COMMITTEE TO STUDY THE NEEDS RELATED TO THE BEHAVIORAL AND COGNITIVE CARE OF OLDER PERSONS

(Senate Bill 121, 2017 Legislature)

Tuesday, April 10, 2018
9:00 a.m.

Legislative Building
401 South Carson Street
Carson City, Nevada
Room 3137

with videoconference to

Grant Sawyer State Office Building
555 East Washington Avenue
Las Vegas, Nevada
Room 4401

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LEGISLATIVE COUNSEL BUREAU

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MEETING NOTICE AND AGENDA

Name of Organization:	**Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons (Senate Bill 121, 2017 Legislative Session)**
Date and Time of Meeting:	Tuesday, April 10, 2018 9:00 a.m.
Place of Meeting:	Legislative Building, Room 3137 401 South Carson Street Carson City, Nevada

Note: Some members of the Committee may be attending the meeting and other persons may observe the meeting and provide testimony through a simultaneous videoconference conducted at the following location:

Grant Sawyer State Office Building, Room 4401
555 East Washington Avenue
Las Vegas, Nevada

If you cannot attend the meeting, you can listen or view it live over the Internet. The address for the Nevada Legislature website is http://www.leg.state.nv.us. Click on the link "Calendar of Meetings/View."

Note: Minutes of this meeting will be produced in summary format. Please provide the secretary with electronic or written copies of testimony and visual presentations if you wish to have complete versions included as exhibits with the minutes.

Note: **Items on this agenda may be taken in a different order than listed. Two or more agenda items may be combined for consideration. An item may be removed from this agenda or discussion relating to an item on this agenda may be delayed at any time.**

I. ROLL CALL.

II. PUBLIC COMMENT.
(Because of time considerations, speakers are urged to avoid repetition of comments made by previous speakers. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted in person or by e-mail, facsimile, or mail before, during, or after the meeting.)

III. OPENING REMARKS FROM THE CHAIR.
Senator Joyce Woodhouse, Chair

For Possible Action

IV. APPROVAL OF THE MINUTES OF THE MARCH 5, 2018, MEETING.

For Possible Action

V. PRESENTATION ON PROGRAMS, SERVICES AND TREATMENTS OFFERED TO OLDER PERSONS WITH COGNITIVE DISEASES AND THEIR CAREGIVERS.
A. Cleveland Clinic Lou Ruvo Center for Brain Health
B. Perry Foundation

For Possible Action

VI. DISCUSSION RELATED TO THE DEMENTIA FRIENDLY NEVADA INITIATIVE.
Washoe County - Community Action Group Member

For Possible Action

VII. DISCUSSION ON COMMUNITY RECOMMENDATIONS RELATED TO THE NEEDS OF OLDER PERSONS WITH BEHAVIORAL AND COGNITIVE HEALTH ISSUES AND THEIR CAREGIVERS.
Alzheimer’s Association

For Possible Action

VIII. DISCUSSION RELATED TO POSSIBLE FUNDING SOURCES, MEDICAID REIMBURSEMENT RATES, MEDICAID WAIVERS, AND SLIDING FEE SCALES TO SUPPORT PROGRAMS AND SERVICES FOR OLDER PERSONS WITH BEHAVIORAL AND COGNITIVE DISEASES.
Department of Health and Human Services

For Possible Action

IX. DISCUSSION REGARDING A “NO WRONG DOOR” PROGRAM TO ASSIST OLDER PERSONS WITH BEHAVIORAL AND COGNITIVE CARE NEEDS AND THEIR CARE GIVERS.
Division of Aging and Disability Services

For Possible Action

X. PRESENTATION REGARDING PROGRAMS AND SERVICES FOR THE CARE OF OLDER PERSONS WITH BEHAVIORAL AND COGNITIVE HEALTH ISSUES OFFERED IN OTHER STATES.
A. Bureau of Assisted Living, Wisconsin Department of Health Services
B. North Dakota - Dementia Care Services Program

For Possible Action

XI. COMMITTEE DISCUSSION OF RECOMMENDATIONS RECEIVED DURING COMMITTEE MEETINGS AND IN RESPONSE TO A SOLICITATION OF RECOMMENDATIONS REGARDING TOPICS RELATED TO THE NEEDS OF OLDER PERSONS WITH BEHAVIORAL AND COGNITIVE HEALTH ISSUES AND THEIR CAREGIVERS FOR FUTURE WORK SESSION.

XII. PUBLIC COMMENT.

(Because of time considerations, speakers are urged to avoid repetition of comments made by previous speakers. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted in person or by e-mail, facsimile, or mail before, during, or after the meeting.)

XIII. ADJOURNMENT.

Note: We are pleased to make reasonable accommodations for members of the public with a disability who wish to attend the meeting. If accommodations for the meeting are necessary, please notify the Fiscal Analysis Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call the Fiscal Analysis Division at (775) 684-6821 as soon as possible.

Notice of this meeting was posted in the following Carson City locations: Blasdel Building, 209 East Musser Street; City Hall, 201 North Carson Street; and the Legislative Building, 401 South Carson Street. Notice of this meeting was posted in the following Las Vegas location: Legislative Counsel Bureau, Las Vegas Office, Grant Sawyer State Office Building, 555 East Washington Avenue. Notice of this meeting was hand delivered for posting to the following Carson City location: Capitol Press Corps, Basement, Capitol Building, 101 North Carson Street. Notice of this meeting was faxed or e-mailed for posting to the following Las Vegas locations: Clark County Government Center, Administrative Services, 500 South Grand Central Parkway; and Capitol Police, Grant Sawyer State Office Building, 555 East Washington Avenue. Notice of this meeting was posted on the Internet through the Nevada Legislature's website at www.leg.state.nv.us.

Supporting public material provided to Committee members for this meeting may be requested from Judy Lyons, Committee Secretary, Fiscal Analysis Division of the Legislative Counsel Bureau at (775) 684-6821 and is/will be available at the following locations: Meeting locations and the Nevada Legislature's website at www.leg.state.nv.us.

MINUTES OF THE MEETING OF THE COMMITTEE TO STUDY THE NEEDS RELATED TO THE BEHAVIORAL AND COGNITIVE CARE OF OLDER PERSONS
(Senate Bill 121 [Chapter 522] Statutes of Nevada 2017)
March 5, 2018

The meeting of the Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons (created by Senate Bill 121, 2017) was held at 9:00 a.m. on Monday, March 5, 2018, in Room 2135 of the Legislative Building, 401 South Carson Street, Carson City, Nevada, with videoconference to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada.

COMMITTEE MEMBERS PRESENT IN CARSON CITY:
Senator Woodhouse, Chair
Senator Ratti
Senator Goicoechea
Assemblywoman Benitez-Thompson, Vice Chair
Assemblyman Daly
Assemblyman Wheeler

COMMITTEE MEMBERS PRESENT IN LAS VEGAS: None

COMMITTEE MEMBERS ABSENT:
None

STAFF:
Sarah Coffman, Principal Deputy Fiscal Analyst, Fiscal Analysis Division
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division
Judy Lyons, Committee Secretary, Fiscal Analysis Division
Kristin Roberts, Senior Principal Deputy Legislative Counsel, Legal Division

EXHIBITS:

(Exhibit A)	Meeting Packet and Agenda
(Exhibit B)	Transcending the Tragedy Discourse of Dementia, Sanford Center for Aging
(Exhibit C)	Community Health Programs for Seniors, Dignity Health
(Exhibit D)	Family Caregivers Providing Complex Chronic Care To People with Cognitive and Behavioral Health Conditions, AARP
(Exhibit E)	Valuing the Invaluable 2015 Update, AARP
(Exhibit F)	Caregiving in the U.S.- Executive Summary, AARP
(Exhibit G)	Caregivers of Older Adults: A Focused Look at Those Caring for Someone Age 50 +, AARP
(Exhibit H)	AARP Caregiving Resources

(Exhibit I)	The CARE Act, AARP
(Exhibit J)	Nevada Caregivers Resource Guide, AARP
(Exhibit K)	Prepare to Care, AARP
(Exhibit L)	A Planning Guide for Caregivers in the LGBT Community, AARP
(Exhibit M)	We Need to Talk…
(Exhibit N)	At the Crossroads
(Exhibit O)	Dementia Friendly America
(Exhibit P)	Age and Dementia Friendly Winnemucca and Humboldt County
(Exhibit Q)	Suicide Prevention for Older Persons, DPBH

I. ROLL CALL.

Chair Woodhouse called the meeting of the Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons (Committee) to order at 9:06 a.m. and the secretary called roll. The members were present at the Carson City meeting location. Assemblyman Wheeler joined the meeting at 9:38 a.m.

II. PUBLIC COMMENT.

This agenda item was taken out of order.

Chair Woodhouse asked for public comment from attendees in Las Vegas and Carson City. There was no public comment at either location.

III. OPENING REMARKS AND COMMITTEE INTRODUCTIONS.

This agenda item was taken out of order.

Chair Woodhouse thanked everyone for attending the meeting and conveyed meeting room protocol. She announced the Committee's final meeting dates scheduled for April 10, 2018, and June 14, 2018, and communicated that staff would be sending out a solicitation to stakeholders for recommendations related to the behavioral and cognitive care needs of older persons. She said the recommendations will be discussed at the April 10, 2018, meeting, and the Committee will move forward with a work session at the June 14, 2018, meeting.

IV. APPROVAL OF THE MINUTES OF THE JANUARY 29, 2018, MEETING.

> SENATOR GOICOECHEA MOVED FOR APPROVAL OF THE MINUTES FROM THE JANUARY 29, 2018, MEETING.
>
> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

V. PRESENTATION ON SCREENING, DIAGNOSIS AND TREATMENT OF BEHAVIORAL AND COGNITIVE DISEASES PREVALENT IN OLDER PERSONS.

A. University of Nevada, Reno – School of Medicine – Sanford Center for Aging

Dr. Peter Reed, Director, Sanford Center for Aging, University of Nevada, Reno, indicated that an estimated 43,000 Nevadans live with dementia. National studies demonstrate only 50 percent of people who experience symptoms of dementia or live with Alzheimer’s receive a diagnosis, and suggests there is tremendous under-diagnosis and a need for early detection. Dr. Reed said when a diagnosis is made, oftentimes physicians work directly with the patient’s spouse or adult child caregiver rather than the patient. There is a great deal of stigma and fear associated with Alzheimer’s and dementia, both in the public as well as among people who may be experiencing symptoms, which can serve as a deterrent for those seeking that diagnosis. Once the diagnosis is made, frequently people become labeled by their family, friends, care providers, and society, which triggers assumptions regarding those people’s capabilities, and subsequently, those people begin losing their right to make decisions.

Dr. Reed brought attention to an article that he and some colleagues published in the American Medical Association’s (AMA) Journal of Ethics (Exhibit B). The article relates to transcending the tragedy discourse of Alzheimer’s disease and determining ways to support people so they can live well. He said he spent his career as a researcher and a policy advocate studying ways to offer effective care and support to people who live with dementia. He acknowledged an advocate from Australia, Kate Swaffer, who was diagnosed with early onset Alzheimer’s in her fifties and wrote a book describing her experience of being diagnosed, living with the disease, and the changes that took place. She coined the term “prescribed disengagement.” Dr. Reed said as soon as Ms. Swaffer’s diagnosis was made, she was given a list of things she could no longer do, such as work and drive or spend time alone with her grandchildren. He emphasized the fear that is associated with people living with dementia and their capabilities.

During his employment at the Alzheimer’s Association, Dr. Reed realized assumptions about people with dementia regarding their capabilities were being made without giving consideration to their remaining strengths. His thought was to develop individualized or person-centered approaches that would enable people to maximize their remaining strengths while providing support for the things they could no longer do.

Dr. Reed said the Alzheimer’s Association hosted a nationwide series of town hall meetings in 2005 as a result of a petition received from people who were living in early stages of dementia. Those people voiced that the Alzheimer’s Association provided outstanding support to caregivers, but the support provided to individuals living with the disease was not as robust. Dr. Reed shared the following quotes received from people who attended the town hall meetings and were living with a dementia diagnosis (page 3, Exhibit B):

"My doctor just kind of let me go, because he was of the belief that there was no treatment. He just kind of cut me loose. You have dementia and there's nothing that can be done. It's a progressive illness…Goodbye."

"There is a stigma that goes along with the disease. Many people are worried about sharing the fact openly."

"People shy away when they realize you have had this diagnosis…like a reaction that might be associated with BO (body odor)."

"When I came down with Alzheimer's, my friends weren't my friends anymore. They don't come to talk with me or just to be with me."

"People didn't know how to talk to me even though I was the same person I was five minutes before I told them I had dementia. They just saw this big A on my forehead. They didn't look at me as the same person—I was stupid, or could not carry a conversation, or have a single thought of my own, which was very distressing to me."

Dr. Reed said a different view of behaviors and dementia has been around for quite a while. In 2005, the Alzheimer's Association released a series of dementia care practice recommendations specifically for long-term care, and in the section on behavior, it stated the behavior and the emotional state of people with dementia are often forms of communication, because residents may lack the ability to communicate in other ways. The recommendations go on to say that residents need opportunities and sufficient time to express themselves, and offer approaches to becoming proactive in trying to minimize those behaviors rather than manage them.

Dr. Reed expanded on the ability to communicate, and suggested behaviors among people living with dementia are a communication of "unmet" needs. He said his point was not about targeting the disease or the behaviors, it was about ensuring that these people have high-quality care and support in their everyday life, such as with dressing, eating or using the restroom. He said when people respond to the behavior associated with these unmet needs as problematic, challenging or unmanaged, they are demonstrating a reactive approach. If the cause of the behavior can be identified, then the behavior may be preventable if better care and support is provided in everyday situations. Dr. Reed empathized that if people are unable to communicate their needs because of the changes that come along with Alzheimer's and dementia, and caregivers are not responding to those needs, then a state of agitated behavior was perfectly understandable. He recognized that people with dementia will communicate effects such as boredom, loneliness, hunger, thirst, and pain in whatever means are available to them.

Dr. Reed spoke of a Canadian researcher named Sherry Dupuis who coined the term "responsive behaviors," to get at that exact sentiment, to convey the idea that people are responding to stimuli and not misbehaving when they act out. He reiterated the frustration that can be experienced by those with cognitive impairment when they are unable to verbally and clearly articulate their needs; therefore, they cannot obtain the help they need.

Dr. Reed said nonverbal communication displayed by people with dementia is misunderstood by staff in long-term care homes, day programs, home-care settings, and by family members. They are seeing these negative reactions as a symptom of the disease.

Relative to the behavioral and psychosocial symptoms of dementia, Dr. Reed stated he believed the symptoms of the disease include the inability to understand one's surroundings, the inability to care for oneself in terms of activities of daily living, and the inability to communicate one's needs effectively. He said becoming agitated due to a lack of support is a normal and expected response to an unfortunate situation.

Dr. Reed shared a story about his grandmother who had dementia and lived in a nursing home. She was eventually evicted due to what the facility deemed "behavioral problems" that ultimately resulted in flooding one floor of the facility. Dr. Reed stated there was certainly an unmet need that was not filled in his grandmother's everyday life that resulted in her flushing clothes down the toilet. He hypothesized that she was bored and lonely, and staff was not engaging her with meaningful activities. He justified that maybe she was beginning to experience incontinence, soiling her clothes, and out of embarrassment tried to hide the evidence. He said they were plausible theories, but staff acted in a reactive manner to what they considered to be a problem rather than being proactive and identifying the roots of the issue.

Dr. Reed emphasized that behaviors in dementia represent miscommunication. He implied people are misinterpreting the motives and actions of people living with dementia and are not taking the time to understand the source and how to be proactive in promoting well-being in everyday life. Dr. Reed acknowledge Dr. Al Power, the author of *Dementia Beyond Drugs*, a book that recognizes the inappropriate use of antipsychotic medication to address behaviors. The author states even if there was a pill that would get rid of all behaviors and dementia, and have zero negative side effects, he would not prescribe it, because it would only mask the underlying need and would prevent the opportunity to provide the individual with good care and support.

Dr. Reed stated that understanding Alzheimer's and dementia and acquiring the appropriate training were key factors in the prevention of miscommunications and the support of well-being. Staff in facilities and home care, including families, need training to understand how to access and interpret the source of behavioral communications. Additionally, training can help reduce stigma and reshape the assumptions made about people living with dementia. He emphasized the need to regulate training hours and scrutinize the content and quality of the training to insure people are taught how to interpret behavioral communication and provide better everyday care.

Dr. Reed acknowledged his service on the State Task Force for Alzheimer's Disease. He said a work group was formed within the organization to explore the quality of training that exists in Nevada, and to make recommendations relevant to enhancements or more effective rollouts in an effort to reframe the manner in which people living with dementia are viewed. Another objective is to understand what could be done collectively to prevent challenging behaviors.

Senator Ratti commented on Dr. Reed's statement about diagnosis, and how a person's behavior changes instantly without progression of the disease. She recalled a documentary relating to the power of music that helps people with dementia retain memories, and that it was powerful in terms of care. She made a request to the Committee to explore the benefits of music and art programs as a future agenda item.

In response, Dr. Reed concurred that music, art, and pets were all positive forms of reconnecting with family, friends and caregivers. He said developing dementia is not a reason for people to lose interest in the things they have enjoyed their entire lives. Dr. Reed identified a documentary called "*Alive Inside*," a music and memory program that utilizes iPods to deliver music playlists to people with Alzheimer's to help reduce agitation and normalize everyday life. The Perry Foundation launched a music and memory initiative in Nevada through a grant provided by the Centers for Medicare and Medicaid Services to purchase iPods to promote music to enhance the lives of those living with dementia in nursing homes across the state, reducing the use of antipsychotic medications.

B. Dignity Health

Ms. Joanna Jacob, Ferrari Public Affairs, attended the meeting on behalf of Dignity Heath - St. Rose Dominican and their three acute care hospitals in Southern Nevada. She introduced Colleen York, Senior Peer Counselor Coordinator, and Katie Ryan, Director, Public Policy and Advocacy, Dignity Health.

Ms. Katie Ryan stated Dignity Health is a not-for-profit health system that invests its proceeds back into the community. In FY 2017, total community benefit equated to $107 million, or $190 million when including uncompensated care reimbursement from Medicare (page 3, Exhibit C). In FY 2017, Dignity Health awarded $364,000 in grants to local organizations, such as the Boulder City Lend a Hand project that provides transportation to seniors and the Veggie Buck Truck that delivers fresh fruits and vegetables to food desert areas.

Ms. Ryan explained that Dignity Health offers two types of community benefit programs, evidence-based disease management programs and the Caregiver's Program, along with a wide variety of wellness core programs, including fitness, stress management and senior peer counseling. She promoted the Helping Hands program, a transportation program that provides rides to clients for medical appointments, shopping or to run errands. The program has 41 drivers, including 37 volunteer drivers, 3 full-time employees and 1 part-time employee.

Ms. Colleen York, Senior Peer Counseling Program Coordinator, Dignity Health

Ms. York, a social worker for over 30 years, with 28 years of experience in a hospital setting, testified that many senior patients resist counseling due to the stigma associated with it. She testified that Dignity Health's Senior Peer Counseling program provides preventative series that have diminished some of the stigma associated with seeking counseling.

Ms. York explained that the Senior Peer Counseling program is a nationwide program developed by the Center for Healthy Aging for adults age 50 and older. Trained volunteer seniors, some retired health care professionals and teachers, provide confidential, personal and supportive counseling for seniors. She recalled an article published by the New York Times that emphasized the detriment of loneliness, stating it can affect the health and longevity of older adults. Loss and bereavement are also challenging for the older population. Ms. York indicated that senior peer counselors will listen to the senior clients' feelings, affirm their strengths, consider alternatives, provide resources, teach then new coping skills and set goals and redirect their lives to a greater meaning and purpose.

The Senior Peer Counseling program was launched in 2007 and was funded by a grant. Fees for service are voluntary and depend on the clients' financial situation. Ms. York said a $10 donation per counseling session is requested; however, most of the senior clients do not pay anything.

Ms. York stated the Senior Peer Counseling program has 20 senior peer counselors who are trained in serving an average of 30 to 35 senior clients per month, and has served close to 4,000 senior clients since 2007. She said the program also indirectly benefits the 20 volunteer senior counselors by giving them a sense of purpose and pride. The counselors are required to receive 72 hours of training with continuous bi-monthly supervised sessions, and is overseen by Dr. Judy Nelson, a clinical psychologist, and herself.

In closing, Ms. York said the senior peer counselors provide the opportunity for each of their senior clients to be seen and heard, and makes a positive difference in the senior client's quality of life.

VI. PRESENTATIONS ON PROGRAMS, TRAINING AND RESOURCES FOR CAREGIVERS OF OLDER PERSONS WITH BEHAVIORAL AND COGNITIVE HEALTH ISSUES.

A. AARP

Mr. Barry Gold, Director of Government Relations, AARP Nevada, summarized the following handouts that were provided to the committee members and the public:

1. *Family Caregivers Providing Complex Chronic Care To People with Cognitive and Behavioral Health Conditions* (<u>Exhibit D</u>): A paper that reports on results from a national survey showing that caregivers of family members with challenging

behaviors were more likely to perform more than one medical/nursing task, and often do so with resistance from the person they are trying to help. Key findings included the following:

a. Caregivers of people with challenging behaviors are more likely to be adult children compared to caregivers of people without challenging behaviors.
b. People with challenging behaviors were generally sicker than their counterparts. Nearly nine in ten people with challenging behaviors have chronic physical health diagnoses.
c. More than one-half of caregivers said the hardest things they did were helping with incontinence, wound care, medications, and food preparation.
d. Medication management was difficult and time consuming.
e. Providing complex chronic care is often not a choice and is stressful.
f. Caregivers of family members with challenging behaviors who performed medical/nursing tasks almost always reported higher levels of stress than caregivers of people without such behaviors.
g. Sixty-one percent of caregivers of family members said they "sometimes to always" felt stressed.
h. Caregiving helps people avoid nursing homes.

Mr. Gold disclosed that some of the data in this handout was from 2013 and 2015, but was informative for caregivers.

2. *Valuing the Invaluable* (Exhibit E): A report partially based on the CARE Act that recognizes the crucial services of those who provide unpaid care and support. Mr. Gold noted that, in Nevada, there are approximately 350,000 family caregivers, approximately 500,000 caregivers overall (including paid caregivers), which equates to approximately $4.0 billion of uncompensated care.

3. *Caregiving in the U.S*.(Exhibit F).

4. *Caregivers of Older Adults: A Focused Look at Those Caring for Someone Age 50 +* (Exhibit G).

5. *AARP Caregiving Resources* (Exhibit H): Mr. Gold acknowledged the following AARP presentations:
   - ABCs of Caregiving – provides resources available to caregivers.
   - Prepare to Care – provides the framework to transitioning both the caregiver and the family member through the process of caregiving, such as with giving up a driver's license, transitioning to Medicare, and/or prepping meals. The programs are offered in both Northern and Southern Nevada.

6. *The CARE Act* (Exhibit I): The CARE Act has passed in a total of 39 states. The CARE Act helps family caregivers when their loved one goes into the hospital and with their transition back home. The Act helps that family caregiver stay involved in the treatment plan and the discharge planning.

7. *NV Caregivers Resource Guide* (Exhibit J): This guide includes resources not just for caregiving, but resources that can help take care of people, such as the Nevada Housing Division, Health and Human Services, Long-Term Care Ombudsman, Consumer Health Assistance, Livanta, Nevada 2-1-1, etc.

8. *Prepare to Care* (Exhibit K): A guide that includes information, checklists, resources and to help one get organized and find the support needed to care for someone.

9. *Planning Guide for Caregivers in the LGBT Community* (Exhibit L).

10. *We Need to Talk…* (Exhibit M).

11. *At the Crossroads* (Exhibit N).

Mr. Gold said AARP Nevada makes joint presentations with the Alzheimer's Association and Nevada Senior Services because they have acquired expertise working directly with clients, whereas AARP is not a direct-service organization.

Mr. Gold mentioned there was a bill in the 2017 Legislative Session that did not pass, but allowed caregivers who are still employed the flexibility to use their sick leave to care for a family member. He was hopeful that piece of legislation would come back again in the 2019 Legislative Session.

Mary Liveratti, President, AARP Nevada

Ms. Mary Liveratti announced that many times caregivers are not available to attend AARP-sponsored presentations; therefore, the AARP has developed a program that offers brown-bag sessions in the workplace during lunch time. She clarified that brown-bag sessions are not restricted to age or membership.

Ms. Liveratti turned her focus to livable communities that are both age friendly and dementia friendly. She reported that two years ago the Alzheimer's Association invited Dementia Friendly America to take part in discussions on becoming dementia friendly in Nevada. She said an action group was formed consisting of people from law enforcement, faith-based groups, Nevada agencies, community providers, as well as people with dementia and their care partners to develop the Dementia Friendly Nevada initiative. Through a $1.0 million federal grant received by Nevada's Aging and Disability Services Division (ADSD), seven grants were awarded to local communities to fund dementia-friendly planning, of which four were awarded to Las Vegas, Reno, Winnemucca and Elko. She acknowledged both Ely and a tribal organization from another rural community for their impressive proposals, and said they would be considered in the next round of grants. Ms. Liveratti clarified that each grant is for $10,000, and is used as seed money to develop community goals that support a dementia-friendly community.

Ms. Liveratti expressed that people with dementia and their care partners provide valuable input to the initiative, because they give perspective on what it is like to live with the disease. She noted it is important for this population to know what is being said and planned for in the community.

Ms Liveratti referred to her handout titled Dementia Friendly America (Exhibit O), and identified Dr. Jennifer Carson as a resource for capacity building and facilitation support. Relative to her handout, she stated Dementia Friendly America has created predesigned toolkits that can be easily adapted, depending on a community's needs, to avoid planning certain community sectors from scratch. Dementia Friendly Nevada offers evaluation support through the Sanford Center for Aging, and partners with the Alzheimer's Association, Cleveland Clinic Lou Ruvo Center for Brain Health, and Nevada Senior Services, among others.

Ms. Liveratti explained that once a grant is awarded to a community, the community is responsible for collaborating with people, organizations and businesses to work toward a dementia-friendly vision. Ms. Liveratti conveyed there are four phases to working toward a dementia-friendly community.

- Phase 1: Form the action team consisting of key community leaders.
- Phase 2: Perform a needs assessment for the community. The action team determines what services to provide and identifies any gaps in service for families living with Alzheimer's or other dementias.
- Phase 3: The stakeholders pick two or three sectors, such as health care, transportation and community involvement, that focus on the specific needs of the community. The planning begins for addressing these sectors.
- Phase 4: Implement the plan and put ideas into practice.

Ms. Liveratti touched on the sustainability of a dementia friendly community, and referenced Winnemucca's livable community publication called Age and Dementia Friendly of Winnemucca and Humboldt County (Exhibit P). Ms. Liveratti gave credit to Gini Cunningham for spearheading the dementia friendly initiative in Winnemucca and for coordinating and acquiring funding for a Memory and Music program through her hospital's auxiliary. She recruited local high school students to load music on iPods for nursing home residents.

She said AARP received one challenge grant in 2017, which was awarded to the Lou Ruvo Center for Brain Health to provide a website for Dementia Friendly Nevada. The website provides information at both state and community levels.

Senator Ratti asked if the Dementia Friendly Essentials (Exhibit O), published by Dementia Friendly America, provided information regarding zoning recommendations in dementia-friendly communities. She spoke about a planned community in Sparks that did not allow for adult day care.

Ms. Liveratti said she was not familiar with zoning regulations in dementia-friendly communities, but would reach out to Dementia Friendly America for that information.

Ms. Liveratti mentioned that Dementia Friendly America has incorporated benefits, such as the Purple Table program, designed for those living with Dementia/Alzheimer's or other special needs, to dine in a more predictable environment with additional accommodations. The restaurant will provide the accommodations that work best along with a little extra patience and attention from staff who have been trained to understand different needs. Other-dementia friendly communities incorporated support to banking and financial institutions by providing training relative to unique customer service issues and abuse and financial exploitation. Ms. Liveratti said she could inquire with Dementia Friendly America about other community programs that might be offered.

Assemblywoman Benitez-Thompson expressed concern relative to caregivers and their lack of sleep due to their loved ones not sleeping through the night. She recognized the Seniors in Service companion program, but encouraged more research into supporting caregivers with sleep deprivation.

Mr. Jeffrey Klein, President and CEO, Nevada Senior Services

Mr. Klein thanked the Committee for its work and for addressing the critical role of caregivers who are an essential part in insuring behavioral and cognitively challenged older adults are able to remain in the community. He reported that Nevada has over 500,000 caregivers in the state that are at great risk for depression and other mental and physical health issues. Nevada has one of the highest senior suicide rates in the U.S., which is even more pronounced with caregivers. Over 59 percent of Nevada Alzheimer and dementia caregivers report high levels of emotional distress and 38 percent report high physical stress. In that population, 75 percent of caregivers are women, the majority are middle aged and employed outside of the home. They engage in rigorous personal care tasks frequently. He said many family caregivers experience a tremendous amount of stress by taking on daily caregiving activities associated with loved ones, particularly their parents, such as with bathing, administering insulin, and managing incontinence. Results show that family caregivers are lonely, socially isolated, use more prescription drugs than others their age, experience decreased levels of physical activity, suffer from sleep deprivation, and are a victim of self-neglect, predominantly with health care, which sometimes leads to premature death. It is not unusual for a family caregiver to pass away before the person they are caregiving for. Mr. Klein said family caregivers are reluctant to reach out for help, so on one hand they carry a large burden and at the same time are very much removed from the normal resources that might support them.

Mr. Klein expressed that access to available services for caregivers are not positioned geographically or physically to help the bulk of caregivers, particularly of highly vulnerable and low-income caregivers. He informed the committee members that most of the adult day cares in Southern Nevada are located in the North Las Vegas and Henderson areas. Boulder, Nye, and Mesquite lack these core services. Additionally, adequate access to in-home respite and other services lacks in both urban and rural communities.

Mr. Klein said caregivers have unmet needs related to education, training, wellness, supportive services, and respite. Nevada Senior Services (NSS) is the only community non-profit provider in the State of Nevada in the adult day care environment. There are several county facilities, but all of the other licensed facilities in the state are proprietary, for-profit businesses, resulting in a lack of response to the state's most economically and vulnerably challenged people. He informed the committee members that the Nevada Senior Services' adult day care center is the only seven-day facility in the state that provides respite to caregivers, while their Henderson facility is the only six-day facility and all other adult day care facilities are five-day per week facilities. Nevada Senior Services has the longest hours of operation of any facility in the state, a 12-hour daily operation. In addition, NSS offers services from wellness through chronic problems and assisted over 3,000 people in 2018, mostly who are caregivers. He said the NSS provides evidence-based education through their Care Partner Institute, and is one of the first Rosalynn Carter Institute for Caregiving (RCI) REACH (Resources Enhancing Alzheimer's Caregiver Health) sites in the country. Mr. Klein explained that the REACH program provides in-home, one-on-one intervention support to distressed family caregivers. The program's objective is to identify the caregiver's issues that cause stress, introduce skills-building exercises to manage their depression and stress, and offer training to aid them in handling behavioral challenges of the person they are caring for. He also referred to the Skills2Care program, which requires an occupational therapist to visit the home of the person with dementia to identify any environmental issues that may be of concern, and sort out physical issues that might be impacting the caregiver's ability to manage the process of caregiving in terms of both behavioral management and home safety management.

Mr. Klein stated NSS received a $1.0 million Administration for Community Living grant to launch the nation's first hospital-to-home transition program for persons with dementia. He explained that hospitals were having a problem with effectively discharging dementia patients to their home without having a reoccurring admission problem. The NSS initiated the Care Transition program that was built from an evidence-based model, using an existing platform developed by Rush University Medical Center in Chicago, to research methods on how to support dementia patients and their care partners to get them successfully transitioned home and to provide resources to avoid expensive re-institutionalization.

Mr. Klein acknowledged the Care Consultation program, developed by the Benjamin Rose Institute, that provides a telephone-based coaching system for caregivers. The program provides caregiver's access to a live coach dedicated to finding caregiver resources and problem solving. He said the program is a highly effective, evidence-based program offered in Clark, Lincoln, Esmerelda and Nye counties.

The Rosalynn Carter Institute for Caregiving also developed the Caring For You, Caring For Me program that brings together both professional and family caregivers in a 10-hour exchange on topics to help navigate key caregiving issues. Mr. Klein said the program is very effective.

The NSS provides in-home respite and adult day care to caregivers for three to eight hours per week so they can catch up on work, go shopping, see a movie, etc. He said the NSS staff strongly urges caregivers to visit friends, socialize, and engage in activities that help them deal with the stresses and strains of life and escape the caregiving process.

Nevada Senior Services offers adult day care for up to 12 hours per day. The program is held in a safe and secure environment and offers recreational programs and evidence-based fine arts programs, linking music, art and dance, in a combination of activities to help people receive cognitive stimulation and preserve memory and safety.

Mr. Klein recognized the Brain Dance program offered by the NSS, which utilizes physical movement to teach people simple memory cycles of movement that are then linked to music and other activities. It has become an official evidence-based program.

Lastly, Mr. Klein said the NSS offers an in-home safety modification program called RAMP (Renovate Accessible Mobility Prevention) that provides an occupational therapist to assess the family environment and make modifications to allow the caregiver and care recipient to function safely in the home.

Mr. Klein reported nearly 25 percent of family caregivers have an early on-set dementia, which has created public policy issues that the NSS has begun to explore in coordination with hospitals and other community agencies.

Mr. Klein referred to NSS as a sole-community agency that collaborates with AARP, the Alzheimer’s Association, and other organizations to serve the community. However, the majority of the programs offered have limited availability, whether in the Las Vegas Valley or statewide. He said discussions need to be initiated regarding caregiver supports and how they can be transition from Older Americans Act money. He elaborated that most of the caregiver programs are supported by Title III of the Older Americans Act, which is distributed through the ADSD, and that respite programs are partially supported through Medicaid and the Home and Community-Based Waiver. He stressed the majority of services offered by NSS do not have permanent funding other than the grant resources that come in mostly from outside the state, so finding permanent and expanded sources of funding will be critical to the NSS’s long-term success.

Mr. Klein looked to Nevada’s Legislature to address funding related to older adults with behavioral and cognitive care needs and their caregivers, and provided the following recommendations:

1. Look at ways to fund evidence-based behavioral demonstration projects that target the delivery of better services to older adults with behavioral cognitive mental health challenges and their caregivers. Then, make those resources available through a transition to payment models, which means managed care organizations on the private side and a transition to reimbursable services under Medicaid and the Home and Community-Based Waiver on the state’s side.

2. Look at developing scalable resources for urban, rural and frontier communities. Mr. Klein proposed an idea, considered by the NSS, to dispatch a mobile team to the rural communities, such as Pahrump, Mesquite, Tonopah, Caliente and Pioche, to provide respite and caregiver support. He said the idea is to provide one-day, once-a-month respite and caregiving in a neighborhood setting, such as in a VFW hall, a senior center, or a church. He suggested partnering with other agencies, such as Helping Hands or the Food Bank, to fulfil those resources as well.

3. Provide an enhanced process to pilot evidence-based initiatives. As stated earlier, Nevada Senior Services began as an evidence-based initiative secured through a grant. Mr. Klein emphasized the need to look for ways to build out the toolbox with evidence-based resources, try them out, scale those resources to Nevada's communities, and embed them in more permanent solutions. He said a short-term grant is wonderful for launching an initiative, but it is no way to fund an initiative. As a result, it is not unusual in social services to see new grant programs survive only a few years, no matter how successful the program may be.

4. Provide more specific state funding to Nevada's aging and disability resource centers. He said the programs are funded primarily with federal dollars, which limits the reach of those programs and constantly puts those programs at risk of what happens in Washington D.C. He said the state needs to explore ways to support caregiver-based programs.

5. Address the disparity between behaviorally complex programs in supportive services. For example, Mr. Klein said the Home and Community-Based Waiver program pays $40 per day for adult day care for persons who seek only socialization, and Medicaid pays $54.54 for up to six hours per day, which includes nursing care and nutrition. He pointed out that some people attend day care 12 hours per day, and because of these low rates and the lack of behavioral parity, many centers turn persons away, whereas the NSS, a non-profit organization, turns no one away. He emphasized that many persons with moderate Alzheimer's have no place to go if the NSS is not available.

   Mr. Klein stated the answer in part is to encourage statewide provider access to a higher rate of pay, similar to what is done with mental health and development and disability patients who need enhanced services with better trained staff and lower staffing ratios. He noted this enhanced benefit would encourage other providers to expand their day care services.

Senator Goicoechea expressed concern for the families who live in frontier areas like Dyer, Nevada, and whether mobile teams offering one-day service would work in those types of areas. He said families in those isolated areas will care for their loved one's with Alzheimer's until it is beyond safe, and that they struggle with access to the next level of care. He indicated services related to persons with behavioral and cognitive care needs, and their caregivers, need to be available in all Nevada counties and jurisdictions. Senator Goicoechea communicated a strong interest in Wisconsin's community-based residential facilities (CBRFs) and North Dakota's dementia state-funded dementia care services. He felt confident that, with funding, the idea of

CBRFs would attract volunteer support and work in the rural and frontier areas. He conceded that without volunteer support, CBRFs would be unaffordable. He emphasized the struggles related to caring for someone with cognitive needs in the rural areas, and promoted the idea of reaching out to other states to research other methods of providing behavioral and cognitive care to the rural population.

Senator Woodhouse communicated that staff would be reaching out to sources in North Dakota and Montana to inquire about their rural and frontier programs.

Senator Ratti stated she that the Aging and Disability Resource Centers (ADRC) were tasked with identifying available services throughout Nevada, and was curious about the programs they were promoting in non-urban counties.

VII. PRESENTATION ON SUICIDE AWARENESS, EDUCATION AND PREVENTION AS IT RELATES TO OLDER PERSONS.

Department of Health and Human Services - Division of Public and Behavioral Health

Ms. Misty Vaughan Allen, Suicide Prevention Coordinator, Office of Suicide Prevention, Division of Public and Behavioral Health, recalled the Study of Suicide Prevention, an interim study in 2001 and 2002, which created the Office of Suicide Prevention. At that time, Nevada had the second highest suicide rate in the nation. Ms. Vaughan Allen reported that in 2016, Nevada had the fifth-highest rate of suicide (page 2, Exhibit Q); in 2014 and 2015, Nevada was the only state that did not increase its suicide rates; and since 1999, the nation's suicide rate increased 24 percent. Nevada's suicide rate increased 15 percent in 2016.

Ms. Vaughn Allen stated suicide accounted for over 44,000 deaths in the U.S. in 2016, of which 51.0 percent were committed using a firearm. She said Nevada's suicide by firearm rate dropped from 57.0 percent to 51.3 percent. The Division of Public and Behavioral Health (DPBH) attributed Nevada's decreased rate in suicide by fire arm to its partnership with gun shows and gun shops. National statistics for 2016 showed that 3.7 men took their life for every female, and Nevada statistics revealed guns were the leading cause of death for ages 8 to 17, and that Nevada's elderly aged 65 and older had the highest suicide rate in the nation.

Ms. Vaughan Allen moved to the chart on page 3 (Exhibit Q) of her handout and reported that Clark County's suicide rate declined and almost approached the national suicide rate in 2016, whereas Washoe County's suicide rate skyrocketed. The reason for Washoe County's spike in suicide was unclear; but impacts from the opioid crisis was implied. Nevada's veterans had the third-highest suicide rate in the country with a 1:5 ratio, which measures close to the national average. She noted when DPBH first started collecting data from Nevada military and veterans, almost 25 percent of suicides were veterans. The military cohort with the highest rate of suicide are Vietnam veterans, followed by early military and veteran's in their early twenties.

Nevada’s suicide rate was double the rate of suicides compared to the national elder rate of suicide. Montana and Wyoming average suicide rates were very close to Nevada’s, but when Nevada’s overall suicides dropped out of the top ten, its senior rates were still one of the highest in the nation.

Ms. Vaughan Allen stated Nevada’s youth rate of suicide meets the national average, but its older adults, veterans and middle-age adults do not. Many research studies showed 30 to 40 percent of those who died by suicide had made a previous attempt. Nearly 75 percent of those who took their life saw a physician or an acute care facility within four months of their death. Twenty percent were seen by their primary care physician or hospital the day they took their life.

Ms. Vaughan Allen stated she had an intern in 2017 who worked with the Washoe County Medical Examiner’s Office from UNR and was tasked with analyzing suicide case studies to research the means, the number of attempts, and possible connections to behavioral health care. Out of the 172 suicide deaths that occurred in Washoe County, rural communities, and some of the Sierra counties that Washoe County covers, 22 percent saw a primary care physician within the month of their suicide. Of those 22 percent; 11 percent committed suicide after they left a hospital or acute care facility, and 11 percent saw their primary care physician within the week they took their life.

Ms. Vaughan Allen stated that depression in older adults can be disguised as head pain, stomach pain or body aches, and sometimes fails to get recognized by health care providers. Because of these missed opportunities, the DPBH is looking at other initiatives. She said, in 2013, the DPBH developed the Committee to Study Suicide Fatalities for Nevada. The study was based on suicides committed by those 18 years of age and older. Some of the reports and recommendations revealed missed opportunities for primary care and pharmacy providers. However, another potential opportunity for help was the family support system, which emphasizes the importance of finding ways to get the family properly trained to recognize the symptoms of depression prior to a crisis.

Ms. Vaughan Allen guided the committee members to page 6 (<u>Exhibit Q</u>) of her handout, the Governor’s Strategic Direction. She said Nevada’s veterans, older adults and adults have suicide rates well above the national average. She said youth suicides were the ninth-highest rate in the nation, but with the help of several youth grants over multiple years, the rate improved to 25th in the nation. Youth suicide rates remain high across the nation and is a serious health concern.

Ms. Vaughan Allen cited the Zero Suicide Initiative, which was instituted by the U.S. Air Force in the 1990’s due to their extremely high rate of suicide. They developed a closed system that required training and commitment from everyone involved. The initiative was so effective that it reduced suicides committed by members of the Air Force by 40 percent, as well as reduced domestic violence, interpersonal violence, and minor interpersonal violence. Ms. Vaughan Allen stated recognizing concerns of suicide at the primary care office instead of the emergency room would lower the level of disruption to many lives and provide cost savings. She announced a group from the

DPBH planned to travel to Denver, to the Governor’s Association, to focus on how to advance the state’s strategy in suicide prevention.

Ms. Vaughan Allen stated that not everyone with thoughts of suicide has a mental health concern, and for many the driver is environment related. Suicides committed by military and veterans are identified with relationship, employment and purpose issues. She said we need to figure out what triggers one’s thoughts of suicide, and connect that person to resources that can help treat some of the other issues that might be going on.

The Behavioral Health Services of Henry Ford Health System transformed its mental health care delivery system by participating in the Perfect Depression Care initiative. Ms. Vaughan Allen reported that after implementing the initiative, zero suicides were reported for ten quarters straight.

Ms. Vaughan Allen indicated that suicide is not about wanting to die, it is a way of communicating an unmet need. To elaborate, she communicated an example of a 65-year-old man who was hospitalized for chronic health issues. His daughter was aware of his suicidal thoughts, but the hospital discharged him without notifying her. The man was sent home alone, and when his daughter found him in his home, he was attempting suicide. The daughter returned her father to the hospital for thoughts of suicide, but hospital administration alerted that he would be released 24 hours later. The daughter struggled with scheduling follow-up care for her father, which resulted in the DPBH intervening and finding the care her father needed.

Ms. Vaughan Allen conveyed that suicide is a high-level risk for caregivers of persons with dementia. She said medical providers do not like to talk about suicide, and there are limited resources for people once they leave a facility. She reiterated that thoughts of suicide are not triggered by the desire to die, they occur when people want to end feelings of pain, loss, or being overwhelmed, and that many older adults experience thoughts of suicide when they feel burdensome to their families. According to hospice nurses, people with terminal illnesses do not have high thoughts of suicide.

Ms. Vaughan Allen guided the committee members through the warning signs of suicide by elderly patients (page 12, Exhibit Q). She said conversing with patients about their warning signs is important, but keeping patients safe is more important. She said 70 percent of elders commit suicide by firearm, and in rural communities, this tends to become the option when they do not see another alternative. Ms. Vaughan Allen brought attention to some resources for people at risk for suicide, one being a new behavioral health care facility that is scheduled to open in Washoe County (page 15, Exhibit Q).

Ms. Vaughan Allen said any health care provider should be able to recognize the signs of depression, anxiety, and pain that would allow early intervention to take place. She spoke of a health care system, Beacon Health, that reported heart attack death rates decreased by 40 percent over the past ten years. The strategy was attributed to intervention, by simultaneously calling the entire heart attack team to the same room as soon as the hospital was alerted of a patient transport. She asked the committee members to imagine what happens to a mental health patient when they have thoughts of suicide. She imagined the benefits of that same type of intervention, but for people who have thoughts of suicide. She stated people desperately want to talk about their thoughts of suicide, and that the tools are there, but resources are stretched. Ms. Vaughan Allen recognized Assembly Bill (A.B.) 105, that it was a huge step in addressing some of these needs, specifically the required two hours of continuing education in suicide prevention for most health care providers.

Ms. Vaughan Allen targeted the need for follow-up care. The highest risk of suicide in elderly patients is 24 to 48 hours after a person leaves the acute care facility. She said follow up should be performed after a mental health crisis to make sure a person's safety plan is in place, and that a family member needs to be involved in discharge planning. She acknowledged the mental health advance directive that is used to communicate a person's wishes regarding their preferences relating to facilities, medications, and contact(s) for discharge purposes.

She pointed out other training opportunities (page 16, Exhibit Q) for health care providers who are mandated to obtain continuing education units. She suggested the following courses: *Counseling on Access to Lethal Means (CALM)* and *Choosing and Preventing Suicide in Emergency Department Patients*.

Senator Goicoechea asked if there was a record that identified the number of veterans that relocated to Nevada after they were discharged from the military. He said he was not surprised to see Wyoming, Montana and Nevada as states with the highest average suicide rates. He emphasized that older people who live rural lifestyles do not want to become a burden on their families or generate financial impacts. He felt serving this population with community-based means of care would be key to making them feel less burdensome on their families.

Ms. Vaughan Allen replied that she would research the number of veterans that relocated to Nevada and forward that information to the Committee. Additionally, she would research programs that were specific to veteran-friendly communities.

Chair Woodhouse instructed Ms. Vaughan Allen to forward her research to Ms. Coffman.

VIII. PRESENTATION REGARDING PERFORMANCE AUDIT, *DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC AND BEHAVIORAL HEALTH, ADULT MENTAL HEALTH SERVICES, COMMUNITY-BASED LIVING ARRANGEMENT HOMES, 2017 (LA 18-13)*.

Legislative Counsel Bureau – Audit Division

Mr. Rocky Cooper, Legislative Auditor, Audit Division, Legislative Counsel Bureau, identified Mr. Todd Peterson as the Audit Supervisor for the performance audit related to Adult Mental Health Services Community-Based Living Arrangement (CBLA) Homes. He stated the audit was originally scheduled for Northern Nevada Adult Mental Health Services (NNAMHS), and the intent was to learn from the NNAMHS engagement and use the experience gained to audit Southern Nevada Adult Mental Health Services

(SNAMHS). However, significant concerns regarding living conditions were apparent in the NNAMHS audit; therefore, the Audit Division decided to include both entities in one audit and address the living conditions at both locations at the same time. Mr. Cooper clarified that NNAMHS and SNAMHS are still in the audit process, as the auditors are looking at provider payments, financial situations and payroll practices. The results of that portion of the audit will not be released for several more months. He elaborated that the audit is very detailed, and involves 16 providers and 45 homes.

Mr. Todd Peterson, Audit Supervisor, Legislative Counsel Bureau

Mr. Peterson directed the committee members to the audit's Intoduction, beginning on page 45 (Exhibit A) of the meeting packet, which provided background information regarding the Division of Public and Behavioral Health (DPBH), its agencies that provide adult mental health services, and caseload and financial information for FY 2017.

Mr. Peterson explained that NNAMHS and SNAMHS provide housing and residential services to the adult mental health clients they serve. The services are delivered by contracted providers who operate CBLA homes, and the providers are paid rent, utilities, and staff service hours, up to a predetermined number of hours per month per client, by the DPBH. He said supervision and assistance with activities of daily living and behavioral management, based on unaudited information provided by the DPBH, was paid by the state at an average rate of $1,450 per month per CBLA client. This amount does not include client payments to CBLA providers from the Social Security Administration or other income. Mr. Peterson clarified that the average number of clients living in the CBLA homes, that were inspected for audit purposes, was four.

Mr. Peterson relayed that 2017 Legislation passed A.B. 46, which required the creation of regulations governing the certification of CBLA provider homes. As a result of A.B. 46, the State Board of Health adopted regulations governing CBLAs, effective July 1, 2017.

Mr. Peterson stated the objective of the audit was to determine if controls for monitoring providers of CMLA services were adequate to insure the safety and welfare of adult mental health clients at NNAMHS and SNAMHS. Audit findings showed adults in need of mental health care live in dismal conditions at many CBLA provider homes. Serious deficient conditions were prevalent at most of the homes tested. Although the DPBH developed policies and procedures to inspect provider homes, staff implementation of procedures was inadequate. He said when home inspections are not performed properly, deficiencies go undocumented, corrective actions are not taken and unsafe and unhealthy conditions can continue and proliferate. Without strong inspection and certification processes, the Legislative Auditor voiced serious concerns relative to the current model used for funding CBLA provider homes. He said providers operate a business that inherently is driven by a profit motive, and in the absence of adequate inspection and certification activities, providers may limit their level of care to maximize profits at the detriment of client services.

Mr. Peterson communicated that unannounced visits were performed at 37 of 105 CBLA provider homes that serve NNAMHS and SNAMHS clients. The inspections were performed using evaluation criteria developed by the DPBH. Because providers typically operate more than one home, the number of providers included in the inspections exceeded 70 percent of the total providers.

During the CBLA home inspections, over 2,000 pictures were taken to document the living conditions. Mr. Peterson said the pictures in the audit report include examples of some of the worst conditions captured by a clear photograph. Based on auditor judgement, observations were not counted as an exception unless corrective action was needed to provide a safe, healthy, and reasonable living environment (page 54, Exhibit A).

Mr. Peterson reported that 36 of the 37 homes inspected exposed numerous unsanitary conditions, including but not limited to, excessively dirty floors, ceilings and walls; mold and mildew; rodent and insect infestations; human waste; and no hand soap or toilet paper in the bathrooms. The audit specifies that although clients' behavior might contribute to occurrences of unsanitary conditions, observations indicated that the unsanitary conditions had not been addressed for some time. A list of the unsanitary conditions found, the number of homes that presented those conditions, and photographs of the conditions can be viewed starting on page 55 (Exhibit A) of the meeting packet.

Mr. Peterson said 34 of 37 homes inspected revealed numerous conditions that could impact the personal health and safety of clients living in the homes. Personal health and safety hazards are those conditions that expose a client to serious injuries and illnesses. He said although it may be impossible to anticipate and control all potentially hazardous events from occurring, personal health and safety hazards at CBLA homes can be mitigated. Conditions observed at CBLA homes included no disaster response plan; expired, spoiled or improperly stored food; broken bathroom and bedroom doors and locks; and broken and exposed glass. The audit includes a bulleted list of the conditions found at these homes, as well as pictures (page 57, Exhibit A).

The audit states 33 of 37 homes inspected uncovered conditions that increased the danger of fire for the clients, such as smoking and use of candles inside bedrooms and missing and disabled smoke detectors. Mr. Peterson indicated the combination of multiple unsafe conditions in a home, coupled with residents with varying degrees of mental illness, made these conditions unacceptable. The audit includes a bulleted list of the conditions and the number of homes where the conditions were observed, along with photographs (page 58, Exhibit A).

Mr. Peterson conveyed that 28 of 37 homes inspected showed signs of inadequate medication management practices. Proper medication management includes giving the prescribed medication and dose at the right time, and accurately documenting its administration. He expressed that when medications are not administered correctly, the client's physical or mental health can be significantly affected. Additional details regarding the conditions and number of homes where these conditions were observed, along with photographs, were provided in the audit on page 60 (Exhibit A).

In 36 of the 37 homes inspected, the Auditor observed conditions that contributed to bleak living environments for clients, such as inadequate lighting; water damage; holes in walls or floors; and leaking or clogged plumbing. Non-certified provider homes, on average, had more deficiencies. Seven of the 37 homes inspected were of CBLA providers that were not certified by SNAMHS. Mr. Peterson explained that non-certified providers were used by an organization that provides case management services outside of SNAMHS; however, SNAMHS pays some of the CBLA costs for those clients. He relayed that SNAMHS did not regularly inspect the non-certified provider homes, and according to staff, SNAMHS was required to give non-certified home providers two to four weeks' notice before performing inspections. According to legislation passed in 2017, all providers of CBLA services were required certification. According to the DPBH, their relationship with the provider that was referring clients to these non-certified homes has been terminated.

Although the DPBH developed policies and procedures to inspect provider homes, staff implementation of procedures was inadequate. Mr. Peterson indicated that 12 of 37 homes inspected by the Audit Division were also inspected by the agency's staff within 5 days of the performance audit inspections. The agency did not document most of the deficiencies observed by the Audit Division.

During the inspections, young children of caregivers were found living in 2 of 37 CBLA homes. In one home, the child's parent was not present and the mentally ill clients provided childcare while the parent worked another full-time job outside the home. Because the child's parent was not present, and mentally ill clients were caring for the child, the auditor contacted the Clark County Department of Child and Family Services (CCDFS), who responded promptly and arrived at the home to assess the situation. The CCDFS began an investigation, and as of September 2017, the CCDFS reported the child still lived in the home, but was attending daycare while the mother worked at the other job outside of the home.

In 11 of 20 CBLA homes inspected in Southern Nevada, the staff member identified as the caregiver spoke little to no English, the language of the clients living in the home. When these individuals were encountered, management often interceded to translate and help answer questions. Mr. Peterson noted that caregivers are responsible for tasks that necessitate client interaction, such as when administering medications and supervising client activities. He said, in addition to the quality of care given to the clients, he had serious concerns with the arrangement of caregivers living in the homes, observing oppressive working conditions that may circumvent labor laws and payroll requirements. For example, the audit included visits to CBLA provider offices to review records. Three of 11 providers were unable to produce payroll records for the caregiver who was in the CBLA home during the inspection.

For many homes visited in Southern Nevada, one caregiver lived in the home. Mr. Peterson said when caregivers were asked what the procedure was when the caregiver had to leave the home, some responded that they only leave occasionally and would call the provider to arrange for someone else to stay temporarily in the home while they were gone.

Mr. Peterson reiterated that, because of serious concerns relative to the working arrangement of caregivers living in CBLA homes and the need to address concerns over client safety and welfare, the audit report included only one audit objective so the report could be issued sooner. Additional work concerning labor laws and payroll practices will be conducted as part of a future audit that is currently in progress. He directed the committee members to the bottom of page 67 (Exhibit A) of the meeting packet that provides six recommendations related to improving controls to insure the DPBH effectively inspects CBLA homes. The process of CBLA certification begins on page 69 (Exhibit A).

Mr. Peterson indicated that, although the DPBH was responsible for certifying providers of community-based living arrangements, certification activities performed by the DPBH were inadequate. Specifically, reviews and assessments required for provider certification were not performed for most of the 20 CBLA providers tested, and were untimely for others for up to 5 years.

New legislation providing for the certification and regulation of all CBLA providers was enacted during the 2017 Legislative Session. The bullets on page 72 (Exhibit A) identify what will be reviewed and assessed during the initial certification of providers. Mr. Peterson confirmed the new regulation gives the DPBH authority to issue, renew, deny, or revoke CBLA provider certification, and that certification periods may not exceed two years for renewal. He said the DPBH indicated it is in the process of developing new policies and procedures for certifying CBLA providers. The audit report gave one recommendation to help insure the DPBH properly certifies CBLA providers (page 73, Exhibit A).

In closing, Mr. Peterson summarized the following appendices:

- Appendix A includes additional home inspection conditions observed by type and region (page 74, Exhibit A).
- Appendix B illustrates the number of conditions observed at each home inspected (page 76, Exhibit A).
- Appendix C provides additional photographs of conditions observed at CBLA homes (page 79, Exhibit A).
- Appendix D summarizes the audit methodology (page 103, Exhibit A).
- Appendix E lists the seven recommendations presented in the audit report and the DPBH's response (page 106, Exhibit A).

Mr. Peterson relayed to the committee members that in addition to accepting the recommendations, the Department of Health and Human Services (DHHS) and the DPBH have put a lot of effort into correcting the issues that were found since the audit was presented to the audit subcommittee. He said they have done their own individual investigation and a lot of progress has been observed that goes well above the recommendations that are listed in the report.

Senator Goicoechea inquired about the displaced clients and their relocation.

Mr. Peterson replied the DPBH found those clients new homes with existing providers.

Senator Goicoechea questioned whether the DPBH had the personnel to enforce the newly passed regulations and to perform the inspections.

Mr. Peterson deferred the question to Ms. Julie Kotchevar, Interim Administrator, Department of Health and Human Services. He clarified that the CBLA homes were being inspected with the DPBH's existing personnel and, in many cases, someone was inspecting the home on a monthly basis. However, the inspections were not performed adequately, and the findings were not communicated to a higher level, or those people at the higher level were not taking the appropriate action.

Senator Goicoechea found it disturbing that the DPBH inspected some of the same CBLA homes that were inspected by the Audit Division and did nothing about the poor conditions.

Ms. Julie Kotchevar, Interim Administrator, Department of Health and Human Services, agreed there was no excuse for the condition of the homes. She reported that case managers from the DPBH inspected the homes and were not trained as facility inspectors, which was troubling, because they were tasked with helping that person achieve stabilization and independence in the community. The DPBH found many failure points in the case managers' ability to identify and report problems. When confronted, the case managers expressed concern relative to finding alternative placement to accommodate the residents. Ms. Kotchevar reported the DPBH took immediate corrective action by closing 11 provider homes and relocating the displaced residents to licensed provider homes within 24 to 48 hours of notification. The DPBH transferred the responsibility to inspect the CBLA homes to the Bureau of Health Care Quality and Complaints (HCQC) that regulates hospitals and other types of facilities. The HCQC is not responsible for placing residents if a facility is shut down, so there is no conflict of interest when a resident has to be relocated.

Senator Ratti stated that she had the opportunity to hear this report in front of the DPBH in the Committee on Health Care; therefore, she did not want her lack of questions to appear as a lack of interest.

Chair Woodhouse indicated the issues in the audit report have generated a lot of discussion. She repeated Senator Goicoechea's earlier question relative to the DPBH's ability to engage enough staff, that are trained properly, to perform inspections at the same level executed by the Audit Division for their performance audit.

Ms. Kotchevar concurred, and emphasized that the DPBH reclassified vacant Psychiatric Case Worker positions, tasked with CBLA inspections as part of their case management, to Health Facility Inspector positions in the HCQC.

IX. PUBLIC COMMENT.

(Because of time considerations, speakers are urged to avoid repetition of comments made by previous speakers. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted in person or by e-mail, facsimile, or mail before, during, or after the meeting.)

Chair Woodhouse asked if anyone in Las Vegas or Carson City wanted to address the Committee under this agenda item.

Ms. Mary Liveratti acknowledged her volunteer position with the Nevada Caregivers Coalition. She explained that each year, during National Caregiver's Month, the organization pays tribute to exceptional caregivers for their work. Additionally, the event expands visibility to the work that caregivers do. She announced that the Nevada Caregivers Coalition was soliciting nominations at this time, particularly in Southern Nevada.

Ms. Donna DePauw referred to the performance audit as "heart-wrenching," and expressed concern that her husband, who has Alzheimer's, could go on Medicaid and possibly be placed in a home such as those described in the audit report. She stated that after seven years of caregiving she was forced to give her husband up to a facility; however, she still gives care and the disease still controls her life.

Ms. DePauw acknowledged that most caregivers who attend her support group are middle-class people, such as herself. She said she could spend down whatever assets she had to put her husband in a Medicaid facility, but she did not like the idea and felt it would be inappropriate. She asked for a grant system to help the middle class pay for better facilities so loved ones did not have to be placed in the care of an expensive state agency. She said a shared room in a subpar facility costs over $5,100 per month. She agreed with Dr. Reed's statement relative to understanding behaviors, and that challenging behaviors should not be excused as a side effect of dementia or Alzheimer's.

Ms. DePauw shared her frustration regarding the lack of training in facilities. She indicated a Medical Technician at a facility has 16 hours of training, yet they are allowed to give out pills, including opioids. She voiced the need for behavioral health professionals to be present in facilities 24 hours per day and for better enforcement of facility regulations.

Ms. DePauw testified that in-home caregivers charge $25 per hour and require a 3-hour minimum.

Ms. Barbara Singer, volunteer, Alzheimer's Association, testified that she is the facilitator for two Alzheimer support groups located in Minden and Carson City. She said there are 18 to 20 people in her group, and that attendance is becoming more prevalent. She said she did not understand why the number of training hours required to be a childcare worker increased, yet caregivers for individuals with Alzheimer's did not. She said there was a major concern amongst her support group relative to the lack of trained caregivers for individuals with Alzheimer's and the costs associated with it.

Her support group voiced concerns about the destiny of their loved ones when they could no longer manage the physical tasks of caregiving. She testified that many paid caregivers do not know how to care for dementia patients, and that training is not required by any laws. She communicated that each time an agency sends out a caregiver, it is not the same person, and people with dementia need consistency. Ms. Singer asked the committee members to consider addressing two issues related to dementia/Alzheimer's: training and cost.

Ms. Kathy Pantner testified that her husband resided in an assisted living facility before he was transferred to a memory care facility. He developed a urinary tract infection (UTI) that was not detected and passed away of encephalitis four days after admittance to the hospital. Ms. Pantner emphasized there is a lack of training associated with caregivers who serve those with dementia/Alzheimer's. As a retired Registered Nurse, she offered to train the caregivers at her husband's facility. She stated she was appalled that Medical Technicians do not understand the side effects or reactions to medications, and that they do not stay with the patient to ensure the medications are swallowed. She said she blamed the facility and its caregivers for her husband's death. She stated if a caregiver cannot identify a UTI, then they should not be working in a health facility.

Senator Ratti brought attention to the Long Term Care Ombudsman (LTCO) program, that advocates for older persons and provides information regarding services to protect a resident's health, safety, welfare and rights. She said the program could be helpful if issues do not rise to the level of licensing standards in a care facility. She understood the LTCO program could help families who are not necessarily well positioned to navigate the layers, rules, bureaucracy and regulations. Senator Ratti stated the advocacy groups should be distributing information relative to the LTCO.

At the request of Chair Woodhouse, Ms. Sarah Coffman, Principal Deputy Fiscal Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, relayed information to the committee members relative to the town hall meeting, hosted by the Alzheimer's Association, scheduled for March 20, 2018. She said an e-mail was sent to the members indicating that the designated meeting locations had not been identified in the rural areas; however, three locations had since been assigned to Sparks, Elko and Las Vegas. Ms. Coffman announced that she would e-mail the specific details to the committee members.

Chair Woodhouse announced the Committee to Study the Needs Related to the Behavioral and Cognitive Care of Older Persons was scheduled for April 10, 2018.

XVIII. ADJOURNMENT.

The meeting adjourned at 11:40 a.m.

Respectfully submitted,

Judy Lyons, Committee Secretary

APPROVED:

Senator Woodhouse, Chair

Date:

Copies of exhibits mentioned in these minutes are on file in the Fiscal Analysis Division at the Legislative Counsel Bureau, Carson City, Nevada. The division may be contacted at (775)684-6821.

PERRY
FOUNDATION

PRESENTATION FOR:

COMMITTEE TO STUDY THE NEEDS RELATED TO THE BEHAVIORAL AND COGNITIVE CARE OF OLDER PERSONS (SENATE BILL 121, 2017 LEGISLATIVE SESSION)

April 10, 2018

Robert Kidd, President / CEO

About the Perry Foundation

Mission

To improve the quality of care for our most vulnerable population.

The Perry Foundation is a non-provider based 501 c(3) organization that provides evidence-based education to caregivers and healthcare professionals in Nevada's Nursing Facilities and Assisted Living Communities with the mission of improving the quality of care for our loved ones within these communities. Our education is grounded in a person-centered approach and promotes consistency and professionalism in the delivery of care, ensuring caregivers are equipped with the tools necessary to provide the best care possible

Program Impact - 2017

Education & Training

2,540 Hours of CEUs Awarded

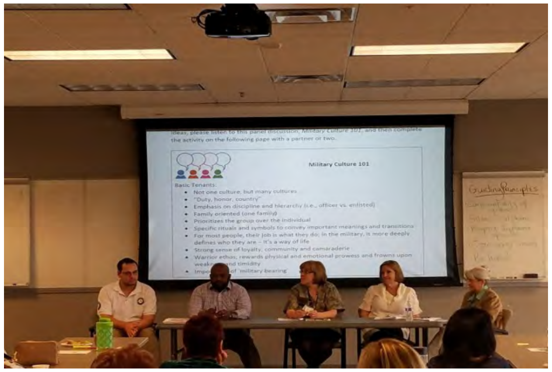
43 CNA Graduates

14 IV Cert Graduates

Rosalind Franklin University
Lou Ruvo Center for Brain Health
Quality Behavioral Health Workshops
Nevada Department of Veterans Services
HealthInsight Nevada
Elder Care and Support Summit
Bravo Zulu
Payment Reform Webinars
Survey Readiness Webinars
NALA Spring Expo
Perry Foundation
Endeavor Awards
Perry Foundation Academy of Health
Nevada Assisted Living Association
UNR Sanford Center for Aging
NATCOA
Drive for Quality Golf Tournament
Resident Safety Collaborative
Quality First Workshops

Bravo Zulu: *Achieving Excellence in Relationship-Centered Care*

Developed by the Perry Foundation, *Bravo Zulu* addresses the third component of the Nevada Department of Veterans Services' *Veterans in Care (VIC)* initiative. Bravo Zulu was presented in a series of eight (8) educational workshops in both Las Vegas and Reno to hundreds of care partners from all walks of life.



The Nevada Department of Veterans Services believe there to be over 2,000 veterans in care facilities throughout the state. Bravo Zulu highlights the differences in caregiving for a veteran vs. a non-veteran and teaches techniques to improve care for those with dementia or other cognitive health issues.

Nevada Music & Memory Initiative

Funded in part by a grant provided by the Centers for Medicare & Medicaid Services, we have launched the Nevada Music & Memory Initiative inspired by the Sundance Film Festival award winning film, *Alive Inside*. The goal of this initiative is to enhance the quality of life for Nevada nursing home residents living with Alzheimer's and other dementia related diseases while reducing the use of anti-psychotic medications.

State of the Long-term Care Industry

- Industry Overview
  - Largest increase in new construction of facilities in Nevada history
  - Turnover is at an all-time high
- Acuity in Facilities Continue to Rise
- Nursing Shortage Worse in the Nation

Medicaid Reimbursement & the Behavioral Complex Care Program (BCCP)

- Medicaid Reimbursement Drought
- Affected Quality of Care
- Change in Business Models
- 2015 Legislative Session – Birth of BCCP

Behavioral Complex Care Program (BCCP)

- The BCCP is available for any Nevada Medicaid Fee-For-Service (FFS) recipient over the age of 18, residing in a free-standing Medicaid Certified Nursing Facility (NF).
- The BCCP is a tiered payment reimbursement benefit for recipients who demonstrate consistent aggressive behaviors ranging from self-injury/self-harm, to refusing medications/ADL's.
- These behaviors are supported by a severe mental health diagnosis alone, or a medically-based diagnosis which supports the aggressive behavior(s).

Tier Rates

- **Tier I** - Behaviors requiring a minimal amount of intervention or assistance. Reimbursement is $111.23 per day. Renewal is annual.
- **Tier II** - Serious behaviors requiring moderate intervention. Reimbursement is $222.45 per day. Renewal is every 180 days.
- **Tier III** - Extreme behaviors exhibiting danger to themselves or others requiring frequent intervention. Reimbursement is $326.26 per day. Renewal is every 90 days

**These rates are in addition to the base rate.

Next Steps

- We feel that education is at the core of any next steps regarding the behavioral and cognitive care needs of older persons in Nevada.
    - Proper assessments of those living with these issues.
    - Utilizing a person-centered approach in all care-planning and training.
    - Minimizing Legal 2000s in care facilities.
    - Arming all care-partners to include at-home caregivers and even law enforcement with the tools that have traditionally been reserved for clinical care facilities.

Questions

24/7 Helpline
800.272.3900

alz.org/mnnd

NORTH DAKOTA
DEMENTIA CARE SERVICES PROGRAM

This project is supported by funding through the North Dakota Department of Human Services, Aging Services Division.

north dakota
department of
human services

alzheimer's association®
THE BRAINS BEHIND SAVING YOURS.®

3rd leading

cause of death in North Dakota,
the highest in the nation.

14,000 people

in North Dakota aged 65 and older are living with Alzheimer's and more than 5 million nationwide.

30,000

Alzheimer's caregivers in North Dakota are providing 35 million hours of unpaid care valued at nearly $425 million.

MEDICAID

Medicaid costs are set to skyrocket to

$244 million

by 2025 as the Baby Boomers continue to enter the age of greatest risk for Alzheimer's.

North Dakota Dementia Care Services Program

In 2009, ND Legislature passed the Dementia Care Services bill (House Bill 1043) to provide information, education and support to those impacted by any form of cognitive impairment in North Dakota.

Aging Services Division of the ND Department of Human Services awarded the Alzheimer’s Association the contract for the work.

Goals: Families

- Increase family support
- Decrease care partner depression/burden
- Reduce acute health service use
- Delay premature LTC placement

Goals: Professionals

Increase knowledge of professionals working with those impacted by cognitive impairment.

Increase early detection, diagnosis, and connection dementia supportive services.

ND Dementia Care Services Program
Programs & Services

- Care Consultation
- Professional, Community and Law Enforcement Education
- Health Care Provider Outreach and Education
- Community Outreach

Care Consultation

- Assessment of needs and strengths
- Personalized assistance with developing a plan for current and future care
- Connections to community services and resources
- Solving common dementia-related challenges
- Providing education and support
- Providing ongoing emotional support and education as dementia progresses

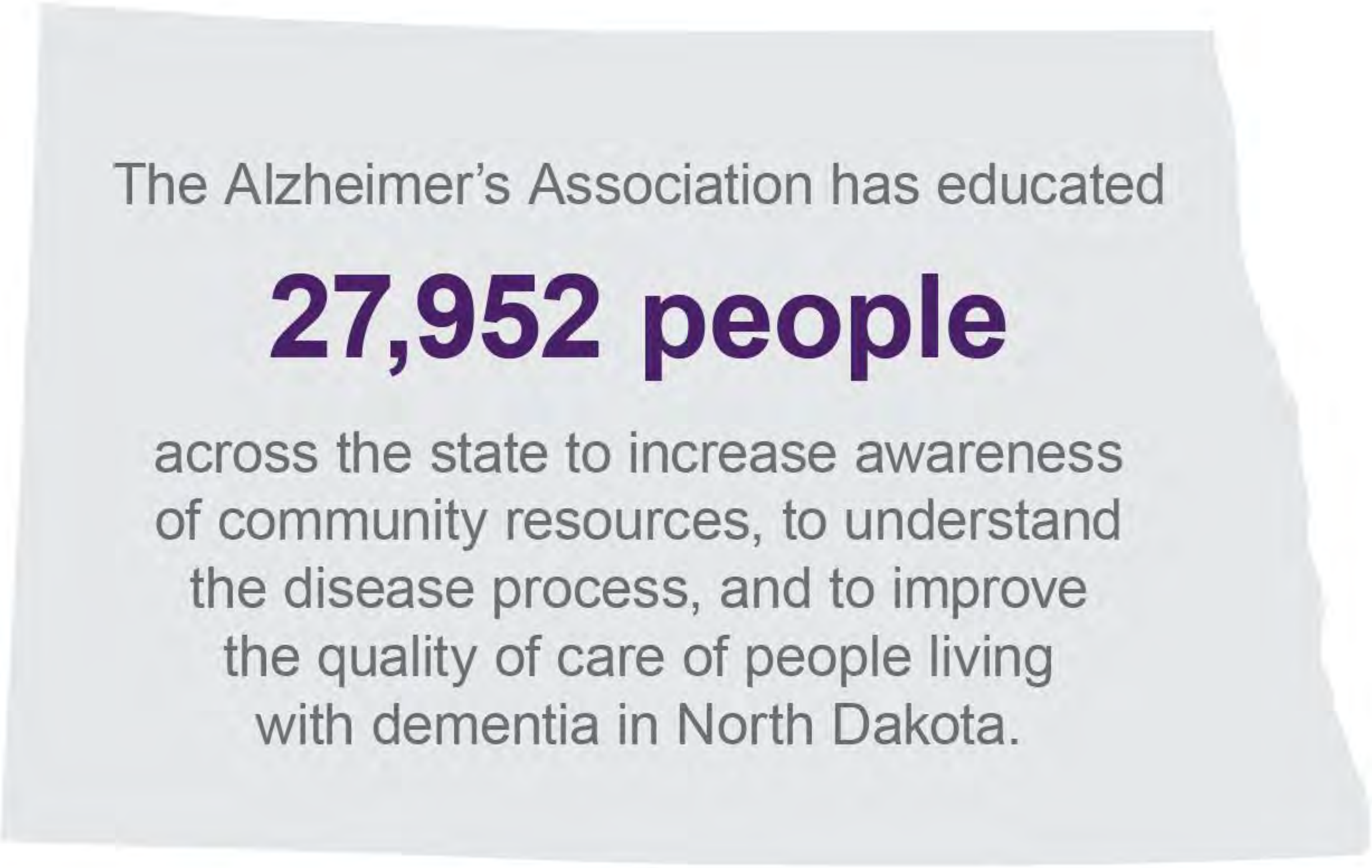
Physician Outreach

- Outreach provided to medical staff in clinics, hospitals, and public health agencies.

- Educate providers on early detection, diagnosis, and referrals for care consultation support, which may not be provided in a clinic appointment due to the constraints within a typical medical appointment.

Impact of DCSP

Since 2016, Alzheimer’s Association has supported the families of 1,755 people living with dementia, including providing 6,728 care consultations for 3,898.



The Alzheimer's Association has educated

27,952 people

across the state to increase awareness of community resources, to understand the disease process, and to improve the quality of care of people living with dementia in North Dakota.

Program Outcomes

- ND legislature appropriated $2.2 million on the DCSP over 42-month period.

- Estimated savings was $39.2 million in long-term care cost savings such as those incurred through hospital or emergency-related services and delays in LTC placement.

UND Center for Rural Health Medical School

Program Outcomes

- Caregivers who participated DCSP had greater cost savings (hospital and rural ambulance) compared to those caregivers who were less engaged.
- More likely to establish power of attorney and health care directives.
- Caregivers in DCSP were twice as likely to delay nursing home placement or decrease likelihood of placement.

UND Center for Rural Health Medical School

NORTH DAKOTA DEMENTIA CARE SERVICES PROGRAM

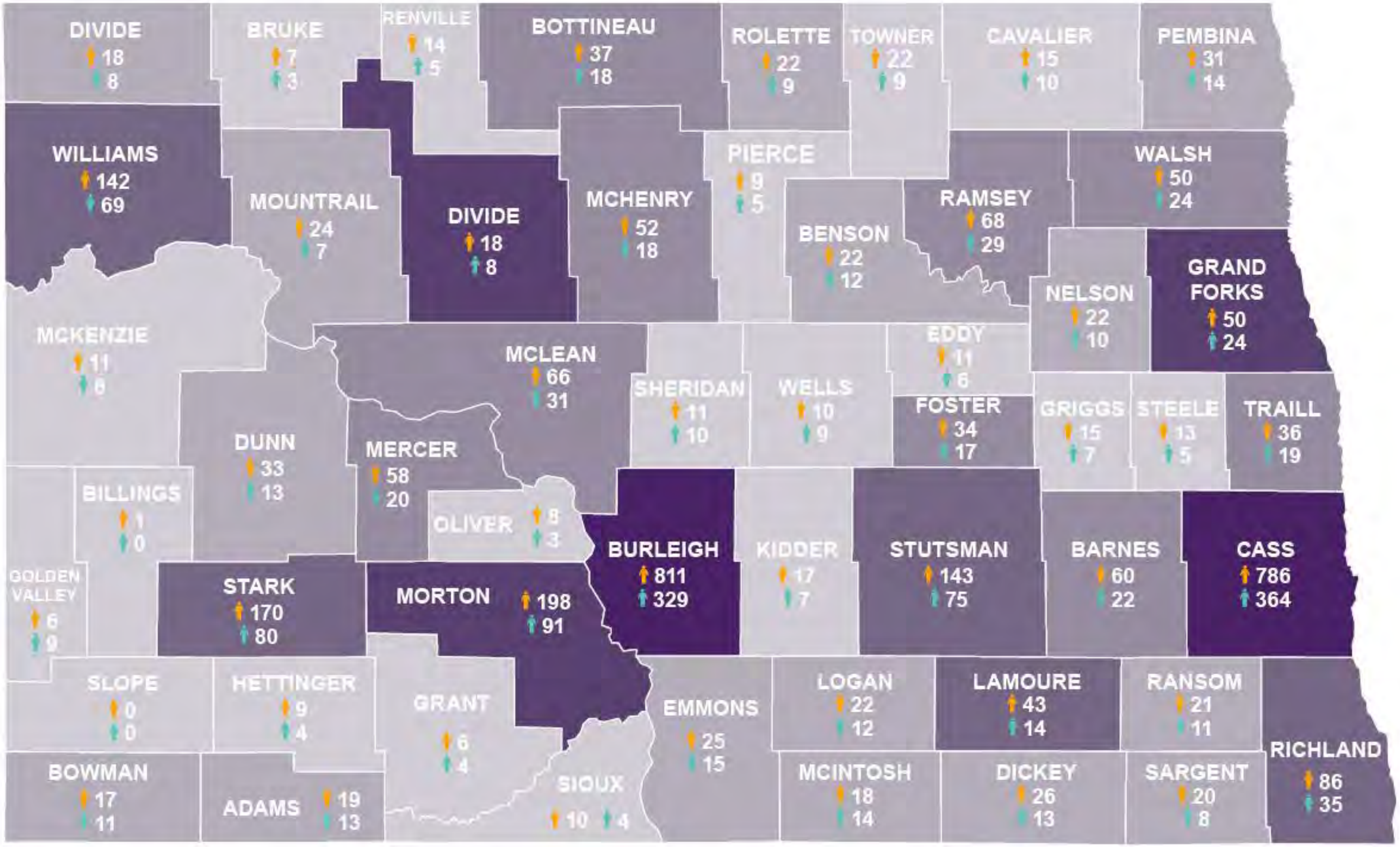
FAMILIES AND INDIVIDUALS SERVED BY COUNTY[1] (JAN. 1, 2010 TO SEPT. 30, 2016)

Since January 1, 2010, the Alzheimer's Association has supported the families of 1,755 people living with dementia, including providing 6,728 care consultations for 3,898 caregivers. Our work continues to reach the estimated 14,000 people[2] living with dementia, and approximately 30,000 unpaid family and friends[2] who care for them.

NUMBERS SERVED

▨ = 0-25
▨ = 26-50
▨ = 51-100
▨ = 101-250
▨ = 251-1,000
▨ = 1,000+

🟧 = Caregivers
🟦 = People with disease



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1. Data collected by the Alzheimer's Association for the Dementia Care Services Program contract January 1, 2010 through September 30, 2016.
2. 2018 Alzheimer's Statistics North Dakota (alz.org/facts)

north dakota
department of
human services

alzheimer's association®

Alzheimer's Association Programs & Services

- 24/7 Helpline 1.800.272.3900
- Website (www.alz.org/mnnd)
- Support Groups
- Medic Alert/Safe Return
- Research/TrialMatch

Alzheimer's Association Programs & Services

"We feel very fortunate to have someone available to guide us to a point of better understanding and dealing with this devastating condition."

– anonymous caregiver

"I feel this program has helped my mother, who is the caregiver, to have the courage and confidence to take charge of her life because of being well informed. I am grateful for this person because I feel my mother's stress has been reduced because of it. This program may help the transition, if ever needed, transpire more smoothly."

– anonymous caregiver

Staff Locations
ND Dementia Care Services Program

Mandan Staff Office
406 West Main Street, Suite 105
Mandan, ND 58544
701.258.4933

Minot Staff Office
1015 S Broadway, Suite 37A
Minot, ND 58701
701.837.0062

Fargo Staff Office
2631 12th Ave S, Suite A
Fargo, ND 58103
701.277.9757

Grand Forks Staff Office
311 S 4th Street, Suite 202
Grand Forks, ND 58201
701.775.8544

Maddock Staff Office
105 Central Ave, Suite 111
PO Box 273
Maddock, ND 58348