CMS 310, Project A, Task 7
LTSS Webinar
Home and Community Based Services
February 22, 2012

Nicole: Hello everyone. We're going to get things started. My name is Nicole Condon. I'm with Kauffman and Associates and today our long-term services and supports webinar will focus on the *** *(00:15)* services that make up home and community based services in Indian country. Our speakers today include Cynthia LaCount. She's the Director of the office of the American Indian and Alaskan Native and Native Hawaiian programs at the Administration on Aging and then Dr. Bruce Fink from Indian Health Service who will later on have a conversation with representatives from the Pueblo Zuni home and community based services program. So let's get started. Cynthia, do you want to take over?

Cynthia: Okay. I certainly will and let me know if I need to pick up my phone, Nicole. Good afternoon, everyone. I'm real excited to be taking part in our long-term services support webinar this afternoon and I'm very excited to be the new director of the Title VI programs at the Administration on Aging. So let's go ahead and get started and this webinar is all going to be a conversation. It's very important to all of us that you ask questions and participate in the discussion please. Before I begin, I also want to make mention of our long-term services and support conference that will be held in Denver, March 21st through the 23rd and when Dr. Fink is on I'm sure he will tell you more about it. But make note of those dates and plan to join us in Denver *** *(1:50)* of long-term care and support for our frail individuals in Indian country. Alright, starting with slide two, long term care in Indian country: long-term care is a huge catchphrase. It talks about...

(Background noise.)

Cynthia: There's a lot of background noise. I just wanted to make sure that you could hear me. Long-term care is a big catchphrase that includes a range of personal, social, and medical services to assist people with either functional or cognitive limitations who have trouble providing self-care.

(Automated announcement: 'All guests have been muted. You can unmute your line by pressing star six.')

Cynthia: Thank you. Are we back?

Nicole: We are. I was able to mute all participant lines and we'll open it back up at the end for Q and A.

Cynthia: Okay Nicole. Thank you. And as I'm doing my little presentation here, my opening introduction, when I'm talking I may use the term tribal elders or frail elders. I'm not always referring to elders, I'm referring to any individuals who have functional or cognitive limitations and need assistance. Long-term care is also defined in Indian country as supporting family caregivers. Of course, because of our culture many, many of us are caring for frail relatives in our homes or in their homes and we also need to provide care and assistance to those family caregivers. In tribal communities when we're talking long-term care it most always is including how we can include our culture and how we can provide culturally appropriate services to maintain our frail individuals in their homes and communities in a cultural manner that they will be very comfortable in. That's kind of the key for Indian country is how we can maintain our cultures. Slide three long-term care: we also have kind of three different levels of long-term care. The first being very informal care, which is the least restrictive care and often the care that we provide just because. And it's just because our grandma needs a ride to the grocery store and help getting groceries or just because Auntie Linda across the street needs a ride to the senior

center to have lunch or just because we're going to make a visit. We had a big snow storm and we're going to stop in and make sure Auntie Linda or grandma is doing all right. But informal care can include service assistance such as shopping assistance, participation in Title VI, transportation visits, or frequent checks. The kind of type of care that any of us would provide informally to our family and friends. The next level of care that we talk about are a little bit more formal services and usually those types of services that are planned and case managed and with a specific goal of maintaining that frail individual in their home and community and those formal services can be actually setting up home delivered meals under Title VI or making arrangements with the public health nurse to do weekly visits or having CHR's deliver medication, providing home health care. There's a whole range of more formal and community-based services that we'll get into. And then the final level, the most restrictive level that we talk about is the institutional care which includes hospitals and nursing homes, and ultimately we know we will have frail individuals who may need that level of care at sometime in their continuum, but we want to prolong that level as long as possible and maintain individuals at home.

Bruce: Cynthia, I'm sorry to interrupt, but I think we were out of sync with your slide. So I want to make sure we get back on sync.

Cynthia: We are on the slide that is number four, 'What are home and community-based services?'

Bruce: Okay. Great.

Cynthia: It talks about Indian services, and home and community-based services are anything that we're going to provide in the home or the community that's going to help maintain that frail individual living at home or in the community.

Bruce: We've got it. Good.

Cynthia: And those services include our nutrition services whether they are through Title VI or Title III and it includes both congregant and home delivered meals, nutrition planning, and consultation, meaning that we may need to have an IHS nutritionist or dietitian come in and work with the family or the caregiver in preparing proper meals for that individual. Transportation assistance is often provided by Title VI program or the CHR's, medical appointments, the senior center, assistance with grocery shopping or any other services or assistance they need a ride for. Home visits are very critical and can accomplish visual check, companionship counseling, home assistance, referrals, and checking vitals. The home visits can be a whole different level of care from the very medical home visits which could include a public health nurse or a community nurse coming in or it could be other trained staff such as even senior companions who are trained to go into a home and do a visual check and make sure there's food in the refrigerator, and make sure there up and dressed for the day, those types of home checks and all of this we're talking coordinated care. So no single program is going to be an island in this home and community based service delivery. And then we also have the home healthcare provided through Indian Health Service or social services are another entity and perhaps your tribes have other home healthcare workers that we can all learn about as we're going further into today's discussion. When we look at home and community-based services we're also looking at personal care, which includes assistance with bathing, grooming, dressing, eating, toileting. We're looking at health support services, housekeeping, shopping assistance, laundry, mending. Again, services that are going to be in the home provided in the home. We hear about the stress of providing care to a frail person. So it's important to provide support for the caregiver which includes respite care to allow them a break and some time to themselves. To

enable an individual to remain living in their homes, we need to be certain that home is safe. For many of us in Indian country that home safety goal can be met through tribal housing, NAHASDA. Very frequently our seniors are in a tribal house. In the IHS injury prevention programs which may be safety or sanitation programs - I'm not sure what it would be called in your area - and then, of course, law enforcement to do that level of safety checks. Medication assistance can also be provided as a home and community-based service, but I caution that if we are providing medical assistance that it is provided by a medical professional. Next is a chart that my predecessor in this position, Yvonne Jackson had developed. We have to bring Yvonne into everything we do. On the left side are medical services listed, medical monitoring - that's the home visits that we've been talking about - checking for vitals, physician or primary care, therapy care, pharmacy services, and again CHR's very, very frequently will deliver medications - not monitoring medications, but making those deliveries. Health diagnostic services, mental health, hospital acute care, dental services, transportation, education and eventual *(?) (10:50)* care. On the right-hand side is more of what we're talking of home and community-based care and I've gone through many of these so I won't now, but those again are the level of whatever care we need to provide to maintain an individual living at home, which is our ultimate goal. The next slide is some of the programs that Administration on Aging provides through the older Americans Act and I won't go through those. They are all listed and there's additional information about each of them on the AOA.gov website or you can contact any of us at AOA in the Title VI office for more information about our programs. But we have a whole range of programs that help maintain individuals at home. And finally...my final slide before we get into our main discussion is looking again at the types of services offered in Indian country and realizing that every tribe and community are different, but these are some of the programs that

we often have, the Title VI services. Sometimes programs will have Title III through the state. CHR's: I used to be a CHR and a CHR director and I remember we would all tease one another that the saying was, 'if nobody else will do it call the CHR's; they're always filling in.' Our IHS public health nurses, our community health nurses, again the safety and sanitation, veterans administration services which I think Bruce is going to mention more, social services, whether they be tribal or BIA or County, USDA commodities and commodity programs can also do education, uh, nutrition education. And I know that many CHR's and federal fix programs will often deliver commodities to the elders. Youth programs: I don't think we're doing enough intergenerationally in Indian country, but if we're looking at home chores and some of those home and community-based services, just some community supports and a little socialization. College and high school kids might be great folks to be bringing in to help out as well as visits. And which brought in again the schools. There's a lot of school programs and especially college programs where students can get credit for providing services in the community and I wanted to be sure and mention housing for the services that they provide. There's a lot of question marks up there on the next two lines, because I know there's a lot of services that are not included in my slide that many of you are providing at your tribal level. We'll take questions and comments at the end. I would like to introduce Dr. Bruce Fink right now. Many of you know Bruce; he's been a player in our tribal long-term care and tribal aging programs for many years. Bruce works with Indian Health Service and primarily is in charge of their elder care initiative. So Bruce I think you are next. Thank you.

Bruce: Thank you, Cynthia. Thanks for that overview. While I start my comments, Nicole I sent you a slide with introductions of the folks who are going to be on the next conversation. Do you have that for the session?

Nicole: I will load that now.

Bruce: Okay. Thank you. I will just make a couple of bridging comments and then I will get into the next part of the session which I'm excited to start with. And just reflect a couple of things that I learned from Cynthia. Here's what I heard her say, I heard her say that there's a variety of services that we provide in the homes and in communities that help keep individuals who have some degree of disability whether it's because they're elderly or because they have another cause for disability. Younger folks with disabilities helps keep them in their homes and communities. It helps keep them a part of our lives, part of our communities, part of our lives, part of the tribal life and able to stay in that important role and I also heard her say that we have a number of programs operating in the communities that aren't a perfect match for those services, but that try to put those services together for community members and tribal members and that every community, every tribe is different in what resources are available. There's some major funding streams that help fund some of these services. The biggest funding stream nationally for our home and community-based service is the family. The family provides most of the care that folks with disability - whether they're older or younger - need. But other major streams for funding include the Medicaid program operated through the state. Also state home and community-based services programs, which often have... Often the states have developed their own programs in addition to the state Medicaid program. There's also VA services that Cynthia mentioned for eligible veterans. There's a number of services to help support elders in the home including the home-based primary care program. And of course, funding the services that are provided through AOA and the Title VI, the aging network, also Title III of the older Americans Act in the aging network as well as Indian Health Service funding and tribal funding. Increasingly over the last decade we've seen tribes stepping up and stepping in and creating

programs to keep tribal members in the community with disabilities. So you have a variety of funding sources and we have a variety of services that are needed. We have a variety of programs in each tribal community. How do we put it all together? That's the topic of the next part of this session, the conversation with folks from the Pueblo Zuni and before I introduce them all I will just make this observation... I mean we've asked the folks in Zuni to come and talk about what they are doing, not because they are so different from everyone else, but because - every tribe in every community is different, but because they've done what so many tribes have done and are trying to do which is to put all of these disparate pieces together to provide services for their members in their communities. So we're going to hear from Zuni about the pieces they have in place and how they put it together and then we'll have time at the end for some questions and conversation with all now 50 plus folks who are on the line. I'll start with introductions. We have with us Theresa Bowannie who is the Administrator of the Zuni Home Health Care Agency and they are providing both home care services, but also a variety of other services that we'll hear about from Theresa. I'm just going to check as I do introductions to make sure everybody is with us. Theresa are you on the line?

Theresa: Yes. I'm here.

Bruce: Thanks. That's great. When you speak we may ask you to speak a little louder, because you are a little quiet on the line.

Theresa: I'll get closer.

Bruce: Thank you. And Karen Leekity , who is the Director of the Zuni Senior Center, but once again, just like Theresa what Karen does, what the Senior Center does is much more than what you might think a typical senior center does. And Karen did I get that right?

Karen: Yes.

Bruce: Okay. Thank you. I'm glad you're here. And then we have Kay Redman who is an Indian Health Service physician and a lead in Elder Care at the Zuni IHS Hospital that serves the Pueblo Zuni. Kay, are you online?

Kay: I am. Hello everyone.

Bruce: Great. And Dr. Chris Piromalli who is the Lead for the Zuni Indian Health Service Hospital in Palliative and End-of-life Care. Are you with us, Chris?

Chris: I am.

Bruce: That's great. It's really fantastic to have you all with us and I'm just going to... We're going to try to have a conversation here. So we'll start with some questions. I might actually direct the first set of questions... I know Theresa and Karen, I know you guys are sitting together so I'll let you all take the first set of questions. Tell folks online a little bit about what are the services that are available to individuals in Zuni who may need help with activities and daily living?

Karen: We're with home health care agencies. This is Karen. We provide an array of services with our elders who need assistance. For the Zuni Senior Center our Title VI program has the caregiver grant which we have two caregiver outreach workers that can go out and check on elders in their home. We also have the senior companion program where we send out volunteers, elder volunteers out into the community to provide four hours of visitation or light housekeeping, light chores, prepare a meal. That's what we have and we also have the adult day care program which provides respite to the caregiver and also it gives an elder... These are aged 70 and over - up to 100 years old. These elders attend adult day care to receive the one to five ratio of care in our adult day care and much of this time the caregivers take a break from taking care of these

elders and that's what our Senior Center provides. And, I will turn it over to Theresa for home healthcare.

Theresa: Hi. For home health we provide skilled nursing and home health aide services through the clinical portion of the home health part. Personal care we have attendant services through the Medicaid program. Palliative care, that's also under skilled nurse and it's somewhat set up a little bit differently from the hospice services that are available elsewhere. We also have medical supplies and equipment *** *(22:33)* rental as well as looking on, hopefully setting up transportation services which will help lift as well as non-emergent services.

Bruce: That's terrific. This is all sort of from the tribal side. I heard about adult senior center. A variety of services that are really kind of supportive services for elders living in their home including the adult day care and we'll come back to that in a few minutes, I hope. Senior companion, having elders who can be in home with seniors for up to four hours a day and do light chores and meal preparation and then the use of the caregiver grant, which is the Title VI fixed fee grants for outreach and for respite care and then on the home health side, both traditional skilled home health but also personal care, that's through the Medicaid program and then a palliative care program, which I hope we'll come back to in a few minutes and we'll talk more about that. And then the medical supply and equipment, and it sounds like in the works is a development of transportation services. Dr. Redman and Dr. Piromalli can you tell us a little bit about how the IHS, how the hospital side sort of fits into that array of services? What are the services that the hospital are able to provide? How do they fit in with the tribal side services?

Kay: So this is Kay Redman and we up at the hospital utilize all these things, both through home health and through the senior center and we'll contact people via the phone or even through a referral that we can send out and kind of work those things. In the hospital we also

have... I work with the elder program, which is a multidisciplinary program with different people within the hospital really looking and assessing need that individuals from trying to make more of a net for those people so that they don't fall through and often times we are working with home health and again with the senior center, but also working with our PHN's, who are a pretty active group in our own hospital who go out and see individuals, work here with us and even with other groups in the community. And in addition to the elder program we also have a fall clinic , which is similar for people - not exclusively elders, but for others who are at risk for falling.

Bruce: Great. Thank you. Chris?

Chris: This is Chris Piromalli and I'm on the palliative care side. So again its amazing how integrally we work with many of the local tribal programs. So for example, our palliative care program is run through home health services and so from the hospital side we're very much a primary care centered model and so often times we'll run across patients who are at the end-of-life and so the primary care providers have... Our palliative care program has a resource so they can make referrals of their patients to home health and then we actually have a palliative care team and we meet together with the home health team to review our end-of-life cases and then we actually go through all of the various factors that are involved with end-of-life care, and it's a wonderful time for a *** disciplinary team to kind of discuss each patient and to make some recommendations to the primary care providers on ways that we can provide better care for them, and so... The wonderful thing is that our committee really helps to propose things of how we can provide better care, but at the same time keep the primary care providers involved and encourage them to do home visits and then...as well as their home health team actually goes to the home to do those home visits as well.

Bruce: Great. So what I'm hearing is at the hospital side, there's some specialty elder care services that really bolster the ability of the community as a whole to take care folks in the community. That elders program at the hospital, which does I gather geriatric interdisciplinary team does assessment and management of frail elders?

Chris: Exactly.

Bruce: And then also the palliative care services at the hospital that identify people at the hospital who need more intensive care towards end of life and also works closely with the home health base palliative care program to kind of deliver that. And then I also heard the ability at the hospital level to do some home visits, um episodically, as a way to sort of bring services again to the folks in their home. Oh, and the fall clinic. Thinking about Cynthia's comment about safety is a critical piece of keeping frail individuals safely at home and in the community with the ability to sort of identify those folks who are at risk for fall and do some therapeutic approaches, do some things to reduce their risks. So it sounds like there's a variety of services at the hospital that allow a little more intensive care if you will, of the folks living in the community who may be frail. Did I get that right?

Chris: Perfect.

Bruce: Good. Well I would love to hear more and I bet others would too, about a couple of things. I would love to hear more about the elder day program, Karen from you and about how do you pay for that? Who pays for the services provided through elder day health? Who are the folks who take advantage of those services? How do they find you? What's it like there?

Karen: Let's see. Initially we started our adult day care program in 1998. We identified several elders who needed more attention through our congregant meal sites. They came to eat and they needed much more assistance with personal care with eating and so we started our

program with welfare to work volunteers and when we built our new senior center we had a small room that served about six elders, but we outgrew that. We now have a nice adult day care, assisted living, which would serve 25 elders and this was built through an Indian community services block grant through our tribe and the services... We actually had no money for the services and the program, but through volunteers and the welfare to work people, through our TANF program, we wanted to take care of our elders, because these were real elders who were getting on in their years and we continue with a small state funding which we still are now. In the meantime we were trying to get license through our state of New Mexico for Medicaid reimbursement and we are still doing our application. We got licensed in 2007. It was a long process to where we didn't get a license right away. But we served our elders who need the one to five ratio of care. And under the licensure we have certain regulations and requirements that we need to meet and hopefully we can get Medicaid licensing and certification to charge under Medicaid. We are still trying to pursue that. Our state's Medicaid program, the funding was cut. So we're still waiting for that.

Bruce: Okay. Thank you. That's really helpful. That's really interesting. Theresa I wonder if you could tell us a little bit about sort of about the palliative care program that you're operating through the home health and how it fits in with your home care program too.

Theresa: Prior to the palliative program we were providing basically the skilled nursing home health services and we saw the need of palliative, because of the various issues that were coming up and we were fortunate to connect with the UNM Robert Wood Johnson foundation grant and through there we did research and with Dr. Fink's assistance, we were able to develop the service and expand on what we were already doing. From there a disciplinary team was developed which reviewed cases and provide technical assistance currently with the help of Dr. Piromalli.

From there new ideas are coming up and part of our developing is to include what we already have in place. Currently we build on the routine home care basis to ever build under the hospice, the known hospice program is not clear, because of the many taboos these days within our belief system.

Bruce: So you've managed to put together a palliative care program outside of the sort of Medicaid Medicare hospice, formal hospice program, but still able to meet the needs for end-of-life care using the Medicaid home care program and the skilled nursing resources you've got and then the collaboration with the hospital?

Theresa: Yes, as well as the senior center.

Bruce: And the senior center as well.

Theresa: *** programs.

Bruce: That's terrific. You know I'm aware of something that I don't know if everybody else is aware of on the line, but I would love for you to share it and that's the work of the elderly services coordinating group and what happens with that. I don't know if one of you could describe that for the folks on the call.

Theresa: Initially, our elderly services coordinating committee was initiated when Dr. Bruce was *** here to identify the services for our community's elders and it was initially called the elders task force. And we felt our programs in our community, tribal programs, IHS programs together to provide us how they could be able to serve elders in their communities, such as transportation, such as medical, social issues that we thought were lacking services to our elders and we came together as a task force and pretty soon we got all the gaps filled and the time ran on. Just recently about a couple of years ago we fill that once a month. But about two years ago we changed that because all the gaps were filled and now we had a core group of programs in

our community that we partnered with in getting the services together and we became the Zuni elderly services coordinating committee and we have that group going. We had our meeting earlier before we went online and our core group of *** partners with Zuni home and health care agency, Zuni wellness center, Zuni career and education department, Zuni Housing Authority, social services , which ***, Zuni Police Department, IHS, the PHN, CHR's, adult day care, senior volunteers. Those are the programs that we now have and we continue with the services that are... We update our services. We meet on a quarterly basis now to see what we need to do in providing as much comparable we need for services to our elders in our community. And we have it ongoing and we met this morning. The Zuni Police Department was here and we are going to keep our community police team going and we share a lot of information regarding elder services. And some of these are also being planned. We're trying to bring back life, the adult protection team where *** as well as assessments in other areas that we need or are lacking or have not.

Kathleen: Bruce?

Bruce: Yes.

Kathleen: I'm sorry. We were messing around with the phone here. We were trying to figure out how to get in touch with you. Anyways, this is Kathleen Tom Garcia with the Salt River Pima-Maricopa Indian Community in Scottsdale, Arizona, and we had a question, and I'm sorry to go back a little bit. You had mentioned something in regards to hospice, working with the hospice because of a culture piece. Can you elaborate on that a little bit more on what you're doing?

Bruce: Yes. That sounds great. Before we get to that, Kathleen let me just... Why don't we... We're very close to sort of opening up all questions and that will be the first question.

Kathleen: Thank you Bruce.

Bruce: So thank you for raising that question, but I was just going to summarize a little bit about where we are then and just ask one final question of the panel before we open it up broadly. I'll take the moderators privilege I guess. So what I heard about the elderly services coordinating committee is that you've managed to pull together and keep together a group...the disparate programs, the different programs at...in the community that actually provide services for elders. We know that as a way to coordinate those services and also to build new services. We know that the one thing that's really true in every community, not just in Indian country, but elsewhere is that elder services cross all the boundaries to keep our elders safe and at home, means we have to cross all the boundaries, all the turf areas, and it sounds like the elderly services coordinating group has been a way for you to do that within the Pueblo and that's really interesting. I know that there are others on the line who have taken similar approaches. One last question, and I think you've talked about it a little bit, but what do you think is next for the Pueblo? Where do you see the gaps? Because we know we're never done. It's never good enough for our elders. What's next, in the way... Where are the gaps in long-term services and what would you love to see happen next and what are you working towards? And I will say that is for anyone...for Theresa, Karen, Chris, or Kay.

Theresa: Well, for Zuni Elder Services and Zuni Home Health Care, we would like to see an assisted living for our elders, because we see a lot of our elders who are not provided family caregiver services. So we need someone to provide the services because our elders need to stay at home. They don't want to be located off the reservation in a nursing care home facility. We're looking at assisted-living and we're going to plan for that. That also includes the disabled

population, those that require more than what county can provide, something that is hospital like. More like in a family type atmosphere that we're hopefully going to see sometime in the future.

Bruce: That's great. And that makes a lot of sense. Chris or Kay any other comments to add?

Kay: I would say especially from you know with end-of-life issues, more education. We're trying to pursue better programs to educate our elders about advance directives and realizing that they do have lots of choices to make and really getting the family members involved in that. I think one of the wonderful things is you know as it was mentioned since we're not under hospice we do have the unique privilege of you know, getting elders involved with home health much earlier and developing the relationships earlier so that this way when it does come to you know the end-of-life that all those issues have been considered and at the same time they have relationships with the healthcare providers and the home health team that is going to be providing the palliative care services and I think with the more education we have both as a community, as well as amongst the healthcare providers, we can provide better services you know so that patient questions are honored.

Bruce: Well, and that's great and that's a great segue to the first set of questions we had, which I think are really...I think mostly directed to you, Theresa, which was about the cultural piece of palliative and end-of-life care and I have a feeling we'll probably want to have a whole webinar based on this. So we won't be able to take too much time for this today. I think that will be a topic for a future conversation, but I think... I know you've done a lot of work to navigate this pathway to a respectful way to give folks to talk about this important topic with folks in the community.

Theresa: Yes. That was a major task working with the many taboos and the cultural piece of our population base, mainly around the elders. Our belief system is... Well, all Native

Americans I'm sure pray for, is censored around life or long life and to talk about end-of-life it's like our prayers and the end-of-life talks rarely go together and so what we did in overcoming the taboo - or not really overcoming, but work with the belief system is we initially went out and spoke with families that had up to about a year experience with existing families and we had a set of questions that it didn't always work where our questions were answered. It was a very difficult task to do, but we were able to accomplish a meeting with about eight families who were willing to be interviewed and based on those kind of questions about how they dealt with, how was the family members condition, we were basically saying that they are at the end-of-life, how was it presented to them by the medical providers, how they would have liked for it to be presented if the experience was something that fix it or just various questions in how the coping, what, what we would be able...what they would want to see within the communities for coping, any kind of assistance and from...based on all of those interviews and then researches and meetings with what we have locally a cultural advisory committee, taking advice from them, talking to various elders, basically talking to anybody who showed an interest in the service. We came out with what we have now within the community and it's working well for us and we do address advanced directives, but it's a slightly different approach from the norm and it seems to be working for us.

Nicole: Theresa we're having a hard time hearing you. I think if you could speak a little bit louder that would be great.

Theresa: I can try to get as close as I can to the phone that we have.

Bruce: Thank you for that.

Theresa: Did I address the question that you have?

Bruce: It sounded great. That was really helpful Theresa. I think this is a topic area that we could probably spend one or many hours on and probably will in the next year as we continue this series. I wonder if there are other questions. Nicole, have we been collecting questions or do we need to take folks off mute to ask questions?

Nicole: Yes. I can do that right now.

Bruce: We'll ask everybody to keep their phones on mute unless you have a question. But we can take additional questions now either for the team from Zuni or for Cynthia who spoke initially.

(Automated announcement: 'All guests have been on unmuted.')

Bruce: Anyone with questions? We can...

Female: I have a question.

Bruce: Good.

Female: Are we going to get any contact information like on the presenter?

Bruce: What would you like contact about? What would you like to ask or who would you like contact information?

Female: Well, Theresa.

Bruce: Sure.

Female: I would like to contact her personally at some other time and get more information from her.

Female: Bruce could everybody's e-mail and phone numbers be included on your slide for posting?

Bruce: We can sure do that.

Female: Thank you.

Female: So, that information will be on the website.

Bruce: What we may want to do is actually... I'll tell you what. Why don't we start this way, is have questions come... We'll post the questions from the webinar just to come to Kauffman and then be distributed after that, if that's okay? Just let... We'll put an address up on the website for questions, follow-up questions and then you can send those questions and let us know who you're needing to send them to and we can forward them on. Why don't we do that for this session. Then we would make sure we get the questions to the right folks. Does anybody have other questions for the team? I have many more, but I'll hold my tongue to give other folks a chance to talk.

Nicole: Bruce, I think Christian has a question.

Bruce: Good.

Christian: I know that you had mentioned that my question would be discussed. Just... I know like you said that the culture piece in regards to the advance directive and all, I know you said that could be another day for another topic, but could you shed a little light on what approach they have been using and discussing with the clients in regard to that advanced directives, because like you said, the culture piece is there and some of the tribes elders you can't just sign that form. So, what approach is she using?

Bruce: So Theresa, I guess that...a little more detail on... You mentioned that you have a different approach to advanced directives. It would be great to hear a little more.

Theresa: Okay. The approach we use currently is like a third party person, not really talking about advance directives, but not directing the question to the patient, but in a sense talking about a third person, and explaining what it is and what the feelings are about it, and then eventually the conversation turns. The patient themselves start participating and then...

Christian: Can you print that?

Theresa: Yeah.

Bruce: So I'd ask everyone to put their phones on mute so we could hear Theresa. Thanks.

Theresa: Okay. Did you hear that first part?

Christian: Yes. About approaching the third-party and when you discuss it usually the patient gets involved?

Theresa: Yes. The patient gets involved and then they start participating in the discussion about the advance directive and through the conversation the advance directive is developed and sometimes it takes them a while to sign off on it. Sometimes they sign off on it at the discussion form.

Christian: And if they continue to decline in signing that advance directive, what's your next step?

Theresa: We respect their wishes and we don't push it at all.

Christian: Okay.

Bruce: That sure makes sense to me. From what I know of palliative care that what we're offering is the opportunity but I also heard Theresa say that the discussion is an indirect one sometimes.

Theresa: Right.

Bruce: And that sounds like a really... It's an important strategic approach. We're getting close to the top of the hour. There probably are more questions and folks are sometimes shy about asking them over the line, so what we'll do... We'll be posting this webinar to the long-term care...long-term services and support website and also an opportunity there for folks to ask additional questions that we can route to the center. So we'll look for those questions and we'll

try to continue this conversation further after the session. I did want to mention something that Cynthia mentioned at the beginning which is that we have a long-term care, long-term services and support conference, a tribal long-term services and support conference in Denver, March 21st through the 23rd and it's an opportunity really to see programs from all over Indian country that are providing an array of services around long-term services and support - to ask the detailed questions about how they're doing it, what they're doing, and how they're doing it and how they're paying for it, who's coming and who's helping them, and you know how it all comes together. And a draft agenda is available on the website. Nicole, can you give us the web address for folks or I don't know if it's possible yet to post it on the slide or on the whiteboard just at the very end here so folks know where to go?

Nicole: Yeah. It is in the chat box for everyone to see.

Bruce: Perfect.

Nicole: And it has information on how to get to the site and the website has the agenda at-a-glance and it also has the webinar information where we will be posting the presentation of today's webinar within about one 24 hours.

Bruce: That's great. So it's www.Kauffmaninc.com/ltss. Thank you for that. And thank you to Theresa Piromalli, Karen Leekity, Dr. Kay Redman, Dr. Chris Bowannie from *** for sharing and to Cynthia LaCount for giving us the background introduction and I know we're all collectively welcoming Cynthia to her new role as Director of the American Indian and Alaskan Native and Hawaiian program at AOA, the Title VI program.

Cynthia: Thank you Bruce.

Bruce: Last word is to you Cynthia.

Cynthia: Last words to me. We'll see everybody in Denver on March 21st through the 23rd and this was a very exciting session. It's wonderful to hear what Zuni is doing. Thank you Zuni. I think the main point I want to drive home and will continually drive home is how many supportive services we are actually providing in Indian country and that our best ticket is going to be collaboration and coordination with all the programs we are already offering to provide long-term care for our seniors and for frail individuals. Thanks Bruce.

Bruce: Thank you with those final words. Thank you all. Keep your eyes out for future webinars and we'll see you all in Denver.

(End of Webinar - 56:35 - one participant still on the line after webinar ends.)

Pamela: Hello.

Nicole: Hello, do you have another question before you were going to get off the line?

Pamela: I did. My two questions were basically, does the Zuni program also provide respite vouchers for the caregiver for someone to actually come into their home with the respite?

Nicole: I was actually going to take your questions. I see them in the chat room and send them to Bruce, because I think he can answer those better than I can. Would that be all right?

Pamela: That sure will and you don't know whether or not this would be a conference that it would be good for an elder to attend to advocate back to their tribe if they don't have all these services to come and learn?

Nicole: I would think so. I'm not very familiar with the topic. I'm just helping to facilitate the call, but I think it would be beneficial; but again I think Bruce would be able to kind of give you more information regarding that.

Pamela: Okay.

Nicole: So I'll send this along. In fact, if you want to email me more information that way I can connect you two directly.

Pamela: ***.

Nicole: Okay. Sounds good.

Pamela: Okay and for some reason I didn't get the updated link for this webinar. I don't know what I need to do to make sure I get it for the next one.

Nicole: I'll put you on our list serve.

Pamela: Thank you.

Nicole: You're welcome. Alright. Well, if you have any other questions or concerns let me know. Again, my name is Nicole Condon and your information on how to contact us is also on the website.

Pamela: Okay. Well, I really enjoyed the presentation. Thank you.

Nicole: Thank you. Have a good day.

Pamela: You too. Bye-bye.

Nicole: Bye.

(End time 59:23.)