2017 SENATE HUMAN SERVICES

SB 2215

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2215
1/24/2017
Job Number 27266

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A bill relating to hospital discharge policies.

Minutes:

Attachments 1-8

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

Senator Poolman, District 7: (1:09-2:15) **See Attachment #1** for testimony to introduce the bill and provided in favor of the bill.

Josh Askvig, Director, AARP of North Dakota: (3:30-9:15) **See attachment #2** for testimony in favor of the bill.

Senator Anderson: You have this person designated in the chart as the family caregiver but yet If they don't execute a release and sign that paperwork, they are still not going to get any information, is that correct?

Josh Askvig: That is correct, they would have to comply with all of the normal federal HIPAA regulations and privacy regulations.

Josh Askvig: (10:03-21:35) Resumed testimony.

Mike Chaussee, Advocacy Director, AARP of North Dakota: (23:30-27:50) **See Attachment #3** for testimony in support of the bill. (27:55-28:40 personal story about parents.)

Dianne Billey, AARP Executive Council: (30:00-34:45) **See attachment #4** for testimony in support of the bill. (Provided testimony from Barbara Handy-Marchello **See attachment #5**.)

Ellen Schaffer, Volunteer, AARP: (36:25-38:55) Testified in favor of the bill. I am a retired nurse and I have done both hospital and home health nursing. I can testify that yes hospitals may already have discharge plans in place. I need more than two hands to account for discharge medications that may not be correct when a patient gets home from the hospital. In that case the home healthcare nurse then has to do what we call a medication reconciliation. We have to contact the doctor to make sure the medication they are taking is correct. (Gave an example from family diabetic (37:15-38:25)). Those opposed to this bill will say that they already have discharge plans in place, and if so how does something like this happen to a family. It is why this bill is so important to designate the family caregiver and make sure they know what there is to do when they get home.

Moira Solberg, Director, Volunteer Caregivers for the Elderly: (39:30-43:15) **See Attachment #6** for testimony in support of the bill.

Chair J. Lee: I do not think it is entirely fair to suggest that the larger health operations are not responsible about their patients.

Moira Solberg: I am not saying that but they are so afraid of the liability of it that they are not making it always. This doesn't happen every case but if I am in a situation and I have a hospitalist and I tell the doctor that he can't hear the doctor doesn't like me anymore. I am just a layperson in their eyes. It is hard sometimes because they can shut the caregiver down.

Senator Anderson: How do you think this bill solves the problem you just described?

Moira Solberg: It does to a degree that now I have some importance, and I'm the one that is their link between them going home and the one who is probably going to take them to their follow-up visit. I am the one transporting them. This would at least give me a legitimacy.

Vice Chair Larsen: Is there only one caregiver designated to the hospital or can there be multiple caregivers per patient?

Moira Solberg: In our situation, I am the director of the program but I may have a volunteer who is the one for a particular person. Usually that person has friended the family. Children will call the one person. Generally, it is just one person. 99% of the time it's not about snoopy kids, it's about concerned kids. I always encourage the children to call the nurses station. I am not a medical person. As a volunteer, I'm not going to give them medical instruction.

Chair J. Lee: Even the nurses station shouldn't be giving them information if the patient does not want that. Asked for testimony in opposition.

Jerry Juenera, President, North Dakota Hospital Association: (48:00-52:45) **See Attachment #7** for testimony in opposition to the bill.

Chair J. Lee: Recognizing the necessity of the HIPAA release, why couldn't that be on the same form as the one where someone is designated their caregiver would be. Doesn't seem that it is duplicative if there is going to be HIPAA at the same time.

Jerry Juenera: We could create a form that would include all of that.

Chair J. Lee: No further testimony was present and closed the hearing on SB 2215.

Attachment #8(online newspaper article) provided after the hearing.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2215
1/24/2017
Job Number 27316

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A bill relating to hospital discharge policies.

Minutes:

No Attachments

Chair J. Lee: Brought the meeting to order and opened SB 2215 for committee discussion.

(1:15) Senator Anderson: I don't like adding a bunch more things to what the hospitals are required to do on discharge. Most of the things that we heard about are misinformation or they were not told when they should have been told. I'm not sure this solves those issues. For Example, someone talks about they did not know the side effects of morphine – the doctor should have told them that and so should the pharmacist when they got that dispensed to them. Apparently they didn't catch it. You usually get a booklet with instructions when you go in for a procedure and if you don't read it you might not know about what might happen afterward. Every hospital right now criteria goes out discharge, and comes back, to take care of them for free. I'm not crazy about adding more regulations to that.

Vice Chair Larsen: is this the disconnect though that when the caregiver is trying to help out the person and then they go back or call the doctor with a question and they are told they are not the caregiver and they can't give them information. Or, you are not the person who is the designated one.

Senator Anderson: I asked that question and they have to have the form filled out regardless of whether they are the designated caregiver or not. So if the patient fills out the form that says they have permission it doesn't make any difference whether you are the designated caregiver or not.

Senator Clemens: What is AARP's interest in this? They seem like they're on a mission to get this accomplished.

Chair J. Lee: Because they are representing people who are caregivers all over the state in large numbers. There are a ton of uncompensated caregivers in the state. And if we have not been in that situation we will be someday. Their point is that there are folks who are struggling to keep up and in a lot of cases it is an older spouse or it might be an adult child that is balancing a lot of things. I am sympathetic to the situation but I don't know if all of them are doing the discharge reporting as consistently as some. There is no way to know that.

Senator Kreun: A caregiver does not mean that if they are the executor of the state and it does not mean they are the healthcare director. So, can that caregiver even get the information when they are picking up that individual if they have not contact.

Chair J. Lee: They can, under this bill, if they are designated as the caregiver, but the patient the one to determine whether that access is given.

Senator Kreun: What qualifications does this caregiver have?

Chair J. Lee: They don't even have to be. It could be anybody but the person has to be designating that individual.

Senator Kreun: Who's to say that that individual is going to understand anything that hospital tells them? There is no guarantee that person can go there and understand what they are doing so my point then is, is this bill applicable. There's no guarantee with or without this bill.

(7:05) Senator Anderson: I don't mean to denigrate the work or the duty of the uncompensated caregiver; my question is if a bill like this really helps the situation any. The hospital gives me all the info I need on discharge. I am not sure they are going to give me any more information because we pass this bill. We heard the one instance where the old guy designated his wife as the person they should contact. How does that help if the wife can't remember?

V-Chair Larsen: I think the caregivers are thinking that the bill will give them authority or recognition that is who they are.

Senator Heckaman: I think it is going to be important in lots of communities' given the fact that our population is so mobile now and we don't live like we used to. There are many people in my community that have no family in the area and they don't want to move to a larger community where that family is. So as a result, neighbor takes care of neighbor and I think that is where this will be beneficial. That neighbor can go to the hospital and they can be the designated caregiver and they can understand those directions. A lady in my community tried to get out of the hospital and being on so many meds that she couldn't keep things straight and she needed someone to help since she had no family around. This has some benefit in those cases. (Gave a personal experience where she could not get information for her husband even though she is the primary policy holder and had to sign a document first.) This makes it clear that there are many people in North Dakota that don't have an opportunity to have someone already signed on.

Senator Anderson: On the story you just told, if that hospital didn't have you listed then they are not going to tell you that stuff.

Senator Heckaman: This was the insurance company. On my policy, it lists my name as primary and he is on there as my spouse.

Senator Kreun: I have had the health directive of a friend of mine as well as the power of attorney and if you don't have those things in place prior to, whether you are a caregiver or not, you are not going to get the information. Unless you have signed documents, you are not going to get it. I couldn't even get meds for my wife. They didn't care. You've got to do that stuff ahead of time. The people we're talking about won't have that done ahead of time.

Vice Chair Larsen: Moved a Do Pass.

Senator Heckaman: Seconded.

A Roll Call Vote Was Taken: 4 yeas, 3 nays, 0 absent.

Motion carried.

Senator Larsen will carry the bill.

Date: 1/24 2017

Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2215

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 Larsen Seconded By Sen Heckaman

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) 4 No 3

Absent 0

Floor Assignment Sen. Larsen

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

REPORT OF STANDING COMMITTEE

SB 2215: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (4 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). SB 2215 was placed on the Eleventh order on the calendar.

2017 HOUSE HUMAN SERVICES

SB 2215

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2215
3/13/2017
29127

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Carmen Hart

Explanation or reason for introduction of bill/resolution:

Relating to hospital discharge policies.

Minutes:	1, 2, 3, 3A, 4, 5, 6

Chairman Weisz called the committee to order and opened the hearing on SB 2215.

Nicole Poolman appeared in support. (Attachment 1) (:01:32-:02:22) This weekend my grandfather was discharged from the hospital with a chest tube that has to be drained every other day. There is no one there to do this since both of my grandparents are in their 90s. Now my father has to drive an hour each way every other day to provide this care.

Chairman Weisz: Are there any questions from the committee?

Representative Schneider: think that we heard that this was already being done when it was heard in the house.

N. Poolman: I have heard that too, but 1 in 3 still are not getting the training they need.

Representative Westlind: What kind of liability issues did you address?

N. Poolman: If the hospital trains the caregiver and the care giver doesn't do it correctly, the hospital cannot be held liable.

Representative D. Anderson: Are the uncompensated caregivers going to have liability issues then?

N. Poolman: I don't know.

Representative Damschen: Did you ever contact the hospital to see why?

N. Poolman: Yes, and the doctor said that he should have never have been sent home with the tube in place with no one to care for it.

Representative Westlind: We are already doing this in the hospital in our community, and to me, this is duplication and would just add more paperwork.

N. Poolman: I don't know if they have policies in place. I know that the doctor thought that someone administratively was doing this and offering a consultation, and the consultation did not occur.

Representative McWilliams: If this bill was enacted, was it possible that this could have happened anyway?

N. Poolman: I think any policy could be missed or ignored.

Chairman Weisz: Further questions from the committee? Further testimony in support of SB 2215?

Josh Askvig, State Director of AARP, appeared in support. (Attachment 2) (:08:03-28:54)

Chairman Weisz: (:29:00) Are there any questions from the committee?

Representative Porter: Inside of your survey did you ask for the names of facilities that are not doing this?

J. Askvig: I don't think that we did that. The people that are following me in testifying will give you more examples.

Representative McWilliams: For hospitals that are currently doing this, what does this bill do?

J. Askvig: If they are already doing it, there should not be many changes at all. We are just trying to close the loop holes.

Representative Porter: Based on the response to Representative McWilliams, how do you see this bill different than the one we had in the house as HB 1039?

J. Askvig: HB 1039 still leaves the loop holes in place. We are trying to close the loop holes.

Representative Skroch: Why are we seeing two bills that are almost the same?

J. Askvig: We did not like HB 1039 and urged you to vote against it because of the loop holes that were left in it. HB 1039 does not offer the liability protection for the hospitals.

Representative Skroch: In your survey you list all kinds of concerns of caregivers? How does this bill make that better?

J. Askvig: It is to make you aware that they are working hard and do experience stress and financial strain. I have a family caregiver that I know of in ND that was given discharge instructions to care for after a surgery. It was never clearly stipulated what materials she was to use and how that bandage should be replaced to prevent infections, so she went out and bought a lot of materials that was opened and about to use, and then found out she had a nurse friend that lived next door. Her nurse friend told her not to use those materials, because they could actually end up creating or increasing infection. Therefore, she had to buy new materials.

Representative McWilliams: Why include $860 million of uncompensated caregivers?

J. Askvig: That is what it would cost the state for someone to be paid to do whatever these caregivers are doing.

Representative McWilliams: I am not sure how you quantify the care that families should be doing this. Parents give a million dollars of care to children, and they are not compensated either. It is just something they do as parents.

J. Askvig: That is what we know based off of our research. There are situations where family members don't do it.

Representative Damschen: This still requires the volunteers. I wonder if the people that were surveyed realized that they were not automatically going to get a caregiver?

J. Askvig: If you are making an amendment to pay every caregiver, we would support it for sure, but I don't think you are doing that. This is about the ones that are helping their loved ones at home and that they receive the kind of training they need to receive to be able to do this correctly.

Representative Damschen: The people that contacted me seemed to understand that this bill would automatically give a caregiver for those who needed one. We really are not doing anything except putting into code something we are already doing.

J. Askvig: I agree with you on everything except the last thing you said. There are loop holes that this bill addresses.

Representative P. Anderson: Is there any information about readmission to the hospitals for more training?

J. Askvig: There is. I don't have the figures in front of me in terms of readmission. One of the goals is to lower readmissions.

Representative Schneider: I had a couple of caregivers that said they had not been given the instructions they needed, so they took their loved one back to the emergency room for more training or help, but I suppose that would not be considered a readmission to the hospital.

J. Askvig: I would bet that it wasn't necessarily an expense for the patient or hospital either.

Dianne Billey, volunteer on the AARP Executive Council, appeared in support. (Attachment 3) (:46:38-:51:53)

Chairman Weisz: Are there any questions?

Chairman Weisz: Is there further testimony in support of SB 2215?

Ellen Schafer, volunteer for AARP, appeared in support. (Attachment 4) (:52:07-:54:36)

Chairman Weisz: Are there any questions from the committee?

Chairman Weisz: Is there further testimony in support of SB 2215?

Chairman Weisz: Is there any support in opposition to SB 2215?

Jerry Jurena, Pres. of the ND Hospital Association, appeared in opposition. (Attachment 5) (:55:57-1:02:00) Over the last week or so I have been approached on several occasions, and I do not hate caregivers! I am not anti AARP. However, why do we need a state law to address something that is already addressed by the federal and accreditation guidelines?

Representative Damschen: We have heard some issues where things were done or not done by caregivers. Does this bill address all of that?

J. Jurena: From what I see, we are going to continue doing what we are already doing. We are providing education to the caregiver and the patient when they leave the hospital. I see nothing in the bill that is going to insure the understanding of the patient on the other side.

Representative Devlin: Do you think the amendments made the bill better, or it had no impact?

J. Jurena: No, I don't see anything that will make any difference. I asked 3 lawyers, and they said there is nothing in this law that will stop them from being sued.

Representative McWilliams: Does this bill do anything above and beyond what is already required in Medicare and Medicaid?

J. Jurena: From my prospective, no.

Representative Schneider: What is being proposed in the amendment does give you a clear definition of the liability.

J. Jureau: You can be sued by anyone for anything. I don't think this would help you not be held liable.

Representative Schneider: That would definitely not be my opinion. If you had to suggest some other language, what would it be?

J. Jureau: I see those amendments, but I can't answer what the lawyers would tell us one way or another. Being sued several times and held liable for cases that we thought there was no way we would be held liable, I don't see that language helping.

Dan Hannaher, Health Policy Consortium, appeared in opposition. I am going to introduce someone, but I want to say something before I do that. We are trying to make sure that the people are assigned a case manager before they are taken out of the hospital. I am introducing Dr. Chris Meeker. (1:08:08:-1:10:56)

Dr. Chris Meeker, Chief Medical Officer at Sanford Health, Bismarck, appeared in opposition. (Attachment 6) (1:11:16-1:14:07) I also brought the policies for discharge from Sanford Health. It is a 5-page document that I can give out copies if anyone would like to see it. One point in the policy is that the patient has the right to be active and participate in the development of their discharge plan of care. Upon admission, the nurse assesses the patient for the following and documents on the Admission Navigator: prior living situation, risk factors related to past medical history, prior level of functioning, home and family, preference for religion, nutrition, concerns or fears related to present admission, abuse and/or neglect, financial concerns, advance directive, and high risk assessment. The case manager/social worker reviews the patient's prior living situation, availability of caregivers, prior use of adaptive equipment, insurance source, current services or anticipated discharge services, and the patient and family goals for discharge. As you can see, the bill in questions does not add much to what we already have in place.

Chairman Weisz: Are there any questions from the committee?

Representative Schneider: You were here when the AARP testified, and I am wondering if you disagree with the gaps that were noted?

Dr. Meeker: I don't disagree with them, but I don't think adding this to ND Century Code is going to change anything.

Representative Schneider: I am seeing several things that you are not doing now.

Dr. Meeker: We are going to do everything we can to make sure that you are able to go home and not have to be readmitted to the hospital.

Representative Schneider: I don't understand why you are in opposition to this then. We often have duplication in federal and state guidelines, and I don't understand why you are against closing those gaps.

Dr. Meeker: I just don't think that making it a law will change poor medical care, and that is really what those gaps are. This doesn't exclude observation patients from inpatient patients.

Representative Schneider: One of these things this would add to this is huge. One of the amendments that you don't have right now is protection from liability.

Dr. Meeker: I am not aware of any liability protection. Right now our attorneys said that our liability would be covered with our regular liability insurance.

Representative Schneider: Thank you.

Representative McWilliams: With the Medicaid and Medicare policies that are in place, is there some kind of oversight to whether the hospitals are doing this?

Dr. Meeker: There are penalties for bad discharge policies. There are a number of ways CMS can penalize you for this.

Representative Damschen: Back to Sen. Poolman's example, how would your discharge policy have addressed that?

Dr. Meeker: I do not have enough information about that situation, but we would do as much as we can to make sure the caregivers have as much training as they can have.

Representative Skroch: In your regulations you have that hospitals consider the availability and capability of the caregiver to provide home care. How would hospitals be able to insure that someone would be able to do appropriate care of the patients?

Dr. Meeker: You need to assess the educational level of the people you are training.

Representative Skroch: Have you ever had any legal action because of things that did or didn't happen at home?

Dr. Meeker: I can honestly say I have never seen that.

Representative McWilliams: When a hospital is using telehealth, would having the name of the caregiver in their medical record be beneficial to somebody on the other end of telecare helping that patient?

Dr. Meeker: ND has not gotten to that level yet. We don't have a secure way of getting information out there on a secure server.

Representative McWilliams: If the home caregiver has a problem that they think there is an infection starting, can they call the hospital and talk to someone that could help them even if their name is not on the records?

Dr. Meeker: Yes, they would be given information to assist them in the care of the situation. That would not be a HIPPA violation, because you are not giving personal information.

Representative P. Anderson: In Minnesota they passed this legislation. Are you aware of the difference between this bill and what Minnesota has? Another question was asked, but could not hear because her microphone was not on.

J. Askvig, State Director of AARP, appeared. I am aware of the differences. Their legislation is more stringent in terms of timelines and other things that have been criticized about it. Hospital support has varied widely across the country in terms of how much opposition, to neutral, to support of a version of this bill. In the interim we looked at 25 versions that had passed, and this was the version that at that point the hospitals said would probably fit best for ND. The version in front of you isn't our preferred version, but we are happy to accommodate it just as we said. Chairman Weisz closed the hearing.

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2215
3/21/2017
SB 29534

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Carmen Hart

Explanation or reason for introduction of bill/resolution:

Relating to hospital discharge policies.

Minutes:	1, 2

Chairman Weisz called the committee to order and opened the discussion on SB 2215. This is the same bill that we had in the House which was killed in the Senate a couple of days ago.

Representative P. Anderson: You heard me talk about Minnesota. My daughter has been a hospitalist in Minnesota for 9 years. She said their CARE bill went into effect January 1, 2017, and she said it hasn't affected their discharge policy at all. They were testifying that it was a non-event. I have to vote for this bill based upon constituent requests.

Representative McWilliams: I move for a do not pass on SB 2215.

Representative Skroch: Second.

Representative Westlind: I have a sheet from the hospital in Cando, and they start immediately getting all the information they need and they are trained in the hospital. These procedures that are in 2215 are already in place in our hospital. I would have to vote for a do not pass.

Chairman Weisz: I am handing out a copy of the Sanford discharge policy that we had requested before. (Attachment 1)

Representative Westlind: I have a copy of our discharge plan from our hospital. (Attachment 2)

Vice Chairman Rohr: Mr. Chairman, are you struggling with this bill?

Chairman Weisz: I am disappointed that the Senate killed the House one.

Vice Chairman Rohr: I would have trouble supporting this as well. I worked as an administrator, and we did this. We developed policies and implemented them, etc.

Representative Skroch: I fear for people that do things wrong and then come back and say that it was the hospital's fault for lawsuits.

Vice Chairman Rohr: The hospitals are incentivized to make sure that these people are given appropriate discharge instructions, because they won't be paid by Medicare if they continually show that readmission rates are elevated for certain diagnoses.

Representative Skroch: Anything that is trying to be accomplished in this bill can already be done. I honestly don't see a need.

A roll call vote was taken. 12 Yeas, 1 Nay, 1 Absent.

Representative Westlind will carry the bill.

Date: 3/21/17
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2215

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. McWilliam Seconded By Skroch

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson		✓
Vice Chairman Rohr	✓		Rep. Schneider	absent	
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 1

Absent 1

Floor Assignment Westlind

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

REPORT OF STANDING COMMITTEE

SB 2215: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (12 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). SB 2215 was placed on the Fourteenth order on the calendar.

2017 TESTIMONY

SB 2215

SB 2215
Attach #1
1/24

SB 2215
Testimony to Senate Human Services

Madam chair and members of the committee, my name is Nicole Poolman, state senator from District 7 representing Bismarck and Lincoln. SB 2215 was put forward by the interim Human Services committee after studying caregivers in North Dakota. It encourages hospitals to provide adequate training for family caregivers before a patient leaves the hospital.

The bill ensures that hospitals will:
*Ask patients if they want to appoint a family caregiver
*Record the family caregiver in the medical record
*Notify the family caregiver when the patient is to be discharged from the hospital
*Show the family caregiver how to provide medical tasks they'll be asked to provide at home

With proper training, family members can provide the appropriate level of care to keep a patient at home. With over 62,000 caregivers in North Dakota providing over 58 million hours of unpaid care annually, this not only provides a safe environment for the patient, it makes a difference to North Dakota's bottom line.

SB 2215
Attach #2
1/24

AARP® Real Possibilities in

North Dakota

January 23, 2017
Senate Human Services Committee
SB 2215- DO PASS
Josh Askvig
jaskvig@aarp.org or 701-989-0129

Chair Lee, members of the Senate Human Services Committee, I am Josh Askvig, State 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. We stand in support of SB 2215

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. Nationwide, we have nearly 38 million members. We hear from our members every day – about their dreams to live longer, healthier and fulfilled lives.

AARP has been raising the profile of family caregivers in North Dakota and across the country. 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. For the individuals doing this work in North Dakota it is a labor of love, but it comes with stress, burnout and often times at a cost to their own health and financial stability. Providing support for these caregivers is critical toward ensuring that individuals can safely stay in their homes as they age. Our loved ones can remain independent at home with caregiver support.

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.

2215
#2
1/24

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 policy proposal that 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.
Let me walk you through the bill:

Page 1, Lines 6-16- this part of the bill provides definitions to ensure clarity in the remainder of the bill. Specifically, it outlines what constitutes an aftercare task, most importantly including those complex medical or nursing tasks outlined above. Also, it provides a definition of discharge to clearly stipulate when the aftercare instructions would be provided. Last, it provides a clear definition of who is considered a caregiver for the purposes of the bill.

Page 1, Lines 17-24 AND Page 2, lines 1-11- This is the meat of the bill. This part of the bill ensures:

1. Hospitals ask patients if they would like to designate someone as an "uncompensated caregiver" (subsection "b.") – we believe most often that is a family member which is why AARP refers to these individuals as family caregivers most often. However, as stated in the definition it does NOT require them to be a family member, an important distinction we will discuss later in how the CARE Act differs from the rules hospitals already follow.
2. 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 (subsection "c."). This is an important piece of the bill. It recognizes the caregiver as an important component of keeping the patient safe and ability to heal when they leave the hospital. It also ensures the hospital knows who will be providing care when the patient leaves the hospital. Also, it ensures that the patient's caregiver is recognized in the medical record by the hospital to share at the most critical times for the patient. A quick note, this bill does nothing to change federal privacy rights or HIPPA regulations. These regulations and information release proceedures would all still need to be met and followed.
3. Because we've identified the importance of the role of the caregiver, the bill also ensures hospitals to let the family caregiver know when the patient is to be discharged – whether the patient is going home or being transferred to another facility (subsection "d."). Again, this bill does nothing to change federal privacy rights or HIPPA regulations. They would all still need to be met and followed.

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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 show the caregiver how to do what he or she is being asked to do (subsections "e." and "f."). 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.
5. The last part just ensures that the discharge instructions get recorded in the medical chart (subsection "g.").

Page 2, Lines 7-11 – This part of the bill ensures that hospitals use national standards and federal regulations.

Page 2, Lines 12-22 – This piece of the bill provides some relief for hospitals to address concerns they raised through ongoing discussions. Specifically:

1. Ensures that legal healthcare directives are followed.
2. Ensures that hospitals can discharge patients in a timely manner. This section specifically was written to address concerns we heard about how the CARE Act would cause delays in discharge proceedings. You will likely hear they feel it conflicts with subsection "f." above. Subsection "f." says they have to provide an "opportunity" for instruction before discharge.
3. This part makes it clear that hospitals don't have to chase down a caregiver if a patient declines to designate one.
4. Here the bill addresses a major hospital concern we heard as we discussed this bill, the question of liability. This section clearly states that a hospital cannot be held liable for mistakes made by a caregiver in home setting, as long as they follow the provisions of the statute.

It is worth noting that this bill has changed dramatically from the initial bill discussed in the 2015 session due to significant and appreciated input from North Dakota hospitals. We were thankful for the opportunity to work with them and are disappointed that despite all of the adjustments they have indicated that they still want to stand in the way of supporting North Dakota family caregivers.

We know from discussions and previous testimony that hospitals argue that they already do much of what the bill is asking or that the requirements in the bill are duplicative of the Medicare and Medicaid Cost of Participation or the Joint Commission of Hospital Accreditation standards. So before I turn the podium over to Mike Chaussee from our office to talk about the data and support from North Dakotan caregivers, let me walk you through where SB2215 will close loopholes in the existing federal rules or standards.

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Specifically, AARP evaluated the Medicaid and Medicare rules and the Joint Commission standards. Our experts also looked into the laws and regulations that govern hospitals in North Dakota. Attached to your testimony is a chart outlining how the CARE Act differentiates from current regulations and standards.

As you can see from the attachment, there are loopholes that exist in the current rules. The CARE Act simply looks to close them to ensure that caregivers get the information and instruction they need. You may here about these requirements being stringent or causing the need for additional staff requirements. We would note that the bill is silent on how the instruction or demonstration would need to be provided. 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. It also may be an opportunity for the use of telehealth.

My final point before I give way Mike. I anticipate you will hear continued concerns about liability. As I mentioned this is addressed in the bill. The language on page 2, lines 20-22. This language was provided during the discussions by the hospitals. If they have suggestions to improve it we would welcome them.

Chair Lee, committee members, thank you for your time. I'd be happy to try to answer any questions you might have. Otherwise, I will turn it over to Mike Chaussee, as well as a couple of people ready to testify and share their caregiving stories.

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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
Identification of Family Caregiver and Including him/her in Patient Record	No requirement for identification of the family caregiver or including the information in the patient record **33-07-01.1-20. Medical records services.**	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). 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. 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.	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.

CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	COND[illegible]NS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDIT[illegible]ON OF HEALTHCARE ORGANIZATIONS
Notification of Caregiver if Patient is Being Discharged or Transferred	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. **33-07-01.1-09. Governing body**	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.	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.
Provide Training of Any After Care Tasks Caregiver Will Need to Perform	Instructions to family members upon discharge are required. Training on after care tasks may be implied but not specified.	The CoPs requires that "**as needed,** the patient and family members or interested persons must be counseled to prepare them for post-hospital care. 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".** **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.**	The Joint Commission's standards do not require actual instruction of the caregiver in the continuing care needed. 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. 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. 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

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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.

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AARP Real Possibilities in

North Dakota

January 24, 2017
Senate Human Services Committee
Testimony on Hospital to Home Transitions – The CARE Act
Mike Chaussee - AARP North Dakota
mchaussee@aarp.org or 701-390-0161

Chairman Lee, members of the Senate 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 more about AARP's thoughts on how to improve hospital to home transitions.

AARP conducted a telephone survey of about 1,000 North Dakota residents 45-years-old and older in November and December. I'd like to focus my testimony on some of the findings from that survey.

First, we discovered that the specific requirements found in the CARE Act (SB 2215) are important to North Dakotans. Of the people surveyed, more than 80-percent say they support requiring hospitals to record caregiver information when patients are admitted to the hospital. The exact figures can be found on the bar graph near the top of page one. The percentages of support increased when we asked respondents about the other requirements of the bill. Ninety-percent say they support requiring hospitals to keep caregivers informed of major decisions. And 93-percent say they support requiring hospitals to demonstrate medical tasks to family caregivers.

It's interesting to note that the numbers are fairly consistent among party affiliation. The percentages by are found in the middle section of the front page of the document provided.

We learned a couple of other things from the survey. We learned that almost half of the people surveyed are either currently acting as a family caregiver or have in the past (47%). Those who serve as family caregivers drive their loved ones to appointments (87%), help them with meals (79%), and perform medical tasks as well. Nearly two-thirds say they

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oversee medical management (64%) and more than six in ten say they are responsible for other medical or nursing tasks (61%).

We also asked them how often they perform those medical or nursing tasks. Over half say they do it daily (51%) and another 20-percent say they do it weekly. So, more than seven in 10 people perform a medical or nursing task once a week. It's easy to see then why it's so important for AARP to attempt to get them the instruction and demonstration necessary to perform those tasks.

The survey takers think it's important too. When we asked respondents if they think it would be important for them to receive instruction on medical tasks for their loved ones if they were asked to care for them – 90-percent said it would be extremely or very important.

Now, the last statistic we would like to share is how well hospitals are doing in preparing them for the tasks they'll be asked to perform. We asked current and former caregivers if they were provided with instruction or demonstration of any medical tasks that they'd be asked to perform upon discharge. More than 30-percent said, "No."

Even if we consider that percentage an improvement since the NDSU Extension Service reported about 50-percent of caregivers were getting that information when it conducted a non-scientific survey two years ago – Even if - nearly one in three people in the AARP study still say they received no instruction.

Statistics can be informative, but they rarely tell the whole story. That's why we asked a member of our executive council to say a few words. Her name is Dianne Billey and she drove here from Ellendale, North Dakota.

Before I turn it over to her, do you have any questions? The sheets provided summarize most of the relevant information from the survey.

Thank you.

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AARP Real Possibilities **Research**

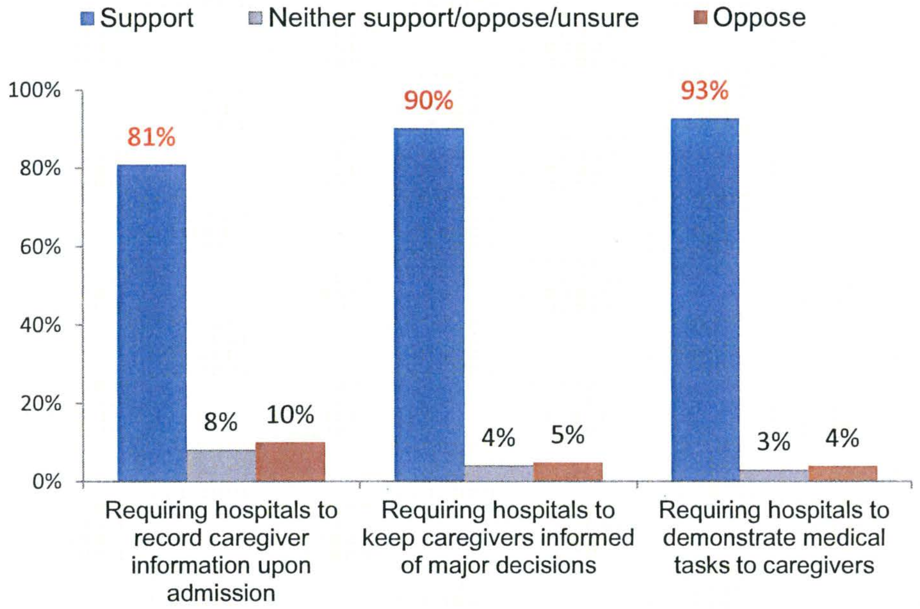
2016 AARP North Dakota Caregiving Survey: Overwhelming Support for the CARE Act

More than 80 percent of North Dakota likely voters age 45 and older support the measures in The Caregiver Advise, Record, and Enable (CARE) Act.

Lay caregivers provide help when their loved ones go into the hospital and as they transition home. The bill features important provisions that require hospitals to prepare family caregivers for the difficult job ahead.

Support for the three CARE Act measures asked about in this survey – recording the name of the caregiver, keeping caregivers informed and demonstrating medical tasks to caregivers – reaches well over the majority for likely voters in North Dakota regardless of their political party.

Support for Proposals to Help Family Caregivers When Loved Ones Go into Hospitals Among North Dakota Likely Voters Age 45+ (n=877)



Likely Voters	Republicans	Democrats	Independents
Record caregiver information	82%	85%	85%
Keep caregivers informed	91%	95%	91%
Explain and demonstrate	91%	98%	94%

Most North Dakota residents age 45 and older have experiences as family caregivers, or believe they are likely to be unpaid caregivers in the future.

Current Caregivers = 15%

Past Caregivers = 32%

55% of those who haven't provided care think they will in the future.

CAREGIVERS OVERSEEING MEDICATION MANAGEMENT = 64%

CAREGIVERS RESPONSIBLE FOR MEDICAL OR NURSING TASKS = 61%

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90% of Caregivers say it's important to get instruction upon discharge from the hospital.

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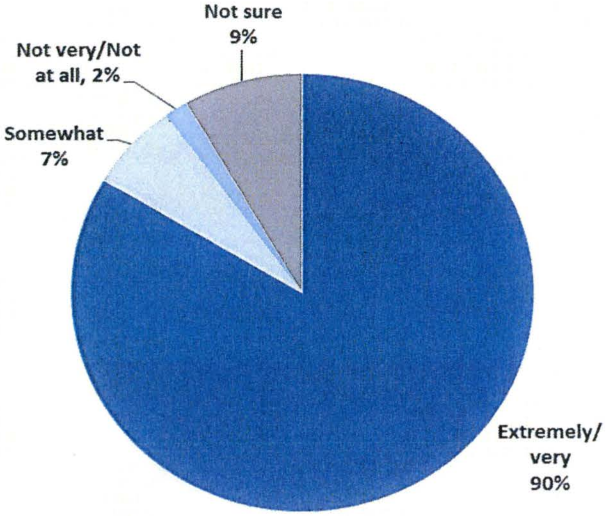

Q: If your family member or loved one was being discharged from a hospital and you were caring for him or her, how important would it be for you to get instruction on medical tasks you may need to provide?

3 out of 10 family caregivers say they were not provided the instruction or demonstration they needed from the hospital to perform their jobs at home.

Additional findings:

North Dakota caregivers report feeling stressed out emotionally and strained financially.

Stressed Out = 60%

Financially Strained = 28%

Hard to Get Enough Rest = 50%

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Methodology:

AARP North Dakota commissioned a telephone survey of 1,004 residents age 45+ to learn about their experiences with family caregiving. The sample utilized RDD landline and cell phones. This report highlights results from residents interviewed from November 18 through December 27, 2016. The data was weighted by age and gender to reflect residents in North Dakota age 45+. The survey has a margin of sampling error of ±3.2 percent. The survey annotation will be made available at www.aarp.org/research.

AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million that helps people turn their goals and dreams into 'Real Possibilities' by changing the way America defines aging. With staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and promote the issues that matter most to families such as healthcare security, financial security, and personal fulfillment. AARP also advocates for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name. As a trusted source for news and information, AARP produces the world's largest circulation magazine, AARP The Magazine and AARP Bulletin. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. To learn more, visit www.aarp.org or follow @aarp and our CEO @JoAnn_Jenkins on Twitter.

AARP staff from the North Dakota State Office, Campaigns, State Advocacy and Strategy Integration (SASI), and AARP Research contributed to the design, implementation, and reporting of this study. Special thanks go to AARP staff including Joshua Askvig, Lyle Halvorson, and Michael Chaussee – AARP North Dakota State Office; Chryste Hall, Scott [illegible]sser, and Pricilla Hume – Campaigns; Denise Gaines – SASI; and Brittne Nelson, Angela Houghton, and Cheryl [illegible]nes – AARP Research. Please contact Terri Guengerich at 202-434-6306 for more information regarding this survey.

AARP Research | For more information about this survey, please contact Terri Guengerich at:

202.434.6306 or e-mail tguengerich@aarp.org

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Real Possibilities
Research

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AARP Real Possibilities in

North Dakota

January 24, 2017
Testimony to the Senate Human Services Committee
SB 2215 – Hospital Discharge Policies
Dianne Billey, AARP Executive Council Member

Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Dianne Billey and I serve as a volunteer on the AARP Executive Council.

As I've continued to learn during my time working with AARP, family caregivers have an extremely difficult job. We tried to capture some of the stories of family caregivers in North Dakota in the book provided with this testimony (Voices of North Dakota Family Caregivers, 2016).

In it we've included quotes from family caregivers like Carol, who says "Caregivers need better training from professionals before sending patients home from (the) hospital." Or from Marilyn, from Mayville, North Dakota – who says, her biggest problem was providing wound care. She says if materials were provided to her, or if she'd have been told where to get them, she'd have done a much better job taking care of her husband.

Then there's Vel Rae from Fargo. She provided care for her son who lost his battle with cancer. She said while she was treating him she didn't realize the morphine he was taking would cause memory loss and confusion - which only added to **her** confusion while providing the care.

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As we continue to hear stories like Carol's, Marilyn's, and Vel Rae's – it becomes easier to make connections to other people we know who have similar stories. I know Pat Muldoon, the focus of a story that ran on the front pages of the Bismarck Tribune and Grand Forks Herald Monday. She's sacrificed 15 years of her life taking care of her husband – and injured herself in the process. He spent his last days in a nursing home, but with her help, he was able to live at home for more than a decade longer than he otherwise would have.

We know there are many, many more stories out there.

More than 30 states have also put a premium on training family caregivers by passing versions of the CARE Act. Those states include Nebraska, Wyoming, Alaska and Indiana. Most recently, Governor John Kasich also signed the CARE Act in Ohio.

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 – and their loved ones at home, where we know they want to be.

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January 24, 2017

Senate Human Services Committee

I am speaking in favor of **SB No. 2215**

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.

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. Senate Bill 2215 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

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[redacted] Bill [redacted]

Hospital discharge policies – Uncompensated Caregivers

Senate Human Service - Senator Lee Presiding

Good morning Chairwomen Lee and The Human Services committee. My name is Moira Solberg and I am the Director of Volunteer Caregivers for the Elderly here in Bismarck., ND.

I am the "boots on the ground" person who along with many of my volunteers, work extremely hard at keeping our seniors out of the hospital and facilities-but we need heroes like you to help us do this.

Times have changed. It is no longer about common sense. ND's little hospitals have been or are in the process of being "swallowed' up by corporate hospitals.

Do you realize that with the "current" HEPA regulation that the hospital doesn't have to give you any information about your own spouse or there cares? Let alone if you have someone else taking care of your mom if you do not live by her.

The larger "corporate" hospitals no longer allow your own physician to see you. You have a "Hospitalist" This has a tremendous communication liability and the Hospital does not want to take the responsibility of what they are causing.

Recently I had one of our recipients who is 97 yr. old bachelor whose blood pressure had skyrocketed. I took him in to Sanford Hospital. When I had left the evening before, he was resting comfortably. When I came back the next morning, they were preparing him to do extensive testing, and an MRI. I asked why and the nurse explained to me that he was acting unusual and he did not make sense. I asked her if she realized he could not hear hardly anything. This annoyed her.

While she was taking his blood pressure she asked him a question and he responded "Yes". Afterword I asked "Ed, did you hear what she said" in which he responded "no". This happen d three times until she had the embarrassment of realizing the only thing that was wrong with his head was his hearing! How much money they spent on unnecessary tests because his file is the size of the bible and he is being treated by people who do not have the time to go through it and are unfamiliar with him. I was his only link between them him and his continued cares. His regular doctor will get a "written report" in a couple of days after his discharge.

ND has a history of being "Mavericks" Big business has looked at our little sate as "simple and easy to control" but as in many other pieces of great legislation that you do to represent your constituents , please do not let them tell you "that this is already being done" Hospital policy covers this"… If this truly was the case this bill should have no opposition.

In a time where health care has been facing so many cuts we need to rely on friends, family and volunteers to fill in the gaps. This bill doesn't cost our state anything other than holding the correct people responsible for what they should already be doing.

Thank you for your time and all you do in representing me and the ones I assist not big business.

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NDHA
North Dakota
Hospital Association
Est. 1934

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 SB 2215

Senate Human Services Committee

Senator Judy Lee, Chairman

January 24, 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 Senate Bill 2215 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.

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- 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 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

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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.

- Finally, 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

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Caring for the caregivers: ND study finds challenges in helping elderly stay at home

By Patrick Springer on Jan 22, 2017 at 3:13 p.m.

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WEST FARGO—Patricia Muldoon spent years taking care of her disabled husband. As his condition deteriorated with age, she quit her job to be a round-the-clock caregiver so he could stay at home.

She devoted the last 15 years of her husband's life—he died in July at age 77—to caring for the man who asked her four times to be his wife before she gave a heartfelt yes.

"All my life, I loved him to the moon and back," she said. "He was a lovely man."

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But with little outside support, Muldoon sacrificed to care for her husband. She injured her back multiple times, and ultimately could no longer take care of him, requiring him to spend his last days in a nursing home.

Muldoon remains frustrated that the state didn't do more to help, since years of care in a nursing home—which typically costs $6,000 to $7,000 monthly—would have cost far more.

"The state seemed not to understand," said Muldoon, a former nurse's aide. Ten hours of respite care a week would have made a big difference, she said, at modest cost. "They still don't get the picture."

North Dakota ranks low in comparison to other states in the proportion of funding that is devoted to helping elderly residents remain at home. For every dollar, 85 cents went to nursing homes and 15 cents going to home- or community-based services, according to an analysis by AARP of 2011 figures.

"We know that older adults in North Dakota want to stay safe and independent at home as long as they can," said Josh Askvig, state director of AARP North Dakota. The advocacy group estimates that the money spent to support one person in a nursing home could pay for three in a home- or community-based setting.

The North Dakota Legislature is considering several bills that would help provide support for caregivers, the result of an interim study on the gaps in services and recommended solutions.

Proposals under House Bill 1038 include a $197,580 pilot project for caregiver training, $200,000 in federal funds for a respite care program, an increase of $1.5 million in support for service for the elderly and disabled, and a report on levels of state spending for nursing home care as well as home- and community-based support.

"These are, I think, some important steps," Askvig said of the proposals under consideration in the Legislature. North Dakota has made progress, he added. He estimated the proportion of funding for at-home care of the elderly probably now is closer to 20 percent than 15 percent from a few years ago.

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But the challenges for taking care of the state's elderly will grow as the population ages, a study for lawmakers completed by North Dakota State University Extension pointed out. Between 2010 and 2040, the number of adults 85 and older in North Dakota is expected to grow by 43 percent, an increase of about 7,200 people. By 2025, 18 percent of the state's population is estimated to be 65 or older.

The 62,100 caregivers in North Dakota provide an estimated $860 million in uncompensated care, according to a study by AARP. The authors of the NDSU Extension study said those figures underscore the importance of supporting caregivers.

The study identified challenges facing caregivers, including:

• 80 percent provide nursing care, yet half reported receiving no training.

• 50 percent of caregivers surveyed reported insufficient respite care, adding to their stress and burden.

• Many reported experiencing a financial burden from their caregiving, including having to quit working or work fewer hours.

"There's always a challenge of finding enough money to pay for the institutional caregiving, which we need," said Jane Strommen, a gerontology specialist with the Extension Service and one of the report's authors. "The challenge is being able to find enough money for the entire continuum."

Although financial support for caregivers lags, "That's actually the most cost-effective way to care for the elderly," Strommen said.

"Especially in rural areas, providing home-based services is very challenging for a number of reasons," including workforce shortages and long distances, Strommen said. Even in urban areas, however, the availability of services does not always mean that adequate services are available, she said.

"My biggest hope is the study brings attention to the needs of caregivers," said Heather Fuller, an assistant professor of human development and family science at NDSU and

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another author of the legislative study. "The struggles are often pretty silent and pretty hidden."

Another bill before the Legislature, Senate Bill 2215, would establish discharge protocols for hospitals to ensure that caregivers have opportunities for instruction and training in providing aftercare.

Mike and Marilyn Worner, a retired couple in Mayville, are among the supporters for specifying discharge plans.

Last year, after Mike Worner came home from major shoulder surgery, Marilyn had conflicting instructions from the physician and nurses, and was confused about how to properly change her husband's bandages.

"I had no idea what to do," Marilyn Worner said. Luckily, a neighbor who was a retired nurse was able to help.

"We have no grievance against hospitals," Mike Worner said, adding his surgery turned out well. "In my opinion, we have a void in the laws."

Patricia Muldoon, who is 70 and relies on Social Security, uses a walker because of her back injuries. She once had a home aide who came in to clean her apartment and do her laundry, but that service was eliminated in budget cuts several years ago.

Her husband had suffered from polio as a child, which left his right side largely paralyzed. He worked despite his disability; first in a factory, then at a highway weigh station and finally as a greeter at a bingo hall.

But in his later years, he was stricken with post-polio and his health deteriorated. He fell frequently and developed dementia, increasing the burden of care and the toll on Muldoon's body, especially her bad back.

"I hope they pass this caregiver act," she said, referring to pending legislation. "I want other people to get that help that I didn't get. I hope something gets done, because people need help."

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Patrick Springer

Patrick Springer first joined the reporting staff of The Forum in 1985. He can be reached by calling 701-241-5522. Have a comment to share about a story? Letters to the editor should include author's name, address and phone number. Generally, letters should be no longer than 250 words. All letters are subject to editing. Send to letters@forumcomm.com

pspringer@forumcomm.com

Att. 1
SB2215
3-13-17

SB 2215
Testimony to House Human Services

Chairman Weisz and members of the committee, my name is Nicole Poolman, state senator from District 7 representing Bismarck and Lincoln. SB 2215 was put forward by the interim Human Services committee after studying caregivers in North Dakota. It encourages hospitals to provide adequate training for family caregivers before a patient leaves the hospital.

The bill ensures that hospitals will:

*Ask patients if they want to appoint a family caregiver
*Record the family caregiver in the medical record
*Notify the family caregiver when the patient is to be discharged from the hospital
*Show the family caregiver how to provide medical tasks they'll be asked to provide at home

With proper training, family members can provide the appropriate level of care to keep a patient at home. With over 62,000 caregivers in North Dakota providing over 58 million hours of unpaid care annually, this not only provides a safe environment for the patient, it makes a difference to North Dakota's bottom line.

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3-13-17

AARP Real Possibilities in

North Dakota

March 13, 2017
House Human Services Committee
SB 2215- DO PASS
Josh Askvig
jaskvig@aarp.org or 701-989-0129

Chairman Weisz, members of the House Human Services Committee, I am Josh Askvig, State 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. We stand in support of SB 2215.

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. For the individuals doing this work in North Dakota it is a labor of love, but it comes with stress, burnout and often times at a cost to their own health and financial stability. Providing support for these caregivers is critical toward ensuring that individuals can safely stay in their homes as they age. Our loved ones can remain independent at home with caregiver support.

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 person who will be taking care of them at home, a little easier.

While I know you have heard this bill before, I still think it would benefit us walking through the bill:

Page 1, Lines 6-16- this part of the bill provides definitions to ensure clarity in the remainder of the bill. Specifically, it outlines what constitutes an aftercare task, most importantly including those complex medical or nursing tasks outlined above. Also, it provides a definition of discharge to clearly stipulate when the aftercare instructions would be provided. Last, it provides a clear definition of who is considered a caregiver for the purposes of the bill.

Page 1, Lines 17-24 AND Page 2, lines 1-11- This is the meat of the bill. This part of the bill ensures:

1. Hospitals ask patients if they would like to designate someone as an "uncompensated caregiver" (subsection "b.") – we believe most often that is a family member which is why AARP refers to these individuals as family caregivers most often. However, as stated in the definition it does NOT require them to be a family member, an important distinction we will discuss later in how the CARE Act differs from the rules hospitals already follow.
2. 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 (subsection "c."). This is an important piece of the bill. It recognizes the caregiver as an important component of keeping the patient safe and providing the ability to heal when they leave the hospital. It also ensures the hospital knows who will be providing care when the patient leaves the hospital. Also, it ensures that the patient's caregiver is recognized by the hospital to share at the most critical times for the patient. A quick note, this bill does nothing to change federal privacy rights or HIPAA regulations. These regulations and information release procedures would all still need to be met and followed.
3. Because we've identified the importance of the role of the caregiver, the bill also ensures hospitals let the family caregiver know when the patient is to be discharged – whether the patient is going home or being transferred to another facility (subsection "d."). Again, this bill does nothing to change

federal privacy rights or HIPAA regulations. They would all still need to be met and followed.

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 show the caregiver how to do what he or she is being asked to do (subsections "e." and "f."). 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.
5. The last part just ensures that the discharge instructions get documented (subsection "g.").

Page 2, Lines 7-11 – This part of the bill ensures that hospitals use national standards and federal regulations.

Page 2, Lines 12-22 – This piece of the bill provides some relief for hospitals to address concerns they raised through ongoing discussions. Specifically:

1. Ensures that legal healthcare directives are followed.
2. Ensures that hospitals can discharge patients in a timely manner. This section specifically was written to address concerns we heard about how the CARE Act would cause delays in discharge proceedings. You will likely hear they feel it conflicts with subsection "f." above. Subsection "f." says they have to provide an "opportunity" for instruction before discharge.
3. This part makes it clear that hospitals don't have to chase down a caregiver if a patient declines to designate one.
4. Here the bill addresses a major hospital concern we heard as we discussed this bill, the question of liability. This section clearly states that a hospital cannot be held liable for mistakes made by a caregiver in home setting, as long as they follow the provisions of the statute.

It is worth noting that this bill has changed dramatically from the initial bill discussed in the 2015 session due to significant and appreciated input from North Dakota hospitals. We were thankful for the opportunity to work with them during the interim. Additionally, we recently met with them again to discuss possible further changes, a few of which we will suggest to more clearly address their concerns. Unfortunately, we were left disappointed that it appears they still want to stand in the way of supporting North Dakota family caregivers.

Before we get into suggested edits, let me address one concern up front. We know from discussions and previous testimony that hospitals argue that they already do much of what the bill is asking or that the requirements in the bill are duplicative of

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the Medicare and Medicaid Cost of Participation or the Joint Commission of Hospital Accreditation standards. Let me walk you through where SB2215 will close loopholes in the existing federal rules or standards.

Specifically, AARP evaluated the Medicaid and Medicare rules and the Joint Commission standards. Our experts also looked into the laws and regulations that govern hospitals in North Dakota. Attached to your testimony is a chart outlining how the CARE Act differentiates from current regulations and standards.

As you can see from the attachment, there are loopholes that exist in the current rules. The CARE Act simply looks to close them to ensure that caregivers get the information and instruction they need. You may hear about these requirements being stringent or causing the need for additional staff requirements. We would note that the bill is silent on how the instruction or demonstration would need to be provided. 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. It also may be an opportunity for the use of telehealth.

So now that we know there are loopholes, let me talk through some possible amendments that might address other concerns.

We are aware that hospitals are concerned about the CARE Act delaying a discharge due to not reaching a designated caregiver. Understanding that concern we suggest that on page 2 under the section "23-49-03. Limitations – Immunity" that the current "2." be reworded and split into two subsets. You can read the suggested amendment on the handout "AARP Suggested Amendments." This edit also further ensures that hospitals know they do not need to delay a discharge due this bill.

Additionally, we were made aware of concerns about potential conflict with federal privacy and HIPAA regulations. While it is contained in the existing bill, it is a bit unclear. To clarify this we have attached suggested edit that would split this out from the original "2." Under "23-49-03. Limitations – Immunity." The attached amendment labeled "*3.*" and "*4.*" on our suggestions would explicitly ensure that hospitals do not need to change their patient information disclosure proceedures to comply with the CARE Act.

I anticipate you will hear continued concerns about liability. As I mentioned we feel this is addressed in the bill in the language on page 2, lines 20-22. This language included in the current version was suggested by the hospitals during the Interim. However, because this continues to be raised, this was a specific point of discussion

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between us and the hospitals since we saw you in January. The last suggested edits are to provide the committee with additional options to provide more clarity on the issue of liability. Specifically, the amendment adds two new items "7." and "8." clearly further stipulating that hospitals are not liable for following the CARE Act. It also ensures that if someone is designated as a caregiver that does not want to be a designated caregiver they are not obligated to perform the tasks.

Before I give up the podium, I think it worth sharing some additional new information we have regarding public opinion on the provisions in this bill. AARP conducted a telephone survey of about 1,000 North Dakota residents 45-years-old and older in November and December.

First, we discovered that the specific requirements found in the CARE Act (SB 2215) are important to North Dakotans. Of the people surveyed, more than 80-percent say they support requiring hospitals to record caregiver information when patients are admitted to the hospital. The exact figures can be found on the bar graph near the top of page one. The percentages of support increased when we asked respondents about the other requirements of the bill. Ninety-percent say they support requiring hospitals to keep caregivers informed of major decisions. **And 93-percent say they support requiring hospitals to demonstrate medical tasks to family caregivers.**

This support isn't partisan, it is fairly consistent among party affiliation. The percentages are found in the middle section of the front page of the document provided.

We learned a couple of other things from the survey. We learned that almost half of the people surveyed are either currently acting as a family caregiver or have in the past (47%). Those who serve as family caregivers drive their loved ones to appointments (87%), help them with meals (79%), and perform medical tasks as well. Nearly two-thirds say they oversee medical management (64%) and more than six in ten say they are responsible for other medical or nursing tasks (61%).

We also asked them how often they perform those medical or nursing tasks. Over half say they do it daily (51%) and another 20-percent say they do it weekly. So, more than seven in 10 people perform a medical or nursing task once a week. These findings reinforce the bill's intent to get them the instruction and demonstration necessary to perform those tasks.

The survey takers think it's important too. When we asked respondents if they think it would be important for them to receive instruction on medical tasks for their loved ones if they were asked to care for them – 90-percent said it would be extremely or very important.

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The last finding we would like to share is how well hospitals are doing in preparing them for the tasks they'll be asked to perform. We asked current and former caregivers if they were provided with instruction or demonstration of any medical tasks that they'd be asked to perform upon discharge. One-third of respondents said, "No."

Even if we consider that percentage an improvement since the Interim study done by the NDSU Extension Service that reported about 50-percent of caregivers weren't getting that information when it conducted a non-scientific survey two years ago – Even if - **nearly one in three people** in the AARP phone survey **still say they received no instruction.**

Statistics can be informative, but they rarely tell the whole story. That's why we asked a member of our executive council Dianne Billey from Ellendale and Ellen Schafer from Bismarck to say a few words.

Before I turn it over to Dianne and Ellen, do you have 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
Identification of Family Caregiver and Including him/her in Patient Record	No requirement for identification of the family caregiver or including the information in the patient record **33-07-01.1-20. Medical records services.**	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). 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. 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.	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.

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CARE Act	NORTH DAKOTA ADMINISTRATIVE REGULATIONS	CONDITIONS OF PARTICIPATION (CoPs)	JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
Notification of Caregiver if Patient is Being Discharged or Transferred	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. **33-07-01.1-09. Governing body**	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.	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.
Provide Training of Any After Care Tasks Caregiver Will Need to Perform	Instructions to family members upon discharge are required. Training on after care tasks may be implied but not specified.	The CoPs requires that "**as needed,** the patient and family members or interested persons must be counseled to prepare them for post-hospital care. 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".** **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.**	The Joint Commission's standards do not require actual instruction of the caregiver in the continuing care needed. 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. 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. 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

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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.

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SB 2215

AARP Suggested Edits

REWORD Page 2 Lines 12-22 with the following

23-49-03. Limitations – Immunity.

1. This chapter may not be construed to interfere with the rights of an agent operating under a valid health care directive under chapter 23-06.5.

2. ~~This chapter does not require a hospital to adopt discharge policies that would delay a patient's discharge or transfer to another facility or require the disclosure of protected health information without obtaining a patient's concent as required by state and federal laws governing health information privacy and security.~~ *In the event the hospital is unable to contact the designated caregiver at the time of discharge or transfer:*

> *a. The lack of contact shall not interfere with, delay or otherwise affect the discharge or transfer of the patient.*
>
> *b. The lack of contact shall not interfere with, delay or otherwise affect the medical care provided to the patient.*

3. This chapter does not require a hospital to disclose protected health information without obtaining the patient's consent pursuant to the hospital's established procedures for releasing personal health information and in compliance with applicable state and federal law.

4. If the patient declines to consent to the release of personal health information, the hospital is not required to provide notice to the designated caregiver and shall not release the personal health information.

~~3.~~ *5.* This chapter does not require a patient designate an uncompensated caregiver

~~4.~~ *6.* This chapter does not create a private right of action against a hospital or a hospital's employee, contractor, or duly authorized agent for providing the instruction and services required under this chapter.

7. A hospital and its employees shall not be held liable, provided it has complied with this chapter and acted reasonably and in good faith, for the services rendered or not rendered by the caregiver to the patient at the patient's residence.

8. A designation of a caregiver by a patient does not obligate the designated caregiver to perform any aftercare tasks for the patient.

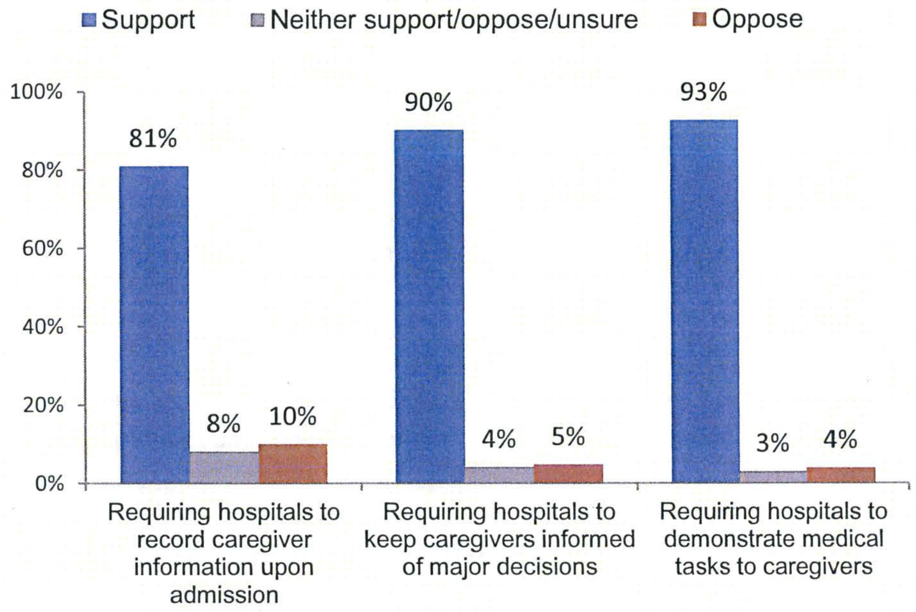
2016 AARP North Dakota Caregiving Survey: Overwhelming Support for the CARE Act

AARP Real Possibilities
Research

More than 80 percent of North Dakota likely voters age 45 and older support the measures in The Caregiver Advise, Record, and Enable (CARE) Act, which will help unpaid family caregivers when their loved ones go into the hospital and as they transition home. The bill features three important provisions that require hospitals to provide instructions on the medical tasks the family caregiver may need to perform at home, keep a family caregiver informed of major decisions, like transferring or discharging the patient, and to engage with caregivers by recording the name of the family caregiver when a loved one is admitted into a hospital.

Support for the three CARE Act measures asked about in this survey – recording the name of the caregiver keeping caregivers informed, and demonstrating medical tasks to caregivers – reaches well over the majority for likely voters in North Dakota regardless of their political party.

Support for Proposals to Help Family Caregivers When Loved Ones Go into Hospitals Among North Dakota Likely Voters Age 45+ (n=877)



Likely Voters	Republicans	Democrats	Independents
Record caregiver information	82%	85%	85%
Keep caregivers informed	91%	95%	91%
Explain and demonstrate	91%	98%	94%

Most North Dakota residents age 45 and older have experiences as family caregivers, or believe they are likely to be caregivers in the future. North Dakota residents age 45 and older say they have provided care -- either currently (15%) or in the past (32%) -- on an unpaid basis for an adult loved one who is ill, frail, elderly, or who has a disability. Of those who have never provided care, over half (55%) say it is likely they will do so in the future.

Current family caregivers in North Dakota are women (61%) who are 55 years of age or older (68%) and have been employed either full- or part-time while providing care (63%). They are likely to be married (67%), and have at least a two-year college degree (59%). About one in six also have a child 18 or under living with them (16%). The median age of the loved one they care for is 80 years of age.

North Dakota current and former caregivers report feeling stressed out emotionally (60%) and strained financially (28%). Caregivers find it difficult to get enough rest (50%), exercise regularly (32%), maintain a healthy diet (26%), or experience their own health problems (22%). Six in ten working caregivers are also stressed out in trying to balance their work and family.

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Methodology:

AARP North Dakota commissioned a telephone survey of 1,004 residents age 45+ to learn about their experiences with family caregiving. The sample utilized RDD landline and cell phones. This report highlights results from residents interviewed from November 18 through December 27, 2016. The data was weighted by age and gender to reflect residents in North Dakota age 45+. The survey has a margin of sampling error of ±3.2 percent. The survey annotation will be made available at www.aarp.org/research.

AARP is a nonprofit, nonpartisan organization, with a membership of nearly 38 million that helps people turn their goals and dreams into 'Real Possibilities' by changing the way America defines aging. With staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and promote the issues that matter most to families such as healthcare security, financial security, and personal fulfillment. AARP also advocates for individuals in the marketplace by selecting products and services of high quality and value to carry the AARP name. As a trusted source for news and information, AARP produces the world's largest circulation magazine, AARP The Magazine and AARP Bulletin. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates. To learn more, visit www.aarp.org or follow @aarp and our CEO @JoAnn_Jenkins on Twitter.

AARP staff from the North Dakota State Office, Campaigns, State Advocacy and Strategy Integration (SASI), and AARP Research contributed to the design, implementation, and reporting of this study. Special thanks go to AARP staff including Joshua Askvig, Lyle Halvorson, and Michael Chaussee – AARP North Dakota State Office; Chryste Hall, Scott Musser, and Pricilla Hume – Campaigns; Denise Gaines – SASI; and Brittne Nelson, Angela Houghton, and Cheryl Barnes – AARP Research. Please contact Terri Guengerich at 202-434-6306 for more information regarding this survey.

AARP Research | For more information about this survey, please contact Terri Guengerich at:

202.434.6306 or e-mail tguengerich@aarp.org

AARP
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AARP Real Possibilities in

North Dakota

March 13, 2017
Testimony to the House Human Services Committee
SUPPORT SB 2215 – Hospital Discharge Policies
Dianne Billey, AARP Executive Council Member

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Dianne Billey and I serve as a volunteer on the AARP Executive Council.

As I've continued to learn during my time working with AARP, family caregivers have an extremely difficult job. We tried to capture some of the stories of family caregivers in North Dakota in the book provided with this testimony (Voices of North Dakota Family Caregivers, 2016).

In it we've included quotes from family caregivers like Carol, who says "Caregivers need better training from professionals before sending patients home from (the) hospital." Or from Marilyn, from Mayville, North Dakota – who says, her biggest problem was providing wound care. She says if materials were provided to her, or if she'd have been told where to get them, she'd have done a much better job taking care of her husband.

Then there's Vel Rae from Fargo. She provided care for her son who lost his battle with cancer. She said while she was treating him she didn't realize the morphine he was taking would cause memory loss and confusion - which only added to **her** confusion while providing the care.

As we continue to hear stories like Carol's, Marilyn's, and Vel Rae's – it becomes easier to make connections to other people we know who have similar stories. I know Pat Muldoon, the focus of a story (attached) that ran on the front pages of the Bismarck Tribune and Grand Forks Herald recently. She's sacrificed 15 years of her life taking care of her husband – and injured herself in the process. He spent his last days in a nursing home, but with her help, he was able to live at home for more than a decade longer than he otherwise would have.

We know there are many, many more stories out there.

More than 30 states have also put a premium on training family caregivers by passing versions of the CARE Act. Those states include Nebraska, Wyoming, Alaska and Indiana. Most recently, Governor John Kasich also signed the CARE Act in Ohio.

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 – and their loved ones at home, where we know they want to be.

Thank you for your time and I urge you to support SB 2215 the CARE Act.

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caregivers: ND study finds challenges in helping elderly stay at home

By **Patrick Springer** on Jan 22, 2017 at 3:13 p.m.

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WEST FARGO—Patricia Muldoon spent years taking care of her disabled husband. As his condition deteriorated with age, she quit her job to be a round-the-clock caregiver so he could stay at home.

She devoted the last 15 years of her husband's life—he died in July at age 77—to caring for the man who asked her four times to be his wife before she gave a heartfelt yes.

"All my life, I loved him to the moon and back," she said. "He was a lovely man."

But with little outside support, Muldoon sacrificed to care for her husband. She injured her back multiple times, and ultimately could no longer take care of him, requiring him to spend his last days in a nursing home.

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hat the state didn't [illegible] of care in a nursing home—which typically costs $6,000 to $7,000 monthly—would have cost far more.

"The state seemed not to understand," said Muldoon, a former nurse's aide. Ten hours of respite care a week would have made a big difference, she said, at modest cost. "They still don't get the picture."

North Dakota ranks low in comparison to other states in the proportion of funding that is devoted to helping elderly residents remain at home. For every dollar, 85 cents went to nursing homes and 15 cents going to home- or community-based services, according to an analysis by AARP of 2011 figures.

"We know that older adults in North Dakota want to stay safe and independent at home as long as they can," said Josh Askvig, state director of AARP North Dakota. The advocacy group estimates that the money spent to support one person in a nursing home could pay for three in a home- or community-based setting.

The North Dakota Legislature is considering several bills that would help provide support for caregivers, the result of an interim study on the gaps in services and recommended solutions.

Proposals under House Bill 1038 include a $197,580 pilot project for caregiver training, $200,000 in federal funds for a respite care program, an increase of $1.5 million in support for service for the elderly and disabled, and a report on levels of state spending for nursing home care as well as home- and community-based support.

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portant steps," Askvig said of the proposals under consideration in the Legislature. North Dakota has made progress, he added. He [illegible]imated the proportion of funding for at-home care of the elderly probably now is closer to 20 percent than 15 percent from a few years ago.

But the challenges for taking care of the state's elderly will grow as the population ages, a study for lawmakers completed by North Dakota State University Extension pointed out. Between 2010 and 2040, the number of adults 85 and older in North Dakota is expected to grow by 43 percent, an increase of about 7,200 people. By 2025, 18 percent of the state's population is estimated to be 65 or older.

The 62,100 caregivers in North Dakota provide an estimated $860 million in uncompensated care, according to a study by AARP. The authors of the NDSU Extension study said those figures underscore the importance of supporting caregivers.

The study identified challenges facing caregivers, including:

[illegible]0 percent provide nursing care, yet half reported receiving no training.

• 50 percent of caregivers surveyed reported insufficient respite care, adding to their stress and burden.

• Many reported experiencing a financial burden from their caregiving, including having to quit working or work fewer hours.

"There's always a challenge of finding enough money to pay for the institutional caregiving, which we need," said Jane Strommen, a gerontology specialist with the Extension Service and one of the report's authors. "The challenge is being able to find enough money for the entire continuum."

Although financial support for caregivers lags, "That's actually the most cost-effective way to care for the elderly," Strommen said.

"Especially in rural areas, providing home-based services is very challenging for a number of reasons," including workforce shortages and long distances, Strommen said. Even in ailability of services does not always mean that adequate

aid.

"My biggest hope is the study brings attention to the needs of caregivers," said Heather Fuller, an assistant professor of human development and family science at NDSU and another author of the legislative study. "The struggles are often pretty silent and pretty hidden."

Another bill before the Legislature, Senate Bill 2215, would establish discharge protocols for hospitals to ensure that caregivers have opportunities for instruction and training in providing aftercare.

Mike and Marilyn Worner, a retired couple in Mayville, are among the supporters for specifying discharge plans.

Last year, after Mike Worner came home from major shoulder surgery, Marilyn had conflicting instructions from the physician and nurses, and was confused about how to properly change her husband's bandages.

"I had no idea what to do," Marilyn Worner said. Luckily, a neighbor who was a retired nurse was able to help.

"We have no grievance against hospitals," Mike Worner said, adding his surgery turned out well. "In my opinion, we have a void in the laws."

Patricia Muldoon, who is 70 and relies on Social Security, uses a walker because of her back injuries. She once had a home aide who came in to clean her apartment and do her laundry, but that service was eliminated in budget cuts several years ago.

Her husband had suffered from polio as a child, which left his right side largely paralyzed. He worked despite his disability; first in a factory, then at a highway weigh station and finally as a greeter at a bingo hall.

But in his later years, he was stricken with post-polio and his health deteriorated. He fell frequently and developed dementia, increasing the burden of care and the toll on

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er bad back.

[illegible]hope they pass this caregiver act," she said, referring to pending legislation. "I want other people to get that help that I didn't get. I hope something gets done, because people need help."

Explore related topics: NEWS NORTH DAKOTA LEGISLATURE ELDERLY CAREGIVERS NURSING HOMES NORTH DAKOTA

Patrick Springer

Patrick Springer first joined the reporting staff of The Forum in 1985. He can be reached by calling 701-241-5522. Have a comment to share about a story? Letters to the editor should include author's name, address and phone number. Generally, letters should be no longer than 250 words. All letters are subject to editing. Send to letters@forumcomm.com

pspringer@forumcomm.com

Attachment 3A
SB 2215
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VOICES OF NORTH DAKOTA FAMILY CAREGIVERS

What they do might surprise you

I ♥ Caregivers℠

AARP Real Possibilities

Table of Contents

In North Dakota, more than 62,000 family caregivers help parents, spouses, children with disabilities and other loved ones live independently at home.

They provide a wide range of services for their loved ones, including bathing, dressing, transportation, grocery shopping, meal preparation, housework, and managing finances. They often serve as care coordinators, communicating with health professionals and accompanying their loved ones to medical appointments. Family caregivers provide emotional support, too.

Caregiving, once one of the most personal and private family matters, is now becoming a very public issue. Today caregiving for an older relative affects real people in North Dakota from all walks of life from women, men, farmers and business leaders, to teachers, laborers, and lawyers plus many more.

The voices of North Dakota family caregivers matter, and we at AARP are committed to sharing them for all to hear. When we set out to gather the voices of North Dakota family caregivers, we had no idea what we would uncover. Our goal in creating this publication was to bring together North Dakota caregiver facts, data about caregivers, and most importantly stories and experiences of North Dakota caregivers presented "in their own words" style.

Finally, the last few pages of this booklet contain recommendations to improve family caregiver supports in North Dakota. They have been evaluated by North Dakota State University Extension and the Interim Human Services Committee. We fully support these recommendations and encourage the Governor, Legislature, businesses, and local communities to implement them.

Josh Askvig
AARP North Dakota
State Director

Mike Chaussee
AARP North Dakota
Associate State Director, Advocacy

WHO ARE NORTH DAKOTA FAMILY CAREGIVERS?

Across North Dakota, family caregivers give their hearts every day, helping their parents, spouses, and other loved ones stay at home.

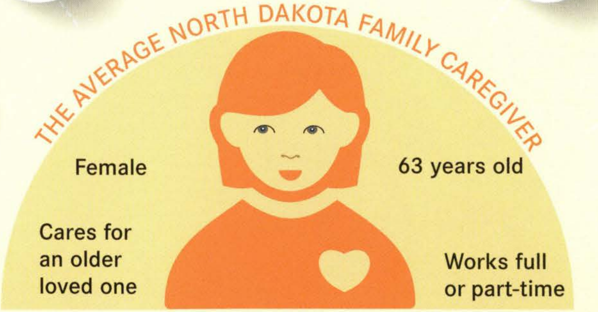
62,100
family caregivers

Provide 58 million hours
of unpaid care anually

Estimated at $860 million
in unpaid care annually

While they wouldn't have it any other way, family caregivers have a huge job. They:

- Use their own money to help provide care
- Change their work schedules
- Oversee medication
- Manage medical tasks
- Aid with household chores
- Help manage finances
- Provide transportation to appointments
- Help with shopping



THE AVERAGE NORTH DAKOTA FAMILY CAREGIVER

Female

63 years old

Cares for an older loved one

Works full or part-time

Source: Valuing the Invaluable 2015 Update: Undeniable Progress, but Big Gaps Remain (PPI)

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HOSPITAL TRANSITIONS:

When a patient moves from a hospital setting to either home or another care facility.

Despite the vast importance of family caregivers in the individual's day-to-day care, many caregivers find that they are often left out of discussions involving a patient's care while in the hospital and, upon the patient's discharge, receive little to no instruction on the tasks they are expected to perform. The federal Centers for Medicare and Medicaid Services (CMS) estimates that $17 billion in Medicare funds is spent each year on unnecessary hospital readmissions. Additionally, hospitals desire to avoid the imposition of new readmission penalties under the federal Patient Protection and Affordable Care Act (ACA).

The following testimonials are just some of the things that the family caregivers of North Dakota are saying about the importance of hospital transitions.

"Caregivers need better training from professionals before sending patients home from (the) hospital."

—Carol, Bismarck

"(Legislators) should know the difficulty we have in hospital situations to get info about parent's condition and prognosis even with "release info" forms. Many caregivers are surprised to learn that so many additional costs are involved in patient care; so "awareness" should be in media, nursing home pamphlets, etc."

—Terry, Bismarck

"Though I did receive directions for my "nursing tasks," it was a problem because I received conflicting instructions from several persons before we exited the hospital. I believe that careful, consistent, oral, and written directions would have been of great assistance to me. Also, since my largest problem was wound care, if materials were provided for me, or if I were even told where to get them, I would have been better able to care for my husband."

—Marilyn, Mayville

"I was the caregiver for my son while he fought cancer and lost the battle… There were times when I needed more discussion about his care. I didn't realize that the morphine he was taking would cause some memory loss and confusion."

—Vel Rae, Fargo

"Doctors need to be more aware of what will happen to patients after they leave the hospital. Will the patient's needs for nutrition, exercise, socialization, and medical appointments be met? Older people need someone caring and responsible who knows the situation and is willing to do whatever needs to be done to optimize the older person's quality of life… Cooperation among medical professionals and family members is the key to success, the key to keeping older people in their homes, happy and healthy and enjoying life as much as possible."

—Janet, Bismarck

WORKPLACE FLEXIBILITY:

Workplace policies that allow family caregivers to successfully balance their career and caregiving duties.

Workplace flexibility will help to support family caregivers who work full-time while providing care for their loved ones.

Today, many North Dakota workers have no family leave, or paid or unpaid sick leave through their employers. And, each day, working family caregivers may face the loss of pay or the loss of their jobs. Making expanded leave available for family caregivers will help them manage their caregiving responsibilities without having to choose between their jobs and their loved ones.

Consider that as the population continues to age, more and more adults are finding themselves in caregiving situations. Roughly 20 percent of the American workforce serves as unpaid caregivers. This number is expected to grow as individuals work longer and begin caring for spouses or other family members. So even at a small workplace, chances are a couple of people are family caregivers. 74% of family caregivers have worked at a paying job at some point during their caregiving experience and 61% are currently employed. So when we talk about "working caregivers," or caregivers who are employed outside the home, we're not talking about some subset. We're talking about the majority of family caregivers. In a recent national survey, one in five retirees left the workforce earlier than planned because of having to care for an ill spouse or other family member. The average length of caregiving is 4.3 years.

A recent Interim Human Services Committee study on family caregivers found that 92% of family caregivers reported having a poor work/life balance as a caregiving challenge. In that same survey, 65% of family caregivers reported unsupportive workplace policies as a challenge.

The following testimonials are just some of the things that the caregivers of North Dakota are saying about the importance of workplace flexibility.

"My job has been flexible but my time away requires me to make time up or not get paid. I also help take care of my granddaughter due to my daughter being a nurse. I don't seem to find time to take care of my own needs."

—Sherry, Bismarck

"I work full-time and appreciate the flexibility at my job to be able to use sick leave to be at doctor's appointments, etc. I wish that all working caregivers had this option."

—Merry, Granville

"I care for my 90-year-old aunt Margaret. She is in assisted living so gets personal care and meals covered. My husband and I assist her to medical appointments, financial paperwork, shopping, and any other tasks that may come up that assisted living cannot provide. We work full-time and it is a challenge to balance all her needs. I enjoy helping her and being there for her. I often wonder if she had not been able to afford expensive costs of assisted living, where would she be?"

—Katie, Bismarck

RESPITE CARE:
Temporary relief to family caregivers from their caregiving duties.

Respite care helps to support family caregivers, many who are on call 24 hours a day, seven days a week, by giving them a hard-earned, well-deserved break – allowing them to recharge and continue the essential role they serve in helping their loved ones live safely at home. Family caregivers often put aside their own needs – skipping doctors' appointments, developing poor eating habits, and not getting enough sleep.

Family caregivers need some relief. National, state, and local surveys have shown respite care to be the most frequently requested service from family caregivers. Caregivers commonly experience emotional strain and mental health problems, especially depression. Women are more likely to have experienced stress and worry than men. Similarly, women were less likely to feel as if they had enough time and feel well-rested than men.

The following testimonials are just some of the things that the caregivers of North Dakota are saying about the importance of respite care.

> "The most rewarding part of my 24/7 caregiving job is knowing my husband can stay with me in our home and can be well taken care of. No one knows the obstacles facing handicapped people until they are involved in the care of someone. I could write a book on things that could improve his life and mine. We would be willing to help anyone who would like to visit with us about this. I am glad I can care for my husband. It would be nice to have a little more time for myself without worrying about him."
>
> **—Donna, Velva**

"I lost my dad four months ago, and my mom doesn't have much time left. I cherish the time I have. It is very difficult because I work FT (full-time) and PT (part-time) and I take care of my granddaughter two nights a week."

—Mary, Bismarck

"I'm solo caregiving 24/7, it's a full-time job. I haven't had a break now for about 15 years."

—Larry, Carson

"Forty-eight years ago when I promised my husband I would 'have and hold' him 'in sickness and health,' I had no idea that his sickness would destroy my health. Five years ago he was diagnosed with dementia that was so limiting that someone has to watch over him 24/7... A little more help from North Dakota would have made such a difference in our lives."

—Pat, West Fargo

CONCLUSION:

AARP North Dakota believes the words of family caregivers help tell the story.

These testimonials combined with the research done by the North Dakota State University Extension entitled the ***North Dakota Family Caregiver Supports and Services Study*** show the need to make improvements to family caregiver supports in North Dakota.

A couple of highlights from the research:

- Roughly 50% of our state's family caregivers performing medical or nursing tasks do not get the appropriate instruction or training to perform these tasks.
- North Dakota family caregivers struggle to find assistance to get the breaks (respite care) they need to alleviate burn-out.
- Family caregivers in North Dakota are unaware of the services and supports available for their loved one or themselves.
- Even when they learn about the services, navigating the complex web of supports, programs, and information is confusing. Even the researchers with advanced education said they found it difficult to navigate the existing information sites and materials.
- Working North Dakota family caregivers struggle to find an appropriate work and life balance.

** Full report can be found at: https://www.ag.ndsu.edu/aging/documents/nd-family-caregiver-supports-and-services-study.*

RECOMMENDATIONS to Support Family Caregivers.

The report outlines five categories of recommendations to improve family caregiver supports in North Dakota.

1. Create programs and policies to foster an increase in the training and education of both informal and professional caregivers. (This recommendation includes the need to provide in-person instruction about medical/nursing tasks that the caregiver will need to provide at home.)
2. Increase access to respite care across the state.
3. Improve outreach (i.e. marketing) and resources (i.e. technology) to help family caregivers find, connect to, and navigate available services.
4. Close the gaps in caregiver support services in rural areas.
5. Improve avenues for sustainable funding for family caregivers and programs that support them.

These recommendations speak to the issues outlined above. We look forward to working to pass legislation and implement policies that improve the lives of family caregivers and their loved ones in North Dakota.

Read more stories from North Dakota family caregivers, or share your own.

aarp.org/iheartcaregivers

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AARP Real Possibilities in

North Dakota

AARPND @AARP_ND

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Testimony from Ellen Schafer
SB 2215
House Human Services Committee
March 13, 2017

Chairman Weisz and Committee Members,

I am Ellen Schafer, a volunteer for AARP North Dakota. I am here on behalf of Senate Bill 2215. I am a retired nurse as of this past spring and have done both hospital and home health nursing. I can testify that, yes, hospitals may already have discharge plans in place, but I need more than two hands to account for the number of times those plans have failed. Most often I noticed discharge medications were not correct so the burden fell on me and other home health nurses to reconcile the medical mistakes. We'd have to contact doctors to make sure they were taking the correct medications and the correct amounts.

I want to provide an example of that. It recently happened in my own family. A sixth grade relative of mine was hospitalized in Jamestown with a blood sugar reading of 378. She was transferred to a Fargo hospital where she was diagnosed with diabetes and a severe kidney infection. She also was running a temperature of 103 degrees. After almost a week in the hospital she returned home with her grandmother who was taking care of her as her mom had died this past September. When they left the hospital her grandmother believed she was to give 20 units of medication Lantus, but she noticed the paperwork read two units. Confused, and wondering why her granddaughter's blood sugar was again in the 300's, she contacted the doctor and discovered the paperwork was wrong.

Those opposed to this bill will say they have discharge plans in place. I am here to say, while that might be true, there is still plenty of room for error. If the policies are so good, how does this happen? We need better discharge policies and we need caregivers to be contacted and provided direction. SB 2215 will ensure that both the patient and caregiver receive the appropriate discharge instructions that they will be required to do once the patient returns home from the hospital.

Thank you.

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SB2215

NDHA
North Dakota Hospital Association
Est. 1934

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 SB 2215
House Human Services Committee
Representative Robin Weisz, Chairman
March 13, 2017

Good morning Chairman Weisz and Members of the House Human Services Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here to testify regarding 2017 Senate Bill 2215 and ask that you give this bill a **Do Not Pass** recommendation.

We appreciate the intent of the bill; however, hospitals are already highly regulated regarding discharge procedures. Hospitals are required to follow federal and state mandated discharge procedures in order to be licensed and participate in Medicare and Medicaid. Accreditation standards, i.e. The Joint Commission, also dictate discharge procedures. I am not aware of any findings, either at the federal level or by accrediting bodies such as The Joint Commission, that North Dakota hospitals are not following these already well-established discharge policies and procedures.

Hospitals have been addressing these rules and regulations every day effectively without the need for a state law to reiterate what is mandated by these federal and state licensing, accreditation, and participation requirements.

This bill would place additional requirements on hospitals that are unnecessary and could create additional questions and potential liability. It mandates hospitals to have written discharge policies which are already required; that hospitals must document an uncompensated caregiver designated by the patient to be placed in the patient's record, and that the hospital provide the patient and uncompensated caregiver "instruction and training" for the patient's aftercare before the patient may be discharged, again, which is already required.

This bill creates expense by requiring additional documentation of care to be provided by the uncompensated caregiver in a non-hospital setting after discharge. This additional documentation will likely require additional time and expense for hospitals. Hospitals already have a shortage of professional staff and this bill is requiring additional work with no additional funds to accomplish the additional documentation, thus creating an unfunded mandate imposed on the hospitals.

This bill could create a delay in discharging patients because the required documentation of the notification and education of the caregiver. What if the caregiver isn't responsive to the discharge 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 hospital staff is?

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. Again, hospitals have been mandated to have discharge planning processes in place for some time and I am not aware of any citations either at the federal level or state level that says they are not providing a discharge plan to the patient.

The bill also creates a potential violation of the patient's privacy rights because it requires the hospital to give sensitive medical information to the uncompensated caregiver. Unless the patient has signed a HIPAA compliant authorization - a federal requirement to release information - the hospital may be disclosing protected health information in violation of state and federal laws. Hospitals will now have to ensure that every patient has signed an appropriate authorization for release of information before it may fulfill its duties under this bill.

The bill also potentially creates additional liability for the hospitals. Hospitals 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 and document the aftercare instructions and training to the uncompensated caregiver. 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. In addition to civil liability, it is unclear how a violation of this law might affect a hospital's reimbursement, licensing, or accreditation. There is no guidance regarding how non-compliance would impact a hospital.

An identical bill was introduced (2017 HB 1039), which was amended to simply 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 the hospitals already work with referring facilities and families on the coordination of care upon discharge. These are issues hospitals have been addressing every day effectively under well-established federal, state, and accreditation requirements. We prefer this approach over creating an unnecessary state law that is going to create additional cost, uncertainty, and potential liability while not providing any real benefit for patients.

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

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att. 6

House Human Services Committee

Rep. Robin Weisz, Chair
March 13, 2017

Chairman Weisz, and members of the House Human Services Committee, my name is Chris Meeker, M.D. I am a board-certified emergency medicine physician and chief medical officer at Sanford Health in Bismarck. Sanford Health is the largest, rural, not-for-profit health care system in the nation with more than 26,000 employees in 126 communities across nine states. Our footprint includes 39 hospitals, 225 clinics and 1,360 physicians in 81 specialty areas of medicine.

I appreciate this opportunity to speak to you briefly about Senate Bill 2215 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.

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 efforts 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, and, despite language to the contrary, has potential to slow the discharge process, resulting in prolonged emergency department holding, surgical delays, and the inability to accept transfers from critical access hospitals because of the lack of any empty inpatient beds.

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

Chris Meeker, M.D.
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att. 1
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3-21-17

March 20, 2017

Rep. Robin Weisz, House Human Services Committee

Chairman Weisz,

Thank you for the opportunity to share information regarding Sanford Health discharge policies. As you know, hospital discharge planning is thoroughly regulated by the Centers of Medicare and Medicaid (CMS) and Joint Commission Standards (TJC). Additionally, the N.D. Department of Health's rules for hospital licensing specify discharge planning requirements.

In Dr. Chris Meeker's SB 2215 comments last week, he shared excerpts from the Sanford Health Discharge Planning Policy. Because Sanford's hospital policies are proprietary, I may not share the full policy but will share verbatim the portions of the policy to which Dr. Meeker referred:

1. Patient has the right to be active and participate in the development of their discharge plan of care.
2. Upon admission, the nurse assesses the patient for the follow and documents on the Admission Navigator:
    a. Prior living situation
    b. Risk factors related to past medical history
    c. Prior level of functioning
    d. Home and family
    e. Preference for religion
    f. Nutrition
    g. Concerns or fears related to present admission
    h. Abuse and/or neglect
    i. Financial concerns
    j. Advance Directive
    k. High Risk Assessment
3. The Case Manager/Social Worker reviews the patient's medical record and, if indicated, interviews the patient and/or family to assess:

a. Patient's prior living situation

b. Availability of caregivers

c. Prior use of adaptive equipment

d. Insurance source

e. Current services or anticipated discharge services needed / Patient goals for discharge

4. The Case Manager/Social Worker determines if further discharge planning needs are present and need to be addressed before discharge. The patient's needs for significant personal care and nursing care equipment as well as post-hospital services and their availability are identified. All of these needs are discussed with the patient and/or family.

Each hospital's internal policies are likely different, but all adhere to the CMS, TJC and NDDoH requirements and all have the same purpose: to establish a consistent approach to safe, efficient discharge planning for all hospitalized patients.

In the SB 2215 public hearing, Mr. Josh Askvig was asked why the bill passed without opposition in Minnesota. He stated he did not have insight to answer the question. Dr. Meeker asked me to relay this: Minnesota has capacity in their referral centers that North Dakota often does not. North Dakota hospitals are often full.

Despite language to the contrary, this bill has potential to slow the discharge process, resulting in prolonged emergency department holding, surgical delays, and the inability to accept transfers from critical access hospitals because of the lack of any empty inpatient beds.

Please do let me know if you have questions or would like more information.

Thank you for your consideration.

Sincerely,

MWalth

Marnie Walth
Strategic Planning and Public Policy

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3-21-17
SB 2215

POLICY/PROCEDURE: Discharge Planning

DEPARTMENT: Patient Care- Nursing Service	Effective: 8-2015
	Revised:

PURPOSE:
To ensure a plan is in place to meet the patient's continuing healthcare needs post-hospitalization.

DEFINITION:

- Discharge Planning - A process and service whereby patient needs are identified and evaluated. Assistance is given in preparing the patient to move from one level of care to another.

POLICY:

- Towner County Medical Center shall provide Discharge Planning for all patients. The discharge planning process shall be initiated at the time of admission.
- Multiple disciplines may be involved in the discharge planning process, including, but not limited to:
  - Medical Staff
  - Nursing Staff
  - Rehabilitation Services Staff
  - Social Service
  - Pharmacy
- Written discharge instructions shall be given to the patient/family in a manner that the patient/family can understand.

PROCEDURE:

- The initial assessment/evaluation for discharge planning needs shall be conducted during the nursing admission assessment.
- Availability and location of needed services are assessed.
- Referrals are made to needed services.
- The patient or family member will be made aware of services and how contact can be made.
- Patient education is documented in the medical record.