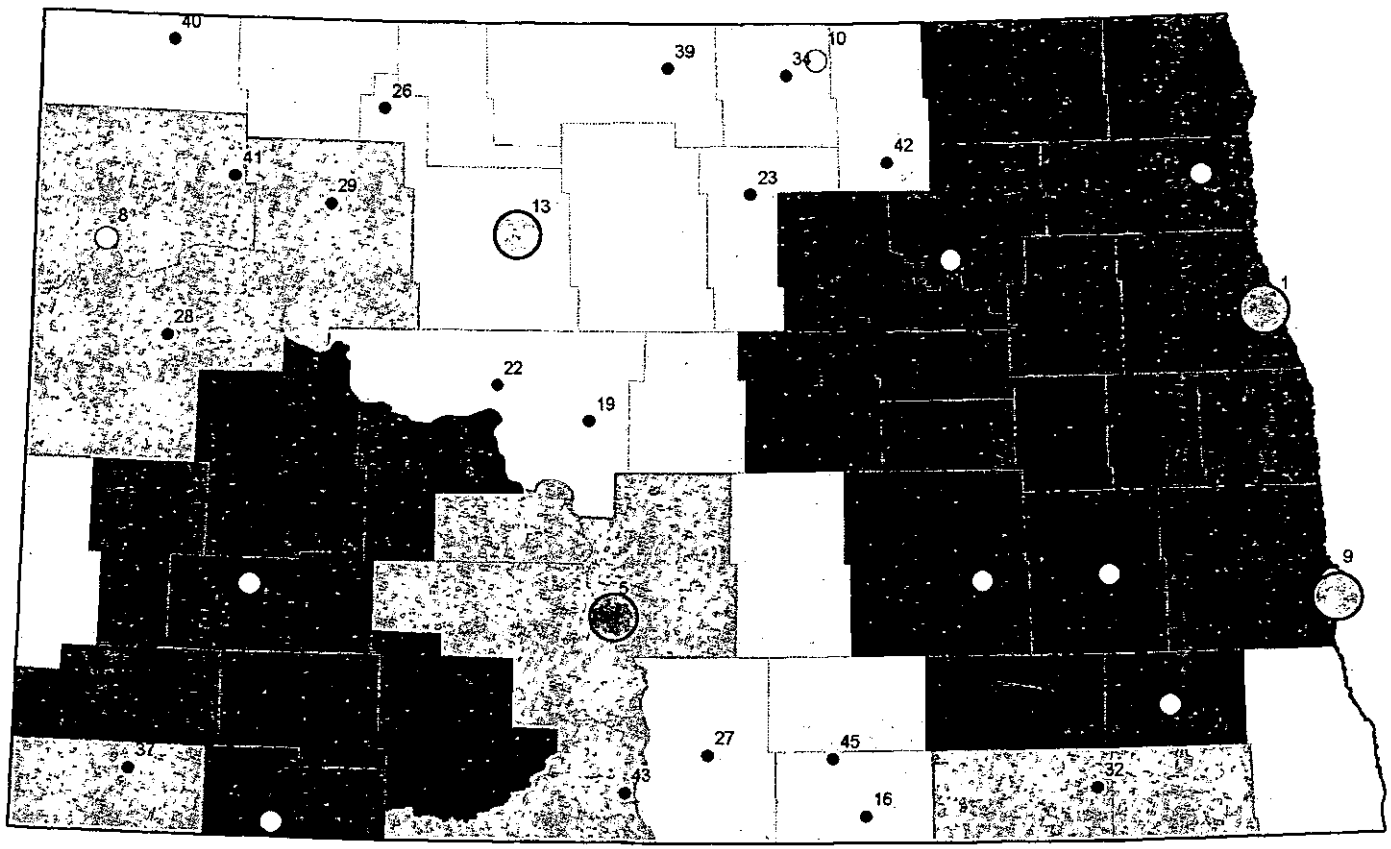

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HB 1339 January 19, 2009

Testimony – Human Services Committee
North Dakota EMS Association
Mona Thompson, NDEMSA Representative

Good Morning Chairman Weisz and members of the committee. My name is Mona Thompson, I am representing the North Dakota Emergency Medical Services (EMS) Association. I thank you for the opportunity to testify in support of HB 1339.

The NDEMSA has two primary concerns with the language and intent of this bill. The first is, if this bill is adopted in its current form, it will over extend the ability of rural ambulance services to perform long-distance transports of suspected stroke patients. The second is there is no provision under current Medicare and Medicaid reimbursement guidelines for payment when an ambulance service would bypass a licensed hospital to transport to another hospital which is a further distance from the closest licensed hospital.

Regarding our first concern regarding the transport distances, Primary Stroke Centers would essentially be the 6 hospitals in Bismarck, Fargo, Minot, and Grand Forks. This would mean that all patients which meet stroke triage criteria, must be transported to the closest of the Primary Stroke Center hospitals in the 4 major population cities in the state; bypassing all other licensed hospitals. This would mean total "run" times of up to, and sometimes exceeding, 8 hours for our volunteer EMTs. Most of these volunteer EMTs would have to leave their regular jobs to do so. This one factor may "break" the fragile fabric that is holding a majority of our volunteer ambulance services together today.

The second factor which concerns the NDEMSA is there is no provision in current CMS guidelines for an ambulance service to bypass a licensed hospital and then transport to a hospital in Fargo, Bismarck, Minot, or Grand Forks. This means the additional mileage resulting from the longer transport would go unreimbursed. In addition, in the majority of stroke cases, the BLS ambulance service would request an intercept from an ALS ambulance service. So then, 2 ambulance services would be expected to somehow divide the Medicare or Medicaid reimbursement for one base rate and what could be a substantial amount of unreimbursed, additional mileage.

When the cumulative impact of both factors is considered, this bill, while it has possibly very positive prospects for more positive patient outcomes, may very well be something that is beyond the ability of our state's EMS agencies to do.

We would like to suggest an amendment to this bill. We have discussed this with the AHA representative and would be happy to meet with Representative Porter (primary sponsor) and the AHA to work out the details of an amendment.

Chairman Weisz, thank you for this opportunity to testify and I would be happy to answer questions the committee may have.

NDHA
North Dakota Healthcare Association

4

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

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

Testimony in Support of HB 1339
January 19, 2009

Chairman Weisz, members of the House Human Services Committee. I am Arnold Thomas, President of the North Dakota Healthcare Association, here in support of HB 1339.

HB 1339 sets out a workable organizational structure, process and measurable goals for strengthening emergency response to stroke events on a regional and state wide basis. Among its provisions, the bill provides criteria for hospitals seeking to self designate as stroke centers. It provides direction for onsite assess stroke assessments, address, and stoke patient transport. HB 1339 creates an expert task force to work with the Department of Health in fulfilling the goal of an effective and efficient state wide response action plan for stroke events.

Perhaps most importantly, HB 1339 commits to use of evidence based protocols and standards while respecting the diversity within the emergency service provider community.

We think this proposal will enhance provider response to this particular emergency event on a local, regional and statewide basis and is compatible with ongoing local, regional and state wide all--hazard planning efforts.

HB 1339 has a fiscal note. If the fiscal note is due to the Department of Health notification and publication responsibilities in this bill, North Dakota Healthcare Association volunteers to work with the bill sponsors in identifying notification alternatives to those contained in HB 1339.

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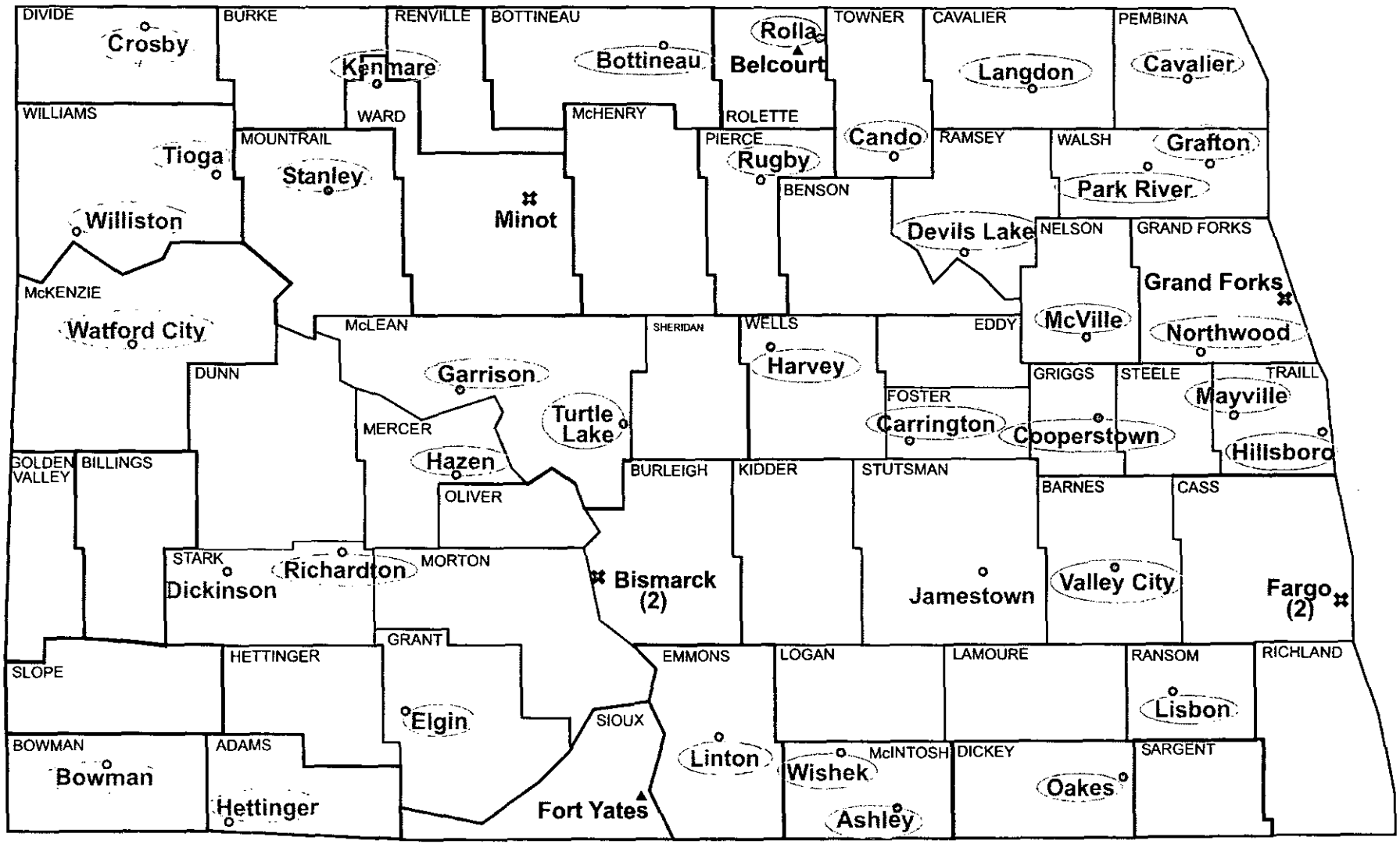
North Dakota Hospitals & Critical Access Hospitals



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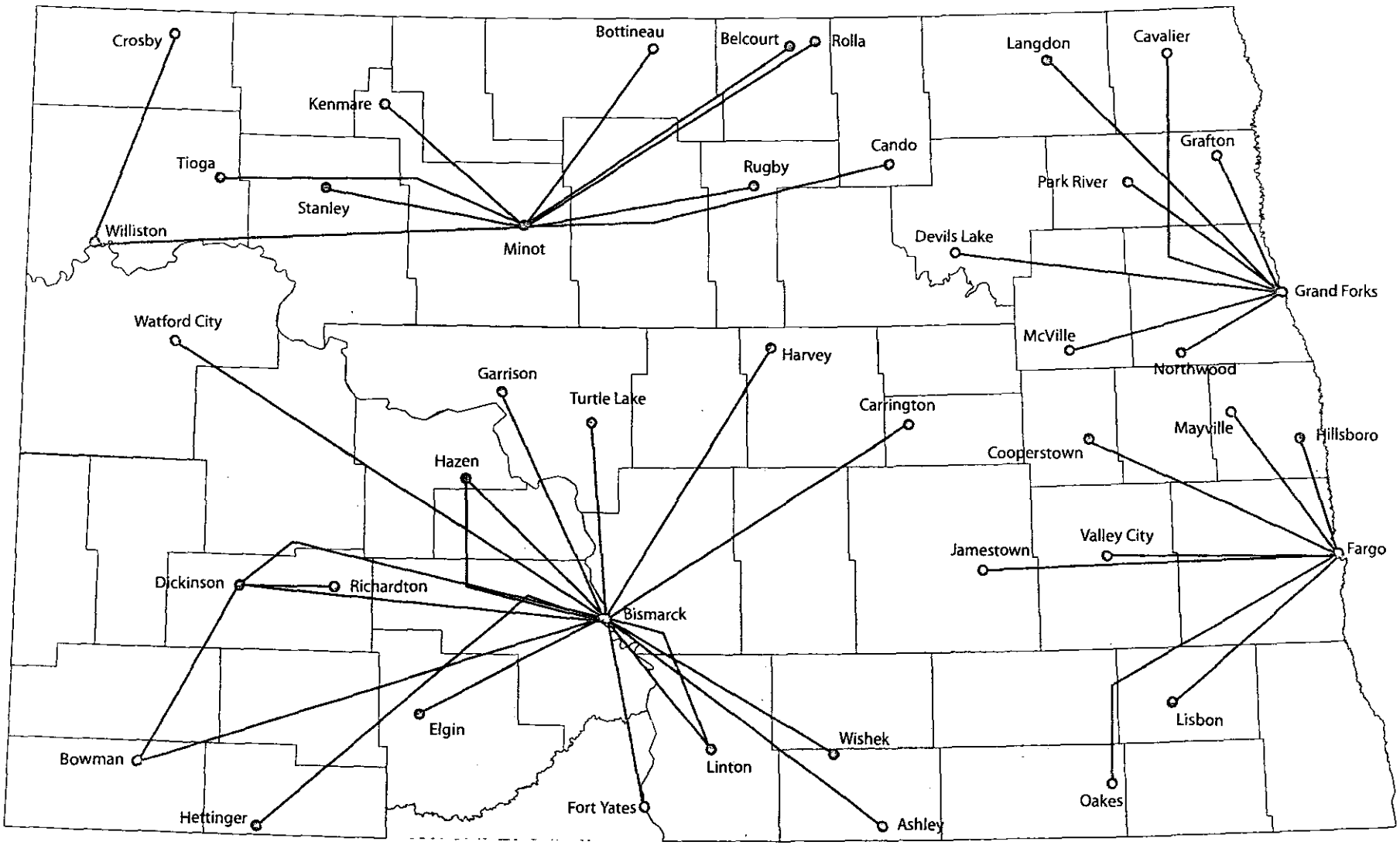
- Tertiary Hospital - CAH Network
- Indian Health Service Hospital
- Critical Access Hospital

10/08

NDHA
North Dakota Healthcare Association

Trauma Regions and Referral Patterns

Source: NDHA



#1

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House Bill 1339

House Human Services Committee
Monday, January 19, 2009

AHA Testimony

Chairman Judy Lee and members of the Senate Human Services Committee. I am June Herman, Senior Director of Government Relations for the American Heart Association in North Dakota. I am here today to testify in support of House Bill 1339, and ask for a "do pass" recommendation from this committee.

House Bill 1339 provides for two distinct actions:

1. Establishes criteria for Primary Stroke Center designation in the state, towards which hospitals can voluntarily seek certification
2. Provides for a Stroke System of Care Task Force, which is tasked with making recommendations for stroke triage and transport.

Primary Stroke Center Designation

Only the 6 largest North Dakota hospitals with 24/7 neurology back-up would qualify to seek PSC designation at this time. Although once the state moves forward with tele-stroke capabilities, other hospitals could qualify due to access to the neurology back-up. Certification is not a bill requirement of the 6 hospitals. HB 1339 defines Primary Stroke Center designation to recognize the investment of those hospitals who do seek to go through the extensive self-evaluation and quality improvement process required of The Joint Commission.

Given our state's geography and patient referral pattern, a large hospital may continue to serve as a hub of acute stroke services to the area of the state they serve without PSC certification. North Dakota has well-established patient referral patterns, and EMS services are collaborative partners with all area hospitals. Rural hospitals will continue to play a critical role in stroke treatment. Many currently assess and refer patients on to hub hospitals for advanced acute stroke interventions, if such interventions are still possible. Some hospitals "drip and ship" – provide tPA and send the patient to the hub hospital in their region. (State investment in tele-stroke capabilities would extend neurology consults to the smaller hospitals.)

As Primary Stroke Center certification is defined in HB 1339 as meeting The Joint Commission criteria, a state level certification and review committee, is not needed. Hospitals provide proof of certification to the Department of Health.

Stroke System of Care Task Force and Responsibilities

HB 1339 instructs the Department of Health to establish a task force. Membership is rural and metro, hospital and EMS, physicians and other representative deemed key to the stroke work. The bill establishes a timetable for providing initial recommendation by April 2010. Recommendations would address triage and a plan for coordination and communications. From the recommendations, rule may be considered through the normal administrative rules making process. The process allows for all ND stakeholders to determine what works best for our state, and to consider the challenges and resources in various areas of our state while seeking to provide optimum care for the stroke victim.

Other Considerations

The Stroke Task Force would be able to consider that the state has already placed into administrative rules some provisions for hospital by-pass when in the best interest of patient care. Deviation from those rules is possible on a case-by-case basis. In addition, Medicare EMS transport reimbursement language indicates that our state carrier could consider reimbursement if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. These are two important factors for the task force to consider, as is EMS capacity to respond, triage and transport. Foremost again is optimum care for the stroke victim.

In addition, North Dakota has received a four year, $350,000 per year Heart Disease and Stroke capacity building grant from Centers of Disease Control and Prevention (CDC). Through use of these federal funds, the Heart Disease and Stroke Prevention Program is directed to improve acute stroke care through the establishment of primary stroke centers, planning groups to develop recommendations to establish statewide systems of care and a standardized stroke-triage assessment tool. It will be the federal funds granted to the Department's Heart and Stroke program that will provide the ability to fulfill HB1339 staffing directives.

Due to those federal funds, we have a limited window of opportunity to advance acute stroke care in North Dakota in the next two years. Without federal funding, the state is without a statewide Heart Disease and Stroke program, even though it addresses the number 1 and 3 chronic disease in North Dakota. To provide you with perspective – in the first 5 year federal grant cycle, ND was approved, but unfunded. After the first year, federal funds were available to start a state program, leaving year 2 for start-up efforts, years 3 and 4 for data gathering and convening of stateholders to draft a state plan, and then the 5th year to prepare for another 5 year grant.

Unfortunately North Dakota was again approved, but unfunded, and North Dakota was again left without a state program and staffing to provide public health leadership for stroke and heart care as of July 2007. A year later, July 2008, additional federal funding was made available for North Dakota. We are in the start up phase again, with a real opportunity to achieve improved stroke care over the next two years.

North Dakotans ages 65 and older are more likely to die from heart disease and stroke than any other age group. In fact, 95 percent of stroke deaths and 87 percent of heart disease deaths in 2005 were people 65 and older. Sixty-eight percent of North Dakotans with a history of stroke are 65 and older, with stroke the leading admission cause for Long Term Health Care. In 2003, North Dakota Medicare (ages 65 and older) payments for heart disease and stroke hospital discharges exceeded $61 million dollars.

The most pronounced change in the state's population will be a dramatic increase in the elderly population. In 2000, 14.7 percent of the state's residents were 65 and older. By 2010 the proportion of elderly will jump to 17 percent, and will move to 23 percent by 2020.

Your committee's Do Pass recommendation on HB 1339 will establish the important cornerstones for acute stroke care in North Dakota in advance of our state's significant population shifts and increased stroke burden.. At this time, I would be happy to respond to any questions you may have. Thank you.

For More Information

We have many educational booklets to help you make healthier choices to reduce your risk, manage disease or care for a loved one. Topics include:

- Nutrition and weight management
- Smoking
- Cholesterol
- High blood pressure
- Physical activity
- Controlling risk factors
- Cardiovascular conditions
- Treatments
- Procedures
- Stroke and more

To learn more, call us toll-free at **1-800-AHA-USA1 (1-800-242-8721)** or contact your nearest American Heart Association office. You can also visit our Web site, **americanheart.org.**

For information on stroke, call **1-888-4-STROKE (1-888-478-7653)** or visit us online at **strokeassociation.org.**

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For heart- or ris[illegible]ed information, call the America[illegible] Association at 1-800-AHA-USA1 (1-800-242-8721) or visit us online at americanheart.org.

For stroke information, call our American Stroke Association at 1-888-4-STROKE (1-888-478-7653) or visit strokeassociation.org. For information on life after stroke, call and ask for the Stroke Family Support Network.

The statistics in this brochure were up to date at publication. For the latest statistics, see the Heart Disease and Stroke Statistics Update at americanheart.org/statistics.

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Warning Signs of a Stroke

Our Easy-Reading Guide to Emergency Action

My Dad **Had a Stroke**

Let me tell you what happened. Last week, my father and I went fishing. He suddenly dropped his gear. He said his right arm and leg felt weak.

I knew he had high blood pressure. At first, I thought he just hadn't taken his medicine. Then he started to not speak clearly. He said that he saw a curtain or shadow coming over his vision and he felt kind of funny in the head.

Dad said he felt OK in a few minutes. But I decided not to wait. I knew what was happening to him. He had the warning signs of a stroke. I called **9-1-1** for help.

Dad is still in the hospital, but he's alive. I helped to save his life by knowing the warning signs of stroke and acting quickly.

Note: The people shown in this brochure are models. The events are based on real-life stories. But they didn't happen to the people in the photos.

Learn the Signs

The signs or symptoms of a stroke can appear suddenly. Knowing these warning signs may help save your life or the life of someone you love. The signs or symptoms of a stroke are:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

Not every person has all the signs or symptoms of a stroke. When you see ANY of them, act quickly.

Take Quick Action

If stroke warning signs occur:

- Do not ignore the warning signs, even if they go away! Some people may have only one or two signs. Other people may have more.
- Check the time. When did the first warning sign start? You will be asked this important question later.
- Act quickly. **Call 9-1-1.** Stroke is a medical emergency.
- Every second counts!

Write down the emergency medical services phone number(s) and put them by your phone.

Emergency Medical Services:
9–1–1 *(if available in your area)*

Police:

_____

Ambulance:

_____

Fire Department:

_____

#3

Testimony
House Bill 1339

Senate Human Services Committee
Wednesday, February 4, 2009

Chairman Judy Lee and members of the Senate Human Services Committee. I am Tom Kloster, a stroke survivor. I am here today to testify in support of House Bill 1339, and ask for a "do pass" recommendation from this committee.

I'm the stroke victim that benefited from a hospital trying one more tool, with little time left, to make a difference in a person's life. I became the first North Dakotan to have a procedure using a corkscrew-like device to remove a clot from my brain, called the Merci-clot retrieval procedure. Without such an intervention having been tried, my outcome would be very different, and I would not be here today and sharing my story with you.

Last summer, I suffered a stroke that shut down 2/3rds of my brain. I walked outside and for some reason I just fell, obviously the stroke paralyzed my right side. My neighbor stepped out and saw me and so he came out and called 911.

When I came in I couldn't respond to any questions, I couldn't talk, and I couldn't move my right side. Doctors typically have a short window to remove clots from stroke victims veins or arteries before brain damage is irreversible. Dr. Herbel spent hours trying to clear the clot using the typical method of treatment, which involves shooting a drug toward the clot and trying to dissolve it. But it wasn`t working.

So as a last ditch effort he tried out a new procedure never before performed in North Dakota. Using the Merci retrieval device, Dr. Herbel ended up dragging the clot out of my brain.

The stroke I suffered has left me with minor memory loss, but I still remember my near-death experience like it was yesterday.

Not all stroke stories turn out this way, and I am truly grateful for my outcome. I realize I am very fortunate in that I qualified for the procedure, and that my outcome was positive, which it may not be for others who may receive this same procedure.

HB 1339 is not about providing the same stroke intervention I received. My story only serves to highlight that there are new treatments becoming available that can extend the time of treatment for stroke victims like me. I realize there are many issues that a stroke workgroup will need to work through in making recommendations regarding stroke triage and transport. By not engaging in those discussions, nor looking to new systems based on emerging medical treatments or tele-medicine systems, you are leaving stroke victims such as me to the side. That is a human cost to many North Dakota families, and a financial one for many, including the state, for rehabilitation or long term care.

At this time, I would be happy to respond to any questions you may have on my testimony. I encourage you to provide a unanimous Do Pass to this bill which is very dear to my heart, and my brain. Thank you.

Submitted after the hearing.

State Department of Health
HB 1339

During the hearing on HB 1339 the Senate Appropriation Committee had the following question:

Why are contractual expenses ($180,000) more than FTE expenses ($107,000)?

The Heart Disease & Stroke Prevention Program (HDSPP) received a cooperative agreement from the Centers of Disease Control & Prevention to develop a comprehensive heart disease and stroke prevention program. The HDSPP allocated $90,000 per year or $180,000 per biennium for quality improvement initiatives. This amount is included in the operating line item as a contractual expense in the department's appropriation bill (SB 2004). Upon further review of the grant it was determined that there were many other duties such as an in-service educational program, public health education assessments, and programs to improve high blood pressure and high cholesterol, to mention a few, that are not directly associated with HB 1339. It is estimated that approximately $80,000 per biennium would be needed for contracted services relating to HB 1339. The Department is not requesting an FTE to carry out this project.

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

House Bill 1339

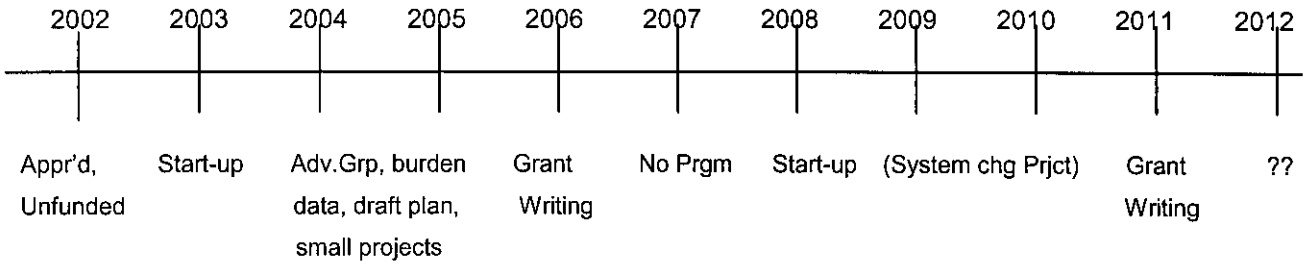
Senate Appropriations Committee

AHA Testimony

Chairman Holmberg and members of the Senate Appropriations Committee. I am June Herman, Senior Director of Government Relations for the American Heart Association in North Dakota. I am here today to testify in support of House Bill 1339, and ask for a "do pass" recommendation from this committee.

This project requires no General Fund appropriation. North Dakota has received a four year, $350,000 per year Heart Disease and Stroke capacity building grant from Centers of Disease Control and Prevention (CDC). Through use of these federal funds, the Heart Disease and Stroke Prevention Program is directed to improve acute stroke care through the establishment of primary stroke centers, planning groups to develop recommendations to establish statewide systems of care and a standardized stroke-triage assessment tool. It will be the federal funds granted to the Department's Heart and Stroke program that will provide the ability to fulfill HB1339 staffing directives.

Due to the federal funds, we have a limited window of opportunity to advance acute stroke care in North Dakota in the next two years. Without federal funding, the state is without a statewide Heart Disease and Stroke program, even though it addresses the number 1 and 3 chronic disease in North Dakota. This timeline provides you with perspective –



North Dakota's state program to address the #1 and #3 chronic disease is on a federal funding cycle that unfortunately limits its public health leadership for stroke and heart care. As stroke is the leading admission to long term care, medical care costs born by the state will escalate as our elderly population demographics dramatically increase.