8: Appendices

Appendix A: Needs Assessment Survey

Please take a few minutes to share your experience and suggestions about how to improve the services and resources available in Montana to support persons with Alzheimer's disease or related dementias.

1. What is your year of birth? _____

2. What is your zip code? _____

3. What is your gender? _____ Female _____Male

4. Which of the following best describes you? (please select only one)
   _____ Person with Alzheimer's disease or dementia
   _____ Spouse or partner of person with Alzheimer's disease or dementia
   _____ Son, daughter ,or other family member of a person with Alzheimer's disease or dementia
   _____ Non-family caregiver of a person with Alzheimer's disease or dementia
   _____ Health-care provider
   _____ Social service provider
   _____ Public employee or official
   _____ Other, please specify _____

5. Do you provide home-based care for someone who has Alzheimer's disease or dementia?
   _____ Yes
   _____ No
   a. If Yes, how many hours do you care for this individual PER WEEK? _____
   b. If Yes, what type of health insurance does the person you care for currently have? (*check all that apply*)
   _____ Medicare
   _____ Medicaid
   _____ Veteran's benefits
   _____ Private insurance
   _____ They do not have any health insurance
   _____ Other, please specify _____

6. Identify the three (3) most pressing needs in Montana for persons impacted by Alzheimer's disease or other dementia. (Please rank items from 1 to 3 with "1" indicating most pressing.)

_____ Information about the types of services available and how to use them
_____ Access to services
_____ Quality of services
_____ Affordability of service
_____ Support for families and caregivers
_____ Education and training
_____ Other, describe _____

Based on your experiences in Montana, please indicate your satisfaction with the following aspects of services and information available to individuals with Alzheimer's disease or other dementias.

Place an "x" in the appropriate box for each item. 1 = very dissatisfied, 4 = very satisfied

	1	2	3	4	Don't know
Access to services					
Quality of services					
Affordability of services					
Support for families and caregivers					
Education and training					
Information about the types of services available					
Information about how to use available services					

What recommendations do you have about how to improve the services and resources in Montana that are available to persons with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen.

Survey Data Results

1. Did you attend a Town Hall meeting?

Yes	204	71%
No	82	29%

2. Survey respondents county of residence

County	Number	(%)
* Cascade	46	16.4%
* Yellowstone	41	14.6%
* Gallatin	35	12.5%
* Missoula	30	10.7%
Valley	24	8.5%
Flathead	18	6.4%
Pondera	13	4.6%
Lewis & Clark	9	3.2%
Custer	8	2.8%
Fergus	5	1.8%
Jefferson	5	1.8%
Ravalli	5	1.8%
Silver Bow	5	1.8%
Liberty	4	1.4%
Dawson	3	1.1%
Lake	3	1.1%
Phillips	3	1.1%
Prairie	3	1.1%
Rosebud	3	1.1%
Golden Valley	2	.7%
Lincoln	2	.7%
Musselshell	2	.7%
Park	2	.7%
Beaverhead	1	.4%
Carbon	1	.4%
Deer Lodge	1	.4%
Granite	1	.4%
Hill	1	.4%
Natrona	1	.4%
Powell	1	.4%
Roosevelt	1	.4%
Stillwater	1	.4%
Toole	1	.4%

* Urban

Rural

3. Which characteristic best describes you?

	Number	(%)
One with Alzheimer's	8	3%
Family of One with Alzheimer's	142	50%
Caregiver of One with Alzheimer's	16	6%
Professional Service Provider	86	31%
Public Employee or Official	26	9%
Not Specified	4	1%

4. Do you provide home-based care for someone with Alzheimer's or dementia?

Yes	71	25%
No	213	75%

5. If yes, what type of health insurance does the person you care for have?

Health Insurance	Number	(%)
Medicare	57	80%
Medicaid	9	13%
Veteran's Benefits	13	18%
Private Insurance	36	55%
They do not have insurance	3	4%
Other	9	13%

6. What are the most pressing needs in Montana?

Needs	% of 1st	% of 2nd	% of 3rd	# Prioritized (1, 2, or 3)
Information about types of services available and how to use them	40%	13%	6%	171
Access to services	29%	12%	14%	154
Quality of services	19%	10%	6%	98
Affordability of services	37%	13%	12%	178
Support for families and caregivers	29%	18%	13%	172
Education and training	25%	11%	11%	133

7. What is your level of satisfaction with the following aspects of services and care?

Cell Percentages	1	2	3	4	Don't know
Quality of services	13%	28%	25%	4%	30%
Affordability of services	7%	21%	29%	12%	32%
Support for families and caregivers	26%	25%	16%	2%	30%
Education and training	16%	30%	20%	4%	30%
Information about the types of services available	12%	38%	17%	5%	28%
Information about how to use available services	14%	37%	16%	3%	30%

Appendix B: Map of Montana Town Hall Meetings

Appendix C: Cultural Considerations in Residential Care Facilities

The following areas are examples of how to create comfortable environments for inclusion of all types of individuals.

Intake Forms and Documentation—Because the intake process and forms are often a first encounter for individuals and families, they can be powerful tools in creating a safe and affirming space.

In a safe and confidential space, make sure to ask the individual of their race and cultural preferences as well as sexual orientation and gender identity. If they prefer not to disclose, be respectful. In lieu of terminology such as "husband" or "wife," use "partner," "significant other," and/or "domestic partner" in addition to the traditional "husband" and "wife."

In lieu of terminology for gender restricted to "male" or "female," also have a box/line dedicated to "they," "FTM (female to male)," "MTF (male to female)," as well as a blank line for individuals to self-identify. Transgender and gender non-conforming clients should feel that their gender identity is respected. Ask a client's gender pronoun and make sure to respect the response. Mis-gendering someone can have devastating impacts.

Modify the definition of "family" to extend to non-biological family and allows clients to assign who their family is. This could be a domestic partner, significant other, and/or friends who have been a significant support in their lives.

Training—Provide a welcoming and affirming environment by offering culturally competent training to employees to ensure respectful and dignified care is being delivered.

There are many resources available for training programs for specific populations such as lesbian, gay, bisexual, or transgender (LGBT).

Facility Accommodations—Policies and practices written into a facility's by-laws can shape an individual's sense of safety, and the overall care.

Establish a Non-Discrimination Policy within the facility that declares protections for individuals based on their sexual orientation, gender identity and gender expression, as well as race and other defining characteristics. This can extend to both employees and residents. This sets a precedent for quality care and reaffirms a safe space.

Consider allocating a "Cultural Liaison" to ensure policies are being followed and culturally-appropriate programs are offered.

Consider a cultural support group for residents to come together and feel safe.

Specifically for LGBT residents, consider inclusive signage posted on the door/window to signify the facility is LGBT-inclusive and affirming.

Also, gender neutral restrooms for transgender and some gender non-conforming individuals, including the clients and family and friends who may be visiting them provides a safer and more welcoming accommodation.

Allow residents to dress and accessorize in accordance with their gender or race identity. Assess whether a transgender patient is using hormone replacement therapy, and ensure that staff is informed on how to administer it as needed.

Practices should be in place to ensure partners, friends, or family members in minority populations can visit without the fear of discrimination or mistreatment.

Assure that all staff and caregivers understand the modified definition of family and understand that all are welcome to visit patients.

Appendix D: Stages of Dementia

Developed by the Montana Alzheimer's/Dementias Work Group

Dementia Stages and Characteristics	Needs
Stage 1: Normal Aging • No deficits • May be more inclined for workup/prevention if there is a strong family history of dementia. **Clinical Stage: Normal/Preclinical**	Wellness and risk-reduction General wellness and brain health Advance Planning with help from experts in: • Legal documents • Financial (long term care insurance) • Plan for aging/long term care planning • End of life wishes
Stage 2: Possible Mild Cognitive Impairment • Personal awareness of cognitive decline that may be affecting daily life. • Self-reported symptoms may not be recognizable by friends/family/coworkers or evident on medical exam. **Clinical Stage: Mild Cognitive Impairment**	**Above needs as well as:** • Wellness and risk-reduction • Public awareness/Education • Knowledge of early signs of dementia and what to expect • Community members are comfortable talking about aging and dementia • Knowledge of community resources • Begin building dementia-friendly communities so citizens are comfortable and competent to support individuals with dementia and their families and everyone knows where to go for resources • Advance Planning/Long-term care planning • Aging in place plan including accessibility, safety, and security issues • Personal wishes for aging • Review of unpaid and paid caregiver options • Skilled medical provider cognitive examination to evaluate potential causes of memory loss • Consider joining a memory loss registry

Dementia Stages and Characteristics	Needs
Stage 3: Mild Dementia • Friends/family/coworkers may begin to notice deficits. • Problems may be measurable with cognitive testing • Social and work performance issues • Decline in ability to plan/organize • Word-finding difficulty	**Above needs as well as:** *Public awareness/dementia friendly communities* • Protocols in place for employees who may have concerns about a coworker's cognitive ability • Employers support employees in caregiving roles *Medical care* • Skilled medical provider cognitive examination to diagnose dementia • Diagnosis discussion includes individual and caregiver/family • Educate on trajectory of disease • Education regarding appropriate community resources • Develop pathways for diagnosis and post-diagnosis care individualized to each patient • Referral to a neurologist or other specialist if warranted *Caregivers* • Caregiver support groups • Knowledgeable about available resources • Training in managing dementia at home • Home and community-based services • Services provided in a consistent and coordinated fashion • Adult day care • Advance planning/Long-term care planning *Research* • Public is knowledgeable about available research studies • Support ongoing research studies • Encourage more dementia studies in Montana *Training* • Offer continuing education/certification option for direct-care workers • Offer training for first responders on how to best handle individuals with ADRD *Policy implications* • Collect public health surveillance data on dementia through BRFSS • Create policies to support caregivers • Conduct a formal needs assessment to fully assess the financial impact and burden of disease in communities to effectively develop appropriate policies and determine workforce shortages • Support incentives for health care workers to pursue careers in geriatrics
Clinical Stage: Mild Dementia	

Dementia Stages and Characteristics	Needs—Above needs as well as:

Stage 4: Moderate Dementia
• Clear cognitive deficits
• Impaired short term memory
• Difficulty with simple math
• Decreased capacity to perform complex tasks i.e. cooking, cleaning, managing finances, driving
• Reduced memory of personal history
• Possible personality changes
  • More subdued and withdrawn
  • Agitated in challenging situations
 	
Clinical stage: Moderate Dementia
	Public awareness/dementia friendly communities
	• Improve public safety of individuals with dementia who wander
	• Review of driving safety issues
	Medical care
	• Skilled medical provider cognitive examination to make diagnosis of dementia, if not already done
	Caregivers
	• Support groups
	• Respite care
	• Advance planning/Long-term care planning
	• Consider legal protective actions such as payee and guardianship/conservatorship roles with help for legal services
	• Re-review plan for aging and initiate long term care planning, if not already done
	Home and community-based services
	• Adult day care
	• Meals on Wheels
	• Senior center meal sites
	• Personal care assistance through in-home care including; dressing, bathing, medication administration, housekeeping, laundry, grocery shopping, and meal preparation
	• Transportation
	• Assisted living
	Policy implications
	• Provide affordable assisted living options by increasing reimbursement through Medicaid waiver and increasing the number of Medicaid waiver slots
	• Improve wages for direct care workers

Stage 5: Moderately Severe Dementia • Major gaps in memory • Confused about time/date and place • May need assistance with some activities of daily living, i.e. dressing **Clinical stage: Moderate Dementia**	• Diagnosis of dementia made if not done already • Whether at home or in a facility, care is provided by an interdisciplinary team of medical providers i.e. social workers, occupational therapists, physical therapists, speech therapists, nursing *Caregivers* • Advance planning/Long-term care planning • Review end of life wishes • Re-review long term care plan • Consider increased home and community-based services • Consider placement in a memory care assisted living or nursing home

Dementia Stages and Characteristics	Needs

Stage 6: Severe Cognitive Impairment (Moderately severe dementia)
• Worsening memory
• May begin to forget names of family and friends
• Significant personality changes
  • May become suspicious
  • May have hallucinations (seeing or hearing things that are not there)
  • May have compulsive or repetitive behaviors
• May wander and become lost
• May need extensive help with activities of daily living
• May need help with toileting and may experience bladder and/or bowel incontinence
• May need help with bathing
• May experience disruption of sleep/wake cycle
 	
Clinical stage: Moderate dementia
	Above needs as well as:
	• Diagnosis of dementia made if not done already
	• Provide education on how to manage behavior changes at home
	• Improve facilities' abilities to manage behavioral issues to avoid transfer to the state mental hospital

Stage 7: Very Severe Dementia • Loss of ability to respond to the environment • May lose ability to speak • May lose functional ability • Muscles may grow rigid • May have difficulty walking, sitting up independently • More extensive help with activities of daily living needed (eating and toileting) • Swallowing may be impaired **Clinical Stage: Severe Dementia**	**Above needs as well as:** • Diagnosis of dementia made if not done already • More emphasis on palliative care • Consider hospice care • Increase availability of hospice providers, particularly in rural areas

Appendix E: Montana Workforce Training Programs

The **Montana Geriatric Education Center** (MTGEC) provides a multitude of educational topics to various professional disciplines and some support for training for direct care workers and caregivers.

The Center was recently awarded a Geriatric Workforce Enhancement Program (GWEP) grant that provides geriatric education and training to health care workers in order to improve health outcomes for older adults.

Programming will be provided for patients, families, caregivers, direct care workers, health professionals, students, family medicine residents, and faculty in a variety of settings.

Mountain Pacific Quality Health is currently working with nursing home facilities on several training projects including:

- Dementia topics
- Staffing stability to help facilities attract, train, empower, and retain quality help.
- Quality Assessment and Performance Improvement (QAPI) and quality measures to enhance quality of care addressing antipsychotics, activities of daily living, incontinence, pain, depression, falls, pressure ulcers, urinary tract infections, catheters, weight loss, physical restraints, and vaccinations.

Training is provided through webinars, in-services, and/or handouts.

Through the Affordable Care Act, direct care workers in long-term care facilities need to show proof of annual education in the management of dementia. However, dementia training programs are still not routinely done in many facilities.

There are many examples of effective, tested, and validated training programs, including **Staff Training in Assisted-living Residences (STAR)**. This program allowed for improved staff satisfaction and knowledge while improving resident behavior[8].

The **Hand in Hand training** is another example of this type of training.

The **HealthCARE Montana** grant is a new program in Montana that is revising the curriculum for nursing education and other health professional curriculum in the state. MTGEC is working with this program on the geriatric component.

The HealthCARE Montana program goal is to improve health care training opportunities in Montana at the two-year college level, while enhancing pathways to baccalaureate degrees, and provide successful employment for students with attention to adult learners and veterans, particularly in rural locations.

Montana Area Health Education Centers and the Montana Office of Rural Health have created many programs and committees to support Montana communities and the state's health care workforce, such as the training of Community Health Workers.

The **Montana Hospital Association** (MHA) and the **Montana Health Care Association** (MHCA) also offer training programs on dementia care on a regular basis.

Montana Gerontology Society holds an annual conference providing professional development and continuing education in the field of aging for multiple health care and social service disciplines.

The **National Association of Mental Illness** (NAMI) offers training programs specifically for managing behavioral issues.

The **Alzheimer's Association** offers many training toolkits.

Appendix F: Goals and Guidelines for Residential Care from the Alzheimer's Association

Alzheimer's Association Goals of Care and Clinical Practice Guidelines for Residents with Dementia Living in Residential Care

Goals of Care

Staff and families will act as care partners with residents with dementia to achieve optimal functioning and quality of life.

Staff will use a person-centered approach to care in managing residents with dementia with an emphasis on consistent care approach throughout all shifts.

Staff will use flexible approaches to care to help anticipate needs and prevent problems in order to meet the changing needs of residents with dementia.

Staff will assist residents with dementia to maintain cognitive and functional abilities as long as possible.

Clinical Practice Guidelines

Complete comprehensive and holistic assessments and care plans.

Screen for appropriate nutritional care.

Promote proper nutrition and hydration given resident preferences and life circumstances.

Assure mealtime is pleasant and enjoyable with ample staff to observe and interact with residents.

Assess pain routinely using a systematic approach to ease distress associated with pain and improve quality of life.

Tailor pain management to each resident's needs and risk profile.

Offer many opportunities for social engagement, respecting resident's preferences, even if that preference is solitude.

Promote a physical environment that is comfortable and inviting, encouraging and supporting independence while encouraging safety.

Ensure staffing patterns allow for residents with dementia to have sufficient assistance so their needs are met.

Encourage consistent staff assignments to promote quality relationships between staff and residents.

Reduce risk of falls by assessing underlying causes of falls for the individual.

Avoid physical restraints by addressing underlying problems that prompt the use of restraints.

Encourage and support residents with dementia mobility choices, enabling him/her to move about safely and independently. However, unsafe wandering and successful exit seeking should be avoided.

Maintain open communication with family members.

Appendix G: Availability of Residential Care in Montana as of February 2015

Low-income senior housing

- 159 low-income senior housing facilities across Montana.
- Ratio is roughly one low-income senior housing complex for every 1,000 Montanans age 65 and older.
- 34% of counties do not have a low-income senior housing complex.

Assisted living facilities

- 201 assisted living facilities with a total of 5,643 beds.
- 60 facilities have Category C (memory care) designation for a total of 1,265 beds.
- 123 assisted living facilities accept Medicaid waiver recipients.
- Ratio is one assisted living facility for every 796 Montanans age 65 and older, and only one designated memory care bed for every 126 Montanans 65 and older.

Nursing homes

- 83 nursing facilities in the state with a total of 6,588 beds.
- Ratio is one nursing home for every 1,925 Montanans age 65 and older, and one nursing home bed for every 24 Montanans 65 and older.
- 21% of counties have no access to a nursing home facility and three counties (Petroleum, Judith Basin, and Treasure) have no access to either an assisted living or nursing home.
- 81 out of 83 facilities accept Medicaid.
- 31 nursing home facilities have secure dementia units.
- 35 facilities have a contract with Veterans Affairs (VA) to provide nursing home care to an average of 120 veterans a month.
- The Montana Veterans Home in Columbia Falls and the Eastern Montana Veterans Home in Glendive provide long-term residential care and are operated by the State of Montana. The total operation cost in 2014 for the Columbia Falls facility was $10.38 million with one-third of the costs covered by federal funding. Total operation cost for the Eastern Montana Veterans Home in 2014 was $2.9 million with the majority covered by federal funds.

- The average length of stay in a nursing home is 1.92 years. However, the length of stay varies by payer source, as do resident demographics:

  Medicaid
  - Average length of stay is 2.45 years.
  - Average age is 77.
  - Medicaid accounts for 60% of nursing home costs.
  - Nursing home costs are the largest portion of Montana's long-term-care budget with expenditure of almost $162 million in 2014.

  Medicare
  - Medicare only covers short-term skilled stays usually for rehabilitation following a hospital stay.
  - Average length of stay is 88 days.
  - Average age of individuals covered by Medicare in these facilities is 88.
  - Medicare accounts for 12% of nursing home costs.

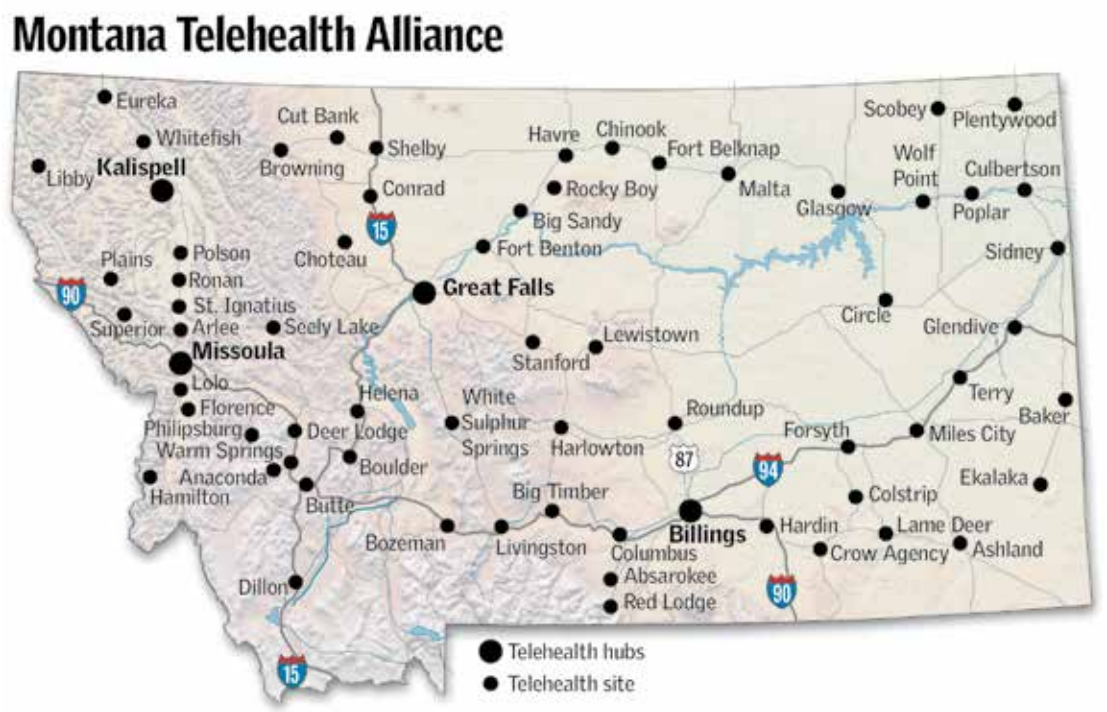
  Private insurance
  - Average length of stay is 1.27 years.
  - Average age is 85.
  - Accounts for 28% of nursing home costs.

Appendix H: Telehealth Availability Across Montana

There are several telehealth/videoconferencing networks across Montana, including the Native American reservations. The telehealth networks could be used to improve dementia care in areas with particularly low numbers of health care providers specializing in dementia care. The networks could also be used as a means to provide educational topics on dementia care.

Each of the seven reservations in Montana has video conferencing capabilities, which can be used for telehealth visits. Some, although not all, of the reservations have telehealth equipment that allows checking vital signs, etc.

- Partners in Health Telemedicine Network—St. Vincent Healthcare
- Eastern Montana Telehealth Network (EMTN)—Billings Clinic
- REACH Montana—Benefis
- St. Patrick's has a telehealth network that includes telepsychiatry for ambulatory patients (clinic appointments), telegenetic counseling for patients in their cancer center, and telediabetes education. Their reach includes their ambulatory clinics and the western Montana region.
- Montana Telehealth Alliance, which serves as a community resource for interested telehealth entities in Montana.
- Montana Veterans Administration has a telehealth and videoconferencing network that allows monitoring of a variety of medical issues including vital signs, weights, diabetes, and mental health. This service is available free of charge and reduces the need for clinic visits.



Appendix I: Proposed Dementia Navigator System

- Appropriate Referral to initiate discussions, educate, inform, provide resources, establish goals based on current needs (dementia specialist vs. designated agency)
- In-home assessment by licensed practitioner (e.g., RN, LCSW)
- Identify support person or point of contact early on
- Obtain authorizations as indicated for collaboration of the health care team

- Utilize systematic approach to discussing issues and addressing needs
- Perform Medication Review & Education and set standards for routine review of medications and chronic condition status
- Make appropriate referrals based on findings: Physical and or Occupational Therapy, Geriatrician, Pharmacist, Neurologist, Financial Counselor, etc.
- Development of Care Plan
- Completion of immediate goals (Advance Directives, Legal Proxy decision-maker)

- Establish home health plan using non-paid and/or paid services, as appropriate
- Designate point of contact for assisting with on-going management and trouble shooting
- Provide framework for routine review of care plan and additional in-home assessments for detection of problems
- Resource sharing for further assistance, as needed. (hot line vs. direct call to agency)
- Review long-term goals

Appendix J: References

1. Alzheimer's Association. *2016 Alzheimer's disease facts and figures*. Chicago, IL: 2016 Contract No.: 4/26/16.
2. Global CEO Initiative on Alzheimer's Disease. Big data research initiative to fight Alzheimer's disease: A research collabortion to advance Alzheimer's drug development, treatment, and care—and stop the disease by 2025. ISPOR 20th Annual International Meeting; Philadelphia 2015.
3. Baptista MA, Santos RL, Kimura N, et al. Quality of life in young onset dementia: an updated systematic review. *Trends in Psychiatry and Psychotherapy* 2016 Mar;38(1):6-13. PMID: 27074338. DOI: 10.1590/2237-6089-2015-0049.
4. Montana Department of Health and Human Services Senior Long Term Care Division. Montana State plan on aging. Helena, MT. 2011.
5. Montana Department of Commerce. Montana state and county population projections. 2013.
6. Verbeek H, Zwakhalen SM, van Rossum E, et al. Dementia care redesigned: Effects of small-scale living facilities on residents, their family caregivers, and staff. *Journal of American the Medical Directors Association* 2010 Nov;11(9):662-70. PMID: 21030001. DOI: 10.1016/j.jamda.2010.08.001.
7. Alzheimer's Association. *The impact of Alzheimer's disease on Medicaid costs: A growing burden for states* Chicago, IL2015 [4/26/16]. Available from: www.alz.org/documents/national/medicaid_costs_report.pdf.
8. Smyth W, Fielding E, Beattie E, et al. *A survey-based study of knowledge of Alzheimer's disease among health care staff*. BMC Geriatr 2013;13:2. PMID: 23282030. PMCID: PMC3543846. DOI: 10.1186/1471-2318-13-2.
9. Houle MC. An aging population, without the doctors to match. *New York Times*. 2015.
10. Galvin JE, Tolea MI, George N, et al. Public-private partnerships improve health outcomes in individuals with early stage Alzheimer's disease. *Clinical Interventions in Aging* 2014;9:621-30. PMID: 24748780. PMCID: 3986334. DOI: 10.2147/CIA.S60838.
11. Gibson AK, Anderson KA. Difficult diagnoses: Family caregivers' experiences during and following the diagnostic process for dementia. Am J Alzheimers Dis Other Demen 2011 May;26(3):212-7. PMID: 21362754. DOI: 10.1177/1533317511400306.
12. Perry M, Draskovic I, van Achterberg T, et al. Can an EASYcare based dementia training programme improve diagnostic assessment and management of dementia by general practitioners and primary care nurses? The design of a randomised controlled trial. *BMC Health Services Research* 2008;8:71. PMID: 18384675. PMCID: PMC2391160. DOI: 10.1186/1472-6963-8-71.
13. Szymczynska P, Innes A, Mason A, et al. A review of diagnostic process and postdiagnostic support for people with dementia in rural areas. *Journal of Primary Care & Community Health* 2011 Oct 1;2(4):262-76. PMID: 23804844. DOI: 10.1177/2150131911404705.

14. Ronnlund M, Sundstrom A, Adolfsson R, et al. Self-Reported Memory Failures: Associations with Future Dementia in a Population-Based Study with Long-Term Follow-Up. *Journal of the American Geriatrics Society* 2015 Sep;63(9):1766-73. PMID: 26280989. DOI: 10.1111/jgs.13611.
15. United Health Foundation. *Primary Care Physicians-United States*. 2015.
16. Van Vleet A, Paradise J. *Tapping nurse practitioners to meet rising demand for primary care* 2015 3/18/16. Available from: www.kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care.
17. National Rural Health Association. *What's different about rural health care?* 2015 [10/26/15]. Available from: www.ruralhealthweb.org/go/left/about-rural-health.
18. Lockwood T., *Wyoming Legislature Unanimously Supports Care Act*. AARP; 2015.
19. Reinhard SC, Feinberg L, Choula R, et al. *Valuing the invaluable: 2015 update* 2015 3/18/16. Available from: www.AARP.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.
20. American Association of Retired Persons. *Caregiving in Montana: A survey of Montana registered voters age 45-plus*. AARP Research Center, 2015.
21. Institute of Medicine. *Envisioning the national health care quality report*. Washington, DC: 2001.
22. Grand JH, Caspar S, Macdonald SW. Clinical features and multidisciplinary approaches to dementia care. *Journal of Multidisciplinary Healthcare* 2011;4:125-47. PMID: 21655340. PMCID: PMC3104685. DOI: 10.2147/JMDH.S17773.
23. Odenheimer G, Borson S, Sanders AE, et al. Quality improvement in neurology: dementia management quality measures. *Journal of American Geriatrics Society* 2014 Mar; 62(3):558-61. PMID: 24397784. DOI: 10.1111/jgs.12630.
24. National Association of Primary Care. *Primary care navigator training programme for dementia: Evaluation of its impact*. 2015.
25. Montana Health Care Association. *Nursing Home Facts*. 2014.
26. The John A. Hartford Foundation. *Innovative models of care*. 2012.
27. Nurses Improving Care for Healthsystem Elders-New York University Models of care 2016. Available from: www.NicheProgram.org/models_of_care.
28. Alzheimer's Society. *Building dementia-friendly communities: A priority for everyone*. 2013.
29. Pinquart M, Sorensen S. Helping caregivers of persons with dementia: which interventions work and how large are their effects? *International Psychogeriatric* 2006 Dec;18(4):577-95. PMID: 16686964. DOI: 10.1017/S1041610206003462.
30. Family Caregiver Alliance. *Family caregiving: State of art future trends*. San Francisco, CA 2007.
31. Montana Department of Health and Human Services Senior Long Term Care Division. *Montana State Plan on Aging for Period October 1, 2015–September 30, 2019*. 2015.
32. Yaffe MJ, Orzeck P, Barylak L. Family physicians' perspectives on care of dementia patients and family caregivers. *Canadian Family Physician* 2008 Jul;54(7):1008-15. PMID: 18625826. PMCID: PMC2464807.
33. Montana Department of Health and Human Services Senior Long Term Care Division. Presentation to the 2015 health and human services joint appropriations subcommittee. In: MDHHS, editor. Helena, MT. 2015.

34. Bamford C, Arksey H, Poole M, et al. Person- and career centered respite care for people with dementia: Developing methods of evaluating the effectiveness of different models. In: Organisation NIoHRSDa, editor. Newcastle upon Tyne 2009.

35. Phillipson L, Jones SC, Magee C. A review of the factors associated with the non-use of respite services by carers of people with dementia: implications for policy and practice. *Health and Social Care in the Community* 2014 Jan;22(1):1-12. PMID: 23530738. DOI: 10.1111/hsc.12036.

36. Upton N, Reed V. Caregiver coping in dementing illness—implications for short-term respite care. *International Journal of Psychiatric Nursing Research,* 2005 May;10(3):1180-96. PMID: 15960246.

37. Sorrell JM, Cangelosi PR. Caregiver burden or caregiver gain? *Journal of Psychosocial Nursing and Mental Health Services,* 2009 Sep;47(9):19-22. PMID: 19772247. DOI: 10.3928/02793695-20090730-04.

38. Montana Department of Health and Human Services Senior Long Term Care Division. *The Montana Medicaid Program Report to 2015 Legislature.* Helena, MT. 2015.

39. Verbeek H, Zwakhalen SM, van Rossum E, et al. Effects of small-scale, home-like facilities in dementia care on residents' behavior, and use of physical restraints and psychotropic drugs: a quasi-experimental study. *International Psychogeriatrics* 2014 Apr;26(4):657-68. PMID: 24411467. DOI: 10.1017/S1041610213002512.

40. Verbeek H, Zwakhalen SM, van Rossum E, et al. Small-scale, homelike facilities versus regular psychogeriatric nursing home wards: a cross-sectional study into residents' characteristics. *BMC Health Services Research* 2010;10:30. PMID: 20113496. PMCID: PMC2827474. DOI: 10.1186/1472-6963-10-30.

41. Kok FJ, van Heuvelen M, Scherder E. Small scale homelike special care units and traditional special care units: Effects on cognition in dementia; a longitudinal controlled intervention study. *BMC Geriatrics* 2016;16:1-8.

42. HJR 16: State-operated institutions: *The use of small mental health treatment facilities*, (2014).

43. Alzheimer's Association. *Dementia care practice recommendations for assisted living residences and nursing homes*. Phase 3 end-of-life care. Chicago, IL2007.

44. Alzheimer's Association. *End-of-life care*. 2015.

45. Montanans for Research and Cures. *Giving hope to hundreds of thousands of Montanans and their families*. Billings, MT. 2016.

Together
we can make it happen