

2017 HOUSE HUMAN SERVICES

HB 1039

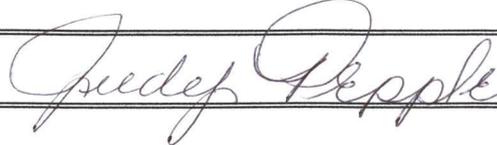
2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

House Bill 1039
1/4/2017
26544

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to hospital discharge policies.

Minutes:

Attachment 1

Chairman Weisz: opened the hearing for HB 1039

Rep. Kathy Hogan 1:00 (Testimony see attachment 1)
4:29

Chairman Weisz: Are there any questions?

Representative P. Anderson: do neighboring states have a similar bill?

Representative Kathy Hogan: yes, there are numerous states that have similar bill, a range of care act bills. This is a national movement; I am sure over 25 states have those standards.

Representative Westlind: I worry about the amount of work that will be added to the nursing staff when they do a discharge plan like this.

Representative Kathy Hogan: I think most of these standards are already requirements; I don't think we are adding significantly to their work load. It is just that the caregiver has to be notified.

Representative Porter: if they are already doing it why does it have to be in the century code and why are you now saying that there has to be a mandate on them? If this is a good clinical practice that is already being done why are you saying that it has to be done?

Representative Kathy Hogan: What we had heard that is that it was not being done. Notification of the Caregiver is not standard practice. They are given formal discharge plans, but not implemented. They need to be accountable for what they say they are doing; the standards are in place but the accountability is not always in place. Major concerns are the designation of the caregiver the training of the caregiver.

Representative Rohr: Will you clarify page 2, line 19?

Representative Hogan: The chapter does not require it but it does require that it be asked. If patient does not wish to designate a caregiver, they don't have to; that's their choice.

Representative McWilliams: Your husband was discharged with a plan but it was not followed through. What did the hospital fail to accomplish in its duties into the discharge plan? How would this bill address that?

Representative Hogan: The prior appointments were not scheduled as well as follow up appointments. When notified regarding same, they failed to find where it happened in the system. People can assume that this is being done and they could find it not so and be confused as to what their next steps will be to get follow up care in place.

Representative Westlind: Wasn't that more of an administration problem and proper supervision of the staff?

Representative Hogan: The discharge plan said they would do it, but it didn't happen. That is our concern. The standards are in place but in terms of protecting patients particularly those who are dependent on the caregiver.

Representative Westlind: I will review our policy and talk further with you when I get the results. I am on a board and will check this at my hospital.

12:00

Chairman Weisz: is there anyone that cannot be back at 1:15?

Myrie Solberg: cannot.

Chairman Weisz: we will take your testimony before we break.

Myrie Solberg: We are a volunteer organization and we are the communications to family and will take them home. Generally, most hospitals will communicate with us, will give the care and explain to us discharge plans. Problems with Hippo regulations at times poses problems for them to get information. Some elderly do not remember the instructions because of numbers of them and follow up instructions. Hospitals, at times, fail to follow through with their connection with their patient after being discharged. Upon further communication with the hospital, they neglect being available to working with the discharged patient. This would be a tool that you could be an advocate for them.

Chairman Weisz: This hearing will be continued at 1:15

Adjourned

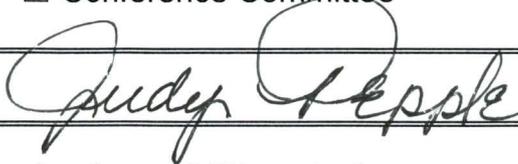
2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1039
1/4/2017
26565

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to hospital discharge policies

Minutes:

Attachments: 1, 2, 3, 4, 5,

Chairman Weisz: called the committee back to order and we will continue our hearing on HB 1039. Further support for HB 1039?

1:00

Mike Chaussee Advocacy Director at AARP North Dakota

You have already heard what a family care giver is earlier today, so I will skip that.

The part that hasn't been discussed is that we know health care is going to be dramatically different and it is dramatically different than it was 20 years ago. We are living longer, so our needs are changing. (Attachment 1)

I am going to go off script here for a few minutes. My father was taken to the ER by ambulance on Monday. He has MS and some other issues that go with that. I noticed at the hospital last night when I was visiting him the white board that I hadn't seen before was fantastic. It had a place for a family contact. I took a picture of it. This is awesome, but the more I thought about that the term family contact was there, but listed underneath that was my mother. She is a great person, but she is not his care giver. In fact, she had surgery on her elbow yesterday, so wouldn't even be remotely be able to provide any care. If the question was asked to him about who is your care giver, not necessarily family contact, I believe his answer would have been my brother who has moved in with them and is taking really pretty much care of him at this point in time. I thought that was just a good thing to go off script and let you know. We think it is important to share stories and in that book that Josh handed out.

see attachment 6 from 1/4/17 HB 1038)

You asked earlier, Vice Chairman Rohr about other states. I called the national office yesterday. Thirty-three states and territories have some version of the care act passed.

We know that family care giving is not as easy job. There is a lot to do to take care of patients when they go home. This bill helps lay the foundation for the care, it gives family care givers a fair start. A chance to get off on the right foot, know what they are doing when they get home, have confidence when they are doing it and help them do it right. We also hope that

it will help them keep from getting frustrated in their jobs and maybe they will do it a little bit longer. We know that can save money down the line. Even if it is only for a few more months or a year if they can help to sustain those people and keep them in their homes as long as possible we think it would be worth it. We know that North Dakotans want to stay as home desperately think so.

Chairman Weisz: Are there any questions from the committee?

Representative Porter: Definitions on line 12 you use the word discharge. That means the person's release from the hospital following a patient's admission to the hospital. What happens in the case of the emergency department visit? That is not considered to be an admission it is considered to be an outpatient visit.

Mr. Chaussee: We want as much training as possible to be given whenever a person leaves a facility. We understand that it is a different time and place, but any information that can be given to the caregiver is helpful. There might be times that the caregiver cannot be identified until there is some kind of formal admission, so that would change that.

Chairman Weisz: Do you believe you have understated those who would be mandated under this?

Josh Askvig, State Director for AARP North Dakota. We are dealing with hospital discharge only, not other types of facilities.

Chairman Weisz: So someone going to an outpatient facility or going to the clinic for a procedure.

Josh Askvig, State Director for AARP North Dakota I would just say that if an admission hasn't happened and someone hasn't officially designated a caregiver than that would not have to take place.

Representative Porter: You say in your testimony that the hospital cannot have policies that delay a patient's discharge or transfer to another facility. So if the patient is discharged to home does that mean it can delay their discharge?

Josh Askvig: No

Representative Porter: So there can never be a delay in discharge based on the way that the language reads to you.

Josh Askvig: I don't have the bill in front of me so I apologize for that. That language was specifically put in there to address the hospital concerns from last session and the discussions we have had in the interim. Sometimes we had instances where we had to discharge people right now. We can't wait. There is no other way and we were willing to be flexible. It is not our preferred language, but we are willing to accept that language to be flexible and say, "Let's be sure when somebody is admitted into the hospital. Other facilities are probable lacking. This is not perfect. If you want to amend it to do that I don't know that you would find a lot of objection from us. I am sure there are others in the room that would have questions to throw into the mix of that.

Representative Porter: So whether a patient is discharged to another facility or home, it doesn't matter, but flat out this does not require a hospital to adopt a discharge policy that would delay a patient's discharge, so you could just put a period after that and be done with it.

Josh Askvig: According to the language it isn't required, I would think there is some merit into that discussion, but I would have to chat before I would agree to that. Because I believe there is a difference between a discharge or transfer.

Chairman Weisz: further questions

Representative Westlind: Nurses are overworked and this is asking them to set aside more time. The training can be very intense or very minimal. Treating a wound is much more training than putting a band aid over a sore. Where does the compensation come from for that? The hospital would have to stand the added cost.

Mr. Chaussee: Understandable, but we feel that giving the family caregiver the training will save money down the line for hospitals with fewer readmits. We know that nurses are overworked, but if we can do anything on the front end to stop things from happening down the line, we think it's a good idea.

Representative Westlind: It says in her that they designate a care giver. Medicare already says that they should designate a support person. Is there a difference between a support person and a caregiver? Also I talked to my director of nursing over the noon hour and she stated that they do this on everyone where they have a designated care giver or support person. I can understand your concern on this bill, is there duplication of what is already being done.

Mr. Chaussee: We do think it happens in places. There are hospitals that do a good job, but we don't think it happens across the board. Lots of people telling us they did not receive training. The more we can enter on the front end and let people know that the training is coming and be very deliberate about it. That will help.

Representative McWilliams: My understanding is that if you have a hospital mandated by law to create training for them doesn't that put the liability back on the hospital? So if someone did not clean the room properly that the hospital would still have that liability simply because it is written in the law.

Mr. Chaussee: I am going to turn to Josh Askvig here for that.

Chairman Weisz: We are not going to go back and forth here.

Mr. Chaussee: It goes back to the language that was written with the hospitals in mind. That last section of the liability issues, we tried to work with the hospitals to clean that up as much as possible.

Chairman Weisz: Further questions?

Representative Porter: As I look at this more and more, the questions keep popping into my

head in regard to the definition of discharge meaning that the person was released from the hospital. It doesn't say where they were release back to. So even if someone was discharged to a facility where there are nurses doing the care they would still potentially the way this is written they have to train them anyway. Even though they are going back to a skilled facility, so that would be redundant.

Mr. Chaussee: This only applies to the person if they designate a caregiver. If they didn't designate a care giver in the beginning, they probably won't designate one when they are discharged either, so the nursing home staff can certainly do the care if someone ends up there.

Chairman Weisz: This is uncompensated, so the ones in a facility would be compensated.

Mr. Chaussee: That is not my point. My point is that if you are admitted and you designate someone and you are transferred back to a nursing home for skilled care, they still have to show that uncompensated person how to take care even though the nursing staff at the nursing facility. The way this reads it doesn't matter if they are discharged to the Mayo Clinic, the word discharge still follows that patient and the family care giver would have to be shown or taught something even though the patient is going to Mayo Clinic for something else.

Mr. Chaussee: If that has been designated, I see your point. That could be something that could be tweaked.

Chairman Weisz: Further questions from the committee?

Vice Chairman Rohr: I get what you are doing here and I think your intention is really great, but my concern goes back to the facility. It says here documentation of the details of the discharge plan. Who is going to monitor the accountability of the hospitals do this training. Is that the state's responsibility then. How is the accountability going to be established?

Mr. Chaussee: The accountability was not in it. We are trying to present something that can get passed. This is a compilation of what we thought might work.

Chairman Weisz: Further questions? Is there further testimony in support of HB 1039.
29:39

Barbara Handy-Marchello, Caregiver (Testimony attachment # 2)

I am here in support of H 1039 and I hope the questions can be worked out. I think it needs to be passed. I hope you will give it a do pass out of committee. It will add another layer of help to people of ND as they face their medical concerns

Chairman Weisz: Thank you. Any questions from the committee?
Further testimony in support of HB # 1039?

Ellen Schafer, Volunteer with AARP (Attachment # 3)

Chairman Weisz: Further support of 1039? None

Chairman Weisz: Any opposition to HB 1039?

Jerry Jurena, President of North Dakota Hospital Assoc. (attachment #4)
I ask that you would give a do not pass recommendation.

Chairman Weisz: any questions from the committee? None

Chairman Weisz: further testimony in opposition

D. Hannaher, Executive Director of the Health Policy Consortium
(Attachment # 5)

Chairman Weisz: questions

Representative Devlin: Who are the members of the consortium

D. Hannaher: Trinity Hospital in Minot, Altru Health System in Grand Forks and Sanford Hospitals in Bismarck and Fargo.

Chairman Weisz: Further questions? None. Further opposition?

Kristen Rohrs North Dakota Nurses Assoc. (No written testimony)

Nurse and I am speaking on behalf of the North Dakota Nurses Association.
This bill could increase the work load of hospital nurses. The burden of documentation already makes the discharge process difficult and I feel this bill would further compound that.
The vast majority of nurses are already doing these steps governed by the regulatory and accrediting bodies. I don't see how the components of this bill will bring the outliers into compliance. Thank you for your time.

Chairman Weisz: questions

Vice Chairman Rohr: How do we make sure that the patients are aware that if they are unhappy with their discharge instructions or if they have trouble when they get home. How do we make sure there is follow through? Do they know they can call the Health Dept.?

Kristen Rohr: So one of the things that is require as a hospital is that we give patients on admission a list of who to call if they have an issue. There are also people that call each patient that is discharged to be sure they are doing alright.

Chairman Weisz: Questions

Chairman Weisz: questions?

Closed hearing on HB 1039

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1039
1/18/2017
27164

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to hospital discharge policies

Minutes:

Chairman Weisz: called the committee to order.
We have HB 1039 before us.

Representative Devlin: As we heard all of the testimony from the hospital association, health policy council and I am quite sure every hospital in my district and in the surrounding districts they were quite sure this bill was not needed at all. Everything that is in this bill they are required to do right now. When I talked to a couple of advocates, they still believe there is a purpose for this bill. They want the patient or guardian to be able to designate an uncompensated care giver. I don't have a problem with that and I don't think the hospitals do either. I think the hospital has to do it, but I could certainly put it in code that they should establish and maintain the written discharge policies in accordance with the Medicare and Medicaid policies of participation. These discharge policies apply to all patients of the hospital, regardless of whether the patient receives Medicare or Medicaid. I believe and they believe they are required to do that, but it might give some comfort to people if it were in statute. If there is a problem, they need to talk to their facility and then they need to talk to the department of health if they don't believe it is being done. I think maybe we need a motion to just kill the bill. I have an amendment that I will pass out and it essentially does what I just said. It explains the definitions which we have had and it explains the uncompensated care giver. It puts in our statutes that hospitals have to establish and maintain their discharge policies. Also it puts in statute that a patient or patient's guardian may identify an uncompensated care giver and the other section is what was in there before. As it goes around I am more than willing to put forth this amendment. It may not be acceptable to other people in the room. Whatever the Chairman's wishes are. If you want me to propose an amendment for discussion purposes, I am willing to do that.

Chairman Weisz: Go ahead.

Representative Devlin: I move to accept the amendment to HB 1039.

Vice Chairman Rohr: I second that motion.

Chairman Weisz: Ok committee you should all have a copy of the amendment, so discussion?

Representative Damschen: I am just wondering where the instructions for the caregiver to provide the service is in these amendments. What services need to be provided and how they are taught.

Representative Devlin: I will have to find the letter from one of the hospitals. I can read it, but everything that was asked for in the instructions, the discharge papers, everything else is already required. They are getting that information. If they are not getting that information whatever we do here is not going to make any difference. They should be complaining to the facility management and they can complain to the Health Dept. All we are doing is duplicating exactly what hospitals and others are required to do right now.

Representative Damschen: I am just wondering if we need any amendment.

Representative Devlin: Mr. Chairman I might point out that was my original intent.

Chairman Weisz: Whatever the wishes of the committee.

Representative Devlin: There may be a question whether a patient or guardian has that legal right to identify someone as their uncompensated caregiver. That does not appear in anything the hospitals have and it does not appear in statute. The rest of it is federal requirements.

Representative McWilliams: One of the things that I did see in the original bill was that it clarified some of the legal responsibility of the caregiver. It clarified the access to some of the medical records and medical information. That was presented as one of the challenges that we currently face as a caregiver. Doctors refusing to talk to the families who may actually be caring for that person. That was one point that I liked about the original bill. I didn't like much else about it, but I did like that part. It could be addressed here or elsewhere.

Representative Skroch: I think in cases where you have a caregiver that takes a competent person home they should be able to designate a caregiver without any difficulty? If they don't have someone that is their durable power of attorney for medical. If they are able to go back home and they have their mental faculties, I think they can appoint anyone as their caregiver. Whoever they choose and they can determine on their own whether or not they wish to share their personal medical records with that individual caregiver.

Chairman Weisz: I suppose there isn't anyone here that can address the actual HIPPA. Representative Porter you might know more about it than anybody here.

Representative Porter: In the federal HIPPA law, the only way that a health care provider can discuss someone else's medical condition and health related information is with that person's permission. So what Representative McWilliams talks about and others, it wouldn't make any difference if the person is not sitting in the room and the doctor or nurse practitioner is not

looking right at the patient and says, "Do you mind if I speak with the person you said is your designated caregiver about health condition," they can't do it. The federal law trumps it. Like when family members of mine have been in the hospital the doctor comes in and we are all in the room, the first thing the doctor does is looks at the patient and says, "Do you mind if I discuss what is going on with your family in the room, or would you rather that they leave?" That is the first topic of conversation. That is their HIPPA compliancy to make sure they are not violating that patient's personal wishes.

Chairman Weisz: If they have a power of attorney they have already granted it so then it doesn't apply. Representative Skroch does that satisfy your question?

Representative Skroch: I think that is what we are trying to say. As long as that caregiver has permission from the person being discharged to share medical information with their caregiver, it is not a problem. You are not violating HIPPA laws then.

Chairman Weisz: More discussion?

Representative Devlin: I know in this pile of things I have this, but I will read one of the letters from a healthcare provider that I have worked with for 15 years. She said discharge information is a requirement for both accreditation and state licensing for all hospitals. This proposal is a duplication of those requirements. As a result, if there is a family who did not receive the appropriate discharge information in order to provide care and services it is a facility issue. It should be directed back to the facility, reported to the state health department, or the state ombudsman from the department of human services. Patients are educated for any treatments, dressings, medications. They are provided referral information along with all of the appropriated appointments on discharge. This information is recorded in their medical record and is part of their permanent record. It is important to realize that some patients leave healthcare facilities against medical advice and simply walk out of the facility. The reasons for this may vary, but again if a patient or his family feels they were treated inappropriately or did not receive the information needed to provide care and services for a safe transition to their home, that is a facility problem and doesn't require a duplication of the laws that are already in place. As a critical access hospital administrator and a working RN, paperwork is already overwhelming. Duplicating requirements already in place will not resolve the concerns we have.

Chairman Weisz: I guess I will just add. Your amendment does clarify the uncompensated caregiver.

Representative Schneider: I think that we have a lot of instance where the state law clarifies already existing federal regulations and I think part of it is to insure ease of finding that law and knowing what it is. Part of it is too that federal law can change and we may be in a period where a lot of things change in that federal law. If this is something we feel is important enough and it certainly seemed that the people that were testifying thought it was, that we should probably put it into our state law and insure that people can both find it without having to go through all the federal regulations and that it won't change with the federal law should that happen. It should not create extra paperwork if they are already required to do it there shouldn't be any extra burden and it may even make it more clear to the people that are doing the paperwork. I would like to see the original bill the way it was.

Representative Damschen: The part that I have always been concerned about since we first started talking about this years ago was the training that wasn't being done. It is being done now and is required now. That is the part that I really wanted to see and that seems to be addressed. The part I didn't really like was setting up a caregiver who is probably a volunteer it is kind of like firing a volunteer. If a person is going home without a spouse, they may have a hard time finding someone to sign on as a legal caregiver.

Chairman Weisz: Any further discussion on the amendment.

Representative Skroch: I am going to get a little bit personal here. I have been in a positions where I have had a really major surgery and went home with a personal caregiver that was my husband. The hospital was exceptional in training. They began his training while he was at my side in the hospital. They were training him how to turn on the IVs and things like that. When I went home they made sure I had everything in place if I needed any extra help at home. If my husband needed any extra care and training after he got home, so I think in that regard what Representative Damschen said correct. The hospitals are doing much better in preparing a patient to go home. Sometimes they are going home earlier than they used to but they are ready because they have the training for the people that are taking care of them.

Chairman Weisz: Anyone else? Ok, just so everyone is clear we are voting on the amendment. I think we will have to do a roll call on this.

Roll Call vote taken on the amendment
Motion carried 9 yes 5 no

Chairman Weisz: Now we have an amended bill in front of us. What are the wishes of the committee?

Representative Westlind: I make a motion that we do not pass on HB 1039 as amended

Chairman Weisz: is there a second?

Representative McWilliams: I second the motion.

Chairman Weisz: Discussion? I think we have pretty well discussed it.

Representative Westlind: I would just like to reiterate. I have talked at length with some of my nurses at the hospital and the CEO and this is totally a duplication on services. They already do everything that is listed here.

Chairman Weisz: Further discussion. This is for a do not pass on HB 1039 as amended.

Roll call vote taken on do not pass HB 1039 as amended

Chairman Weisz: Motion failed 2 yes 12 no
What are the committees wishes?

Representative Damschen: I wonder if all of the freshmen realize how a vote on a “do not pass as amended” works.

Chairman Weisz: If the motion is for do not pass a yes vote means you support the do not pass. Was there any confusion when we voted?

Representative Skroch: I would change my vote.

Chairman Weisz: I should have clarified that. If whatever the motion is. A do pass or a do not pass, if that motion fails then of course we look at a motion that is opposite to see if that will pass or fail. Sometimes we deadlock and then a bill can come out of committee with no recommendation. I appreciate that Representative Damschen. I should have clarified that. If the motion is for do not pass you vote yes if you support the motion. In this case it was a do not pass. The clerk will retake the roll call vote. If you are voting yes that means you support a do not pass recommendation and if you vote no that means you are against the do not pass recommendation.

Representative Skroch: We have just passed a replacement bill, correct?

Chairman Weisz: We amended the bill very heavily, but it is an amended bill, so that vote passed to amend it to that bill. There were not more amendments offered. Which I asked for further amendments. Then now we vote on the new bill with the amendments. So we can say no I don't want the bill or yes now I support the bill. We have to vote on what is in front of us now, because that was adopted by the committee by the 9 - 5 vote on the amendment.

Representative Skroch: Now we are voting a do not pass

Chairman Weisz: the motion was for a do not pass on the amended bill. So if you don't like the amended bill I suggest you support the do not pass. If you like the amended bill you would vote against the do not pass. If the motion passes, it will come out of this committee with a do not pass. That would be the recommendation on the floor. If that motion fails, then the chair will entertain a motion basically for a “do pass” and then we will try that to see if that passes. In some cases, that fails. Then it gets interesting. I have had that happen, do that is the process. We can only vote on what is in front of this committee. Representative Westlind made the motion for a do not pass on HB 1039 because we already passed the amendment which becomes the bill. Every time this committee passes an amendment, every one of those becomes part of the bill. Once we are all done amending then you can like it or hate it, but now you have to vote on the bill. You only have two options. Either a do pass or a do not pass. Those are the only two motions then that can come. Once a motion is made, which Representative Westlind did, now if you approve of the motion you have to vote yes. If you don't support the motion you vote no. After the vote if the motion does fail, then the bill is still in front of us. Nothing has been done. There can be more discussion, another motion, but we can only act on the motion that is in front of us. Again now, the clerk is going to call the roll for a do not pass. If you support that we do not need this bill then you will vote yes, otherwise you vote no.

The clerk will call the roll.

Roll call vote taken on a do not pass as amended on HB 1039.
Motion failed 5 yes 9 no

Chairman Weisz: Now the bill is again in front of the committee. The chair will entertain a motion.

Representative Devlin: I will move a do pass as amended on HB 1039

Chairman Weisz: We have a motion of a do pass as amended. Is there a second?

Representative Porter: I second it.

Chairman Weisz: Ok we have a do pass as amended before us. Is there any discussion on this?

The clerk will call the roll for a do pass as amended on HB 1039.

Roll call vote taken on do pass as amended on HB 1039
Motion passed 12 yes 2 no

Chairman Weisz: Do we have a volunteer to carry this bill?

Representative Devlin: I will carry it.

Chairman Weisz: Every amendment supersedes the prior amendment too, so that can also get very confusing. We can adopt an amendment and someone can offer an amendment after that which may change the prior amendment as part of it, so then the bill will change. We can have many sets of amendments. People have different ideas and are trying to fix different things so it is important to keep track of how amendments are offered and how they are adopted. Sometimes we won't vote until I can have the intern put the bill together with all of the amendments. Then everyone understands exactly what they are voting on, because it is easy to get lost in the shuffle. Regardless of whether you are for or against something everyone in the committee should be clear on what they are voting for.

Adjourned

1/19/17 DA

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1039

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-16 of the North Dakota Century Code, relating to hospital discharge policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 23-16 of the North Dakota Century Code is created and enacted as follows:

Hospital discharge policies - Uncompensated caregivers.

1. As used in this section:
 - a. "Aftercare" means assistance related to a patient's condition at the time of discharge provided by an uncompensated caregiver to a patient after the patient's discharge. The term may include assistance with activities of daily living, instrumental activities of daily living, or medical or nursing tasks.
 - b. "Discharge" means a patient's release from a hospital following the patient's admission to the hospital.
 - c. "Uncompensated caregiver" means an individual who, at the request of a patient, agrees to provide, without compensation, aftercare to the patient in the patient's residence.
2. A hospital shall establish and maintain written discharge policies in accordance with the medicare and medicaid conditions of participation. The discharge policies apply to all patients of the hospital, regardless of whether the patient receives medicare or medicaid.
3. A patient or a patient's guardian may identify an uncompensated caregiver.
4. This section may not be construed to interfere with the rights of an agent operating under a valid health care directive under chapter 23-06.5."

Renumber accordingly

Date: 1-18-17
 Roll Call Vote #: 1

**2017 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. HB 1039**

House Human Services Committee

Subcommittee

Amendment LC# or Description: 17.0124.02001

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

Motion Made By Rep. Devlin Seconded By Vice Chairman Rohr.

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson		✓
Vice Chairman Rohr	✓		Rep. Schneider		✓
Rep. B. Anderson	✓				
Rep. D. Anderson	✓				
Rep. Damschen		✓			
Rep. Devlin	✓				
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel		✓			
Rep. Skroch	✓				
Rep. Westlind		✓			

Total (Yes) 9 No 5

Absent 0

Floor Assignment _____

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

Date: 1-18-17
 Roll Call Vote #: 2

**2017 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. HB1039**

House Human Services Committee

Subcommittee

Amendment LC# or Description: _____

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

Motion Made By Rep. Westlind Seconded By Rep. McWilliams

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. P. Anderson		✓
Vice Chairman Rohr		✓	Rep. Schneider		✓
Rep. B. Anderson		✓			
Rep. D. Anderson		✓			
Rep. Damschen	✓				
Rep. Devlin		✓			
Rep. Kiefert		✓			
Rep. McWilliams		✓			
Rep. Porter		✓			
Rep. Seibel		✓			
Rep. Skroch		✓			
Rep. Westlind	✓				

Total (Yes) 2 No 12

Absent _____

Floor Assignment _____

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

Date: 1-18-17
Roll Call Vote #: 3

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1039

House Human Services Committee

Subcommittee

Amendment LC# or Description: _____

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

Motion Made By Rep. Westlind Seconded By Rep. McWilliams

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. P. Anderson		✓
Vice Chairman Rohr		✓	Rep. Schneider		✓
Rep. B. Anderson	✓				
Rep. D. Anderson		✓			
Rep. Damschen	✓				
Rep. Devlin		✓			
Rep. Kiefert		✓			
Rep. McWilliams	✓				
Rep. Porter		✓			
Rep. Seibel		✓			
Rep. Skroch	✓				
Rep. Westlind	✓				

Total (Yes) 5 No 9

Absent _____

Floor Assignment _____

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

Date: 1-18-17
 Roll Call Vote #: 4

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
 BILL/RESOLUTION NO. HB 1039

House Human Services Committee

Subcommittee

Amendment LC# or Description: _____

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

Motion Made By Rep. Devlin Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson	✓	
Vice Chairman Rohr	✓		Rep. Schneider	✓	
Rep. B. Anderson	✓				
Rep. D. Anderson	✓				
Rep. Damschen		✓			
Rep. Devlin	✓				
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel	✓				
Rep. Skroch	✓				
Rep. Westlind		✓			

Total (Yes) 12 No 2

Absent _____

Floor Assignment Rep. Devlin

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

REPORT OF STANDING COMMITTEE

HB 1039: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1039 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-16 of the North Dakota Century Code, relating to hospital discharge policies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 23-16 of the North Dakota Century Code is created and enacted as follows:

Hospital discharge policies - Uncompensated caregivers.

1. As used in this section:
 - a. "Aftercare" means assistance related to a patient's condition at the time of discharge provided by an uncompensated caregiver to a patient after the patient's discharge. The term may include assistance with activities of daily living, instrumental activities of daily living, or medical or nursing tasks.
 - b. "Discharge" means a patient's release from a hospital following the patient's admission to the hospital.
 - c. "Uncompensated caregiver" means an individual who, at the request of a patient, agrees to provide, without compensation, aftercare to the patient in the patient's residence.
2. A hospital shall establish and maintain written discharge policies in accordance with the medicare and medicaid conditions of participation. The discharge policies apply to all patients of the hospital, regardless of whether the patient receives medicare or medicaid.
3. A patient or a patient's guardian may identify an uncompensated caregiver.
4. This section may not be construed to interfere with the rights of an agent operating under a valid health care directive under chapter 23-06.5."

Renumber accordingly

2017 SENATE HUMAN SERVICES

HB 1039

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1039
3/15/2017
Job Number 29222

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to hospital discharge policies.

Minutes:

2 attachments

Chair J. Lee: Brought the hearing to order, all members were present.

Michael Johnson, Legislative Council Staff (0:35-4:50) introduced the bill. Walked through the proposed changes.

Jerry Jurena, President NDHA (5:18-7:20) testified in favor, please see attachment #1.

Senator Anderson: Does this fit what you're doing now, so it's easy enough to comply with?

Mr. Jurena: We're doing this now, in order for a hospital to be licensed in this state the Federal government mandates that you have discharge planning procedures in places. We've been doing this. CMS have criteria for quality assurance; are you looking at the number of readmissions to your facility, we also take a look at patient satisfaction scores, which makes up 30% of our reimbursement; both are there, we're doing it.

Senator Anderson: What I'm hearing you say we don't need another law, yet you're supporting this bill for some reason.

Mr. Jurena: What we're supporting is the engrossed bill that came out of Human Services in the House, which says that we must adhere to the Federal rules and regulations, if we need a law, this is as good as we're going to get. We don't need a state law to say you have to do what the Federal government already is mandating.

Senator Kreun: Item under 1c "uncompensated caregiver" means an individual, who at the request of the patient agrees to provide without compensation aftercare to the patient in the patient's residence. Does this designate any legal responsibility for those individuals as they become a designated caregiver? Do they need a power of attorney to have any of that information so that it's given to them? The Privacy Act, is there a requirement? Are we able to give them this information, and are they legally responsible for that?

Mr. Jurena: Those were some of our concerns in the original bill. In order for us to give information to a caregiver they would have to sign additional forms, the patient would have to be part of that process. Putting the patient caregiver into the patient's record; I talked to three different lawyers, they said this creates an issue of liability once you do that, you are saying that this is a continuation of the hospital care. You've instructed these people, they understand, if something goes wrong the hospital would be sued.

Senator Kreun: Would they need to have power of attorney to do that? He read from the bill. That requires all the information that HIPAA would give to that person, they become more than the neighbor that comes to take care of them. How do you accomplish that without being responsibility?

Mr. Jurena: Yes, there is a lot of the responsibility. That's what we were worried about; putting that information in the patient's chart makes the hospital ultimately responsible. Small hospitals carry from \$25 -\$50 Million liability insurance; larger hospitals carry hundreds of millions. If something goes wrong with the care in the home, and it's documented in the patient's chart, the hospitals are left at the table. There is a lot of responsibility.

Senator Kreun: But you're supporting that.

Mr. Jurena: What we're supporting is that we follow the federal rules and regulations.

Dan Hannaher, Health Policy Consortium (14:25-15:25) testified in opposition. We don't feel the bills are necessary. We continue to do the work that is pushed forward in the bills. On principle we oppose. This version having been watered to its current state, it won't harm us, we don't believe it's necessary.

Josh Askvig, State Director AAPR, North Dakota (15:40-22:05) testified in opposition, please see attachment #2.

V-Chair Larsen: If they're not getting the instruction, does that currently put the hospitals on the hook?

Mr. Askvig: It would be addressed under existing statutes, the original CARE act in 1039 and 2215 actually provided them some immunity, whereas the existing statute would not. The issue is they don't want to be sued, you might be sued anyway over the court rules, at least now they would have some protection under the original and subsequent amendments.

Senator Kreun: You mentioned 1038, the research that supports the caregiver services and what we're going to put into place a website and promotional a lot of activities that will support these caregivers, are we going to need to continue to fill the gap?

Mr. Askvig: The short answer is yes, the study that the interim did shows that. 1038 starts the ball forward, does not address the hospital discharge gap that 1039 in its original form would.

Senator Clemens: Have there been any lawsuits to date involving caregivers and misinformation?

Mr. Askvig: To my knowledge no, I'm not an attorney, they might not call us on those matters.

Senator Clemens: There hasn't been a big issue with caregivers receiving correct information?

Mr. Askvig: There is an issue, one in three say they aren't getting the support or instruction they need. Whether they sue over that, is another matter. But there's an issue, when we first talked about 2215, we shared the voices of North Dakota Caregivers book that talked about some of the stories that we've heard.

Senator Piepkorn: The hospitals are saying right now patients are being discharged and the caregivers are being given the information as mandated by the federal government, is that correct?

Mr. Askvig: If you go to 2nd page, very last row, under the CARE act provide training of any after care task a caregiver will need to perform; nothing in the administrative regulations, it's implied, but not specific, the cost of participation requires 'as needed' that the patient and persons interested must be counseled to prepared them for post-hospital care. The loophole is 'as needed'. There's a loophole, which is what the original bill was looking to close.

Senator Piepkorn: But they are fulfilling their obligation according to the way it's written, is that correct?

Mr. Askvig: They're all maintaining their CMS accreditation, they do have loopholes this would look to address.

Senator Piepkorn: That's the main purpose of the original, is to close loopholes? Pointing out, because of your phone survey that one in three caregivers didn't get instruction they wanted, they might be wanting something that isn't there.

Mr. Askvig: What I would tell you is what we have heard; they didn't feel like they were fully engaged in the process, let me identify who's going to be taking care of me. Then make sure that person knows when they're leaving, making sure they're there for the person. The reason for the bill is to make sure that's clearly stipulated, the version we wanted was 6 pages, it stipulated timelines, etc. and set them up as part of the process, make sure they are fully part of that team, and that if they have questions or concerns they can ask because what I hear they're not sure they have the right to ask that question.

Chair J. Lee: If someone needs 24/7 care, were you expecting some kind of schedule?

Mr. Askvig: I'm not sure that would be addressed in that situation. If family members were doing it, they would be rotating. Do we think we can do better than one in three; yes. Those who are needing 24/7 care are getting some sort of assistance, which is why you have 1038.

The bill would only say that there's one caregiver that needs to be instructed, we wouldn't oppose allowing others to be a part of that.

Senator Clemens: Is it being strenuously encouraged that all patients are fully made aware before discharge of what's needed? It seems to me that that's being taken care of prior to discharge, you're getting it out to your customers, make sure you're involved with the discharge.

Mr. Askvig: We've been doing plenty of education and awareness to do that, there are still loopholes in the existing rules that the original bill would close, so that those gaps don't occur. There are instances where folks aren't aware. We've been doing education for the last 3-4 around family caregiver supports. Two years ago we did Prepare to Care, encourages caregivers to be aggressive, to ensure they get what they want and need.

Senator Kreun: We've been talking about 62,000 caregivers from our interim committee, do you agree that 30% actually need the services we're talking about?

Mr. Askvig: I will get you the figure from our phone survey we did have a figure of those who were providing medical or nursing tasks, it wasn't too far different from what we've heard.

Senator Kreun: That's 18,000 people, I just wanted to make sure we're on the same page.

Chair J. Lee: Closed the public hearing.

Senator Piepkorn: Do the hospital do you ever make an after call?

Mr. Jurena: That's part of the discharge process, that there is follow-up. Can we do better, yes, we are always trying to approve.

Senator Heckaman: We have an option from AARP, fix or kill.

Senator Heckaman: I make a motion Do Not Pass.

Senator Anderson: Second.

Senator Clemens: What's the difference between the original 1039 and this one?

Chair J. Lee: It's exactly the same as the original 2215.

A roll call vote was taken.

Motion passes 7-0-0.

Senator Heckaman will carry.

Chair J. Lee closed the hearing.

Date: 3/15 2017

Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1039

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: _____

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

Motion Made By Sen. Heckaman Seconded By Sen. Anderson

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman	X	
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens	X				
Senator Curt Kreun	X				

Total (Yes) 7 No 0

Absent 0

Floor Assignment Sen. Heckaman

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

REPORT OF STANDING COMMITTEE

HB 1039, as engrossed: Human Services Committee (Sen. J. Lee, Chairman)
recommends **DO NOT PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING).
Engrossed HB 1039 was placed on the Fourteenth order on the calendar.

2017 TESTIMONY

HB 1039

HB 1039 A# 1.
1-4-17

TESTIMONY

HB 1039

House Human Service Committee

January 4, 2017

Representative Kathy Hogan

The first bill addresses hospital discharge planning protocols in last session's Care Act. I want to thank both AARP and the ND Hospital Association for their cooperation and collaboration in working on the newly drafted Care Act bill. There were several working sessions between the groups. We reviewed the current federal and state regulations regarding discharge planning and the experiences of patients and families. The outcome is relatively simple bill.

The interim bill has been simplified to address four areas:

1. Allow a patient to designate a caregiver
2. Requires that the designated caregiver be notified of discharge.
2. Creates a framework for training family caregivers
3. Addresses the liability concerns

I will briefly walk through the bill.

- Section 1 Definitions
- Section 2 Description of what hospital discharge policies must include and references to national hospital standards
- Section 3 Clarify limitations on immunity

HB 1039 passed unanimously in the interim committee.

Thank you for your work and I am willing to answer any questions.

HB. 1039
Att. 1
1-4-17



Real Possibilities in

North Dakota

January 4, 2017
House Human Services Committee
Testimony on Hospital to Home Transitions
Mike Chaussee - AARP North Dakota
mchaussee@aarp.org or 701-390-0161

Chairman Weisz, members of the House Human Services Committee, I am Mike Chaussee, Advocacy Director for AARP North Dakota. Thank you for the opportunity to appear before you today to share AARP's thoughts on how to improve hospital to home transitions.

You heard earlier today about AARP's founder, Dr. Ethel Percy Andrus, the retired teacher turned advocate. We'd like reiterate her commitment to the health and financial security of all Americans, especially the 50+. Her spirit is in all of us as we continue the work of AARP. Again, we are a nonprofit, nonpartisan organization with a current membership in North Dakota of more than 87,000 – about one-third of North Dakotan's over 50 belong to AARP. Nationwide, we have nearly 38 million members. We hear from our members every day – about their dreams to live longer, healthier and fulfilled lives. We're here today speaking for them.

AARP has recently focused a good share of its attention on a group of people whose needs are often overlooked – family caregivers. As you heard during the hearing on House Bill 1038 – they are spouses, partners, relatives, friends or neighbors who provide uncompensated care for loved ones.

We know that family members have been taking care of each other forever, but we also know how we live today is dramatically different than it was even 20 years ago. We're living longer – and because of that our health care needs are changing.

Health care issues can be difficult physically and emotionally on both the patient and the caregiver. Plus, understanding medication and therapy is complex.

We also know something else about older North Dakotans. They want to stay in their homes. They accept the fact they may end up in nursing homes and/or assisted care facilities, but still want to stay at home as long as possible. When someone is willing to help them stay home longer – we think the state should do what it can to help that happen.

Now is the time to mention that these needs will only increase over the next decade and longer. The North Dakota State University study presented to you earlier shows the number of adults aged 65 and older is expected to grow 50 percent by 2025 (*North Dakota Compass*). As the Baby Boomers age, those statistics will follow. By 2040, the number of adults 85 and older will reach nearly 25,000 in the state. (*Growing ND by the Numbers, North Dakota Census Office, 2014*).

We need unpaid family caregivers now. We'll need them exponentially more in the future. That's why it's important to start giving them the support they need to do their jobs. Jobs that allow people to stay at home as long as possible – jobs that free up much needed space in nursing homes and assisted care facilities – jobs that have the potential to save the state and North Dakotans millions and millions of dollars.

Now, how are we doing in our support of these people who are doing so much for us? Well, AARP Public Policy Institute's 2014 Long Term Scorecard provided to you earlier shows that North Dakota ranked 33rd out of 50 states with respect to support that family caregivers receive. The North Dakota State Study shows about 80 percent of people who identify themselves as caregivers provide nursing care of some sort. Of those, half say they received no training. None – that's not a little training, or training they didn't completely understand, they say they received none.

We can go back to the Voices of Caregivers book handed out earlier today to see examples of what North Dakotans say about their transition home (see page 6, *Voices of North Dakota Family Caregivers, 2016*).

I'd like to point out, and you can see it in the book too, it's not like family caregivers are doing just simple tasks like cleaning or putting on new Band Aids. In an AARP study conducted in 2014, we discovered that two-thirds (66%) of North Dakota caregivers are helping or have helped their loved ones with complex care like managing medications. Well over half (56%) help with other nursing and medical tasks.

It's information like that which led AARP to initiate a national effort to get versions of what we call the CARE Act passed. More than 30 states have now passed versions of the CARE Act. Those states include ~~South Dakota~~ ^{Nebraska}, Wyoming, Alaska, Indiana - and within the last two weeks, Governor John Kasich signed the CARE Act in Ohio. House Bill 1039 is the version that has been worked out in North Dakota. We've spent time working with hospitals, human services groups and caregivers to craft a bill we think works for everyone.

The bill asks hospitals to do a few things to make the transition of patients, and the people THEY identify as the person who will be taking care of them at home, a little easier.

Here's what House Bill 1039 ensures:

1. Hospitals ask patients if they would like to designate someone as an "uncompensated caregiver" – we believe most often that is a family member which is why we refer to these people as family caregivers most often.
2. Then – if, and only if, the patient has designated a caregiver, it requires that the family caregiver be documented as part of the official medical record. This is an important piece of the bill. It allows the family caregiver to receive timely information that can allow him or her to provide better care when their job

begins. It opens the door for the hospital to share at the most critical times for the patient.

3. Because we've identified the importance of the role of the family caregiver, the bill also asks hospitals to let the family caregiver know when the patient is discharged – whether the patient is going home or being transferred to another facility.
4. Then, and this is really the key piece of the legislation - the piece the family caregivers continue to ask for...the bill asks hospitals to teach the family caregiver how to do what he or she is being asked to do. Things like how to properly measure and distribute medicine – sometimes even giving shots, how to change bandages and clean wounds, and there's often some kind of equipment – like slings, braces or meters – they should be taught how to use them – how to take them on and off, how to read them and interpret them.

The hospitals have argued that they already do much of what the bill is asking. The AARP national office looked into the laws and regulations that govern them in North Dakota. Attached to your testimony is a chart outlining how the CARE Act differentiates from current regulations and standards.

The burden placed on hospitals by this bill is small. In fact, when we talk about instruction for caregivers, we leave options open for hospitals. They can determine the best way to teach the family caregivers - they could even produce videos and show them at the hospital or provide links to videos family caregivers can watch when they leave.

We also believe this will lead to fewer re-admissions to the hospital, ultimately saving the state money.

Family caregiving is not an easy job. There's a lot to do to take care of patients when they go home. This bill helps lay the foundation for the care. It gives family caregivers a fair start, builds confidence, and prepares them for the tough job ahead. Maybe it will help keep some from getting frustrated or giving up. Maybe it will keep

a few more of them in the job a little longer. Even if it's for just a few more months, a year, maybe more if things go well – would that be worth it?

North Dakotans who desperately want to stay at home think so.

AARP's latest estimates show the state benefits from family caregivers at the rate of \$860 million a year. More than 62,000 family caregivers are working every day across the state – and those are the ones who identify themselves as family caregivers, we know there are likely many, many more who do the job. They can certainly use the help; help that doesn't cost the state any money. But it's help that can change the lives of thousands of North Dakotans today - and many more thousands in the future.

Chairman Weisz, committee members, thank you for your time. I'd be happy to try to answer any questions you might have. AARP State Director, Josh Askvig is here too, as well as a couple of people ready to testify and share their caregiving stories.

NORTH DAKOTA CARE ACT COMPARISON TO STATE AND FEDERAL REGULATIONS

All of these regulations are found in North Dakota Century Code and Administrative Rules. They are all part of Chapter 33-07-01.1 North Dakota Licensing Rules for Hospitals. Access to Regulations is through North Dakota Department of Health; Health Facilities:

http://www.ndhealth.gov/hf/North_Dakota_Hospitals_Critical_access.htm. Upon entering the website navigate to the appropriate regulation through the menu links.

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
<p>Identification of Family Caregiver and Including him/her in Patient Record</p>	<p>No requirement for identification of the family caregiver or including the information in the patient record</p> <p>33-07-01.1-20. Medical records services.</p>	<p>Hospitals and state hospital associations may claim that they currently perform the tasks outlined in the CARE Act (i.e., identification of the caregiver in the medical record, notifying the caregiver of a transfer or discharge, and providing instructions for the caregiver to perform post-discharge medical tasks).</p> <p>While the CoPs include requirements for patient's rights and discharge planning, the federal regulations and State Operations Manual that provides interpretive guidelines of the regulations do not include the specific provisions of the CARE Act.</p> <p>While the CoPs require the hospital to notify a family member or representative of the patient's admission into a hospital, the CoPs do not require the hospital to provide the patient an opportunity to designate a caregiver or for the information to be added to the patient's medical record.</p>	<p>The Joint Commission's standards for medical record keeping require information identifying the patient and "the name of any legally authorized representative." There is no mention of nor any requirement of the need to elicit and document the identification of the patient's caregiver.</p>

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
<p>Notification of Caregiver if Patient is Being Discharged or Transferred</p>	<p>Although a specific requirement to notify the caregiver is not included, discharge planning must be consistent with patient and family needs, inferring family involvement. In addition, the family receives instruction upon discharge (see below). This would imply some sort of notification of the patient's pending discharge or transfer.</p> <p>33-07-01.1-09. Governing body</p>	<p>It cannot be assumed that the person identified as a family member or legal representative for the purpose of admission notification is the patient's caregiver. Further, the reference to a family member or legal representative is not inclusive of all individuals the patient may want to identify as a caregiver. The CARE Act simply requires the hospital to ask the patient or the patient's representative if s/he would like to designate a caregiver.</p>	<p>While the Joint Commission's standards state that the patient's family should participate in the patient's discharge or transfer, the standards do not specify the role of the patient's caregiver. The Joint Commission's standards state that when the family is involved in decision making or in ongoing care, they must be included in the discharge process. However, the Joint Commission's standards do not recognize that the patient's primary caregiver may not be a family member.</p>
<p>Provide Training of Any After Care Tasks Caregiver Will Need to Perform</p>	<p>Instructions to family members upon discharge are required. Training on after care tasks may be implied but not specified.</p>	<p>The CoPs requires that "as needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.</p> <p>While the CoPs include language for hospitals to provide education and training to caregivers as part of the discharge planning process, the regulation includes a loophole with the language "as needed".</p> <p>This language allows for the hospital to determine when education and training will be provided to caregivers, which allows them the option to opt out from providing education and training to caregivers.</p>	<p>The Joint Commission's standards do not require actual instruction of the caregiver in the continuing care needed.</p> <p>Before the hospital discharges or transfers a patient, it must inform and educate the patient about the type of post-discharge care a patient is going to need.</p> <p>Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need.</p> <p>However, this is clearly not the same as providing instruction or training to the patient's family. And furthermore, the patient's family may or may not include the</p>

7

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
		The CARE Act simply closes the loophole and requires that all caregivers be trained to perform the post-discharge tasks necessary to keep the patient safe.	individual designated as the patient's caregiver. There is no specific mention of providing training to caregivers.

January 4, 2017

House Human Services Committee: Representative Robin Weisz, Chair. Committee members Rohr, Bert Anderson, Dick Anderson, Pamela Anderson, Damschen, Devlin, Kiefert, McWilliams, Porter, Schneider, Seibel, Skroch, Westlind.

I am speaking in favor of **HB No. 1039**

A couple of years ago, I testified in favor of a similar bill by stating "I am entering into a new phase of life as the caregiver to my mother." Well, I am thoroughly established in that role now, and as my mother's cognitive abilities fail, it has become even more important to me and to her that I have plenty of information from her caregivers about how best to maintain her health.

In the past two years, I have attended all of her medical appointments, at first dealing with mysterious, or even slightly hostile, looks from her doctors. Now, the doctors look over her head at me to confirm or explain her statements. I ask doctors to write down information about her care and I take notes in my special "Mom" book. And we are fortunate to have a good deal of help from the nursing staff at the Mandan Edgewood Assisted Living facility where she now lives.

I have been aggressive in questioning doctors and nurses about her health needs and how best to manage her care in her home. I don't care if I offend doctors and other medical professionals (and I have sometimes offended them) with my questions. It is our right to have this information and necessary for continuing health care and recovery. If we were to leave the clinic with inadequate information, we would have to return to Emergency or Walk-in for more help. This can be difficult if my mother is not well.

At 90, my mother has a range of ordinary health issues and has suffered a few broken bones. Good health maintenance will allow her to continue living in assisted care instead of a nursing home and, hopefully, not in a hospital. This is especially important because of her limited financial means.

I have found that there is no way to adequately prepare for the various medical problems and emergencies that we all face as we age. However, the one thing I have learned in the past few years is that I will eventually be sitting in the hospital emergency room again facing something I have never even thought of before. I won't even know what questions to ask. I will be very dependent on hospital staff providing me with necessary information. This bill, if it becomes law, will be exactly what I need to help me manage the next steps of my family's health care.

Thank you for your attention to the needs of families who have to provide care to a loved one. House Bill 1039 will help to remove some of the worry and difficulty for the caregiver and promote better health for the patient.

Barbara Handy-Marchello
Bismarck, North Dakota

Att #3
H.B. 1039
1-4-17

Testimony on HB 1038 and 1039
House Human Services Committee
1/4/2017
Ellen Schafer
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My name is Ellen Schafer and I am a volunteer for AARP. I am here today in support of the Caregiver Act that would ensure that family caregivers are kept informed, provided explanations, and education for tasks the caregiver will be required to provide at home after a loved one is discharged from the hospital. I feel it is very important that family caregivers be able to appropriately perform tasks for their loved ones before they are discharged from a hospital. In the hospital, nurses have 24 hours to ensure that a family member knows how to adequately perform tasks such as monitoring and adjusting one's diabetic medications according to one's glucose results, pain medications, pain pumps, wound care, or caring for a colostomy appliance, or even help with setting up ones medications. This initial education process should begin in the hospital. Learning these cares can often be overwhelming to someone who does not have a medical background. Once a patient is home from the hospital, home health nurses have limited hours in one's home. Usually a home health care visit consists of 3 hours a week for several weeks where they could reinforce the education learned in a hospital and help the patient monitor and adapt care learned from a hospital to one's home environment setting.

I am in support of increased access to respite care to support family caregivers. Family caregivers in North Dakota don't ask for much. They take on huge responsibilities that can be overwhelming, stressful, and exhausting to care for their older parents, spouses, adults and children with disabilities and other loved ones. They do it without compensation and they do it in the patient's home, where an overwhelming number of North Dakotans say they want to remain as long as possible. These dedicated family caregivers need your support. More than 62,000 North Dakotans identify themselves as family caregivers. By caring for their loved ones in their homes, they save the state more than \$860 million by keeping them out of taxpayer-funded nursing homes and from returning to hospital emergency rooms. Caregivers provide care to their loved ones 24 hours a day 7 days a week and often go without a break when no other family members are available. National state and local surveys have shown respite care to be the most frequently

requested service from family caregivers. If one is able to receive help with respite care, they return refreshed and will be able to adequately provide the care their loved ones require.

I would like to share my experience with caring for my mom. Under the family medical leave act, I was able to take 3 months away from my job as a nurse to care for my mom who was dying from cancer. I was more than honored to be able to provide the care my mom needed so that she could stay in her own home. As my mom's disease progressed, I had little relief from my siblings who were not either financially able to take time away from their jobs or they lived over 100 miles from my mom. As my mom grew weaker, I slept on the floor by her side so that if she was up during the night I would hear her moving about and I did not want her to get up and fall. In doing this, I could help her with whatever her needs might have been. I distinctly remember the morning before my mom died. It was about 4am and I was trying to catch a few winks at her feet. It amazed me how little sleep she needed during this time and I was exhausted. My mom sat up and was sitting on the couch. I recall her exact words, "Ellen why won't you sit up and talk to me," and I recall my exact answer to her, "Oh Mom I am so tired." Had I known that these were almost the last words with my mom I would have gladly sat up and talked to her. I recall mom's words too, "Ellen is it supposed to hurt this bad," and I said "no mom" and contacted a hospice nurse to come and start a morphine drip right away. Fortunately for my mom, I was a nurse and knew the medical system and could get her the help she needed. Not every family is fortunate to have a nurse in their family to help care for their loved ones.

4 HB 1039
1-4-17



Vision

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

Mission

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

Testimony: 2017 HB 1039
House Human Services Committee
Representative Robin Weisz, Chairman
January 4, 2017

Good morning Chairman Weisz and Members of the Human Services Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here to testify regarding 2017 House Bill 1039 and ask that you give this bill a **Do Not Pass** recommendation.

While we can appreciate the intent of the bill, it would place additional requirements on hospitals that are unnecessary. All hospitals want to ensure proper care of patients after their discharge and to avoid unnecessary readmissions. These are issues hospitals address every day - and do so effectively.

This bill would require hospitals to establish written discharge policies that must allow a patient to designate an uncompensated caregiver and require documentation of that caregiver. It would mandate that hospitals notify the designated uncompensated caregiver of the patient's discharge or transfer to another facility and that the hospital provide the patient and uncompensated caregiver "instruction and training" for the patient's aftercare before the patient may be discharged.

Our member hospitals oppose this bill for the following reasons:

- It creates additional expense by requiring additional documentation of care to be provided by non-hospital staff in a non-hospital setting after leaving the hospital.
- The bill will require hospitals to hire additional staff. The hospitals already have a shortage of professional staff and hiring additional people will be difficult.

- There are no funds allocated to provide this service. This bill creates an unfunded mandate imposed on the hospitals.
- It will create additional delay in discharging patients because the caregiver must be notified and given instruction and training in how to care for the patient after leaving the hospital. All of this must be done before the patient may be discharged. What if the caregiver isn't responsive to the notification? What if the caregiver must travel for an extended period in order to get to the hospital? What if the caregiver isn't available when the appropriate staff is?

This bill does have language that says a hospital is not required to adopt discharge policies that would delay a patient's discharge or transfer to another facility. It does not say, however, that a hospital is not required to provide the necessary notification or training if it would delay discharge. These two provisions of the bill are at odds with each other. How is a hospital to proceed if the caregiver is not responding in a timely manner? Should it discharge the patient anyway and not fulfill its duty to notify and train the caregiver? Or should it delay the discharge? This puts hospitals in a no win situation.

- The bill also creates a potential violation of the patient's privacy rights because it requires the hospital to notify the uncompensated caregiver. Unless the patient has also signed a HIPAA compliant authorization to release information, the hospital may be disclosing protected health information in violation of state and federal laws governing health information privacy and security. Hospitals will now have to ensure that every patient has signed an appropriation authorization for release of information before it may fulfill its duties under this bill.
- The bill also potentially creates additional liability for the hospitals. We have no control of the care that would be provided by the uncompensated caregiver to the patient after discharge. The hospital, however, is required to provide instruction and training to the uncompensated caregiver regarding how to provide aftercare for the patient. What if the uncompensated caregiver misunderstands or forgets the instructions? What if the care is performed poorly and harms the patient? Is the hospital responsible for failing to ensure the uncompensated caregiver sufficiently understood the discharge plan? Although the bill contains a vague immunity from liability provision, even if it is enforceable, hospitals will still undoubtedly be sued and will incur costs in defending themselves.
- Lastly, and probably most importantly, we are not aware of any problems or issues regarding the current method of discharge planning hospitals now offer. Hospitals have licensing and accreditation requirements they must abide by in their discharge practices.

And hospitals do work with referring facilities and families on the coordination of care upon discharge. This bill adds no further benefit to patients while creating a burdensome unfunded mandate on hospitals.

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

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,
Jerry E. Jurena, President
North Dakota Hospital Association

HB 1039 AH 5
1-4-17

January 4, 2017

House Human Service Committee

Testimony Regarding HB 1039

Dan Hannaher, Health Policy Consortium

Chairman Weisz, and members of the House Human Services Committee, my name is Dan Hannaher. I am Executive Director of the Health Policy Consortium.

I appreciate this opportunity to speak to you briefly about House Bill 1039 regarding Aftercare and hospital discharge policies. During the 64th Legislative session HB 1279 was considered and defeated, I believe because it was considered redundant and duplicative to standards and practices already being followed by hospitals. During the interim the Human Services Interim Committee continued to consider a number of issues related to caregiving, including hospital discharge policy. We constructively participated in those efforts, and indeed the bill you have before you is clearly less onerous than what had been previously debated.

Despite the language improvements, however, it is our position that this bill is still unnecessary and duplicative. Any hospital that wishes to participate in the federal Medicare program is required to have written discharge policies. That means every hospital in North Dakota. The standards and processes around Discharge Planning and Patient Rights are thorough and detailed.

The Centers for Medicare and Medicaid Services (CMS) through their Conditions of Participation (CoP) establish rules around Discharge Planning, as does the Joint Commission's Standards for Accreditation (TJC).

CMS regulations for Hospital Discharge Planning include:

- Patients have a written discharge plan developed.
- Patients have specific discharge instructions provided in writing.
- Patient goals and preferences for discharge are taken into account.
- Patient caregivers are active partners in the discharge plan.

- Hospitals consider the availability and capability of the caregiver to provide home care.
- Discharge planning begins within 24 hours of admission.
- Discharge Planning Process is completed prior to discharge.
- Discharge instructions are presented in a way that the patient and caregiver can understand.

All of these requirements must be documented in the patient medical record.

Beyond the CMS and Joint Commission, the North Dakota Department of Health also provides rules for hospital licensing. (Chapter 33-07-01.1):

“Every patient must receive effective discharge planning consistent with identified Patient and family needs from the hospital. Discharge planning must be initiated in a timely manner. Patients, along with necessary medical information, must be transferred or referred to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.”

The Dept. of Health also provides as a resource a Survey Protocol of Regulations and Interpretive Guidelines for Hospitals which reflect again the rules established by CMS.

Mr. Chairman and members of the committee. We are appreciative of efforts to quantify and resolve issues related to caregiving, both inside and outside the hospital setting. We recognize that with the thousands of patients cared for in North Dakota everyday problems can and do occur. Despite all our human efforts, mistakes happen. That’s why we have rules and regulations to guide the work performed in our facilities.

The problem is, Mr. Chairman, we already have all these rules in place. We respectfully oppose this legislation. It’s not needed.

I’m happy to try and answer any questions. Thank you.

AH1

Testimony
House Bill 1039 – Erica Cermak, on behalf of the Alzheimer’s Association, ND/MN
Chapter
House Human Services Committee
Representative Robin Weisz, Chairman
January 4, 2017

Chairman Weisz and members of the Committee, my name is Erica Cermak, I am the Government Affairs Representative for the ND/MN Chapter of the Alzheimer’s Association. I’m writing today to encourage your consideration of House Bill 1039, which will help North Dakota Seniors remain in their homes by ensuring ND Seniors and their Caregivers have access to resources and education for at home care upon discharge from a hospital setting.

In ND alone, 14,000 North Dakotans age 65 and older are living with Alzheimer’s Disease, an estimated 30,000 people caring for those with Alzheimer’s or Dementia and an estimated 62,000 caregivers providing care to North Dakotans statewide. For persons with Alzheimer’s or Dementia, the caregiver systems an individual has in place to manage their disease contribute significantly to reducing their risk of ER visits, hospital visits and helps ensure better medication management. House Bill 1039 would help ensure ND senior citizens remain in their homes by requiring that upon discharge from a hospital facility, the patient and their caregivers are informed of the discharge plans, designated caregivers are notified when a loved one is admitted to a hospital and ensure the designated caregiver is prepared to provide medical tasks the caregiver will perform at home.

North Dakota facilities maintain a high standard of care and do have systems in place to assist families with at home care after discharge. However, there is sometimes a disconnect between the family and the facility. In fact, according to the 2016 NDSU Family Caregiver Support study, nearly half of the caregivers surveyed indicated they felt they did not get the instruction or training needed to perform at home tasks prior to discharge of their loved one (<https://www.ag.ndsu.edu/aging/documents/nd-family-caregiver-supports-and-services-study>).

The ND/MN Chapter of the Alzheimer’s Association believes the bill before this committee provides a reasonable, responsible, and achievable solution to help ensure ND Seniors are properly cared for and their Caregivers are prepared to help facilitate that care upon discharge from a hospital. We ask this committee for favorable consideration of House Bill 1039.

Thank you Chairman Weisz and members of the committee for the opportunity to provide testimony to you. Please feel free to contact me directly if you have any questions.

Erica Cermak, Government Affairs Representative, ND/MN Chapter, Alzheimer’s Association.

HB 1039
#1
3/15



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Testimony: 2017 HB 1039
Senate Human Services Committee
Senator Judy Lee, Chairman
March 15, 2017

Good morning Chairman Lee and Members of the Senate Human Services Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here to testify regarding 2017 Engrossed House Bill 1039 and ask that you give this bill a **Do Pass** recommendation.

The House amendments to the bill provide that when discharging patients, hospitals must adhere to the requirements established by the federal government in the Medicare and Medicaid Conditions of Participation. Hospitals want to ensure proper care of patients after discharge and avoid unnecessary readmissions and they do already work with referring facilities and families on the coordination of care upon discharge. These are issues hospitals have been addressing every day effectively without the need for a state law to reiterate what is already mandated by these federal requirements.

We support the engrossed bill and ask that you give it a **Do Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,
Jerry E. Jurena, President
North Dakota Hospital Association

HB 1039
2
3/15
Pg. 1



North Dakota

March 15, 2017
Senate Human Services Committee
HB 1039
Josh Askvig
jaskvig@aarp.org or 701-989-0129

Chair Lee and members of the Senate Human Services Committee, for the record my name is Josh Askvig, State Director, AARP North Dakota. We appreciate the opportunity to offer comments today on HB 1039.

You have heard the story about AARP's founder, Dr. Ethel Percy Andrus, the retired teacher turned advocate. We'd like reiterate her commitment to the health and financial security of all Americans, especially the 50+. Her spirit is in all of us as we continue the work of AARP. Again, we are a nonprofit, nonpartisan organization with a current membership in North Dakota of approximately 87,000. Nationwide, we have nearly 38 million members. We hear from our members every day – about their dreams to live longer, healthier and fulfilled lives.

One of the things we continue to hear from our members in North Dakota is the work they do as caregivers for their loved ones. Through our research we know that there are approximately **62,100 individual caregivers in North Dakota that provide over 58 million hours of uncompensated care valued at over \$860 million.** In recent years, the role of family caregivers has greatly expanded from coordinating and providing personal care and household chores to include medical or nursing tasks such as wound care and injections.

We know that family members have been taking care of each other forever, but we also know how we live today is dramatically different than it was even 20 years ago. We're living longer – and because of that our health care needs are changing. Health care issues can be difficult physically and emotionally on both the patient and the caregiver. Plus, understanding medication and therapy is complex.

That is why AARP began exploring ways to assist these family caregivers to best support them. AARP came up with a no state dollar cost policy proposal that asks hospitals to do a few things to make the transition of patients, and the people THEY identify as the

1039
#2
3/15
Pg. 2

person who will be taking care of them at home, a little easier. That is what we call the CARE Act. HB 1039 is NOT the CARE Act.

I want to step back a second and explain how we got here just so we are all on the same page. Last session, the legislature, because of this committee's wisdom passed a study on family caregiver supports. The study was done by the Interim Human Services Committee, which forwarded two bills, HB 1038 and HB 1039. HB 1039 as originally introduced WAS the CARE Act.

As you may recall, this committee passed a version of the CARE Act (SB 2215). The CARE Act looks to close the loopholes in existing rules and procedures that govern hospital discharge. As a refresher, I have again attached the chart that shows the loopholes that exist in current regulations that the CARE Act seeks to close.

HB 1039 as amended does NOT do that. It simply restates that the existing rules apply. That is NOT what we want to happen. Let me be clear, we think hospitals in North Dakota provide good care, but we do know they have gaps in their rules that should be tightened up to prevent more individuals from slipping through them. The latest argument we have heard from hospitals against the CARE Act it is not needed because it is duplicative but they seem unconcerned about duplication in this bill.

Chair Lee, members of the committee that brings me to my point, this bill in its current form is a bad bill. It confuses the issue at hand, and does nothing to address the finding from our 2016 phone survey that 1 in 3 caregivers doing medical or nursing tasks did NOT get the instruction or demonstration they wanted and say they needed.

We suggest two options for HB 1039. Option 1 is to amend the bill back to its original form and pass the CARE Act again. Option 2 is to give it a DO NOT Pass and kill the bill. Let me be clear, AARP does NOT support the bill in its current form and could not support it unless it addresses the loopholes in the existing rules.

Thank you and I would be happy to answer any questions.

NORTH DAKOTA CARE ACT COMPARISON TO STATE AND FEDERAL REGULATIONS

All of these regulations are found in North Dakota Century Code and Administrative Rules. They are all part of Chapter 33-07-01.1 North Dakota Licensing Rules for Hospitals. Access to Regulations is through North Dakota Department of Health; Health Facilities:

http://www.ndhealth.gov/hf/North_Dakota_Hospitals_Critical_access.htm. Upon entering the website navigate to the appropriate regulation through the menu links.

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
<p>Identification of Family Caregiver and Including him/her in Patient Record</p>	<p>No requirement for identification of the family caregiver or including the information in the patient record</p> <p>33-07-01.1-20. Medical records services.</p>	<p>Hospitals and state hospital associations may claim that they currently perform the tasks outlined in the CARE Act (i.e., identification of the caregiver in the medical record, notifying the caregiver of a transfer or discharge, and providing instructions for the caregiver to perform post-discharge medical tasks).</p> <p>While the CoPs include requirements for patient's rights and discharge planning, the federal regulations and State Operations Manual that provides interpretive guidelines of the regulations do not include the specific provisions of the CARE Act.</p> <p>While the CoPs require the hospital to notify a family member or representative of the patient's admission into a hospital, the CoPs do not require the hospital to provide the patient an opportunity to designate a caregiver or for the information to be added to the patient's medical record.</p>	<p>The Joint Commission's standards for medical record keeping require information identifying the patient and "the name of any legally authorized representative." There is no mention of nor any requirement of the need to elicit and document the identification of the patient's caregiver.</p>

1039
#2
3/5
Pg. 3

1039
#2
3/15
PA.4

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
<p>Notification of Caregiver if Patient is Being Discharged or Transferred</p>	<p>Although a specific requirement to notify the caregiver is not included, discharge planning must be consistent with patient and family needs, inferring family involvement. In addition, the family receives instruction upon discharge (see below). This would imply some sort of notification of the patient's pending discharge or transfer.</p> <p>33-07-01.1-09. Governing body</p>	<p>It cannot be assumed that the person identified as a family member or legal representative for the purpose of admission notification is the patient's caregiver. Further, the reference to a family member or legal representative is not inclusive of all individuals the patient may want to identify as a caregiver. The CARE Act simply requires the hospital to ask the patient or the patient's representative if s/he would like to designate a caregiver.</p>	<p>While the Joint Commission's standards state that the patient's family should participate in the patient's discharge or transfer, the standards do not specify the role of the patient's caregiver.</p> <p>The Joint Commission's standards state that when the family is involved in decision making or in ongoing care, they must be included in the discharge process. However, the Joint Commission's standards do not recognize that the patient's primary caregiver may not be a family member.</p>
<p>Provide Training of Any After Care Tasks Caregiver Will Need to Perform</p>	<p>Instructions to family members upon discharge are required. Training on after care tasks may be implied but not specified.</p>	<p>The CoPs requires that "as needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.</p> <p>While the CoPs include language for hospitals to provide education and training to caregivers as part of the discharge planning process, the regulation includes a loophole with the language "as needed".</p> <p>This language allows for the hospital to determine when education and training will be provided to caregivers, which allows them the option to opt out from providing education and training to caregivers.</p>	<p>The Joint Commission's standards do not require actual instruction of the caregiver in the continuing care needed.</p> <p>Before the hospital discharges or transfers a patient, it must inform and educate the patient about the type of post-discharge care a patient is going to need.</p> <p>Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need.</p> <p>However, this is clearly not the same as providing instruction or training to the patient's family. And furthermore, the patient's family may or may not include the</p>

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
		The CARE Act simply closes the loophole and requires that all caregivers be trained to perform the post-discharge tasks necessary to keep the patient safe.	individual designated as the patient's caregiver. There is no specific mention of providing training to caregivers.

1039
#2
3/15
Pg. 5