MICROFILM DIVIDER

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SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2403

2007 SENATE HUMAN SERVICES

SB 2403

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. **SB 2403**

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **January 30, 2007**

Recorder Job Number: **2235**

Committee Clerk Signature Mary K Monson

Chairman Senator J. Lee *opened the hearing on* ***SB 2403*** *relating to exemptions to the moratoriums on the expansion of basic care bed capacity and long-term care bed capacity.*

Testimony from Barbara Walz was presented but not covered. Listed as #6

Senator Richard Marcellais, District 9, Bellcourt - *In Favor*

ATTACHMENT # 1 *Covered Testimony*

S Erbele: How many beds are represented in that August retirement?

S Marcellais: The same amount of beds that are in my testimony.

S Erbele: 45?

S Marcellais: Right

S Lee: Has construction started on the facility?

S Marcellais: No

Representative Merle Boucher, District 9, - *In Favor*

ATTACHMENT # 2 – *Covered testimony*

S Lee: There is a fiscal note, but there is no fiscal impact.

R Boucher: There is no fiscal note, basically two key comments were made extends from 48 months to 72 months, reality is that would be a 24 month extension under current law.

There are 13,000-15,000 residents in Turtle Mountain community. When you look at the numbers you have more people, you have more people in elderly group by age numbers and population totals. Been in the community all my life, seen the needs that traditions have and the community, given a preference to take care of their family members in the home, but are situation where can't do it or have relatives close by to provide the care services. Have visited the Turtle Mountain Retirement Home which is where elderly live and there is a wide range of people there, called an "assisted living" arrangement to those who are in need of skilled care and it's really not available. In the population numbers of the area, one can easily justify for those kinds of services. Urge a strong recommendation as a DO PASS on this 24-month extension.

S Heckaman: Can you tell me where you are in the process of working on this, or someone else?

S Boucher: By my observation, one of the issues is to finalize the financial package and proceed with the plans. They have hired a management group to take care of management and do those kinds of things. There are a lot of things in progress, but they have encountered a number of obstacles.

Dawn Charging - District 4 - TM Band of Chippewa Indians - *In support*

[discussed the health care needs of the people] Diabetes is one of the largest killers and disease in our people. *Reads from a quote:*

"For a variety of reason, Native Americans have had historically shorter life expectancy, and have experienced earlier onset of chronic health care conditions. These factors bring elderly Native Americans to nursing home settings at younger ages than non-Indian individuals living in the same area."

It is quite an honorable intention for them to being doing this for their people. On our reservation, we have a million acres that are separated by the Missouri River and our elders have one or two options. One is to be in the home with someone unless the are no longer able to be cared for which requires nursing care. They end up in a swing-bed situation, or there are two nursing facilities in our region. Very often, it is not a culturally comfortably thing to do. They are outside their home and their family. One of the goals is to build a facility in their community, staffed by their people and maintain that comfort zone for their people all the way through the end of their life.

David Doc. Brien – Chairman of the TM Board of Chippewa - *In Favor*

ATTACHMENT # 3 HANDED OUT

Eide Bailey forecast on the 5-year feasibility financial forecast. Also feasibility study from March 2004. *Reads from Executive Summary to bring up some points.*

This is simply an attempt of our Indian Reservation, Turtle Mountain Band of Chippewa to serve its own people on its own land. Tribal members find it difficult for several reasons, one being economic, to travel to visit our elders in outside nursing homes.

S Lee: You don't have existing nursing homes that have vacancies?

D Brien: I don't have numbers, but there are 2 nursing homes in Rolette County.

S Lee: Are any of your members served by those nursing homes at this time?

D Brien: Yes

S Warner: The financing available by the end of the year which is 2007, this was written in 2006.

D Brien: This was written 1 or 2 months ago, I believe.

S Warner: You felt the financing should be at the end of February, which is next week.

D Brien: Yes, I had planned to have a letter of credit here this morning to attach to your packet, but don't have that.

S Erbele: Two questions: 15 basic, 45 long-term, that's 60, how soon would you see yourself being at capacity of reaching the 60?

D Brien: I would say, August of 2008.

S Erbele: Could you give a two sentence answer to email nursing home administrators that are emailing from my district saying, "Don't do this, 48 months is long enough, not fair to us." How do I answer those folks?

D Brien: I would say that all we're trying to do is serve our own people on our reservation. Our own elders, keeping our elders home, that's our goal. I know there are economic considerations that bring up reasons not to give us an extension.

S Warner: I know the reservation is very small, most of the community lives off the reservation, is that facility projected to be on the reservation?

D Brien: Yes, on the reservation property.

S Lee: I'm looking at the feasibility study that was done in March of 2004. In order to be competitive, page 2. *Reads from testimony.*

That statement is 180 degrees off from what you're telling us is what you really want to serve your own people, how are going to make sure that you have the beds for you to make this financially sustainable? You have to have a pretty high population.

D Brien: We have 30,000 tribal members nationwide. 10,000 of the members live in Rolette County. We're working to bring the members home with that effort.

S Lee: Will you be employing people outside of tribal members as needed? Will there be equal consideration given to all employees?

D Brien: Absolutely, the most qualified of course. If there are Federal dollars involved, we have to use the EDOC guidelines requirements, of course.

S Heckaman: I work on the Spirit Lake reservation in the schools there and I have some knowledge of the elders there that are living in private homes and the issues it creates for the families, in your band of Chippewa, will you be extending this to other bands of Indians.

D Brien: Yes, absolutely, whoever is in need. This is one piece of the cultural ways to support our elders and serve our people.

S Lee: On page 10, talking about shared services, "This project is dependent on shared services arrangements..." What kind of support is the tribe prepared to give to this until it does become self-sustaining, and what is your plan to make it self-sustaining?

D Brien: I can't point to any authorized or appropriate dollars at the Tribal level at this time, but can tell you that the tribe would; we have 175 general fund employees that serve at the digressional of the Tribal Council, we are prepared to mobilize those employees and pay their salaries to serve this institution. We have 800 employees in Rolette County in the Reservation, and 475 are under the direct supervision of the tribal government. 150 are paid directly through tribal coffers.

S Erbele: The beds expire on August of 2007, which means they were purchased 48 months back, in 2003. Can you describe the delays, why you weren't able to implement within 48 months, I'm sure the feasibility studies play a part in that. What other delays have you encountered?

D Brien: The primary department in our tribe in financing is the Tribal Planning Office. I'm observing that our tribal planning office is stretched to the limit. They have way more objectives and duties than they can accomplish. The lack of tribal planning and financial resources in management support we have, internally causes these projects to not get completed.

In reality, we should have the nursing home under construction right now, and be ready to be occupied this spring. Our financing is NOT locked down.

S Erbele: So, the Tribal Planning wasn't affective in this case, in a timely manner?

D Brien: There is the project now in terms of priority. This project is the top priority in the chairman's office and the tribal council. We are working with planning to make sure this is accomplished.

S Lee: We recognize the challenges to you. I hope you recognize the challenges to us. It has to be a good reason to proceed. We will give it appropriate consideration.

Cheryl Kulas - *In Neutral*

I want to testify as a tribal member, I will testify as a neutral position as commissioner of Indian affairs.

S Lee: Tell us which hat you're wearing and we'll mark you down twice.

Cheryl Kulas – *Neutral position first*

TESTIMONY # 4 –*Passed out Real Choices Cultural Model & Final Report Real Choices Systems Change Grant, Cultural Model, Olmstead Commission*

The Chippewa do have an elder care facility. An elder care congregate housing facility provides housing for a number of individuals who cannot live in apartments. They also have an assisted living facility as well. Important to note, the community has been dealing with this issue of care over a period of years.

We do understand at some point all of us are going to age and in the process aging, we need to offer a grant, the Indian Affairs Commission to apply to develop a Cultural Model. This is to help define what is important in a system of care for American Indians. Because the population is growing, the important piece is the number of key variables which are highlighted in red.

The last page, "Real Choices in Tribal Plans," we have plans that each of the communities organized an elders group. 13,000 enrolled members are overflowing to other communities as a growing population. The Native Americans in ND come home and stay home.

Cheryl Kulas background: Employee of the state for 17 years, 12 years in the Dept. of Public Instruction, 6 years as Commissioner of Indian Affairs. It has brought a whole different prospective to me. One of the reasons I left Dept. of Public Instruction, I had to spend a lot of time caring for my mother. *Her responsibility as an elder child is to care for her mother. Father is being cared for at home by the family members, speaks of challenges [43:26m]*

Important to provide a safe environment. Problems: living longer, higher rates of chronic disorders, diabetes. The document reflects that people stay in the community. *When caring for her mother, she had to find a place for her in Grand Forks, ND.* Important to provide care in our own community. The tribe has in reserve of $1 million for initial operation. The tribe is aware that they will not be able to stock that facility right away and have it fully staffed, but recruitment is the issue. There are enough people in this community.

S Lee: I've wrestled with same issues with my father and had to move him miles away to where the services WERE available. The background of the people may not be as important as the quality of care. I live in a community with lots of refugees and immigrants. Over 1,000 Muslims in our area. 30 – 40 languages and dialects being spoken in our schools. I understand what the speakers are saying about the cultural facility sensitive to the Native American culture, but what do we do when other cultures come? We will NEVER be within 100 miles of home. Why is your request more important than theirs might be?

C Kulas: The fact that tribal governments are sovereign, they have the right to define their care and it's a RIGHT they have. We hope it can be adapted into making materials available in communities that would make it a lot easier.

David Doc Brien: Wanted to respond to S. Lee's question: If other groups came forward and asked for an extension, I would say to them, "If you want to raise the money to build a building, and assemble the necessary management staff to care for your own people in your own home town, go for it."

S Lee: That is where in many cases Medicaid enters in. That is how can we balance the challenge?

D Brien: How do we balance the economic and the human? That's the challenge. The state should allow them to serve their own people no matter what the culture.

S Lee: We probably wouldn't care if there wasn't a price tag., that's the problem, and the daily costs of increasing the number of long-term care beds. It isn't that we're not sensitive and understanding to the issue, we're just trying to figure out how to pay the bill.

D Brien: Yes, I understand, within the needs of personal desires.

OPPOSITION

Shelly Peterson, Pres. Of the ND Long Term Care Association [NDLTCA] - ***In Opposition***

TESTIMONY # 5 *Covered testimony Explained attached handouts [60:00m]*

Recognized the need 73:30m

[74:34m] Brought up the bad debt issues. It relates to the culture. 4.7 million in outstanding debt in collections. The top issues, children or guardians not paying the bill, or late on recipient liability. Explains about "recipient liability." When we looked at the facility, we noted they need assistance, they don't have the resources in many situations. When a person thinks that they are Medicaid eligible and you go into the nursing facility (56-58%) that Medicaid is paying the bill. It's a myth that Medicaid pays the full bill. Whatever their income is, of the $3,000 you can have in the bank, you might have a burial account for when you die, but the income you receive has to pay the nursing home, and what you get is $50 out of the check that you can

keep for whatever you want, the remainder goes to the facility in recipient liability. some older people haven't understood that. In some cases, that check will support multiple families, and given warmly and shared. There is great reluctance to stay in the facility when they find out they can't keep their checks. Not being able to share your resources with your extended family is a big issue.

Also the issue on any tribal land owned by that older person; if you have any land in possession and issue a transfer of that land to other family members, so that they can be supported, is an issue on transfer issues. We need to do a lot more education on how to pay for long-term care. Medicaid pays the difference.

S Lee: I have a question on some facilities have under 90% occupancy. Can you tell me why Evergreen is in four different places?

S Peterson: We agree with you. The license them in four different individual facilities as opposed to one facility, and so we need to get the information from the Health Dept. and report it that way. It's how it's reported by the Health Dept., they are licensed as four separate facilities.

S Lee: In Morgan they have a secured facility for memory care.

S Erbele: In some facilities they are as low as 70% occupancy. How much of that is related to the shortage of staff VS shortage of patient population available?

S Peterson: The last thing you want to do is stop admissions, because you're stopping additional income from coming into the door, so you do that only as a last resort. In rural ND we see a lack of demand, the older people seem to be leaving the community, going to the urban centers, going to where their children live and getting care and services there. It is a combination. We have data on each facility. You never want to fall below 90%. Most of the issues would be related to occupancy. Staffing would be a part of the equation.

S Lee: I know a number of people have moved to the larger communities, not only because of adult children living there, but because of medical facilities being there, wasn't because someone told them to do that, it was something they were pleased to do.

I'm seeing a lot of Good Samaritan names on here, I know they are exploring developments of facilities in urban areas, would they look at transferring those beds within their system? They can do that, can't they?

S Peterson: Yes, they can do that. There is one in West Fargo that will be opening in 2007, Nov. The facility in projected in Bismarck, they have transferred 20 beds into Bismarck. It is their hope they will transfer in 40 more beds. Beds out of service are Crosby and Devils Lake. Sensitive issue taking beds out of rural ND and you consider closing a facility, like Good Sam in New Town it becomes a significant issue with the community. As the center closes, you recognize you'll get care and services out of town.

S Warner: A comment, I'm on the board of Newtown one and there was a huge amount of resistance at the time of closure and the conversion, but it's a wonderful facility now. It's sustainable, the excess space was converted into professional offices, there is a chiropractor in there now, I think some housing offices, the space has not gone to waste.

S Peterson: That was a very painful process for the community, and polarized people and it has been a very good ending to that transition.

CLOSED

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. **SB 2403 B**

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **January 30, 2007**

Recorder Job Number: **2327**

Committee Clerk Signature	Mary K Monson

Minutes:

Chairman Senator J. Lee brought the committee back to order to discuss SB 2403.

S Peterson: 55 nursing facility beds, they probably paid anywhere from $10,000 - $15,000 per bed, where the basic-care beds those are going on the market for about $1,000 a bed, so they've probably have expended ½ million to $700,000 to try and get the license, I would guess. Regarding getting their money back, if they're willing in the seller and willing-buying market, so they could put them on the market and resell those, however, whoever purchases those had the same 48 months, and if the tribe used everything except a few months, they only have a few months to put those beds in service also.

S Erbele: They'd have to have them sold by August?

S Peterson: They'd have to have them sold and in operation in the new site by August for the first deadline of beds to go off and then every so many in months thereafter. Requested a general clarifying, if every time you sell them a new provider, would they get 48 months, and the answer came back, "No." It's just a one time 48 months.

S Lee: Then they're lost forever.

S Peterson: They're lost forever, however there are a couple of entities that could put those into service if they sold them now. If they waited a month or two it would be less likely. Where

you may see it is where there is excess capacity. Theoretically, if a Bismarck hospital has excess capacity and could license and operate a nursing facility. Grand Forks is in dire need as well. Williston might also be in a position.

S Erbele: And the money is gone?

S Peterson: The way the money works is, it's an unallowable cost, so even though the tribe spent that money, they had to come up with funds from somewhere to purchase the beds and then the new entity that purchased the beds, you can't put that in your cost report, you have to come up with the money from some other source, Medicaid won't pay for those beds over. It has to be some resource.

S Lee: The extension from 24 for 48 months was made for the circumstance in the first place, so it isn't like this is new.

S Peterson: The agreement we had was, they are the ones that chose 48 months, and indicated that was more than efficient time.

S Lee: We aren't going to deal with that right now.

CLOSED

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. **SB 2403 C**

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **January 31, 2007**

Recorder Job Number: **2455**

Committee Clerk Signature	Mary K Monson

Minutes:

S Lee: Continue the discussion on 2403, which relates to the moratorium deadline being extended for the Turtle Mountain. This offers some challenges to other facilities in the area as we have discussed earlier, there are some other options that are available. What is the wish of the committee?

S Eberle: Moved for a **DO NOT PASS on SB 2403.**

S Dever: Second motion

Roll call on DO NOT PASS on SB 2403 – 4-2-0 Passed

Carrier: S Dever

FISCAL NOTE

Requested by Legislative Council
01/24/2007

Bill/Resolution No.: SB 2403

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2005-2007 Biennium		2007-2009 Biennium		2009-2011 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2005-2007 Biennium			2007-2009 Biennium			2009-2011 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill extends the amount of time that the Turtle Mountain Band of Chippewa Indians has, on basic care beds transferred before August 1, 2005, to meet state licensing requirements from forty-eight months to seventy-two months from the date of acquisiton.

This bill has no fiscal impact.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name:	Debra A. McDermott	Agency:	Dept of Human Services
Phone Number:	328-3695	Date Prepared:	01/24/2007

Date: 1-31-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2403

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Not Pass

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman		✓
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner		✓

Total (Yes) 4 No 2

Absent 0

Floor Assignment Senator Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2403: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2403 was placed on the Eleventh order on the calendar.

2007 TESTIMONY

SB 2403

A#1

Testimony
Senate Bill No. 2403 – relating to exemptions to the moratoriums of the expansion of basic care bed capacity
Human Services Committee
Senator Lee, Chairman
January 30, 2007

Chairman Lee, members of the Human Services Committee, I am Senator Richard Marcellais, from District 9, of Belcourt I am here today to provide you with testimony on behalf of the Turtle Mountain Tribe relating to exemptions to the moratoriums of the expansion of basic care capacity and long term care bed capacity.

The Turtle Mountain Band of Chippewa requests your assistance for a one-time, 24 month extension on SB 2404 for the Nursing Home Project. The tribe was allowed to participate in the long-term care initiative and purchased 45 long-term care bed licenses and 15 basic care bed licenses.

Under the terms issued by the State, some of the beds licenses are supposed to be retired into the State system in August 2007. With aggressive construction timelines, it will still be unlikely that the licensing procedures can be completed by August of 2007.

Staffing the facility will be obtainable, as our Tribe has many graduates in the medical field, with 90 plus currently enrolled, which 17 are seniors, graduating this year. Our medical and business graduates have stated that they are willing to staff the Nursing Home.

Thank you very much for the opportunity to appear in support of Senate Bill # 2403.

2403

A#2

TESTIMONY SB 2403
SENATE HUMAN SERVICES COMMITTEE
CHAIRPERSON – SENATOR JUDY LEE

Madame Chair Lee and members of the Senate Human Services Committee. For the record I am Representative Merle Boucher, a member of the House of Representatives from District Nine (9).

I appear before your committee this morning to express my support for Senate Bill 2403.

Subsection Four (4) of Section One (1) extends the amount of time that the Turtle Mountain Band of Chippewa Indians needs to complete its basic care facility.

Subsection Four (4) of Section Two (2) extends the amount of time that the Turtle Mountain Band of Chippewa Indians needs to complete their nursing facility.

The Turtle Mountain Band of Chippewa Indians have envisioned for a long time a facility that would provide basic care and skilled nursing services for their tribal members. They have encountered numerous obstacles. Yet, they have continued to persevere.

I am asking that this committee give careful consideration for a DO PASS on SB 2403 to allow them the opportunity to complete their project.

Thank you for your consideration. I am willing to respond to any questions you may have.

Respectfully submitted:
Merle Boucher, Minority Leader
North Dakota House of Representatives

2403

A#3

Turtle Mountain Band of Chippewa
Nursing Home Project

Executive Summary

The Turtle Mountain Band of Chippewa is in the completion process of establishing a nursing home facility for its elderly tribal members. There are significant demographic and cultural reasons why this facility is needed in this community. There are also significant challenges to developing this facility in this community, the primary challenge being poverty and lack of access to capital. The recent introduction of the New Market Tax Credit program (NMTC) by the Federal Government, as a means of injecting equity into low income communities, holds promise as a way to finally accomplish the development of this long term care facility, which has been a priority of the Turtle Mountain community for almost a decade. As stated under a moratorium issued by the State of North Dakota, the Tribe was allowed to participate in the long-term care initiative and began purchasing bed licenses.

Previous attempts at financing the facility involved application to the North Dakota USDA Rural Facilities program. Turtle Mountain requested a combination of direct and guaranteed loans for the construction of the facility. Upon provision of this application (which included a feasibility study) in 2004, additional information was required by the USDA, including an additional feasibility study. This second feasibility study was completed in November of 2005. The second study recommended a similar financing package with a combination of direct and guaranteed loans from USDA Community Facilities program. With the submission of this second application a third feasibility study was requested by USDA addressing issues of critical care which proved to be irrelevant to the project. Although USDA is aware of the time constraints we face, they are aggressively working with our Tribe to successfully complete this project in a timely fashion.

In July of 2006 a decision was made to also explore NMTC as a way to complete and expedite the project. Currently Turtle Mountain has developed an attractive financing package using NMTCs. The Turtle Mountain Tribe is determined to develop this facility and is optimistic that financing will be completed by the end of this calendar year. Here are some of the reasons for our optimism:

This project is the number one priority for the elders of this Tribe and our community is committed to completing this project; 2) Ground breaking is scheduled for Spring 2007; 3) Both feasibility studies have demonstrated results indicating that the facility will be self-sustaining and of great benefit to the Turtle Mountain Community; 4) The Tribe received a million dollar grant from the Shakopee Mdewakanton Sioux Community to purchase the necessary bed licensees, and have completed all architectural drawings for the facility, and further have secured an additional million dollar grant from Shakopee Mdewakanton needed to operate the facility; and 5) The NMTC financing structure will inject an additional 1.4 million dollars of equity into the project completing a very

A#3

attractive capital structure for the project, with Stearns Bank committing 4.7 million for this project; and 6) our Tribe has many graduates in the medical field (medical doctors, social workers, physical therapists, clinical psychologists, nurses, nutrition, and diabetic specialists) to fully staff the nursing home. The Tribe also has 90+ currently enrolled in the medical field, which 17 are seniors, graduating this year. Our Tribal members have stated that are very interested in fulfilling the positions needed for this project.

The Turtle Mountain Band of Chippewa is looking forward to closing the financing package of this project with USDA, and Stearns Bank by end of February 2007 to use the intended New Market Tax Credits.

At present time the Tribe has retained 45 long-term care bed licenses and 15 basic care bed licenses needed for the upcoming nursing home complex. Under the terms issued by the State, some of the beds licenses are supposed to be retired into the State system in August 2007. The Tribe is requesting a one-time extension for the bed license time line. The imminent closing on the financing package by the end of this year will lead to ground breaking for the facility in the spring of 2007. With aggressive construction timelines it will still be unlikely that the licensing procedures can be completed by August of 2007. Therefore the Tribe will be requesting a one-time 24 month extension to complete construction operations and licensing procedures.

POINT OF CONTACT:

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Executive Director
Tribal Planning & Economic Development Office
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Ablue62@aol.com (email)

#3

Turtle Mountain Care Center

A Feasibility Study
Presented by:
Health Management
Services, LLC.

March 2004

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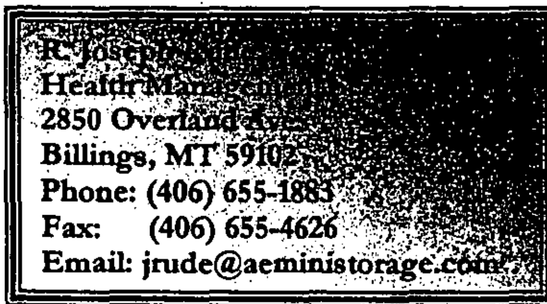
INTRODUCTION

This study analyzes the feasibility of constructing a 45-bed nursing home and 15-bed basic care facility in Belcourt, North Dakota near the Canadian Border. In June 2003, the Turtle Mountain Chippewa Tribe approached Health Management Services, LLC after examining the need for services for the elderly in the Turtle Mountain Reservation and the surrounding communities. This study is designed to test the demographic and financial feasibility of the 60-bed facility. The study will therefore examine both the needs of the Turtle Mountain Chippewa Tribe, the surrounding communities, as well as the current market's ability to respond to such needs. A critical aspect of this study will be positioning the facility to compete in the local market.

Belcourt is located about 10 miles south of the Canadian/ US border, and is the largest community on the Turtle Mountain Reservation, and is one of the largest communities in the county. Belcourt itself has no nursing home of its own, and the nearest facility is located in Dunseith. The Tribal Council of the Turtle Mountain band of Chippewa have retained the services of Health Management Services in assisting them in making a functional facility design that promotes quality care, operates affordably, and also to make the determination that the new facility could benefit the communities in and around the Turtle Mountain Reservation.

For questions or correspondence regarding this application, please contact: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Health Management Services (HMS) is a regional health care facility management and marketing consulting firm based in Montana. Past and present clients are from Idaho, Montana, North Dakota, South Dakota, New Mexico, and Wyoming. HMS is the single largest administrator of Native American nursing homes in the United States.

GOALS OF THE TURTLE MOUNTAIN CHIPPEWA TRIBE

The following three principles are guidelines established by the Turtle Mountain Chippewa Tribe as guidelines or goals used in the analysis of this feasibility study. The Chippewa Tribe has established a long-term care project for the Turtle Mountain area that will satisfy the following goals:

1. ***The Tribe* [illegible] *manner.***
2. ***The Tribe desires to cultivate job growth* [illegible] *around the Turtle Mountain Reservation.***
3. ***The Tribe desires to build a retirement complex that operates self sufficiently.***

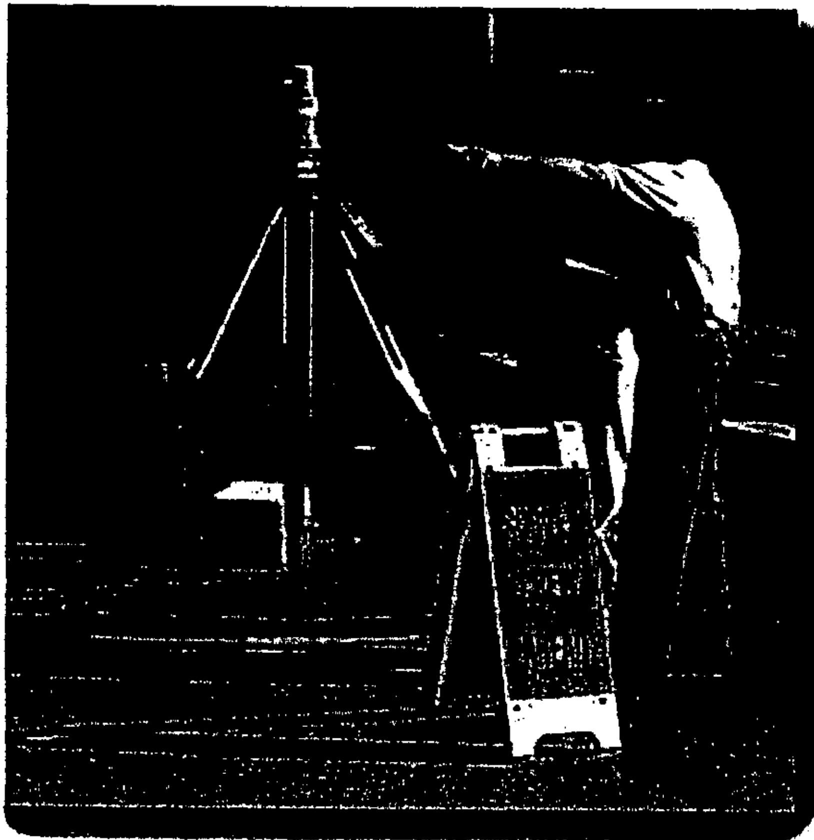
The proposed facility would be available to the elderly population of the entire service area, both Native American and non-Indian. The facility will be built to meet and exceed Federal and State Medicaid and Medicare regulations.[1]

This is a four-part study. Part one describes the market or service area for long-term elderly care in and around Belcourt, North Dakota. Part two is a description of the proposed facility and an analysis of estimated construction costs. Part three offers projected operational costs based on area research and data from comparable HMS facilities. This section will focus on the proposed facility in terms of staffing and financial feasibility. Finally, part four presents concluding considerations and recommendations.

[1] Because a primary source of payment for nursing home care is Medicare and Medicaid, a facility open to both Native American and non-Indian populations would require adherence to Federal and State Regulations concerning Medicare and Medicaid.

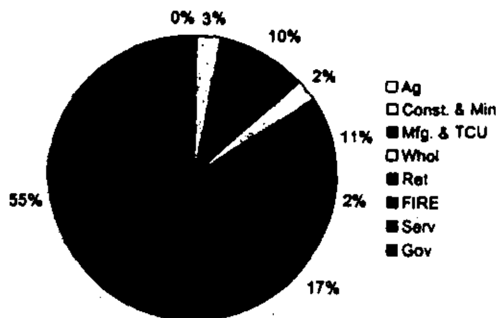
PART I: ASSESSING NEED

- Geographic Service Area
- Service Area Population
- Target Population
- Determination of Patient Need & Existing Health Care Services
- Final Assessment



GEOGRAPHIC SERVICE AREA

The proposed facility would serve elderly and chronically ill residents of Rolette, Towner, Pierce and Bottineau Counties (See Map of Service Area on page.7). These four counties are set in a scenic region of northern North Dakota that includes the *Turtle Mountain Indian Reservation, Turtle Mountains, International Peace Gardens, Lake Metigoshe State Park, and the Lake Metigoshe Ski Resort.* The Local economy is relatively independent and survives on the jobs provided by government, retail trade, and service industries. Services are the largest facet to the local economy in the counties surrounding Rolette. However, from within the target county we find that 55% of the population is supported by government jobs.



Currently, the largest employer in Rolette County is the Turtle Mountain Band Government. This is to say that the Federal Government is the largest employer both in the county and on the Reservation.

Page 7 shows the county maps of an area considered to be the primary service area for the larger project. The map also shows the reservation boundaries.

The principal communities that would be served by a new facility are located in Rolette, Towner, Pierce, and Bottineau Counties, as shown on the map. These communities include:

Rolla- Also called the "Jewel City," it is the county seat of Rolette, and is perfect for small town living. It is located 8 miles east of Belcourt just outside of the Turtle Mountain Indian Reservation on US highway 281. This town is host to recreational hunters in the fall and their annual International Ragtop Festival on the 3rd and 4th of July.

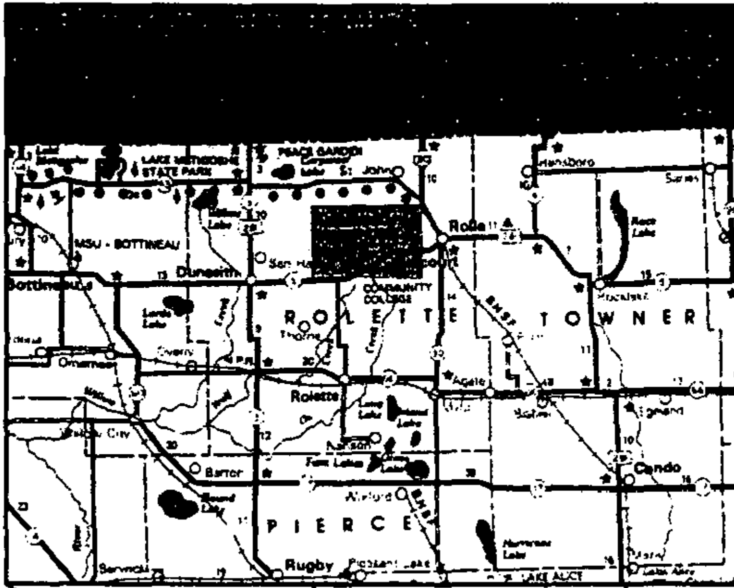
Rolette- A town with a population of approximately 700, many of the travelers in the Rolette area enjoy the use of the local golf course on their way to viewing the International Peace Gardens. The town of Rolla is accessible by its location on state route 66 or by air at the Rolette Airport with its 2,700 ft runway (fuel and tie downs available). Presentation Medical is the local health facility that services 48 licensed beds.

Belcourt- Located at the foothills of the Turtle Mountains. A progressive town on the Turtle Mountain Indian Reservation it keeps in harmony with the technically advancing world. In town are numerous art displays and sculptures created by the local artisans.

Dunseith- Is the "Gateway to the Peace Garden." It is located on the junction of Hwy. 281 and Hwy. 5, 41 miles north of Rugby. It is a short drive north to the world-famous Peace Garden. The area is full of year around activities with the summer being the busiest time.

Bottineau- On the eastern side of Bottineau County is the town of the same name. On state route 5 it is 40 miles west of Belcourt and is 30 miles south west of the International Peace Gardens. With its close proximity to the Lake Metigoshe recreational area it boasts fishing boating skiing, duck hunting and golfing among its available recreations.

MAP OF SERVICE AREA



SERVICE AREA POPULATION

The Turtle Mountain Indian Reservation lies entirely within the county of Rolette, which we have set as our main service area.

Table 1-General Population Data for Rolette County, All Ages[2]

County	2000	2001 Estimate	Percent Change
Rolette	13,675	13,745	.5%

Further estimates and projections for Rolette County can be drawn from its recent historical census reports. In comparing census data from 1990 and 2000, we find there was an overall increase for Rolette County of 7.1%. Other demographic facts for Rolette County and the data for Pierce, Towner, and Bottineau Counties can be found at www.census.gov. (See also Appendix 1). The largest minority population in Rolette County is Native American (73%). This holds true in Towner (2.1%), Pierce (.7%), and Bottineau (1.5%). The Native population in the four counties region is 10,230 which is 36.4% of the population in the service area, and more than 98% of the Native American population lives inside of Rolette County.

[2] Found at www.census.gov

TARGET POPULATION

Medicare and Medicaid require that any certified nursing home or basic care facility make their services available to all who qualify for such care, without regard to race, creed, age, payer source or economic status. While primary consideration would be given to the elderly in and around Belcourt, non-elderly individuals needing nursing home care will also be served as space provides.

For a variety of reasons, Native Americans have had historically shorter life expectancy and have experienced earlier onset of chronic health care conditions. These factors will bring elderly Native Americans to nursing home settings at younger ages than Non-Indian individuals living in the same area. In part, this complicates the exercise of forecasting bed need because the primary population served would be those age 60 and older Native American and other minority populations, and 65 and older Non-Indian Residents. These demographic groups in Rolette, Pierce, Towner, and Bottineau Counties will require a careful examination. Provided in Tables 2 and 3 are population data for those natives 60 and older as well as non-Indians 65 & older in each county. Native American population and the total population in the service area are used for this analysis.

Table 2: Rolette, Pierce, Bottineau, and Towner Counties Native American Population Age 60 and Over (2000 Census Report Data)

Age	Rolette	Pierce	Bottineau	Towner	Total
60-64	259	0	7	0	**266**
65-69	204	0	0	3	**207**
70-74	114	0	13	2	**129**
75-79	132	0	0	6	**138**
80-84	79	0	0	0	**79**
85+	44	0	0	0	**44**
Total	**832**	**0**	**20**	**11**	**863**

The total elderly (60+) Native American population in the four-county area is 863, nearly 1/3 of which are between the ages of 60-64.

Table 3: Rolette, Pierce, Bottineau and Towner Counties Total Population Age 65 and Over (2000 Census Report Data)

Age	Rolette	Pierce	Bottineau	Towner	Total
65-69	418	238	372	144	**1172**
70-74	433	259	323	150	**1165**
75-79	317	223	316	143	**999**
80-84	177	168	217	102	**664**
85+	159	232	289	134	**814**
Total	**1504**	**1120**	**1517**	**673**	**4814**

Adding the Native American population at risk between the ages of 60-64, the target population becomes 5080. Of that population, 2477 are over the age of 75, or 51% of the entire elderly population. It is important to note that the population above has the age of 75 greatest needs for long-term care services.

There exist others portions of the population that are more difficult to identify as potential users. These include younger adult who require the use of these types of facilities as a result of chronic conditions such as MS, MD, traumatic brain injuries, spinal injuries, strokes, etc. Commonly, Nursing Homes and Basic care Facilities have some percentage of its population made up of younger adults due to these conditions. That number will vary more by service offerings at the facility, than by specific characteristics of the population. Often these clients require more therapies and are regarded by the industry as heavy care. For the purposes of this study they are not included in our customer base because it is difficult, if not impossible to predict the number of clients in these categories.

DETERMINATION OF PATIENT NEED/EXISTING HEALTH CARE SERVICES

In the current long-term care industry, determination of need for long-term elderly care is based on national data. Nationally, about 10% to 12% of the elderly population relies on long-term care services such as nursing home, basic care, home and community care, or home health care. In the 1970's, laws required states to regulate health care growth through a Certificate of Need (CoN) Program. This federally mandated program used a formula that estimated 10% of the elderly population would live in nursing homes. Since most states have dropped their CoN programs. A number of alternate care settings have been developed. Utilization has changed and varies from one location to another depending upon what alternative services are available.

In addition to Health Management Service's determination of need in the elderly population for long-term care, other studies have utilized different formulas for determining need. A report by the National Academy for State Health Policy in 2000, found that the number of people over 75 occupying nursing home beds is 117 per thousand or 12%[3]. This estimate is higher than HMS' own estimate because it begins its assessment after the age of 75. Adding in the population from 65-75 needing long-term care would bring this estimate down. Another report (Long-Term Care: A Single Entry Point for Three Populations, State of Hawaii. 1995) estimates about 6% of the elderly population is in need of long-term care.[4] On the Hawaii report it is important to note that they consider home and community care in their assessment of demand. These percentages are merged with population data from Rolette, Piece, Towner and Bottineau Counties and the bed availability in the area to show alternative calculations of bed need. The table on the following page compares separate formulas of determining need for long-term care in the elderly population. Estimates range from conservative to liberal.

[3] Available: For additional information contact www.nahp.org

[4] Available: www.hawaii.gov/lrb/ltc/ltccp3.html

Table 4: Bed Need Estimates

	Total Population, In the Four County Area At Set Demographic	**Long-Term Care Formulas / Estimated Need**	**Bed Availability / Bed Need (Estimated Need – Bed Availability)**
NASHP report (Over 75)	2477	12% / 297	227 / 70 [5]
LTC: Single entry point (Over 65)	4814	6% / 289	227 / 62 [6]
HMS estimates (Over 65 plus 60-64 Native American)	5080	5% / 254	227 / 27 [7]

About 5% of the population over 65 (over 60 for Native American and other minority populations) require the services of a nursing home or basic care facility. Table 5 shows these numbers:

Table 5: Patient Need

Population Segment	Patient's Needing Services
Native American	44
Non-Indian Population	210
Total Population	254

Based on these calculations, the number of patients in the area who require care is approximately 254, including an estimated 44 beds Targeted to serve the Native American population. In July, only 227 beds were available in the area. Four long-term care facilities are presently available in the four-county region, located in Bottineau, Dunseith, Rolette, and Cando. Table 6 lays out the bed availability of these facilities.

[5] This figure represents Nursing Home beds only. It did not predict Basic care bed need.

[6] This figure identifies total need for long term care in all settings, including Home and Community Care.

[7] Based on data from experience in the Northern Great Plains Native Populations.

Table 6: Existing Facilities in the Service Area[8]

Nursing Homes	Bed Availability
Dunseith Community Nursing Home, Dunseith	42
Presentation Medical, Rolette	48
Good Samaritan, Bottineau	81
Towner County Living Center, Cando	56
Total	**227**

In the current long-term care market, approximately two thirds of the beds used by the elderly population are nursing home beds, the remaining third are basic care beds. This use pattern is fairly consistent with national trends. Future development will most likely favor the creation of more basic care facilities.

As the current need in the service area population is 27(including Basic care)[9] to 70 (nursing home only)[10], the new facility proposed by the Chippewa Tribe, 45 nursing home beds and 15 basic care beds, would adequately meet the needs.

It is the understanding of HMS that the bed licenses will be acquired by the Turtle Mountain Tribal council. It has been their assurance to us that all of the bed license needs will be facilitated in a timely manner.

The following provides summary information about other long-term care facilities in the service area. These are currently serving the needs of the elderly in Rolette, Bottineau, Pierce, and Towner Counties. These facilities may be affected by the proposed project. Some of the facilities will compete directly with the Turtle Mountain Reservation Care Center and others will be referral sources.

[8] Heart of America Nursing Facility not included in bed count due to nominal Native populations in Pierce county

Westhope Home not included in bed count due to its proximity.

[9]. HMS approach, see above table

[10]. NASHP approach, see above table

Nursing Home and Basic care Facilities:

- **Bottineau Good Samaritan Center.**
  -Administrator: Terry Goehring
  -Additional Amenity: none
  -Number of Beds: Currently 81
  -Last Renovation: 1993

- **Dunseith Community Nursing Home.**
  -Administrator: Eloise Gutzke
  -Additional Amenity: none
  -Number of Beds: Currently 50 Cutting to 42
  -Last Renovation: 1980

- **Towner County Living Center.**
  -Administrator: Timothy Tracy
  -Additional Amenity: Basic Care Unit, Independent Living Center, Drug and Alcohol Rehab.
  -Number of Beds: Currently 60 Cutting to 56
  -Last Renovation: 1999 complete renovation

- **Presentation Care Center.**
  -Administrator: Kimber Wraalstad
  -Additional Amenity: none
  -Number of Beds: Currently 48
  -Last Renovation: 15 years ago.

In Home Care:

- **Trinity Hospitals Home Health.** Operates in Towner County with one nurse. Had 16 patients in the past year. Their operations are minimal and most of their referrals in that area go to Prairieland home care.

- **Prairieland Home Care.** Runs typical in home long-term care throughout the four county service area.

- **Mercy Home Care.** Towner County operations only. Their patients are short term

patients that are referred to them after surgery or other traumas. They are not a long term care provider.

- **Altru Home Services.** Altru has three major care areas: In home, Hospice, and Specialty care. They do not operate in Towner County.

While these several health care outlets operate in the Turtle Mountain region, a gap in skilled nursing home and basic care still exists in the area.

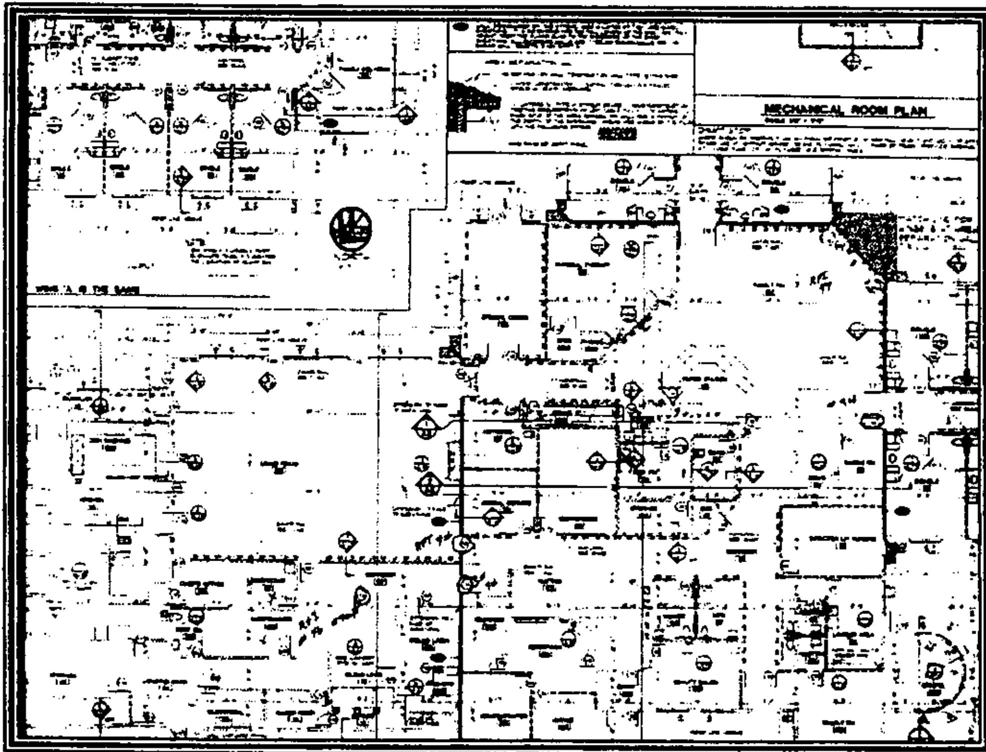
FINAL NEEDS ASSENSSMENT

Using the various approaches to determine bed need, this analysis shows that the level of elderly target population is currently available to result in good utilization of the proposed facility. It is important to note that the combined Native American and non-Indian populations needing services is necessary for the proposed 60-bed facility. Because of the current gap in the surrounding market, HMS believes that the Turtle Mountain Band of Chippewa Indians could successfully build and operate the proposed new facility. The key to making this project work will be the Tribe's ability to position the facility to relocate their elderly community. It will be necessary for the tribe to market to there own elders currently residing off the reservation in nursing homes form the surrounding areas.

The balance of this study addresses the proposed facility's detail, the availability of staff, and the projected financial performance of the facility.

PART II: PROJECT DESCRIPTION

- Design Details
- Financing Construction Costs



FACILITY DETAILS

HGFA Architects have been selected to produce a draft design of the new facility. A drawing concept for an existing facility has been included to show a concept similar in design to the proposed construction project. (Please see Figure 1). The facility is designed as an axel-spoke concept. The nurses station is an axel or center of the facility with the patient and administrative areas designed as spokes radiating out from the center. The administrative area is located at the front of the building to greet visitors and provide a buffer to the nursing staff. This location of administration and entrance helps reduce interruptions and facilitating a smoother flow for the nursing staff.

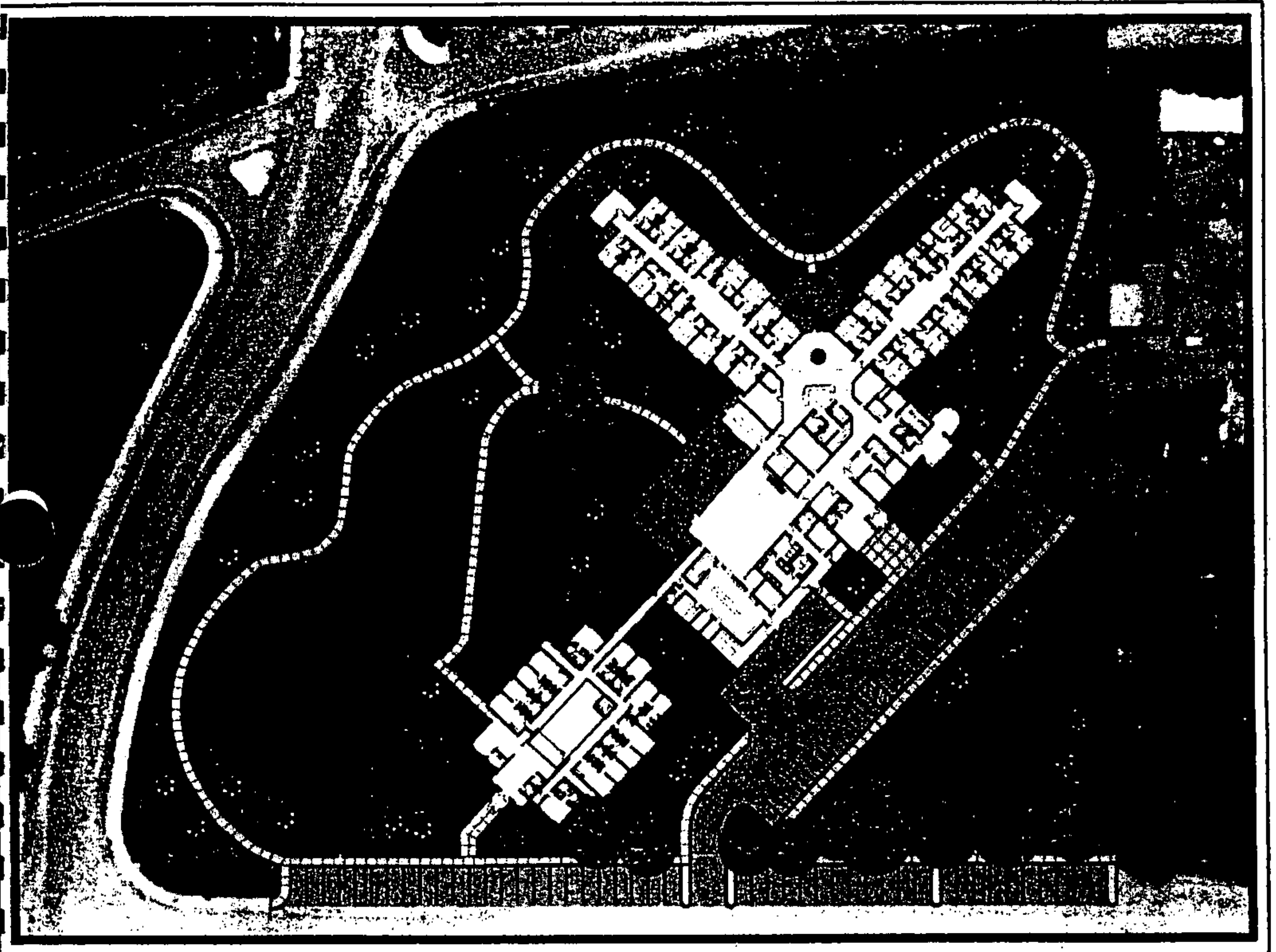
The basic care facility is located adjacent to the dining area so the two facilities can easily share the dining facilities. This location also allows for easy sharing of laundry and house keeping services.

This table below detail square footage breakdown according to the drawings.

Table 7: Square Footage of Major Units

Nursing Home	27,500 sq. ft.
Basic care Complex	7,500 sq. ft.
Total Complex	**35,000 sq. ft.**

FIGURE 1: SAMPLE SITE PLAN FOR THE PROPOSED FACILITY AND SCHEMATICS (FOLLOWING PAGES)



FINANCING CONSTRUCTION COSTS

Cost

At $115 to $125 per square foot, HMS anticipates the nursing home portion of the facility to cost approximately $3,300,000. For the basic care portion of the facility HMS expects the cost to be approximately $115 to $125 per square foot, or $900,000. The total project construction cost of $5,500,000 will be necessary for the nursing home and basic care facility. This estimate includes architectural and engineering fees, land and site improvement costs, and movable equipment costs. Table 10 lays out these estimates. This total includes architectural and engineering fees. Any additional spaces, such as clinics and dialysis, units or child day care will be built at similar cost and priced for rental to occupants at market value. These costs are not considered in this study.

Table 9: Estimated Project Costs (Based on $120 per square foot)

Costs	
Nursing Home Construction	$3,300,000
Basic care Facility Construction	$1,000,000
Architectural and Engineering Fees	$500,000
Furnishings and Equipment	$500,000
Movable Equipment	$200,000
ESTIMATED TOTAL PROJECT COST	**$5,500,000**

Pages 20-22 show the design concept that was used to provide these estimates for construction. This drawings show separation between the basic care facility and the nursing home, but allows for shared services by attachment to the nursing home. This concept is not a final schematic. This design requires approximately a five-acre site (roughly 480 ft. x 480 ft.).

PART III: A NEW FACILITY

- Human Resources
- Operational Costs

HUMAN RESOURCES

The following is a summary of the key employees required to operate the facility. Based upon our review of the service area, local recruitment will be sufficient. The most critical group to consider will be the nursing staff. A review of area resources show that nurses are trained in the local area. This will help in the development of staffing patterns.

Administrative Staff

A new facility would require an administrator licensed in the state of North Dakota. An individual for this position should be sought from in or around the Turtle Mountain Area. If the position cannot be filled through a local search, usually a national or regional search will be necessary. In addition to an administrator, a full time bookkeeper and receptionist will be needed.

Nursing Staff

As in all nursing home and basic care facilities, the nursing staff requires appropriate qualifications. A new 60-bed facility would require about five to six licensed positions, including a registered nurse to act as director of nurses (RN), three Licensed Practical Nurses (LPN) and more than 20 Certified Nursing Assistants (CNA).

Maintenance Staff

The head of maintenance position usually requires a low-pressure boilers license and experience with general maintenance and repair. A facility of this size may require an assistant who could deal with grounds maintenance activity.

Dietary Staff

The dietary staff would require a certified dietary manager, as well as, cooks and dietary assistant staff appropriate to the census of the two facilities. Normally, it will take 7 people to fill the nearly 5 FTEs in the dietary department. As a general rule, the addition of a basic care facility to a nursing home only adds minimally to the dietary staff.

Nurse Trainer

Key to a stand alone Nursing Home will be a staff development/trainer position to train CNAs and provide general orientation as well as continuing education to the entire staff.

Social Services

For each 90 licensed beds in the nursing home, a Social Services Director is required. In order to make this position full time, facilities will include marketing and intake responsibility as a part of this job description.

Activity Department

The nursing home will require a full time Activity Director. A full time activity assistant is also necessary to meet the needs of the Basic care Facility.

Total Staffing Requirement

About 45 individuals would be needed to adequately staff for the two facilities. These positions would require training that could occur on-site. (For a summary of staffing patterns see appendix 4.)

Training and Educational Resources

Several training and educational resources are near the four-county area, including Belcourt Community College, MSU Bottineau, Minot State University, UND Lake Region near Devils Lake. These resources could be utilized as recruitment centers for new staff.

Availability of Labor

In the state of North Dakota there is 3.0% unemployment with a labor force of 345,293. The 1999 Indian Labor Force Report found 65.46% of Native Americans residing within the Turtle Mountain area are unemployed. Pierce County unemployment rate is 2.7 % with a labor force of 2,661. Rolette County unemployment rate is 12.6% with a labor force of 5,738. Bottineau County unemployment rate is 4.0% with a work force of 3,358. Towner County unemployment rate is 3.1% with a work force of 1,305.

PROJECTED CENSUS & OPERATING COSTS

Projected Census Figures:

The assumption that a new facility would target a larger service area that includes Pierce, Rolette, Bottineau and Towner County, Is central to our analysis of financial feasibility. Making a new facility competitive and profitable requires a strong commitment to maintaining a high census.

The following census data is estimated. In the table below, data shows an average census of 13 residents in the nursing home after the first year of operation. This projection is based on an average census, beginning with 3 residents at the start of the year and ending with 20 residents at the close of the year. Average yearly census would increase each following year. Census patterns for the basic care facility should be similar.

Table 10: Census

CENSUS	Year 1	Year 2	Year 3
Nursing Home	13	27	38
Basic Care	3	8	13

Projected Revenue and Expenses:

As noted above, the proposed facility should be at near capacity census by the end of the third year. The following tables lay out the expected revenues and expenses that would be generated by the proposed facility. While performance may vary, with quality management and rigorous marketing a new facility could be profitable by the third year (Tables 11 and 12). The loss in the first two years (revenue minus expense) reflects the necessary tribal subsidy for successful operation.

Table 11: Projected Revenue for a 60-bed Facility[11]

REVENUE:	Year 1	Year 2	Year 3
Nursing Care	$768,538.25	$1,586,345.64	$2,203,156.39
Basic Care	$69,193.74	$185,274.30	$278,836.50
TOTAL REVENUE	$837,731.99	$1,771,619.94	$2,481,992.89

Table 12: Projected Expenses for a 60-bed Facility

EXPENSES:	Year 1	Year 2	Year 3
Nursing Care	$1,670,765.46	$1,919,885.78	$2,086,441.28
Basic care	$83,227.59	$85,775.92	$88,274.25
TOTAL EXPENSES	$1,753,993.05	$2,005661.70	$2,174,716.53
Net Operating Income	**($916,261.06)**	**($234,041.76)**	**$307,276.36**

Operating expenditures are based on staffing requirements by HCFA and the State of North Dakota to operate a Medicare/Medicaid Certified facility. These requirements include a full-time Director of Nursing (DON), at least 8 hours per day of Registered Nurse (RN) staffing, and two eight hour shifts of Licensed Practical Nurse (LPN) staffing. Staffing by Certified Nursing Assistants (CNA's) would be a function of census. Increase in staffing, in all shifts, would also be a function of census, growing as the number of residents grows. The actual staff patterns will depend on the acuity of the residents in the Nursing Home. Both Medicare and Medicaid rates improve with an increase in resident acuity. Other staffing would include a full-time administrator, a full-time dietary manager, and a Resident Care Coordinator.

Staffing efficiency improves dramatically with increases in census. The planned co-location of the Nursing Home, Basic care Facility provides for the sharing of administration, kitchen maintenance, house keeping and laundry staff.

[11] Projected financial performance is based on data from other Native facilities under HMS management.

PART IV: A VISION FOR LONG-TERM CARE SUCCESS

•Conclusions and Recommendations

CONCLUSIONS AND RECOMMENDATIONS

The following five points summarize the findings of this report. It is important to remember that the Tribe has specific goals that it intends to achieve with this project. We are confident that the project meets their goals and does so in a financially feasible way.

1– Attaining Goals

The proposed facility can meet the goals set down by the Tribe. The current design provides a framework by which compassionate care for the elderly can be provided, economic stimulation can occur, growth in the Belcourt area, and the creation of a profitable facility can all be met.

2 – Being Competitive

A new facility will be most successful if it is able to compete with other long-term care resources in the area. In order to do this, the facility should be designed and marketed in such a way that it will attract people from outlying areas.

3 – Startup and Perseverance

During a startup phase, the Tribe needs to take steps that would prepare it to financially subsidize the start up and operation of the new facility until it breaks even. It is reasonable to assume that up to 30 months of support may be necessary.

4 – Shared Services

This project is dependent on the shared service arrangements discussed in this project to make the new facility successful. The arrangement of dietary, laundry, custodial, and other services has not been finalized. If a final arrangement is not made concerning these issues, the Tribe may spend a longer period of time subsidizing the start up of this operation.

5 – Management

Finally, the Tribe should seek and secure competent management for a new facility with extensive experience in Native American long-term care.

Turtle Mountain
Budget Packet

30 year loan 5%

	January	February	March	April	May	June
Nursing Home Income:						
701.00 Private	$ 8,285.68	$ 7,447.88	$ 9,554.64	$ 10,884.71	$ 12,633.06	$ 12,024.24
701.01 Medicare	$ -	$ 1,199.04	$ -	$ -	$ -	$ -
701.02 Medicaid	$ 65,509.16	$ 61,393.48	$ 78,582.08	$ 75,560.87	$ 86,518.60	$ 83,928.98
Total Nursing Home Income	**$ 73,794.84**	**$ 70,040.40**	**$ 88,136.73**	**$ 86,445.58**	**$ 99,151.66**	**$ 95,953.22**
Basic Care Income:						
Medicaid	$ 6,554.64	$ 6,131.76	$ 8,193.30	$ 7,929.00	$ 9,831.96	$ 9,514.80
Total Basic Care Income	**$ 6,554.64**	**$ 6,131.76**	**$ 8,193.30**	**$ 7,929.00**	**$ 9,831.96**	**$ 9,514.80**
TOTAL INCOME	**$ 80,349.48**	**$ 76,172.16**	**$ 96,330.03**	**$ 94,374.58**	**$ 108,983.62**	**$ 105,468.02**
Expenses:						
Total Nursing Management	$ 6,311.46	$ 5,737.69	$ 6,598.34	$ 6,311.46	$ 9,146.77	$ 10,017.89
Total Patient Care	$ 46,686.85	$ 43,697.05	$ 47,337.85	$ 45,821.95	$ 48,268.21	$ 46,722.30
Total Housekeeping	$ 1,663.76	$ 1,556.42	$ 1,700.96	$ 1,646.09	$ 1,725.76	$ 1,670.09
Total Activities	$ 1,631.69	$ 1,484.82	$ 1,714.48	$ 1,640.69	$ 1,578.66	$ 1,719.52
Total Dietary	$ 9,900.31	$ 9,223.18	$ 10,603.47	$ 10,244.80	$ 10,858.76	$ 10,726.86
Total Laundry	$ 1,614.80	$ 1,605.20	$ 1,644.56	$ 1,638.80	$ 1,664.40	$ 1,658.00
Total Maintenance	$ 11,407.70	$ 12,595.40	$ 11,295.94	$ 8,626.70	$ 9,306.28	$ 8,630.68
Total Medical Records	$ 60.45	$ 56.55	$ 72.54	$ 70.20	$ 80.60	$ 78.00
Total Social Services	$ 1,898.28	$ 1,729.14	$ 1,984.42	$ 1,899.78	$ 1,817.11	$ 1,985.26
Total Administrative & General	$ 20,271.30	$ 20,268.27	$ 20,313.55	$ 20,364.56	$ 20,223.71	$ 20,206.26
Total Employee Benefits	$ 16,801.29	$ 16,281.62	$ 16,892.94	$ 16,632.96	$ 17,177.32	$ 17,213.56
Total Interest and Depreciation:	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00
Total Expenses	$ 152,397.89	$ 148,385.34	$ 154,309.05	$ 149,048.00	$ 155,997.57	$ 154,778.41
NET PROFIT/LOSS	**$ (72,048.41)**	**$ (72,213.18)**	**$ (57,979.02)**	**$ (54,673.42)**	**$ (47,013.95)**	**$ (49,310.39)**

Tu[illegible]ntain
Budget Packet

30 year loan 5%

	July	August	September	October	November	December
Nursing Home Income:						
701.00 Private	$ 1,733.98	$ 3,289.14	$ 4,893.11	$ 6,310.05	$ 7,440.00	$ 7,381.23
701.01 Medicare	$ 246.85	$ 462.85	$ -	$ -	$ -	$ -
701.02 Medicaid	$ 13,161.52	$ 21,599.62	$ 33,672.05	$ 43,588.03	$ 54,586.24	$ 56,651.16
Total Nursing Home Income	**$ 15,142.35**	**$ 25,351.60**	**$ 38,565.16**	**$ 49,898.08**	**$ 62,026.24**	**$ 64,032.38**
Basic Care Income:						
Medicaid	$ 1,638.66	$ 3,277.32	$ 3,171.60	$ 3,277.32	$ 4,757.40	$ 4,915.98
Total Basic Care Income	**$ 1,638.66**	**$ 3,277.32**	**$ 3,171.60**	**$ 3,277.32**	**$ 4,757.40**	**$ 4,915.98**
TOTAL INCOME	**$ 16,781.01**	**$ 28,628.92**	**$ 41,736.76**	**$ 53,175.40**	**$ 66,783.64**	**$ 68,948.36**
Expenses:						
Total Nursing Management	$ 5,237.43	$ 4,782.00	$ 5,009.71	$ 5,237.43	$ 5,737.69	$ 6,598.34
Total Patient Care	$ 27,967.49	$ 30,860.98	$ 35,747.23	$ 42,280.27	$ 44,418.01	$ 45,887.11
Total Housekeeping	$ 1,514.96	$ 1,539.76	$ 1,526.09	$ 1,601.76	$ 1,586.09	$ 1,638.96
Total Activities	$ 1,658.68	$ 1,522.86	$ 1,604.69	$ 1,684.72	$ 1,479.42	$ 1,695.88
Total Dietary	$ 7,487.97	$ 7,743.26	$ 8,234.80	$ 8,941.87	$ 9,079.69	$ 9,564.97
Total Laundry	$ 1,495.76	$ 1,515.60	$ 1,542.80	$ 1,565.20	$ 1,590.80	$ 1,594.96
Total Maintenance	$ 7,793.48	$ 9,196.35	$ 8,039.81	$ 9,788.33	$ 9,932.21	$ 11,019.70
Total Medical Records	$ 12.09	$ 20.15	$ 31.20	$ 40.30	$ 50.70	$ 52.39
Total Social Services	$ 1,975.12	$ 1,807.81	$ 1,893.78	$ 1,979.46	$ 1,728.24	$ 1,981.32
Total Administrative & General	$ 18,831.48	$ 18,675.71	$ 23,881.98	$ 18,801.25	$ 20,331.84	$ 20,251.90
Total Employee Benefits	$ 13,804.73	$ 13,958.19	$ 14,584.58	$ 16,291.41	$ 16,406.93	$ 31,839.13
Total Interest and Depreciation:	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00
Total Expenses	$ 121,929.19	$ 125,772.65	$ 136,246.68	$ 142,361.98	$ 146,491.61	$ 166,274.66
NET PROFIT/LOSS	**$ (105,148.18)**	**$ (97,143.73)**	**$ (94,509.92)**	**$ (89,186.58)**	**$ (79,707.97)**	**$ (97,326.30)**

T[illegible] Mountain
Budget Packet

30 year loan 5%

		Year July '03-June '04	
Nursing Home Income:			
701.00	Private	$ 91,877.71	
701.01	Medicare	$ 1,908.74	
701.02	Medicaid	$ 674,751.80	
Total Nursing Home Income		$ 768,538.25	
Basic Care Income:			
	Medicaid	$ 69,193.74	
Total Basic Care Income		$ 69,193.74	
TOTAL INCOME		$ 837,731.99	
Expenses:			
Total Nursing Management		$ 76,726.21	$ 15.95
Total Patient Care		$ 505,695.30	$ 105.16
Total Housekeeping		$ 19,370.67	$ 4.03
Total Activities		$ 19,416.09	$ 4.04
Total Dietary		$ 112,609.96	$ 23.42
Total Laundry		$ 19,130.88	$ 3.98
Total Maintenance		$ 117,632.57	$ 24.46
Total Medical Records		$ 625.17	$ 0.13
Total Social Services		$ 22,679.72	$ 4.72
Total Administrative & General		$ 242,421.81	$ 50.41
Total Employee Benefits		$ 207,884.67	$ 40.11
Total Interest and Depreciation:		$ 409,800.00	$ 85.22
Total Expenses		$ 1,753,993.05	$ 364.73
NET PROFIT/LOSS		$ (916,261.06)	

Turtle Mountain
Budget Packet
Year 2

Census

Historical Facility Census

	July	August	September	October	November	December	January	February	March	April	May	June
3 Yrs. Previous	0	0	0	0	0	0	0	0	0	0	0	0
2 Yrs. Previous	0	0	0	0	0	0	0	0	0	0	0	0
Previous Year	3	5	8	10	13	13	15	15	18	18	20	20

	July	August	September	October	November	December	January	February	March	April	May	June
Projected Census	21	22	23	24	25	27	28	29	30	31	32	33

Turtle Mountain
Budget Packet

30 year loan 5%

	January	February	March	April	May	June
Nursing Home Income:						
701.00 Private	$ 15,466.60	$ 14,399.24	$ 15,924.40	$ 18,745.89	$ 20,212.89	$ 19,840.00
701.01 Medicare	$ -	$ 2,318.14	$ -	$ -	$ -	$ -
701.02 Medicaid	$ 122,283.77	$ 118,694.06	$ 130,970.14	$ 130,132.61	$ 138,429.76	$ 138,482.81
Total Nursing Home Income	**$ 137,750.37**	**$ 135,411.44**	**$ 146,894.55**	**$ 148,878.50**	**$ 158,642.66**	**$ 158,322.81**
Basic Care Income:						
Medicaid	$ 16,386.60	$ 15,329.40	$ 18,025.26	$ 17,443.80	$ 19,663.92	$ 19,029.60
Total Basic Care Income	**$ 16,386.60**	**$ 15,329.40**	**$ 18,025.26**	**$ 17,443.80**	**$ 19,663.92**	**$ 19,029.60**
TOTAL INCOME	**$ 154,136.97**	**$ 150,740.84**	**$ 164,919.81**	**$ 166,322.30**	**$ 178,306.58**	**$ 177,352.41**
Expenses:						
Total Nursing Management	$ 9,868.04	$ 8,970.94	$ 10,316.58	$ 9,868.04	$ 9,419.49	$ 10,316.58
Total Patient Care	$ 56,025.07	$ 52,635.81	$ 57,293.22	$ 55,666.18	$ 57,727.22	$ 57,846.99
Total Housekeeping	$ 2,630.34	$ 2,472.24	$ 2,655.14	$ 2,581.49	$ 2,679.94	$ 2,605.49
Total Activities	$ 1,727.32	$ 1,576.52	$ 1,808.54	$ 1,734.76	$ 1,668.42	$ 1,815.74
Total Dietary	$ 12,800.20	$ 12,128.88	$ 13,298.06	$ 13,052.85	$ 13,548.54	$ 13,537.31
Total Laundry	$ 1,743.76	$ 1,735.12	$ 1,763.60	$ 1,763.60	$ 1,783.44	$ 1,782.80
Total Maintenance	$ 11,463.32	$ 12,645.96	$ 11,354.09	$ 8,682.32	$ 9,359.37	$ 8,688.83
Total Medical Records	$ 112.84	$ 109.33	$ 120.90	$ 120.90	$ 128.96	$ 128.70
Total Social Services	$ 1,961.96	$ 1,787.82	$ 2,050.00	$ 1,963.20	$ 1,877.64	$ 2,051.20
Total Administrative & General	$ 20,326.92	$ 20,318.83	$ 20,371.69	$ 20,420.18	$ 20,276.80	$ 20,264.40
Total Employee Benefits	$ 18,215.62	$ 17,593.47	$ 18,432.51	$ 18,118.73	$ 18,217.95	$ 18,452.10
Total Interest and Depreciation:	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00
Total Expenses	$ 171,025.39	$ 166,124.92	$ 173,614.34	$ 168,122.26	$ 170,837.77	$ 171,640.15
NET PROFIT/LOSS	$ (16,888.42)	$ (15,384.08)	$ (8,694.54)	$ (1,799.96)	$ 7,468.80	$ 5,712.26

Turtle Mountain
Budget Packet

30 year loan 5%

		July	August	September	October	November	December
Nursing Home Income:							
701.00	Private	$ 12,137.85	$ 14,472.20	$ 14,067.68	$ 15,144.11	$ 14,307.69	$ 15,330.24
701.01	Medicare	$ 1,727.96	$ 2,036.53	$ -	$ -	$ -	$ -
701.02	Medicaid	$ 92,130.65	$ 95,038.32	$ 96,807.15	$ 104,611.27	$ 104,973.54	$ 117,660.10
Total Nursing Home Income		**$ 105,996.46**	**$ 111,547.05**	**$ 110,874.84**	**$ 119,755.38**	**$ 119,281.24**	**$ 132,990.34**
Basic Care Income:							
	Medicaid	$ 11,470.62	$ 13,109.28	$ 12,686.40	$ 13,109.28	$ 14,272.20	$ 14,747.94
Total Basic Care Income		**$ 11,470.62**	**$ 13,109.28**	**$ 12,686.40**	**$ 13,109.28**	**$ 14,272.20**	**$ 14,747.94**
TOTAL INCOME		**$ 117,467.08**	**$ 124,656.33**	**$ 123,561.24**	**$ 132,864.66**	**$ 133,553.44**	**$ 147,738.28**
Expenses:							
Total Nursing Management		$ 10,316.58	$ 9,419.49	$ 9,868.04	$ 10,316.58	$ 8,970.94	$ 10,316.58
Total Patient Care		$ 49,777.83	$ 49,994.83	$ 48,603.22	$ 52,960.86	$ 51,473.57	$ 55,808.07
Total Housekeeping		$ 1,782.49	$ 1,794.89	$ 1,748.99	$ 1,819.69	$ 2,509.49	$ 2,617.94
Total Activities		$ 1,775.06	$ 1,631.22	$ 1,705.96	$ 1,786.22	$ 1,565.60	$ 1,797.38
Total Dietary		$ 11,428.76	$ 11,471.54	$ 11,444.85	$ 12,051.86	$ 11,681.93	$ 12,674.96
Total Laundry		$ 1,674.32	$ 1,684.24	$ 1,686.80	$ 1,704.08	$ 1,706.00	$ 1,733.84
Total Maintenance		$ 7,851.63	$ 9,249.44	$ 8,095.43	$ 9,846.47	$ 9,982.77	$ 11,077.85
Total Medical Records		$ 84.63	$ 88.66	$ 89.70	$ 96.72	$ 97.50	$ 108.81
Total Social Services		$ 2,044.42	$ 1,871.44	$ 1,958.40	$ 2,046.28	$ 1,786.00	$ 2,048.14
Total Administrative & General		$ 18,889.63	$ 18,728.80	$ 23,937.60	$ 18,859.40	$ 20,382.40	$ 20,310.05
Total Employee Benefits		$ 16,756.69	$ 16,540.56	$ 16,470.53	$ 17,946.19	$ 17,523.07	$ 33,322.90
Total Interest and Depreciation:		$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00
Total Expenses		$ 156,532.05	$ 156,625.12	$ 159,759.53	$ 163,584.37	$ 161,829.28	$ 185,966.52
NET PROFIT/LOSS		**$ (39,064.96)**	**$ (31,968.79)**	**$ (36,198.29)**	**$ (30,719.70)**	**$ (28,275.84)**	**$ (38,228.25)**

T[illegible]ountain
Budget Packet

30 year loan 5%

		Year July '03-June '04	
Nursing Home Income:			
701.00	Private	$ 190,048.81	
701.01	Medicare	$ 6,082.63	
701.02	Medicaid	$ 1,390,214.20	
Total Nursing Home Income		$ 1,586,345.64	
Basic Care Income:			
	Medicaid	$ 185,274.30	
Total Basic Care Income		$ 185,274.30	
TOTAL INCOME		$ 1,771,619.94	
Expenses:			
Total Nursing Management		$ 117,967.88	$ 11.91
Total Patient Care		$ 645,812.85	$ 65.20
Total Housekeeping		$ 27,898.10	$ 2.82
Total Activities		$ 20,592.78	$ 2.08
Total Dietary		$ 149,119.77	$ 15.05
Total Laundry		$ 20,761.60	$ 2.10
Total Maintenance		$ 118,297.48	$ 11.94
Total Medical Records		$ 1,287.65	$ 0.13
Total Social Services		$ 23,446.54	$ 2.37
Total Administrative & General		$ 243,086.72	$ 24.54
Total Employee Benefits		$ 227,590.34	$ 21.46
Total Interest and Depreciation:		$ 409,800.00	$ 41.37
Total Expenses		$ 2,005,661.70	$ 202.49
NET PROFIT/LOSS		$ (234,041.76)	

Turtle Mountain
Budget Packet
Year 3

Census

Historical Facility Census

	July	August	September	October	November	December	January	February	March	April	May	June
3 Yrs. Previous	0	0	0	0	0	0	0	0	0	0	0	0
2 Yrs. Previous	3	5	8	10	13	13	15	15	18	18	20	20
Previous Year	21	22	23	24	25	27	28	29	30	31	32	33

	July	August	September	October	November	December	January	February	March	April	May	June
Projected Census	34	34	35	35	36	37	38	39	40	40	41	42

Turtle Mountain
Budget Packet

30 year loan 5%

		January	February	March	April	May	June
Nursing Home Income:							
701.00	Private	$ 20,990.38	$ 19,364.50	$ 21,232.54	$ 24,188.25	$ 25,897.77	$ 25,250.91
701.01	Medicare	$ -	$ 3,117.50	$ -	$ -	$ -	$ -
701.02	Medicaid	$ 165,956.54	$ 159,623.04	$ 174,626.85	$ 167,913.04	$ 177,363.13	$ 176,250.85
Total Nursing Home Income		**$ 186,946.93**	**$ 182,105.04**	**$ 195,859.39**	**$ 192,101.29**	**$ 203,260.90**	**$ 201,501.76**
Basic Care Income:							
	Medicaid	$ 24,579.90	$ 22,994.10	$ 24,579.90	$ 23,787.00	$ 24,579.90	$ 23,787.00
Total Basic Care Income		**$ 24,579.90**	**$ 22,994.10**	**$ 24,579.90**	**$ 23,787.00**	**$ 24,579.90**	**$ 23,787.00**
TOTAL INCOME		**$ 211,526.83**	**$ 205,099.14**	**$ 220,439.29**	**$ 215,888.29**	**$ 227,840.80**	**$ 225,288.76**
Expenses:							
Total Nursing Management		$ 10,153.75	$ 9,230.68	$ 10,615.28	$ 10,153.75	$ 9,692.21	$ 10,615.28
Total Patient Care		$ 64,958.51	$ 60,992.89	$ 65,392.51	$ 63,294.20	$ 65,609.51	$ 63,714.20
Total Housekeeping		$ 2,820.83	$ 2,650.45	$ 2,845.63	$ 2,753.84	$ 2,858.03	$ 2,777.84
Total Activities		$ 1,811.80	$ 1,654.30	$ 1,895.17	$ 1,814.44	$ 1,747.03	$ 1,897.57
Total Dietary		$ 15,076.99	$ 14,257.39	$ 15,577.25	$ 15,056.90	$ 15,615.23	$ 15,543.76
Total Laundry		$ 1,842.96	$ 1,827.92	$ 1,862.80	$ 1,850.00	$ 1,872.72	$ 1,869.20
Total Maintenance		$ 11,518.94	$ 12,696.53	$ 11,412.24	$ 8,737.94	$ 9,412.46	$ 8,746.98
Total Medical Records		$ 153.14	$ 147.03	$ 161.20	$ 156.00	$ 165.23	$ 163.80
Total Social Services		$ 2,023.78	$ 1,844.19	$ 2,114.35	$ 2,024.22	$ 1,936.31	$ 2,114.75
Total Administrative & General		$ 20,382.54	$ 20,369.39	$ 20,429.84	$ 20,475.80	$ 20,329.89	$ 20,322.55
Total Employee Benefits		$ 19,151.82	$ 18,467.43	$ 19,266.94	$ 18,923.92	$ 19,044.49	$ 19,038.94
Total Interest and Depreciation:		$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00
Total Expenses		$ 184,045.06	$ 178,288.19	$ 185,723.21	$ 179,391.01	$ 182,433.12	$ 180,954.86
NET PROFIT/LOSS		**$ 27,481.77**	**$ 26,810.95**	**$ 34,716.09**	**$ 36,497.28**	**$ 45,407.68**	**$ 44,333.90**

Turtle Mountain
Budget Packet

30 year loan 5%

		July	August	September	October	November	December
Nursing Home Income:							
701.00	Private	$ 19,651.75	$ 22,366.13	$ 21,407.34	$ 22,085.16	$ 20,603.08	$ 21,008.10
701.01	Medicare	$ 2,797.65	$ 3,147.36	$ -	$ -	$ -	$ -
701.02	Medicaid	$ 149,163.91	$ 146,877.41	$ 147,315.24	$ 152,558.11	$ 151,161.90	$ 161,237.91
Total Nursing Home Income		**$ 171,613.32**	**$ 172,390.90**	**$ 168,722.58**	**$ 174,643.27**	**$ 171,764.98**	**$ 182,246.02**
Basic Care Income:							
	Medicaid	$ 21,302.58	$ 21,302.58	$ 22,201.20	$ 22,941.24	$ 22,201.20	$ 24,579.90
Total Basic Care Income		**$ 21,302.58**	**$ 21,302.58**	**$ 22,201.20**	**$ 22,941.24**	**$ 22,201.20**	**$ 24,579.90**
TOTAL INCOME		**$ 192,915.90**	**$ 193,693.48**	**$ 190,923.78**	**$ 197,584.51**	**$ 193,966.18**	**$ 206,825.92**
Expenses:							
Total Nursing Management		$ 10,615.28	$ 9,692.21	$ 10,153.75	$ 10,615.28	$ 9,230.68	$ 10,615.28
Total Patient Care		$ 61,485.93	$ 61,485.93	$ 62,244.20	$ 64,307.51	$ 62,454.20	$ 64,741.51
Total Housekeeping		$ 2,771.23	$ 2,771.23	$ 2,693.84	$ 2,783.63	$ 2,705.84	$ 2,808.43
Total Activities		$ 1,872.85	$ 1,720.99	$ 1,796.44	$ 1,876.57	$ 1,648.18	$ 1,884.01
Total Dietary		$ 14,331.05	$ 14,161.33	$ 14,051.90	$ 14,538.75	$ 14,083.18	$ 14,954.15
Total Laundry		$ 1,803.28	$ 1,803.28	$ 1,802.00	$ 1,813.20	$ 1,811.60	$ 1,833.04
Total Maintenance		$ 7,909.78	$ 9,302.53	$ 8,151.05	$ 9,904.62	$ 10,033.33	$ 11,136.00
Total Medical Records		$ 137.02	$ 137.02	$ 136.50	$ 141.05	$ 140.40	$ 149.11
Total Social Services		$ 2,110.63	$ 1,931.97	$ 2,021.22	$ 2,111.25	$ 1,843.17	$ 2,112.49
Total Administrative & General		$ 18,947.78	$ 18,781.89	$ 23,993.22	$ 18,917.55	$ 20,432.96	$ 20,368.20
Total Employee Benefits		$ 18,063.62	$ 17,839.62	$ 18,050.07	$ 19,259.14	$ 18,693.88	$ 34,262.26
Total Interest and Depreciation:		$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00	$ 34,150.00
Total Expenses		$ 174,198.46	$ 173,778.02	$ 179,244.19	$ 180,418.55	$ 177,227.41	$ 199,014.47
NET PROFIT/LOSS		**$ 18,717.44**	**$ 19,915.46**	**$ 11,679.59**	**$ 17,165.96**	**$ 16,738.77**	**$ 7,811.44**

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30 year loan 5%

		Year July '03-June '04	
Nursing Home Income:			
701.00	Private	$ 264,045.93	
701.01	Medicare	$ 9,062.52	
701.02	Medicaid	$ 1,930,047.95	
Total Nursing Home Income		$ 2,203,156.39	
Basic Care Income:			
	Medicaid	$ 278,836.50	
Total Basic Care Income		$ 278,836.50	
TOTAL INCOME		$ 2,481,992.89	
Expenses:			
Total Nursing Management		$ 121,383.41	$ 8.83
Total Patient Care		$ 760,681.08	$ 55.32
Total Housekeeping		$ 33,240.85	$ 2.42
Total Activities		$ 21,619.35	$ 1.57
Total Dietary		$ 177,247.88	$ 12.89
Total Laundry		$ 21,992.00	$ 1.60
Total Maintenance		$ 118,962.39	$ 8.65
Total Medical Records		$ 1,787.50	$ 0.13
Total Social Services		$ 24,188.35	$ 1.76
Total Administrative & General		$ 243,751.63	$ 17.73
Total Employee Benefits		$ 240,062.11	$ 16.37
Total Interest and Depreciation:		$ 409,800.00	$ 29.80
Total Expenses		$ 2,174,716.53	$ 158.16
NET PROFIT/LOSS		$ 307,276.36	

Att 4

NORTH DAKOTA INDIAN AFFAIRS COMMISSION
REAL CHOICES CULTURAL MODEL
January 30, 2007

The North Dakota Indian Affairs Commission Real Choices Project was a grant funded by the North Dakota Department of Human Services – 2003 – 2005. The intent of the grant was to develop a culturally congruent model of home and community based care for American Indians in North Dakota.

PROJECT PRINCIPLES:

- The culture and values were to be an integral part of all aspects of planning and service delivery.
- The project was to be consumer driven.
- The project was to be mindful of limited services and will coordinate with existing services.
- Keep and retain the uniqueness of each community.
- **Ensure decisions are based upon the values of the individual and community.**

The NDIAC Real Choices Project considered programs that work in Indian Country.[i] There are several examples to draw from that have a positive history of providing services in Indian Country. The program similarities include:

- Strong community connection
- Staff have similar values as the community
- Intimate knowledge of the community
- The Program is properly funded
- Have FTE's to get the job done
- **Is locally controlled**

WHAT WE LEARNED FROM THE PROJECT

In the context of the cultural model we believe these are policy considerations:

- Elders are valued
- Family takes care of family
- Multi generational households are common
- Tribes have their own definition of who they consider family
- Tribes have their own ways to describe family members
- Family members make have a prescribed role
- Language is key to the tribe
- Cultural, customs and traditions define the members and tribe
- Intimacy of the family, community and tribe is inherent
- Relationships are important
- The history of the tribe and it's members is key to understanding

NEEDS IN THE PRESENT DELIVERY SYSTEM

These appeared to be systemic in nature. We found a need:

- for funding
- for FTE's
- to improve communication and information, at all levels

2403

- to ensure elders receive all services
- **for buffers from harm**
  (elders and disabled, as do others, are exposed to myths about culture, misinformation, stereotyping, ethnocentrism, and assumptions). Elders and the disabled need to be to feel and know they are safe).
- **to keep them well, physically, emotionally, mentally and spiritually**

RECOMMENDATIONS PERTINENT TO SERVICE DELIVERY FOR AMERICAN INDIAN ELDERS AND DISABLED

a. How Services are delivered:

- Redefine outreach by providing transportation to go to the elders instead of them coming to the service provider.
- Holistic approach to health as opposed to just physical, medication, etc.
- "Elders Day Out" concept.
- Reciprocity: community concept of keeping good things going, giving. For example, elders work with youth in teaching language and traditions.
- Simplify language of service promotion materials. Don't use acronyms
- Need to build in time for relationship-building between consumers and providers.
- Need to have "cultural-brokers" to speak for, translate and introduce consumer to provider.
- Need consistency in staff.
- Politics enter into turnover in staff, e.g. as tribal administrations change; some long-term administrators can be replaced. Long-term administrators have had the time to build relationships. Those skills are lost, as is the ability of a program to build up a cadre of resource people to afford a continuum of services.
- Make services more accessible in a location that is familiar to consumers.
- Host morning meetings for elders versus the afternoon.

b. How Communication Materials Are Provided.

- Should delineate all service programs available, a comprehensive document.
- Include eligibility criteria.
- Include less generic statements about "services to elders" and more specific information about actual services provided.
- Use less acronyms and professional jargon, and simpler, more descriptive language.
- Use formats suitable for vision-impaired, Native-language predominant and English speakers.
- Use more descriptive, graphically illustrated and easy-to read materials.
- Publications and media materials, where applicable, should reflect images of Native peoples (e.g. photos, layout & design, delivered in a communication manner applicable to the community served).
- Stakeholders believe that information should be delivered in alternative formats: e.g. written, visual, audio-visual, etc.

b.1 Where Materials Are Disseminated.

- Provide information in locations where most services are received, from usual providers.
- Provide information in a one-stop location sensitive to the physical needs of the aged and disabled population.
- Materials delineate where services/help is available.

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c. Change to the Intake Process.
- Be respectful and helpful at all times.
- Organizations should have expectation of cultural competency skill in workers.
- Service area would be entire state/region (not just off-reservation/on-reservation).

d. Recommendations for Transportation:
Tribal leaders collaborate with tribally-based human-service related agencies on the reservations. Purpose is to develop a transportation plan for inclusion of elders in rural areas to provide a more comprehensive transportation system.

e. Recommendations for Funding:
- Consideration be given to a more flexible funding scheme be developed and used based on consumer needs in the provision of services.
- Establish a system for providing funding for transportation of elders and disabled.
- Provide and/or create opportunities for tribal funding for elders to help elders.

f. Recommendations for Inter-Agency Collaboration and Relationship Building:
- Indian Health Services assume a more central role in improving services.
- Coordinate services to the extent possible to maximize resources, to fill gaps in service, to limit duplication, and to eliminate the number of new and different people a client has to see. This present confusion for elders who may not understand different people for different functions.
- Create opportunities for people to meet people to build strong foundational relationships.

g. Recommendation for Staff-Training:
The vision for training includes:
- State, regional and local county offices that provide training offer clearer, simplified methods for responding to information needed on Medicaid applications particularly the issues attendant to recipient liability and options available to clients.
- Provide culturally responsive training of the population served.
- Trust building is a major factor in building client response and satisfaction.
- Understanding culture is a key factor in building client response in provision of service and self-care.

h. Recommendation for Advocacy:
- To support advocacy efforts, both consumers and service providers agreed:
- Elder groups should be established and supported on every reservation.
- **State legislation is needed allow for greater access to services on reservation case management services.**
- Recognition of the role of the American Indian elder in the community.

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RECOMMENDATIONS FOR A CULTURAL MODEL OF SERVICE DELIVERY

1. Story-telling by elders, people with disabilities, advocates and other consumers is an important part of building understanding as it is framed out of cultural experience. This dialogue is crucial for shaping cultural understanding and for visioning and designing culture-based programming.

2. Because of historical trauma, planning must be predicated upon listening in Native communities. Only when all the stories are told can the focus shift to problem-solving.

3. Policy formulation at all levels for American Indian communities and individuals needs to support the traditional model of multi-generational care giving practiced by native peoples however it is defined in each culture.

4. Reciprocity: community concept of keeping good things going, giving. For example, elders work with youth in teaching language and traditions.

5. Need to build in time for relationship-building between consumers and providers.

6. Need to have "cultural-brokers" to speak for, translate and introduce consumer to provider.

7. Organizations have expectation of cultural competency skill in workers.

8. Culturally responsive training of the population served.

9. Recognition of the role of the American Indian elder in the community.

10. Trust is a major factor in informing providers of cultural factors.

11. Use formats suitable for vision-impaired, Native-language predominant and English speakers.

12. Publications and media materials, where applicable, should reflect images of Native peoples (e.g. photos, layout & design, delivered in a communication manner applicable to the community served).

Att4

RECOMMENDATIONS FOR FUTURE ACTION IN NORTH DAKOTA

The final Partnership Planning Meeting, held on June 28, 2005 focused on solutions to identified issues and involved each of the Tribal Nations in mapping out a future action plan specific to their respective areas in the state. (See attached summaries from the Spirit Lake Nation, Standing Rock Sioux Tribe, Turtle Mountain Band of Chippewa Indians, Mandan, Hidatsa and Arikara Nation, and Trenton Indian Service Area.)

1. The summary of focus group issues, the outcome of the final partnership planning meeting, and other information gathered during the project period, provide a clear direction for future action in North Dakota which includes the following:

2. To follow-up with each tribal entity regarding their progress in meeting the goals outlined in their respective action plans

3. To incorporate the recommendations for a culture-based model of service into the Real Choice Systems Change Grant – Rebalancing Initiative, administered by the Aging Services Division of the North Dakota Department of Human Services.

4. To provide information, and to monitor the work of the newly established interim Legislative Committee on Tribal and State Relations. The committee is to study tribal-state issues, including **government-to-government relations**, the delivery of services, case management services, child support enforcement, and issues related to the promotion of economic development.

5. To work with the Department of Human Services to identify and revise specific laws, administrative code and policies which support a culture-based model of service.

6. To seek additional funding sources to carry out the numerous initiatives identified as a result of this project.

7. To seek support for the addition of an American Indian representative on the State Council for Independent Living.

---

[i] [T]he term "Indian country," is a legal term…meaning all land within the limits of any reservation under the jurisdiction of the United States government,…(b) all dependent Indian communities within the borders of the United States,…and (c) all Indian allotments, the Indian titles to which have not been extinguished. Utter, 1993.

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REAL CHOICES TRIBAL PLANS

2005

GOALS	SPIRIT LAKE	TURTLE MOUNTAIN	STANDING ROCK NATION	MANDAN, HIDATSA AND ARIKARA	TRENTON INDIAN SERVICE AREA
Goal 1	An elder housing complex in each district	A more culturally responsive environment	Create Elder advisory council	Coordinate and collaborate across multiple jurisdictions	Make elders and people with disabilities a tribal priority
Goal 2	A housing complex for adults with disabilities	Networking service providers and consumers	Bill of Rights for Elders	Improve access to services	Develop methods to increase access to information
Goal 3	Directory of local services	Enforcement of elder abuse code	Develop standards of care to simplify access to services	Use of culturally appropriate services	Utilize and expand opportunities for elders to help elders
Goal 4		Increase ease of access to health services	Develop tribal management information system and network collaboration	Increase access to information	Develop a single plan of care concept
Goal 5		Care facilities for elders and the disabled	Develop culturally based services: Home and community based services, language and protocols	Building relationships	

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Testimony on SB 2403
Senate Human Services Committee
January 30, 2007

Chairman Lee and members of the Senate Human Services Committee, thank you for the opportunity to share information regarding the impact of SB 2403. My name is Shelly Peterson; I'm President of the North Dakota Long Term Care Association (NDLTCA). I am here to request your support in maintaining the 48 month timeframe for putting purchased or transferred beds in service and for maintaining the moratorium.

I would like to address this issue by providing some background information on why we thing this is good public policy.

Over 100 years ago, North Dakota started to develop care facilities and today we have 83 licensed nursing facilities and 54 licensed basic care facilities. Every community, it seemed wanted a care facility to address the needs of their elder population. It was our way of caring and today we still have a strong presence of nursing and basic care facilities.

In 1993, North Dakota ranked sixth highest in the nation for the number of nursing facility beds; with 78.5 beds per thousand elderly. At that time, the United State Average was 53 beds per thousand elderly. In 1993, North Dakota was considered to be over-bedded.

In 1996, a comprehensive report was published regarding long term care in North Dakota. The report and study was initiated because of legislation directing that a study be conducted and a comprehensive report be prepared by the Legislative Council in conjunction with the State Health Council and the North Dakota Department of Human Services. Three of the recommendations included:

Report of the Taskforce on Long-Term Care Planning
June 1996

Recommendations

1. The Taskforce recommends that establishment of effective case management of long term care services in Indian reservations and service areas be a priority of the State of North Dakota (Page 10).
2. Consider adopting a permanent moratorium on the construction of any additional nursing facility beds and basic care beds as defined and authorized on August 1, 1995 (Page 17).

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3. Consider establishing a bed bank for any nursing facility beds that are no longer licensed. The bed could be reallocated to other locations where additional beds may be needed. Any reallocation of beds would occur only if a shortage of nursing facility beds exists after full implementation of home and community based services in that particular region of the state (Page 17).

In 1998, the Taskforce on Long-Term Care Planning adopted additional recommendations. Two specific to this issue include:

1. Consider studying an incentive package to assist rural communities and nursing facilities to close or significantly reduce bed capacity and provide alternative long term care services to the elderly of the community (Page 10).
2. Continue the current moratorium that prohibits an increase in the nursing facility bed capacity and basic care facility bed capacity in accordance with current law (Page 16).

It is the goal of the State Health Council that North Dakota strives for 60 nursing facility beds per 1000 elderly. Through bed reduction, facility closings and a continued growth in our senior population, North Dakota now has 65.3 beds per 1000 elderly.

NURSING FACILITY BEDS PER THOUSAND

Region and Area	**Nursing Facility Beds Per 1000 Elderly**	**Basic Care Beds Per 1000 Elderly**
I – Williston	60.47	28.48
II – Minot	59.06	15.62
III – Devils Lake	68.81	17.03
IV – Grand Forks	71.40	14.42
V – Fargo	60.55	19.26
VI – Jamestown	76.66	19.01
VII – Bismarck	61.06	15.37
VIII – Dickinson	72.02	13.36
Statewide Averages	65.3	17.25
Statewide Goal*	60.0	15.0

*Nursing facility goal established by North Dakota Taskforce on Long-Term Care Planning in 1996
*Basic Care Goal established by State Health Council in 1994.
In 1996, North Dakota had 89 beds per thousand elderly, the sixth highest rate in the nation.

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In 2007, the North Dakota Department of Human Services proposed legislation, SB 2109 to make the nursing facility and basic care moratorium permanent. This is a departure from the legislature revisiting this issue almost every legislative session. SB 2109 passed the Senate 45-0 on January 23, 2007, with an emergency clause.

The method that North Dakota has adopted to re-distribute beds is to allow all facilities to sell their beds. It is recognized that we have a mal-distribution of beds, high need areas that may not have a sufficient number of beds (Bismarck/Mandan as an example) and a surplus of beds in rural North Dakota. For the re-distribution to work, rural nursing facilities must be willing to give up/sell their beds. This has been a slow process but one that we believe will be successful in time.

When a facility sells their beds, the new entity purchasing the beds has 48 months to put those beds in service in the new location. In the 2003 session, the law was amended to allow 48 months, rather than 24 months to put a bed in service. The law was changed at the request of the Turtle Mountain Band of Chippewa Indians. The tribe was interested in purchasing beds and they felt 24 months was not a sufficient length of time to put beds in service. We agreed to support this change as long as the 48 months was evenly applied to everyone.

We worked closely with the Turtle Mountain Band of Chippewa Indians assisting them to find and purchase the beds they felt they needed. We have also offered to further assist the Turtle Mountain Band of Chippewa Indians should they desire to sell their beds rather than put them in service.

Today many rural facilities are facing significant financial challenges. The financial crisis is caused by low occupancy and a lack of qualified staff. Of the 83 licensed nursing facilities, nearly two-thirds (58) are located in rural North Dakota. In the most recent cost reporting period, 19 rural nursing facilities experienced an annual occupancy below 90%. In this past year, 11 rural facilities were compelled to stop admissions because they didn't have sufficient numbers of staff to care for residents. Testimony presented during the 1997 legislative session indicated that there are currently four nursing facilities located on or near Indian reservations in North Dakota. Below is data regarding occupancy, staff and resident demographic data.

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Facility	1997 Capacity	2007 Capacity	Occupancy Today	Number and Percentage of American Indians					
				Staff			Residents		
				Total	#	%	Total	#	%
Dunseith Community Nursing Home	54 NF	42 NF	71%	57	38	67%	30	23	71%
Rolette Community Care Center	48 NF	46 NF	74%	62	26	42%	34	20	59%
Rock View Good Samaritan Center	56 NF	42 NF	88%*	60	15	25%	37	10	27%
New Town Good Samaritan Center	59 NF	18 BC	67%	2	11	18%	2	12	17%
		7 AL	100%				0	7	0%

*On January 29 will stop admissions because of staffing crisis.

NF – Nursing facility beds; BC – Basic care beds; AL – Assisted living units

We support all entities receiving 48 month to put beds in service. The agreement in 2003 was any bed not put in service within 48 months would no longer be eligible for license and would forever leave the system. If you allow an exception for one, we know of others who may also request an exception and request additional time to put their transferred beds into service.

In looking at the occupancy issues, and the staffing crisis in rural North Dakota, the last place to build a new nursing facility would be rural North Dakota. However, anyone that purchases beds should be given the full four years to build their facility.

I want to touch upon one last issue. In 2006, the Indian Affairs Commission concluded a comprehensive study regarding improving services to elders and disabled individuals within the four reservations and Trenton Indian Service Area within North Dakota. The goal of the study was to create a vision of culturally congruent services for American Indian elders and people with disabilities.

The project was consumer-driven providing meaningful involvement from all stakeholders, including American Indian elders, people with disabilities, family members, advocates, service providers and community leaders.

The project was guided by a Steering Committee made up of American Indian and employed individuals with knowledge of reservations and state systems.

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In the report it stated the use of care facilities by tribal people has been governed by generally five primary factors:

1. A strong tribal value of caring for elders in the home;
2. The degree of medical necessity;
3. Lack of localized services;
4. Economics, and;
5. The degree of culturally congruent services available in facilities on, off, and near reservations (Page 8).

In the report, elders stated there were major gaps in information and they were not aware of programs or services available to them. A major challenge identified by the study:

"Designing a service delivery system based on the American Indian cultures of North Dakota is a departure from the non-natives methods of institutionalizing the elderly and the ill. In North Dakota huge sums of money are spent to sustain a system adverse to honoring and recognizing the role of elders in our society. Today, tribal elders teach the language to our next generations, care for grandchildren, lead us in prayer and know the ways of "the people." We cannot afford to have them in an institution."

The report contains numerous recommendations, one being: Seek additional funding sources to carry out the numerous initiatives identified.

In conclusion, we want every community to succeed in caring for their elders. We believe the current state law of re-distributing beds and providing 48 months to put beds in service remains the best public policy for everyone. If the Turtle Mountain Band of Chippewa Indians can't meet this time frame a better alternative may be assisting them financially to implement their dream of creating a culturally congruent model of home and community based care for their elders.

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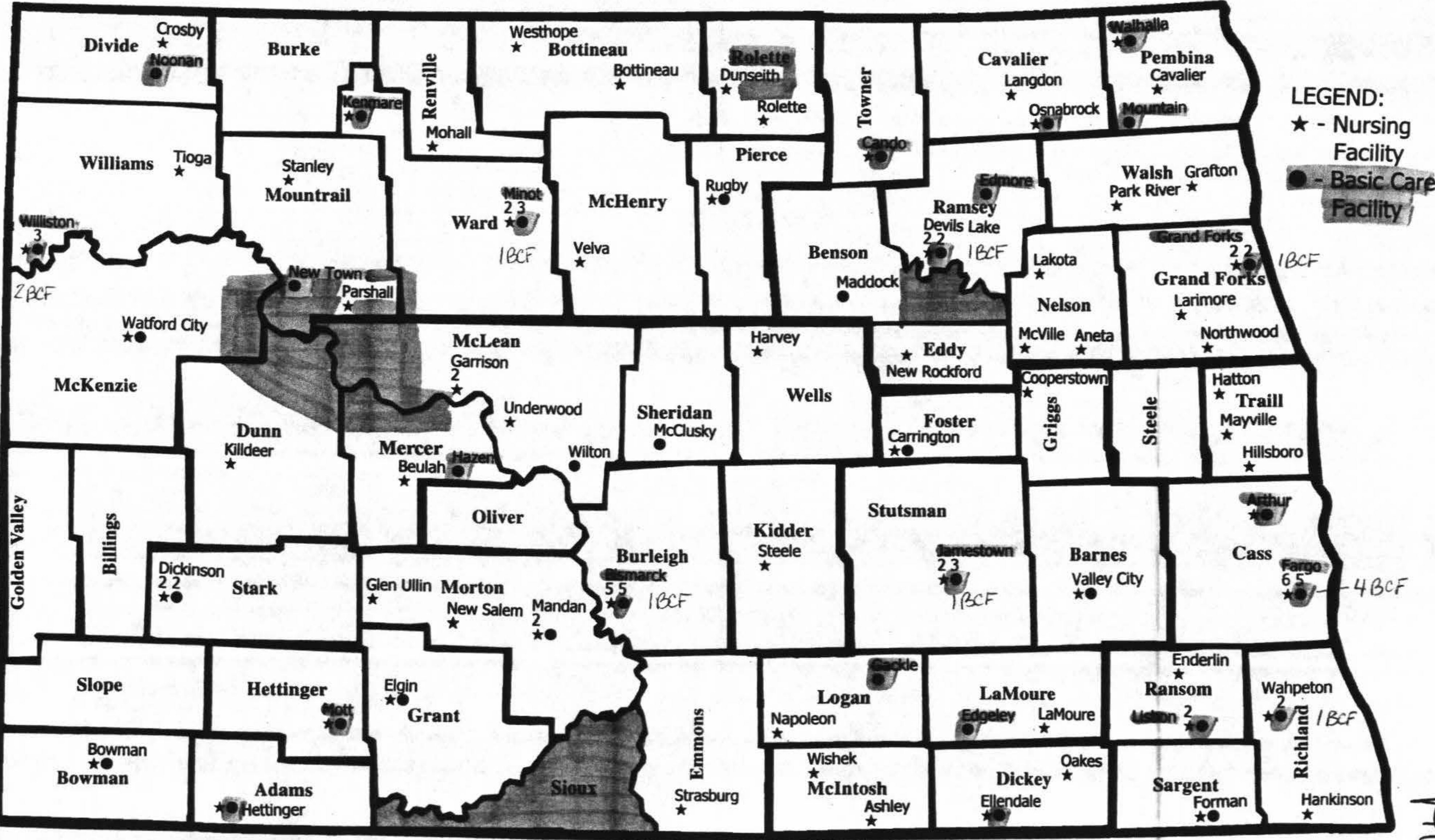
2403

North Dakota Long Term Care ASSOCIATION

Basic Care and Nursing Facilities

Below 90% Occupancy **Counties Map**



Facilities are listed by county not geographic location.

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Nursing & Basic Care Facilities Below 90% Occupancy

Nursing Facility	City	Bed Count	Average Occupancy
Osnabrock Good Samaritan Center	Osnabrock	31	60.8%
Hillcrest Care Center	Hettinger	82	73.9%
Dunseith Community Nursing Home	Dunseith	42	81.0%
Tri-County Health Center	Hatton	55	81.1%
Rock View Good Samaritan Center	Parshall	42	81.6%
Aneta Parkview Health Center	Aneta	39	82.8%
Rolette Community Care Center	Rolette	46	82.9%
Nelson County Health System Care Center	McVille	39	85.0%
St. Rose Care Center	LaMoure	46	87.2%
St. Catherine's Living Center	Wahpeton	110	87.4%
Wedgewood Manor	Cavalier	60	88.2%
Luther Memorial Home	Mayville	99	88.4%
Jacobson Memorial Hospital Care Center	Elgin	25	88.9%
Heartland Care Center	Devils Lake	103	89.1%
Prince of Peace Care Center	Ellendale	60	89.3%
Park River Good Samaritan Center	Park River	74	89.4%
Four Seasons Health Care Center, Inc.	Forman	35	89.4%
Northwood Deaconess Health Center	Northwood	77	89.6%
Devils Lake Good Samaritan Center	Devils Lake	66	89.6%

Basic Care Facility	City	Bed Count	Average Occupancy
Hillcrest Care Center	Hettinger	6	23.5%
Pembilier Nursing Center	Walhalla	13	48.1%
Osnabrock Good Samaritan Center	Osnabrock	6	52.8%
New Town Good Samaritan Center	New Town	18	54.2%
Prairie Villa	Arthur	5	54.3%
Baptist Home of Kenmare	Kenmare	60	54.9%
Manor on Main	Noonan	32	60.7%
St. Francis Residence	Cando	10	61.7%
Edmore Memorial Rest Home	Edmore	30	62.5%
St. Catherine's Living Center	Wahpeton	16	64.6%
Bethel Lutheran Home	Williston	9	66.7%
Mott Good Samaritan Nursing Center	Mott	6	68.1%
Borg Pioneer Memorial Home	Mountain	43	69.0%
Evergreens of Fargo	Fargo	18	69.9%
North Dakota Veteran's Home	Lisbon	111	72.4%
Manor St. Joseph	Edgeley	40	73.8%
Evergreens of Fargo	Fargo	18	74.1%
Gackle Care Center	Gackle	41	81.5%
Evergreens of Fargo	Fargo	18	82.4%
Evergreen Place	Ellendale	20	82.9%
Kensington	Williston	71	83.3%
Evergreens of Fargo	Fargo	18	83.3%
Lake Country Manor	Devils Lake	6	86.1%
Maple View II East	Bismarck	24	86.5%
Senior Suites at Sakakawea	Hazen	34	88.0%
Parkwood Place Inn	Grand Forks	40	88.3%
Emerald Court	Minot	16	88.5%
Rock of Ages	Jamestown	53	88.7%

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SB 2403

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FINAL REPORT
REAL CHOICES SYSTEMS CHANGE GRANT

CULTURAL MODEL

SUBMITTED TO THE NORTH DAKOTA OLMSTEAD COMMISSION

2403

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OVERVIEW

The need to develop culturally congruent services for Native American elders and people with disabilities is a recognized concern in the state of North Dakota. Elders and people with disabilities are often forgotten populations, living without services or with limited assistance because of many different barriers. Yet traditional Native philosophy states that elders and those with disabilities are to be protected and respected.

The movement toward increased options for home and community-based care for the elderly and people with disabilities has created an awareness of the needs of Native Americans and other special populations. This project sought to begin developing a map for improving services to these especially vulnerable populations.

PURPOSE AND HISTORY OF REAL CHOICES PROJECT

When the North Dakota Indian Affairs Commission submitted its application for the Real Choices Grant it primary intent was to develop a culturally congruent model of home and community based care for American Indian elders and Native disabled in North Dakota. A part of this vision was to be accomplished through the development of training for consumers and service providers.

Through this methodology, the goals were to (1) increase tribal consumers control and knowledge of personal health care options, to (2) increase the knowledge of service providers of culturally-congruent service delivery strategies for American Indian elders and disabled and to (3) improve service delivery systems by creating a framework for a cultural model of home and community-based care for American Indians in North Dakota.

The project was based on the following principles:

The culture and values will be an integral part of all aspects of planning and service delivery. Cultural appropriateness will be planned into all phases, where appropriate on the continuum of care for the elderly and disabled.

The project would be consumer-driven and would provide meaningful involvement from all stakeholders, including American Indian elders, people with disabilities, family members, advocates, service providers, and community leaders.

Because existing services were inadequate to the need and lack coordination, the project would coordinate with existing service providers to promote the effectiveness of program implementation, service delivery and sustainability.

The project sought to accomplish these encompassing tasks through dialogue and relationship-building with critical stakeholders from all across the state of North Dakota. The project recognized from inception that developing a culturally-congruent model for true systems change would require a comprehensive effort on the part of all stakeholders interested in the well-being of American Indian elders and people with disabilities.

1. DESCRIPTION OF GRANT ACTIVITIES FROM BEGINNING OF THE PROJECT TO THE END.

The project began with the development of a Steering Committee made up of American Indian and employed individuals with knowledge of reservation and state systems. These included staff from the North Dakota Indian Affairs Commission, the North Dakota Department of Human Services' Tribal Liaison Office, Aging Services Office and the Native American Training Institute. Early on the steering committee established a database of service providers and reservation stakeholders. This database would be used to create and sustain an on-going dialogue as well as connect individuals and programs essential for systems change. These individuals became the 'partners' who gathered at the Stakeholder Partnership meetings.

The first Stakeholder Partnership meeting was held on March 3 & 4, 2004. The purpose of the meeting was to provide information to all partners in order assess the current level of services and develop a vision for improvement. The meeting was attended by state, regional, private- sector providers, and tribal program representatives (e.g. Aging Services, Medicare-Medicaid, state and tribal 1- 21Vocational Rehabilitation programs, the Older Blind Program, Social Security and the National Resource Center on Native American Aging. Dialogue was facilitated by the North Dakota Consensus Council to determine the effectiveness and limitations of programs and services.

A second two-day Stakeholder Partnership Meeting was held on April 5 & 6, 2004. The meeting was attended by many of the same representatives as well as additional stakeholders. The agenda included presentations by the Aberdeen Area Indian Health Service, Contract Health Services Office, the Bureau of Indian Affairs, Social Services Office, AARP, Tribal Vocational Rehabilitation 1-21 Programs, and N.D. Centers for Independent Living, and the ND Mental Health Association. Once again, dialogue was facilitated regarding assessment and limitations of services.

In May and June of 2004, Real Choices focus groups were conducted with tribal consumers, advocates, tribal, private, and state service providers. The focus groups were conducted on each of the four reservations in North Dakota and in the Trenton Indian Service Area. In August of 2004 an additional focus group was held with urban Indian consumers in order to broaden the scope of comments and to expand the participation by people with disabilities.

The purpose of the focus groups was to assess the current level of services available, determine service gaps, and to assess local strengths, and preferences for services. These findings were to yield sufficient information from which assumptions could be drawn to develop a cultural construct for service delivery. Additionally, the Steering Committee hoped to raise the level of health and service literacy among American Indian elders and disabled.

Upon completion of the Real Choices focus group meetings findings were compiled and a summary of recommendations were made for their use as a framework for a culturally -congruent model of home and community-based services.

This information was presented at the third Stakeholder Partnership Meeting held on November 5, 2004. At this meeting, consumers and providers were requested to review findings, and begin a solution-focused dialogue. At the same time, Job Service North Dakota provided research information on population trends for American Indians both nationally and within North

Dakota. The National Resource Center on Native American Aging presented aggregate data on aging trends among North Dakota American Indians and risk behaviors impacting elder and disabled populations. The information was designed to support stakeholder strategic planning and decision-making.

Based upon the information presented the Steering Committee ascertained that the next steps in the project would need to change. The original grant was intended to develop training for consumers and service providers. However, it was evident from the information gathered that training would be premature. The Steering Committee decided additional time was needed to articulate a process to assist tribal consumers in developing ownership and commitment, goals and direction for services. They also recognized the tribal consumers' need to understand services and options available to them. This critical first step was viewed as necessary before any type of training could occur.

Following approximately five Steering Committee meetings, the Project Director requested a change in the projects' scope of work. In May of 2005 the Olmstead Commission authorized the change and approved a no-cost extension into the 2005-2007 biennia to complete the project. As a result, the project hosted two additional Stakeholder Partnership meetings in May and June of 2005. These meetings were designed to facilitate solution-oriented forums for tribal consumers. Special guests provided information on data, needs-based service models, innovative programming, friendly service delivery strategies and creative funding solutions. The meeting offered participants an opportunity to build community engagement and ownership, and an avenue for continued advocacy to maintain momentum built by the project.

The fifth and final Stakeholder Partnership meeting held June 28, 2005 was well attended by over 65 participants, inclusive of elders from all tribal communities, a county director, six state legislators, and state and tribal providers. It was anticipated that the final product would be a used for further planning, visioning and implementation to improve services.

USE OF SERVICES WITHIN A CONTINUUM OF CARE

The use of care facilities by tribal people has been governed by generally five primary factors: 1) a strong tribal value of caring for elders in the home, 2) the degree of medical necessity (mandatory because of health status), 3) lack of localized services, 4) economics and 5) the degree of culturally congruent services available in facilities on, off and near reservations. Research prior to the inception of the project was based on a 1999 study conducted by the National Council on Disabilities on the disabled American Indian population, and a two-phased nationwide survey of long-term care of American Indian elders conducted by the National Resource Center on Native American Aging at the University of North Dakota.
Some of the findings of the focus groups closely aligned with national findings. Other findings, while valid, were not evaluated as a part of this project. Those findings which mirrored the national studies, revealed the following:

- There was a lack of a formal service delivery structure for American Indian elders and those with disabilities in the native communities across the state.
- The systems for home and community based care, and long-term care for American Indian elders and those with disabilities do not mirror that of the State of North Dakota.
- The complex structure of federal responsibility for Indians results in jurisdictional conflicts, both intra-agency and inter-agency, competition, and jurisdictional confusion.

- These conflicts often times lead to a lack of accountability and inadequate or no services provided.
- Very often the norm of experience of elders and those with disabilities results in most care being provided informally, by family members and other persons living in homes. In many cases this is the result of culturally defined value and prerogative.
- American Indian people in rural areas encounter even greater barriers to supportive services and accommodations.
- There is a long standing need for a broad range of personal, social and medical services for the reservations' aged and disabled.
- The options for planning and providing care services that includes home and community based care and other services are limited.
- Limited or inaccessible public transportation and transportation personnel for people with disabilities and elders.
- Lack of culturally competent and culturally appropriate service delivery.
- Lack of culturally diverse disability service professionals, particularly in rural areas.
- Inadequate culturally appropriate outreach.
- Lack of bilingual speakers, interpreters, and language-appropriate communication materials.
- Long distances to obtain services.
- Lesser awareness of the need and/or lack of resources to facilitate access to services in rural areas.

FOCUS GROUP PROCESS

The summary of the meetings, attached in Appendix B. is the result of seven focus groups. Meetings were held on each of the four reservations, the Trenton Indian Service Area and Bismarck, North Dakota. The latter two meetings were held to further look at the needs of the disabled American Indian population in the state.
The structure of each focus group included a three-hour meeting with service providers in the morning, and two and one-half hours in the afternoon with elders and elder-advocates. In instances where attendance was nominal, groups were combined. Each group received a printed copy of questions, one set of questions was focused at service-providers, and the other focused on consumers. Focus Group questions are attached in Appendix C.

Table 1 below provides data for each meeting held and the number of attendees by type (consumer, provider, program administrator and other). It is important to note that a number of elders were cared for in their homes and possibly homebound. If the plan to invite people to the focus group meeting did not specifically use local media, (elders in their homes often listen to the radio; or if the media advertisement did not recognize community norms and strategies for media distribution, the message more than likely did not reach the elder directly or their caregiver. For example, at Turtle Mountain focus group meeting in the morning, there were four providers, three of whom served in the role of both service provider and elder-caregiver. The afternoon session was attended by eight elders and twelve service providers.

TABLE 1

Summary of Meeting Attendees by Type

Date	Meeting by Type	Location	Consumers	Providers & Other Agencies	Presenters	Staff Facilitator
3/4/04	1st Partnership Day 1	Bismarck	0	10	5	5
3/5/04	Day 2	"	0	13	4	5
4/5/04	2nd Partnership Day 1	"				
4/6/04	Day 2	"				
5/27/04	Focus Group Standing Rock Tribe	Fort Yates	1	12	0	3
6/1/04	Focus Group Turtle Mt. Band of Chippewa	Belcourt	8	12	0	3
6/8/04	Focus Group Spirit Lake Nation	Fort Totten	0	11	0	4
6/16/04	Focus Group Mandan, Hidatsa & Arikara Nation	New Town	9	6	0	4
8/4/04	Focus Group Disability	Bismarck				
8/5/04	Focus Group Disability	New Town				
8/6/04	Focus Group Trenton Indian Service Area	Trenton	8	4	0	2
11/5/04	3rd Partnership Mtg.	Bismarck	1	23	3	3
5/26/05	4th Partnership Mtg – Day 1	Bismarck	8	15	4	4
5/27/05	4th Partnership Mtg. - Day 2	Bismarck	8	13	3	4
6/28/05	5th Partnership Meeting	Bismarck	15	52	1	4

PROGRAM DESIGN

At mid-point in the project, it became apparent that all tribal communities were at different stages. Infrastructure development within each community varied greatly and it was also evident that additional work needed to be done in community assessment, development of resources, building consumer interest, and dialogue and community engagement.

Knowing that in order for community change to occur, a framework was needed. The following model, developed by Boston University, identifies five elements necessary for effective and sustained change to occur. Those elements include: (1) vision and planning (2) supportive policy development, (3) skills necessary to bring about change, (4) resources and (5) incentives and sanctions.

In using this framework, it became incumbent upon the project to interface those elements of the change model to tribal-specific cultural prerogatives. Some areas are general in characteristics and others are tribal-specific. The project identified the following critical components important for the service-delivery model to change.

VISION AND PLANNING

Advocates and providers need to understand that story-telling is an important part of building understanding as it is framed out of cultural experience. This dialogue is crucial for shaping cultural understanding and for visioning and designing culture-based programming.

Visioning is a process firmly grounded in Native cultures. The social protocols for arriving at a vision may vary greatly across cultures, and carried out in very specific ways.

- It must be on-going.
- Plans but reflect community needs and norms.
- Planning is essential to progress.
- Because of historical trauma in native communities, planning must be predicated upon listening. Only when all the stories are told can the focus shift to problem-solving.

SUPPORTIVE POLICY DEVELOPMENT

- Self-advocacy for elders and people with disabilities is critical and must be supported on a policy level. Legislation introduced during the 2004-2005 biennium was indicative of tribal consumer wants and needs.
- Tribal councils, the state legislators and other policy makers must take a primary role in building, providing and sustaining adequate services.
- Policy formulation at all levels for American Indian communities and individuals needs to support the traditional model of multi-generational care-giving practiced by native people however it is defined in each culture.

SKILLS NECESSARY TO BRING ABOUT CHANGE

There are a variety of skills needed within the community to bring about change – organizers/group facilitators, leaders for inspiration, policy-makers to engender advanced support for community-driven initiatives, and grant writers to secure funding support.

- Communities need a cohesive group of people to be change-makers.
- Creating change and developing leadership in community development are learned

and needed skills.

- Leaders need to have commitment, know community norms, and understand the difference between the formal and informal power structure.

RESOURCES

- Community-based resources must be identified, developed and/or strengthened in order to increase and improve services. (e.g. Qualified Service Providers, advocates, culture, etc.).
- Resources often overlapped and were not often identified specifically for "elders" or "people with disabilities". It is necessary to identify non-conventional community resources.
- Families and relatives can be quality service-providers and cultural-brokers.

INCENTIVES AND SANCTIONS

- There are currently very few sanctions and or incentives for providing ineffective or effective services to the elderly and disabled populations.
- Incentives do not necessarily have to be monetary.

SUMMARY OF SERVICE-RELATED ISSUES

The project sought to create a vision of culturally congruent services for American Indian elders and people with disabilities through the Focus Group and Stakeholder Partnership meeting process. The Steering Committee believed it was critical that a wide audience of consumers and service providers have input into the vision for improvement of services. This process provided a comprehensive view of realistic and practical possibilities as well as limitations. The recommendations for change encompassed several main areas described below.

PROVISION OF SERVICE:

The provision of services is an area that received a lot of attention in the Stakeholder Partnership meetings.

a. Service Delivery

The vision created by partners and stakeholders focused on culturally competent services or services that took into account the culture of the consumers.

Throughout this process, relationship and trust-building practices were a consistent message of consumers. Elders, people with disabilities and their advocates stated that, when relationships and trust were built, the provision of services was far more satisfactory. In many cases, however, both staff turnover and limited services inhibited this process.

b. Information.

Stakeholders believed there were several critical issues with regard to the flow of information to consumers. Elders stated there were major gaps in the information flow and were not aware of programs or services available to them, while service providers believed their materials were adequately disseminated. These issues involved the method of dissemination, the type and manner in which information was provided and the appearance of materials.

Information on resources was often not sought out until it was needed (e.g. when a family member assumes care for an elderly parent, when one becomes disabled, or when a loved one required assistance.) Information needed to be readily accessible in places often used by elders and disabled

Other concerns were the inconsistencies of written information. Many elders, people with disabilities and their advocates experienced difficulty in accessing eligibility criteria and a comprehensive list of services. Consumers expressed concern that some written communications they relied on did not delineate all the services or programs available but made generic statements about "services to elders", etc.

Consumers expressed concern with not having all the information to meet their needs. On the other hand, service providers stated that updating and changing brochures to keep pace with was cost-prohibitive.

Finally, consumers stated they were most likely to pick up a brochure and read it if it had visual images pertinent to Native Americans. Brochures which appealed to them contained pictures of Native people (either historical or contemporary), Native American designs, and text in their Native languages.

c. Intake Process

Many consumers expressed concern with the intake process and wanted to see this area vastly improved. The most striking comments came from individual elders and advocates who claimed many elders "went without services" rather than be mistreated or disrespected at the intake process.

The intake process for most services involved approaching a receptionist or intake worker. Many elders expressed this first contact was critical for setting the tone for services. In many cases, elders felt workers treated them with cold efficiency at best, rudeness at worst. Elders believed intake workers should have knowledge of tribal traditional ways of communicating and should use this knowledge to adjust intake styles when working with Native American consumers.

Finally, consumers expressed frustration with the barriers to services based on location. Elders would like to see a "seamless" system in which services could and would be provided regardless of location on-or off the reservation.

d. Funding

The stakeholder groups convened for this project believed inadequate funding was a major barrier to many services. However, they also believed that funding did not have to be a barrier given greater flexibility in its usage, greater program awareness and increased advocacy.

Consumers discussed the need for funding that met their needs, as opposed to funding specific services. Elders stated that sometimes they had unique needs, such as ramps or translation services, and had difficulty finding the appropriate agency or, if they did find an agency the funds had already been expended. They believed it was important that funds be spent based on needs of the consumer and thereby more flexible.

Finally, consumers stated consistently funded elder and disability advocacy organizations often proved most successful (i.e. MHA Elder Organization, Spirit Lake Elder Organization, Tribal 121/Vocational Rehabilitation Programs, etc.). Specific tribal funding often denoted a priority and allowed flexible and creative programming. In addition, elders advocating on behalf of other elders was most effective in keeping elder issues at the forefront. In the same manner, people with disabilities were better served by formal advocates and other people with disabilities.

e. Transportation

Many stakeholders also expressed the need for comprehensive transportation services. Given the rural nature of the reservations, transportation is often an issue for many consumers. However, for elders and people with disabilities, this can often be a more pronounced issue because of an individuals' inability to drive. Stakeholders expressed an interest in connecting current services to a more comprehensive transportation system.

f. Inter-Agency Collaboration and Relationship Building

Consumers and service providers both spoke of the need for collaboration and relationship-building. It was recognized that relationships are at the heart of Native philosophy and therefore must be built into the system. Thus, service providers who were most successful in developing services with consumers and tribal organizations were those who spent time building relationships before, and during the provision of services. Consumers stated that, although they recognized employee turnover as part of the system, it was difficult for them and they would like to see it minimized.

In addition to the importance of relationships as integral part of communicating with Native peoples, the role of historical trauma and the breakdown of trust between consumers and service-providing agencies were noted. This lack of trust made it even more imperative that strong, foundational relationships be created and maintained before services are provided.

g. Staff Training

The findings of all consumer groups convened under the Project believed staff training was critical to creating a culturally-congruent system. Understanding the Medicaid process and cultural awareness and sensitivity training were the major areas identified.

h. Self-Advocacy

Both consumers and service providers believed that advocacy was of high importance in creating change within a system. All of the work being conducted to create and sustain an ideal system of services for elders and people with disabilities could not come about without proper and sustained advocacy. Thus, it was recognized that advocacy played a vital role in any change model.

In observing what was successful in advancing issues for elders and people with disabilities, it appeared that strong advocacy from self-represented groups was most effective. The efforts of the elder groups at the Mandan, Hidatsa, and Arikara Nation and the Spirit Lake Nation were two examples of this success. Consumers believed it to be important that advocacy groups be established, nurtured and maintained.

2. CHALLENGES TO IMPLEMENTATION AND HOW THEY WERE MET.

There were four major challenges that confronted this project. 1) Timing was the initial challenge. The Grantee came into the project on the second RFP of the program, thus starting late in the process. 2) There was a lack of professional knowledge of the aging and disabled service-delivery process. 3) Ability to engage a representative population of American Indians with disabilities, and finally 4) designing a culture-based model for service delivery presented a unique challenge.

CHALLENGE #1 – TIMING

The Grantee, NDIAC, applied for the Real Choices Systems Change grant in July of 2003, in response to the second request for proposals. NDIAC was awarded the grant in September 2003, seven months into a three-year 36 month grant cycle. Additionally, the grant contract was not formalized until early December of 2003.
Formal direct experience of federal fiscal reporting procedures presented challenges to NDIAC support staff and changes in the States' procurement laws also presented minor challenges to an office with multiple duties. Monitoring the workflow of the sub-contractor, maintaining the projects documentation process and dissemination of materials to providers and consumers presented challenges.

HOW THE CHALLENGE WAS MET

The learning curve of the project relied heavily on both the National Resource Center on Native American Aging and the expertise of the North Dakota Department of Human Services. Outsourcing the substantive research and outreach deliverables of the grant freed up the time of the project director to focus on administrative oversight. The Steering Committee met regularly and provided guidance and vision.

CHALLENGE #2 - CONTRACTOR AND SUB-CONTRACTOR PROFESSIONAL KNOWLEDGE OF AGING AND DISABILITIES ISSUES.

Because of the limited staff of the North Dakota Indian Affairs Commission (NDIAC) a majority of the work of the grant was outsourced to the Native American Training Institute, Inc., NATI. The subcontractor has significant experience in understanding American Indian cultural nuances, working among American Indian communities and tribal governments, and in providing training about American Indian culture. The subcontractor lacked direct professional experience in working with the aged and disabled populations.

HOW THE CHALLENGE WAS MET.

In order to address this challenge, the project engaged the experience of the various offices within the North Dakota Department of Human Services to provide the leadership necessary to complement project needs. The NDDHS Aging Services, Tribal Liaison, and Vocational Rehabilitation Directors agreed to serve as the projects' steering committee and became key players in both the design and guidance of the project. Also of assistance was the Director of the National Research Center on American Indian Aging, located at the University of North Dakotas' Center for Rural Health. While the National Resource Center representatives were not fully involved in the steering committee process, they did provide significant research and information on both national and North Dakota specific data on American Indian aging issues, which formed the foundational premise from which to gather further information on tribal infrastructure and health literacy and service-delivery needs of the elder and disabled.
Also, representatives of the various agencies within the NDDHS, Department of Health, federal human service agencies, e.g. Social Security Administration, Indian Health Service, and the Centers for Independent Living, provided content expertise to support the project.

CHALLENGE #3 – ABILITY TO ENGAGE A REPRESENTATIVE POPULATION OF AMERICAN INDIANS WITH A DISABILITY.

The Real Choices Project was not able to identify and fully engage this population. Little dialogue surfaced about the delivery system needs that serve this population.

HOW THE CHALLENGE WAS MET.

The project ultimately sought technical assistance from the Tribal 1-21 Vocational Rehabilitation projects to identify candidates to engage. I-21 projects proved to have a wealth of information about the circumstances of their clients, their communities, and their needs.

CHALLENGE #4: DESIGNING A CULTURE-BASED MODEL FOR SERVICE DELIVERY.

Because this Real Choices project addressed a much different dimension than that of other projects, the design had to first, identify issues of service delivery needing change, and then determine if the issue was a delivery issue, or a cultural prerogative issue. This was not only an identified challenge, but is a goal of the project.

Designing a service delivery system based on the American Indian cultures of North Dakota is a departure from the non-natives methods of institutionalizing the elderly and the ill. In North Dakota huge sums of money are spent to sustain a system adverse to honoring and recognizing the role of elders in our society. Today, tribal elders teach the language to our next generations, care for grandchildren, lead us in prayer and know the ways of 'the people'. We cannot afford to have them in an institution.

In North Dakota the American Indian population has never been afforded a model for elder services based upon their beliefs and values. Although there are meagerly funded tribal programs providing services, the elder eventually will come in contact with an outsider who typically has a foreign view. There are many levels of government responsible for caring for the needs of these populations, including tribal, county, state, and federal. Regrettably the agencies that have a 'trust' responsibility, Indian Health Service and the Bureau of Indian Affairs, are a part of the challenge.

The challenge of deciphering multiple programs, eligibility and the needs and wants of the consumer lies at the local level. Presently the county level offers case management for those who qualify for home and community-based services. It was encouraging to learn that the purpose and design of the Qualified Service Provider, QSP, program and its' design works in Indian Country. Programs that are sought in Indian Country follow the American Indian cultural norms and are based in a relationship. The project did find long standing methods and ways of doing business needed to be re-evaluated.

It is important to note that the project never intended to have tribal consumers become vested in the non-native system of care. Giving credence to the non-traditional care-giving system already in place in Native communities and authenticating it through this project allows North Dakota an opportunity to embrace American Indian elders and disabled.

HOW THE CHALLENGE WAS MET.

The Real Choices Project addressed a much different dimension than that of other projects. The design had to first identify and determine if the issues expressed by consumers were systems delivery issues based on factors common to small, rural communities, or issues predicated

upon a lack of understanding of the nuances of tribal culture. The project then had to devise a process "model" for change. A critical step, as initially envisioned, was to then provide training on health literacy for consumers and culturally congruent training for providers.

The premise upon which to design a change model for a variety of communities had to take into consideration that each tribal community was at a different stage of awareness and development in their system of care. (These factors are explained in-depth in the section on Lessons Learned.) The Project held focus group sessions in each tribal area, which provided a greater opportunity for input. Following the first year of gathering information it became apparent that training was premature and that a subsequent change in the scope of work of the project was needed.

In communities where fewer consumers were involved in focus groups, the sub-contractor sought ways to further engage consumers. It became apparent that involving policy makers was imperative to building support for change. In order to create greater involvement of consumers the project recognized that assistance from communities and individuals was crucial. When and how elders and those with disabilities were able to take part required special travel considerations. Accessibility was another major issue.

The project then reassessed and modified it goals to address each tribal communities' needs as well as consumer needs. The steering committee engaged in a more focused effort to involve a greater number of consumers and key providers into the effort. Since few consumers had the funds to travel, funding for attendance and participation at meetings was offered. To assure greater engagement of providers, the project requested the support of the Governor's office. By engaging a greater number and type of provider and increasing the number of consumers, greater opportunities for advocacy among stakeholders and understanding and consensus-building among policy-makers were created. The ND Department of Human Services office encouraged attendance by county directors. Participants were offered strategies for community ownership, mobility, self-advocacy and change as well as awareness of model programs of care from which to draw upon and design their own systems of home and community-based care.

FUTURE STEPS AND SUSTAINABILITY

Finally, to maintain momentum and sustainability of the project, new players were brought into the dialogue. The NDIAC Real Choices Grant established linkages. Findings of the NDIAC Real Choices grant will be coordinated with the NDDHS Rebalancing Initiative Grant. In addition, the findings of the grant were presented to the annual Tribal Summit hosted by United Tribes Technical College, an event attended by tribal representatives within the state and region.

3. MAJOR COORDINATION ACTIVITIES WITH OTHER ENTITIES AND WHETHER AND HOW THEY WERE EFFECTIVE.

The major coordinated activities with the NDIAC Real Choices grant were multiple steering committee meetings, focus group meetings held in each tribal community and Bismarck totaling seven, and the Stakeholder Partnership meetings totaling five. Each activity served a purpose and was a necessary function to facilitate the goals of the grant.
The Steering Committee met frequently with the Contractor and Sub-Contractor. The Committee brought a macro-view of the delivery system, an understanding of the population being served, knowledge of the formalized delivery system and was committed to the purpose of the grant.

Focus Groups provided a micro view of the delivery system specific to their unique community. Participants shared culturally relevant concerns, the informal system of care, gaps, problems, solutions, and created the awareness of the importance of self-advocacy strategies.
The Stakeholder Partnership meetings bridged the micro and macro views. Participants offered information about services, data, facts, identified gaps and offered solutions. Service-providers were available to present on the questions needing answers. They recognized culturally relevant concerns and were committed to the elders and the disabled.

The major players supporting the North Dakota Indian Affairs Commission were the North Dakota Department of Human Services offices of Aging Services, Tribal Liaison, Vocational Rehabilitation, Medicaid and representatives from the various offices including Adult Protective Services, Medicaid; and Vision Services. The North Dakota Association of Retired Persons, AARP, was a consistent participant in the NDIAC Real Choices events, as was the North Dakota Division of Protection and Advocacy, P&A, through their regional tribal representatives. Protection and Advocacy was an active participant at both the local reservation level focus group meetings as well as at the Stakeholder Partnership meetings. Tribal and non-tribal service-provider attendance and on-going engagement in the project was stable across each reservation, but varied in representation from each community.

4. COORDINATION WITH OTHER AGENCIES AND THE LEVEL OF EFFECTIVENESS OF COORDINATION WITH EACH.

Coordination with other agencies was complicated and symbolic of the issues that elders, the disabled and their advocates struggle with in locating, deciphering, and receiving services.

Because of the unique status of American Indians and the multiple levels of citizenship they maintain, a diverse cadre of government agencies, including tribal, county, state and federal were involved in the project.

Supporting the NDIAC Real Choices grant were the NDDHS offices of Aging Services, Tribal Liaison, and Vocational Rehabilitation. Other NDDHS divisions involved include Medical Services (Medicaid Policy); Client Assistance Program; Vision Services; and Human Service Center staff. Some state offices or divisions have a long consistent relationship with the ND tribal communities. But historically the tribal-state relationship is relatively new and unfamiliar.

Based upon trust responsibilities Tribes and the federal government have had an on-going relationship. These relationships are tied into treaties and federal law. Indian Health Service, I.H.S, has the statutory and fiduciary responsibility for the health in Indian communities. An understanding of the I.H.S. delivery system denotes its complexity and the necessity to

coordinate services for the elders and the disabled so they are seamlessly met. Other federal agencies involved in the project were the Social Security Administration, (SSA) and the Bureau of Indian Affairs (BIA).

The level of coordination in ND Indian Country with the Real Choices grant was extremely valuable, but could be viewed as complicated. Too often a 'one size fits all approach' is used by non-tribal entities to coordinate services or to build relationships, but each reservation community is unique and there are often differences within the tribal communities.

Embracing elders and their organizations was an integral part of the project. Community Health Representatives, CHR's, a link between the I.H.S. facility and the community, participated in focus groups and Stakeholder Partnership meetings.

Tribal 1-21 Vocational Rehabilitation projects were involved in the Stakeholder Partnership meetings, but also provided technical assistance in identifying American Indians with a disability to participate in the project. Services are limited for adult AI's with a disability living in Indian Country, with the exception of the Tribal 1-21 Projects.

Another type of government invited to participate in the Real Choices project was County government. County Social Services, CSS, are responsible through state statute to administer numerous economic assistance programs and provide case management services for Home and Community Based Services, HCBS. Regrettably there was little involvement with CSS, but they are a key player to ensuring all resources are available to the elders and individuals with disabilities.

Real Choices also sought coordination with other non-governmental agencies and organizations. Those included the North Dakota Mental Health Association, Protection and Advocacy, Independent Living Centers, and AARP.

Higher Education was asked to be involved. UND Center for Native American Aging/Center for Rural Health provided Real Choices with technical assistance and real data.
In the final Stakeholder Partnership meeting Minot State University's Center for Disabilities attended and participated. There involvement was critical to ensure linkage with the Rebalancing Initiative to support and sustain the goals of the Real Choices project.

Real Choices was also fortunate to have the support of the Governor and the ND Indian Affairs Commission, comprised of the elected leadership of the ND Tribes. Their support allowed their Executive Director, who is also a Cabinet member, to be the Grantee. Six legislators participated in the final Stakeholder Partnership meeting. They were given the opportunity to listen to the tribal advocates and organizations to increase their understanding of the dynamics and the issues.

Due to the nature of this project, determining the level of effectiveness cannot be reliably measured in such a short period of time. The system is cumbersome and complicated and agencies may be apt to work in isolation, but coordination is necessary to ensure services are seamless. The probability of improving effectiveness would greatly increase if Tribal communities had an individual or agency responsible for providing coordinated services or case management to these populations.

5. MAJOR ACCOMPLISHMENTS, UNSUCCESSFUL INITIATIVES AND LESSONS LEARNED.

MAJOR ACCOMPLISHMENTS

- Good engagement from all tribal communities.
- The project was able to secure sincere and committed involvement of service-providers from all communities and the state.
- Each tribal community now has plans focused on a continuum of care for their consumers.
- Project facilitated the movement toward the formation of an elder association on the Turtle Mountain reservation.
- Awareness that the way American Indian elders and disabled receive services should be different.

UNSUCCESSFUL INITIATIVES

There were two primary initiatives undertaken to better address some outstanding issues identified that were not wholly successful, 1) an effort to expand home and community-based case management to tribal entities, and 2) inability to engage certain groups.

INITIATIVE #1 – To Expand Home and Community- Based Case Management to Tribal Entities.

The need for reservation-based Home and Community-Based, HCBS, case management became evident as information was gathered through focus-groups. Initial focus group findings from all 5 tribal areas became available in year one. The Steering Committee drafted a bill which was submitted to the 59th Legislative Assembly. That bill would have allowed the North Dakota Department of Human Services to contract with the Tribal entities to fulfill HCBS services, presently performed by County Social Service agencies. The bill eventually became a part of a larger State-Tribal Relations Committee.

The State-Tribal Relations Committee is to be comprised of legislators or their designees. A citizens' committee component is to be comprised of tribal chairpersons or designees, and the director of the North Dakota Indian Affairs Commission or designee. The State-Tribal Relations Committee will examine this issue, among others, throughout the 2005 – 2007 interim. While not un-successful, House Bill 1524 will allow for further and continued dialogue between legislators, tribal leaders, consumers and providers prior to the next legislative assembly.

INITIATIVE #2. To Engage Certain Groups did not materialize.

Greater involvement was desired. However, timing of invitations sent county social services representatives to attend meetings was too short, and while responses were sent, few attended. The project was unable to identify a core of American Indians with disabilities to attend and participate. While there was attendance by several individuals with disabilities, the project had to rely on the Tribal Vocational Rehabilitation V1-21 directors for recommendations, and for disability stakeholder feedback.

LESSONS LEARNED:

Program literature needs to be geared to various levels of literacy, and focused on age-related needs, e.g. larger print, use of native language where appropriate, geared toward non-English speaking consumers, non use of acronyms, more culturally-specific graphic images, and use of graphics in the place of text.

- The message needs to be consistent.
- Be prepared to offer financial accommodations and other social supports to encourage attendance, such as transportation assistance or reimburse expenses to attend meetings.
- Be mindful of the schedules of the elders, when do they prefer to meet and how long can they meet.
- Gear the transmission of information toward more traditional methods of teaching older learners, e.g. use of easy to read language, more visual graphics versus text, use of observation, anecdotal information, etc.
- Support by policy makers, legislators and agencies are crucial to effect systems change.
- The support of the Governor and Tribal leadership is also crucial to effect change.
- Importance of creating opportunities to establish personal interactions and relationships between consumers and providers.
- Take into consideration community norms of experience and protocols when planning work in Native communities.
- Consumers and mid-level providers were missed in the planning. Counties came late to the dialogue and should have been engaged sooner.
- Notices for meetings and other communications needed to be more-timely.
- The process facilitated greater personal interaction and cultural understanding.
- Cultural nuances became evident through interaction – such as the use of humor, ability of making light fun of each other, teasing each other, important protocol for relationship building. These may need to be identified or explained to capture their importance.
- Incorporating cultural values into meetings such as starting and ending with a prayer (usually requested of an elder) and serving of food are important social protocols.
- Small groups should choose their own spokespersons.

LESSONS LEARNED ABOUT TRIBAL COMMUNITIES:

When proposing to work with Tribal Communities, it is important to:

- Recognize that each community is different and that one size doesn't fit all.
- Recognized that each community may be at a different stage of development with more or less of the following resources:
- Human resources, (skills, intellectual property, experience and expertise and more programs and individuals within programs to support the disabled and elder population.
- Fiscal resources- i.e. funded programs from which to draw upon, i.e. Meals-on-Wheels, Elder protection teams, Community Health Representative Programs, for-profit, and private-sector providers to build a continuum of care.
- Physical infrastructure, e.g. hospitals versus clinics, congregate elder facilities, assisted living centers and nursing homes within close proximity to the reservation. Some had less and some had none.
- Policy Infrastructure developed, e.g. tribal regulatory laws, Elder abuse codes.

6. ROLES OF PARTNERS AND CONSUMERS

STATE PARTNERS

The primary partners in the project were the NDDHS Divisions of Aging Services, Tribal Liaison, and Vocational Rehabilitation. Also a close partner in the project was the ND Protection and Advocacy Project, with participation from tribal outreach staff.
Two state agencies served in the role as Steering Committee members, DHS – Aging Services Division, Tribal Liaison Office, and the Division of Vocational Rehabilitation served as members of the Steering Committee.

The National Resource Center on Native American Aging, located at the University of North Dakota, Center for Rural Health. They provided current national and North Dakota specific research on issues pertinent to Native American aging. They also provided NDIAC Real Choices project research data to support recommendations for a work product.

In their various capacities, program directors within the DHS served to provide information to the Project on services available in tribal communities; identified presenters for the stakeholder partnership meetings; and as a liaison to local county social service offices and human service centers serving tribal communities.

SUBCONTRACTOR

Because of its' relatively small staff, the NDIAC outsourced a majority of the outreach work of the project to a local tribally directed non-profit organization, the Native American Training Institute, Inc., NATI. NATIs' primary strength is their work with the human service delivery system, specifically culture-based training for child welfare personnel. They included conducting outreach to the tribal communities through the use of focus groups held at each of the five tribal communities; developing a summary of findings from the focus group results, developing a training module and conducting training for consumers and providers at each reservation community. Several elements within the summary of findings were used to form the premise for a cultural model of service delivery.

CONSUMERS

Representatives from tribal communities were consistent throughout the project, representing the health delivery sector, human service sector, tribal housing, elder-abuse programs, tribal government, tribal elder organizations and disability advocacy programs.

Vocational Rehabilitation 1-21 Program Directors were invited to participate in the project as were tribal Community Health Representatives, CHR, Indian Health Service, IHS, personnel, including service unit directors, contract health offices and mental health directors. Also invited were directors of tribal elderly protection teams and tribal elder association representatives. Letters of invitation were sent to the tribal representatives on the Governor's Committee on Aging. These programs were to articulate issues of tribal consumers. The most consistent and primary participation in the project was by the Vocational Rehabilitation 1-21 staff, CHRs, and tribal elder associations.

7. EVALUATION

A formal evaluation model was not used to evaluate the NDIACs' Real Choices Systems Change Grant, and was not based on a single distinct model of assessment. As proposed, the project endorsed and used a model that provided for formative and summative evaluation thus offering continuous improvement. This model is consistent with a widely accepted model consistent with the Continuous Improvement Model used by the U.S. Department of Education.

The substantive work of the project used key respondent interviews as identified in the original proposal. These methods were used because they supported the participatory approach congruent with American Indian cultures.

KEY RESPONDENT INTERVIEWS AND ON-GOING INFORMATION SHARING:
Core research and evaluation of the project was the use of interview and focus group methodology that provided a free-flow process of information gathering. Open-ended qualitative interviews allowed a flow of feedback to inform and guide the work of the project.

- Tribal consumers were key respondents in the focus group process as were reservation-based service providers.
- Some interviews were conducted using a self-directed approach.
- Informal talks with professionals and community advocates
- The project worked extensively with individual tribes and community members to produce change in awareness.
- Presentations were made to Tribal chairpersons through the North Dakota Indian Affairs Commission and the United Tribes Board of Directors' annual summit.

Through this process the project was able to identify patterns, trends, themes and suggestions for improving services, determine the access and/or lack thereof of individual and community based care needs.
While there was no direct research associated with the project, the information from which distinct decisions were made derived directly from the above referenced sources. A formal process of evaluation of focus group meetings, other than the first stakeholder meetings, was not undertaken. Rather, collection of stakeholder satisfaction and/or dissatisfaction was gleaned from informal responses from participants, letters from stakeholders, stakeholder and consumer respondent processes. Weaknesses and strengths of the project were discussed in Steering Committee discussions and were identified within the context of each meeting summary.

8. ENDURING CHANGES

- Of utmost importance, the project brought a measure of awareness among tribal elders about the importance of self-advocacy and ownership of what services were needed and desired within their communities. Through listening sessions and focus group meetings on each reservation, gaps in service-delivery were identified.

- Networking is an enduring outcome. The project opened the door for consumers and providers to engage in direct dialogue on a level playing field, i.e. a dialogue in which the consumer is not viewed as a client, and the provider is not offering a service but is a co-collaborator on designing a system that works.

- The creation of tribal elder committees for advocacy was the most enduring change.

- Established elder organizations which were further along on developing a continuum of care for their tribal community shared models of elder abuse codes with other tribes. These codes were developed in-conjunction with their tribal legal departments. As a result of this project, one elder association became enrolled as a quality service provider with the State Department of Human Services.

- For the first time in history, an Interim Legislative Committee will examine tribal case management services as state issue.

- Finally, a culture-based model for service delivery will be made available to the Olmstead Commission and to the Department of Human Services.

9. RECOMMENDATIONS PERTINENT TO SERVICE DELIVERY FOR AMERICAN INDIAN ELDERS AND DISABLED

a. How Services are delivered:

- Redefine outreach by providing transportation to go to the elders instead of them coming to the service provider.
- Holistic approach to health as opposed to just physical, medication, etc.
- "Elders Day Out" concept.
- Reciprocity: community concept of keeping good things going, giving. For example, elders work with youth in teaching language and traditions.
- Simplify language of service promotion materials. Don't use acronyms
- Need to build in time for relationship-building between consumers and providers.
- Need to have "cultural-brokers" to speak for, translate and introduce consumer to provider.
- Need consistency in staff.
- Politics enter into turnover in staff, e.g. as tribal administrations change; some long-term administrators can be replaced. Long-term administrators have had the time to build relationships. Those skills are lost, as is the ability of a program to build up a cadre of resource people to afford a continuum of services.
- Make services more accessible in a location that is familiar to consumers.
- Host morning meetings for elders versus the afternoon.

b. How Communication Materials Are Provided.

- Should delineate all service programs available, a comprehensive document.
- Include eligibility criteria.
- Include less generic statements about "services to elders" and more specific information about actual services provided.
- Use less acronyms and professional jargon, and simpler, more descriptive language.
- Use formats suitable for vision-impaired, Native-language predominant and English speakers.
- Use more descriptive, graphically illustrated and easy-to read materials.
- Publications and media materials, where applicable, should reflect images of Native peoples (e.g. photos, layout & design, delivered in a communication manner applicable to the community served).
- Stakeholders believe that information should be delivered in alternative formats: e.g. written, visual, audio-visual, etc.

b.1 Where Materials Are Disseminated.

- Provide information in locations where most services are received, from usual providers.
- Provide information in a one-stop location sensitive to the physical needs of the aged and disabled population.
- Materials delineate where services/help is available.

c. Change to the Intake Process:

- Would be respectful and helpful at all times.
- Organizations should have expectation of cultural competency skill in workers.
- Service area would be entire state/region (not just off-reservation/on-reservation).

d. Recommendations for Transportation:

Tribal leaders collaborate with tribally-based human-service related agencies on the reservations. Purpose is to develop a transportation plan for inclusion of elders in rural areas to provide a more comprehensive transportation system.

e. Recommendations for Funding:

- Consideration be given to a more flexible funding scheme be developed and used based on consumer needs in the provision of services.
- Establish a system for providing funding for transportation of elders and disabled.
- Provide and/or create opportunities for tribal funding for elders to help elders.

f. Recommendations for Inter-Agency Collaboration and Relationship Building:

- Indian Health Services assume a more central role in improving services.
- Coordinate services to the extent possible to maximize resources, to fill gaps in service, to limit duplication, and to eliminate the number of new and different people a client has to see. This present confusion for elders who may not understand different people for different functions.
- Create opportunities for people to meet people to build strong foundational relationships.

g. Recommendation for Staff-Training:

The vision for training includes:

- State, regional and local county offices that provide training offer clearer, simplified methods for responding to information needed on Medicaid applications particularly the issues attendant to recipient liability and options available to clients.
- Provide culturally responsive training of the population served.
- Trust building is a major factor in building client response and satisfaction.
- Understanding culture is a key factor in building client response in provision of service and self-care.

h. Recommendation for Advocacy:

- To support advocacy efforts, both consumers and service providers agreed:
- Elder groups should be established and supported on every reservation.
- State legislation is needed allow for greater access to services on reservation case management services.
- Recognition of the role of the American Indian elder in the community.

10. RECOMMENDATIONS FOR A CULTURAL MODEL OF SERVICE DELIVERY

1. Story-telling by elders, people with disabilities, advocates and other consumers is an important part of building understanding as it is framed out of cultural experience. This dialogue is crucial for shaping cultural understanding and for visioning and designing culture-based programming.

2. Because of historical trauma, planning must be predicated upon listening in Native

communities. Only when all the stories are told can the focus shift to problem-solving.

3. Policy formulation at all levels for American Indian communities and individuals needs to support the traditional model of multi-generational care giving practiced by native peoples however it is defined in each culture.

4. Reciprocity: community concept of keeping good things going, giving. For example, elders work with youth in teaching language and traditions.

5. Need to build in time for relationship-building between consumers and providers.

6. Need to have "cultural-brokers" to speak for, translate and introduce consumer to provider.

7. Organizations have expectation of cultural competency skill in workers.

8. Culturally responsive training of the population served.

9. Recognition of the role of the American Indian elder in the community.

10. Trust is a major factor in informing providers of cultural factors.

11. Use formats suitable for vision-impaired, Native-language predominant and English speakers.

12. Publications and media materials, where applicable, should reflect images of Native peoples (e.g. photos, layout & design, delivered in a communication manner applicable to the community served).

11. RECOMMENDATIONS FOR FUTURE ACTION IN NORTH DAKOTA

The final Partnership Planning Meeting, held on June 28, 2005 focused on solutions to identified issues and involved each of the Tribal Nations in mapping out a future action plan specific to their respective areas in the state. (See attached summaries from the Spirit Lake Nation, Standing Rock Sioux Tribe, Turtle Mountain Band of Chippewa Indians, Three Affiliated Tribes, and Trenton Indian Service Area.)

1. The summary of focus group issues, the outcome of the final partnership planning meeting, and other information gathered during the project period, provide a clear direction for future action in North Dakota which includes the following:

2. To follow-up with each tribal entity regarding their progress in meeting the goals outlined in their respective action plans

3. To incorporate the recommendations for a culture-based model of service into the Real Choice Systems Change Grant – Rebalancing Initiative, administered by the Aging Services Division of the North Dakota Department of Human Services.

4. To provide information, and to monitor the work of the newly

established interim Legislative Committee on Tribal and State Relations. The committee is to study tribal-state issues, including government-to-government relations, the delivery of services, case management services, child support enforcement, and issues related to the promotion of economic development.

5. To provide the results of this project to North Dakota's delegates to the Whitehouse Conference on Aging. Two of the state's delegates are enrolled tribal members. Several areas of concern identified by this project are federal issues, specifically health issues related to Indian Health Services.

6. To work with the Department of Human Services to identify and revise specific laws, administrative code and policies which support a culture-based model of service.

7. To provide follow-up on the Recommendations for Change (see pages 11-15), focusing on the areas of information, intake process, transportation, funding, provision of services, inter-agency collaboration, staff training, and advocacy.

8. To seek additional funding sources to carry out the numerous initiatives identified as a result of this project.

9. To seek support for the addition of an American Indian representative on the State Council for Independent Living.

REAL CHOICES CULTURAL MODEL
REAL CHOICES
CULTURAL MODEL
Narrative

The purpose of the Real Choices Project was to develop a culturally congruent model of home and community based care for American Indians in North Dakota. That is to define what is culturally appropriate with North Dakota Indian Country, not the non-native system of care.

The project was based upon the following principles:

- The culture and values were to be an integral part of all aspects of planning and service delivery.
- The project was to be consumer driven.
- The project was to be mindful of limited services and will coordinate with existing services.

Staying true to the principles of the project, the cultural model framework needed to:

- Keep and retain the uniqueness of each community;
- Ensure decisions are based upon the values of the individual and community.

Based upon the principles and assurances, Real Choices then considered programs that work in Indian Country.[i] There are several examples to draw from that have a positive history of providing services in Indian Country. The program similarities include:

- Strong community connection
- Staff have similar values as the community
- Intimate knowledge of the community
- The Program is properly funded
- Have FTE's to get the job done
- Is locally controlled

Our next step was to incorporate what we learned from the Project. So what did we learn? We learned about the values, norms, and practices of the tribe and their members. In the context of the cultural model we believed these were policy considerations.

- Elders are valued
- Family takes care of family
- Multi generational households are common
- Tribes have their own definition of who they consider family
- Tribes have their own ways to describe family members
- Family members make have a prescribed role
- Language is key to the tribe
- Cultural, customs and traditions define the members and tribe
- Intimacy of the family, community and tribe is inherent
- Relationships are important
- The history of the tribe and it's members is key to understanding

We learned about the needs in the present delivery system. These appeared to be systemic in nature. We found a need:

- for funding
- for FTE's

- to improve communication and information, at all levels
- to ensure elders receive all services
- for buffers from the ugliness
- to feel and know they are safe
- to keep them well, physically, emotionally, mentally and spiritually

And we learned about the issues of cultural difference and race. These appeared to come from within the individual. We found:

- Myths
- Misinformation
- Stereotyping
- Ethnocentrism
- Assumptions

Staying true to the principles of the project…

- How do we create a framework to keep and retain the uniqueness of each community and ensure decisions are based upon the values of the individual and community?

- If we embrace the goodness in the present tribal home and community based care delivery system, what would this look like?

- What are the values of the tribe/values of the individual – and what do they look like? Real Choices cultural model for Home and Community Based Services.

- If weaknesses in the present system are supported in order to alleviate them – what would this look like?

- If we were to challenge the issue of disrespect – what would this look like?

HELPER BASICS

If we respect something, we value it.
or
If we value something, we respect it.

Decisions about "helping" are based on community values.

Decisions about "helping" are consumer driven.

Decisions about "helping" are based on the individual's values.

The Real Choices project declared the project was to be 'consumer" driven, culture and values were to be an integral part and decisions are based upon the values of the individual and community.

1. PUTTING THE CULTURAL MODEL INTO PRACTICE.

To ensure that the model is "Consumer" driven, the model must understand the consumer – aka – human being. .

We as human beings have several ways in which we define ourselves, they can be based on:

- Values – Family, money, land, sovereignty
- Beliefs – Religious, traditional, political
- Roles – mother, teacher, judge
- Responsibilities – work, family
- Relationships with Others – sister, boss
- Titles – Mrs., elder, legislator
- Culture – ceremonies, customs

Do you know how your client sees themselves?
What role and responsibilities do your clients have?
Do you know who they are in the context of their community?

Based upon the principles of the Real Choices project, we also need to be mindful of limited services, and retain the uniqueness of each community.

Based on these principles, *the cultural model uses the structure most natural to the consumer (these tend to be comforting and considers the consumer "in the context of their community values and norms."*

Use of natural helpers

- Family, friends, spiritual leaders

Use of local practices and ceremonies

- Burning of sage, medicine bundles
- Lighting candles
- Eliminating all germs

Use of existing programs

- What is available within the community?
- Where do people tend to go?
- Who do they want to go to?

The Real Choices principles:

- *include the culture and values an integral part of all aspects of planning and service delivery.*
- *the cultural model framework needed to keep and retain the uniqueness of each community, and*
- *ensures decisions are based upon the values of the individual and community.*

2. POLICY CONSIDERATIONS

To ensure culturally appropriateness policies must be evaluated for cultural congruency and must answer the questions:

- Do the policies support the values of the consumer?
- Do policies value or devalue the natural helping structure? Tribes have their own definition of who they consider family.

- Do policies recognize different definitions of family and incorporate them into their planning/design process for home and community-based care? Are non-blood relatives recognized?
- Do policies recognize and support the role of family members based upon the family and tribal structures?
- Are policy decisions based on the beliefs of the consumer?
- Do policies allow for compensation?
- Do policies hinder or help the language? Are languages incorporated into policy considerations? Are terms used that should not be used?

The Real Choices project allowed us to learn some of the values, norms, and practices of the tribe and their members.

- The elder is valued.
- Values are followed and reinforced when elders are kept in their community.
- Family takes care of family and there are many multi-generational households.
- Tribes have their own ways to describe a family members' role within the family structure.
- Indigenous language is key to the tribe and the individual.
- Culture, customs and traditions define the members of a tribe. It is known and comforting for them. Do the policies allow and ensure the customers culture and customs are valued?
- The history of tribe helps members understand today. Do the policies consider the history of the tribe?

3. ADMINISTRATIVE CONSIDERATIONS

We found similarities of success among the programs in North Dakota Indian Country.

- The program has a strong community connection.
- Staff values are similar or the same as that of the community.
- Staff tended to have an intimate knowledge of the members, including such things as landmarks and locations, language, including the slang, and the implicit/explicit rules.
- The programs are properly funded, except one example, but there appears to be a love/hate sentiment. They love the program, but hate the limitations.
- Programs are properly staffed.
- Staff members are properly trained.
- Members are aware of these programs and know where they are located and who is running them. They tend to be very busy places.
- The programs are locally based and locally controlled.
- Policies are congruent with the needs of the community members.
- Staff can be creative to get the job done.

We learned about the needs in the present delivery system that appear to be systemic in nature. Based upon what we heard and learned, these identified needs put elders at risk of leaving their home and community. They are:

- to increase funding and FTE's
- to improve communication and information, at all levels
- to ensure elders receive all services
- for buffers from the ugliness
- to feel and know they are safe

- to keep them well, physically, emotionally, mentally and spiritually

Real Choices can only recommend they be alleviated. But we would also stress a careful review of program policies to ensure they do not contribute to the risks.

Real Choices heard and learned about the issues attendant to the culturally different, to issues of race. These issues appear to come from within the individual. We found:
- Myths
- Misinformation
- Stereotyping
- Ethnocentrism
- Assumptions

Real Choices believes these can be resolved through education, information and training.

4. WHAT WORKS IN INDIAN COUNTRY

	QSP*	CHR*	VR 1-21*	TRIBAL-477*
Connection to Community	X	X	X	X
Similar Individual Values	X	X	X	X
Community Knowledge	X	X	X	X
Funding	X		X	X
FTE's	N/A	X	X	X
Local Control	X	X	X	X

*QSP – Qualified Service Provider

*CHR – Community Health Representative

*VR 121 – Tribal Vocational Rehabilitation

*Tribal-477 – Employment and Training

APPENDIX A.

SUMMARY OF FOCUS GROUP ISSUES

INFORMATION:

- Would be coordinated with all other services in a written format
- Would be distributed
- Would delineate services/help available (as opposed to generic "provide services for elderly"
- Would be provided in a one-stop location sensitive to the needs of the aged and disabled population.
- Provided in Native languages as well as English.
- Targeted to Native people (e.g. photos, layout, delivered in a communication manner applicable to the community served).

INTAKE PROCESS:

- Would be respectful and helpful at all times.
- Organizations have expectation of cultural competency skill in workers.
- Service area would be entire state/region (not just off-reservation/on-reservation).

FUNDING:

- Use of a flex-fund approach based on needs
- A system for transportation spending and availability of funding.
- Tribal funding for elders to help elders.

PROVISION OF SERVICES:

- Redefine outreach by providing transportation to go to the elders instead of them coming to the service provider.
- Holistic approach to health as opposed to just physical, medication, etc.
- "Elders Day Out" concept.
- Reciprocity: community concept of keeping good things going, giving. For example, elders work with youth in teaching language and traditions.
- Simplify language of service promotion materials. Don't use acronyms
- Need to build in time for relationship-building between consumers and providers.
- Need to have "cultural-brokers" to speak for, translate and introduce consumer to provider.
- Need consistency in staff.

INTER-AGENCY COLLABORATION

- Indian Health Service needs to have a central role in improving services.
- Deliberate networking with other providers to reduce duplication of services.
- To coordinate services and to maximize resources to fill gaps in service
- Need to have opportunities for people to meet people.

STAFF TRAINING

- In understanding the Medicaid application and program nuances.
- Culturally responsive training of the population served.

ADVOCACY

- Elder groups established and supported on every reservation
- Change state legislation to allow for greater number of qualified service providers.

APPENDIX B. –
WORK PRODUCTS

FOCUS GROUP SUMMARIES*

The following is a summary of focus group meetings held on all four reservations. The list also includes summaries of three additional focus group meetings held at respectively Bismarck, Trenton, and Fort Berthold to secure additional input from the disabled consumers. These additional tasks were undertaken as a result of the re-evaluation of project at completion of focus group input.

**For clarification purposes, the summary includes questions asked of providers and their responses, followed by questions and answers of consumers. Each set is provided by tribal community focus group.*

STANDING ROCK SIOUX TRIBE FOCUS GROUP
PRAIRIE KNIGHTS CASINO
MAY 24, 2004

1. **How do we develop service literacy among consumers and providers?**
   - Services are experiential; what people perceive is what they believe about programs.
   - Because we are funded by tax, we can't advertise. The people who use the services are the ones who talk about the services (advertise).
   - Community Health Representatives, CHRs, are the lynchpin for services; can serve as advocates and specialists. Has tremendous potential.
   - Protection and Advocacy, P&A, divided organization up by services; but consistency is important. It is important to see the "face" of someone who represents the service.
   - It is important to build trust, become familiar with the people on the reservation and working with their existing programs; not coming on the reservation and telling them what they need.
   - People go from program to program. It would be nice to have one book that has all of the services available to them. A directory that has all of the services (tribal, county, state, etc.).
   - Early Headstart has a directory that one person uses quite a bit.
   - People like to talk to people; they can use the directory but don't always.
   - In layman's terms, describe the services available. In addition, translate or interpret for the elderly. Example: IHS has a paper out but have to be a lawyer to understand it.

2. **How do we incorporate cultural input?**
   - The elderly need language interpretation. Indian Health Service, I.H.S., has a line item for interpreters but has yet to fill position. Need skilled interpreters – can't just have janitors or whatever who speak the language. Need to also know the system.
   - Example of elder who didn't get out of van because he was afraid his pants would fall down and he was weak but the van driver panicked and said he didn't want to get out or understand he had to get out. It is often little things that cause misunderstanding.
   - Get courtesy from MedCenter and St. Alexius but not from IHS. They make concessions but our own health services don't.
   - Need to have more meetings of community services so we know what is available and who does what.
   - Need to develop hiring practices for people who work with the disabled.

- We don't know how to network and coordinate services. Create better communication.
- Use more informal contacts to get cultural input.
- Trust is a major factor in informing providers of cultural factors.
- Self-esteem and being independent are important. There is an intergenerational dependence on TANF and people are afraid of doing it another way or haven't thought of doing things in a different way.
- Customer service is lacking in many organizations. People won't come back again if they are treated badly. Many go without because they were refused services or not treated friendly or in a flexible way.
- CHRs have health fairs that allow programs to come onto the reservation and let people know what they offer.
- Have people who have elders in the home but can't find people to help them in the home. Nature of hours is difficult (not big chunks of time, just a few hours here and there). We've lost a lot of culture.
- There is a lot of culture on the reservations and we need to learn to respect that. Used to be scared of asking questions but now just ask them.
- Points of contact are critical to understanding cultural input. Has four cultural contacts and two would be comfortable asking questions and the other two would not. Finding those people who you are comfortable with and can ask questions of is critical. Need to have points of contact.
- CHR and staff from medical centers used to do cultural sensitivity sessions (they come down here and we go up there). Don't do it much anymore. Logistics are difficult.
- Bismarck (Community Health Services Organization) meets every month and has a sustained network established; a structure needs to be established on the reservation.
- Culture is always on the back burner; younger people don't understand the culture the way older people understand culture. Loss of culture.
- Critical piece was using the reservation system to build or have a success – a taste of success was helpful in moving along toward more success.

3. **How do we deal with cultural conflict upfront?**
4. **In creating a culturally congruent model how do we impact systemic change?**
5. **What are the best and most effective approaches?**
6. **How can we help provider understand facts from myths?**
7. **In your experience what are the difficulties in serving Native American or diverse populations in pre-services (enrollment, etc.)?**
8. **In your experience what are the difficulties in serving Native American or diverse populations in actual services?**

- Elderly – some barriers are lack of services, elders taking the back burner, no reservation-wide elderly organization for advocacy; getting information to elderly (what is available, etc.); close to 500 elders 60+, in 10 years or less, we will double the population.
- Bureaucracy in government is difficulty; took one family 5 years to get a ramp in front of their house. Many times, system doesn't give a response or get a respectful response.
- Inflexibility of government regulations; rules are rules and people come after.
- Limited resources are available; sometimes a person has to wait a month for one day to make an appointment for a month after that.
- Need to have more services for education. "New Hope" program in Sioux Falls(?).
- The elders are forgotten. Many times, the only people who will help are one or two family members.

- Confidentiality is an issue. Sometimes people leave the reservation to get services because they don't want everyone back home talking about them.

9. In your experience, what are the difficulties in serving Native American or diverse populations in evaluation?

10. Describe exemplary programs, staff, services, etc. that have demonstrated cultural competency.

- Room at St. Alexius for American Indian families to do cultural ceremonies, etc. such as smudging and/or singing. Bad example is our IHS doesn't even do that. Next step for medical centers is to recognize our spiritual leaders.
- CHR was doing home visit. Client was very depressed. Doctor told him he had diabetes. Wasn't explained well; he said he had to take medicine for the rest of his life but thought he only had 30 days to live because he only had 30 day prescription.
- Three pharmacists who fill 800 prescriptions per day.
- "To be eligible for VR project, you have to be an enrolled member living on or near a reservation..."; the idea of taking a program such as voc rehab and applying it to the people and having the people who understand the culture running the programs. Providing for needs as opposed to having hard and fast rules designed for a different group of people.
- CHR created partnership with Women's Way.
- "Availability of services"; says services are available but isn't reality. CHR isn't a transporting service but almost lost their program because they were transporting. Biggest problem is lack of transportation for elderly. What good are programs if you can't get to them?
- Tribal leaders and Indian Affairs Commission and state government leaders have worked on building relationships and enjoy an understanding. Need to maintain good working relationships.
- A senior center in Nevada (Washoe) had a whole building built for the seniors; one half was dining room and every day, they would have a meal. On other side was fireplace, couch chairs, etc. Garden in back with picnic table, etc. Had a van to transport elders. Students in immersion program worked with elders to do cultural activities such as picking traditional foods, making baskets, etc.

<u>ADDITIONAL COMMENTS</u>:

- Could the NATI expand services to provide technical assistance to tribal elderly services?
- Make more people aware of issues that most people don't think of regarding Native Americans.
- Creating more opportunities for non-Natives to interact and find answers to questions from knowledgeable Native people; have them be a part of support groups around the state, for example.
- Medicaid dollars is a big issue. Many dollars are dedicated to nursing homes but more dollars are needed to keeping elderly at home as long as possible instead.

TURTLE MOUNTAIN BAND OF CHIPPEWA
FOCUS GROUP -SKY DANCER CASINO
JUNE 1, 2004

PROVIDER QUESTIONS AND RESPONSES

1. **How do we develop service literacy among consumers and providers?**
2. **How do we incorporate cultural input?**
3. **How do we deal with cultural conflict upfront?**
4. **In creating a culturally congruent model, how do we impact systemic change?**
5. **What are the best and most effective approaches?**
6. **How can we help providers understand facts from myths?**
7. **In your experience, what are the difficulties in serving Native American or diverse populations in pre-services (enrollment, etc.)?**
8. **In your experience, what are the difficulties in serving Native American or diverse populations in actual services?**
9. **In your experience, what are the difficulties in serving Native American or diverse populations in evaluation?**
10. **Describe exemplary programs, staff, services, etc. that have demonstrated cultural competency**.

- The key is to find the people who are sincere and who want to be there. True advocates. Then give them support and network with other like that.
- Maury Hiltz (?) from P&A really did help. Duane Gourneau is helpful. He works for mental health and truly cares about people.
- We're here because we care. Dudley Zimmerman from IPAT was also really helpful. We would have to beg and beg for services and nobody would show up. But he followed through with services.

CONSUMER QUESTIONS AND RESPONSES

1. **Who is my main contact person in the community for help and why?**
   - Resources often happen by accident. We shouldn't have to do that. There should be something there.
   - I'm always leery about the state trying to help us because they're often forced to and don't always stay there.
   - SILC (State Independent Living Council) has not been helpful; in fact, has been a barrier to many Indian issues.
   - There are a couple of people who are being barriers. Make it hard for us to get services to our people in our communities. It's a big problem in the community. It's hit and miss.
   - I've been the go-to person and it doesn't bother me but the services need to be centralized and it should be a Tribal effort and cooperative - "One stop shop".
   - The person that individuals go to should have the verbal information but should also have something on paper – a resource directory of sorts – that will allow people to learn more.
   - Lots of people use the hospital as their main source. Those services should be expanded.
   - Big conflict right now. Can't get medication filled because of procedural rules. Need hospital to be professional and resourceful rather than put up barriers as they do now.
   - So-called partners sometimes aren't even aware of what each other does (ex: WIA didn't know what VR was).
   - Usually talk to people at Tri-Care. Private foundation for nursing and health care. Get

very little help from any other entities. Started with them but then went to Belcourt hospital.

- It was difficult when the people "fall through the cracks" of middle income and don't qualify for some services.
- State, counties do not share any information! The hardest part is finding people who want to be helpful. When you finally find out about services, they're "out of money".
- It would be interesting to find out who got the services after the money was out. It would probably be white people and people the county workers know. Take our statistics but don't share money. Example of lady who went in and was visibly Indian and was told no money. Went in with her mother, who was white and program had money.

2. **What are any barriers you've experienced in pre-services (enrollment, etc)?**
It's important to have good working relationships with other entities. But once in awhile there are agencies that don't want to have anything to do with Native Americans or serving Native Americans.

3. **What are the strengths/good things you've experienced in pre-services?**
4. **What are any barriers you've experienced in receiving services?**

- State is using HIPAA as excuse for not providing services. Example of institutional racism.
- Get case management out of state/Devils Lake (VR refers from the Tribe to the county). Clients are discharged early or caseworkers don't accept them or don't follow up. They are not providing services they are supposed to. Sometimes they say they are providing services when they are not (example of child taken from San Haven and didn't know until 25 years later that he was gone).
- The four Indian reservations have more brain power per capita than the whole state. They think, "those poor Indians". We have the answers and we don't need people to come and tell us.
- At IHS, they have only one psychologist. Limited services available and doctors become so overwhelmed. Causes accidents and medication is not monitored, people have died because doctor can't keep up.
- Services are not here and family members have to take her to Minot or other places where services are available. Had to go to Devils Lake for Adult Protective services but they told her they couldn't do anything for her because she was on the reservation. Tried to use tribal services but didn't get them.
- Distances are big barrier to getting services. Especially with gas prices now. Hurts because family can't go and visit, elderly are used to being home in their own community, etc. It's terrible that we send them out of the community.
- When her mom was at retirement home close, they had activities with fiddling and jigging and stuff. Now she's at other home and they don't have activities for her to do.
- County/state uses jurisdiction as issue for not providing services but use our statistics to get funding. It's a perceived barrier. Nothing is preventing the county from going into Tribal court and advocating.

5. **What are the strengths/good things you've experienced in receiving services?**

- Tri-care was helpful in providing services. They went to bat for my dad with VA. VA was going to cut off services. They took a cut in what they receive in order to make it work for him. It's a clue/a real strength. They are surviving as a non-profit because they are providing a service. Maybe we need to do that with CHRs, for example. Pay them

for providing a service as opposed to just paying them to be there. They don't participate in cooperative type services.

- I'm working with learning disabilities and I have people who have made it "successful".
- The more you meet with people, talk with people, give people information, the better response. Don't wait for them to follow up but do the follow-up yourself. Have to be ambitious and aggressive enough to keep advocating.
- Need to have Tribal Disabilities Act. Issue is legality. Will be having meeting on it to discuss the issue.
- Fresh start program (for job training through TANF) is doing a good job.
- Example of finding part in law that states that someone on VR has requirements that are waived for food stamps.
- Care Medical (through Mercy Hospital, another private provider) will come and fix her wheelchair or leave one if they have to take it. They ask her if she needs help. They come to the community rather than having the family go somewhere else. Another example of providing services rather than just being there.

6. **Describe an outstanding experience you've had receiving services.**
7. **How do we develop service literacy among consumers and providers?**
8. **How do we identify unique services and/or funding sources?**
9. **What are the cultural considerations of disagreeing with a provider?**

The four 121 programs were supposed to have cooperative agreements with the state. Some of the programs didn't have a cooperative agreement for ten years. Sees it as state putting it off because they believe the programs will go away. They are the ones who are responsible for getting these agreements. Use the casinos as excuse. Have to go through legal teams, etc. They are out of compliance but don't have consequences. Another example of institutional racism.

10. **How do we deal with cultural conflict?**

- Mixture of French/Chippewa/Cree/Michif people. But we're not culturally significant. Kind of accept everything. Have to identify our community culture rather than individual racial/ethnic culture.
- Develop something similar to AIHEC and the tribal colleges for people with disabilities. Need to have some cohesion and collaboration.
- There is a plan coming down for some kind of entity – nursing home, assisted living, basic care, long-term care or something else – so we are supposed to be planning. Tribe is buying the bed (slot) from the State. Shakopee is giving them money to buy beds. Every time tribal administration changes, the priority goes to the back. The offer from Shakopee is still on the table but is not being taken advantage of. Used to have a "bring Our People Home Committee" but they're all dead now. The biggest problem was the planning process and being able to access the beds. State issued the moratorium on beds when it was cheaper to buy the beds so the price of beds doubled. Tribe has 42 beds purchased so far. Still a competition for resources. We have to learn how to deal with the urban/reservation issues as well as the loss of culture issues. We have to make tough choices now and we shouldn't have to.

<u>ADDITIONAL COMMENTS</u>:

- It would be important for conversation to have court, law, legal people here because they work with the tribe as far as civil commitments. Also, need to be trained about Olmstead and people with disabilities.

- It would be helpful to have our own tribal policies regarding disabilities and elderly.
- Housing issue: The federal government gives us housing money. Lady has house a year and a half old and its going into foreclosure. Don't want to pay for it because of all the black mold and wood rot, structurally it's not a $79,000 house. When go to housing, says can't help. Written to all sorts of people but nobody will answer her questions or help. Were supposed to give her new materials but contractor gave her rusty nails, warped doors, old paint, etc.
- No accountability; no consequences for not following through. Like old Indian agents who took rations for Indians and gave them rancid meat.
- Need to have services for caregivers; respite care for the primary caregivers (who are often family). Do we have a system for that? Should we be thinking about developing such a system given the situation currently?
- Social security related issues are major. We need to have a representative here all the time to answer questions about social security. Only get a recording in Minot. Hospital has videotape and has a Benefits Coordinator but don't provide right sort of information. Crisis situation. About a quarter of VR work is on social security.
- Large issue is the social security losing information. Making people pay back because of their lack of information or have to re-submit and re-submit information. Spend a lot of time on training and posters regarding "ticket to work" but said it was only for people who work full-time. Program is a failure. Doesn't work for most people, who can only work part-time.
- People from Tribe, housing, schools, etc. need to be here.

SPIRIT LAKE NATION FOCUS GROUP
SPIRIT LAKE CASINO & RESORT
JUNE 8, 2004

PROVIDER QUESTIONS AND RESPONSES

1. **How do we develop service literacy among consumers and providers?**
2. **How do we incorporate cultural input?**
3. **How do we deal with cultural conflict up front?**
   - Humor
   - If I was provider, I would try to hire minority group representation to work. I would ask the Tribe to come in and teach us the culture and some ways.
   - We put on Northern Plains Conference. We try to have sessions that deal with minorities. You can't control what other people say and do but you can control what you say and do to them.
   - Education of my self and of those who I serve. One of the things I am working on is trying to get more cultural sensitivity training for our organization.
   - We do that too. Try to educate staff so they can be more understanding and have more respect.
   - I just try to be nice to people. Listen to them and not be negative.
   - It's something that goes on here but it's not just with non-Indians but it's also with those who aren't from this tribe. Lady complained about "white social worker", was told the worker wasn't white, she was from Turtle Mountain. Lady said, "That's even worse!"
   - In our program curriculum, we use the medicine wheel to help develop life skills. We concentrate on areas that are most needed: communication, self-esteem, building health bridges. Use our own tiospayé [family kinship system] to help them understand.

4. **In creating a culturally congruent model, how do we impact systemic change? What are the best and most effective approaches?**
5. **How can we help providers understand facts from myths?**

   - I talk to people about our culture. Try to get them to understand that we come from two different worlds. Our ancestors had a spiritual philosophy that was orally handed down, today's culture is all text orientated. Try to dispel myths like we don't pay taxes and we always get a check each month. One of the myths is that our culture didn't have anything wrong. The difference is that they dealt with their problems spiritually long ago. We have lost that.
   - Agree with the previous comment.

6. **How can we help providers understand facts from myths?**
7. **In your experience, what are the difficulties in serving Native American or diverse populations in pre-services?**

   - There are too many programs out there that people think are there to DO the things for them. No self achievement.
   - Programs weren't intended to do everything for everybody.
   - Funding and rural issues. Services available in other parts of state that aren't available here because of distances.
   - Denial stages. We get people coming through program but drop out. Once

we talk about self-esteem and get them to think about liking themselves, they do a lot better.

- With Senior Services program, no matter how hard we try to provide meals, we always get someone who complains about them. Don't appreciate what we offer them. It's sad. Seems like the older they get, the crabbier they get. They just get hateful.
- I try to stress to drivers that take meals out to deal with special issues of elderly. Example of older lady in wheelchair who wanted meal delivered directly to her in front of her. Drivers should accommodate her since that is who we serve.
- My grandfather received meals and he sometimes found hair in his food but I just made a meal for him instead. Had experience of giving this elderly woman her meal in her house and she thanked me and said I did a good deed for her. Made me feel really good.

8. **In your experience, what are the difficulties in serving Native American or diverse populations in pre-services?**
9. **In your experience, what are the difficulties in serving Native American or diverse populations in actual services?**
10. **In your experience, what are the difficulties in serving Native American or diverse populations in evaluation?**
11. **Describe exemplary programs, staff, services, etc. that have demonstrated cultural competency.**
    - Dealing with driver example (above).
    - We have an elderly program that deals with problems really well.
    - I have to incorporate a lot of the cultural into the life skills sessions as motivation and relate back to our culture to help them understand (medicine wheel). Presenter taught that if everyone could work from the heart, a whole lot can be done. Look for the good in everyone and everything.
    - We provide services to Native Americans so we try to be sensitive to that and take them to pow-wows if they want or decorate their rooms.
    - Like what she said about looking for the good in everyone and work from the heart. My dad talked the same way.
    - I have problem with cultural competency. We're trying to teach that there was a civilization that existed before.
    - Cultural competency program I see is the elder's day out. It is the tribe giving it's elders the day out and then giving them educational programs. Health staff is there taking sugar and heart information for health.

CONSUMER QUESTIONS AND RESPONSES

1. **Who is my main contact person in the community for help and why?**
    - IHS clinic. He just recently had surgery so he has medicine and bandages. Just found out nurse will be gone for two weeks so I will be doing that. We have to take trips to Bismarck.
    - College president has a background in health, and wants to be helpful for us.
    - IHS psychologist, at TM is the LSW at IHS, Tribal and county social services, DD case management.
    - Education is important. People don't know about services until they need the services. Legislators need to hear from people about the need for home and community based care.
    - Main contact is with tribal council and district representative. Most of the time, we run into funding problems.

2. **What are any barriers you've experienced in pre-services (enrollment, etc.)?**
3. **What are the strengths /good things you've experienced in pre-services?**
4. **What are any barriers you've experienced in receiving services?**
5. **What are the strengths/good things you've experienced in receiving services?**

6. **Describe an outstanding experience you've had receiving services.**
   - Example from Turtle Mountain. By coordinating work with LSW at TM, got a person with traumatic brain injury back home where they wanted to be.
   - One of the things I think we do is have "elders day out". Elders come to casino and have speakers come in and then they have lunch and play bingo.
   - Project Care. In cooperation with Spirit Lake Sioux Tribe, Devils Lake, etc. to develop a kidney dialysis process. Worked together to provide this service
   - How do we develop service literacy among consumers and providers?
   - With senior services, we have outreach worker who goes out to community and has face-to-face contact with them; that works well.
   - Agree. Outreach worker comes to see my Dad and helps explain a lot.
   - Indian Health. I ask a lot of questions and keep going back until I get an explanation about the medications I take.
   - On the provider side, being aware of your language and not using acronyms for everything.
   - Agree.
   - Education. Sometimes it helps if not just the agency explains it but someone else does it from another perspective. Also have repeat of information that seems to help.
   - Very important for us to have caring attitude. People can sense if we are genuine. People are afraid of giving social security number because they are afraid of losing something else. Let them know we are there for them.
   - attended sessions by NATI and I think I took more away from that than they could ever know (Historical Trauma). Education did it for me and I had no idea I was going to learn so much.
   - Have younger daughter who works in nursing home and its sad sometimes. Sometimes the elderly Indians don't want Indians to wait on them – part of respect. Lot of elderly Indians that are very lonesome. Makes her feel good about what she is doing and whom she is serving. One of her dreams is to have an elderly home here.
   - Having patience when giving service. Give it over and over. Can't give up if they don't understand the first time. Through the years, everything was given by brochure, then on overhead, now on powerpoint. But keep giving the information over and over.

7. **How do we identify unique services and/or funding sources?**
   - We get calls all the time and refer them to housing (for ramp) or some other agency, depending on the need.
   - Agencies do good job of calling and asking if they don't have service.
   - We have the radio that gives us a lot of information.
   - When there is something I need to know, I usually just start asking questions of the programs available. Calling around and asking questions. We've been able to get handicapped access in his bathroom and hospital bed in living room and wheel chair.
   - I just go to the tribal council and hollar around (hehehe...). I just listen to people and see what they do in their programs.

- Grapevine. I found out from other people that they were giving out shoes for people with Diabetes.
- I call Carol at elderly program at Benson county. Through Myna's program also, they are able to help.
- We refer to human service center.
- I refer to Ramsey County Social Services
- I make my usual contacts and then if I can't find out anything, I call other contacts from other tribes. If I can't find anything out there, I go to the Internet. I use the American Indian Disabilities Technical Assistance Center, North Dakota Association for the Disabled.
- My mom finds out information from talking to other people and through brochures. My grandfather got a brochure from another elderly woman in the community about SSI and that's how he found that out.

8. What are the cultural considerations of disagreeing with a provider?
9. How do we deal with cultural conflict?

- Working on the REZ, my boss understands that I need time to deal with illness and family and gives me time off.
- Elders will work with group working on gangs (initiation was to beat up an elderly) to establish ordinance on how to use cultural interventions for youth. Gangs are Native-oriented so the elders are working on that issue to help youth understand culture.
- One experience. I heard people yelling and came out and saw own cousin verbally yelling at my Grandfather. He hit my grandpa twice in the head. When I tried to call police, my cousin attacked me. My grandpa called the police and they found my cousin. Our elders and young people were sacred. No contact with cousin anymore. My grandfather didn't want to but we told him to press charges for elder abuse.
- My sister, who is elderly, a young person attacked her and she ended up in a wheelchair. Went through all the necessary procedures with law enforcement but she was treated as the perpetrator instead of the victim. They were waiting to throw her in jail after she got out of hospital.
- Education. I worked with and observed cultural conflict. Been in situations where non-Native don't understand culture and then Indians don't or won't stand up for themselves because of their culture.
- After I attended the NATI training, we decided to enhance services for reservations. We are working on draft of tribal resolution for elder abuse, adult protective services. We have agreement that a lot of people aren't aware of. Working with Turtle Mountain on this.
- I attended a meeting at Standing Rock, a gentleman from the high school did singing and dancing. Really a good way to teach students their culture and also adults who aren't aware of culture. I think that would be a good way to help.
- Dealing with cultural conflict, I find the best way I deal with it is through humor. If you can use humor about yourself with the person you have a cultural conflict with. Our ancestors used humor to deal with conflict. That's how they survived.

OTHER COMMENTS:

- When I ask our clients about using cultural materials, they say they feel really good about it. They feel proud and I use it as self-esteem builder.
- What I would like to see is more providers for the elders. Not just meals but programs for youth; used to be program where youth came and did stuff for elders like

cut the lawn, etc. Good for youth to keep them out of trouble and contacted with elders.

- Agree. It would cut down a lot of the abuse issues. I was taught to respect elders but elders don't take on role as elder and are not respectful themselves.
- Create support groups to help each other.
- Betty Keegan said there was a movement toward single point of entry for services (one stop shop).
- Issue of grandparents taking care of grandchildren. Lot of time there is not financial assistance for them and it creates a lot of hardship.
- Expand elder's day out.
- Suggestion: you guys come out and do something during those times when they have elder's day out.
- Have a new generation of elders. Many have advanced degrees. Learning how to be proactive as elders.
- One of the problems in prosecuting tribal elder abuse is that the elders need to serve as witness and many are reluctant to.

THREE AFFILIATED TRIBES REAL CHOICES FOCUS GROUP
4 BEARS CASINO
JUNE 16, 2004

PROVIDER QUESTIONS AND RESPONSES

1. **How do we develop service literacy among consumers and providers?**
2. **How do we incorporate cultural input?**
   - I was raised in a home with two tribal members (foster care) and I find that you treat everyone in the same way, approach everyone with respect and not to stereotype. We get in trouble when we try to treat people differently.
   - You've got to educate yourself.
   - There are so many different cultures that you're looking at, so it's hard to answer this.
   - I ask them what they need. We have meetings so they can socialize. We have parties for them. We help them with whatever they say they need.
   - I know my language and that helps a lot. They are more at ease and they like to talk to me because we talk the language.
   - There is a different way of communicating from the elders and the school kids. Some elders need to be prepared more when they come up against a change.
   - I like what that guy said. We don't separate but it's a very sensitive thing. Us elders are very modest, our lives are so much different. My grandmother has taught me her way of living. We want someone to come into our world and ask us what the needs are, what is the best thing for them.
   - I would say to communicate. This elderly lady in Parshall lived alone, I had to have someone communicate with her to see what she needs because she was used to living alone. Communicating with person, family, whatever, you need to get across how you are trying to help them. Accept that people are different and communicate with each other.
   - In our experiences, it's worked with elders, you communicate, greet them non-aggressively, why you are there, upfront about it. Can't be in a hurry. Have to do that front stuff. If don't, they are going to back up and not respond to you. Move in slowly. If a non-Native is coming in to bring services to elderly, need to have someone familiar with the elders to introduce the service providers and make them feel comfortable. Move slowly and be sincere and upfront.
   - I can relate to cultural diversity. Grew up in inner-city. I have to reiterate that it was communication. My grandfather told me not to tolerate each others' cultures but enjoy each others cultures. You need to attend ceremonies and learn to enjoy what is going on. Tell folks about yourself as well as asking people to tell about themselves. I can't say anything but...make friends. Mention who you know that they may know. Apologize if you make a mistake.
   - Two words that stick out with me are communicate and educate.
   - How do we deal with cultural conflict up front?

3. **In creating a culturally congruent model, how do we impact systemic change? What are the best and most effective approaches?**
   - Through lots of discussions, we came to an understanding of what elders wanted. We are community oriented. We don't try to own anything, we don't try to take credit. We just work with them and meet their needs. We are right there in the community. We When I

first transferred back to the reservation, the Bureau was changing and asked for new ideas on how to work with communities. Anson Baker and I decided to move some of the staff back to the agencies. The program failed because we didn't do enough planning. The community has to be cohesive. As elders, in planning and recognizing the isolation of the communities, we recognize the trend is to expect everyone to go to the services instead of having services come to them.

- It's important to give people choices. Maybe they want to meet in their homes, maybe they want to meet in an office I have set up in the community. We also have to look at our hiring, recruitment, new staff. In new training, would the elders be willing to provide input and training so that service providers can know what is appropriate? There is prejudices that go both ways too. There are people who don't like me just because I'm white. But I understand that. We need to know the impacts and the history and why we have the conflicts we do.
- Number one is to have people meet face to face. Elders want to feel workers out too. You can't trust everybody. Need to build that trust. Maybe they feel embarrassed because they have poor house, but if they get to know you, they will invite you to their house. Many times, they trust women more than men. One elder wouldn't work with a social worker at all because of her bad experience but she worked with a Native social worker.
- I sometimes serve as a 'liaison' and help develop relationships. That helps when you know someone who knows someone.
- Our agencies have to give our representative more leeway. When I work on the reservation or with older people, they give us more time. There are certainly pieces of information we need to get but there is no time frame so if I can take my time and approach it slowly, it is helpful.
- We deal with six counties and every county is different. Montrail county seems to help quite well. We have a lot of families where a family member cares for family in Montrail county. We encourage the family to come in and learn to also be advocates and care for their families. Some elders don't have family.
- Flexibility, communication are keys to a culturally congruent model
- Advocacy is major part of the success of the model; elders themselves are involved and know the systems, both tribal and county.
- I got really sick in 1998. My brother talked to Fred and he got me down to Rochester. He saved my life. If he didn't do that, I would've died. My uncle called me and I went to visit him in the hospital. He was laying in bed. I told him the best thing is for him to start walking. The next week, he was walking around and got better and was gone.

4. How can we help providers understand facts from myths?

- One big myth is that we still live in tipis. When you go other places, there are still people who believe those myths. Another one is that "all you Indians get paid for being Indian".
- Education. Have to educate them.
- You've got to start with in-service training for new people. In education, we used to have a 'cultural test' we would give to people working with Indians. Many of the people working with are people couldn't pass the test.
- If we go back to the communication but go one step further and work on developing relationships. How do we help establish relationships and help people get to know each other? I don't believe in brochures for information. Need to help people get to know each other so we can start breaking down the stereotypes.

- Elder doesn't take her pills on Sunday because she doesn't believe in it. Have to accept that even if you know it's hard on them.
- You have to talk to elders slow, smooth and make them realize what you're going to do for them and help them understand.
- Long time ago, as the elders got older, the put them in nursing homes, the stories came out that they knew they were going to die if they got put there. Lot were in their 60s but looked a lot older. There is a fear of nursing homes.
- There is so much going on as to how they think of us as Native Americans. I don't want to say anything unkind. I was married to a non-Native and there is a lot of misinformation out there. I don't want to go there. Those bad things are still here. Lot of us can't work because there is not enough work here on the reservation. So many times, they come with a survey and we fill out all kinds of stuff but we never see what comes out of it.
- My kids were raised here and they got along but we have our problems even here. We have non-Indians say that there are too many Indians in town. Non-Indians are busing their kids to other schools and Indians are sending their kids are busing to other Indian schools. All the non-Indians are moving out of town and down by the river, just beautiful homes, and leaving the Indians in the town. No matter what, some people will learn to get it and some won't.
- From movies, Natives are portrayed a lot (ex: Dances with Wolves). But we need to educate the younger ones.
- We live with misunderstanding and we deal with it by teaching our children right, how to respect each other. If you create prejudice, you are going to teach prejudice to your child, make it a burden.
- Learn to be friends, learn to share. I again would ask folks who are American Indian to tell us when/if we screw up.
- We moved to Dickinson from Pennsylvania (but both of us were from New York) with our children. One day a young Native American boy came to the door and brought my 16-year-old daughter a star quilt. She stayed friends with him for a long time. Still has it.

5. **In your experience, what are the difficulties in serving Native American or diverse populations in pre-services?**
6. **In your experience, what are the difficulties in serving Native American or diverse populations in actual services?**
7. **In your experience, what are the difficulties in serving Native American or diverse populations in evaluation?**
8. **Describe exemplary programs, staff, services, etc. that have demonstrated cultural competency.**

CONSUMER QUESTIONS AND RESPONSES

1. **Who is my main contact person in the community for help and why?**
2. **What are any barriers you've experienced in pre-services (enrollment, etc.)?**
   - We have taken our health facilitator and put her at the clinic. She's very far away from the community.
   - When something does happen, you really don't know who to contact. We work with our coordinators so they know what the services are so they can refer elders to the appropriate places.
   - I didn't know we didn't give service to non-members, but we limit to members.

- In talking on the phone to a non-Indian service, they told me to go to the Tribe for services. "Shouldn't you go back to the Tribe for this...?"
- In the past, especially in the Four Bears community, if we don't have the resources, I try to call the Tribe. I call too early and nobody is there, if someone is there, they don't know anything. Don't have the right numbers and can't get ahold of anybody. Fill out applications and they get lost, get no correspondence with them.
- Go to social services, they ask have you gone to Tribe, have you gone to this place or that place... In the end, you just say the hell with it. A lot of seniors just give up. It is our culture that we don't like to ask for help and then when they say, "well, you need to go over here". We would rather not get services than to go beggin' around. That's how I see it.
- I think one of the main barriers to services is IHS doesn't even have an ambulance. New Town provides service but our people can't afford the charge for it. With public health, you can't get sick after 5 p.m. or on weekends. We have to do a lot of the services for CHR because they don't have services all the time.
- When you go to public health, you sit there and wait all day. They don't go by appointment. You get tired of it and leave. When we go to see the doctor out in Minot or somewhere else and they give us prescription, they won't fill it at the pharmacy. They just give you a little bit of pills or don't have the kind we need so lot of times we go without.
- Dental – if you don't call the first day of the month, you are out the whole month.
- The whole system is underfunded.

3. **What are the strengths /good things you've experienced in pre-services?**
4. **What are any barriers you've experienced in receiving services?**
5. **What are the strengths/good things you've experienced in receiving services?**
6. **Describe an outstanding experience you've had receiving services.**

- Assistance with hearing aids and monitors
- Helping elders getting around with wheelchairs, elders really appreciate the services we provide (elder program)
- My sister had to move to Bismarck and the elderly program helped her move, the Tribe gave her some financial help. She took dialysis there and everything was working out. Her kids wrote a thank you letter. She was walking because of help she received to get to Bismarck.
- There are three Tribes here. Went to see this one lady to go make her breakfast. I went there and introduced myself and told her I was there in place of another Coordinator. Got upset. She was from different Tribe and didn't know me or my family. So I left and got a hold of niece.
- Been proud of this program and these guys for what they're doing. They're doing a good job.
- Seen many services from our elder program staff. When we have elder who needs a variety of services, they are able to coordinate that; bring all those services together. Keep positive attitude has helped.
- This elder program is doing a lot more than any government agency because we all have a genuine concern for elders.

7. **How do we develop service literacy among consumers and providers?**
8. **How do we identify unique services and/or funding sources?**
9. **What are the cultural considerations of disagreeing with a provider?**

10. How do we deal with cultural conflict?

OTHER COMMENTS:

- Elders program has been in existence since 2000. They have 501(c)3 status. There is a Director and Coordinator in each segment and an overall Director. Try to coordinate with county and community health. Purpose is to provide services to the elderly in their home as long as possible. Financial services, eyeglasses, dental care, emergency services, transportation, and advocacy. We find coordinating all of these services is a major task. We're finally getting a handle on that area. For example, five elders in New Town receiving nursing assistance from county. Our staff tended to them before this resource was accessed. Area having difficulty – accessing grants. Would like to develop third-party billing so they can generate revenue.
- Elder program can get phone service for $1/month
- If it wasn't for the elder program, who knows if we would be deceased or not. The elderly program services have helped a lot of people. When our staff go and visit with elderly, provide services, it tells the elderly that they are a person and they are a part of the community. Otherwise, they are left all alone and are isolated from the community.
- A lot of transportation to the health facility and picking up of medication. People don't have the money to keep going back and forth for these things. The program keeps people alive. The program is consistent and not just hit-and-miss. Has become a critical part of services.
- The elders group had many meetings to decide where to go, what services to provide. Did surveys and questionnaires to find out what the community wanted.
- The elders are treated better now with the elder program.
- In most of the homes, we have safety appliances. We get them through insurance. Medicaid can pay for it if Doctor says its necessary. If someone doesn't have financial resources, elder program will pay for it.
- Trying to coordinate health services with IHS and CHR programs but we are very short of help; try to make our rounds. Two ladies who have gone for CNA training. Some elderly have family and those we can just check on. Lot of them have nurses but we still check on them. It really works out when the family can get paid to be caretakers for the elderly. Within Montrail County, we have 40 caretakers. Example of knowing of a service and making it accessible.
- Getting back to culturally relevant services. Last week, we got a nursing assistance for a gentleman. We had a coordinator who could introduce the nurse to the gentleman and helped them to get to know each other and make him more comfortable.
- In my own family, we didn't have these services. When my grandmother was older, she had to go to nursing home. She would fight nurses and I would have to go over and help with taking care of her. Same with my mom. I wish we would have had these services when they were getting older.
- We've come a long way in helping elders. We have real good strengths in our services. Workers help clean house, wash clothes, mow lawns, etc. They go above and beyond their duties. We even build ramps for them. They use the GA workers; kind of hard to get them to work but we keep on them.
- One thing we really need help is getting pills for elders in Bismarck, Minot, off-reservation. They have to come back and get medication.
- We really help everybody and we never did have that before. This program really helped a lot of people.
- Voc rehab just started in 2000.

- One good thing happening in the communities is exercise classes, like in Twin Buttes. People come and take the elders to the classes if they don't have transportation. My elderly mother is starting to enjoy these classes.

BISMARCK • PEOPLE WITH DISABILITIES FOCUS GROUP
AUGUST 4, 2004

1. **Who is your main contact person in the community for help and why?**
2. **What are any barriers you've experienced in pre-services (enrollment, etc.)?**
   - He had a drinking problem and the payees for him were abusing that and taking his funds and giving him a few bucks for a jug of wine. He lives up here in Bismarck now in independent living. CIL and Social Security work together.
   - On Standing Rock, there is no agency/person who does this for them (guards their money).
   - Need to train our Native service providers so they know about independent living instead of just sending people to nursing homes.
   - First stop is BIA social services, and IHS mental health on issues that are larger group.
   - John Eagleshield is working to make CIL's the payees because they feel some of the county workers are not culturally competent.
   - Forms – lot of big long words and I would crush it up and throw it away instead of filling it out. After met Diana, she would help him.
   - Man who was illiterate was getting mail from Social Security and they gave him benefits when he was working full-time. They didn't make him pay it back (they think) but sometimes they create more problems than not.
   - Lot of times, don't explain letter but just tell them where to go and someone does it for them. Feel comfortable with Diana because she tries to explain it to me and doesn't just tell me what to do. Finds a way to do things that we need.

3. **What are the strengths/good things you've experienced in receiving pre-services?**
   - Diana explains things in a way that makes sense. Those other big offices use these big words and I just sit there like "What is she talking about?!"
   - Payees abuse the people who they are supposed to provide for.

4. **What are any barriers you've experienced in receiving services?**
   - Issues of double-whammy – discriminated against because they are Native and also because they are disabled.
   - Had a hard time getting commodities because of the new ways; had to "talk my way into commodities".

5. **What are the strengths/good things you've experienced in receiving services?**
   - Sissy and Mavis were supposed to meet with Bob Gomez to establish CIL's on reservations. This may meet the needs of the populations because now, the people need to move to Bismarck to avoid getting placed in nursing homes and/or getting abused by payees. Or have a similar organization that can provide the sort of services that they provide.

6. **Describe an outstanding experience you've had receiving services.**
   - Up here, you can go places and see people and it's a step up from living in Fort Yates.

7. **How do we develop service literacy among consumers and providers?**
   - Tribal radio is one way because a lot of people listen to the radio
   - Tribal newspapers

- Outreach is important; may be a way to get to the people who need services and don't get them. Important to have Indian workers there who understand the culture and ways.
- As a consumer, I am interested in how the system works and why things are the way they are.

8. How do we identify unique services and/or funding sources?

- Wonder about this myself; usually have to call Diane for her advice
- Other agencies don't provide basic things like faxing things to other agencies or make copies and all that. If I don't do it, they won't get it done.

9. What are the cultural considerations of disagreeing with a provider?

- I only worked with Joanie and Marilyn and they never said anything, they just filled it out and sent it off.
- He is now in debt and doesn't qualify for services for housing because she (Joanie) didn't pay for it. Other people broke in and damaged house and so he had to pay for it.

10. How do we deal with cultural conflict?

- Meet with the agencies and try to explain the cultural differences so that people know and are educated.
- I could pass but my kids are dark-skinned so I get a lot of rude comments about them not being her children.
- Other Comments:
- Lack of follow-up in communities with people with disabilities.
- On-reservation issues are more about survival. Indians in Bismarck can access most services.
- If family has relatives who stay over in independent living housing, there are rules and regulations that limit the time they can stay. Sometimes families don't like these rules. Other times, relatives abuse their relatives and overstay their welcome and the people with disabilities don't want them there.
- There are some organizations who can fund through mini-grants the development of resource directories.
- There is a need for research to show the need for the ILC's, similar to the state, have a tribal one.
- Not to have tribe handle the financial part of the operations. The tribe needs to learn how to run these things like a business (like a turn-key business).
- Sometimes agencies think consumers don't fill out papers because they are stubborn or uncooperative when it is often only because they don't understand or don't want to go through the hassle (e.g. making copies is something professional organizations take for granted).
- Because I live in a trailer, I need help with working on the trailer. CAP helped with winterizing; I got fuel assistance and because I lived there, she also qualified for the services. I was so grateful for those services. But you can only get help every 10 years.
- How do we find out about these projects that help people fix their houses up.

NEW TOWN • PEOPLE WITH DISABILITIES FOCUS GROUP
AUGUST 5, 2004

COMMENTS:

- Most urgent need is health care. Lot of emergency needs that arise for elders. Hesitate to call 911 because of cost of emergency services.
- Also a very urgent need to know of health information before Alzheimer's disease may take over. Making a living will. Should have choices about legal guardianship before dementia.
- As homeowner, needs help for simple household repairs or renovations. Saves up money but emergency needs come first and money gets taken for that.
- Have nothing for elders in my segment; there are two elder workers there but needs are not met.
- Had a elder home "on the hill" but now are other people living there too that drink and disturb the elders, young families and young singles, etc.
- Lack of communication in the segments – elders didn't know about the earlier meeting.
- All of the reservations will probably have some of the issues. Hurts me to see how the elders are treated. How they can't get around by themselves and there always alone. Workers don't do the work for the elders, want people to just visit them and the work is secondary. Loneliness out there by themselves. Only areas of activities are in the New Town area. How many programs come through and then they take and question the elders and don't do anything. Do surveys and interviews and are tired of not getting results. Some people will get a grant and then set themselves up a position, and then when grant is over, we don't see that.
- Though issue was of housing and house is getting old, lot of mold in there, has to get fixed up. I'd like to see the elders get a life insurance. Tribal programs, casino get life insurance. We got an elders program that's not running too good, I hear. People are putting money in their own pockets. I'm going to find out and see for myself if the rumors are true. Each of us here think a lot about our children and grandchildren and want to take care of them after we're gone.
- Elders taking care of grandchildren. My son came back from Iraq and can't find a home. Everybody forgets about the veterans and the elders. Veterans put their life on the line for this country and yet the people on the council are getting the gain and putting money in their pockets.
- The elder group, I don't know where it went..? I was on the council and these same problems existed when I left and I wonder why these agencies are set up in the state and don't always tell us about them or tell us about them later. I hope another administration comes in and changes it. Don't trust Governor Hoeven. He's a redneck, always has been. He wants our water.
- Let us elders know what is going on with this project. Don't just forget about us and we never hear about this again.
- Here, we had elderly homes and the young drunks took over. Housing Authority oversees that, Tribe has one. Rents are very high. Had buses in all the communities too. I don't see them anymore. There were also health clinics set up but we don't see them anymore either. IHS keeps cutting each year, same with 638. Each year, the budget goes down.
- IHS and CHS is a joke. Can't even get no transportation. And if you want to go anywhere, you have to give them 48 hours notice. So you have to plan to get sick. That Director is worried about his check. And these grants too. You guys get the money but nobody else does.

- People have to be held accountable. Nobody around when you call them but they get paid lots of money.
- I don't know why I'm here. Nobody told me anything but I just came here. Most of remember Elbowoods. None of the stuff they promised is coming. The state and the federal government do not fulfill their promises. We're sort of a doomed people. You try to get a quick fix when you can and then people don't do their jobs and everything goes down the tubes. I have to be cynical. I can't believe the state is coming through with any money. The money is not going to come unless it's coming from the feds. People have good intentions but it always falls into the wrong hands and I've seen very few things work for the long-term. In Twin Buttes, we have to go to the counties and then the Tribe gets mad because we go there. The Tribes don't really care, they just do what they have to. It's kind of getting to be a joke. If we don't take care of ourselves, nobody is going to do it.
- There's only one worker for the seniors in our segment and she had a lot of miles to cover her area. She had 800 miles on her car and they were worried about it. But that's only 4 trips.
- In the future, need to have a packet of information sent to all the elders and make it mandatory for elders program to be here without pay. Pliga and Emerson and I were on there and every time something came up and we would be there. Now it is becoming a political thing because it is elected. We used to be the No Group. We would say no to travel and no to spending money.
- I believe we need housing for assisted living. I work in my church, go into homes and give communion. The homes I visit, the elders still need a lot of care, have a lot of handicaps. There do some visitations from the elderly program but I do see this other organization that supposed to come to help them but they don't come (CHRs). Our CHRs are not helping each other and coming together.
- In some areas, they're not doing nothing.
- Used to be after surgery, nurses would come in.
- I visit these homes on my own. I'm an arthritic person and my hands are hard to use. These other people are worse off than I am.
- We tried to get people to work together and they say "yeah, yeah, yeah" and then they forget about us.
- Most communities are about the same. We have the resources and the programs but they're not taking care of us.
- It's really exclusive. It's hard to get a hold of them and get them to help you.
- We need nurses to come into the homes and visit. I know a patient here that they didn't come the first day she was home from the hospital and she needed dressing and all that. I hate to see that.
- All of this I wrote up come from the bottom of my heart and I didn't know it was a disability thing. The worker told me to be sure to come and write something up for the elders. I think the elders are mistreated. I hate to say that because I'm getting there myself. Every time there is election, they say can you put out tobacco for me so I can get elected. But then they forget about us. I used to be a temporary CHR and the Director tells me if elder or anybody is sick but they have a car, don't take them because they can use there car. But I would just go ahead and take these patients where they needed to go but now everyone is bickering. CHRs don't want to give services because they say the elders already have their own nurses and they should be doing that. I really feel sorry because my aunt is 80-some years old and she lives alone and she has a trailer and she would come to all our houses at night time because she don't want to be by herself.

These places I see in Killdeer and Parshall and New Town, they really have it nice because they have transit buses where they can go on shop. If they could have help with getting groceries and get somebody to take them to a movie or to bingo or something like that.

- CHRs ought to be trained too. They take my blood pressure and they dang near cut my arm in half. Elders are lonely and they need more people just to spend time with them.
- I agree with what she is saying. They do have senior workers but we have only one and you can't find her a lot of the time.
- My sister over here, she's 96, and she sometimes doesn't get her meals. The community is the one supposed to be doing this and know who the elders are. Each of the communities should be the same with what services they offer.
- I tried to get my friends/relatives to come to this meeting but they said, "How many meetings to come to these and talk and nothing happens".
- Troubles that were there 10 years ago are still there. Jefferson Smith was a man who did a lot of the pushing for the council.
- We had an incident a coupla nights ago when my brother went to Fort Totten, he got some medication and he's sposed to take it and he went into a seizure and somebody's supposed to check on him and they called all these departments to check on him but nobody checked on him. At midnight, they called the cops and the cops came and couldn't open the door. Couldn't get door open. Finally did and they barely got him the medicine. Can only get sick from 8-5 p.m. but also not get sick during the lunch hour either. This is the worst it has ever been. Closest ER is Stanley or Watford City.
- All of us elderly are on some medication and we have to get there before 5 to get it. If it's on a weekend, we have to live for 3 days without medication. I told my doctor and he told the pharmacist to give elderly medication enough for the weekend but they didn't do that.
- Each reservation should help each other but they don't. They had enough money to pull out my teeth but ran out of money before they could put dentures in so I don't have no teeth.
- I don't see what an outsider can do to change things on the reservation. I would like to know what your role is. It takes time and pain to make changes and to be able to help our elders. I see the needs of our elders but our main problem is financial. To be able to meet all the needs of the elders take a lot of money and we are trying to coordinate services with the Tribe, CHR and all that. We took a cut in our budget and the Tribe cut it so we are suffering from that and we realize that there are a lot of services that we cannot meet. We just hired a new director and we've been at a stand still. We've got good hopes that our elder program will do good again. We're looking for grants and a grant writer so we can meet the elders needs. They're pulling all the grants. It takes a lot of hard work and changes can't be made overnight.
- I suggested to one of the board members that maybe we should have a workshop that would talk about legal guardianship, living wills, etc. so that someone can take care of this before you get to the stage when you can't do it yourself. Need to have a lawyer to tell us how to do these things.
- One thing I'd like to say about the services is that we have some services, we don't have all services but people should be held accountable and if they were held accountable, we would get the services.
- We only got one worker and we don't even know if she's there but even if she is, she can't get around to all the elders.
- We should have somebody lobbying at the federal and state level that can get our needs

met. The elder organization is still a tribal organization so they give money from JTAC but they take it back and the council will help themselves to our budget. Nobody to try to enforce. There needs to be a vigilante outfit. I tried to form one but it didn't work...(hahaha....)

- We went to talk to council and they wouldn't even recognize us. One time we had to wait until midnight and then the Tribal Chairman said, "Oh, we forgot you!"
- Like my friends here said, it's all true. The more we talk, it don't get anywheres. We don't here it back. We can sit here all day and we can tell you our problems and you say you'll do something about it but you won't. I used to get shots for arthritis. I can't get them no more even though I have insurance because they say I'm the only one who needs it and they don't have the money for it. Where are the people who are supposed to help the elders? My sugar pills too. They took half of them and I get the other half. I have to do it myself and I'm scared to do it myself. I don't want to overdo it.

MANDAREE ELDERS CONCERNS AND NEEDS

***the following was typed and submitted by a mandaree elder*

- Elder transit bus with wheel chair lifts on the side for elders who are disabled or in a wheel chair. To make this effective the senior citizens would need an elder care worker to ride with the elders to assist them in any way, and also they would need a certified bus driver who would be willing to be dedicated in serving the elders.
- A local telephone paid by the tribe. This phone would be used in an emergency to the nearest emergency hospital (which most likely would be in Watford City). This phone would be used set up only to call 911 or a CHR certified person who would be able to help in case of a life threatening situation.
- To ensure safety for the elders they would need a "security alarm system" around the elder's home. This security system would alarm the police or fire departments say if there were to be a fire or a burglary or any kind of emergency.
- For elders who are in wheel chairs or disabled they should have electric wheel chairs to help them get around their house easier. These electric wheel chairs are advertised on T.V. and are free for elders who are on social security.
- Independent living quarters. Apartment building where senior citizens only stay. This would not be like a nursing home but apartments separately built in one area. These homes would include alarm systems, emergency calling and cable T.V. as a daily entertainment.
- Once or twice a month have a hair dresser come down to the elder's home and give them hair cuts if they needed or wanted it. Or all elders travel to New Town or Dickinson to get their hair cut at the TAT's expense.
- Once a month take elders to a dinner or bingo ECT... Some thing fun and entertaining for the elders, like a cook out or a picnic for the elders.
- (referring to idea #1) This bus in service 7 days a week. Such as Sundays the bus would pick the elders up to go to church. Whether it be Catholic or the First Baptist Church in Mandaree.
- The elders should have some kind of insurance. Whether it is health or life insurance.
- Periodically have a field nurse come to check on elder's medication, to see if they need to be refilled or anything in that matter.

TRENTON INDIAN SERVICE AREA FOCUS GROUP• TRENTON SENIOR CENTER AUGUST 6, 2004

1. **Who is my main contact person in the community for help and why?**
   - TISA is "everything", tribal council and administration; right here in Trenton is all we got.
   - Access services from the county, people have come in and done presentations
   - Available to people of Trenton but don't take advantage of it – should come to us instead of having us go to meetings.
   - Some of it is free but not things you really need (wheelchairs, etc.); If we really need something, we can get it (NDAD in Williston).
   - But I tried to get one for my relative and he didn't get it. Didn't get help from either Williston or Fargo office when son had accident.
   - Tracy
   - CHRs; very good CHR program here. I've been to other places and they wouldn't even think of taking someone to the next town to get a haircut.
   - There're about 12 of them; they have all kinds of different titles though.
   - Very good coordination between programs; if a person needs services and they don't qualify for it, another program will pick them up.

2. **What are the barriers you've received in receiving services?**
   - Contract health – run out of money quickly and they go by priority. People are getting billed for their hospital bills and they are getting sent to collection agencies.
   - If somebody gets ill and it's an emergency, you have to contact Contract Health before or they will deny the payments, "disapproved". You can only get sick during work hours but not on weekends. They should have somebody on call.
   - A Doctor said, "This is why you've been disapproved. You have the wrong name. Your name is Turcotte". True story.
   - Lack of money for services is one of the biggest problems. There is money out there if they go after it.
   - With our income, they put us on Medicaid, and our recipient liability is $800. I can't afford that. They will serve us here but if it's anything for after hours or that the clinic can't do, then we have to go through Williston and then TISA won't pay for it (or will with a lot of red tape).
   - We're elderly here and don't need the stress of having to deal with the bureaucracy. Sometimes we just don't receive services because of this.
   - If you ask the right people, you can find the information but we don't know the right people.
   - We're in the dark about some of the services we have and we're never told so we're kind of skeptical; it's the administration.
   - Belcourt doesn't want to help us thought; they count us but they don't provide us with any services. We're kind of forgotten because we're a little village. We built what we have on our own. We're the "Lost Tribe".
   - I went up there and talked to them at Belcourt and they said that they will take of care of their people there first, and if there is anything left over, it will be for you.
   - People are having problems with glasses; not having the right prescription or not having them right once you get them. They tell you they're okay. I've had to get my own glasses at Williston (IHS).

5. **What are the strengths/good things you've experienced in services?**

- Prescription drugs; being able to get medication.
- Housing is another good program. We pay for it but it's a nice house to live in and we can own it. There are programs to modify a home if you need to because of age or disability (NAHASDA program). Making more homes handicapped accessibility.
- Excellent school; ISEP (Indian Services Education Programs??).
- Very good dental services. Good dentists that come out here and nice staff.
- Are trying to get an assisted living facility (Alisha Hanson)

TRENTON SENIOR CLUB

-Made up of 6 members
-Represent the elders of TISA
-Not elected or appointed, self-regulated; elects themselves
-Senior Center is in their name, also have bus in their name
-Has to do more with activities (social) rather than problems, etc.

6. **How do we develop service literacy among consumers and providers?**

- Whenever we tell elders about programs, we always do it in this way – a meeting. I think we should have someone who will go and tell them one-on-one about the programs so if they have questions or don't understand, they can ask without embarrassment.
- No real good communication network; half the time I don't know what is going on.
- We don't really know either; we're supposed to have a newsletter that comes out every 2 months and we might get 6 months. Newsletter is not very informative. Lot of child-related articles, not a lot about elders.
- Three different doors and they say they post it at one of them. You don't have time to stand there and read anything.
- I've asked the CHRs about what's happening and they don't know. They're in their own world. They don't know about what's going on.
- We're supposed to have monthly community meetings to know what's going on and we've had two in the last year. We don't know when community meetings are and we're not notified about a lot of events.
- If someone is getting out of the hospital, they would contact TISA and the public health nurses and that's how information gets passed on. This is how it is supposed to work but it doesn't always work that way.
- There is a resource booklet that Tracy put out; "where did you get it?"; I think I got it but I didn't look at it.

9. **What are the cultural considerations of disagreeing with a provider?**

- I am worried about disagreeing with a provider because I am worried there will be repercussions. Won't offer help. The saying is that we're trying to tell them how to do their job.
- There's many times I've gone down there and I've been treated like I was stupid and illiterate and I didn't like how that felt. Like she said, it's like, "show me your school".
- Lot of white people taking tribal jobs and they don't understand Indian culture so they don't understand us.
- It's because we don't have qualified tribal people for the jobs.
- Even if we do have qualified members, they hire others. There are some other positions that our people could do those jobs.

- Native lady in the office tries to get appointments and the other one gives people a hard time.

10. How do we deal with cultural conflict?

- Our community is so spoiled. I don't know that we know how to deal with the conflict. Some live on one side of the railroad tracks and some live on the other side. There are divisions. The "Johnson's" are better than the "Smith's" over here. Family/relative divisions.
- I find that going into Canada, it's very different. Metis vs. mitchif.

OTHER COMMENTS:

- A big thing I hear over and over is that we fill out these forms time after time after time. And then that's it. Always the same thing. CHR brought a new form the other day. Fill them out and then hear no more. Don't really know what they are for. calls and calls and people don't pay attention; we feel like, "Oh, we're just old people".

APPENDIX C.

RESEARCH ON AMERICAN INDIAN POPULATION TRENDS
AND
AMERICAN INDIAN AGING TRENDS AND BEHAVIOR RISK FACTORS

Population Trends Important For American Indian Communities In Forecasting Pending Health Care Issues Among American Indian Elders And Disabled
Nelse Grundvig, N.D. Job Service
Presented at the November 5, 2004 NDIAC Stakeholder Partnership Meeting

Key points:

- Since 1920, the Western one-half of the Great Plains has been going through a sizable population out-migration.
- Areas in North Dakota where there is population growth or limited de-population are the larger state communities, and tribal communities.
- The median average age of the United States population is close to the average age of North Dakota. Spirit Lake and Turtle Mt. Area have a younger population than the state, and all tribal areas.
- Baby boomers are reaching retirement age and represent a significant portion of the U.S. wage earners in the United States.
- As that segment of the population changes, their needs will change, and different sets of services will be needed for this population.

Disabled Characteristics:

- The older the population gets, the more likely they are to become disabled.
- N.D. reservations have a higher percentage of people who are disabled compared to the state, particularly adults between the ages of 21 and 65.
- The need will be stronger to provide service.
- Elders, as a group, have higher rates of disability.
- Across the state, a higher percentage of the adults, between the ages of 21 and 65, who are disabled, do work. That pattern is true among all tribes. Turtle Mt. is the lowest, and Spirit Lake is the highest.

Source: 2000 Census

Dependency Ratio:
Dr. Rick Rathke, State Data Center, North Dakota State University developed a term called the Dependency Ratio whose formula uses the number of people who are between the ages of 0 and 16, plus the population 65 and older and contrasts that figure against the working age population. The lower the number of working people there are, the more wages in the system will be needed to support the population. Based on the formula projected out to 2010 (Data were not collected by reservation but county) a table was presented showing that in the year 2000 – the dependency ratio for North Dakota was 57. From 2000 to 2003, that figure went from 57 to 53, and from 2003 to 2005, the figure increased to 55. Projecting out from 2005 to 2010, the ratio would be 57.

Population Trends:

- From 2005 to 2012 the working age population in the United States will be the largest it will ever be in the foreseeable future.
- After 2012 the majority of the population will be comprised of those 65 years of age or older.
- There are 3 distinct generations in the workplace: Baby boomers, Generation X'ers and the Generation Y's.
- Currently the United States has the largest percentage population in a working age group that its' ever had. It will be a short lived phenomenon. Net effect is that the dependency ratio will increase as the group of principal wage earners retires and

decrease in comparison to other groups.

- By 2020 – North Dakota's dependency ratio will rise to the age of 71. The drawback, this group of people is also most likely to pay taxes and for services because they are employed. It is a crisis waiting for us.

Table 2 illustrates counties in which reservation populations reside. By 2010 the following counties will have the following dependency ratios:

Table 2.

Eddy County	84	Benson County	79
Dunn County	74	Sioux County	62
McKenzie County	70	Rolette County	63
McLean County	74	Williams County	63
Mountrail County	69	Ward County	57

The dependency ratio is rising across all counties, meaning there will be more dependents, and fewer people in the wage-earning groups. Rolette counties ratio is projected to decrease in 2010. That projection is based upon the fact that Rolette County has a growing population of children who are age 6 now. By 2010, those children who are age six now, will be moving into the wage earning age group. Counties with children turning 16 by 2010 will see decreases in their dependency rations. Counties with a growth of children will have a ratio that is decreasing.

Issues for consideration:

- How are we going to provide services given the fact that we have a population between the ages of 20 and 64 and the higher percentage which are disabled, and a dependency ratio that is increasing, when the general population is in an out-migration mode?
- What are we doing to do to enhance the lives of our older population when more and more of us are going to be in that category?
- Intergenerational Issues: Fifty percent (50%) of North Dakota grandparents are the primary caretakers of children. That percentage is more pronounced on all reservations in N.D. Spirit Lake is the highest. (DP-2 – US Census).
- Commuting patterns. A large number of people in the state are within 20 minutes of their workplace.
- The average commute to work is less than 16 minutes across the state, excludes most rural areas. The "Golden Hour" is the time when someone gets hurt and can access care within one hour. In doing so they stand a increased chance of survival.
- As we lose population, how, when and where we provide services becomes an issue.

Data On Needs For Home And Community-Based Services And Health Promotion For American Indian Elders.*

Dr. Russ McDonald, Sr. Research Analyst, National Resource Center on Native American Aging, University of North Dakota.

Presented at the November 5, 2004 NDIAC Stakeholder Partnership Meeting

Behavior Risk Factors: Behavior risk factors are factors which increase or decrease functional status and chronic disease rates among American Indian overall health status.

- These factors included smoking, drinking, weight, and exercise variables for elders 55 and over.
- North Dakota reported lower rates for smoking than the national level of 16.6 percent. However, the reported response showed American Indians were closer to the national average of 32.2 %.
- No significant differences existed among the urban, rural, and frontier counties.
- Overall rates of smoking are higher among the tribes but smokers smoke fewer cigarettes.
- Smoking use declined with age, particularly after the age of 75.

Conclusions:

- Non-smokers live longer. Study attributed conclusion on two variables: 1) the greater percentage of smokers were deceased or 2) behavioral changes later in life due to chronic diseases.
- Native elders might use the tobacco for ceremonial use, but still identify themselves as smokers.

Alcohol Consumption:

Using two questions, how long has it been since you last had an alcoholic beverage, and 2) if you drink, how many days in the last 30 days have you had 5 or more drinks in a single day.

Findings:

- Reservation elders were less likely to recently have consumed alcohol, and were less likely to have a drink in the last 3 years.

Rural or Frontier variables

- Rural isolation did not appear to lead to alcohol consumption.
- Those in the country did not drink more than those in the city.
- Those in the urban population were more likely to have consumed alcohol in the last 30 days.

Binge Drinking

- Higher rates of binge drinking are found among frontier and reservation communities.
- Those in urban populations drink more, but frontier, rural and tribes tend to binge drink more.

Aging

- Alcohol use was higher among the younger elders.
- Where alcohol may not be a problem for an older elder, may want to focus on the younger elder.

Overweight and obesity combined

- All areas were above the 40% goal set by the Healthy People 2010 document.
- Urban figures were the lowest – 52.2%
- Tribes were the highest at 82.1%.

Exercise

- Hard work as an exercise was included in the state long term care study, but no data were found on tribes.
- Frontier counties worked a little harder and considered walking and cleaning as exercise.
- Lowest rate of use in urban environments were programs that were facility or program dependent.

SERVICE GOALS:

- Develop tribal environments that offers water aerobics which decreases load bearing weight on knees and ankles.
- Maintain or increase the level of exercise among elders.

Importance of understanding the criteria to determine when elders would begin to need assistance. The term functional limitation is referred to limitation on activities that affect the level of ability and disability in a population. It is also the criteria used for admission to assisted living, community-based long-term care programs, and nursing homes.

ADLs Defined:

Activities of Daily Living (ADLs) include difficulties of eating, walking, using the toilet, dressing, bathing and getting in and out of bed. All are considered fundamental to surviving.

IADS Defined:

Instrumental Activities of Daily Living (IADLs) include cooking, shopping, managing money, using a telephone, light and heavy housework and getting outside. There are one to four levels of need into which individuals can be classified. These levels are tended to be used as indicators of home and community-based services.

Low: level required for no long-term care services.
Moderate: 1 ADL and fewer than 2 IADLs. Home and community-based services suggested.
Moderately Severe: 2 ADLs and 2 IADLs is the average criteria used for admission to assisted living.
Severe: 3 or more ADLs for a skilled nursing facility.

Many Native elders still live in the communities with 3 or more ADL limitations.
This may be a cultural variable and related to the resources they have available.
Those living in an urban environment have some resources available affording them to be more independent longer. North Dakota Native elders – 68.5% fall into that category.

Service Goals:

- Try to keep them in the category, rather than progress to that higher level of need.
- Respite care is needed for elders caring for elders. See the phenomenon occurring more frequently among the Native population.

Rural versus Urban

Functional limitations compared between rural and urban elders) revealed that there is a

migration from rural to urban communities. The Study concluded that elders needing more services begin to move into urban communities where they can get these services. Trend is also for elders to move in with their children in urban areas.
In the rural areas, fewer respondents reported activity limitations, especially at the moderate and severe levels. Urban elders required few or no services and have stayed the same. (From 1st to 2nd survey).

Service Goals:
Since tribal area communities lack facilities, service goals should include:

- Health promotion
- Preventive care
- Maintaining vitality.

Moderate level: 18 %, 17.9% - category represents entry-level functional limitations requiring assistance – usually consistent with remaining in one's home.

Service Goals:

- Provide supportive services to aid persons to remain in their home.
- Train and support informal providers and buffer them with a range of services and contacts for a range of possible tasks, example, assistive technology for transfer tasks.
- Training for informal providers. *

Service Goals for informal care support:

- Disease management example- provide diabetes information to exercise and maintain diet. Greater availability of assistive technology – critical to maintaining individuals in their homes.
- Speech therapy for individuals with a stroke.

Service Goals for Communities:

- Training for skills the community needs and for community facilities. Facilities need Certified Nurses Assistants, Registered Nurses, Occupational Therapists, housekeeping services, and maintenance personnel.
- Community centers – are they being built to accommodate elder activities.
- Exercise facilities for use. Tribal colleges are opening up their facilities for elders to walk. Use of fitness centers. Turtle Mountain and Three Affiliated have fitness centers, Standing Rock and Spirit Lake do not.
- Standing Rock and Turtle Mt. have hospitals, Three Affiliated and Spirit Lake do not. Each community is unique. What is available in one community is not available in another.
- Tribal Health promotions with tribal colleges. These practices should be embedded within tribal communities.
- Define the core that would be needed and doable in each community for home and community-based services.

Service Goals for Personnel required:

- Train personnel to support communities include health educators, physical trainers and therapists.
- Train family & friends for informal care. Increase from little or no services to more services required, and the need for trained personnel begins to increase.

Moderately Severe: Refers to institutional care. There is generally and increasing fee for services. Congregate care, basic-care and assistive living. Regulations vary by state, related back to Medicaid requirements. Should be considered when services are developed.

Service Goal: In planning for moderately severe limitations, Include the development of skilled nursing care for elders as one necessity within the home and community based model. It is a cultural prerogative and goal to maintain the elders in the home as much as possible.

Severe: Refers to terminal care and/or hospice care.

Service Goal:

- Plan for hospice care. It is needed in our native communities. Native elders want to die at home with culturally congruent care.
- Expand existing services to include home and community-based services, and add an assisted living wing. Also create a central location for services.

Question posed to Native elders in the survey, "if at some point in your life, you became unable to meet your own needs, would you use assisted living or a nursing home". The response indicated:

61% - would use assisted living.
10% - would use a nursing home.

The Top Type of services utilized by ND Native Elders:

- Meals on Wheels – 52%
- Transportation – 17% - monies from the State level and other sources.
- Dietary – 13%
- Nutrition – 10

Long-Term Care Needs of North Dakota's American Indian Elders
University of North Dakota Center For Rural Health
National Resource Center on Native American Aging

Leander R. McDonald, PhD
Crystal Evans-Kipp, MA
Twyla Baker-Demaray, BS
Richard Ludtke, PhD

Purpose of the Project:
The purpose of this project was to assist tribes in collecting data they could use to build infrastructure in their communities.
Multiple methods are used throughout the study, but the main method of data collection is the survey instrument (administered face-to-face with the elders).

Population:
- Native American elders residing primarily on reservations
- Individuals age 55 and over living on or around Indian areas.
- Age 55 is considered comparable to 65 and over in the general population

Data is collected on:
- General health status
- Activities of Daily Living (ADL's)
- Instrumental Activities of Daily Living (IADL's)
- Indicators of chronic disease
- Indicators of vision and hearing
- Tobacco and alcohol use
- Diet and exercise
- Weight and weight control
- Social supports

Local Communities Provide:
- Obtaining a resolution from their tribal councils
- Locating a list and selecting names for the sample
- Data collection
- Receiving the findings and getting them to the right people
- Local implementation and coordination

Chronic Diseases – Arthritis:
- ND Native elders arthritis rates decreased by .5%
- ND Native elders are now 16% more likely to experience arthritis than the U.S. general population.

Chronic Diseases – Congestive Heart Failure:
- ND Native elders congestive heart failure rates increased by 2%
- Native elders were 51% more likely to experience congestive heart failure than the general U.S. population.

Chronic Diseases – Stroke:

- ND Native elders stroke rates increased by 2.6%
- Native elders were 7% more likely to experience a stroke than the general population.

Chronic Diseases – Asthma:

- ND Native elders asthma rates increased by 1%
- Native elders were 57% more likely to experience asthma than the U.S. general population.

Chronic Diseases – Cataracts:

- ND Native elders cataract rates decreased by 1.7%
- Native elders were 36% less likely to experience cataracts than the general population.

Chronic Diseases – Breast Cancer:

- ND Native elder women's breast cancer rates decreased by 1.4%
- Native elder women were 13% less likely to experience breast cancer than the U.S. general population.

Chronic Diseases – Prostate Cancer:

- ND Native elder men's prostate cancer rates decreased by .7%
- Native elder men were 115% more likely to experience prostate cancer than the U.S. general population.

Chronic Diseases – Colon/Rectal Cancer:

- ND Native elders colon/rectal rates increased by 1.2%
- Native elders were 26% less likely to experience colon/rectal cancer than the U.S. general population.

Chronic Diseases – High Blood Pressure:

- ND Native elders high blood pressure rates increased by 3.3%
- Native elders were 7% more likely to experience high blood pressure than the U.S. general population.

Chronic Diseases – Diabetes:

- ND Native elders diabetes rates decreased by 11.8%
- Native elders were 158% more likely to experience diabetes than the U.S. general population.

Chronic Diseases – Osteoporosis & Depression – ND II:

- Native elders reported significant rates for both Osteoporosis and Depression.
- Among the Cycle II chronic diseases, these rank in the top six.

Functional Limitations:

- The majority of definitions concerning functional limitations or disability refer to activities of daily living (ADL's) and instrumental activities of daily living (IADL's) as indicators of functionality.

Activities of Daily Living (ADL's):

- Eating
- Walking
- Using the toilet
- Dressing
- Bathing
- Getting in/out of bed

Instrumental Activities of Daily Living (IADL's):

- Cooking
- Shopping
- Managing money
- Using a telephone
- Light housework
- Heavy housework
- Getting outside

APPENDIX D.

HOME AND COMMUNITY BASED CARE MODELS

ALTRU DIABETIC GROUP CARE MODEL

Dr. James Brousseau
Altru Diabetes Center
1000 So. Columbia Road
Grand Forks, North Dakota

DIABETES PROGRAM AT UND CENTER FOR RURAL HEALTH

The program deals with risk factors, overweight, high blood pressure, high cholesterol. Program can reduce the risk by 60% - to develop diabetes. With risk management, can prevent Type 2 diabetes in high-risk groups.

UNDERLYING PRINCIPLES OF GROUP CARE MODEL:

- Ownership of our own health destiny, at the personal or community level, is important to the idea of ownership.
- Attitude is crucially important for disease management.
- Move away from fatalism.
- Example: The fatalism theory follows the adage that if a disease affected my family…my father had it before me, my mother before me, why try".
- Attitude in developing programs is crucial.

PROGRAM METHODS

- Uses chronic care model
- Works with providers
- Sets achievable goals
- Group medical appointments
- Applies translation research
- Will work with doctor, mid-level nurses,
- Set achievable goals

TARGET GROUPS

Women with a history of gestational diabetes (GDM) – diabetes during
Adults with metabolic syndrome (if your waist is greater than 35, if your blood pressure is greater than 130 over 85 or greater, if your blood sugar is greater than 110 and under 125, if your hdl is 40 for men, and women, if your good cholesterol is low – individual will progress and will develop diabetes in 10 years.

IMPROVEMENT MODEL

- Plan-do-study-act

MODEL FEATURES

- 2 hr. appt. – all have high blood pressure
- Warm up
- Education
- Individual sessions
- Discussion
- Physician & other professionals
- Individual summaries prepared by physician
- Focuses on lifestyle balance

- Physical activity
- Weight

CHRONIC CARE MODEL

- Promotes walking: focuses on getting steps from 5,000 to 10,000.
- Walk for ½ hr.
- Progress is measured each time.
- Individual sessions and group session started.
- Debriefing each group medical visit.
- Make changes each visit.

SUSTAINABLE COMMUNITY HEALTH CHANGE MODEL

Dr. Stephen P. Pickard, MD
Center for Disease Control –
North Dakota State Department of Health
Bismarck, North Dakota

UNDERLYING PRINCIPLES OF SUSTAINABLE COMMUNITY HEALTH CHANGE

- Sustainability change won't occur until root causes change.
- What are root causes and how do we change them

WHO CAN CHANGE THE ROOT CAUSES OF DISEASES?

- Social Services?
- Public Policies?
- Personal Behaviors?
- Personal Environment?
- Like most root causes, these must be changed at the community level.

WHY DO SOME COMMUNITY EFFORTS FAIL?

- Community didn't own the problem
- Dependent on external funds
- Leadership failure
- Lack of political support
- Loss of community vision
- Outside interference
- Cultural ignorance
- Missing community change skills
- Failure to address root causes

SUSTAINABLE COMMUNITY CHANGE

- Community skills
    - Trained leaders
    - Technical assistance (non-interfering)
    - Effective solutions (best practices)
    - Address root causes

Problem belongs to the community

- Ownership important
- Concern

SOLUTIONS BELONGS TO THE COMMUNITY

- Community vision (objectives)
- Community resources
- Community leadership
- Support at the highest level

ASSISTING COMMUNITY SUCCESS

- Start with a successful model
- Careful community selection needed
- Community readiness
- Community dependency

COMMUNITY TECHNICAL ASSISTANCE

- Facilitated decision-making/action planning
- Gradual withdrawal with skill transfer

NORTHLAND HEALTH CARE ALLIANCE PACE MODEL
PACE Program - Northland Health Care Alliance
Tim Cox, President

PACE OVERVIEW.
PACE is a corporation of hospitals and long-term care associations. Corporate members are interested in programs that make sense for North Dakota. PACE was established in 1999 as an official federal program. PACE puts the resources where they are needed as defined by the applicant. Local health care program can design their program under this kind of mechanism. Programs need to have incentives applied differently. The intent of the program is to work together with local health care providers to keep elders out of the nursing homes and out of the hospitals. PACE pays to try to keep individuals in their homes. Groups interested in sponsoring a PACE Program have to designate their service area. The PACE Program is still new. Northland is working with programs in other states to facilitate planning. Minimum number of individuals that are needed to make a program work is 50. Northland thinks it is important to have 100 enrollees.

PACE NETWORK: PACE has an interdisciplinary team of 40 PACE Programs in the national system, none of which have lost money. There is some funding for a limited number of demonstration sites. Northland sought and received support of the congressional delegation. Funding will help determine the feasibility stage.

FINANCING
- Medicare
- Median 2002 Monthly Capitation: #1398
- Transition to HCC Risk Adjustment Methodology
- Medicaid
- Median 2002 Monthly Capitation: $2472
- Methodology varies by state. PACE is currently working with North Dakota to figure out actuarial tables to come up with the #.

SLIDING SCALE FEE:
- Use Sparingly: Emergency Room, Hospitals, Nursing Homes.
- Use Generously: Pace Team, Home Health Services, Day Center, Respite.

LOGIC of PACE
- More community-based care.
- Less Hospital care.

STAY ON TOP OF CHRONIC CONDITIONS:
- Congestive heart failure
- COPD & Asthma
- Diabetes & Complications
- Dementia & Behavioral Complications
- Falls & Home Safety
- Seizure Disorders

Present Strategies:
- If feasible, PACE will start a multi-program area.
- Intention would be to expand it where it will work.

- Looking also at a statewide program.
- At-risk is Medicare and Medicaid funding.
- Programs need upfront resources to get started.

New Directions:
- PACE-like Initiatives
- Wisconsin Partnership
- Massachusetts Senior Care Options (SCO)
- PACE Innovations
- Rural PACE
- PACE Flexibility

PACE Flexibility
- Cannot be waived
- Focus on NHC Elders
- Integrated Acute and Long-Term Care
- Interdisciplinary

APPENDIX E.

TRIBAL SPECIFIC CONTINUUM OF CARE STRATEGIC PLANS

REAL CHOICES TRIBAL PLANS
2005

REAL CHOICES TRIBAL PLANS

2005

GOALS	SPIRIT LAKE	TURTLE MOUNTAIN	STANDING ROCK NATION	MANDAN, HIDATSA AND ARIKARA	TRENTON INDIAN SERVICE AREA
Goal 1	An elder housing complex in each district	A more culturally responsive environment	Create Elder advisory council	Coordinate and collaborate across multiple jurisdictions	Make elders and people with disabilities a tribal priority
Goal 2	A housing complex for adults with disabilities	Networking service providers and consumers	Bill of Rights for Elders	Improve access to services	Develop methods to increase access to information
Goal 3	Directory of local services	Enforcement of elder abuse code	Develop standards of care to simplify access to services	Use of culturally appropriate services	Utilize and expand opportunities for elders to help elders
Goal 4		Increase ease of access to health services	Develop tribal management information system and network collaboration	Increase access to information	Develop a single plan of care concept
Goal 5			Develop culturally based services: Home and community based services, language and protocols	Building relationships	

SPIRIT LAKE PLAN

AN ELDER HOUSING COMPLEX IN EACH DISTRICT.

- Elders living by themselves may be lonely, relieving the stress of being alone may improve overall health.
- To feel safe, a sense of security can lead to independence.
- Will enhance socialization.
- Improve elders quality of life.

A HOUSING COMPLEX FOR ADULTS WITH DISABILITIES.

- People with disabilities are Sacred – 'wakan' - They're there for a special reason.
- Consumers biggest request.
- 1 in 3 individuals in Indian Country may have a disability.
- They have no place of their own, very vulnerable.
- There is no emergency housing.
- Need to socialize and feel important.
- Lack of services forces them off the reservation.

A DIRECTORY OF LOCAL SERVICES

- Presently, 26 programs at Spirit Lake state they provide services to the elderly.
- For elders to be able to identify services available.

TURTLE MOUNTAIN BAND OF CHIPPEWA PLAN

DEVELOP A MORE CULTURALLY RESPONSIVE ENVIRONMENT FOR ELDERS.

- Share information at Elders Day-Out Program or other community-related events.

DEVELOP A 'NETWORK' OF SERVICE-PROVIDERS AND CONSUMERS TO ENHANCE ACCESS TO SERVICES.

- Parties work collaboratively.
- All service provider directors meet on a monthly or quarterly basis.

WORK TOWARDS ENFORCEMENT OF ELDER ABUSE CODE.

- Explore ways to hold people accountable for the exploitation of elders.
- Training for elders on issues to protect themselves and their assets.

INCREASE EASE OF ACCESS TO HEALTH SERVICES.

- Create a more elder consumer-friendly in-take physician visit/appointment process at Indian Health Clinics & Hospitals.
- Consider more workable intake models such as the "group visit" model.
- Increase funding support for programs to elders.
- Support for two Benefits Coordinators to manage and disseminate information.

STANDING ROCK PLAN

CREATE AN ELDER ADVISORY COUNCIL

- Could serve in an advisory capacity for Tribal Council decisions.
- Advise on difficult questions.

DEVELOP A CONSTITUTIONAL OR BILL OF RIGHTS FOR ELDERS.

- Enforcement strategies.

DEVELOP STANDARDS OF CARE

- Single point of Entry for all services provided to elderly.
- One Application for all services that collects necessary vitae information.
- Each service provider will know comprehensively all other services for which an elder may be eligible.
- Internet Listing of All Services.

DEVELOP A TRIBAL MANAGEMENT INFORMATION SYSTEM AND NETWORK COLLABORATIVE

- Tracks each elder with necessary care, but also allows seamless integration.
- Would streamline information to maximize efficiency and avoid duplication.
- Would be structured under the "single point of entry" system.
- Community Elders Service Network.
- Creating relationships on an informal basis to formalized with MOU's or contracts.

WORK TOWARD CULTURALLY BASED SERVICES

Home Based elder care, maintaining and strengthening the family integrity.
Services depend on needs of the elder.
The service provision is an approach, not a skill set.
Lakota dynamics into specific policies, practices, and standards to enhance the quality of life for elders.
Always find someone who can speak the Lakota/Dakota language of the elder and pay them as a resource.
Using focus groups to ensure cultural protocols are followed, what is the best way to come into an elders house? Or to start asking personal questions?
Required training – at SBC, cultural competency for Lakota/Dakota elder service providers will be developed and provided at the Sitting Bull College.

MANDAN, HIDATSA, ARIKARA NATION
ELDER ORGANIZATION PLAN

COORDINATE AND COLLABORATE ACROSS MULTIPLE JURISDICTIONS.

- Human Services provides to a 6 county reservation area.
- Services not coordinated with State Human Services and Mental Health.

IMPROVE ACCESS TO SERVICES

- Medicaid – liability
- Paperwork
- Drug Discount Card
- Fear of unknown
- Eligibility requirements – who helps do the paperwork

IMPROVE CULTURALLY APPROPRIATE SERVICES

- Quality Service Providers – minimum time spent with consumer
- Can't drink coffee
- Develop relationships between providers and services
- Continuity of service providers – how to approach and manner of approach
- Cultural Responses/Appropriate behavior
- Barriers to services – non-verbal messages
- Knowledge about the people they serve
- Cross training

CREATE BETTER ACCESS TO INFORMATION

- Localized to tribe and by county.
- Services available
- Compile information
- Transportation Services
- Hours and times when services are available after regular work hours.

BUILDING RELATIONSHIPS

- County
- State
- Streamline (6) six counties and Regional Human Service Centers.
- Need to know state organization structure, programs, services and supports.

TRENTON INDIAN SERVICE AREA
ELDER CARE ISSUES AND THEIR SOLUTIONS

MAKE ELDERS AND PEOPLE WITH DISABILITIES A TRIBAL PRIORITY

- It is important to make elders and people with disabilities issues a tribal priority.

DEVELOP METHODS TO INCREASE ACCESS TO INFORMATION

- Misconceptions about senior services; (e.g. things like recipient liability, etc.).
- People say that they "didn't know" about services.
- Educate staff fully as to what resources are available.
- Have the various programs come to the senior meetings.
- Develop community liaisons, community service experts, to answer questions, contact people or bring issues to the forefront.

UTILIZE AND EXPAND OPPORTUNITIES FOR ELDERS TO HELP ELDERS

- A volunteer list of other elders who can help the service providers.
- Elders feel useful and also learn more about services.
- Make a calling tree of the seniors and have them share what they learned with other elders.
- Annual events or avenues for networking with other Tribes to see how they are doing and what they are doing.

DEVELOP A "SINGLE PLAN OF CARE" CONCEPT.

- A 'single plan of care' concept for the elders.
- A database where information is stored and can be accessed. You could have all the program information, such as eligibility criteria, entered and then when you enter the elders' information, it would match them up for you.

APPENDIX F.

BUDGET SUMMARIES

REAL CHOICES	Total Grant	$85,000.00	
NDIAC Budget			$ 7,000.00
Expended	(meetings & travel)	$ 1,884.25	
Balance			$ 5,115.75 (printing final report)
NATI			$78,000.00
Expended	(consultants)	$60,881.42	
Balance			$17,118.58
Actual Remaining Balance (6/30/05)		$22,234.33	
Carryover			$20,000.00
Turned back			$ 2,234.33

31600 - Indian Affairs Commission **Fund Account Report For Month Ending 06/30/05** **NDS4140AA_2005B**

Fund: H1245 OLMSTEAD REAL CHOICES

		Current Month	Biennium To Date
Revenues			
432005	Reimbursement From Other State	11,761.72	11,761.72
490002	Tsfr Fm Federal Fund	32,308.55	51,003.95
Total	**Revenue**	**44,070.27**	**62,765.67**
Expenditures			
521015	In State - Lodging	0.00	170.50
521020	In State - Meals	0.00	96.00
521030	In State - Vehicle Mileage	0.00	673.32
582005	Booth & Room Rental	0.00	529.84
621325	Other Operating Fees	0.00	414.59
623175	Professionals Not Classified	44,070.27	60,881.42
Total	**Expenses**	**44,070.27**	**62,765.67**

APPENDIX G.

LIST OF ATTENDEES AT ALL MEETINGS

Real Choices Attendee List - ATTENDEES - all meetings								
First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Alan	Allery	University of North Dakota	Box 9038	Grand Forks	ND	58201	(701) 777-3859	alan_allery@und.nodak.edu
Amy	Armstrong	NDCPD - Real Choices Rebalancing Project	500 University Avenue West	Minot	ND	58703	(701) 858-3578	amy.armstrong@minotstateu.edu
Frederick	Baker	Three Affiliated Tribes Elders Organization	PO Box 909	New Town	ND	58763	(701) 627-4593	fbaker@restel.net
Rosalie	Bear	Spirit Lake Elder	PO Box 96	St. Michael	ND	58370	(701) 766-4236	
Mike	Beck	D.H.S. - Vocational Rehabilitation	[inside mail]	Bismarck	ND	58504	(701) 328-8954	sobecm@state.nd.us
Mike	Beck	D.H.S. - Vocational Rehabilitation	[inside mail]	Bismarck	ND	58504	(701) 328-8954	sobecm@state.nd.us
Rhonda	Belgarde	Legal Services of ND	PO Box 1666	Minot	ND	58702	(800) 634-5263	rbelgarde@legalassist.org
Rhonda	Belgarde	Legal Services of ND	(none given)	Belcourt	ND	58316	(701)	
L. J.	Bernhardt	Stark County Social Services	664 12th ST W	Dickinson	ND	58601	(701) 456-7675	45berl@state.nd.us
David	Boner	Protection & Advocacy	900 North Broadway Suite #210	Minot	ND	58703	(701) 857-7686	dboner@state.nd.us
Gloria	Bracken	Lake Region Corporation	224 3rd St SW	Devils Lake	ND	58301	(701) 662-8681	
Donna	Brown	Turtle Mountain CHR	PO Box 900	Belcourt	ND	58316	(701) 477-5696	
Dawn	Charging	Representative District 4	7276 14th Street NW #16	Garrison	ND	58540		
Janis	Cheney	AARP	107 West Main Avenue Suite #125	Bismarck	ND	58501	(701) 355-3648	jscheney@aarp.org

Real Choices Attendee List - ATTENDEES - all meetings								
First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Chrystel	Cornelius	Turtle Mountain Planning	Box 272	Belcourt	ND	58316	(701) 477-2692	
Tracy	Cox	Trenton Community Clinic	PO Box 210	Trenton	ND	58853	(701) 774-0411	tcox@trenton.aberdeen.ihs.gov
Deanna	Dailey	Mental Health Association in ND	PO Box 4106	Bismarck	ND	58502	(701) 255-3692	ddailey@mhand.org
Dan	Dailey	IHS - Standing Rock	409 13th Ave NE	Mandan	ND	58554	(701) 854-8245	dan.dailey.@abr.ihs.gov
John	Danks	M.H.A. Elders Organization	PO Box 423	New Town	ND	58763		
Willie	Davis	Turtle Mountain Vocational Rehabilitation	PO Box 340	Belcourt	ND	58316	(701) 477-5998	wdavis@tm.edu
Lisa	Durkee	D.H.S. - West Central Human Service Center	[inside mail]	Bismarck	ND	58501	(701) 328-8795	87durl@state.nd.us
Carmen	Eagle	M.H.A. Elders Organization	PO Box 400	New Town	ND	58763	(701)	
John	Eagleshield	CHR Program	PO Box D	Fort Yates	ND	58538	(701) 854-3856	srchr@westriv.com
Fritz	Eagleshield Jr	Caregiver Support Program	PO Box D	Fort Yates	ND	58538	(701) 854-4364	
Mary Lynn	Eaglestaff	IHS	115 4th Ave SE #309	Aberdeen	SD	57401	(605) 226-7506	
Vonnie	Ereth	Bismarck-Burleigh Public Health	221 North 5th St	Bismarck	ND	58501	(701) 222-6525	vereth@state.nd.us
Jodie	Fetsch	Custer Health	210 2nd Ave NW	Mandan	ND	58554	(701) 667-3370	jfetsch@state.nd.us
Archie D.	Fool Bear	Standing Rock Sioux Tribal Council	PO Box 418	Fort Yates	ND	58538	(701) 471-4857	sinteska@westriv.com
Gerald	Fox	Vocational Rehabilitation / M.H.A. Elders Organization	PO Box 400	New Town	ND	58763	(701) 627-4368	
Joe N.	Frederick		PO Box 1295	Belcourt	ND	58316		
Pat	Fredericks	M.H.A. Elders Organization	PO Box 400	New Town	ND	58784	(701)	

Real Choices Attendee List - ATTENDEES - all meetings

First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Tess	Frohlich	D.H.S. - Aging Services	[inside mail]	Bismarck	ND	58504	(701) 328-8903	sofrot@state.nd.us
David	G. (?)		(none given)	St. John	ND	58369	(701) 477-0886	
David	G. (?)		PO Box 1300	Belcourt	ND	58316		
Stella	Garcia	Turtle Mountain Elders	(none given)	Belcourt	ND	58316	(701)	
Wanda	Gier	D.H.S. - Vocational Rehabilitation	[inside mail]	Bismarck	ND	58504	(701) 328-8955	sogiew@state.nd.us
Jodi	Gillette	Native American Training Institute	4007 State Street #110	Bismarck	ND	58503		
Evelyn	Good House	Voc Rehab - Sitting Bull College	1341 92nd Street	Fort Yates	ND	58538	(605) 823-4206	sissyg@sbci.edu
Carol	Gourneau	IHS Hospital - Social Services	PO Box 160	Belcourt	ND	58316	(701)	
Jenn	Grabar	Sioux County Social Services	PO Box B	Fort Yates	ND	58538	(701) 854-3821	43graj@state.nd.us
David	Grandbois		PO Box 1500	Belcourt	ND	58316	(701) 477-4841	
Myrna	Greene	Sprit Lake Tribe Senior Services	PO Box 294	Fort Totten	ND	58335	(701) 766-1211	
Delemma	Grey Water	Spirit Lake Tribe Elder Board	3983 Ski Jump Rd	St. Michael	ND	58370	(701) 766-4211	
Paul	Griffin	Consensus Council	1003 East Interstate Avenue Suite #7	Bismarck	ND	58503	(701) 224-0588 ext 106	paulg@agree.org
Clarence	Guy	Spirit Lake Elder Program	(none given)	Fort Totten	ND	58335	(701) 766-1275	
Elaine	Guy	Volunteer and Leadership Program	PO Box 10	Fort Totten	ND	58335	(701) 766-1388	elaineguy@littlehoop.cc
Verna	Hagler		(none given)	Belcourt	ND	58316		
Verna	Hagler		PO Box 1500 #A3	Belcourt	ND	58316	(701) 477-9813	

Real Choices Attendee List - ATTENDEES - all meetings								
First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Jamie	Hall	MHA Vocational Rehabilitation	PO Box 1088	New Town	ND	58763	(701) 627-2441	jamiehall@mhanation.com
Patricia	Hall Hammeron	Native American Training Institute	4007 State Street #110	Bismarck	ND	58503	(701) 255-6374	patsyh@nativeinstitute.org
Delia	Hanson	Trenon Area Elders Association	13158 Hwy 1804	Williston	ND	58801	(701) 572-3429	
Brad	Hawk	UTTC	3315 University Drive	Bismarck	ND	58504	(701) 255-3285	bhawk@uttc.edu
Susan Rae	Helgeland	MHAND	PO Box 4106	Bismarck	ND	58102	(701) 255-3692	shelgelan@mhand.org
Sally	Henry	Turtle Mountain Elders	(none given)	Belcourt	ND	58316	(701)	
Virgina	Hileman	Turtle Mountain Elders	(none given)	Belcourt	ND	58316	(701)	
Mauri	Hilts	Protection & Advocacy	1401 College Drive	Devils Lake	ND	58301	(701) 662-9026	mhilts@state.nd.us
Duane	Houdek	ND Governors Office - Legal Counsel	[inside mail]	Bismarck	ND	58505		
Lynne	Jacobson	D.H.S. - Aging Services	[inside mail]	Bismarck	ND	58501	(701) 328-4610	sojacl@state.nd.us
Tanya	Jetty	Spirit Lake Vocational Rehabilitation	3740 77th Ave NE	St. Michael	ND	58370	(701) 766-4446	tjetty@gondtc.com
Deb	Johnson	Lake Region Corporation	224 3rd St SW	Devils Lake	ND	58301	(701) 662-8681	
Martina	Kazena	Spirit Lake Vocational Rehabilitation	PO Box 291	Fort Totten	ND	58335	(701) 766-4446	
Betty	Keegan	Governor's Committee On Aging	PO Box 444	Rolla	ND	58367	(701) 477-3141	keeganbetty@hotmail.com
Elaine	Keeps Eagle	CHR Program	8191 11th Avenue	Fort Yates	ND	58538	(701) 854-3856 / 854-3737	srchr@westriv.com

Real Choices Attendee List - ATTENDEES - all meetings								
First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Marilyn	Keeps Eagle	Standing Rock B.I.A. - Social Services	PO Box E	Fort Yates	ND	58538	(701) 854-3491 / 854-3737	
Russell	Keplin		(none given)	Belcourt	ND	58316		
Rosalie	Keplin		PO Box 668	Belcourt	ND	58316	(701) 244-2571	
Ken	Keplin	Turtle Mountain CHR Program	PO Box 366	Belcourt	ND	58316		
Peter	Klein	Nutrition & Support Services	PO Box 2623	Belcourt	ND	58316	(701) 330-0352	
Jacelyn	Koch	Custer Health	210 2nd Ave NW	Mandan	ND	58554	(701) 667-3370	jkoch@state.nd.us
Lynette	Kraft	Native American Training Institute	4007 State Street #110	Bismarck	ND	58503	(701) 255-6374	lynettek@nativeinstitute.org
Chadwick	Kramer	ND Indian Affairs Commission	[inside mail]	Bismarck	ND	58505		
Marella	Krein	D.H.S. - Economic Assistance / Medicaid	[inside mail]	Bismarck	ND	58505	(701) 328-4579	sokrem@state.nd.us
Cheryl	Kulas	ND Indian Affairs Commission	[inside mail]	Bismarck	ND	58505	(701) 328-2428	ckulas@state.nd.us
Joseph B.	Laducer	Turtle Mountain Elders	(none given)	Belcourt	ND	58316	(701)	
Lori	LaFlor	Spirit Lake Vocational Rehabilitation	PO Box 304	Fort Totten	ND	58335	(701) 766-4446	llaflor@gondtc.com
Gary	LaFontan		PO Box 434	St. John	ND	58369	(701) 278-2527	
Patti	LaFountain	Turtle Mountain Elders	(none given)	Belcourt	ND	58316	(701)	
Vernon	Lambert	Spirit Lake Tribe Education Department	PO Box 201	Fort Totten	ND	58335	(701) 766-1734	tribaled@stellarnet.com

Real Choices Attendee List - ATTENDEES - all meetings								
First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Gayle	LaRocque	Turtle Mountain Retirement Home	PO Box 1500	Belcourt	ND	58316	(701) 477-5366	
Marsha	Lavalie		(none given)	Belcourt	ND	58316	(701)	
Lois	Leben	Spirit Lake Tribal Council	PO Box 359	Fort Totten	ND	58335	(701) 766-4221	
Gloria	Left Hand	Health Start	PO Box 77	St. Michael	ND	58370	(701) 766-1244	
Zelda	Lilley		PO Box 1500 #A17	Belcourt	ND	58316		
Dale	Little Soldier	M.H.A. Elders Organization	6840 BIA RT 222	Golden Valley	ND	58541	(701)	
Cheryl	Long Feather	Native American Training Institute	4007 State Street #110	Bismarck	ND	58503	(701) 255-6374	cheryllf@nativeinstitute.org
Dennis	Lyon	D.H.S. - Vocational Rehabilitation	[inside mail]	Bismarck	ND	58504	(701) 328-8947	solyod@state.nd.us
Stanley	Lyson	Senator District 1	1608 Fourth Avenue West	Williston	ND	58801	(701) 572-7025	
Edna	M. (?)	Spirit Lake Elder	PO Box 186	St. Michael	ND	58370	(701) 351-5058	
Jane	Martin	Turtle Mountain Housing Authority	PO Box 620	Belcourt	ND	58316	(701) 477-5673	
Kevin	Mashak	Social Security Administration	1680 East Capitol Avenue	Bismarck	ND	58501	(701) 250-4351	kevin.mashak@ssa.gov
Eloise	McAndrews	Three Affiliated Tribes - CHR Program	PO Box 316	Parshall	ND	58770	(701) 862-3849	babe_316@hotmail.com
Leander	McDonald	Center for Rural Health	PO Box 9037	Grand Forks	ND	58202	(701) 777-3720	rmcdonald@medicine.nodak.edu
Francine	McDonald	Center for Rural Health	PO Box 9037	Grand Forks	ND	58202	(701) 777-4043	fmcdonald@medicine.nodak.edu
Lareeta	Meridite	M.H.A. Elders Organization	PO Box 160	New Town	ND	58763	(701)	

Real Choices Attendee List - ATTENDEES - all meetings

First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Sandra	Miller		1901 Bitterroot Drive	Sidney	MT	59270	(406) 488-5520	sjmiller@midrivers.com
Walt	Moran	Trenton Indian Service Area	PO Box 213	Trenton	ND	58853		
Alfreda	Morin	Nutrition & Supportive Services	P.O. Box 1500	Belcourt	ND	58316	(701)	
Loretta	Movchan	Protection & Advocacy	400 East Broadway Ave Suite #409	Bismarck	ND	58501	(701) 328-3946	lmovchan@state.nd.us
Ann	Myers		PO Box 1500	Belcourt	ND	58316	(701) 477-3545	
Bonnie	Nadeau	Turtle Mountain Supportive Services	PO Box 670	Belcourt	ND	58316	(701) 477-9518	dsbel@utma.com
Lynn	Nelson	Lake Region Human Service Center	Box 650 200 Hwy 2 South West	Devils Lake	ND	58301	(701) 665-2241	86nell@state.nd.us
Carol	Newman	M.H.A. Elders Organization	PO Box 492	Mandaree	ND	58757	(701) 759-3547	
Flora	Odegard	I.H.S. Contract Health Services	115 Fourth Avenue SE	Aberdeen	ND	57401	(605) 226-7286	
Donna	Olson	Lake Region Human Service Center	PO Box 650	Devils Lake	ND	58301	(701) 665-2200	
Kenton	Onstad	Representative District 4	3515 66th Avenue NW	Parshall	ND	58770		
Deb	Painte	Native American Training Institute	4007 State Street #110	Bismarck	ND	58503		debpainte@hotmail.com
LaVerne	Parker	Aberdeen Area Indian Health Service	115 4th Ave SE, RM 309	Aberdeen	SD	57401	(605) 226-7501	laverne.parker@ihs.gov
Karol	Parker	IHS - MHA Nation	1 Minnethoe Drive	New Town	ND	58763	(701) 627-7901	kparker@ihs.gov
Louise	Peltier		RR1 Box 46	Dunseith	ND	58327		
Marie	Peltier		PO Box 1500	Belcourt	ND	58316		

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First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Ron	Peltier	Turtle Mountain Housing Authority	PO Box 313	Dunseith	ND	58327	(701) 477-5153	ron_peltier@yahoo.com
Inez	Plenty Chief	M.H.A. Elders Organization	PO Box 382	New Town	ND	58763	(701) 627-3289	
Tana	Pomplun	Social Security Administration	1680 East Capitol Avenue	Bismarck	ND	58501	(701) 250-4200	tana.pomplun@ssa.gov
Karen	Quick	NWWSC	PO Box 1211	Williston	ND	58801	(701) 774-4685	81quik@state.nd.us
Bryan	Quigley	Mountrail County MCSS	PO Box 39	Stanley	ND	58784	(701) 628-2925	
John	Red Bear	Standing Rock Elderly Protection	PO Box D	Fort Yates	ND	58538	(701) 854-3752	
Gloria	Reiter		10 N River Rd	Ft Yates	ND	58538	(701) 854-8259	greiter@abr.ihs.gov
Vic	Renville	Governor's Committee On Aging	4614 145th Drive NW	Williston	ND	58801	(701) 572-0674	renville@dia.net
Elaine	Rodland	Turtle Mountain Elders	RR2 Box 84	Rolla	ND	58367	(701) 477-6138	
Marilyn	Rudolph	NW/NC NSC	PO Box 1266	Williston	ND	58801	(701) 774-4684	
Cherry	Schmidt	Department of Human Services - WCHSC	[inside mail]	Bismarck	ND	58505	(701) 328-8787	
Robin	Schumacher	D.H.S. - Aging Services	[inside mail]	Bismarck	ND	58504	(701) 328-8905	soschr@state.nd.us
Michael	Schwab	Dakota Center for Independent Living	311 East Broadway Avenue	Bismarck	ND	58501	(701) 222-3636	mikes@dakotacil.org
Shannon	Scott	NDCPD - Real Choices Rebalancing Project	500 University Avenue West	Minot	ND	58703	(701) 858-4365	shannon.scott@minotstateu.edu
Darlene	Situran	Standing Rock Housing / Elderly Protection Team	PO Box 441	Fort Yates	ND	58538	(701) 854-3891	

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First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Donna	Skyberg	LRHSC	PO Box 650	Devils Lake	ND	58301	(701) 665-2200	83skyd@state.nd.us
Theresa	Snyder	D.H.S. - Tribal Liaison / Program Civil Rights Officer	600 East Boulevard Avenue	Bismarck	ND	58505	(701) 328-1816	sosnyt@state.nd.us
Elton	Spotted Horse		404 Frontage Road	New Town	ND	58763	(701) 627-4781	espottedhorse@mhanation.com
June	St. Clair		PO Box 1500	Belcourt	ND	58316		
Theodora	Star	M.H.A. Elders Organization	PO Box 425	New Town	ND	58763	(701) 627-2824	
Rose	Stoller	Consensus Council	1003 East Interstate Avenue Suite #7	Bismarck	ND	58503	(701) 224-0588 ext 101	rstoller@agree.org
Yvonne	Swain	Turtle Mountain Elders	(none given)	Belcourt	ND	58316	(701)	
Jennifer	Thomas	Belcourt IHS Public Health Nursing	PO Box 152	Rolla	ND	58367	(701) 477-8469	jennifer.thomas@ihs.gov
Diana	Tomlin	M.H.A. Elders Organization	719 79 E Ave NW	Halliday	ND	58636	(701) 938-3252	osage@pop.ctctal.com
Aaron	Vandal Sr	Turtle Mountain Supportive Services	PO Box 670	Belcourt	ND	58316	(701)	
Laurel	Vermillion	Standing Rock Voc Rehab / Sitting Bull College	1341 92nd Street	Fort Yates	ND	58538	(701)	laurelv@sbci.edu
Elizabeth	Walker	Volunteer and Leadership Program	PO Box 303	Fort Totten	ND	58335	(701) 766-1388	
John	Warner	Senator District 4	33200 331st Avenue SW	Ryder	ND	58779		
Carole	Watrel	AARP	408 East Brandon Drive	Bismarck	ND	58503	(701) 222-4607	cwatrel@bis.midco.net
Gerald	White Sr.	M.H.A. Elders Organization	PO Box 400	New Town	ND	58763	(701) 743-4360	

Real Choices Attendee List - ATTENDEES - all meetings								
First Name	Last Name	Organization	Address	City	State	Zip Code	Phone #	Email Address
Thelma	Winters	Elderly Protection Team	(none given)	Fort Yates	ND	58538	(701) 854-7555	
Linda	Wright	D.H.S. - Aging Services	[inside mail]	Bismarck	ND	58504	(701) 328-8909	sowril@state.nd.us
Juanita	Yellow Wolf	Standing Rock Community Middle School	PO Box 643	Fort Yates	ND	58538	(701) 854-7021	
Toni	Young	Cankdeska Cikana Community College	PO Box 517	Fort Totten	ND	58335	(701) 766-1343	antonette_young@littlehoop.cc
Mavis	Young Bear	Three Affiliated Tribes Vocational Rehabilitation	404 Frontage Road	New Town	ND	58763	(701) 627-2688	mavisyb@mhanation.com

[i] [T]he term "Indian country," is a legal term…meaning all land within the limits of any reservation under the jurisdiction of the United States government,…(b) all dependent Indian communities within the borders of the United States,…and (c) all Indian allotments, the Indian titles to which have not been extinguished. Utter, 1993.

A#5

* Facility converted long term care bed(s) to basic care.
Option to relicense as long term care after one year.
**Facility reconverted basic care bed(s) to long term care.
(3) Transfer 12 beds to Turtle Mountain Band of Chippewa with 48 months to license (8-1-2007)
(4) Transfer 8 beds to Turtle Mountain Band of Chippewa with 48 months to license (8-4-2007)
(6) Transfer 12 beds to Turtle Mountain Band of Chippewa with 48 months to license (08-12-2007).
(7) Transfer 4 beds to Turtle Mountain Band of Chippewa with 48 months to license (08-05-2007).
(8) Transfer 3 beds to Turtle Mountain Band of Chippewa with 48 months to license (9-26-2007).
(9) Transfer 6 beds to Turtle Mountain Band of Chippewa with 48 months to license (10-08-2007).
(10) Transfer 8 beds to St. Catherine's Wahpeton with 48 months to license (11-1-2008).
(12) Transfer 5 beds to Arthur Good Sam. Ctr., 48 months to license (12-31-2008)
(13) Transfer 5 beds to Arthur Good Sam. Ctr., 48 months to license (12-31-2008)
(14) Transfer 10 beds to Arthur Good Sam. Ctr., 48 months to license (12-31-2008).
(15) Transfer 6 beds to Arthur Good Sam. Ctr., 48 months to license (12-31-2008).
(16) Transfer 5 beds to Heartland Basic Care, LLC, 48 months to license (01-01-2010).
(17) Transfer 6 beds to Valley Eldercare Center, 48 months to license (4-24-2010).
(18) Transfer 8 beds to Bethany Homes, 48 months to license (6-15-2010).
(19) Transfer 22 beds to St. Benedict's Health Center, 48 months to license (6-26-2010).
(20) Transfer 4 beds to St. Benedict's Health Center, 48 months to license (6-26-2010).
(21) Transfer 4 beds to St. Benedict's Health Center, 48 months to license (6-26-2010).
(22) Transfer 5 beds to Valley Eldercare Center, 48 months to license (6-22-2010).
(23) Transfer 3 beds to Manorcare Health Services, Fargo, 48 months to license (6-30-2010).
(24) Transfer 4 beds to Valley Eldercare Center, 48 months to license (7-7-2010).
(25) Transfer 2 beds to Villa Maria, Fargo, 48 months to license (7-7-2010).
(26) Transfer 4 beds to Manorcare Health Services, Fargo, 48 months to license (11-20-2010).
(27) Transfer 13 beds to Good Samaritan Society, Bismarck, 48 months to license (12-31-2010).
(28) Transfer 7 beds to Good Samaritan Society, Bismarck, 48 months to license (12-31-2010).

166 NURSING FACILITY BEDS IN LIMBO

* Facility converted long term care bed(s). Option to relicense
as long term care after one year.
**Facility reconverted basic care bed(s) to long term care.
(1) Transfer 15 beds to Turtle Mountain Band of Chippewa with 48 months to license (10-22-2008).
(2) Transfer 12 beds to Emerald Court, Minot with 48 months to license (01-17-2009).
(3) Transfer 7 beds to The View, Inc. with 48 months to license (01-01-2010).

34 BASIC CARE BEDS IN LIMBO

THE WEEKLIES

Fort Berthold elder services in trouble

Compiled by
LAUREN DONOVAN
Bismarck Tribune

Fort Berthold Reservation elders got the bad news last week.

A memo from the elders organization, which has offices and employees in each of the reservation's six districts, said as of Friday, "all financial and home health services are discontinued to the enrolled elders, 60 and older, on and off Fort Berthold Reservation."

There are six district coordinators and three staff.

The move comes about as the Three Affiliated Tribes council tries to get spending under control in light of an $80 million deficit through 2005, with 2006 and various business enterprises still to be audited.

Ramona Two Shields, who directs the elder program, said the organization is facing reality.

"We were willing to take our cuts," she said. "We'll be writing grant applications after we get the tax exempt status."

Still, the elders are going proactive and have started work on a petition to get a reservation-wide referendum.

> **"A loan to pay for another loan is not the answer. We're going to have to tighten our belts."**
>
> *Malcolm Wolf, tribal councilman*

The group used to get $600,000 from the tribe's JTAC trust fund interest and has been budgeted about $30,000.

The JTAC trust fund has been so heavily borrowed against, the tribe can no longer spend the interest on the elders and other programs.

Two Shields said a majority of the tribal elders voted to go into receivership; that is, to have the Bureau of Indian Affairs take over tribal operations.

Two Shields said she warned the elders that receivership is serious business, but "we feel the documents are sufficient to warrant an audit and investigation by the Office of Inspector General of JTAC, tribal and federal dollars."

Tribal councilman Malcolm Wolf said it saddens him to see the elders struggle and he's looking for outside funding.

"A loan to pay for another loan is not the answer," Wolf said. "We're going to have to tighten our belts."

— New Town News

Still chugging along

The idea of a touring passenger train running between Bismarck and Washburn keeps chugging along.

The idea made a big splash when it was introduced a year ago, and Lewis and Clark Fort Mandan Foundation president David Borlaug said it's still moving in the right direction.

Borlaug said the train might be running a year from now, if all goes well.

He said the foundation, along with the Department of Transportation, are working on a feasibility study to help decide where depots in Bismarck and Washburn should be located along the Dakota Missouri Valley and Western track.

He said the train would probably run three days a week and the ride, one way, would take about an hour and a half and there's potential to keep it going to Garrison, for the Dickens Village Festival.

Kristi Frieze, also with the foundation, said the Washburn City Commission should think about the depot when it plans the city's Renaissance zone, a tax incentive area created for redevelopment.

She said as many as 300 people will get off the train in search of something to do and someplace to shop.

Borlaug said one of the issues that will be studied is how to get the train passengers from the depot in Washburn up to the interpretive center.

"We are very, very excited and it is a huge step forward for our foundation," he said.

— Leader-News

Strike three

The McKenzie County School said school spring sport bases were already loaded with golf and track.

The board very narrowly, 4-3, voted "no" on whether it would add spring baseball to the Watford City High School's athletic lineup.

At the heart of a long discussion, following a request by baseball supporters was what it would mean to golf and track numbers.

"We know that the addition of baseball would allow more opportunity for students ...." Said board member David Swenson. "But we also know that there will be an impact on other sports, we just don't know how much."

Pam Ramage said she thought any opportunity outweighs the disadvantages.

School superintendent Steve Holen, said he found it a difficult issue to discuss.

"... the administration and the coaching staff are not in favor of adding another program. I can't fully support it, but I can live with it," he said.

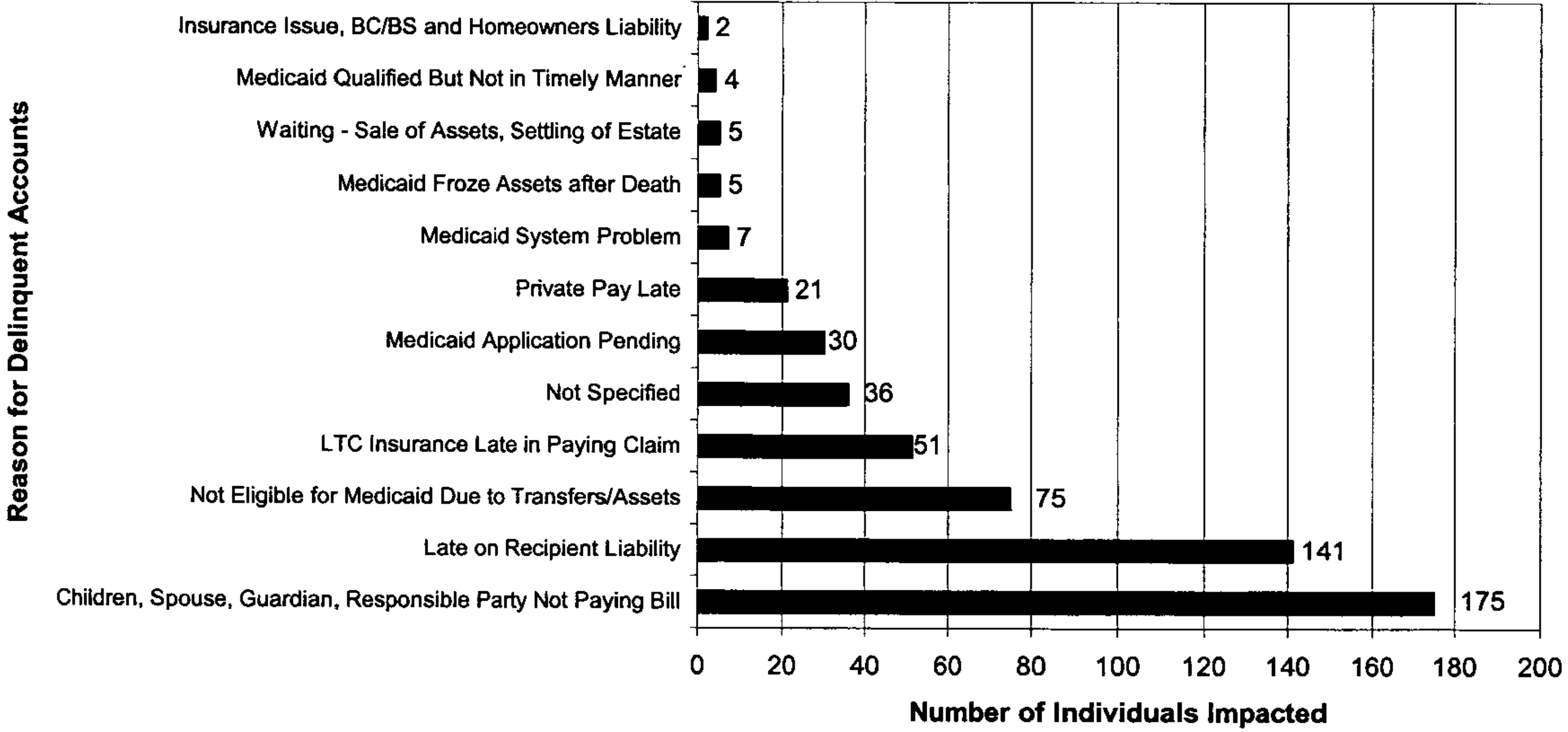
Holen said the school has a nice track facility and a strong track program.

"We are trying to keep the programs that we have, both academically and athletically, strong and competitive in light of declining enrollment. Based on that, it's hard to support adding baseball," Holen said.

— McKenzie County Farmer

2403

BAD DEBT ISSUES



Statewide, nursing facilities are reporting over $4.7 million in delinquent residents accounts. Currently one in ten residents have a problem in paying their monthly nursing facility bill. Today, 564 residents are not current in their nursing facility bill.

North Dakota Long Term Care ASSOCIATION
1900 N 11th St (701) 222.0660
Bismarck, ND 58501 www.ndltca.org

#5

A#6

1/28/07

Dear Senator Lee ,

Can you please read this letter to the Senate Human Services Committee at the hearing this week on SB 2403 – the issue is similar and it appears this a good opportunity to create a dialogue on the problem at hand. I wish I could be there, but, out of state commitments make it impossible.

My name is Barbara Walz. I am writing to ask your support on two things – 1) support an exemption to the moratorium on nursing home beds in the Bismarck/Mandan area for a period of time to allow the cities to catch up on much needed bed capacity and 2) support SB 2012 which would increase funding for nursing homes and create the incentive for transfer of rural beds to the Bismarck area. My mother lives in District 35, and while I am not a current constituent, I grew up in Bismarck, graduated from UND, my family lives in Bismarck, I visit numerous times a year, I have many friends there, and I have been involved in the ND Ambassador Program.

The status of nursing home availability in Bismarck is a tragedy. The state is not providing the necessary nursing home beds for the seniors from the Bismarck area. A change is needed.

I experienced this personally when my father became ill and needed 24-hour care. My dad, Paul Walz, was a lifetime resident of Bismarck who worked for the state Hail, Insurance and Tax Departments and was active in politics. He loved Bismarck and could not walk down the streets of the city without bumping into numerous folks he had known for years. In our search for a nursing home for him, we learned that Bismarck was not an option and that was a shock to us! The only room available for him was in Garrison. Moving him to Garrison where he would have been alone most of the time, was simply not acceptable. We could not treat our loving and caring dad like that! A second option was in-home care and we could not afford the cost of 24 hour, two-person lift care for him. The last option that we looked at was to move him out of state to Arkansas where my sister lived.

We chose to move him via air ambulance ($8K not covered by insurance) to Arkansas where my sister found a nursing room for him. We moved my mom, Marion Walz, there too. For ten months, my mom lived with my sister and spent a minimum of 8-10 hours a day with my dad in the nursing home. It was a second home while he was dying. Each day, my dad asked that we arrange for him to go home to Bismarck. This broke our hearts when we had to tell him that there was no room for him in Bismarck nursing homes.

Although he had good care, he was not in his home environment and he struggled with the cultural differences. For example, vegetables served in Arkansas were okra and greens – not something we grew up on in ND. In addition, dad had a hard time understanding the nurses and CNAs with the strong southern drawls and it created communication issues and situations where he was frightened because he did not know what they were doing to him or telling him to do. He missed his son, daughter-in-law, grand children, neighbors, friends, and former colleagues – he did not have many visitors in the nursing home since he was out of state.

I urge you to support the expansion of nursing home beds in Bismarck through support for 2012 and an amendment to either SB 2403 or SB 2109 to exempt Bismarck/Mandan from the current moratorium – for a period of time to allow the city to catch up on much needed beds.

With the growth of the geriatric population, the shortage in urban settings in the state is a travesty and one which will continue to cause stories such as ours. With the anticipated growth in the geriatric population, the situation will only get worse if it is ignored.

Respectfully submitted,

Barbara A. Walz

2403