2023 SENATE HUMAN SERVICES

SB 2332

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2332
1/25/2023

Relating to an appropriation to the department of health and human services for providing primary, palliative, and hospice home-based services.

11:21 AM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Home, palliative, end of life care
- Access to care
- Direct care patient services

11:22 AM **Senator Jeff Barta District 43** introduction SB 2332 with amendment testimony in favor #16610

11:26 AM **Steve Aystrop Hospice Red River Valley** testimony in favor #16561

11:28 AM **Tracy Caprion Hospice Red Rive Valley** testimony in favor #16571

Written Testimony:
John Ballantyne #16291
Sonia McManus # 16409

11:43 AM **Madam Chair Lee** closed the hearing.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2332
1/25/2023

Relating to an appropriation to the department of health and human services for providing primary, palliative, and hospice home-based services.

2:06 PM **Madam Chair Lee** called the hearing back to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion topics:

- Rural health caregivers
- End of life care
- Hospice utilization
- Care continuum

2:07 PM **Tracee Capron, Executive Director, Hospice Red River Valley** provided additional information verbal testimony in favor

2:10 PM. **Dr. Tracie Mallberg, Chief Medical Officer, Hospice of the Red River Valley Health Care** testimony in favor #16572

2:22 PM **Theresa Stahl, Chief Financial Officer, Hospice of the Red River Valley** verbal in favor

2:23 PM **Brenda Iverson, Director of Marketing and Community Relations** testimony in favor #16597 #16598

2:36 PM **Rochelle Vander Vliet, President North Dakota Hospice Organization** testimony opposition #16850

2:41 PM **Char Trevithick, Manager of the Jamestown Regional Medical Center Home Health and Hospice Agency** testimony opposition #16851

2:45 PM **Madam Chair Lee** closed the hearing.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2332
2/1/2023

Relating to an appropriation to the department of health and human services for providing primary, palliative, and hospice home-based services.

2:51PM **Madam Chair Lee** called the committee back to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion topics:

- Care home setting
- Lack of workforce
- Rural health caregiver

Senator Lee called for discussion.

Senator K. Roers makes motion **DO NOT PASS.**

Senator Hogan seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion Passes 6-0-0.

Senator Lee will carry SB 2332.

2:57 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2332: Human Services Committee (Sen. Lee, Chairman) recommends **DO NOT PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2332 was placed on the Eleventh order on the calendar. This bill does not affect workforce development.

TESTIMONY

SB 2332

SENATE BILL 2332

SENATOR JUDY LEE, CHAIRPERSON

SENATE HUMAN SERVICES COMMITTEE

JANUARY 25, 2023

Chairperson Lee and distinguished members of the Senate Human Services Committee my name is John Ballantyne. I am submitting this written testimony in support of Senate Bill 2332 and ask that you give this bill a **DO PASS** recommendation.

By way of background, I am the Cofounder of Aldevron and was Chief Scientific Officer from inception in 1998 until my retirement from the company at the end of 2021. Along the way I have had the privilege of being involved in the development of next generation biological drugs from first proof of concept studies to full licensure. Consequently, I have an understanding of needs (and the cost of said) across the spectra of human health.

In the relatively recent past I have witnessed several of my friends and colleagues navigate the travails of end-of-life care for loved ones. All of them are people of means but I know that this is a financial burden that most cannot afford. Through a mutual connection I was introduced to the team at Hospice of the Red River Valley (HRRV) where I considered my charitable efforts could be gainful.

As a scientist and businessman, I deal in data and facts rather than emotions and rhetoric. The demographic facts in the state and associated realities outlined below are telling. I consider high quality end-of-life care to be a critical unmet need and that anything that helps HRRV and others in their mission to serve is of paramount importance.

I support this bill because it would establish the necessary commitment of financial resources to provide home-based care to our State's patients and families at the right time and in the right place – in turn enhancing their quality of life.

Healthcare is changing and challenging. Today we have more North Dakotans gaining into Medicare than ever before and their needs are overwhelming. While North Dakota is one of the least densely populated states in the county, ranking 48th in population density, it is tied for fourth in the country in the percentage of its State population that is 85 years of age or older. Because demand for healthcare increases proportionally with age, demand for healthcare services is especially pronounced in North Dakota. North Dakotans in rural areas are generally older, poorer, and have less or no access to insurance coverage than those in non-rural areas – all of which are challenges to providing adequate healthcare. Rural regions in North Dakota continue to experience depopulation that will only exacerbate the current problem of healthcare access and delivery. Forcing the displacement of our residents from the communities in which they call home to access healthcare is no longer a viable solution.

North Dakotans shared their priorities in the 2022 AARP survey identifying that they need and want access to services and supports which allow them to remain in their homes as they age. Yet, many in communities across our State are left alone without the basics of medical care and struggling with symptoms that leave them homebound and isolated – further negatively impacting their overall health, wellbeing, and quality of life. Because of this, illness escalates, and loneliness and depression often appear.

Unfortunately, the standard model of healthcare in a hospital or office setting often falls short for the people who need it most, the chronically ill, elderly, and disabled. Our State ranks nearly last in the nation in hospice utilization, annual wellness visits, and home healthcare utilization.

The goal of remaining safe at home and receiving appropriate, goal-oriented healthcare is out of reach for so many in our State. Many health systems serve a tight radius around their urban communities. Serving rural North Dakota is costly and is the barrier to improving healthcare access to those North Dakotans wanting to age in place.

Senate Bill 2332 will allow for home based primary, home-based palliative, and home-based hospice services to augment the care being provided by rural hospitals and clinics throughout the state, coordinating with services such as local therapy groups, pharmacy services, mental health and counseling services, and when necessary, hospitalizations or even referrals to specialty services. A focused emphasis on home-based services will help provide our North Dakota communities with the care they need and are asking for and aligns with the priorities outlined in the North Dakota State Health Improvement Plan (SHIP). A home-based care model contributes to the quality of life for generations of families while decreasing healthcare costs, and improving the quality-of-care North Dakotans deserve.

It is incumbent that we choose to view the healthcare we provide in this State not as what it is but as what it could and should be. Unfortunately, the North Dakotans suffering the most from the current state of our healthcare systems delivery and accessibility are the least likely to question, challenge, reject, or change it. We can no longer choose to be motivated to rationalize the status quo of our healthcare system as legitimate – justifying our default system may serve as a soothing function. Our acquiescence of the current state of our health affairs robs us of the moral outrage to stand against healthcare inequities and the creative will to consider alternative ways that could work. Our State, in both policy and financially, must be a partner in this journey – because without your support in prioritizing the continuum of healthcare for your citizens, North Dakota will continue to live near the bottom in health services utilization.

This concludes my testimony. Please give Senate Bill 2332 a **DO PASS** recommendation.

Respectfully Submitted,

John Ballantyne, Ph.D.

SENATE BILL 2332
SENATOR JUDY LEE, CHAIRPERSON
SENATE HUMAN SERVICES COMMITTEE
JANUARY 25, 2023

Chairperson Lee and distinguished members of the Senate Human Services Committee, my name is Edith Lohr. I am submitting this written testimony in support of Senate Bill 2332 and ask you to give this bill a **DO PASS** recommendation.

I am currently retired, in 1981 I was hired by the newly formed Board of Directors of Hospice of the Red River Valley (HRRV) to bring their dream to reality by developing and implementing a hospice program in Fargo that would enable terminally ill patients to stay at home until their death. More importantly, HRRV was able to offer comprehensive end-of-life care, providing pain management, nursing care, 24/7 on-call assistance, spiritual support, and respite. I was the sole employee during that first year. Sonia McManus served as the first volunteer nurse and tirelessly worked alongside me. Together we engaged a group of trained volunteers, physicians, pastors, and social workers to provide hospice care to patients and families. We admitted our first patient in June 1981.

HRRV was established as a nonprofit organization. To support the initial endeavor of HRRV we relied solely on grants and donations to fund our operations. In 1983, Congress authorized Medicare to cover the cost of hospice cares – which became known as the Medicare hospice benefit. HRRV was certified fourteen (14) days after the Medicare hospice benefit went into effect and HRRV was the first certified hospice program west of the Mississippi to receive payment from Medicare. I assisted in drafting the benefits later adopted by Blue Cross of North Dakota. Hospice grew rapidly in its first years both by number of professional staff, volunteers, and patient/families served, ninety-eight (98%) percent of those patients were able to remain at home until their death.

By the end of 1983, HRRV served clients in all of Cass County, North Dakota and Clay County, Minnesota. As referrals came in from beyond our service area, it was clear that serving patients beyond the thirty (30) miles from Fargo was cost-prohibitive, but necessary. In recognizing the growing need of patients and families, my team and I developed a satellite model design. Discussions with the leadership of Hillsboro Hospital led to a plan to locate the satellite in Hillsboro. A grant was successfully submitted to the Wheatridge Foundation as a grant requesting funding to start a satellite based in Hillsboro, North Dakota. Our first satellite location was established in 1984, a local professional team was recruited, inpatient care (when needed) was secured from Hillsboro Hospital, and a volunteer network was trained. The satellite model we established worked, and it has been the model replicated time after time as HRRV expanded across eastern North Dakota and western Minnesota.

Replicating this model in western North Dakota will be challenging given the geographic distances, fewer population per area, and recent closing of the smaller inpatient facilities. Based on HRRV's proven track record and over forty (40) years of experience, an operational revenue stream in place, and the pressing unaddressed need in western North Dakota, I see Senate Bill 2332 as the opportunity to effectively serve hundreds of North Dakotans every year who wish to live at home in the last months of life until their death.

Respectfully Submitted,

Edith M. Lohr /s/

Edith M. Lohr
47 Brook Lane
Marlboro, Massachusetts 01503

Sonia McManus /s/

Sonia McManus
3200 11th St. South
Fargo, North Dakota 58104

TESTIMONY
SENATE BILL 2332 – HOSPICE OF THE RED RIVER VALLEY
SENATE HUMAN SERVICES COMMITTEE
SENATOR JUDY LEE, CHAIRPERSON
JANUARY 25, 2023

Chairperson Lee and distinguished members of the Senate Human Services Committee, for the record my name is Stephen P. Astrup, Regulatory and Project Counsel for Hospice of the Red River Valley ("HRRV") and I am joined by my colleagues Tracee Capron, Executive Director for HRRV; Dr. Tracie Mallberg, Chief Medical Officer for HRRV; Brenda Iverson, Director of Community Relations and Marketing for HRRV; and Theresa Stahl, Director of Finance for HRRV. We are here today to provide testimony on Senate Bill 2332 and ask that you give this bill a **DO PASS** recommendation.

While hospice utilization and other healthcare utilizations vary across the United States, North Dakota continually ranks near the bottom in most areas. We have and continue to work tirelessly to reduce health disparities in North Dakota as it relates to hospice care and healthcare services.

Over the past decade or more, our patient populations have changed drastically. We serve patients and families across North Dakota's comprehensive continuum of care and support patients and families right of choice – including where a patient wishes to call home. Additionally, we are fiercely protective of the quality of care provided to patients.

This concludes my testimony. I am happy to answer any questions you may have. Should you have questions subsequent to today's hearing, please feel free to contact me via phone at (701) 356-1522 or via email at stephen.astrup@hrrv.org

HOSPICE
RED RIVER VALLEY

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

Chairman Lee and committee members of the Senate Human Services Committee, I am Tracee Capron, Executive Director, Hospice of the Red River Valley. I testify in support of Senate Bill 2332.

This bill will provide grants for a continuum of home-based healthcare services. The beauty of this whole bill coming together is the fact that people care and want the best for our state. Legislators, community members, hospice, and other healthcare personnel - all want to lend resources and knowledge to help make North Dakota a better place for people to live while remaining in their homes. This is a huge undertaking, but we believe with healthcare partners coming together in our state, we can do this. We can serve all residents in our state. We need to remain focused on this motivating factor as people are suffering, we're having to say no to families with dying loved ones, and this is just not ok. These home-based primary, palliative, and hospice services are needed to help the citizens of North Dakota, improving their quality of life with generational impact while also decreasing healthcare costs.

I want to share the history of the start of hospice care in the state of North Dakota. A legendary group of volunteer community members in North Dakota banded

together in 1978 recognizing a need for our residents. This volunteer group started the first community-based non-profit hospice in the state of North Dakota. Their goal and vision were to make sure everyone had access to holistic end-of-life hospice care to be provided wherever someone calls home. I refer to this time as legendary because our nation had not yet recognized the value of hospice. It wasn't until 1983 that hospice became a Medicare benefit. Now in 2023, 40 years later, it's tragic to think many in our state still do not have access to hospice care in their home. Even more concerning is that rural communities that are critical to our state's infrastructure lack these services.

I ask every person in this room to reflect on where you would want to be and whom would you want to be with in the last days of your life.

North Dakotans shared their priorities in the 2022 AARP survey identifying that they need access to services and supports which allow them to remain in their homes as they age.

Approximately four years ago we experienced a gap in care that truly illustrates the need for support with SB 2332. We received a call that a family from Ashley, North Dakota needed hospice care. This is a rural area of the state we were not yet serving. The patient was currently hospitalized and wanted to be home to die – home, in their community, and with their family. The hospital case manager called indicating this family was pleading for help. They just wanted to go home. Our first thought was that they have a hospital-based hospice not far from Ashley. After calling that hospice, we learned they couldn't serve the Ashley community. Our clinical teams all came together and said 'we need to do this'. Within a few days, we were helping this family get home and began the care of hospice support for them. It was a stretch for all of us, and one we were so thankful we could do, partnering with those in the Ashley community. This experience really exemplifies what a true healthcare partnership should look like. Our organization came

together with Jamestown Regional Medical Center's hospice in this case, we found ways where we could meet the needs of this family – together. Since then, our relationship with Jamestown Regional Medical Center has only strengthened as we share the goal of truly caring for those in Jamestown as well as the rural surrounding communities.

Sadly, over the years we have had many calls that didn't end this way, where we had to say 'no', and we knew this left the families without care. Knowing how this left someone on the other end of the phone is what has and does drive us in our mission to serve the state. THIS needs to be our continued focus, our purpose – while it's simple, it is not easy. There are no do-overs in death and we have to get it right.

Along with doing what is right, we do have to consider cost and sustainability. The fact is that hospice care reimbursement is on average $158 per day. In this reimbursement, a hospice is responsible for medications, equipment, all clinical services, (nurse, social worker, nursing aide, chaplain, physician, nurse practitioner, bereavement), mileage, supplies, testing, and available support 24 hours a day, seven days a week. We see hospice care provided in the more densely populated areas as it allows for greater efficiency and lower operational costs. The real challenge is in providing rural hospice care as the staffing, costs for equipment and supplies, and travel expenses are significantly higher than in our urban areas.

Our organization had to develop a new model to continue to help in rural areas and provide all the needed home-based services. The model which requires serving across the entire care continuum with primary, palliative and hospice care has been proven to increase quality while also being financially sustainable. Our quality commitments are best shown as we received Hospice Honors, ranking us amongst the best hospice organizations in the country as surveyed by the families we served.

We were founded on a dream that all those who need home-based care in our community have the access to care. Chairman Lee and members of the committee, we need your support to make this happen. This grant puts our community first. Without people living in our communities, we don't need buildings to take care of them. By caring for our rural communities, we are fostering the right care at the right time in the right place. That right place connects the continuum of care which may be the skilled nursing facility or a Medicare-certified hospice house. We must start with care in the home first, which is what the people in our state are asking us for. Thank you for the opportunity to testify today in support of SB 2332. This concludes my testimony. I am happy to answer any questions the committee may have before I turn it over to Dr. Tracie Mallberg who will discuss primary and palliative home-based care.

Respectfully Submitted,

Tracee Capron,
Executive Director
Hospice of the Red River Valley
Tracee.capron@hrrv.org
(701) 356-1515

HOSPICE
RED RIVER VALLEY

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

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

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

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

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

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

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

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

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

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

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

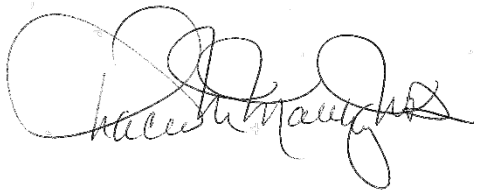
when I asked, I found that the patient did not know how to use the medication in the nebulizer they received, to manage his breathing. I found another patient had been sleeping on her couch for months because she could no longer manage the stairs to her bedroom. I am also given the opportunity to observe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

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

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

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

Respectfully submitted,



Tracie Mallberg, MD, FAAFP, HMDC
Medical Director
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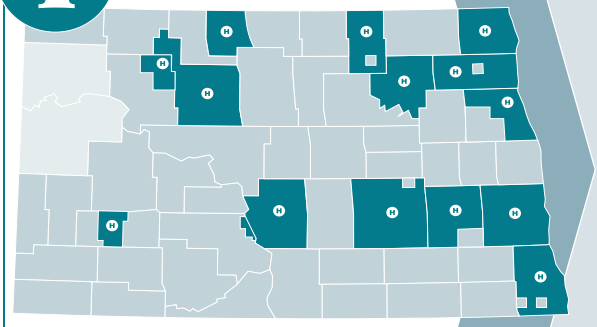
People Want to Stay Home

Let's make it possible with home-based primary, palliative and hospice care.

1 Statewide Problem: Rural Healthcare Availability



- Adequate Medical Service
- Medically Underserved Area
- Medically Underserved Population

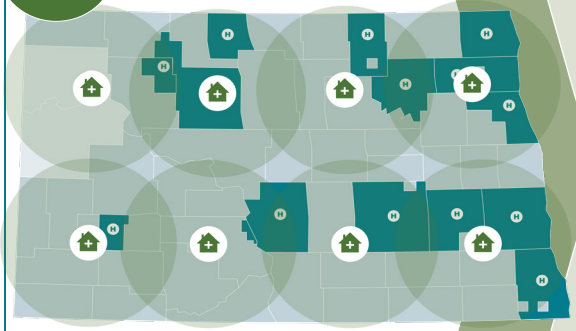
Solution: Enhance Rural Healthcare

Access
We travel in person to see our patients throughout the entire State. Current coverage areas are often limited to 30 miles from a medical site.

Quality
We provide primary, palliative and hospice services through specially trained healthcare professionals.

Holistic Care
Physical, spiritual and emotional support that also extends to loves ones with bereavement and grief counseling.

2 Statewide Problem: New Medical Facilities Costly in Rural North Dakota



- Proposed Medical Service Coverage

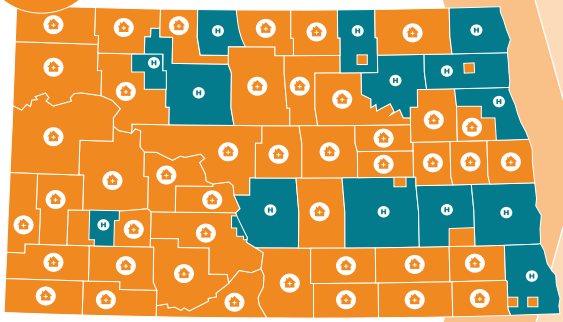
Solution: Provide Positive Economic Impact

Collaboration
We team up with existing local medical partners utilizing existing infrastructure and adding service capacity.

Sustainability
Our non-profit model is balanced with urban and rural patient revenue and it's proven to be sustainable.

Returns
Through our revenues, we re-invest back into the community.

3 Statewide Problem: Healthcare Service Gaps



- Adequate Medical Service
- Gaps in Healthcare

Solution: Partner with Rural Communities

Partnerships
We partner with local communities to get people back home so the population stays as long as possible in the community instead of leaving to larger population centers.

Jobs
Creating demand for highly skilled medical professionals and by educating current highly skilled medical professionals in rural areas, thus meeting the demand for medical services in underserviced areas of North Dakota.

Knowledge
We have the capacity and the proven knowledge to operate medical services within the home and we can utilize this experience to bring much needed medical services to rural areas.

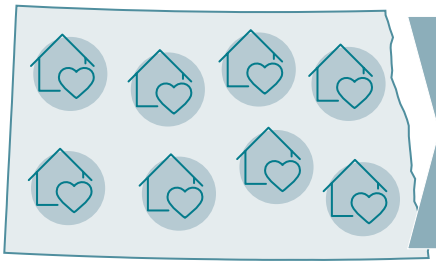
HOSPICE
RED RIVER VALLEY

A Needs-Based Approach

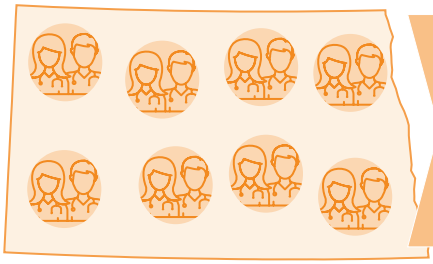
Hospice of the Red River Valley Has the Operational, Needs-Based Investment Approach to be Self-Sufficient in three years.

NORTH Dakota Be Legendary.
Health & Human Services

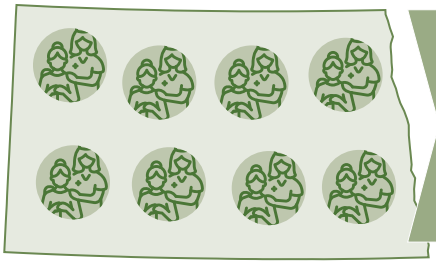
Consider NDHHS appropriation for their role in planning, implementation and oversight.



Priority 1 - Expanding Hospice to Rural Areas:
Staffing, patient related expenses, training, education, certifications, implementation marketing, start-up costs, office fit outs, and transportation
$10.3 million*



Priority 2 - Expanding Primary Care to Rural Areas:
Staffing, patient related expenses, training, education, certifications, implementation marketing, specialized equipment, and overhead
$2.8 million*



Priority 3 - Further Expansion Palliative Care:
Staffing, patient related expenses, training, education, and overhead
$6.8 million*

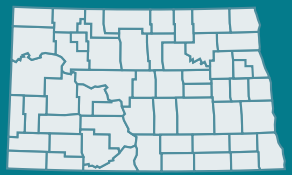
Priority 4 - Creating (2) 12-bed Hospice Houses:
As census and care needs expand, consider adding community-based Hospice Houses
Land, architect & engineering fees, construction, furniture, and equipment, year 1 operating costs until break-even
$62 million*

*Rough Order Magnitude

Why Partner With Hospice of the Red River Valley?

Community Owned Non-Profit Reinvests Back to the Community

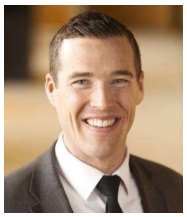
Proven Track Record with Defined Quality Metrics



Commitment to Serving the Care Continuum Across All Counties

Questions Regarding Hospice Services?

Tracee Capron
Executive Director
tracee.capron@hrrv.org



Questions Regarding Hospice Services?

Stephen P. Astrup, JD
Project and Regulatory Counsel
stephen.astrup@hrrv.org

People Want to Stay Home
Let's Help Them

HOSPICE
RED RIVER VALLEY

Providing comfort at the end of life's journey

Summary

- **Hospice** use is very low in North Dakota compared to other states
- **Hospital** use is slightly below average
- **Hospital mortality** is slightly above average
- **Skilled Nursing Facility** use is above average
- **Home Health Care** use is very low
- **Hospice links** to other services are weak
  - For deaths within six months of hospital discharge
  - For deaths within six month of a skilled nursing discharge
  - For deaths within six months of a home health care service

Source: Medicare claims files

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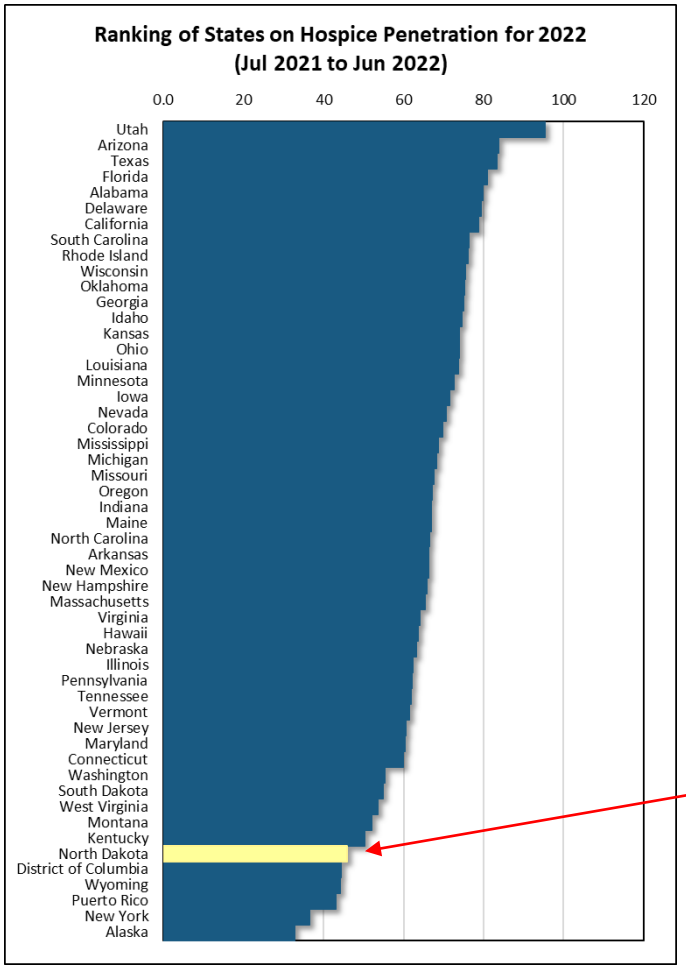
North Dakota Hospice Utilization



- **Hospice** use is very low in North Dakota compared to other states

Ranking 47th out of 52 states! Among the worst in the country for utilizing the hospice benefit

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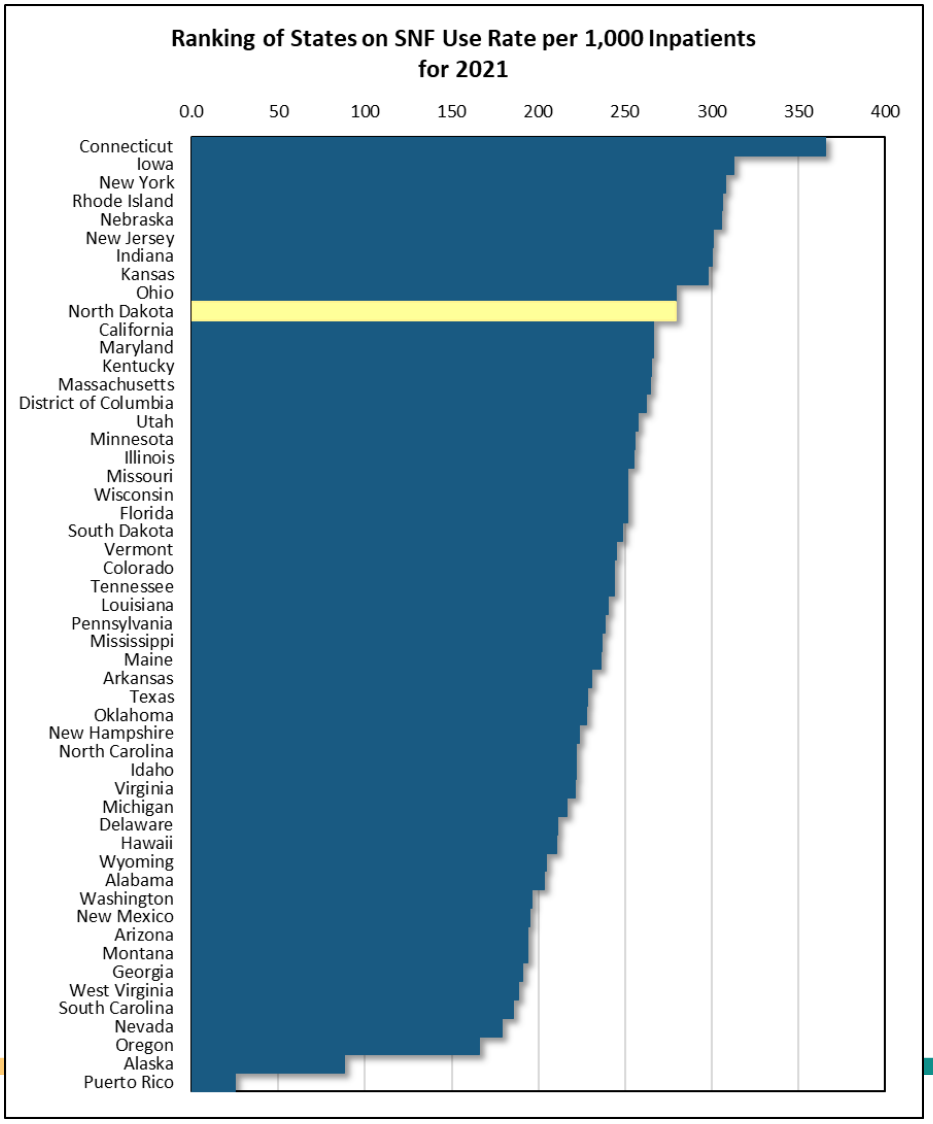
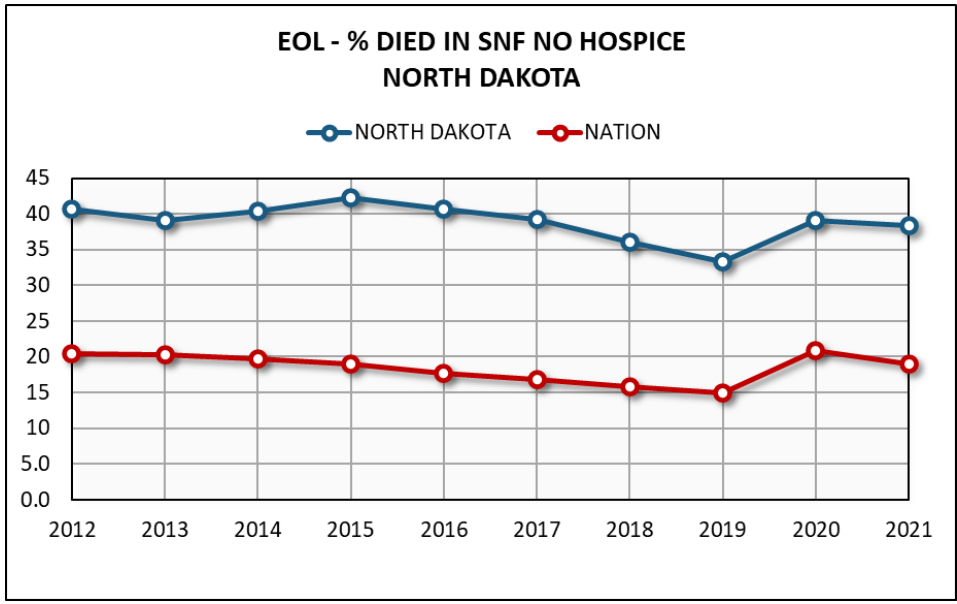
Skilled Nursing Care in ND





SNF use is very high

Dying without hospice – higher than nat'l

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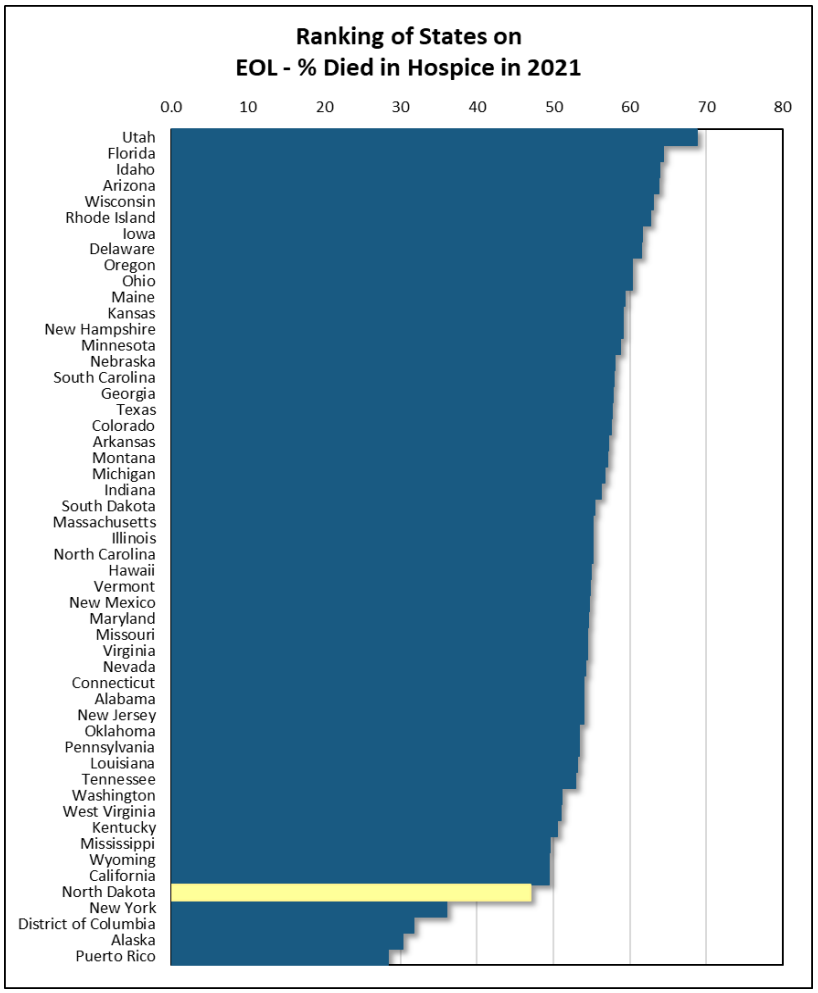
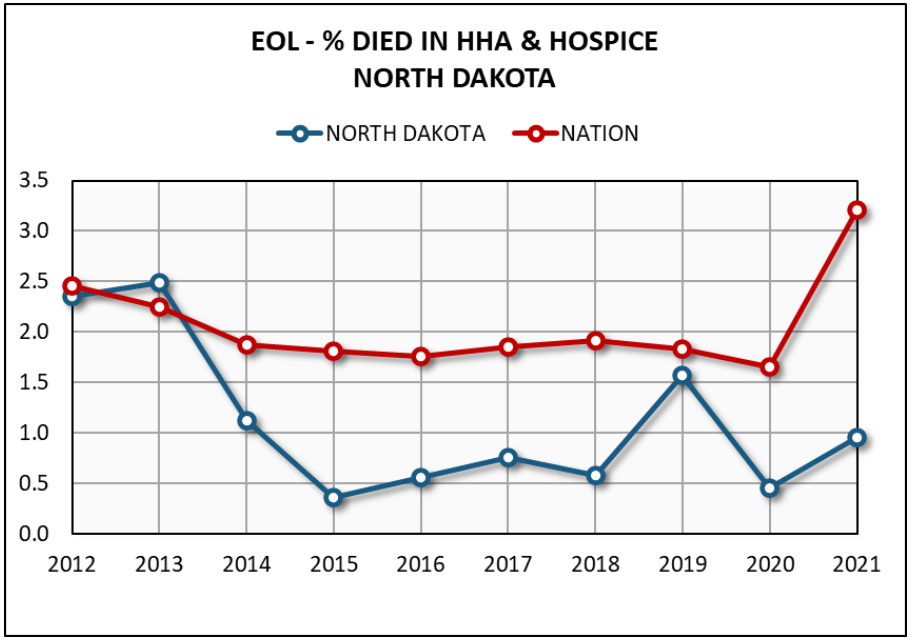
Home Health Care & Hospice



- **Hospice** use is low for enrollees dying within six months of home health services



HOSPICE
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The impact to our residents

- In 2022, of 5,746 residents who died, only 1,886 received hospice.
  - 3,860 people in our state died without the care and support of hospice!

HOSPICE
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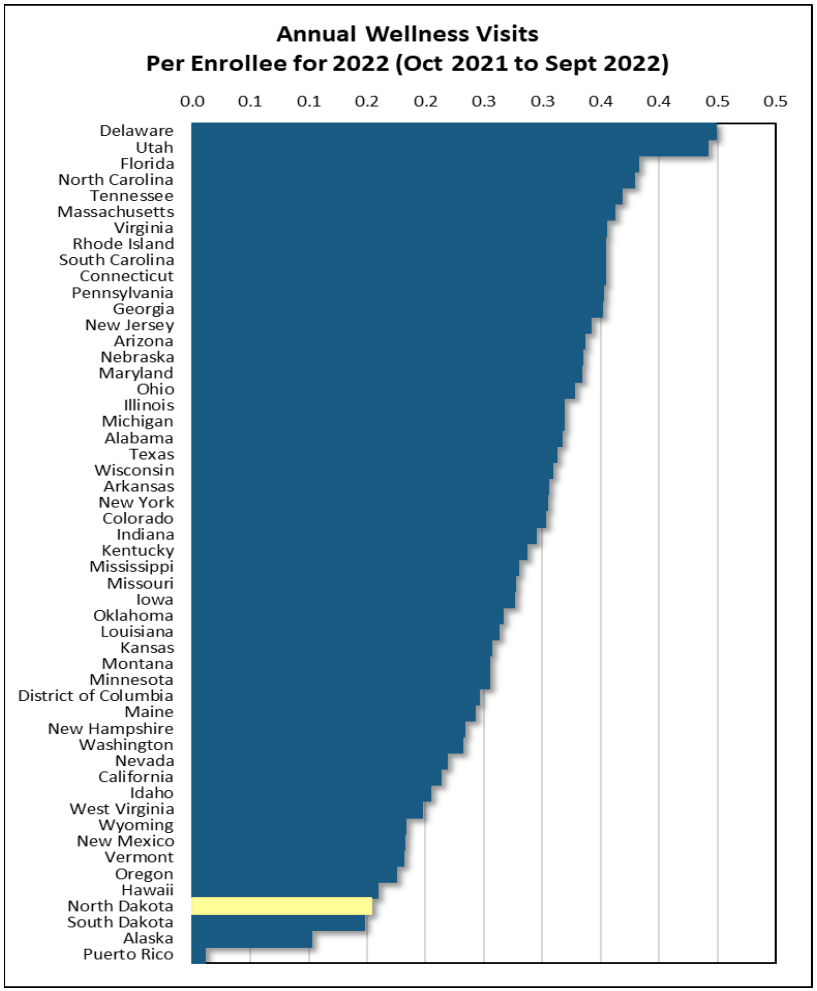
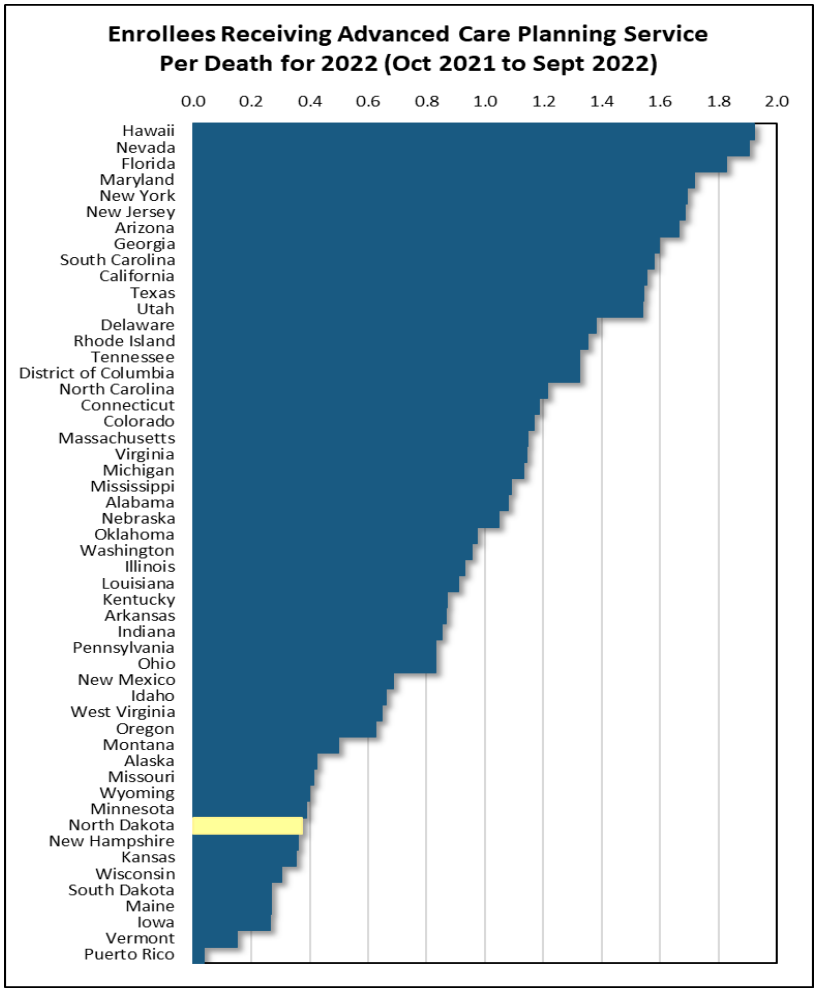
Annual Wellness Visits



- **Annual Wellness Visits** with primary care providers seldom occur in North Dakota

Advance Care Planning



- **Advance Care Planning** is underutilized in North Dakota

HOSPICE
RED RIVER VALLEY

Legislative Assembly

North Dakota Senate

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Senator Jeff Barta
District 43
815 South 21st Street
Grand Forks, ND 58201-4135
C: 701-741-5906
jbarta@ndlegis.gov

COMMITTEES:
Industry and Business
State and Local Government

January 25, 2023

SENATE BILL 2332
SENATE HUMAN SERVICES COMMITTEE - FORT LINCOLN ROOM
SENATOR JUDY LEE, CHAIR

Chairwoman Lee and members of the Senate Human Services Committee, for the record, my name is Jeff Barta. I am the Senator from District 43 in Grand Forks.

Approximately 2 weeks ago I was approached by a constituent from my District asking if I would be willing to help some people introduce a bill about their idea to deliver much needed healthcare services to rural North Dakota. Being a naïve, ambitious freshman Senator, I told him I would be more than happy to listen to what they had to say, but made no promises. He proceeded to provide me the contact number for Tracee Capron, and what I thought would be a 5-minute conversation, turned into a two- and half-hour meeting in the Capitol Café with Tracee and Stephen Astrup, both of whom are here with us today.

During this meeting these two shared with me the status of hospice care in our state and how there was a gap in coverage. Tracee shared their desired mission of delivering home based primary, palliative, and hospice services to all North Dakotans. She told me how they believe that even though there are many obstacles, there is a way to provide these services to the entire state, and that by doing so, we can improve the quality of life for our aging population

by helping them stay in their homes longer; a comment we hear quite often as the desired goal of our parents or grandparents.

I will admit that the bill as presented, needs a little work. Over the last few days, multiple conversations have been had with people across the spectrum of healthcare regarding the intent of this bill. These conversations have led to some suggested changes in the language and I have created a rough draft of the areas we suggest amending that I believe will be more palatable to the committee and the state. Those changes are provided as Exhibit A attached to this testimony and I am happy to review those with you. Nonetheless, I believe the subject matter of this bill needs to be discussed sooner than later and that is why I am in front of you today. This is just the first step in creating a comprehensive, collaborative care program of delivering primary, palliative and hospice care to the residents of ND.

SB2332 is an investment in the future of our rural healthcare delivery. It will allow for the delivery of home based services to augment the care being provided by rural hospitals and clinics throughout the state; working in coordination with services such as local therapy groups, pharmacy services, mental health and counseling services, and when necessary, hospitalizations or even referrals to specialty services.

Behind me are a group of dedicated providers who will provide more details on the needs for, and the merits of, a comprehensive end of life program for rural North Dakotans. Their driving desire to help this population will be evident in the testimony you will hear & read today.

Madame Chair and members of the Health & Human Services committee, I thank you for listening and will stand for any questions you may have. I do believe, however, that the people that will be following me, will be much more informative than I.

EXHIBIT A

Page 1, Line 6, remove “$82,000,000” and insert “$22,000,000”

Page 1, Line 10, remove “an”

Page 1, Line 11, remove “program” and insert “programs”

Page 1, Line 11, remove “is” and insert “are”

Page 1, Line 16 & 17, “remove “and to construct, staff, and operate two 12-bed inpatient units”

North Dakota Hospice Organization

Good Morning Senator Lee and Fellow Committee Members;

My name is Rochelle Vander Vliet. I am a Director of one of the hospice agencies in our state, as well as the President of the North Dakota Hospice Organization. Currently our organization represents 10 Medicare certified hospices: CHI in Bismarck, Dickinson, Williston, Valley City, Hospice of the Red River Valley in Fargo, Heart of America Hospice in Rugby, Sakakawea Hospice in Hazen, Jamestown Hospice, Sanford Hospice in Bismarck, Trinity Hospice, Minot.

As an organization, we support the hospice philosophy and would like to see hospice services expanded in North Dakota. We recognize that there are areas in our state where hospice services are not currently available, particularly in rural areas. We also believe in working collaboratively for the greater good to expand hospice services in the state.

That being said, we do have concerns with the way Senate Bill 2332 is drafted to benefit one hospice entity instead of giving the option of grant funding to be available for multiple organizations. With additional funding, established hospice agencies would have the opportunity to increase their service areas in their given locality, thus benefiting more residents overall.

Therefore we would like amendments to allow multiple organizations to apply and be awarded grant funding for projects related to primary, palliative and hospice services. We would also like provisions ensuring the rural and underserved areas are benefiting from the grant projects rather than new hospice services in areas with established hospice services, and are seeking clarification on the specific language surrounding the "six regional offices" and "two 12-bed inpatient units."

We believe a collaborative group of stakeholders should be required to assist in the process to ensure the available funds provide the greatest impact. The ND Hospice Organization would like to be part of this process.

We are not In Favor of this bill as currently written because it does not allow for inclusion of all hospice agencies in the state. We would only support this bill with the said amendments or a bill that was re-introduced to include perspectives and input from hospice agency stakeholders across the state.

Thank you for your time and consideration.

If you need any information, please contact:
Rochelle Vander Vliet, President NDHO - Rochelle.vandervliet@sanfordhealth.org
Susanne Olson, Hospice Liaison -Susanne.olson@commonspirit.org

Jamestown
REGIONAL MEDICAL CENTER

Good morning Senator Lee and Fellow Committee Members,

My name is Shar Trevithick. I am a registered nurse and the manager of the Jamestown Regional Medical Center Home Health and Hospice Agency in Jamestown. I also am a member of the North Dakota Hospice Organization, and am honored to speak alongside Rochelle Vander Vliet on behalf of Hospice providers in North Dakota.

Providing Hospice care in rural, under-served North Dakota is at the forefront of nearly every conversation we have as Hospice providers. We live and work in these communities where we deliver quality, safe care to our friends, neighbors, and loved ones. We believe that all residents of North Dakota should have quality end-of-life care available to them, and we stand ready to deliver that care. We fully recognize the need to expand access to Hospice care in under-served areas of our state, and I appreciate the opportunity to provide necessary input to you from the perspective of my agency.

As it is written, Senate Bill 2332 is drafted to benefit only one entity. This raises concerns over the quality of care that would be provided when the potential of a care monopoly is created. Care in rural areas is best delivered by those familiar with that region and those residents, not by a singular agency with no local or regional oversight. Hospice providers in rural areas are invested in our communities and most importantly, the people we serve.

Rochelle spoke to you about the general goal of expansion of care, and I would like to focus on the importance of Hospice in North Dakota. Every one of us has a story about how end-of-life care impacted their family- whether it is a story of the wonderful experience a loved one had the end of life because Hospice was present, or a story of a painful journey without the support and care that was desperately needed. Hospice providers are among the most resourceful, driven, compassionate people you will meet. We have been known to put on a backpack and walk through a blizzard to get to a patient who needs us. We have put mattresses in our cars and arrived at homes laden with supplies, medications, and necessities to provide comfort and confidence to patients and caregivers. Each of us has many stories of cases where our agency dug deep to bring care to a patient who otherwise would have experienced suffering and discomfort without the support of Hospice. Unfortunately, we also have stories of cases where we were unable to reach a patient, and every time it is a decision that we wrestle with. Expanding into a new service area requires funds that Hospices simply do not have available- we utilize every dollar we are paid to provide services to the patients we serve within existing service areas, and our expenditures are rising faster than we can adapt to.

All residents have the right to access quality Hospice care, and the responsibility of providing this is recognized fully. The desire to meet this need is strong, and the expertise is present in our state to accomplish this. An amended bill that would specify that multiple organizations can apply for and be awarded funds, as well as clarify how it would be ensured that rural areas are benefiting directly from the funds, would be required to receive the support of Hospice as a whole in North Dakota.

Jamestown
REGIONAL MEDICAL CENTER

Thank you for your consideration in amending the Senate Bill 2332 to reflect the requested provisions, and allowing all stakeholders to provide invaluable input into decisions made affecting end-of-life care options for the residents of North Dakota.

Respectfully,

Shar Trevithick, RN BSN COS-C

JRMC Home Health and Hospice Manager

strevithick@jrmcnd.com

701-952-4816