2019 HOUSE HUMAN SERVICES

HB 1126

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1126
1/30/2019
31834

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature: Nicole Klaman by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:

Relating to basic care facility end of life services

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

Meeting opened.

Chairman Weisz introduced bill.

Representative Tveit: Is this a facility by facility situation?

Chairman Weisz: I believe the health department changed their rules, allowing certain patients to stay in the facility and receive hospice care. This bill would expand those rules to allow the families to be involved in the hospice care as well.

Representative Rohr: Does this change reimbursement?

Chairman Weisz: I was going to ask the department, and I don't know the answer to that question.

Representative Rohr: Does it fit the criteria for hospice as well?

Chairman Weisz: Currently hospice has to come in and do it. This bill will allow family or private hospice to be a part of that care. It does expand that then.

Representative Skroch: Will this dove tail with this legislation we heard that allows for a caregiver to be assigned and assist someone in that situation?

Chairman Weisz: Not really. This is very specific to end of life situation in need of hospice. This allows more flexibility allowing the facility to handle this without having to send the residents somewhere else.

Shelly Peterson, President of ND Long Term Care Association: **(see attachment 1, handed out attachment 2)**

Chairman Weisz: Is it your intent that the facility will help train the volunteers to fulfill their commitment to the patient in case of emergency?

Ms. Peterson: Yes, they would need to be properly trained.

Representative Rohr: Some patients require pain management pumps; could your staff provide that care?

Ms. Peterson: Yes, we can contract with home health and hospice to bring in those extra services. The question now is that whether or not they are meeting criteria.

Representative Rohr: So you still need to develop criteria?

Ms. Peterson: No we already have basic care criteria. It would allow us to provide skilled care, if we have the proper family, staff, or agencies that would provide that care.

Representative Rohr: Drive up the cost?

Ms. Peterson: Right now if they go to nursing facility, it would be a shock to the increase for the facility. It would be far cheaper to care for them in the basic care facility.

Kari Dick, Executive Director at Touchmark at Harwood Groves: (see attachment 3)

Rochelle Schaffer, Registered Nurse and President of the ND Hospice Organization: (See attached 4)

Cheryl Rising, FNP and legislative liaison for ND Nurse Practitioner Association: (see attachment 5)

Opposed testimony.

Bruce Pritschet, Director of the Division of Health Facilities within the Department of Health: (see attachment 6)

Chairman Weisz: The amendments don't change your mind?

Mr. Pritschet: No.

Chairman Weisz: Will Medicaid continue to pay even though they should go to Skilled Care?

Leanne Thiel, Department of Human Services: When basic care is exceeded, currently, they do have to move on to the level of care necessary. But if hospice, I have to check into that.

No further testimony or questions. Meeting closed.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB1126
1/30/2019
31866

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Nicole Klaman by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:

Voting on the bill.

Minutes:

Hearing opened.

Representative Skroch: Motion made to adopt amendment.

Representative Westlind: Seconded.

Chairman Weisz: Discussion? The amendments do narrow it down, and make sure that it is only the residents that are currently in the facility. The original language left it open.

Voice vote: motion carried, amendment adopted.

Representative Skroch: Motion for a do pass as amended.

Representative Dobervich: Seconded.

No discussion on the bill.

Roll call vote: 12 Yes, 0 No, 2 Absent. Motion carries.

Floor assignment: Representative Tveit.

No further questions. Meeting closed.

DP 1/30/19

19.0602.01001
Title.02000

Adopted by the Human Services Committee

January 30, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 1, line 15, remove "admit"

Page 1, line 16, remove "and"

Page 1, line 17, replace "volunteer and" with ", or the individual's designee, volunteers, or"

Page 1, line 18, after "facility" insert ", individual, or the individual's designee"

Page 1, line 18, after "a" insert "person or"

Page 1, line 18, remove "or utilize volunteer and family"

Page 1, line 19, remove "support, or both,"

Renumber accordingly

Date: 1-30-19
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1126

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. Skroch Seconded By Rep. Westlind

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Voice Vote

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Amendment Adopted.

Date: 1-30-2019
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1126

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. Skroch Seconded By Rep. Dobervich

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman	X		Gretchen Dobervich	X	
Karen M. Rohr – Vice Chairman	X		Mary Schneider	X	
Dick Anderson	—	—			
Chuck Damschen	X				
Bill Devlin	X				
Clayton Fegley	X				
Dwight Kiefert	X				
Todd Porter	—	—			
Matthew Ruby	X				
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 12 No 0

Absent 2

Floor Assignment Rep. Tveit

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

Motion Carries.

REPORT OF STANDING COMMITTEE

HB 1126: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1126 was placed on the Sixth order on the calendar.

Page 1, line 15, remove "admit"

Page 1, line 16, remove "and"

Page 1, line 17, replace "volunteer and" with ", or the individual's designee, volunteers, or"

Page 1, line 18, after "facility" insert ", individual, or the individual's designee"

Page 1, line 18, after "a" insert "person or"

Page 1, line 18, remove "or utilize volunteer and family"

Page 1, line 19, remove "support, or both,"

Renumber accordingly

2019 SENATE HUMAN SERVICES

HB 1126

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1126
3/11/2019
Job # 33490

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to basic care facility end of life services.

Minutes: Attachments #1-5

Madam Chair Lee opens the hearing on HB 1126.

(01:50-03:30) Representative Robin Weisz, District 14. Introduces HB 1126 and gives a brief overview.

Senator Hogan: If you have any idea how often this happens?

Representative Weisz: I know there were a handful of requests under this current provision, with the department and that may have to do with the fact that they weren't able to bring anyone in to provide the services We didn't get any real testimony that said we were expecting 10,20 or 50. Looking at the quality of the last few weeks of that individuals

Senator Anderson: I'm wondering why if someone is in a basic care facility, why hospice couldn't come to the basic care facility and provide those just like they do with the people at home. Is there some type of criteria or what?

Representative Weisz: the department can better explain that but, it has to do with them exceeding the basic care criteria. Often times you don't need Red River Hospice to come in. It's up to the long term care facility to make sure things are taking care of everything. They still have to make sure the needs are met it just give more flexibility that isn't allowed now.

Madam Chair Lee: We don't have hospice services everywhere in the state because of the delivery system, isn't that part of it?

Representative Weisz: Yes, that is correct, my understanding is the only place I have been in the Fargo area that used the exemption that the department came up with. Certainly from a rural perspective this helps a lot.

(07:55-18:49) Shelly Peterson, President of the North Dakota Long Term Care Association. Testifying in support of HB 1126. Please see **Attachment #1** for written testimony.

Madam Chair Lee: I'm thinking of what took place when Sanford evacuated in 1997. I have a video at home of the lines of ambulances in the dark to evacuate people who were on stretchers. I can see that people would be able to find family or perhaps volunteers who might help during the daytime, here is the deal we just had a pretty crappy snow storm this weekend. If people can't get there, I'm just a little concerned on how those services will be provided. How would we work through all that?

Shelly Peterson: Half the residents are Medicaid and the other half are private pay. We run into the situation now when we have a blizzard and staff don't show up, the staff that are there, we ask them to stay. What we try to do at end of life is anticipate and care plan and a backup plan is established. We can call contract agencies as a last resort, sometimes they can't even respond because they can't get staff there. We have had fires, for example in Minot Edgewood Vista had a fire, it was a Dementia unit with 22 beds, it was horrible. It was 4:30am close to Christmas, a fire occurred and the facility was on fire, filled with smoke, and the sprinklers went off. You think that sounds horrible, it was the most amazing evacuation and care for those residents. They got the residents out within five minutes, EMS, Staff, and Staff from the neighboring facility that came over and helped as well as people from the neighborhood did an amazing job. All residents were evacuated with little on them except their pajamas and maybe some slippers, out in the snow with no injuries in horrible weather conditions. They temporarily moved all the residents next door to assisted living and found out within days that this wasn't working and they need more care and support. Ultimately, the facility is responsible, if families are not showing up we have to be the ones who say, ok this is not working and you need to transfer. The unexpected is going to happen but you plan in advance and you talk with families. The fire recently down at the Ashley nursing home and hospital, it was at lunch time the facility filled with some smoke, the fire was put out right away but they evacuated in 36 minutes and I think it was that the fear of fire wasn't there but 36 minutes is a long time for an evacuation. There are standards in place and all the basic care rules would still apply so we must meet with those circumstances now and if we happen to have someone at end of life, yes we are going to deal with those now and have a backup plan.

Madam Chair Lee: Would you be looking at putting a plan put in place the time the residents move in? Things like durable power of attorneys for healthcare really should be done when it's sort of a business decision and not a crisis decision.

Shelly Peterson: Yes, generally. Upon admission there is an admission packet and they talk about end of life, care and services, and what is the criteria for your mother when we can no longer meet her needs. You try to plan in advance of those issues. When you see that end of life care and hospice is a good option, you talk to families about that, some are open and some are not. Sometimes it takes a number of discussions. Recently, I had to get involved in a case of a nursing home resident and the spouse wanting to move her husband back home. He has stage four cancer and everything that she described was horrific, and I suggested to her about hospice and the reaction was very awful because to her it was like, no he's not going to die how can you say that. During that admissions process you get a

stack and you go through all the information and you talk advanced directives, when can we not care for them, who should we contact when something happens. We haven't talked about so much, if you don't have the end of life but we would like to talk to them about end of life and having those conversations. Right now, the discussion is if their father or mother meets these criteria we must move out and then we keep on having that conversation as you see them decline and it is still very hard.

(26:30-31:15) Kari Dick, Executive Director at Touchmark at Harwood Groves in Fargo. Testifying in support of HB 1126. Please see **Attachment #2** for written testimony.

Madam Chair Lee: I'm a huge supporter of hospice and was on the board for a time and I wish everybody had hospice but there are parts of the states that don't have it, and I'm having just a little bit of heartburn about relying on volunteers and family members when there isn't that training that hospice staff members and volunteers have also. Help me work though that one would you.

Kari Dick: I think that is part of a larger conversation whether it is appropriate to keep that individual and for some facilities it may depend on whether they have a hospice agency to rely on or if they have knowledgeable staff to help guide that process. Like I said, even at Touchmark there are individuals who don't fit in there and do need to move on to skilled care but we have to partner with the family and the resident and sometimes hospice to determine whether it is an appropriate fit or not. I think it would still allow us in many cases to keep people but in some cases it might not be the right setting. I have to emphasize to that we deal with those types of situation all the time when there is bad weather or when a staff member doesn't show up, and we are used to those types of things and have to adjust accordingly. I don't really see that an any different than the norm for us.

Madam Chair Lee: It is one thing for you to keep staff members that are already there for an extra shift that are already there for several hours, I get that. You just have so much less control over a volunteer or family member.

Kari Dick: If you're dealing with hospice, part of their process outlines everyone's roles and that is a part of our planning process too. At Touchmark, many of our residents are private pay so many could pay for private contractor but that's not the case for everybody and I think you need a backup plan when those situations arise and if it doesn't seem like that is a situation where you are going to be able to count on that care than it might not be an appropriate situation to get into.

(33:58-40:16) Tracee Capron, Executive Director for Hospice of the Red River Valley. Testifying in support of HB 1126. Testimony is as follows: Hospice of the Red River Valley is an independent community owned non-profit hospice agency. We serve over 19 counties in North Dakota and over 19,000 square miles. We would like to make sure, we have been providing care in the state of North Dakota for over 38 years. We allow the families the gift of hospice care. We allow them to be treated with dignity and respect anywhere they call home. I'm here to testify today and ask for support of HB 1126 with the proposed amendments that the ND Long-Term Care Association put forward. First, let me show you what hospice care entails. As hospice providers we are experts at caring for people at the end of their life. The benefits that come to the patient include patient center care, and most importantly the

patient's wishes, values, and goals. We provide payment symptom control, emotional and spiritual support for the patient and their loved ones, grievance services for anyone in the community who has lost someone. Also, we combine our efforts and collaborate with experts in the long term care and basic care facilities. We combine our expertise's to provide the best experience for the patient. We (inaudible) to the Medicare benefit to educate everyone in this process and we do that now. We have to have a plan and it has to be in writing. (inaudible) people in our state call basic care their home. They too should be entitled to receive the hospice Medicare benefits. HB 1126 amended would help these residents have access to the services needed. Today, many are being faced, and it happens to us all the time in our agency, they are up routed from their homes and go miles away to a different facility away from their families, friends, and staff that they know and love. You have lived in your home all of your life, you've raised you children and have to make a decision, and you have decided to go into a facility of basic care. You spend the last year becoming accustomed to those changes, and now you are being told that you have to move again. You have to change everything. Nobody should be forced to move from their home at this time, and with your support of these changes we can keep this from happening. We are committed to being part of the solution to our family, friends, hospice staff, and volunteers to meet the evacuation needs of the patient. Our team of experts work with the patient, family, and facility to come up with a plan. We do this every day and always have in any care setting. From the time you are admitted a care plan is established and a plan and a backup plan are in place. If it goes right, we are called immediately and we work together and we come up with something to do to ensure that the safety needs of the patients are met. We do this in all care settings, we take care of patients that live alone in their home. Your support of HB 1126 has emotional and financial benefits to the patients. When a patient is forced to move out of basic care and are moved to a skilled nursing care facility it can triple the cost, more importantly if there isn't a place to take the patient you have to move them suddenly and they need to go to a facility and you can't get them there, guess where they go? They go into the health system, they go into the hospital, and the costs of one day in the hospital could be 30 days in a basic care facility. What is really interesting is that the day before senate testimony last time we had another example of this when an elderly patient living in a basic care facility had a fall, sudden quick decline, negative 40 degrees and we had to have the family of the patient move. They called me and they were predicting a week but she ended up in the hospital, once she was admitted into the hospital she got hospice services. This is trauma for the patient and the family. It is a burden on our system and everyone. When it comes to hospice care there aren't any second chances to get it right and we do not need to cause more of a burden to anyone at this time. We have the opportunity to live the end of their life with comfort, dignity, and respect in the care setting that they want to be in. I'm asking to please support the changes to basic care facilities in North Dakota by supporting the changes to HB 1126. I did want to comment on a couple of things that about the (inaudible). What is interesting is that we actually serve 36,000 square miles. Our staff are all placed strategically in our service region. (inaudible) We had two cases where staff did stay, it was continuous care overnight around the clock in a facility and in a home. If worst comes to worst and (inaudible) call an emergency and we meet them and take care of them that way. It is part of our plan and we do it every day. That is the only comment that I have at this time other than, safety is addressed at admission and throughout the entire plan of the patient if they change. Thank you for your help and we appreciate your consideration of this.

Madam Chair Lee: I am not as confident that the various hospice programs do this terribly responsibly, I'm not as confident that every family member and volunteer is going to be in the same place. Here is a far less critical example, in April of 1997 when we were sitting here while sand bags were being thrown in Fargo, I called home one day and my husband said "oh, by the way your dad is here" who living in a local assisted living facility. They evacuated the building and told everyone to come and get their family members. At the same time my husband was finding generator to deliver to Grafton where the rural electric had failed. In order to keep the sun pumps running in a farm home which is where my dad would have been living and in my sister and brother in-laws house they didn't want to have the basements flood. I ended up calling my sister in Denver saying could you please get here and handle dad so that my husband can haul the generators to Grafton so that the houses don't flood. There was nothing wrong with my dad's physical health at that point. My point is there are times when family members can't. I couldn't go home. The majority leader was sitting upstairs at his desk with water around his home because sometimes we have to be places that we would rather not be. I realize that those are extraordinary circumstances but it was an extraordinary time, so my concern is he didn't need hospice services, eventually he did and we were grateful for Hospice of the Red River Valley when it was at the end of his life. My concern is more about what happens in this situation where family is depended on and volunteers are depended on. What does a basic care facility do if there is someone who really needs services whose volunteer or family member that are being prevented to get there and take care of that person?

Tracee Capron: When you talk about the family not being able to get there, more than likely the staff won't be able to get there and I can tell you as a family member I am going to try really hard to get to my family because you probably have a staffing issue as well as a volunteer or family issue.

Madam Chair Lee: The assisted living facility evacuated the facility for fear of the sewage failing. If someone is at the end of life and we are depending on people who are torn between an obligation one place or another and its family or volunteers, it is not the same with people in hospice who recognize a different level of responsibility. Help me through that one. I know you're not responsible for every family member and volunteer but I'm trying to anticipate the things we might face and how to address it.

Tracee Capron: I'm not the basic care expert, I'm the hospice expert. What I would say is, we provide and part of the education process that is required under Medicare is we are required to train the facility, family, volunteer, and provide that training to the facilities. We have a group of expert education people that have to, and that is part of their job in the community doing this training. This training opportunity that is provided to the facility, does the facility use those to train the people. I think that is why Medicare originally established that provision is how do you ensure that everyone is trained? They have to be trained from orientation and throughout. We have to provide that same training for our patients and their families and I would think you would pass that on to you families also or in an area that may not have hospice coverage that, that could be utilized. That is where my head went.

Madam Chair Lee: It's not a rhetorical question. I understand the goal here I'm just trying to figure out, the devil is in the details. It would nice if none of those situations happened again but that would be a fantasy.

Tracee Capron: I think what happens are the number of families that we have that we are forced to do this with and they are upset about it. I think that is more common than these rare circumstances because they happen all the time to us. I can tell you one facility in particular when I'm sitting there and I get the call of them saying "I don't know what to do" or you have the daughter that is fighting to find out why are you moving my mother. We are the second state in the country with utilization of hospice services. I think some of that comes from the barriers that we have imposed. One of them being in basic care, if you know that you have to move your family and there is no place to go are you going to pick up that service and utilize it, probably not.

Senator Anderson: In this discussion we have to keep in mind that it says the facility may keep the patient. They are still the ones who are deciding if they don't think that things are adequate or if they can arrange for adequate services and then they have to make the choice of not to keep them. This just allows them to do it.

Tracee Capron: Sometimes there isn't family or sometimes there are circumstances that require more care and that is our responsibility to collaborate and work. Thank you, I respect your thoughts on that but think about the patient and the family because it is more common than you think.

(49:48-52:28) Rochelle Schaffer, Registered Nurse and President of the North Dakota Hospice Organization. Testifying in support of HB 1126. Please see **Attachment #3** for written testimony.

Senator Anderson: What the land area of ND is and what percent of that land area do your 11 facilities cover?

Rochelle Schaffer: I wish I had that math. We are actually working on updating it so I don't actually have it. 1/3 of the state is uncovered.

Madam Chair Lee: Central and North I would think?

Rochelle Schaffer: Yes, I think north of Minot and those areas and then the south west corner I would think that the CHI hospice in Dickinson does not reach all down to the border in that corner either.

Madam Chair Lee: How about that central area?

Rochelle Schaffer: I think that is pretty covered because Valley City covers that through CHI and Red River is close to covering some of that. I also do think south of Bismarck is uncovered from probably an hour south to the border.

Senator Anderson: This is intended to apply hospice services to those areas and those areas where hospice services are not available it's a mood issue because they couldn't keep them there anyways.

Madam Chair Lee: Any more questions for Mrs. Schaffer? If not, thank you very much.

(54:45-1:00:20) Cheryl Rising, FNP and Legislative Liaison for the North Dakota Nurse Practitioner Association. Testifying in support of HB 1126. Please see **Attachment #4** for written testimony.

(1:01:00-1:03:49) Bruce Pritschet, Director of the Division of Health Facilities within the Department of Health. Testifying in opposition to HB 1126. Please see **Attachment #5** for written testimony.

Senator K. Roers: I'm wondering if you have any thoughts about the proposed amendment that Shelly mentioned earlier about the lines stating that the basic care facility is still responsible for the care of the patient.

Bruce Pritschet: That would certainly be a very helpful piece in our opinion would put the facility back on the hook so to speak for the overall care of that resident and not rely on the family or the volunteer if they couldn't get there or if another family member made accusations against them about their quality or something.

Senator K. Roers: Could you see that as an ok middle ground between what you had proposed and the current state where it would still allow the family but then it would create that responsibility piece?

Bruce Pritschet: I think that would go a long way to do that.

Senator Hogan: Did you propose this in the house committee and was there a discussion about it?

Bruce Pritschet: No, it was not proposed in the house.

Senator Hogan: Okay, I was just curious.

Madam Chair Lee: I think we all have the same goal here but the GPS route that seems to get there is a little bit different, so if we can find a way to make that come together, that would be important. We recognize the importance but also the safety factors here. I know that this is a challenge but I would like to ask if some of the stake holders in this might have a chance to get together again, drink lots of coffee and no one can go to the bathroom until we figure out a solution. That is a fairly basic way to describe it. I think we all kind of recognize the challenges are here and we want to make this as streamlined as possible but obviously the safety of the individual is primary but the liability and the responsibility for who is contracting seems to me to be a big issue here. I think we can resolve it but you are all smarter about it than we are so, I don't hear or see anyone else looking to testify but if there is a chance before Wednesday afternoon because we have to get these out. If you might be willing to chat whether it is conference call or getting together face to face and see if you might come up with something we would find that helpful because we would rather do it with you than to you. We don't want to do something bad that is unintended on our part that would hurt either of the parties involved of this either.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1126
3/13/2019
Job #33638

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to basic care facility end of life services.

Minutes: No Attachments

Madam Chair Lee opens the discussion on HB 1126.

Shelly Peterson, President of the North Dakota Long Term Care Association: I was really hoping that we would have something. We met with the Health Department immediately after the hearing on Monday, we came up with that language that we had suggested, the basic care facility continues to be responsible for the care and services of that individual, which they were agreeable to. I thought we had some agreement, we do need a specific exemption as it said notwithstanding to the life safety issue. The attorney with the department was going up at noon on Monday to draft it and we haven't seen or heard anything since. Im not sure because the agreement was, we were just going to wait but we knew that you wanted it back by yesterday or today at the latest and we are just waiting.

Madam Chair Lee: Is it Darlene Bartz?

Shelly Peterson: Well, Darlene Bartz was one and Bruce Prichet. The Attorney is Tara Brandner and I believe she is in the AG's (Attorney General) office.

Madam Chair Lee: She is wonderful; she is our medical marijuana woman.

Shelly Peterson: I know that when they left, they were in agreement with us on that language because they were worried that the responsibility was not clearly with us so, we all agreed with the basic care facility shall be responsible of the care and services of the resident. I think that really addresses that but I don't know what is taking them so long.

Madam Chair Lee: Maybe we will just amend it and if they have a heart attack about it, they can come to the conference committee and let us know.

Shelly Peterson: That sounds great with me.

Madam Chair Lee: What is it, two lines?

Shelly Peterson: That is right.

Senator Hogan: So where are we putting that?

Shelly Peterson: I thought maybe right at the end we could put it, the basic care facility continues to be responsible for the care and services of every basic care resident.

Senator Hogan: We are going to put it at the end of line 19 and it would become line 20.

Shelly Peterson: A new line. Thank you, we have been anxiously waiting so we appreciate that. We can come back this afternoon and see if you.

Madam Chair Lee: We will look at it first this afternoon.

Shelly Peterson: Ok.

Madam Chair Lee: We will meet in the afternoon but we will be talking about medical marijuana.

Shelly Peterson: Thank you very much.

Madam Chair Lee and the committee move on to discuss amendments for another bill.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1126
3/13/2019
Job #33646

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to basic care facility end of life services.

Minutes: Attachment #1-2

Madam Chair Lee and the committee begin the discussion on HB 1126 with the amendment that was proposed to the committee from Bruce Pritschet. (Please see Attachment #1)

Senator Anderson: Personally, I don't see a big problem with family members taking care of the individual but here it wants to make it either the hospice agency or contracted services and not let just a family member take care of the individual. It seems to me that if the individual stayed at home, family members could be taking care of it.

Madam Chair Lee: There are some things that families can do and, some things that they can't and somebody will end up in a hospital if there isn't a hospice close by to provide some of those services and they talked about I think it was a third of the state that does not have coverage for hospice services. I just can't see how easy it's going to be to get any kind of contract signed with family members. You might draft volunteers from church that would help just sit with somebody, that kind of stuff.

Senator Anderson: I don't think it is the intention of the department to do a contract with family members. You can contract with the visiting nurse agency or something else, you're not going to contract with the family members that is not their intention.

Madam Chair Lee: They want contracts with caregivers if it is a higher outside caregiver.

Senator Hogan: This is a real change in the intent of the bill.

Madam Chair Lee: Yes, I think it is too but, I bring up the fact that we had that amendment so that we haven't ignored it when we're moving forward and is there anything that will fit in and probably not.

Senator Anderson: My sense is that we ought to move ahead with it the way it was written and give it a chance to see how it works. We have to rely on the basic care facilities a little bit to say; if we can't find the family we will make other arrangements or transfer them out. Of course all these stories about a blizzard or whatever else, you know that can always happen but you get a 500-year flood or whatever else but you have to take care of that when the time comes, you can't always plan for that detail and encumber so much about what you can do because you are worried about that so I think we can move ahead with it. I'll move a **DO PASS** on it.

Madam Chair Lee: So you don't want the addition that we just talked about?

Senator Hogan: The one that Shelly Peterson proposed. **(Please see Attachment #2)**

Madam Chair Lee: Now that I have the bill in my hand, could you tell me again what that amendment was?

Senator K. Roers: The basic care facility continues to be responsible for the care and services of every resident.

Senator Anderson: That is fine, I don't have a problem with that.

Senator K. Roers: I move to ADOPT AMENDMENT from Shelly Peterson

Madam Chair Lee: Well, Senator Anderson has moved a do pass on the bill.

Senator Anderson: I didn't get a second for it though, so the motion dies because I don't have a second.

Madam Chair Lee: There it goes. We will just make it official the AMEND is from Senator K. Roers, is there a second to the amendment?
Seconded by Senator O. Larsen

Madam Chair Lee: Any discussion on the amendment? If not, please call the roll.

ROLL CALL VOTE TAKEN

6 YEA, 0 NAY, 0 ABSENT
MOTION CARRIES TO ADOPT AMENDMENT

Madam Chair Lee: We have the amended bill before us.

Senator Anderson: I will move a **DO PASS, AS AMENDED.**
Seconded by Senator K. Roers

Madam Chair Lee: Any further discussion? If not, please call the roll.

ROLL CALL VOTE TAKEN

6 YEA, 0 NAY, 0 ABSENT
MOTION CARRIES DO PASS, AS AMENDED.
Senator O. Larsen will carry HB 1126 to the floor.

Madam Chair Lee closes the discussion on HB 1126.

SK
3/13
15

19.0602.02001
Title.03000

Adopted by the Senate Human Services Committee

March 13, 2019

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

Page 1, line 19, after the underscored period insert "A basic care facility continues to be responsible for the care and services of every resident."

Renumber accordingly

Date: 3/13/19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1126

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: See below

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 Roers Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen	X				
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

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

Page 1, Line 19, after the period insert "A basic care facility continues to be responsible for the care and services of every resident."

Date: 3/13/19
Roll Call Vote #: 2

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1126

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 Anderson Seconded By Roers

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen	X				
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Larsen

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

REPORT OF STANDING COMMITTEE

HB 1126, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1126 was placed on the Sixth order on the calendar.

Page 1, line 19, after the underscored period insert "A basic care facility continues to be responsible for the care and services of every resident."

Renumber accordingly

2019 TESTIMONY

HB 1126

HB1126
1/30/2019
#1

Testimony on HB 1126
House Human Services Committee
January 30, 2019

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 214 basic care, assisted living and nursing facilities in North Dakota. I am here to testify and ask for your support on HB 1126.

First, I apologize, I want to propose a number of amendments to correct an error and more clearly demonstrate the primary purpose of this bill.

The primary purpose of this bill is to allow residents of a basic care facility, who receive an end-of-life diagnosis and they begin to exceed the basic care criteria, to elect to remain a resident in the facility if the facility themselves, or through contract, can meet all of their needs. It is not our desire to put that resident or any other resident at risk or provide any less care.

We appreciate the Department of Health addressing this issue with us almost four years ago. We have found few facilities are providing this extended service to residents and families. This past year we discussed this issue and have identified the primary barrier. We approached the Health Department and they were very receptive of our suggestion of reconvening a workgroup to better study and find solutions for improving access to the end-of-life care in a basic care setting. So that was the path we were embarking on until we looked at the law and it appeared the primary barrier was routed in ND Century Code and that is why we are

here. It is our goal to work with you on the law revision and then go back to the Health Department and work with them on further rule changes to better address end-of-life care in this setting.

North Dakota is very prescriptive on care setting, we do not allow "aging in place" and when a person doesn't meet assisted living, basic care or nursing facility criteria, they must move. In reviewing the ombudsman report, admission and discharge concerns are a primary complaint of residents and families.

Receiving a written discharge notice because you don't meet criteria and your needs have changed is very difficult for families to accept. It is difficult to leave the setting you've become accustomed too, and even more difficult to leave your caregivers who many times you've come to depend on and love. Moving is frightening and scary.

In July 2015, basic care rules were amended and rules were put in place to allow basic care facilities to apply for an optional license to provide end-of-life care. Very few have applied for the license because of the NFPA 101 Life Safety Code requirements. That requirement is dictated in line 13 and 14 of the bill and further outlined in rule NDAC 33-03-24.1-23(8&9)

8. A facility that retains a resident requiring end-of-life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 Life Safety Code, 2012 edition, health care occupancy requirements.

9. Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self evacuation when a resident is receiving end-of-life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation capability. Hospice staff, family members, volunteers, or other nonfacility staff cannot replace required facility staff.

We support these standards, however at the end-of-life we would like to allow families, volunteers, hospice staff or one-on-one caregivers, employed by the resident or their representative, to help meet the evacuation needs of the dying person. In the 2015 session you created such a section for end-of-life care in assisted living and it works exceptionally well.

We assure you, we must still meet the evacuation scores of all residents, but this would allow us to use "non-staff" to meet the requirements for the person who is dying. The Health Department raised the question, what if the family doesn't show up, they have good intentions but don't follow through? That is an excellent question and one that would be immediately addressed with family, volunteers or hospice. We must have a safe plan in place to meet the evacuation score of all residents. When it is not working, volunteers or family do not show up, we must secure staff and then meet with the family regarding a new plan or discharge. No one is in favor of putting anyone at risk, all lives matter and the basic care facility is ultimately responsible.

We believe though, when a person has been an existing resident and they get that diagnosis that they have six months or less to live, if we can safely and appropriately meet their needs, or through contract, family or volunteers, we would like to have that option available. Often when a person receives that diagnosis, they continue to meet our criteria and then it is only in the last days or weeks that they need 24/7 care. We believe it is cruel to make someone leave in the last days or weeks of life. We believe through facility staff, and having the option of utilizing non-staff at the end of life, we can assure all residents will be appropriately cared for and in the event of a disaster safely evacuated.

Thank you for consideration of this issue which is important to us, residents and family. Following my testimony, you will hear testimony from Kari Dick, Executive Director with Touchmark at Harwood Groves in Fargo, Tracee Capron, and Executive Director of Hospice of the Red River

Valley, Rochelle Schaffer, Executive Director of Home Care at Sanford and Cheryl Rising, Nurse Practitioner, who has an important story about a patient.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660

HB1126
1/30/2019
#1

Proposed Amendments to HB 1126

Page 1, Line 15, remove "admit"

Page 1, Line 16, remove "and"

Page 1, Line 17, after "family" insert ", or the individual's designee,"

Page 1, Line 17, after "volunteer" insert "s"

Page 1, Line 17, replace "and" with "or"

Page 1, Line 18, after "facility" insert ","

Page 1, Line 18, after facility insert "resident or their representative"

Page 1, Line 18, after "a" insert "person or"

Page 1, Line 18, remove "or utilize volunteer and family"

Page 1, Line 19, remove "support, or both"

With amendments, Lines 15-19 would need:

Notwithstanding contrary provisions in subsection 1, a basic care facility may retain an individual in need of end-of-life services if the facility wraps around the individual's family or the individual's designee, volunteers or staff services to support the individual through end of life. The facility, resident or their representative may contract with a person or a hospice agency to meet the needs of the individual.

HB1126
1/30/2019
#1

NOTIFICATION TO THE DEPARTMENT OF HEALTH REGARDING THE PROVISION OF END OF LIFE SERVICES TO A BASIC CARE RESIDENT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 60907 (04-15)

Optional Service of End of Life Care for Basic Care residents who have elected Hospice services. Notification to the Department of Health must occur within 48 hours of the resident electing hospice services or upon discharge, transfer, death, or when the resident is no longer capable of self-preservation.

Provider's Name		Telephone Number	
Address	City	State	ZIP Code
Total number of residents receiving end of life services (including this resident)			

INITIAL NOTIFICATION

Provide the following dates:	
Date	When the physician identified the terminal illness.
Date	When the resident elected Hospice.
Date	When the hospice services were implemented in the basic care facility.
Date	When the required training and competency evaluation was completed.
Date	When the contract was signed with the Medicare Certified Hospice agency chosen by the resident or family members.

Contact Person for the Medicare Certified Hospice Agency		Telephone Number	
Address	City	State	ZIP Code

THE RESIDENT IS NO LONGER CAPABLE OF SELF-PRESERVATION

On what date did the resident become no longer capable of self-preservation?	
Does the end of life plan of care provide for adequate 24 hour bedside care by facility staff?	☐ Yes ☐ No
E-Scores completed weekly and with a significant change in the resident's evacuation capability and facility staff adjusted accordingly.	☐ Yes ☐ No

FINAL NOTIFICATION

Provide the date for the resident's:		
Discharge Date	Transfer Date	Date of Death
Administrator's Signature		Date

Submit completed form to: North Dakota Department of Health
Division of Health Facilities
600 E Boulevard Ave, Dept. 301
Bismarck, North Dakota 58505-0200
Fax: 701.328.1890

HB1126
1/30/2019 #1

NORTH DAKOTA
DEPARTMENT of HEALTH

HEALTH RESOURCES SECTION
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200
Fax: 701.328.1890
www.ndhealth.gov

MEMORANDUM

TO: Shelly Peterson, NDLTCA President

FROM: Lucille Rostad Lucille Rostad

DATE: December 11, 2015

TOPIC: Hospice Services in a Basic Care Facility NOT Licensed to provide End of Life Care Services

This memorandum is in response to your request for clarification related to how long a resident electing Hospice Services can stay in a Basic Care facility that is not licensed to provide End of Life Care Services.

A resident in a Basic Care facility can elect Hospice Services and stay in a Basic Care facility that is not licensed for End of Life Care Services as long as the resident meets the basic care level of care.

What does this mean?

NDCC 23-09.3-08.1 Admission of residents to basic care facility – Restrictions. A basic care facility may admit and retain only an individual for whom the facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's highest practicable level of functioning. A basic care facility may admit and retain only an individual whose condition and abilities are consistent with the national fire protection association 101 life safety code requirements.

This statute is further clarified in North Dakota Administrative Code 33-03-24.1-01. Definitions. 2., 5., 6., and 16. Based on this information, the admission and retention criteria for a resident in a Basic Care facility includes that the individual may need assistance with activities of daily living which means that the resident is able to help with most of an activity, but cannot do it entirely alone. This includes eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.

The decision of some Basic Care facilities to provide twenty-four-hour a day nurse staffing should not be interpreted to mean that the resident's condition requires twenty-four hour a day nursing care. If the resident declines to the level where continuous, twenty-four-hour a day nursing or medical care is needed, the individual can no longer assist with their own activities of daily living, or the resident is no longer capable of self preservation, with or without assistance, the resident is no longer appropriate to remain in a Basic Care facility.

In summary, a basic care resident can elect to receive Hospice Services and stay in a Basic Care facility that is not licensed to provide End of Life Care Services, until the resident no longer meets the definition of a basic care resident as discussed above, and the care required exceeds the basic care level. If a Basic Care facility becomes licensed to provide End of Life Care Services, the resident who elects Hospice Services would be able to remain in the facility even when the resident exceeds the basic care level of care and requires skilled nursing care.

If you have questions, please contact Lucille Rostad at 701-328-2352.

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#1

33-03-24.1-21. Adult day care services.

1. A facility must obtain approval from the department to provide adult day care services.
2. Use of existing space and equipment to deliver adult day care services is acceptable if this does not diminish the services provided to the residents of the facility and their needs being met.
3. Medications and treatments must be administered only by order of a licensed health care practitioner.
4. Records must be maintained of services provided to individuals participating in adult day care services.
5. An area allowing privacy for adult day care individuals must be developed to allow for rest periods.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-22. General building requirements.

Repealed effective July 1, 2015.

33-03-24.1-23. Optional end-of-life care service.

A facility that intends to retain residents who require end-of-life care must comply with the requirements of this section, apply on an application as specified by the department, and receive written approval from the department prior to providing the services. The facility must meet the following requirements:

1. A facility may not retain residents who require more than intermittent nursing care unless the resident requires and elects to receive end-of-life care from a licensed and Medicare-certified hospice agency and the facility is licensed to provide end-of-life care.
2. A facility providing end-of-life care must employ or contract with a registered nurse to supervise resident care to meet the needs of the residents at all times, either directly or indirectly. The facility must employ a licensed nurse who is on the premises at least forty hours per week to identify and respond to resident needs, care plan accordingly, provide oversight related to care, and review and document the resident's individual needs and care provided.
3. Individuals in need of end-of-life care who require skilled nursing care or are not capable of self-preservation may not be admitted.
4. The facility and the licensed and Medicare-certified hospice agency shall enter into an agreement that delineates responsibilities, with the licensed and Medicare-certified hospice agency retaining the professional management responsibility for the hospice service.
5. The facility and licensed and Medicare-certified hospice agency in consultation with the resident shall develop and implement an interdisciplinary care plan that identifies how the resident's needs are met and includes the following:
   a. What services are to be provided;
   b. Who will provide the services, the facility or hospice agency;

c. How the services will be provided;

d. Delineation of the roles of facility staff and the hospice agency in the care plan process;

e. Documentation of the care and services that are provided with the signature of the person who provided the care and services; and

f. A list of the current medications or biologicals the resident receives and who is authorized to administer the medications.

6. The facility shall notify the department within forty-eight hours of election that the resident has elected hospice, the date the hospice was elected, and the name of the hospice agency serving the resident.

7. The facility shall notify the department within forty-eight hours of the hospice resident's discharge, transfer, death, or when the resident is no longer capable of self-preservation.

8. A facility that retains a resident requiring end-of-life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 Life Safety Code, 2012 edition, health care occupancy requirements.

9. Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self evacuation when a resident is receiving end-of-life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation capability. Hospice staff, family members, volunteers, or other nonfacility staff cannot replace required facility staff.

10. A facility approved to provide end-of-life care shall ensure training and competency evaluation is completed for all nursing and personal care staff members specific to the care and services necessary to meet the needs of the terminally ill resident, and the hospice philosophy and services. The training and competency evaluation may be completed, and documented, by the facility registered nurse, a registered nurse consultant, or a hospice agency nurse. Nursing and personal care staff members shall complete the above training and competency evaluation:

    a. Prior to facility approval from the department to provide end-of-life care;

    b. Within thirty days of employment; and

    c. Annually.

11. A facility that intends to retain residents who require end-of-life care shall comply with the additional requirements in this section and request and receive approval on a printed new license from the department, prior to providing end-of-life care to residents.

12. The facility approved and licensed to retain residents in need of end-of-life care remains responsible for the appropriate delivery of end-of-life care in coordination with the licensed and Medicare-certified hospice agency. If the facility is unable, or becomes unable, to meet the needs of the resident requiring end-of-life care, the resident rescinds election of the hospice benefit, or the facility is unable to comply with these requirements, the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement consistent with the level of care required to meet the resident's needs.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02

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1/30/2019
#2

Testimony on HB 1126
Human Services Committee
January 30, 2019

Good morning Chairman Weisz and members of the House Human Services Committee.

Due to poor weather conditions I, Cathy Anhalt, with Sanford Home Health, am sharing this testimony on behalf of Tracee Capron, Executive Director at Hospice of the Red River Valley.

Hospice of the Red River Valley is an independent, community-based nonprofit hospice, serving 14 counties in North Dakota. We have helped thousands of families gain the valuable gift of time with their loved ones, creating new memories together while receiving comfort, respect and dignity wherever they call home.

I am here today to testify and ask for your support of HB1126 with the proposed North Dakota Long Term Care Association amendments.

First, let me share what hospice care entails. As hospice providers, we are experts at caring for people at the end of their lives. Some benefits for the patient and caregivers include:

- Patient centered care, honoring their values, goals, and wishes
- Pain and symptom control
- Emotional and spiritual support for patient and his/her loved ones

Many people in our state call a basic care facility their home. They, too, are entitled to receive the Medicare hospice benefit. HB1126 as amended will help basic care residents have access to hospice services. Today, many are faced with being uprooted from home and possibly moving many miles to a different facility away from family, friends, routines and caregivers they know and love. We are creating a traumatic experience for patients and families. Nobody should be forced to move from their home in their final days/weeks/hours of life. With your support of these changes, we could keep this from happening.

Hospice of the Red River Valley is committed to being part of the solution to allow family, friends, hospice staff and volunteers to meet the evacuation needs of the patient. Our team of experts will work with the patient, family and the facility to come up with a plan and a backup plan to ensure the safety needs of the patient are met as we do in all other care settings.

Your support of HB 1126 has considerable financial benefits to the patient, family, facility and healthcare system. When patients are forced to move from basic care to skilled nursing it will increase the cost to the patient, family, or the state for those utilizing the Medicaid benefit. Shifting from basic care to skilled nursing increases cost

by double or triple. Even worse, if a patient transitions from basic care to the hospital, the cost for one day in the hospital is similar to 30 days in a basic care facility.
Just yesterday, we had an 87-year-old patient living in a basic care facility, and because she needed additional end-of-life support, she was forced to move out of her home during -40 degree weather to a skilled nursing facility. She will likely die within a week—in an unfamiliar place with all new staff. Is that fair? We can do better.

The loved ones left behind after someone passes will always remember how they felt when their loved one died. There is no 'do-over' or second chances. We have one opportunity to help someone live to the end of their life with comfort, dignity and respect. Please help those living in a basic care facility in North Dakota by supporting HB1126, with the proposed amendments.

Thank you for your help.

Tracee Capron, RN, BS, Ed., MAOL
Executive Director
Hospice of the Red River Valley

HB1126
1/30/2019
#3

Testimony on HB 1126
House Human Services Committee
January 30, 2019

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Kari Dick. I am the Executive Director at Touchmark at Harwood Groves in Fargo. Touchmark at Harwood Groves has a total of 200 Assisted Living, Memory Care, and Independent Living homes. Thirty-seven of these homes are licensed as basic care dementia care homes.

I am here today to testify in support of House Bill 1126 related to end-of-life care in Basic Care. When the initial "end of life" option was added to the Basic Care licensure process in 2015, Touchmark at Harwood Groves was one of the first facilities to add the provision. Prior to this, our community was able to safely accommodate a number of residents through the end of life. Even with the change in rules, our goal was to continue to do this for residents when appropriate and safe. We have utilized Hospice services for many years, and often long before a resident is in his/her final days of life.

It is important to note that Basic Care facilities may continue to bring Hospice into their buildings without the end of life provision. Many residents on Hospice—particularly in a dementia care setting—may be up and walking around while on Hospice. The benefits of Hospice are not limited to the last days or weeks of life. Hospice care allows residents greater pain relief, typically eliminates stressful ER visits and/or hospital stays, and brings greater quality of life to persons with dementia while also reducing the burden often placed on family members. Partnering with a local hospice agency also provides additional help and resources to facilities providing care.

It is only when the resident consistently no longer meets the community's criteria that facilities must follow the Basic Care rules regarding end-of-life care. In many cases, this time period may only be a few days or even just a week or two.

Unfortunately, there is one major part of the rule that creates barriers for facilities. The rule requires Basic Care facilities to add additional staff members to meet the evacuation requirements related to Life Safety Code. In most cases, this applies to night shift coverage—the time period when facilities are at the lowest staffing level. Because there is a significant staffing shortage in long-term care, facilities do not typically have extra staff ready to take on night shifts on short notice and for an uncertain amount of time.

This leaves the facility with no other option but to hire staff to meet the requirement. The recruitment and hiring process itself often takes at least a couple weeks to complete. The new staff member then needs to be trained. By the time this process is complete, an individual who is truly at the "end of life" will likely have passed away.

The challenge associated with meeting this requirement prompted Touchmark to opt out of continued participation in the optional end-of-life Basic Care licensure. Without the ability to

utilize private caregiving agencies and/or family members, we could neither realistically add staff when a resident reached the point of not meeting criteria nor could we reasonably predict when the need would occur.

Touchmark still utilizes Hospice services with many residents up until the individual no longer meets criteria. Unfortunately, in a number of cases, we have been forced to transfer someone in their final days of life to an unfamiliar setting. This is extremely traumatic for a dying person and their family. Instead of focusing on their loved one's needs, families are faced with the task of managing a move, filling out hours of paperwork, and learning to navigate a new facility.

This is not because of our inability to safely care for this individual—instead, it's because the current requirement does not consider private caregivers and/or family members when calculating the facility's evacuation score. The fix is easy—simply allow family members, private caregivers, and other resident representatives to help meet the evacuation requirement.

Like Ms. Peterson, I want to emphasize that providers are not asking to admit persons who are near the end-of-life. I also want to emphasize that there will still be individuals that will require a transfer to skilled care. This change will simply allow Basic Care providers, with the help and support of a local Hospice agency, to help provide a compassionate end-of-life experience to those who can safely live out their last days in the setting which has become their home.

Thank you for your consideration of this important bill.

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#4

North Dakota Hospice Organization

Chairman Weisz and Members of the Committee:

My name is Rochelle Schaffer, Registered Nurse and President of the North Dakota Hospice Organization. Our organization represents the 11 hospice agencies throughout North Dakota. I am here to testify and ask for your support of House Bill 1126, relating to basic care facility end-of-life services.

I have been a representative and advocate for hospice care in North Dakota for the past 7 years in my roles as a Hospice Nursing Director and as the State Hospice Organization's President.

Hospice is a specialized type of end of life care. It is a team of interdisciplinary members that include physicians, nurses, nursing assistants, social workers, chaplains, volunteers, and pharmacists all working together. Along with the individual and family, the hospice team develops a care plan to manage symptoms and promote comfort and safety.

Hospice also provides financial coverage for medications and equipment needs. The hospice team is available 24 hours per day to provide support and guidance to the individual and family. In the months following a hospice death, bereavement services are offered to family and friends.

Hospice care can be provided in any setting an individual calls "home"- a long term care facility, a private home, a group home, or an assisted living facility. Due to current regulation, this is not often offered to a patient living in a North Dakota Basic Care Facility.

Together Hospice and Basic Care Facilities in North Dakota can work together to enable these individuals to stay in the place they call home, just as we currently do in private homes and assisted living facilities. This can be accomplished if the Basic Care Facility is able to permit the use of family and volunteer services, along with Hospice to support the individual through their end of life. Hospice is a benefit to a Medicare beneficiary, as well as most health plans. Individuals have the right to use the benefit just as family has the right to assist in the care of their loved ones, no matter the setting in which they reside. Also consider the potential financial burden on the individual, the family and the health systems if this individual is moved to a higher level of care setting.

I ask that you consider approving House Bill 1126 to ensure the Hospice Benefit with family and volunteer support is a choice to North Dakota individuals living in Basic Care Facilities.

Thank you.

Rochelle Schaffer, RN, MHA
President, ND Hospice Organization

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1/30/2019
5

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

House Human Services Committee

House Bill 1126
Chairman Weiss and Committee Members:

I am Cheryl Rising, FNP and legislative liaison for the North Dakota Nurse Practitioner Association. I am here to testify in support of HB 1126 a bill for an Act to amend and reenact section 23-09.3-08.1 of the North Dakota Century Code, relating to basic care facility end-of-life services

Currently when an individual resides in basic care, is at end of life, and the family requests to have supportive cares, the organization may not keep the resident in the facility and start hospice due to the regulations. I personally go out to assisted living buildings and basic care areas to provide primary care for many individuals in these types of residence. I have had personal experience with wanting to keep a resident in basic care in their own room, surrounded by familiar care givers, family, and have had to explain to the family we are unable to start hospice here, we must send the loved one to the ED and find a place that will be able to start hospice. This is agonizing for the care giver and family to disrupt the relationship that has developed which may have been for years. The most recent experience was a resident that was at basic care, end stage dementia, started to decline, the family wanted hospice and we had to transfer to the ED. This was a difficult time and an inappropriate use of health care dollars and emergency room charges.

The most recent situation in the last two weeks that I as involved with was a patient in an organization that could keep the resident and start hospice if needed. I received a call as I as finishing work on a Thursday that an individual had taken a turn for the worse and could I please come and see the resident. I immediately went to the individual's residence. I knew this patient was declining over the months. I had spoken with the sister, the only living relative, about starting hospice in October and again in December; however, she was so distraught that she was unable to decide at that time. The resident continued in a residential home with a care giver through an organization in Bismarck. I called hospice and left a message while I was in route to see the patient and if the sister wanted hospice would hospice be able to admit and when. I arrived at the apartment, the sister arrived with in 5 minutes. Pt was actively dying, low oxygen saturation, and struggling to breath. The sister did not want her to be moved, asked to keep the patient in her own bed, surrounded with the care givers that have cared for her for years. Hospice returned my phone call, and after discussion stated they would be there as soon as they could get the on-call hospice nurse the packet for admission and get there. I had already written orders for Ativan and Morphine sulfate for comfort. By the time the wonderful

hospice nurse arrived the first dose of Ativan had been given, and the patients breathing improved. I was so grateful to leave knowing she was now being cared for by her own caring team and hospice. The patient lived for 48 hours and expired. The sister was grateful for all the loving care and comfort. If this facility was not able to have hospice the patient would have been sent to the hospital. This was a much different experience for this family member.

NDNPA urges a do pass on this bill so individuals and families can choose hospice where they reside.

Cheryl Rising, FNP, FAANP

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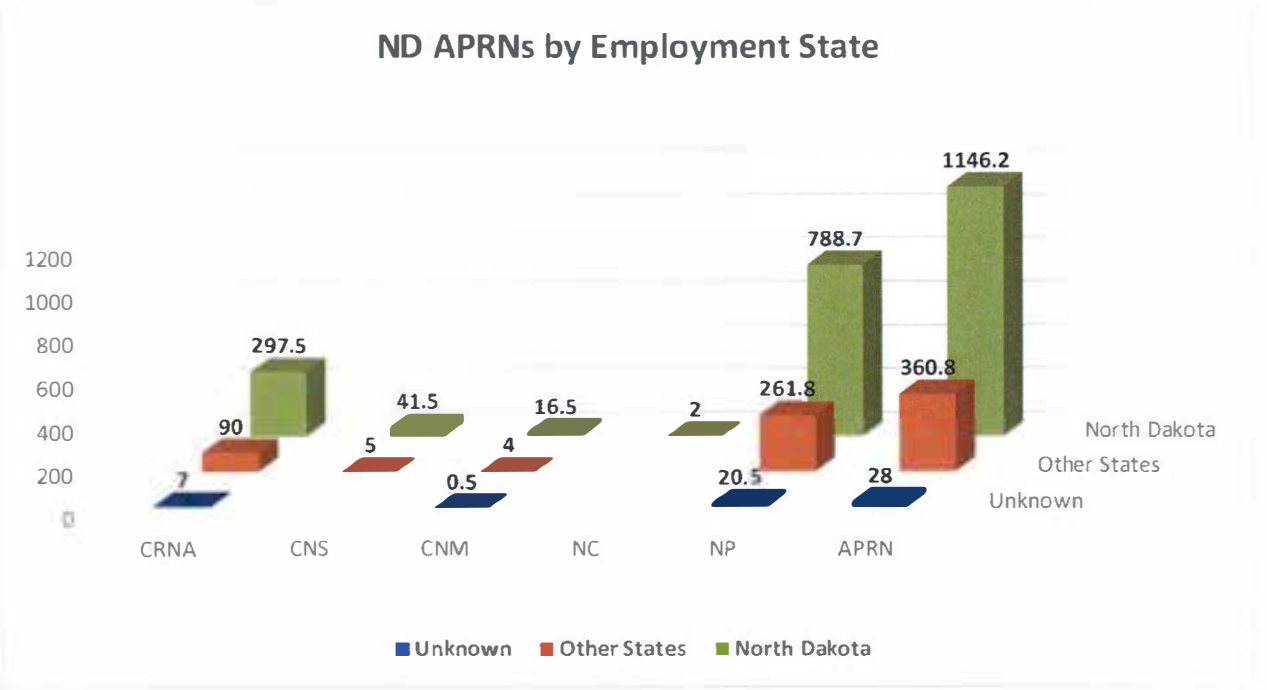
APRNs in ND

Methodology: All providers are counted as one full-time equivalent (FTE). Providers that are dually licensed in more than one discipline are split equally among each discipline. Those that indicated more than one practice state are divided equally to each state and providers that indicated more than one practice location are divided equally to each site.

APRNS: As of September 10, 2018, there are 1,534 advanced practice registered nurses (APRNs) licensed in North Dakota. Of the total APRNs, there are 1071 nurse practitioners (NPs), 394.5 certified registered nurse anesthetists (CRNAs), 46.5 are clinical nurse specialists (CNS), 21 certified nurse midwives (CNMs), and 2 nurse clinicians (NCs). Twelve APRNS were dually licensed, 7 CNS/NPs, 4 CNM/NPs and 1 CRNA/NP. As of November 11, 2018, 1,111 APRNs have prescriptive authority.



Since 2016, there has been a 20% increase (246) of APRNs licensed in North Dakota which included a 29% increase in NPs, 17% increase in CNMs, 4% increase in CRNAs, 8% decrease in CNSs, and no change in NCs. See table 1.

Table 1

ND Licensed APRNs by Employment State						
	Unknown		Other States		North Dakota	
	2016	2018	2016	2018	2016	2018
CRNA	8	7	91.5	90	278.5	297.5
CNS	0	0	5.5	5	45	41.5
CNM	0	0.5	1	4	17	16.5
NC	0	0	0	0	2	2
NP	12	20.5	166	261.8	652.5	788.7
APRN	20	28	264	360.8	995	1146.2

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Nurse Practitioners: North Dakota has 1071 licensed NPs, 788.7 FTE (73.6%) indicated they are currently practicing in North Dakota at least part of the year. Of those practicing within North Dakota, 70.5% are practicing in the more urban cities of Bismarck, Mandan, Fargo, West Fargo, Grand Forks and Minot with 27.8% practicing in more rural areas, and 1.7% are unknown. Please see attached maps of psychiatric NPs and psychiatric NPs and CNS combined.

Although licensed in North Dakota, 261.8 FTE NPs indicated states other than North Dakota as their State of employment including Minnesota (79.5), South Dakota (32), Texas (25.7), Missouri (23), Arizona (11), Wisconsin (10), Washington (8), Montana (7), Iowa (6.5), California (6), Florida (5.7), Georgia (5), Colorado (4), Ohio (3.5), Nebraska (3.2), Utah (3), Arkansas (2), Hawaii (2), Illinois (2), Louisiana (2), Maryland (2), New Jersey (2), Nevada (2), Massachusetts (1.5), Virginia (1.2), Connecticut (1), Indiana
(1), Kentucky (1), Mississippi (1), North Carolina (1), New Mexico (1), New York (1), Oklahoma (1), Oregon (1), Pennsylvania (1), Tennessee (1), Maine (0.5) and West Virginia (0.5).

Of the nurse practitioners practicing in North Dakota 80.2% (632.2/788.7) indicated their specialty area was family medicine. Other specialties included adult, gerontology, neonatal, pediatric, psychiatric, and women's health. See chart below.

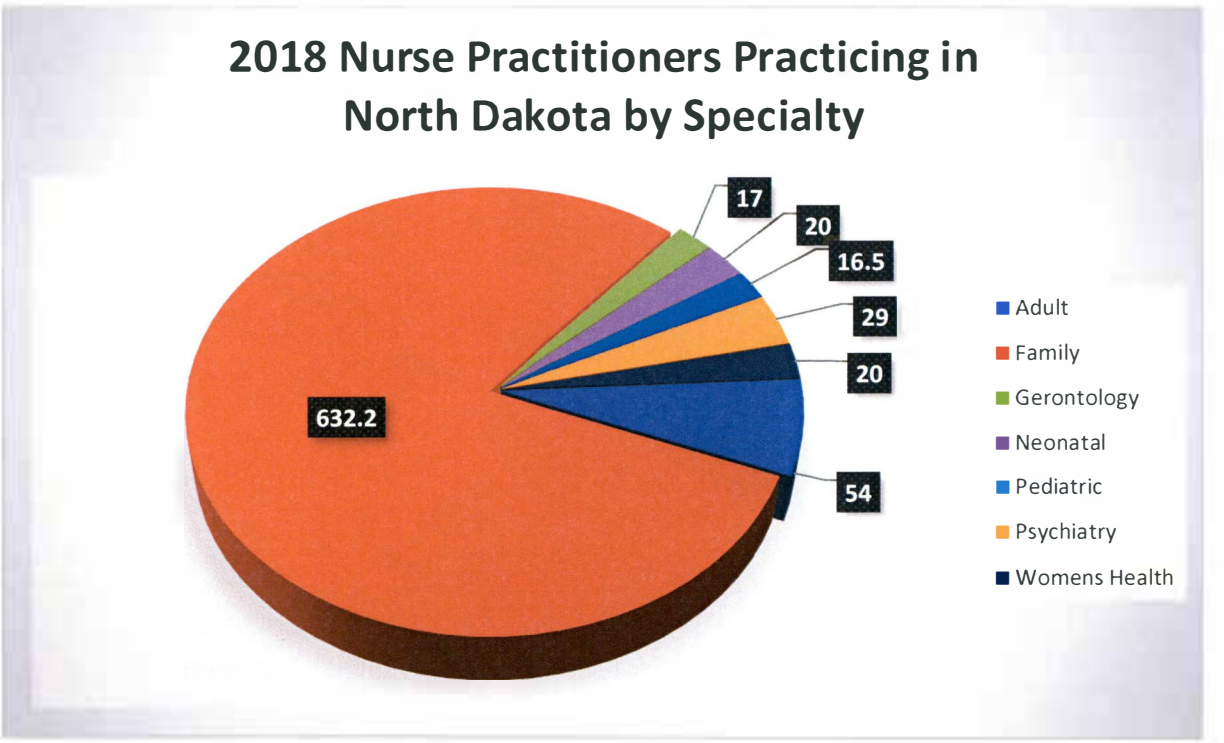

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Table 2

North Dakota Nurse Practitioners by Specialty		
	2016	2018
Adult Medicine	42.5	54
Family Medicine	519.5	632.2
Gerontology	19	17
Neonatal Medicine	18	20
Pediatric Medicine	11	16.5
Psychiatry	20	29
Women's Health Care	22.5	20

Since 2016, the number of nurse practitioners practicing in pediatrics increased by 50%, psychiatry (45%), adult medicine (27.06%), family medicine (21.69%), and neonatal (11.11%) while gerontology decreased by 10.53% and women's health care (11.11%). See Table 2. Currently, 29 nurse practitioners specialize in psychiatry. Of those, 17.5 (60.3%) practice within the more urban cities of Bismarck, Fargo, West Fargo, Grand Forks and Minot. Please see attached map of the locations of NPs with a specialty in psychiatry.

Clinical Nurse Specialists: In North Dakota 46.5 CNS are licensed of which 41.5 (89.2%) indicated they currently practice in the State. Of the 41.5 CNS currently practicing in North Dakota 33.5 (80.7%) are practicing in the more urban cities of Bismarck, Fargo, Grand Forks, and Minot. Please see attached map.

Although licensed in North Dakota, 5 CNS indicated they practice outside of the State. These included Minnesota (2.5), Alabama (1), Iowa (0.5), Ohio (0.5) and South Dakota (0.5). Of the clinical nurse specialists practicing in North Dakota, 60.2% indicated their specialty area was psychiatry and 26.5% indicated adult medicine. Please see chart below.

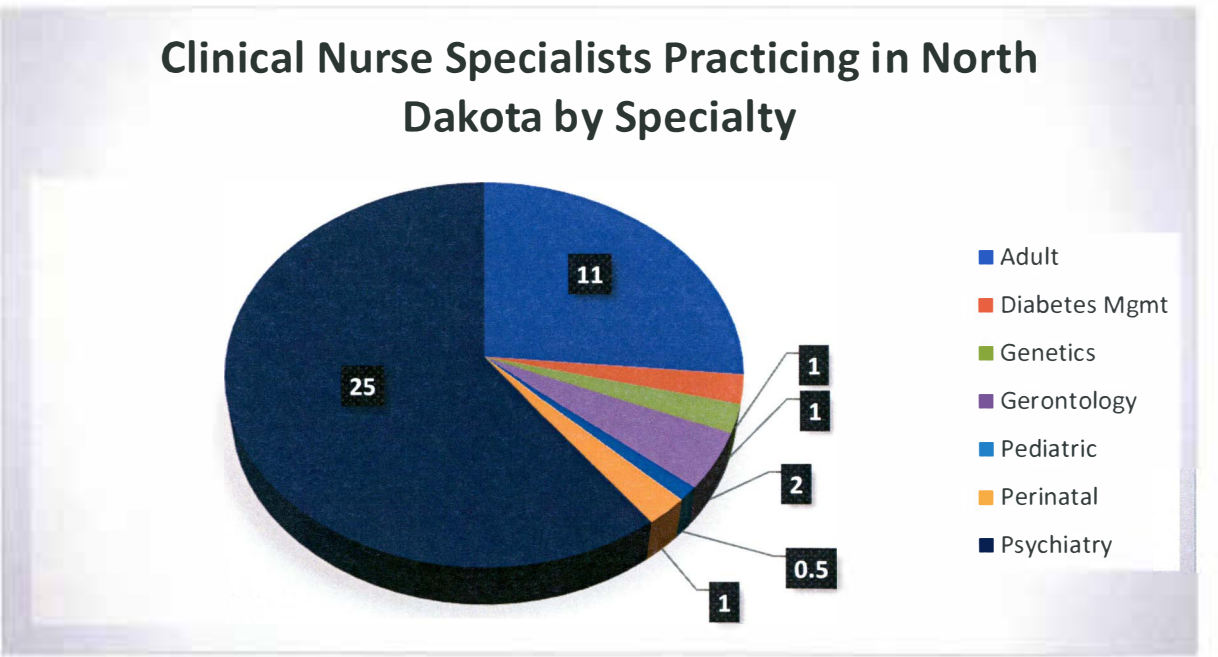

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Table 3

North Dakota Clinical Nurse Specialists by Specialty	2016	2018
Adult	12.5	11
Diabetes Management	1	1
Genetics	1	1
Gerontology	2	2
Pediatric		0.5
Perinatal	2	1
Psychiatry	26.5	25

Since 2016, the number of CNSs practicing in North Dakota has declined by 7.8%. Those practicing in adult medicine declined by 12% and psychiatry by 5.66%. See Table 3. Of the 25 practicing in psychiatry, 74% (18.5) CNSs are practicing in the more urban areas of Bismarck, Fargo, Grand Forks and Minot. Please see attached maps of psychiatric CNSs and psychiatric CNSs and NPs combined.

Certified Nurse Midwives: A total of 21 CNMs are licensed in North Dakota of which 16.5 indicated they are practicing within the State. Two or 12.1% of the CNMs are practicing in rural areas of Belcourt and Williston. The other 14.5 indicated they were practicing in three of the more urban cities including Fargo (7.5), Minot (5), and Grand Forks (2). Although the total number of licensed CNMs increased in 2018 compared to 2016, those that indicated they practice in North Dakota decreased by 0.5 FTE. Please see attached map.

Certified Registered Nurse Anesthetists: North Dakota has 394.5 licensed CRNAs of which 297.5 indicated they are practicing in North Dakota. Of the CRNAs practicing in North Dakota, 84.1% are practicing in the four most urban cities of Bismarck, Fargo, Grand Forks and Minot; 14.2% are practicing in rural areas and 1.7% did not indicate a practice city. The total number of CRNAs practicing in North Dakota increased by 6.8% from 2016 (278.5) to 2018 (297.5). Please see attached map.

Nurse Clinicians: As in 2016, two nurse clinicians continue to practice in North Dakota in 2018. Both nurse clinicians practice in urban areas and specialize in rehabilitation and psychiatry.

2018 North Dakota Nurse Practitioners

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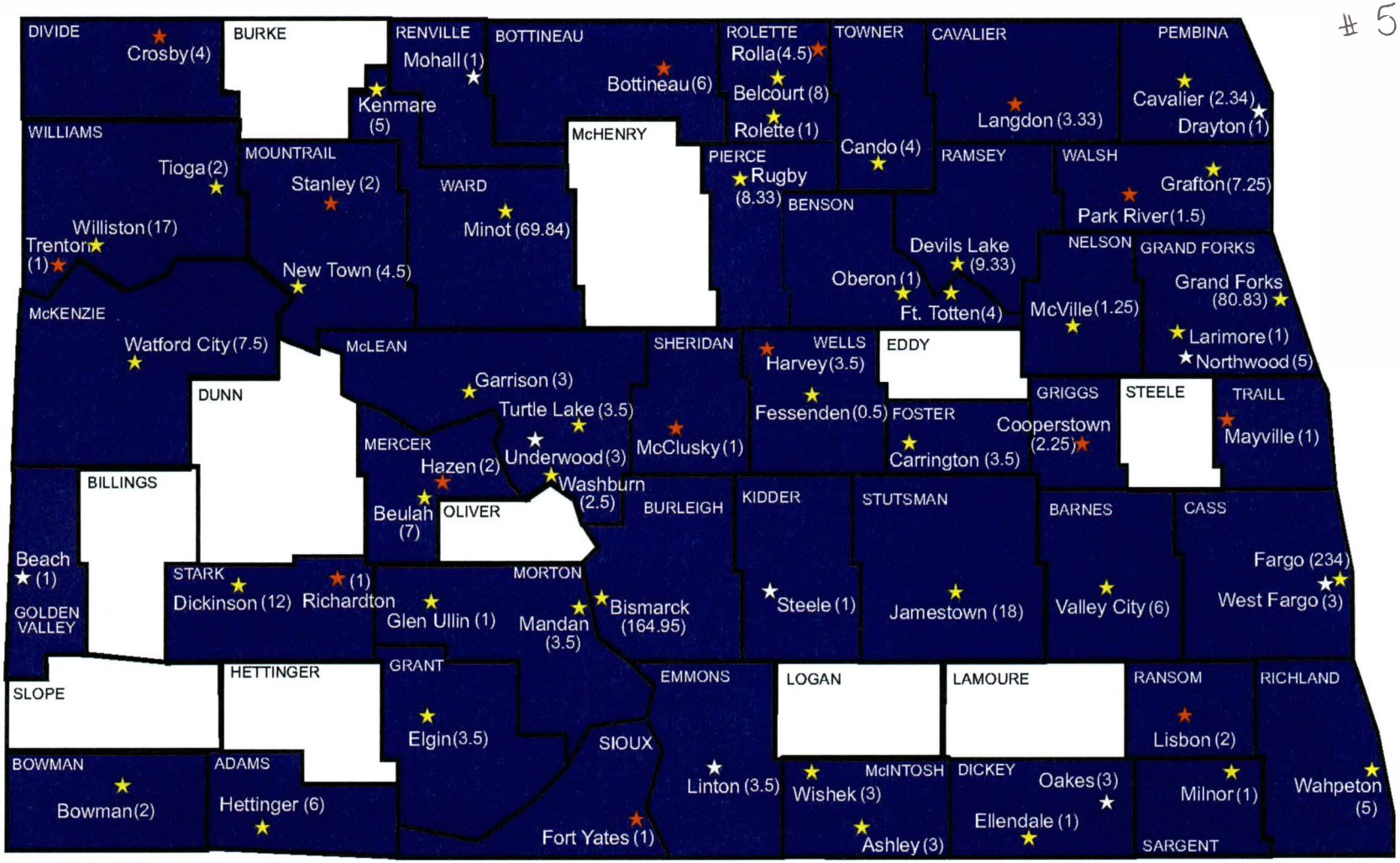

Unknown (13)

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Nurse Practitioners practicing within county
Nurse Practitioners' FTE increased since 2016
Nurse Practitioners' FTE decreased since 2016
No change Nurse Practitioners' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

2018 North Dakota Psychiatric Nurse Practitioners

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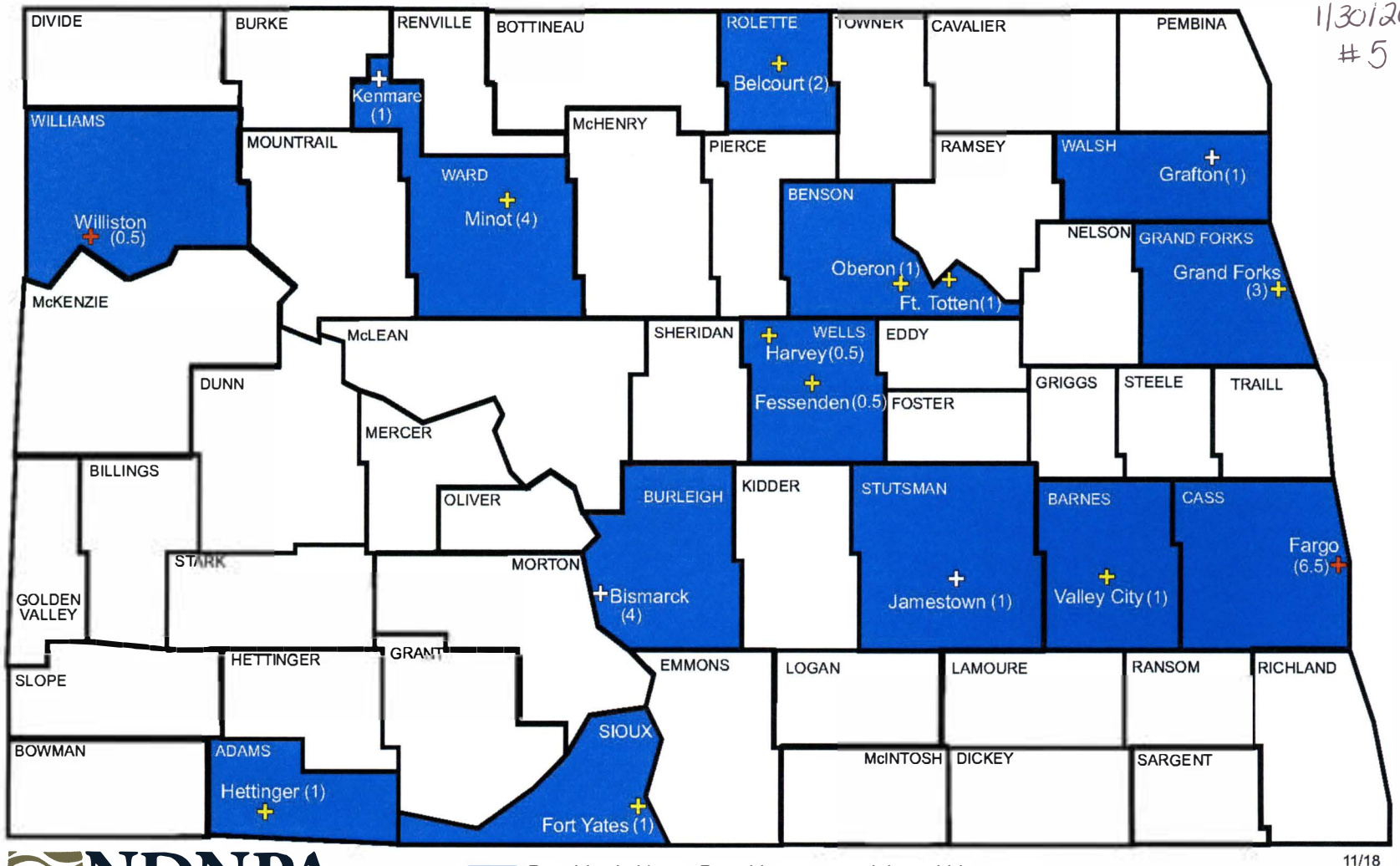

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Psychiatric Nurse Practitioners practicing within county
Psychiatric Nurse Practitioners' FTE increased since 2016
Psychiatric Nurse Practitioners' FTE decreased since 2016
No change Psychiatric Nurse Practitioners' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

2018 North Dakota Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS), and Nurse Clinicians (NC)

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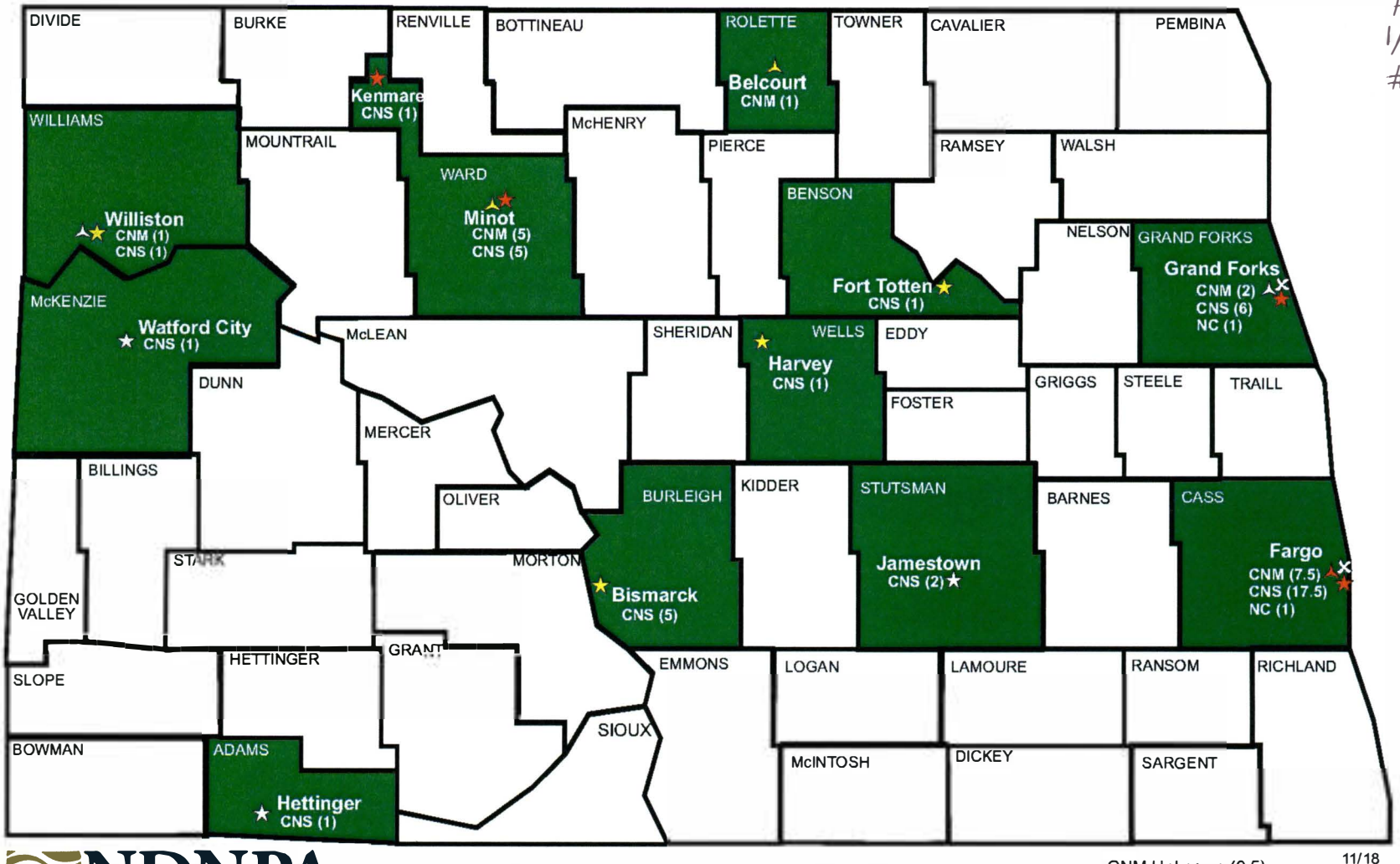

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CNMs, CNS, and/or NC practicing within county
CNM Unknown (0.5)
11/18

CNMs' FTE increased since 2016
CNMs' FTE decreased since 2016
No change CNM's FTE since 2016
No change NC's FTE since 2016

CNS' FTE increased since 2016
CNS' FTE decreased since 2016
No change CNS' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

2018 North Dakota
Psychiatric Clinical Nurse Specialists

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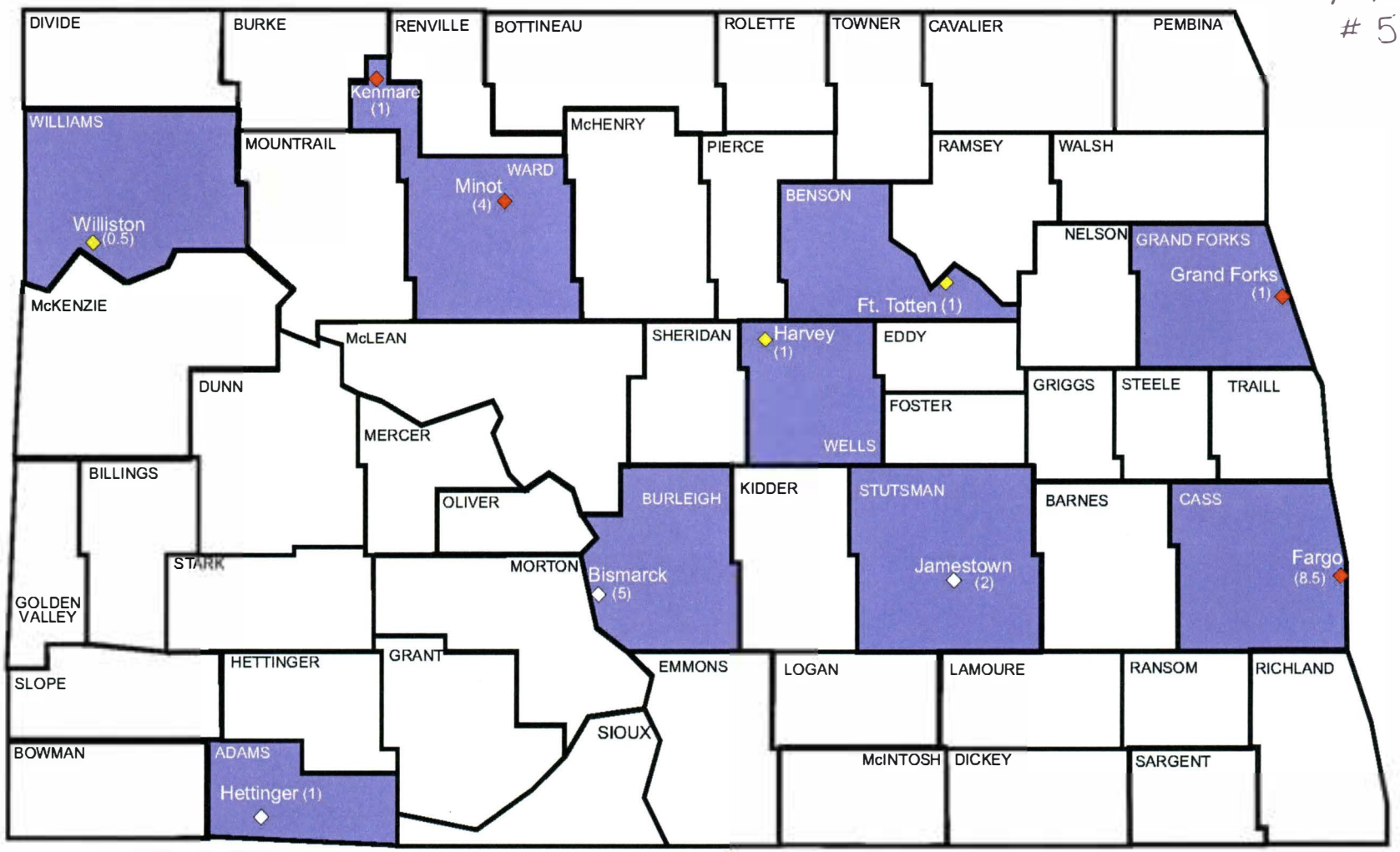

11/18

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Psychiatric CNS practicing within county
Psychiatric CNS' FTE increased since 2016
Psychiatric CNS' FTE decreased since 2016
No change Psychiatric CNS' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

2018 North Dakota Psychiatric Nurse Practitioners and Clinical Nurse Specialists

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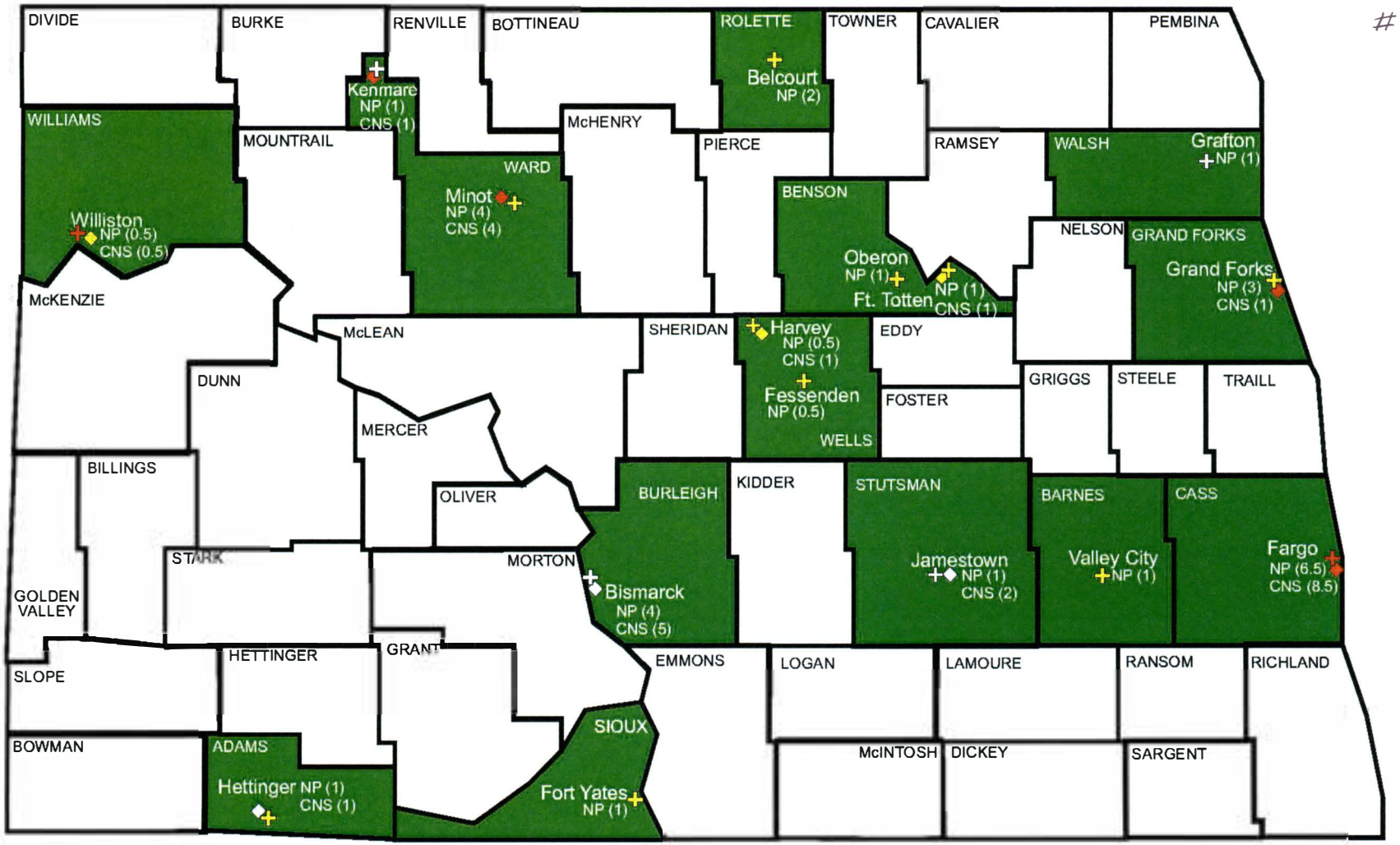

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- Psychiatric NPs and/or CNS practicing within county
- Psychiatric NPs' FTE increased since 2016
- Psychiatric NPs' FTE decreased since 2016
- No change Psychiatric NPs' FTE since 2016
- Psychiatric CNS' FTE increased since 2016
- Psychiatric CNS' FTE decreased since 2016
- No change Psychiatric CNS' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

2018 North Dakota
Certified Registered Nurse Anesthetists

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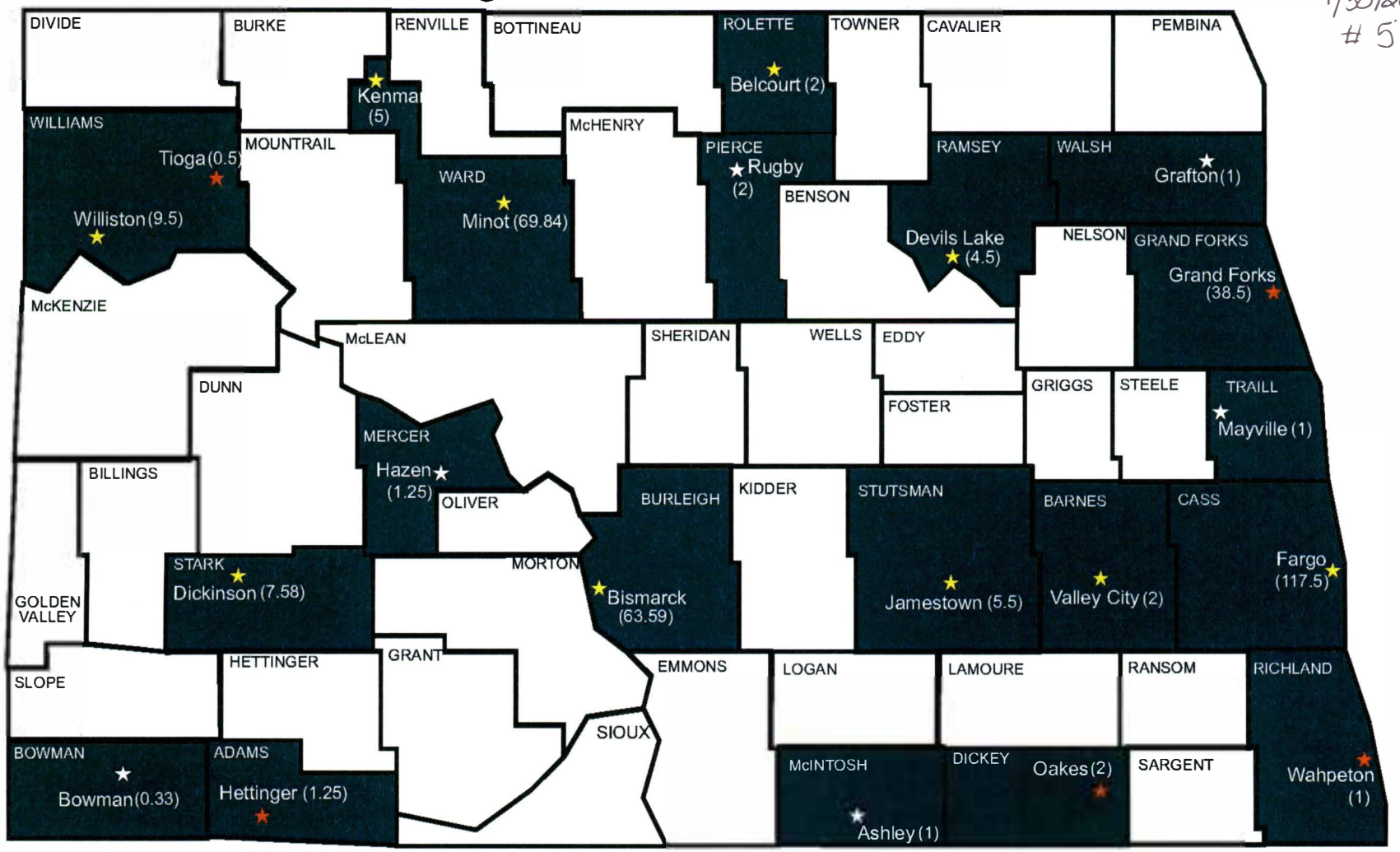

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CRNAs practicing within county
☆ CRNAs' FTE increased since 2016
★ CRNAs' FTE decreased since 2016
☆ No change CRNA's FTE since 2016

Unknown (5)

11/18

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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House Bill 1126
House Human Services Committee
January 30, 2019

Good morning Chairman Weisz and members of the Human Service Committee. My name is Bruce Pritschet, Director of the Division of Health Facilities within the Department of Health. I am here to oppose and provide information on House Bill 1126 related to proposed changes to language within North Dakota Century Code Section 23-09.3-08.1 regarding care provided to end-of-life residents in basic care facilities.

The major changes to state law included in HB 1126, with the proposed amendments, relate to allowing the basic care facility to retain an individual in need of end-of-life services and for care to be provided to meet the individual's needs by family, individual's designee, or volunteers, as well as by facility staff, using a wrap around staffing concept. We do not support this change because we believe this jeopardizes the care and safety of the end of life resident as well as all other residents in the facility.

After a request from basic care facilities, a workgroup was put together to address end-of-life services in basic care. The department of health promulgated rules which allow basic care facilities to provide an optional end-of-life service to existing residents in the basic care facility as long as they contract with a hospice agency, provide staff education related to end-of-life care, and staff in such a manner to provide services to meet the health and safety needs of all residents. These rules became effective July 1, 2015. The rules allow the facility to keep existing residents in need of end-of-life skilled

nursing care as long as they are able to meet the health and safety needs of the resident without compromising the health and safety of other residents in the facility.

In order for a basic care facility to keep an end-of-life skilled resident, the expectation is that the facility continue to meet the care and safety needs, directly or through contract, for all residents in the facility. This means that as the resident's condition declines, additional facility staff may need to be added to meet the health and safety needs of the resident, as well as ensure that the health and safety needs of all residents in the facility continue to be met. Family members or the individual's designee can be present to sit with the resident and provide emotional support while the resident is going through the dying process with no expectation that they are the actual care provider and responsible for evacuation of their loved one in case of an emergency.

This ends my testimony and I would be glad to address any committee questions.

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Testimony on HB 1126
Senate Human Services Committee
March 11, 2019

Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 214 basic care, assisted living and nursing facilities in North Dakota. I am here to testify and ask for your support on engrossed HB 1126.

The primary purpose of this bill is to allow residents of a basic care facility, who receive an end-of-life diagnosis and they begin to exceed the basic care criteria, to elect to remain a resident in the facility if the facility themselves, or through contract, can meet all of their needs. It is not our desire to put that resident or any other resident at risk or provide any less care. The basic care facility continues to be responsible for the care of this resident, nothing in HB 1126 changes that responsibility.

We appreciate the Department of Health addressing this issue with us almost four years ago. We understand six of sixty-four basic care facilities are providing this extended service to residents and families through the end-of-life optional license. This past year we discussed the primary barrier regarding why more basic care facilities are not providing this care. We approached the Health Department and they were receptive of our suggestion of reconvening a workgroup to better study and find solutions for improving access to the end-of-life care in a basic care setting. So that was the path we were embarking on until we looked at the law and it appeared the primary barrier was routed in ND Century Code and that is why we are here. It is our goal to work with you on the law revision and then go back to the Health Department and work with them on further rule changes to better address end-of-life care in this setting.

North Dakota is very prescriptive on care setting, we do not allow "aging in place" and when a person doesn't meet assisted living, basic care or nursing facility criteria, they must move. In reviewing the ombudsman report, admission and discharge concerns are a primary complaint of residents and families.

Receiving a written discharge notice because you don't meet criteria and your needs have changed is very difficult for families to accept. It is difficult to leave the setting you've become accustomed too, and even more difficult to leave your caregivers who many times you've come to depend on and love. Moving is frightening and scary.

In July 2015, basic care rules were amended and rules were put in place to allow basic care facilities to apply for an optional license to provide end-of-life care. Few have applied for the license because of the NFPA 101 Life Safety Code requirements. That requirement is dictated in line 13 and 14 of the bill and expanded in rule NDAC 33-03-24.1-23(8&9)

8. A facility that retains a resident requiring end-of-life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 Life Safety Code, 2012 edition, health care occupancy requirements.

9. Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self evacuation when a resident is receiving end-of-life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation capability. Hospice staff, family members, volunteers, or other nonfacility staff cannot replace required facility staff.

We support these standards, however at the end-of-life we would like to allow families, volunteers, hospice staff or one-on-one caregivers, employed by the resident or their representative, to help meet the evacuation needs of the dying person. In the 2015 session you created such a section for end-of-life care in assisted living and it works exceptionally well.

We assure you, we must still meet the evacuation scores of all residents, but this would allow us to use "non-staff" to meet the requirements for the person who is dying. The Health Department raised the question, what if the family doesn't show up, they have good intentions but don't follow through? That is an excellent question and one that would be immediately addressed with family, volunteers or hospice. We must have a safe plan in place to meet the evacuation score of all residents. When it is not working, volunteers or family do not show up, we must secure staff and then meet with the family regarding a new plan or discharge. No one is in favor of putting anyone at risk, all lives matter and the basic care facility is ultimately responsible.

We believe though, when a person has been an existing resident and they get that diagnosis that they have six months or less to live, if we can safely and appropriately meet their needs, or through contract, family or volunteers, we would like to have that option available. Often when a person receives that diagnosis, they continue to meet our criteria and then it is only in the last days or weeks that they need extra care. We believe it is cruel to make someone leave in the last days or weeks of life. We believe through facility staff, and having the option of utilizing non-staff at the end of life, we can assure all residents will be appropriately cared for and in the event of a disaster safely evacuated.

Basic care rules currently allow a resident to access their home-health benefit while a resident in the facility. This happens when the resident has a hospitalization, comes back in a weakened state, and needs a little extra help for short period of time. They are expected to return to their baseline functioning but need some "extra" help. The resident under their Medicare, home health benefit or privately, contracts for this extra help. The basic care facility is still responsible for the care for this resident in this circumstance and coordinates home-health for this temporary situation. Residents get sick and this is a good way to support them to return to this level of care. We see this hospice provision, acting very similar. The basic care facility is still responsible and they coordinate services, volunteers and family in this last stage of life.

Thank you for consideration of this issue which is important to us, residents and family. Following my testimony, you will hear testimony from Kari Dick, Executive Director with Touchmark at Harwood Groves in Fargo, Tracee Capron, and Executive Director of Hospice of the Red River Valley, Rochelle Schaffer, Executive Director of Home Care at Sanford and Cheryl Rising, Nurse Practitioner, who has an important story about a patient.

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33-03-24.1-21. Adult day care services.

1. A facility must obtain approval from the department to provide adult day care services.
2. Use of existing space and equipment to deliver adult day care services is acceptable if this does not diminish the services provided to the residents of the facility and their needs being met.
3. Medications and treatments must be administered only by order of a licensed health care practitioner.
4. Records must be maintained of services provided to individuals participating in adult day care services.
5. An area allowing privacy for adult day care individuals must be developed to allow for rest periods.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-22. General building requirements.

Repealed effective July 1, 2015.

33-03-24.1-23. Optional end-of-life care service.

A facility that intends to retain residents who require end-of-life care must comply with the requirements of this section, apply on an application as specified by the department, and receive written approval from the department prior to providing the services. The facility must meet the following requirements:

1. A facility may not retain residents who require more than intermittent nursing care unless the resident requires and elects to receive end-of-life care from a licensed and Medicare-certified hospice agency and the facility is licensed to provide end-of-life care.
2. A facility providing end-of-life care must employ or contract with a registered nurse to supervise resident care to meet the needs of the residents at all times, either directly or indirectly. The facility must employ a licensed nurse who is on the premises at least forty hours per week to identify and respond to resident needs, care plan accordingly, provide oversight related to care, and review and document the resident's individual needs and care provided.
3. Individuals in need of end-of-life care who require skilled nursing care or are not capable of self-preservation may not be admitted.
4. The facility and the licensed and Medicare-certified hospice agency shall enter into an agreement that delineates responsibilities, with the licensed and Medicare-certified hospice agency retaining the professional management responsibility for the hospice service.
5. The facility and licensed and Medicare-certified hospice agency in consultation with the resident shall develop and implement an interdisciplinary care plan that identifies how the resident's needs are met and includes the following:
   a. What services are to be provided;
   b. Who will provide the services, the facility or hospice agency;

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c. How the services will be provided;

d. Delineation of the roles of facility staff and the hospice agency in the care plan process;

e. Documentation of the care and services that are provided with the signature of the person who provided the care and services; and

f. A list of the current medications or biologicals the resident receives and who is authorized to administer the medications.

6. The facility shall notify the department within forty-eight hours of election that the resident has elected hospice, the date the hospice was elected, and the name of the hospice agency serving the resident.

7. The facility shall notify the department within forty-eight hours of the hospice resident's discharge, transfer, death, or when the resident is no longer capable of self-preservation.

8. A facility that retains a resident requiring end-of-life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 Life Safety Code, 2012 edition, health care occupancy requirements.

9. Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self evacuation when a resident is receiving end-of-life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation capability. Hospice staff, family members, volunteers, or other nonfacility staff cannot replace required facility staff.

10. A facility approved to provide end-of-life care shall ensure training and competency evaluation is completed for all nursing and personal care staff members specific to the care and services necessary to meet the needs of the terminally ill resident, and the hospice philosophy and services. The training and competency evaluation may be completed, and documented, by the facility registered nurse, a registered nurse consultant, or a hospice agency nurse. Nursing and personal care staff members shall complete the above training and competency evaluation:

    a. Prior to facility approval from the department to provide end-of-life care;

    b. Within thirty days of employment; and

    c. Annually.

11. A facility that intends to retain residents who require end-of-life care shall comply with the additional requirements in this section and request and receive approval on a printed new license from the department, prior to providing end-of-life care to residents.

12. The facility approved and licensed to retain residents in need of end-of-life care remains responsible for the appropriate delivery of end-of-life care in coordination with the licensed and Medicare-certified hospice agency. If the facility is unable, or becomes unable, to meet the needs of the resident requiring end-of-life care, the resident rescinds election of the hospice benefit, or the facility is unable to comply with these requirements, the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement consistent with the level of care required to meet the resident's needs.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02

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NOTIFICATION TO THE DEPARTMENT OF HEALTH REGARDING THE PROVISION OF END OF LIFE SERVICES TO A BASIC CARE RESIDENT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 60907 (04-15)

Optional Service of End of Life Care for Basic Care residents who have elected Hospice services. Notification to the Department of Health must occur within 48 hours of the resident electing hospice services or upon discharge, transfer, death, or when the resident is no longer capable of self-preservation.

Provider's Name		Telephone Number	
Address	City	State	ZIP Code
Total number of residents receiving end of life services (including this resident)			

INITIAL NOTIFICATION

Provide the following dates:	
Date	When the physician identified the terminal illness.
Date	When the resident elected Hospice.
Date	When the hospice services were implemented in the basic care facility.
[redacted]	When the required training and competency evaluation was completed.
Date	When the contract was signed with the Medicare Certified Hospice agency chosen by the resident or family members.

Contact Person for the Medicare Certified Hospice Agency		Telephone Number	
Address	City	State	ZIP Code

THE RESIDENT IS NO LONGER CAPABLE OF SELF-PRESERVATION

On what date did the resident become no longer capable of self-preservation?	
Does the end of life plan of care provide for adequate 24 hour bedside care by facility staff?	☐ Yes ☐ No
E-Scores completed weekly and with a significant change in the resident's evacuation capability and facility staff adjusted accordingly.	☐ Yes ☐ No

FINAL NOTIFICATION

Provide the date for the resident's:		
Discharge Date	Transfer Date	Date of Death
Administrator's Signature		Date

Submit completed form to: North Dakota Department of Health
Division of Health Facilities
600 E Boulevard Ave, Dept. 301
Bismarck, North Dakota 58505-0200
Fax: 701.328.1890

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NORTH DAKOTA
DEPARTMENT of HEALTH

HEALTH RESOURCES SECTION
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200
Fax: 701.328.1890
www.ndhealth.gov

MEMORANDUM

TO: Shelly Peterson, NDLTCA President

FROM: Lucille Rostad Lucille Rostad

DATE: December 11, 2015

TOPIC: Hospice Services in a Basic Care Facility NOT Licensed to provide End of Life Care Services

This memorandum is in response to your request for clarification related to how long a resident electing Hospice Services can stay in a Basic Care facility that is not licensed to provide End of Life Care Services.

A resident in a Basic Care facility can elect Hospice Services and stay in a Basic Care facility that is not licensed for End of Life Care Services as long as the resident meets the basic care level of care.

What does this mean?

NDCC 23-09.3-08.1 Admission of residents to basic care facility – Restrictions. A basic care facility may admit and retain only an individual for whom the facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's highest practicable level of functioning. A basic care facility may admit and retain only an individual whose condition and abilities are consistent with the national fire protection association 101 life safety code requirements.

This statute is further clarified in North Dakota Administrative Code 33-03-24.1-01. Definitions. 2., 5., 6., and 16. Based on this information, the admission and retention criteria for a resident in a Basic Care facility includes that the individual may need assistance with activities of daily living which means that the resident is able to help with most of an activity, but cannot do it entirely alone. This includes eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.

The decision of some Basic Care facilities to provide twenty-four-hour a day nurse staffing should not be interpreted to mean that the resident's condition requires twenty-four hour a day nursing care. If the resident declines to the level where continuous, twenty-four-hour a day nursing or medical care is needed, the individual can no longer assist with their own activities of daily living, or the resident is no longer capable of self preservation, with or without assistance, the resident is no longer appropriate to remain in a Basic Care facility.

In summary, a basic care resident can elect to receive Hospice Services and stay in a Basic Care facility that is not licensed to provide End of Life Care Services, until the resident no longer meets the definition of a basic care resident as discussed above, and the care required exceeds the basic care level. If a Basic Care facility becomes licensed to provide End of Life Care Services, the resident who elects Hospice Services would be able to remain in the facility even when the resident exceeds the basic care level of care and requires skilled nursing care.

If you have questions, please contact Lucille Rostad at 701-328-2352.

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The New York Times

Nursing Homes Are Closing Across Rural America, Scattering Residents

By Jack Healy

March 4, 2019

MOBRIDGE, S.D. — Harold Labrensz spent much of his 89-year life farming and ranching the rolling Dakota plains along the Missouri River. His family figured he would die there, too.

But late last year, the nursing home in Mobridge, S.D., that cared for Mr. Labrensz announced that it was shutting down after a rocky history of corporate buyouts, unpaid bills and financial ruin. It had become one of the many nursing homes across the country that have gone out of business in recent years as beds go empty, money troubles mount and more Americans seek to age in their own homes.

For Mr. Labrensz, though, the closure amounted to an eviction order from his hometown. His wife, Ramona, said she could not find any nursing home nearby to take him, and she could not help him if he took a fall at home. So one morning in late January, as a snowstorm whited out the prairie, Mr. Labrensz was loaded into the back of a small bus and sent off on a 220-mile road trip to a nursing home in North Dakota.

“He didn’t want to go,” said Mrs. Labrensz, 87, who made the trip with her husband. “When we stopped for gas, he said, ‘Turn this thing around.’ ”

More than 440 rural nursing homes have closed or merged over the last decade, according to the Cowles Research Group, which tracks long-term care, and each closure scattered patients like seeds in the wind. Instead of finding new care in their homes and communities, many end up at different nursing homes far from their families.

In remote communities like Mobridge, an old railroad town of 3,500 people, there are few choices for an aging population. Home health aides can be scarce and unaffordable to hire around the clock. The few senior-citizen apartments have waiting lists. Adult children have long since moved away to bigger cities.

“How often have you heard somebody say, ‘If I go to a nursing home, just shoot me?’” said Stephen Monroe, a researcher and author who tracks aging in America. “In the rural areas, you don’t have options. There are no alternatives.”

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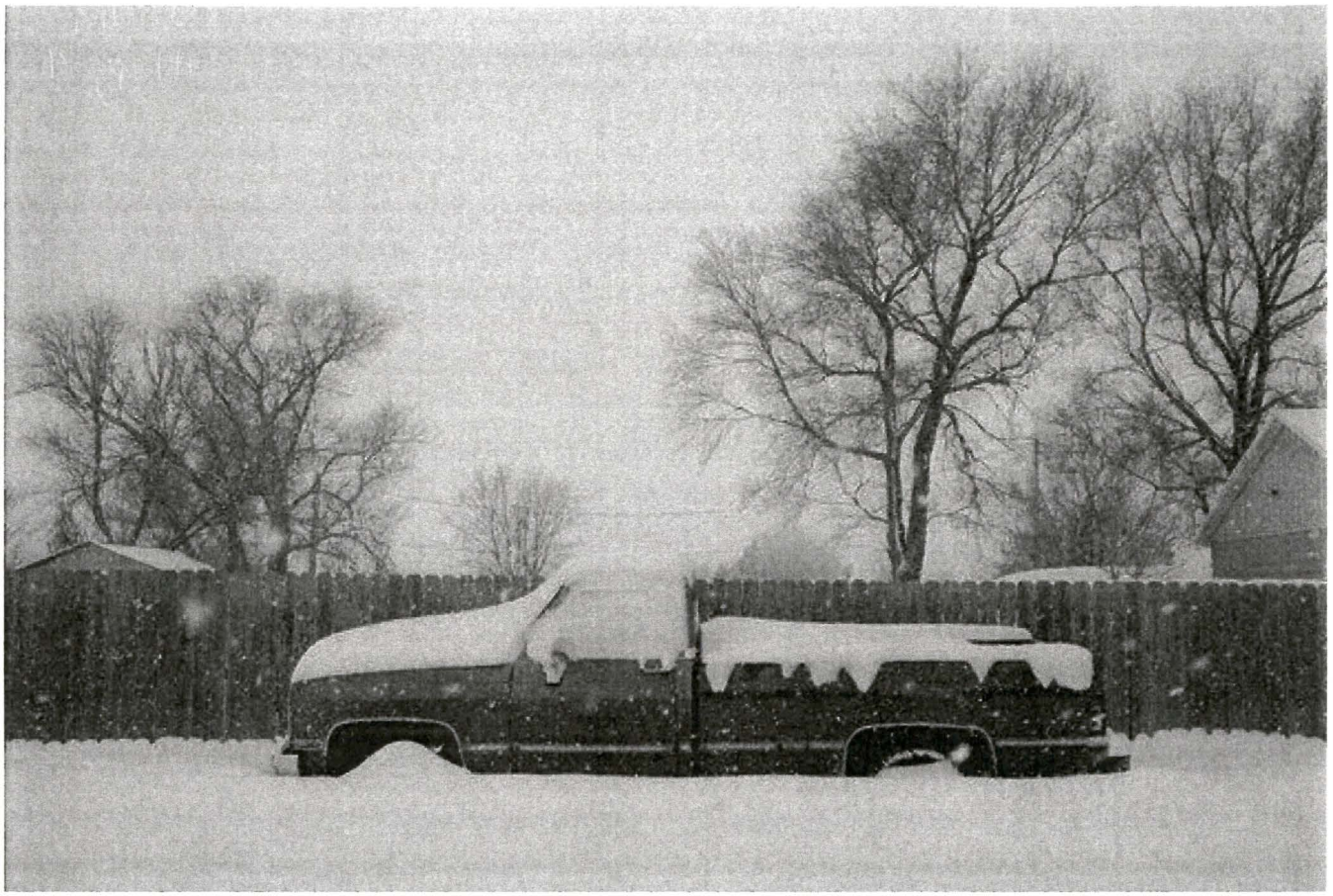

Small communities like Mobridge, an old ranching and railroad town of 3,500 people, often offer few local options for elder care, and winter weather can make it impossible to visit loved ones placed in distant nursing homes. Kristina Barker for The New York Times

The relocations can be traumatic for older residents, and the separation creates agonizing complications for families. Relatives say they have to cut back visits to one day a week. They spend hours on the road to see their spouses and parents.

"Before, I could just drop by five days a week," said the Rev. Justin Van Orman, a Lutheran pastor who moved back to Mobridge to be closer to his 79-year-old father, Robert. "He knew I was there."

Not long after Mr. Van Orman's father moved from Mobridge to a new nursing home about 50 miles away, Mr. Van Orman got a call saying his father had fallen out of bed. Mr. Van Orman had to decide: Should he upend his day to check on him, or wait and take the nursing home's word that his father was O.K.?

Similar scenes are playing out in other heavily rural states. Five nursing homes closed in Nebraska last year, with more at risk of closing. Six shut down in Maine — a record, according to the Bangor Daily News.

Thirty-six rural nursing homes across the country have been forced to close in the last decade because they failed to meet health and safety standards. But far more have collapsed for financial reasons, including changing health care policies that now encourage people to choose independent and assisted living or stay in their own homes with help from caregivers.

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Some nursing homes cannot find people to do the low-paying work of caring for frail residents. Others are losing money as their occupancy rates fall and more of their patients' long-term care is covered by Medicaid, which in many states does not pay enough to keep the lights on.

South Dakota chips in less than any other state in the nation to pay for long-term care for residents on Medicaid, said Mark B. Deak, executive director of the South Dakota Health Care Association. He added that the state's low payment level — a product of South Dakota's fiscal conservatism and distrust of government-run health care — has now created a crisis.

Blowing snow created hazardous driving conditions in February near Mobridge. After the closure of a local nursing home, many area residents wishing to visit loved ones in nursing care face drives of up to four hours even in good weather.
Kristina Barker for The New York Times

Five South Dakota nursing homes have shut down in the past three years, and dozens more are losing money because the majority of their residents rely on Medicaid. At current reimbursement rates, nursing homes in the state lose about $58 a day for each resident on Medicaid, Mr. Deak said. It adds up to $66 million a year in losses statewide.

"The state has not held up its obligation to seniors," Mr. Deak said. "How many more nursing homes closing is it going to take?"

Gov. Kristi Noem has proposed a 5 percent increase in the state's Medicaid reimbursement rate. Mr. Deak

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said that would not be nearly enough to cover the losses.

The 89-bed Mobridge Care and Rehabilitation Center was rated overall as "below average" by Medicare's Nursing Home Compare program, though for patient care, the home received four out of five stars in the agency's assessment. The brown brick building was getting old, and had been damaged by a bad summer storm in 2018.

The nursing home had been part of a chain that switched hands and foundered financially, ultimately ending up in court-appointed receivership. In November, the receiver told a South Dakota judge that the chain's operations were bleeding money, and that it needed to close down the two homes in the chain that were deepest in the red. Mobridge was one.

The South Dakota Department of Health did not object, and the judge agreed to the closure. Word began to spread through the home and through town: The residents had about two months to find somewhere else to go.

Black Hills Receiver, which had taken over operation of the nursing home, said in a November statement announcing the closure that it was working with residents, their families and employees "to make this transition as smooth as possible." The company declined an interview request.

For six days this winter, Loretta Leonard could not make the 20-mile drive from Mobridge to Selby, S.D., to see her husband, Dick, who is 91 and suffers from severe dementia. Kristina Barker for The New York Times

On paper, South Dakota and other rural states still have enough long-term care beds for people who need round-the-clock care. The problem is where they are. When a nursing home closes in a small town, the available beds are often so far away that elderly spouses cannot make the drive, and the transferred residents become cut off from the friends, church groups and relatives they have known all their lives.

Even the closest town can feel as though it is a world away when a blizzard rakes across the prairie and turns the two-lane road out of Mobridge into a billowing scarf of snow.

For six days this winter, Loretta Leonard could not make the 20-mile drive to see her husband, Dick, who is 91 and suffers from severe dementia, at his new nursing home. When he was living close by at the Mobridge home, she often visited him twice a day, sitting down at the piano to play the old polkas and hymns and Depression-era tunes their daughters sang growing up.

"He always knew me," Ms. Leonard, 88, said. "Sometimes I wonder whether he knows me anymore."

The part-time bus driver for the Mobridge nursing home began keeping a list as he dropped people at their new homes: "Residents Who Left." One resident was moved to Aberdeen, 100 miles east. A husband and wife went 73 miles down Highway 12 to Ipswich. Roommates said goodbye. Fast friends landed in different homes. One person ended up in Nebraska.

"Like cattle," said Nadine Alexander, a certified nursing assistant who worked at the Mobridge nursing home for 29 years. "They were just hauling them out."

On the snowy day that Harold Labrensz left Mobridge for his new nursing home in North Dakota, not even the bus driver wanted to make the trip. For seven hours, they crept north along icy roads before arriving.

Mrs. Labrensz chose the facility because it was close to her son's home, and she was able to find a small efficiency apartment just across the street from the nursing home. They spent 68 years together working their land, fishing and raising a family, and Mrs. Labrensz said she wanted to stay close.

"We spent our whole life together," she said.

She was also close by when, three days after arriving in North Dakota, Mr. Labrensz died. The date was Jan. 31 — the same day that, 220 miles away, the Mobridge nursing home officially closed its doors.

Correction: *March 4, 2019*
An earlier version of this article, using information from a source, misstated Ramona Labrensz's age. She is 87, not 76.

A version of this article appears in print on March 3, 2019, on Page A1 of the New York edition with the headline: Rural Nursing Homes Shutter, and Families Splinter

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Testimony on HB 1126
Senate Human Services Committee
March 11, 2019

Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Kari Dick. I am the Executive Director at Touchmark at Harwood Groves in Fargo. Touchmark at Harwood Groves has a total of 200 Assisted Living, Memory Care, and Independent Living homes. Thirty-seven of these homes are licensed as basic care dementia care homes.

I am here today to testify in support of House Bill 1126 related to end-of-life care in Basic Care. When the initial "end of life" option was added to the Basic Care licensure process in 2015, Touchmark at Harwood Groves was one of the first facilities to add the provision. Prior to this, our community was able to safely accommodate a number of residents through the end of life. Even with the change in rules, our goal was to continue to do this for residents when appropriate and safe. We have utilized Hospice services for many years, and often long before a resident is in his/her final days of life.

It is important to note that Basic Care facilities may continue to bring Hospice into their buildings without the end of life provision. Many residents on Hospice—particularly in a dementia care setting—may be up and walking around while on Hospice. The benefits of Hospice are not limited to the last days or weeks of life. Hospice care allows residents greater pain relief, typically eliminates stressful ER visits and/or hospital stays, and brings greater quality of life to persons with dementia while also reducing the burden often placed on family members. Partnering with a local hospice agency also provides additional help and resources to facilities providing care.

It is only when the resident consistently no longer meets the community's criteria that facilities must follow the Basic Care rules regarding end-of-life care. In many cases, this time period may only be a few days or even just a week or two.

Unfortunately, there is one major part of the rule that creates barriers for facilities. The rule requires Basic Care facilities to add additional staff members to meet the evacuation requirements related to Life Safety Code. In most cases, this applies to night shift coverage—the time period when facilities are at the lowest staffing level. Because there is a significant staffing shortage in long-term care, facilities do not typically have extra staff ready to take on night shifts on short notice and for an uncertain amount of time.

This leaves the facility with no other option but to hire staff to meet the requirement. The recruitment and hiring process itself often takes at least a couple weeks to complete. The new staff member then needs to be trained. By the time this process is complete, an individual who is truly at the "end of life" will likely have passed away.

The challenge associated with meeting this requirement prompted Touchmark to opt out of continued participation in the optional end-of-life Basic Care licensure. Without the ability to

utilize private caregiving agencies and/or family members, we could neither realistically add staff when a resident reached the point of not meeting criteria nor could we reasonably predict when the need would occur.

Touchmark still utilizes Hospice services with many residents up until the individual no longer meets criteria. Unfortunately, in a number of cases, we have been forced to transfer someone in their final days of life to an unfamiliar setting. This is extremely traumatic for a dying person and their family. Instead of focusing on their loved one's needs, families are faced with the task of managing a move, filling out hours of paperwork, and learning to navigate a new facility.

This is not because of our inability to safely care for this individual—instead, it's because the current requirement does not consider private caregivers and/or family members when calculating the facility's evacuation score. The fix is easy—simply allow family members, private caregivers, and other resident representatives to help meet the evacuation requirement.

Like Ms. Peterson, I want to emphasize that providers are not asking to admit persons who are near the end-of-life. I also want to emphasize that there will still be individuals that will require a transfer to skilled care. This change will simply allow Basic Care providers, with the help and support of a local Hospice agency, to help provide a compassionate end-of-life experience to those who can safely live out their last days in the setting which has become their home.

Thank you for your consideration of this important bill.

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North Dakota Hospice Organization

Chairman Lee and Members of the Committee:

My name is Rochelle Schaffer, Registered Nurse and President of the North Dakota Hospice Organization. Our organization represents 11 hospice agencies throughout North Dakota. I am here to testify and ask for your support of House Bill 1126, relating to basic care facility end-of-life services.

I have been a representative and advocate for hospice care in North Dakota for the past 7 years in my roles as a Hospice Nursing Director and as the State Hospice Organization's President.

Hospice is a specialized type of end of life care. It is a team of interdisciplinary members that include physicians, nurses, nursing assistants, social workers, chaplains, volunteers, and pharmacists all working together. Along with the individual and family, the hospice team develops a care plan to manage symptoms and promote comfort and safety.

Hospice also provides financial coverage for medications and equipment needs. The hospice team is available 24 hours per day to provide support and guidance to the individual and family. In the months following a hospice death, bereavement services are offered to family and friends.

Hospice care can be provided in any setting an individual calls "home"- a long term care facility, a private home, a group home, or an assisted living facility. Due to current regulation, this is not often offered to a patient living in a North Dakota Basic Care Facility.

Together Hospice and Basic Care Facilities in North Dakota can work together to enable these individuals to stay in the place they call home, just as we currently do in private homes and assisted living facilities. This can be accomplished if the Basic Care Facility is able to permit the use of family and volunteer services, along with Hospice to support the individual through their end of life. Hospice is a benefit to a Medicare beneficiary, as well as most health plans. Individuals have the right to use the benefit just as family has the right to assist in the care of their loved ones, no matter the setting in which they reside. Also consider the potential financial burden on the individual, the family and the health systems if this individual is moved to a higher level of care setting.

I ask that you consider approving House Bill 1126 to ensure the Hospice Benefit with family and volunteer support is a choice to North Dakota individuals living in Basic Care Facilities.

Thank you.

Rochelle Schaffer, RN, MHA
President, ND Hospice Organization

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

Senate Human Services Committee

House Bill 1126
Madam Chair Lee and Committee Members:

I am Cheryl Rising, FNP and legislative liaison for the North Dakota Nurse Practitioner Association. I am here to testify in support of HB 1126 a bill for an Act to amend and reenact section 23-09.3-08.1 of the North Dakota Century Code, relating to basic care facility end-of-life services

Currently when an individual resides in basic care, is at end of life, and the family requests to have supportive cares, the organization may not keep the resident in the facility and start hospice due to the regulations. I personally go out to assisted living buildings and basic care areas to provide primary care for many individuals in these types of residence. I have had personal experience with wanting to keep a resident in basic care in their own room, surrounded by familiar care givers, family, and have had to explain to the family we are unable to start hospice here, we must send the loved one to the ED and find a place that will be able to start hospice. This is agonizing for the care giver and family to disrupt the relationship that has developed which may have been for years. The most recent experience was a resident that was at basic care, end stage dementia, a significant change in status occurred, the family wanted hospice and we had to transfer to the ED. This was a difficult time and an inappropriate use of health care dollars and emergency room charges.

The most recent situation in the last two months that I was involved with was a patient in an organization that could keep the resident and start hospice if needed. I received a call as I as finishing work on a Thursday that an individual had taken a turn for the worse and could I please come and see the resident. I immediately went to the individual's residence. I knew this patient was declining over the months. I had spoken with the sister, the only living relative, about starting hospice in October and again in December; however, she was so distraught that she was unable to decide at that time. The resident continued in a residential home with a care giver through an organization in Bismarck. I called hospice and left a message while I was in route to see the patient. My question to hospice was if the sister wanted hospice would hospice be able to admit and when. I arrived at the apartment, the sister arrived with in 5 minutes. Pt was actively dying, low oxygen saturation, and struggling to breath. The sister did not want her to be moved, asked to keep the patient in her own bed, surrounded with the care givers that have cared for her for years. Hospice returned my phone call, and after discussion stated they would be there as soon as they could get the on-call hospice nurse the packet for admission and get there. I had already written orders for Ativan and Morphine sulfate for comfort. Staff

were in route to get the medication. By the time the wonderful hospice nurse arrived the first dose of Ativan had been given, and the patients breathing improved. I was so grateful to leave knowing she was now being cared for by her own caring team and hospice. The patient lived for 48 hours and expired. The sister was grateful for all the loving care and comfort. If this facility was not able to have hospice the patient would have been sent to the emergency department. This was a much different experience for this family member.

NDNPA urges a do pass on this bill so individuals and families can choose hospice where they reside.

Cheryl Rising, FNP, FAANP

North Dakota Nurse Practitioner Association
www.ndnpa.org
Legislation Tracking Team
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Jenna Herman: jmherman@umary.edu 612-518-3647
Tara Brandner: tbrandner04@gmail.com 701-471-9745
Additional Legislative Committee
Tisha Scheuer: tscheuer28@gmail.com
Allison Peltier: allison.peltier@ndsu.edu
Paula Moch: paulamochfnp@gmail.com

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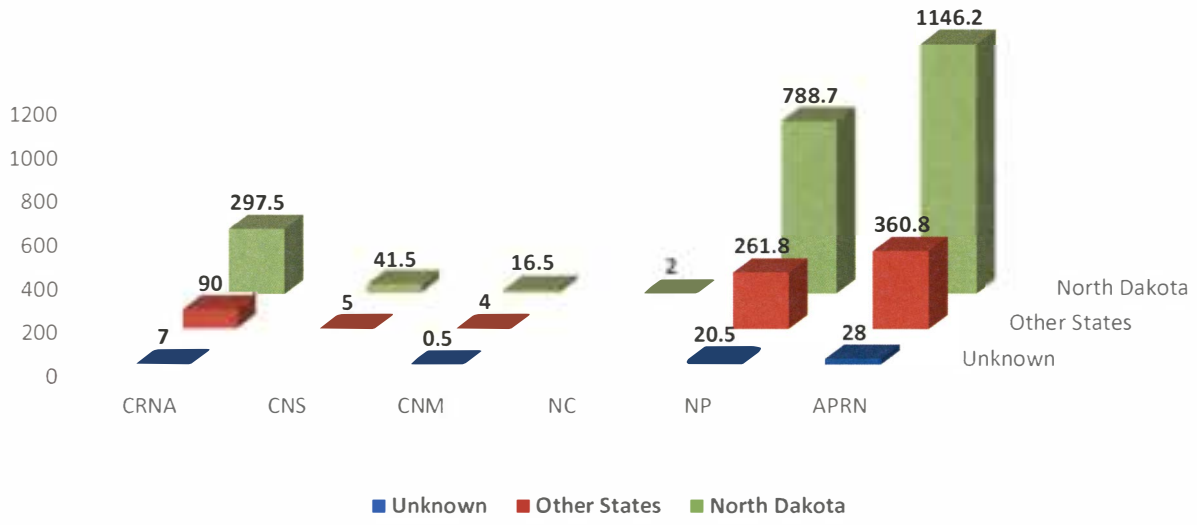
NDNPA
NORTH DAKOTA
Nurse Practitioner Association

APRNs in ND

Methodology: All providers are counted as one full-time equivalent (FTE). Providers that are dually licensed in more than one discipline are split equally among each discipline. Those that indicated more than one practice state are divided equally to each state and providers that indicated more than one practice location are divided equally to each site.

APRNS: As of September 10, 2018, there are 1,534 advanced practice registered nurses (APRNs) licensed in North Dakota. Of the total APRNs, there are 1071 nurse practitioners (NPs), 394.5 certified registered nurse anesthetists (CRNAs), 46.5 are clinical nurse specialists (CNS), 21 certified nurse midwives (CNMs), and 2 nurse clinicians (NCs). Twelve APRNS were dually licensed, 7 CNS/NPs, 4 CNM/NPs and 1 CRNA/NP. As of November 11, 2018, 1,111 APRNs have prescriptive authority.

ND APRNs by Employment State



Since 2016, there has been a 20% increase (246) of APRNs licensed in North Dakota which included a 29% increase in NPs, 17% increase in CNMs, 4% increase in CRNAs, 8% decrease in CNSs, and no change in NCs. See table 1.

Table 1

ND Licensed APRNs by Employment State						
	Unknown		Other States		North Dakota	
	2016	2018	2016	2018	2016	2018
CRNA	8	7	91.5	90	278.5	297.5
CNS	0	0	5.5	5	45	41.5
CNM	0	0.5	1	4	17	16.5
NC	0	0	0	0	2	2
NP	12	20.5	166	261.8	652.5	788.7
APRN	20	28	264	360.8	995	1146.2

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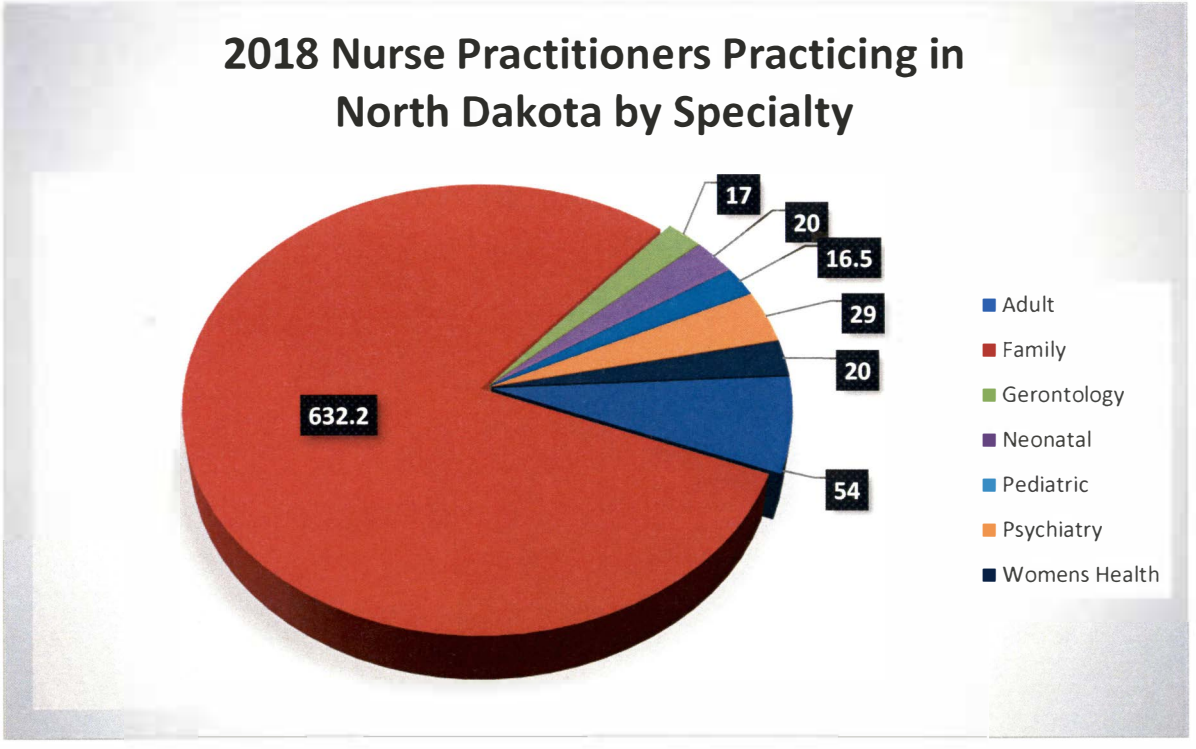
NDNPA
NORTH DAKOTA
Nurse Practitioner Association

Nurse Practitioners: North Dakota has 1071 licensed NPs, 788.7 FTE (73.6%) indicated they are currently practicing in North Dakota at least part of the year. Of those practicing within North Dakota, 70.5% are practicing in the more urban cities of Bismarck, Mandan, Fargo, West Fargo, Grand Forks and Minot with 27.8% practicing in more rural areas, and 1.7% are unknown. Please see attached maps of psychiatric NPs and psychiatric NPs and CNS combined.

Although licensed in North Dakota, 261.8 FTE NPs indicated states other than North Dakota as their State of employment including Minnesota (79.5), South Dakota (32), Texas (25.7), Missouri (23), Arizona (11), Wisconsin (10), Washington (8), Montana (7), Iowa (6.5), California (6), Florida (5.7), Georgia (5), Colorado (4), Ohio (3.5), Nebraska (3.2), Utah (3), Arkansas (2), Hawaii (2), Illinois (2), Louisiana (2), Maryland (2), New Jersey (2), Nevada (2), Massachusetts (1.5), Virginia (1.2), Connecticut (1), Indiana
(1), Kentucky (1), Mississippi (1), North Carolina (1), New Mexico (1), New York (1), Oklahoma (1), Oregon (1), Pennsylvania (1), Tennessee (1), Maine (0.5) and West Virginia (0.5).

Of the nurse practitioners practicing in North Dakota 80.2% (632.2/788.7) indicated their specialty area was family medicine. Other specialties included adult, gerontology, neonatal, pediatric, psychiatric, and women's health. See chart below.



NDNPA
NORTH DAKOTA
Nurse Practitioner Association

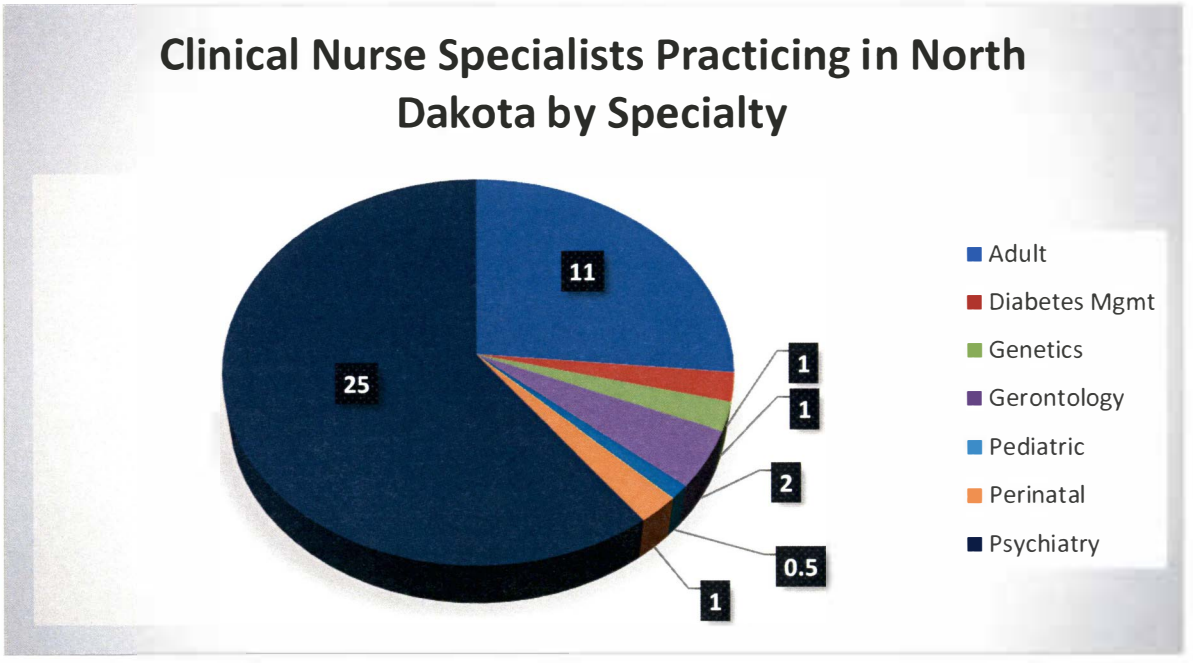
Table 2

North Dakota Nurse Practitioners by Specialty	2016	2018
Adult Medicine	42.5	54
Family Medicine	519.5	632.2
Gerontology	19	17
Neonatal Medicine	18	20
Pediatric Medicine	11	16.5
Psychiatry	20	29
Women's Health Care	22.5	20

Since 2016, the number of nurse practitioners practicing in pediatrics increased by 50%, psychiatry (45%), adult medicine (27.06%), family medicine (21.69%), and neonatal (11.11%) while gerontology decreased by 10.53% and women's health care (11.11%). See Table 2. Currently, 29 nurse practitioners specialize in psychiatry. Of those, 17.5 (60.3%) practice within the more urban cities of Bismarck, Fargo, West Fargo, Grand Forks and Minot. Please see attached map of the locations of NPs with a specialty in psychiatry.

Clinical Nurse Specialists: In North Dakota 46.5 CNS are licensed of which 41.5 (89.2%) indicated they currently practice in the State. Of the 41.5 CNS currently practicing in North Dakota 33.5 (80.7%) are practicing in the more urban cities of Bismarck, Fargo, Grand Forks, and Minot. Please see attached map.

Although licensed in North Dakota, 5 CNS indicated they practice outside of the State. These included Minnesota (2.5), Alabama (1), Iowa (0.5), Ohio (0.5) and South Dakota (0.5). Of the clinical nurse specialists practicing in North Dakota, 60.2% indicated their specialty area was psychiatry and 26.5% indicated adult medicine. Please see chart below.



NDNPA
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Nurse Practitioner Association

Table 3

North Dakota Clinical Nurse Specialists by Specialty	2016	2018
Adult	12.5	11
Diabetes Management	1	1
Genetics	1	1
Gerontology	2	2
Pediatric		0.5
Perinatal	2	1
Psychiatry	26.5	25

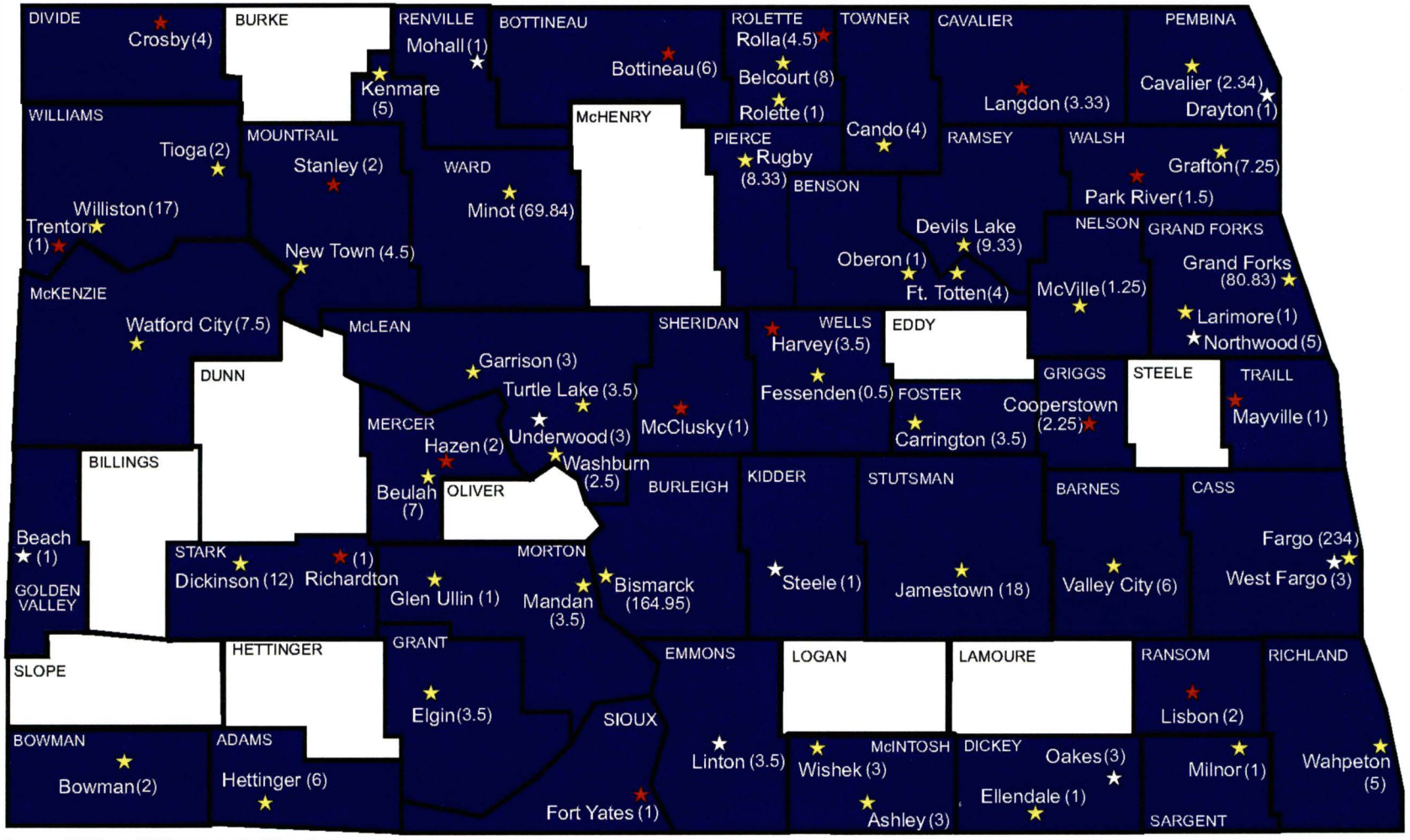
Since 2016, the number of CNSs practicing in North Dakota has declined by 7.8%. Those practicing in adult medicine declined by 12% and psychiatry by 5.66%. See Table 3. Of the 25 practicing in psychiatry, 74% (18.5) CNSs are practicing in the more urban areas of Bismarck, Fargo, Grand Forks and Minot. Please see attached maps of psychiatric CNSs and psychiatric CNSs and NPs combined.

Certified Nurse Midwives: A total of 21 CNMs are licensed in North Dakota of which 16.5 indicated they are practicing within the State. Two or 12.1% of the CNMs are practicing in rural areas of Belcourt and Williston. The other 14.5 indicated they were practicing in three of the more urban cities including Fargo (7.5), Minot (5), and Grand Forks (2). Although the total number of licensed CNMs increased in 2018 compared to 2016, those that indicated they practice in North Dakota decreased by 0.5 FTE. Please see attached map.

Certified Registered Nurse Anesthetists: North Dakota has 394.5 licensed CRNAs of which 297.5 indicated they are practicing in North Dakota. Of the CRNAs practicing in North Dakota, 84.1% are practicing in the four most urban cities of Bismarck, Fargo, Grand Forks and Minot; 14.2% are practicing in rural areas and 1.7% did not indicate a practice city. The total number of CRNAs practicing in North Dakota increased by 6.8% from 2016 (278.5) to 2018 (297.5). Please see attached map.

Nurse Clinicians: As in 2016, two nurse clinicians continue to practice in North Dakota in 2018. Both nurse clinicians practice in urban areas and specialize in rehabilitation and psychiatry.

2018 North Dakota Nurse Practitioners



NDNPA
NORTH DAKOTA
Nurse Practitioner Association

Nurse Practitioners practicing within county
☆ Nurse Practitioners' FTE increased since 2016
★ Nurse Practitioners' FTE decreased since 2016
☆ No change Nurse Practitioners' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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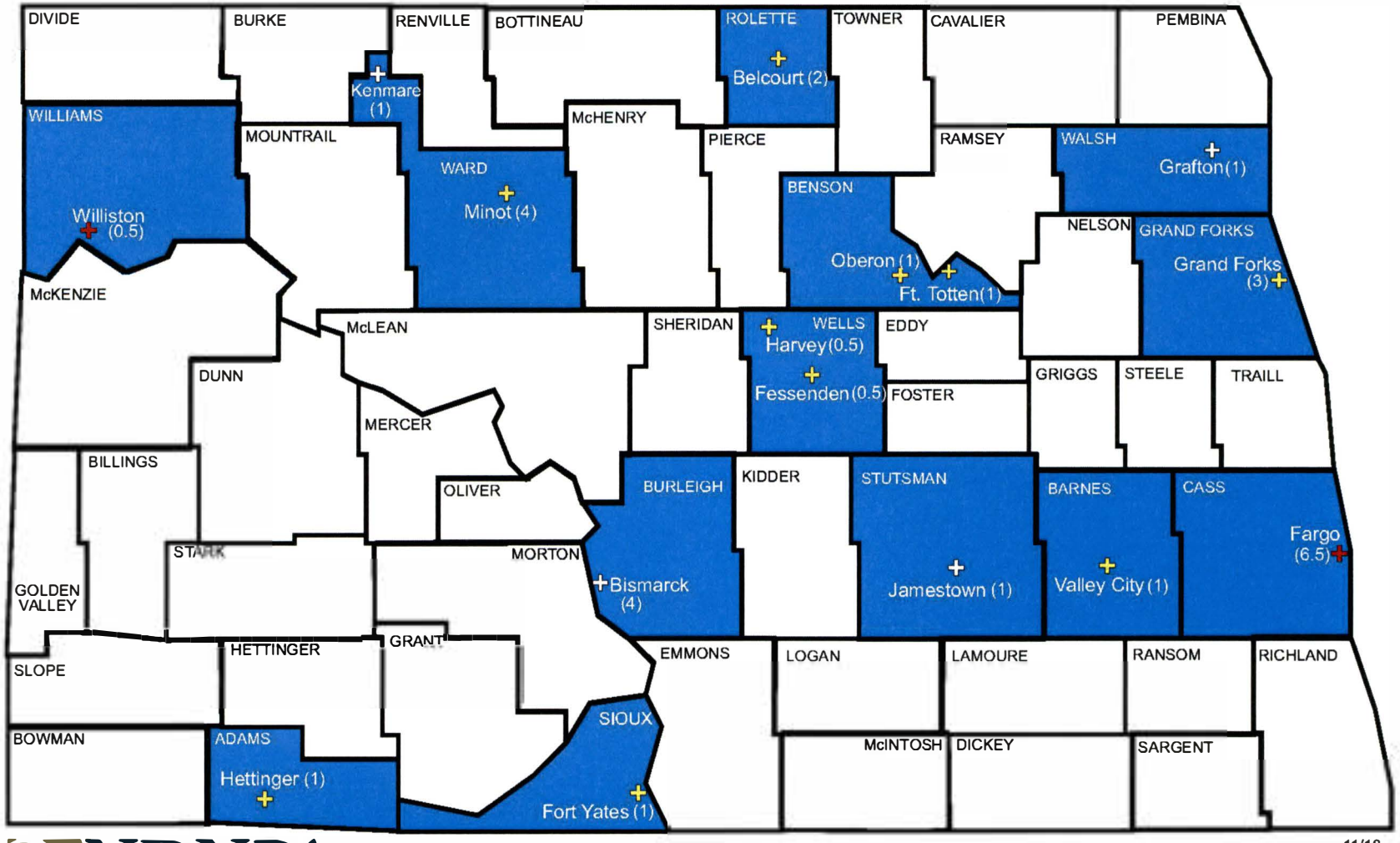
2018 North Dakota Psychiatric Nurse Practitioners



11/18

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

Psychiatric Nurse Practitioners practicing within county
Psychiatric Nurse Practitioners' FTE increased since 2016
Psychiatric Nurse Practitioners' FTE decreased since 2016
No change Psychiatric Nurse Practitioners' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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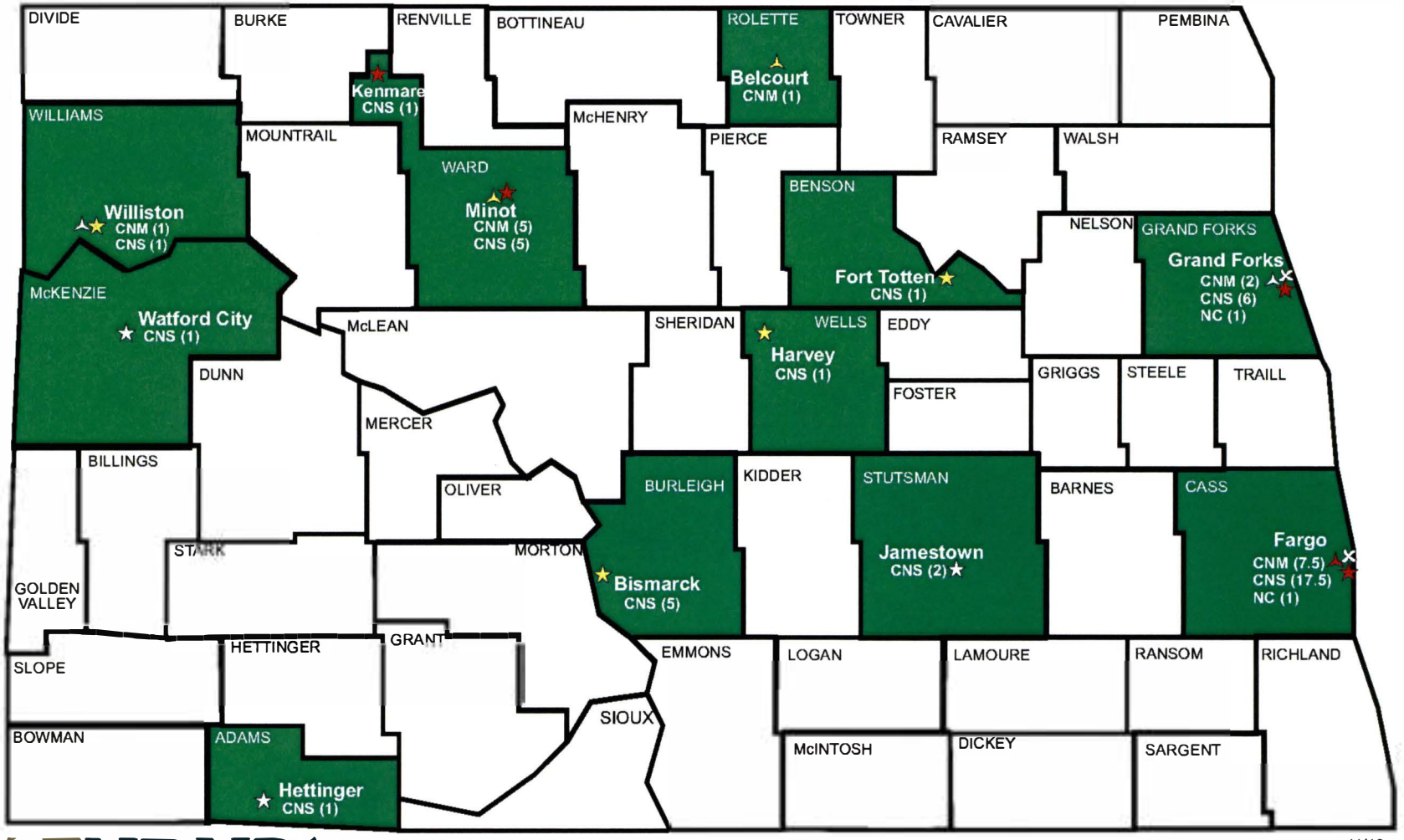
2018 North Dakota Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS), and Nurse Clinicians (NC)



NDNPA
NORTH DAKOTA
Nurse Practitioner Association

CNMs, CNS, and/or NC practicing within county

CNM Unknown (0.5)

11/18

- CNMs' FTE increased since 2016
- CNMs' FTE decreased since 2016
- No change CNM's FTE since 2016
- No change NC's FTE since 2016
- CNS' FTE increased since 2016
- CNS' FTE decreased since 2016
- No change CNS' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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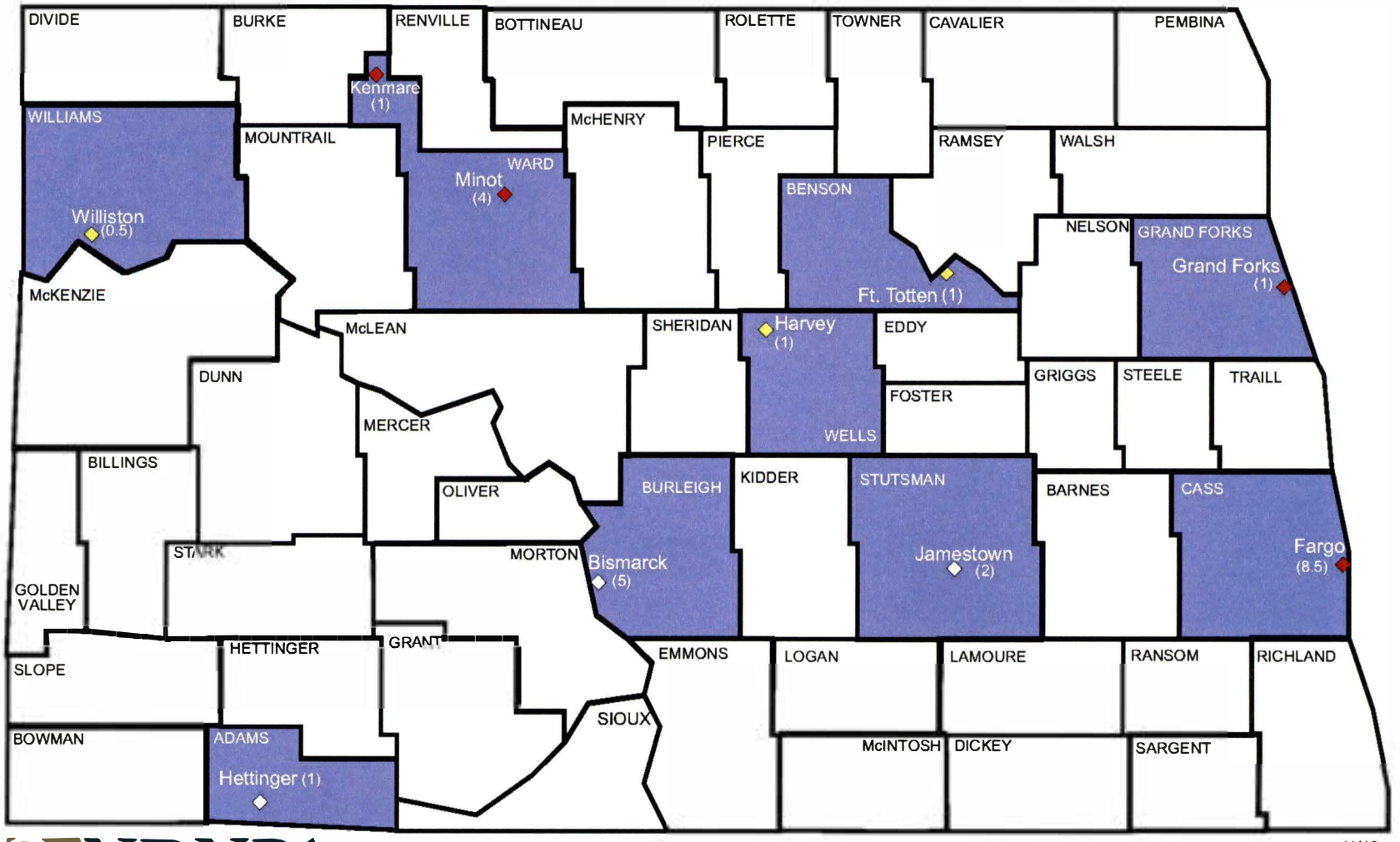
2018 North Dakota
Psychiatric Clinical Nurse Specialists



11/18

NDPA
NORTH DAKOTA
Nurse Practitioner Association

- Psychiatric CNS practicing within county
- Psychiatric CNS' FTE increased since 2016
- Psychiatric CNS' FTE decreased since 2016
- No change Psychiatric CNS' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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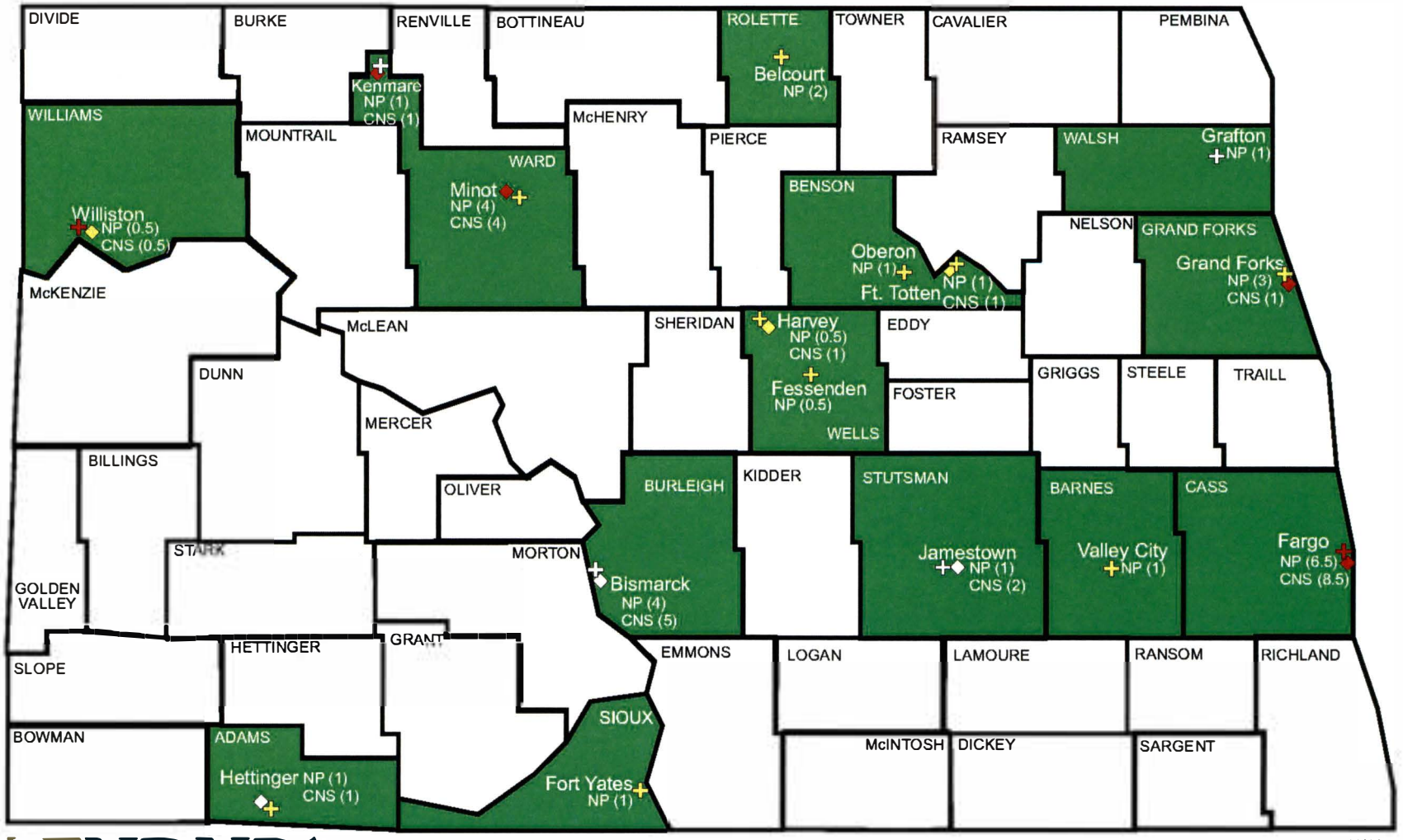
2018 North Dakota Psychiatric Nurse Practitioners and Clinical Nurse Specialists



11/18

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

Psychiatric NPs and/or CNS practicing within county

- Psychiatric NPs' FTE increased since 2016
- Psychiatric NPs' FTE decreased since 2016
- No change Psychiatric NPs' FTE since 2016
- Psychiatric CNS' FTE increased since 2016
- Psychiatric CNS' FTE decreased since 2016
- No change Psychiatric CNS' FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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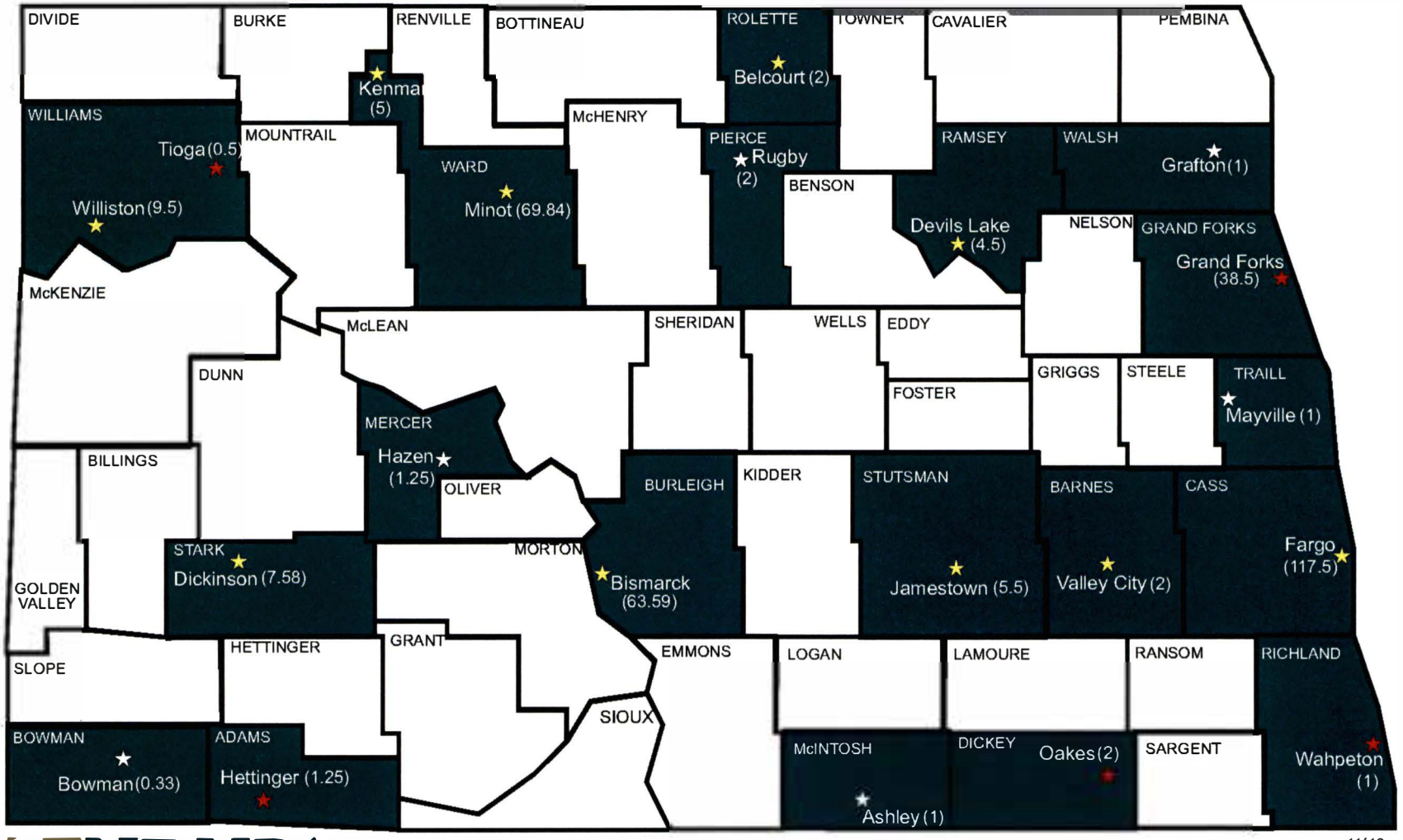
2018 North Dakota
Certified Registered Nurse Anesthetists



Unknown (5)

11/18

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

CRNAs practicing within county
☆ CRNAs' FTE increased since 2016
★ CRNAs' FTE decreased since 2016
☆ No change CRNA's FTE since 2016

* Full time was assumed for each licensed Nurse practitioner. For those that indicated more than one site, the FTE was split equally and not based on actual hours worked.

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House Bill 1126
Senate Human Services Committee
March 11, 2019

Good morning Madam Chair Lee and members of the Senate Human Services Committee. My name is Bruce Pritschet and I am the Director of the Division of Health Facilities within the Department of Health. I am here to provide testimony in opposition to House Bill 1126 and to offer an amendment on behalf of the Department.

We support the presence of family members and their participation in the end-of-life care for basic care residents who need that service. We want residents to have the most effective and best care possible through their end-of-life experience. For some residents, this may be for them to remain in the basic care facility.

In 2015, we worked with the basic care facilities to find a way that residents in need of end-of-life services could receive the care needed in a safe environment and remain in a basic care facility. This was achieved through NDAC 33-03-24.1-23. In fact, to date, seven basic care facilities have elected to provide this service.

While we support the use of family to provide care to residents, we have concerns related to how the bill is currently written. The use of family to provide care to residents should not replace the need of the facility to be responsible for the care and safety of the residents in their facility. As currently written, this bill does not require a basic care facility to provide care directly or through contract. Rather, as written, this bill allows the facility to require the resident or family to find and contract with their own caregivers, family, or volunteers. Families that are in mourning at the end of the resident's life should not be required to provide or arrange for care in order for the resident to remain in the facility.

In addition, as written, hospice may or may not be involved. Basic care facilities do not have experience in providing hospice care. We believe it is necessary for a hospice to be involved to provide the coordination and training of the end-of-life care for a resident.

As a regulatory agency, our goal is to ensure all residents receive quality care in a safe setting. It is important that the basic care facility remains responsible for the care their residents receive. We believe the following amendments will accomplish that goal while still providing a way that the resident can remain at their basic care facility. I would be glad to address questions the committee may have.

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

Page 1, line 15, replace "Notwithstanding contrary provisions in subsection 1, a" with "A"

Page 1, line 15, remove "an"

Page 1, line 16, replace "individual" with "resident"

Page 1, line 16, replace "facility wraps around the individual's" with "resident elects to receive end-of-life care from a licensed and Medicare certified hospice agency, and the facility meets the needs of the resident directly, through services provided by the hospice agency, or contracts with caregivers to provide wrap around care and services.

Page 1, remove lines 17 through 19

Renumber accordingly.

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#1 pg. 1

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

Page 1, line 15, replace "Notwithstanding contrary provisions in subsection 1, a" with "A"

Page 1, line 15, remove "an"

Page 1, line 16, replace "individual" with "resident"

Page 1, line 16, replace "facility wraps around the individual's" with "resident receives end-of-life care from a licensed and Medicare certified hospice agency, and the facility meets the needs of the resident directly through services provided by the hospice agency or contracts, between the facility or resident, and caregivers to provide wrap around care and services. The basic care facility remains responsible for the care and services of the basic care resident."

Page 1, remove lines 17 through 19

Renumber accordingly

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Proposed Amendment to 1126

Page 1, line 19, after the period insert "A basic care facility continues to be responsible for the care and services of every resident. "