

Meeting the Continuum of Care Needs of the Elderly in South Dakota Task Force

Report

November 7, 2008



INTRODUCTION

South Dakota is at a crossroads in developing a sustainable system of long-term care services to meet the needs of its elderly citizens in the near and long term. As indicated in the Evaluation of Long-Term Care Options for South Dakota completed by Abt Associates, Inc. in 2007, referred to as the “Long-Term Care Study”, among the challenges facing the state are:

- A rapidly aging population;
- Geographic mismatch between the places where services exist today and the places where the elderly population is expected to grow over the next 20 years;
- Historically low rates of use of home and community-based services (HCBS) that can help seniors fulfill their desire to remain independent and in their homes;
- Aging skilled nursing facilities;
- Shortages of front-line health care workers;
- Sharply rising costs of care coupled with tightening of Federal dollars for program support and provider reimbursement; and
- Inadequate individual planning and financing of long-term care costs, and limited use of long-term care insurance.

There is strong consensus among stakeholders that the state will be facing huge challenges in terms of numbers of people needing services by 2025 that are not currently available. This challenge is aggravated by the general lack of home and community-based care available in the state. At the same time, there are challenges in the location of existing nursing facility care. Simply put, nursing home beds are not located where the elderly population is growing.

The expense of adding new nursing facility beds and new federal requirements for nursing facilities, e.g., the need to be sprinklered, only add to the fiscal concerns of facilities and the state’s Medicaid program; since 58% of individuals served by nursing facilities rely on Title XIX as their payor source. Accommodating the fiscal growth needed to meet the basic care needs of elders in the future is perhaps the largest challenge facing the state’s long-term care system. To continue with the current system, the projected cost increase to South Dakota is conservatively estimated at \$176.9 million over the next fifteen years. Taking the most aggressive approach to implement policy and system changes targeted at increasing HCBS services will cost \$119.7 million over the same period of time.

Based upon the interest shown by and the participation in the Continuum of Care Task Force, stakeholders in the state appear committed to developing solutions to the challenges in the current and future long-term care system. It remains clear that concerted action is required today in order to meet these challenges.

RECENT HISTORY OF LONG-TERM CARE EVALUATION IN SOUTH DAKOTA

Governor Rounds’ Healthcare Commission established a Long Term Care and Medicaid Subcommittee to evaluate the long-term care system and infrastructure, including Medicaid funding for services, and to make recommendations to the Commission regarding health care policy. The Subcommittee recommended that a comprehensive study of the state’s long-term

care system be conducted. House Bill 1156 was introduced by then Representative Jean Hunhoff and was passed with overwhelming support by the 2006 Legislature and signed into law by Governor M. Michael Rounds. The bill required a study of the long-term care system, to include:

- Long-term care financing, including long-term care insurance;
- Costs of providing long-term care;
- Alternative approaches to providing long-term care;
- Barriers to the provision of quality long-term care services;
- Programs and techniques employed in other states for providing long-term care; and
- Other issues appropriate to the study of the continuum of care.

Abt Associates, Inc., a national consulting firm, was contracted by the state Department of Social Services to assess and evaluate South Dakota's long-term care system as called for in House Bill 1156. The study included consideration and analysis of extensive state and federal data, as well as interviews with over 100 individuals representing over 50 groups, institutions, organizations, and tribal representatives across the state. The study was completed within the framework of four tasks:

1. Evaluate South Dakota's long-term care system in terms of utilization, cost, quality of services and outcomes for the elderly residents of the state across the continuum of care.
2. Project future long-term care needs and future capacity.
3. Identify policy options based on practices in other states.
4. Form policy recommendations.

The study was completed in November, 2007 and shared with Governor Rounds and all members of the South Dakota Legislature. Staff from the Department of Social Services and members of the Long Term Care and Medicaid Subcommittee held public meetings in four regions across the state. They also provided a special briefing for legislators at the beginning of the 2008 Legislative Session as well as for the Joint Appropriations Committee, the House Health and Human Services Committee, the Senate Health and Human Services Committee and the Executive Board of the Legislature.

KEY FINDINGS

Key findings from the Long-Term Care Study include:

Growth in the Elderly Population will Fuel a Rising Demand for Services

The number of elders over age 65 in the state will double by 2025 and represent 24% of the state's population. Most other states will also see increases in the number of elders, but the rate of growth in South Dakota is twice as fast as the national norms. The number of disabled elders, who are more likely to need long-term care services, will increase by 42,000-50,000. Population growth is not balanced across the state. The Sioux Falls metropolitan area and Rapid City area will experience the fastest rates of growth, as well as the largest increases in the numbers of elders.

South Dakota Needs to Rebalance and Replace Nursing Facility Capacity

South Dakota has the 10th highest rate of nursing home bed utilization in the country. In South Dakota, nursing home use is 6 beds per 100 elders compared to a national average of 4.8 beds per 100 elders. If South Dakota can achieve the most aggressive change in use of nursing home beds to that of the national average utilization rate, there would be an adequate total number of beds in the current nursing home moratorium.

However, beds are not necessarily located where they are needed, especially given the expected population trends. Furthermore, many existing nursing homes are old and in need of renovation and replacement. 45% of facilities were originally constructed 40 or more years ago. This adds to the challenges in trying to meet new federal requirements for facilities to become fully sprinklered.

The study outlined three approaches to addressing the demand for care needs in the future. The demand projections from the study were used to tie projected financial impacts of the growth in the elderly population coupled with expanding HCBS utilization under all three scenarios. The financial impact of the growth in the number of elders over the next two decades is staggering. Failure to take the most aggressive approach to reducing nursing facility utilization and increasing HCBS utilization has an even larger financial impact. Below are the cost projections over the next fifteen (15) years under all three scenarios. Scenario 1 includes no effort to implement policy initiatives that reduce nursing facility utilization; Scenario 2 makes some movement toward reducing utilization to national norms; Scenario 3 takes the most aggressive approach to reduce nursing facility utilization to national norms. These are conservative estimates using projected inflation of 3% annually.

	SFY 09 Budget	2015			2025			Total Impact		
		#1	#2	#3	#1	#2	#3	#1	#2	#3
SNF	\$153,942,567	\$226,176,262	\$211,376,943	\$195,244,352	\$307,772,508	\$268,041,003	\$223,563,049	\$153,829,941	\$114,098,436	\$69,620,482
AL	\$8,008,991	\$15,564,519	\$17,479,712	\$18,918,489	\$21,915,148	\$26,236,243	\$30,209,554	\$13,906,157	\$18,227,252	\$22,200,563
In-Home	\$9,296,008	\$13,198,683	\$18,592,016	\$27,888,024	\$18,550,009	\$27,888,024	\$37,184,032	\$9,254,001	\$18,592,016	\$27,888,024
*Assumes 3% inflation annually								\$176,990,099	\$150,917,704	\$119,709,069
								(\$57,281,030)	(\$26,072,395)	

South Dakota Needs to Target Assisted Living Capacity Towards Growing Regions

Although South Dakota ranks slightly above national averages in terms of available assisted living beds, many areas of the state will require increased growth in assisted living capacity to reduce reliance on nursing home care and make a fuller continuum of care available to elders and their families.

South Dakota Needs to Expand Home Health Care Services

While South Dakota has a high rate of nursing home bed use, the state ranks the second lowest in the country in terms of use of skilled home health services. Low rates of utilization are likely due to the lack of available providers, access problems and practice patterns that discourage use of services. The state must double home health service capacity immediately and increase

capacity 3-4 fold by 2025 to meet expected population growth to move to national norm for home health use.

South Dakota Needs to Expand Home and Community-based Services (HCBS)

Home and community-based services cover a wide spectrum of activities, including personal care assistance, cooking, transportation, meals and nutrition services, and assistance with activities of daily living. These services are limited in South Dakota for a variety of factors, including challenges associated with service delivery in the frontier and rural parts of the state. Homemaker services in particular are fragile and there is a high rate of entry and exit of service providers.

There is no doubt, however, that adequate home and community-based services are instrumental to reducing nursing home utilization and to improving the quality of independent living for aging seniors. Without substantial increases in home and community-based services, nursing home utilization will continue at the current rate and cost the state millions more in service costs while denying elders the ability to receive services in their own homes and communities and remain independent as long as possible.

The Labor Force is Not Keeping Pace with the Growth of Elders: Shortages are Imminent

A long term care workforce shortage is evident today, and shortages will get much worse in the next 20 years. Forecasts indicate a significant and widespread shortage of both Certified Nursing Assistants and nurses. Rebalancing long-term care services and reducing the use of nursing home care cuts the estimated staffing shortages in half, but does not eliminate it.

The study recommended the following agenda for action:

- 1. First, set goals and adopt policies that reflect rebalancing. Right-size the industry.** Assure access for the population at risk by developing an “Access Critical Model” that encourages the development of smaller efficient forms of care in areas that are currently underserved, or that are served by facilities that can not remain viable in the longer run.
- 2. Provide flexibility when building new capacity and develop adequate financing:** Seek exceptions to the moratorium that permit bed trading from low growth to high growth regions, and develop financial and loan plans that will move financial capital to priority areas.
- 3. Expand home and community-based services across the state:** Rebalance the continuum of long-term care to provide citizens with care options that will permit them to remain independent and in their communities for as long as possible.

Development of Task Force on Meeting the Continuum of Care Needs of the Elderly in South Dakota

With the leadership of Secretary Deb Bowman, the Department of Social Services convened a large task force of stakeholders to develop recommendations to implement the recommendations identified in the Long Term Care Study. The task force had over 100 members, including representatives from nursing facilities, assisted living services, home care providers, provider associations, legislators, tribes, advocates, and state agencies. See Appendix 1 for complete list of members.

The Task Force on Meeting the Continuum of Care Needs of the Elderly in South Dakota had its first meeting in March, 2008. Gale Walker, chair of the Governor's Health Care Commission, and Deb Bowman, facilitated the meeting. Ground rules were discussed, including the need to leave agency biases out of decisions made by the task force. Subcommittees in three key areas from the study were designated:

1. Expanding Home and Community-based Services
2. Right Sizing- Aligning capacity where current/future needs are projected
3. Financing

Leaders in the provider systems agreed to chair each subcommittee. Cindi Slack, Vice President of Sanford Clinic, chaired the Expanding Home and Community-based Services subcommittee. Gale Walker, CEO at Avera - Parkston, chaired the Right Sizing Subcommittee, and Mark Burkett, CEO at Avera - Platte, chaired the Financing Subcommittee. Each subcommittee also had staff from the Departments of Social Services and Health to assist with preparing information for subcommittee meetings. Task force members were assigned to subcommittees to provide as many stakeholder perspectives as possible. After the initial meeting, the full task force met in May, July, September and October 2008 to consider the work of the subcommittees and come to consensus on recommendations.

SUBCOMMITTEE OBJECTIVES:

Objectives of the three subcommittees were as follows:

A. Expanding Home and Community-based Services Subcommittee

1. Determine how to provide one-stop shopping in South Dakota;
2. Identify gaps in services and develop recommendations to eliminate the gaps; and
3. Identify needed expansion/enhancement of existing services and how to provide them.

B. Right Sizing Subcommittee

1. Use study data to identify facility capacity needed in individual communities and develop an incremental timeline for implementation;
2. Develop an access critical model to ensure a reasonable distance for access for facility based services;
3. Develop a plan for aligning facilities with needs, including increases or reductions in capacity;
4. Develop recommendations for change in the nursing home bed moratorium; and
5. Develop recommendations/process to make needed capacity changes.

C. Financing Subcommittee

1. Develop a financing mechanism that makes available capital for priority and other facilities that need replacement or renovation;
2. Develop financial incentives that promote needed changes;
3. Develop recommendations on how to ensure financial viability when providers serve a higher rate of Medicaid recipients;
4. Develop recommendations on how to ensure service delivery for specialized populations; and
5. Analyze and develop recommendations for future funding of the system of care.

TASK FORCE RECOMMENDATIONS

1. South Dakota needs to develop a single point of entry system to make access to information, assessment and referral to appropriate service providers easier.

1.1. Regional Single Point of Entry – In order to ensure South Dakotans in need of long term care services know what services are available and would be the most appropriate to meet their needs, the task force recommends a single-point of entry system through the Division of Adult Services and Aging within the Department of Social Services be developed. The task force agreed that citizens, regardless of payor source, should have one place to go where everyone receives the same information, screening to determine needs, and referrals to appropriate providers; whether that is a community resource or a nursing facility. Additionally a single point of entry system will:

- assist individuals and their families by serving as a resource;
- streamline access to services and supports;
- empower individuals to make informed choices; and
- help individuals better plan for future long term care needs.

It is the recommendation of the task force that the Department of Social Services develop regional centers within their field office structure to serve as the single point of entry within the state.

1.2. Develop a Coordinated Discharge Planning Process – A significant number of referrals to nursing facilities come through the hospital discharge planning process. Individuals enter the hospital for care and then are unable to return to their home immediately, if ever, because of medical and other needs. The task force recommends the Department of Social Services (DSS) work with hospitals to pilot different models of a coordinated discharge planning process that include having DSS staff on the discharge team and in the hospitals working with hospital staff and families to help develop coordinate and implement a discharge plan. This will make the process easier for all involved but particularly for individuals and their families.

2. The Task Force recommends the State of South Dakota expand existing home and community-based services in order to better meet the needs of seniors throughout the state by supporting them to stay in their own homes and communities as long as possible.

More and more individuals who are older are asking to stay in their homes and communities as long as possible while receiving the necessary support services such as home health, homemaker, respite care, nutrition, adult day services, transportation and others. While South Dakota has a number of these services available in many areas not all are available state-wide or at the level necessary to meet the growing population of elderly. Some services, particularly home health services, are decreasing due to increasing costs and decreasing reimbursement. There are unique challenges in providing home and community-based services in rural and frontier areas; where distances are great and fewer people reside. If the State of South Dakota is to meet the increasing needs, service delivery will need to change. With that in mind the task force recommends:

2.1. The Department of Social Services should work with key stakeholders to identify critical core home and community-based services that need to be available at least regionally.

- 2.2. A committee of key stakeholders work with the South Dakota Board of Nursing to evaluate possible changes in delegation of duties.
- 2.3. Further use of telehealth be explored so some services can potentially be provided by trained personnel who do not have a degree in the medical field while being monitored by a medical professional via video.
- 2.4. Continue working with a committee of key stakeholders from the physician community through the South Dakota Medical Association to determine how to expand home health services and make them more cost effective in order to increase services.
- 2.5. A committee of key stakeholders be formed to work on clearly defining adult day services.
- 2.6. The Department of Social Services should develop information to be shared throughout the medical community and the public to help people better understand why it is imperative home and community-based services be made available across the state; both from a care perspective and a fiscal perspective.
- 2.7. Encourage Governor Rounds and the members of the South Dakota legislature to work with South Dakota's congressional delegation, other rural and frontier states and the Secretary of Health and Human Services to financially support home health services differently for rural and frontier states.

3. The Task Force recommends the State of South Dakota enhance existing home and community-based services to ensure services are comprehensive and meet the needs of the elderly in South Dakota.

It was identified by members of the task force that existing services available in some communities would better assist people to remain in their own homes if the services were better leveraged, intensified and made more accessible. These services include simple things such as chore services, drop-in visitor services, more easily accessible transportation services and others. It was also concluded that a number of these services could be provided by existing providers, service organizations and community volunteers. The task force recommends:

- 3.1. A community education effort be developed to work with leaders and organizations in the community to assist in the development and enhancement of the core community services.

4. South Dakota should implement an access critical nursing facility model to ensure people have access to care within a reasonable distance to their communities.

Population demand projections for nursing facility growth indicate a need for more nursing home beds in only a few communities. Many other communities are projected to need fewer nursing home beds than what is currently available. South Dakota's rural and frontier geography and sparse population requires that special consideration be given to ensure people have reasonable access to nursing home care across the state. This is important so that people needing nursing home care aren't forced to relocate so far from home and families will not have to travel exceptionally long distances to visit their loved ones.

The state currently designates certain hospitals as "access critical" to ensure people continue to have access to hospital services. The task force recommends that access critical nursing facilities be designated to ensure access to nursing homes that otherwise may not remain

viable due to decreasing occupancy numbers. The task force agreed geography, size of facilities, and level of services provided are key factors when considering access critical nursing facility designation. The task force approved the designation of access critical nursing facilities according to the following criteria:

- No other nursing home is located within 20 miles
- The facility is located in largest town within 35 miles
 - One outlier that is located 55 miles from next closest nursing home
- The facility must provide skilled facility services
- The facility is integrated with other health care services, either through affiliation with other services or through formal agreements
- Projected county nursing home demand is less than 60 beds in 2015
- The facility must relinquish any excess moratorium beds

Facilities in the following towns currently meet the access critical designation:

- Philip
- Lemmon
- Chamberlain
- Martin
- Britton
- Miller
- Hot Springs
- Eureka
- White River

The Department of Social Services will evaluate the designation of access critical facilities annually as part of the Medicaid rate setting process.

4.1. Develop reimbursement methodology for access critical nursing facilities.

The task force recommends the rate setting methodology for access critical facilities be modified. For example, facilities now are limited to an overall growth factor of 8% in one fiscal year. This limit will be changed to 10% for access critical facilities. In addition, access critical facilities will receive up to a 2% adjustment to costs.

5. South Dakota should right size the nursing facility industry by realigning moratorium bed levels to reflect projected demand for nursing facility services.

There has been a moratorium on constructing new nursing home beds in South Dakota since 1988, except for an exception made in 2003 for construction of a nursing home on an American Indian reservation. The nursing home moratorium is contained in statute, and facility moratorium levels are based on the number of beds they had licensed as of July 1, 2005. Since that time, many facilities have decreased the number of licensed beds due to decreasing occupancy, although the total moratorium bed capacity in the state remains at 8083. The discrepancy between moratorium beds available and the number of licensed beds in the state can accommodate needed nursing facility growth in areas of the state where demand is expected to exceed current bed supply.

5.1. Encourage nursing facilities to voluntarily relinquish excess moratorium beds by using the number of moratorium beds for setting rates instead of number of licensed beds.

Medicaid rates for nursing facility services are based on the number of licensed beds selected by a facility, which cannot exceed the facility’s moratorium bed number. This has resulted in many facilities reducing their number of licensed beds when occupancy has declined and resulting discrepancies between licensed, or used beds, and moratorium beds.

There was consensus in the task force that linking the rate of reimbursement to the moratorium bed numbers should result in freeing up enough moratorium beds for redistribution to parts of the state where demand will exceed current capacity. This approach is preferable to other ways moratorium beds may be made available, as facilities will determine the level of moratorium beds they need, and Medicaid will not pay for costs associated with unused beds.

5.2. Develop a method to use moratorium beds as the basis of reimbursement.

There are many nursing facilities whose recent occupancy is well aligned with their current moratorium bed level. The task force recommends facilities have the option to adjust their moratorium beds to be within 88% of their recent occupancy levels.

The task force recommends rates for facilities that adjust capacity to within at least 88% of their current moratorium level be held harmless. The next period of rate setting will be based on occupancy as a percentage of moratorium beds. The following example illustrates the rate impact for two different facilities; Facility A has occupancy less than 88% of moratorium capacity. If Facility A reduces their moratorium level to align within 88% of moratorium capacity, they will be held harmless and no adjustment will be made to their rate during the hold harmless period. If the facility does not reduce moratorium capacity, their rate is impacted. Facility B’s occupancy is greater than 88% and therefore there would be no need to adjust their moratorium level and no fiscal impact to their rate.

	Moratorium Capacity	Current Occupancy	Adjusted Moratorium Capacity	Current Rate	Rate if No Occupancy Adjustment Made
Facility A	45	29	32	\$102.73	\$85.77
Facility B	51	50	51	\$134.44	\$134.44

Recognizing that providers need time to evaluate historical and projected occupancy to make an informed decision, there will be a (6) month implementation period for providers to adjust moratorium capacity as needed.

6. South Dakota should expand nursing facility beds through an RFP-like process developed by state agencies for areas in the state that will need additional nursing facility services.

South Dakota had a Certificate of Need process in the 1980’s that required providers of nursing facility and other health care services to justify and request permission to expand services. This program was problematic on several different levels. It was perceived by many as unfair and was administratively burdensome. While it was recognized that some

process for future nursing facility bed expansion is needed, there was consensus in the task force that South Dakota not adopt a traditional Certificate of Need process.

Instead, the task force recommends a “Request for Proposals” (RFP) approach be used to determine future expansion. It is further recommended the state issue, evaluate, and award RFPs for specific geographic areas in need of additional nursing facility beds. The determination of where nursing facility bed expansion is needed should be based on population-based projections for need and occupancy of existing facilities.

6.1. Seek changes to the moratorium statute to allow for expansion in needed areas.

The task force recommends the moratorium statute be changed to accommodate needed expansion of nursing facility beds; however, the total number of moratorium beds in the state will not be increased. The Department of Health (DOH) in consultation with the Department of Social Services should be allowed to approve specific increases to accommodate areas of need. The legislation should also allow DOH to promulgate Administrative Rules for the RFP process that will be used to allow increased beds. If this change is approved by the Legislature and Governor, Administrative Rules should be drafted and implemented to be effective July 1, 2009 to coincide with the effective date of the statute change.

6.2. Develop Administrative Rules for the RFP process.

The task force recommends the Department of Health develop Administrative Rules to outline the RFP process. The following information should be required by facilities in response to the RFP:

- Financial business plan, including payor source information and evidence of community buy-in;
- Population intended to be served, including arrangements with other facilities to ensure people of all socio-economic levels have increased access to services;
- Facility’s quality assurance plan, including 3 year history of regulatory surveys and substantiated complaints; and
- Plan to meet workforce needs, including professional and direct care staff.

6.2.1. The task force recommends the following be prioritized when evaluating proposals to expand nursing facility beds:

- Facilities that give up existing moratorium beds if there is a future need in service area;
- Current providers in service area, with service area to be defined;
- Providers that demonstrate integration with full continuum of care, including providing services in addition to nursing facility services; and
- Consideration to providers serving specialized populations.

6.2.2. In addition to the above priorities, the task force recommends that providers selected to expand beds must:

- Accept people eligible for Medicaid;
- Provide full skilled services; and
- Be in full compliance with licensing regulations.

7. South Dakota needs to maintain a sustainable financial infrastructure for the current and future system of care.

The federal government's share of a state's expenditures for Medicaid is called the federal medical assistance percentage (FMAP) which is determined annually. Making available the general funds to match federal Medicaid dollars to meet the demand in the future was one of the task force's goals. The task force also examined methods to make available dollars for capital construction or renovation and to address the financial challenges providers serving a higher mix of Medicaid residents face in managing finances.

7.1. Provide a mechanism to access capital for replacement/renovation.

The average age of over 80% of nursing facilities in South Dakota is greater than 30 years with over 45% of the facilities over 40 years old. In order to meet the needs of the individuals, facilities will need to be replaced or renovated; placing a significant strain on existing resources. Also, a recent mandate from the Centers for Medicaid and Medicare Services (CMS) requiring facilities to be sprinklered within five (5) years adds another burden.

To ensure dollars are available to support current and future infrastructure needs, the task force recommends a pool of funds be made available through the State of South Dakota for facility capital needs. The funds would be accessed through an RFP-like process.

Similar to the implementation of models in Minnesota and North Dakota, capital payments would be increased on the front end of the project and reduced over time. Criteria for selection would include:

- Priority for access critical facilities;
- Priority for areas showing need based on projected demand;
- Specialized populations;
- Community financial support;
- Facility demonstrates financial viability;
- Provide the full continuum of services.

7.2. Provide financial incentive for providers across the continuum of long term care that serve a higher percentage of Medicaid recipients.

The mix of payor sources within individual facilities plays a significant role for facilities in managing their finances. Recognizing the need to provide an incentive to promote continued access for Medicaid recipients, the task force recommends a financial incentive based on the mix of Medicaid paid days for the facility compared to that of similar providers. The recommendation is that a set pool of funds be made available and allocated to providers based upon the number of Medicaid recipients they are serving that exceed the norm.

7.3. Analyze and develop recommendations for future funding of the system of care.

While the task force recognized the need for additional general fund revenue to leverage federal Medicaid funds, the task force was unable to reach consensus for a recommended fund source.

8. The Departments of Social Services and Health should continue to collect data and analyze the need for additional assisted living facilities in certain areas of the state.

Members of the task force acknowledged that based upon the Abt study there will likely be a need for additional assisted living facilities. However the task force did not address the issue at this time due to not having adequate data in relationship to assisted living facilities and their related costs. The Department of Social Services has begun a process to collect the necessary data in order to more accurately project the need and costs. This information will be shared with all key stakeholders upon its completion.

APPENDIX 1

Continuum of Care Taskforce Members

Belinda Aunge	Nick Fosness	Laurie Pospisil
Lee Baldwin	LaVonne Gaspar	Representative Jim Putnam
Cheryl Bartling	Jeff Gengler	Representative Tim Rave
Sherry Bea Smith	Andy Gerlach	John Red Bear
Gerald Beninga	Pam Giroux	Daryl Reinicke
Bob Boehmer	Clint Graybill	Chip Rombough
Jay Bogan	Senator Tom Hansen	Ruby Sanftner
Deb Bowman	Steve Harl	Dr. David Sandvik
Glenn Bryant	Justin Hinker	Mark Schmidt
Mark Burket	Wendy Hoe	Jeremy Schultes
Doris Burscheim	Doneen Hollingsworth	Ken Senger
Maureen Cadwell	Senator Jean Hunhoff	Dennis Sever
Dewey Callies	Van Hyde	Cindi Slack
Jaci Casanova-Keller	Jim Iverson	Tom Snyder
Gus Chamales	Representative Gary Jerke	Bob Stahl
Dave Christensen	Senator Sandy Jerstad	Chad Stroschein
Anne Christiansen	Bruce Johnson	Allen Svennes
Harold Condon	Marilyn Kinsman	Yvette Thomas
Jim Cornelius	Ron Kortemeyer	Brenda Tidball-Zeltinger
Rebekah Craddock	Kim Malsam-Rysdon	Tim Tracy
Sally Damm	Tom Martinec	Representative Don Van Etten
Marty Davis	John Mengenhausen	Ann Van Loan
Mark Deak	John Miller	Darla Van Rosendale
Loren Diekman	Kathi Mueller	Jim Wahner
Robert Dockter	Jesse Naze	Beverly Wakeman
Sharon Drapeaux	Cory Nelson	Gale Walker
Representative Brian Dreyer	Senator Ed Olson	Joe Ward
Stacey Erickson	Gloria One Feather	Charlie Ward
Tony Erickson	Valerie Osterberg	Carmen Weber
Greg Evans	Peggy Pearson	Pam Wells
Deb Fischer Clemens	Mick Penticoff	Dixie Wilde
Linda Ford	Jason Petick	Sam Wilson
Daniel Fosness	Georgia Pokorney	