

CMS 310, Task 7
LTSS Webinar
The Tohono O'odham Nursing Care Authority
May 23, 2012

Francis: Good morning everyone. My name is Francis Stout. I'm a member of the Tohono O'odham Nation. I'm also a retired nurse from the Indian Health Service and a recipient of the Robert Wood Johnson Foundation award, which is the community health leader award. I want to start first with describing our nation and where it's located. It's located in southern Arizona. It's the second largest reservation in Arizona; Navajo being the largest. We are two point million acres. We're about the size of the state of Connecticut and with a population of 30,205 and of this number 55 years and older are...they total 3,389. Of this group 1,828 are off the reservation... I'm sorry, are on the reservation and 1,481 are off. Now we always realize that some of these that are off the reservation when they feel they need to request special care at the end of life or if they need a different home to come to, we've had several who come back who say they want to be home during this time of their life and so there have been elders from California who've come home and there's always room for them. I want to start... Actually, I'm the Chair of the Board, the TONCA board. The TONCA is Tohono O'odham Nursing Care Authority and it's the governing body of Archie Hendricks skilled nursing care facility. I want to speak a little bit about our board. We are a seven-member board. We are all members of the nation. We represent the health... Some of us have worked as healthcare providers. Some of us have worked with business and we found that this is a very good mix. We had people who've had experience with businesses or managing a business and definitely those who've had some experience with healthcare and this may be in the field, it maybe in an acute care facility or a long-term care facility. So one of the things that we feel has been the...one of the elements that we feel have made us successful is that we are mission and vision driven. We always look at our

mission. When we speak we present our mission first and in our mission we state that we provide leadership for the continuum of care of our aging population, meaning that we don't just always look at our...look within the facility. We look outside to the nation and we are there to provide leadership and assistance in any way that we can. We also believe that strategic planning is very important to a successful entity. I think that in the past we have noticed that strategic plans are made and then they are put on the shelf. We make a great effort to implement our plans. In the past two years we have invited our managers and this past year we even got input from our residents. We confronted them with the question of 'where would you like to see this place in two to five years' and we got some very good answers. The managers do attend our meeting. They are very much a part of the strategic planning and this puts the whole staff on one page and it also moves...and this helps move the *** (*static sound - 4:36*), the projects home. One of the things that we're very interested in is quality, quality of care and as you know quality is not an accident. It's something that everyone has to work for. Our facility in the past two years, three years actually have earned a five-star rating from CMS. CMS comes in and surveys us every year and our staff has been always ready. In fact, our dining room staff, our dietary area also is a department that has won awards and they have worked very hard. They started out with the gold award and two... Let's see, three years have passed, so they are now... So they now have received the platinum award. They are very proud because they know that their hard work has paid off. I'm going to stop now and let Lee talk a little bit about the operational side of our facility and perhaps at the end you may have some questions for me.

Lee: Thank you Francis. Good morning. This is Lee Olitzky. It's a pleasure and honor to be able to present this information to you. My role this morning is the Administrator of the Archie Hendricks Senior Skilled Nursing Facility and the Tohono O'odham Hospice and the soon to

open assisted living residence that we'll talk about a little further in the webinar. The slide you're looking at now is kind of where the blending of the board's philosophy and the nation's philosophy and the operations sort of blend and move into the day-to-day operation. As noted on the slide an element that was key to the ability to develop the nursing home is in the late (?) (6:45) services is the staff housing that is built on site and as it's noted here approximately 34 of our employees live on site with their families. This begins to address the housing need that many nations have these days and the board is considering potentially in the future additional housing to be able to support staff. The way which the board monitors the performance of the staff is through a variety of measures. Francis, if you would ask her she believes very, as does the rest of the board, very significantly in the importance of data and benchmarking. So the staff provides both written and verbal reports and one of the changes that is being made literally as we speak, is that the board will be meeting monthly with the managers to discuss the operation of the facility, any resident issues, any community complaints. Not entering into the operational side, but more or less taking the policy role at the board and examining that with the managers so to continue to ensure excellent care being provided. So the combined approach of the board and management is the concept of developing a strong foundation. So you'll see throughout the remainder of the webinar that the work that's being done at the nursing home, any other services, is based on that foundation, meaning that prior to adding services or approaches to those services we ensure that a foundation is put into place. Not the only four, but the four key areas that were identified to establish this foundation approach were most important, the residents would be treated with dignity and respect, recognition of culture and heritage, and the programs and services in the way which residents receive their care on a daily basis. In order to ensure, to the extent everyone can through this type of approach that there's consistency and quality can be

monitored. We try to develop systems and standardized processes. This may sound like someone is creating an assembly line or manufacturing a product, but in this case it's important for communications. It's important for developing the kinds of services that operate in a nursing facility. As many of you know healthcare facilities are reasonably complex and without systems and standardized processes it can be rather chaotic, not to mention the risk that those staff and residents are placed in if there aren't standardized processes existing. In order to both publish those systems and processes, as well as to ensure that there's a high quality of care, the board has as one of it's, I'd say top three...tier five priorities is training and education of managers and staff to work. The slide suggests that it's a team, but it's actually in many areas ranging from specific skills to additional knowledge. The board has set up a fund for managers and staff to use for continuing education that's related to their employment and I'll talk a little bit further about that and how it's been used to accomplish that. Sound nursing and fiscal practices: we have nursing, but it would be also dietary, housekeeping, and the other support services and there are two sides to this proverbial coin. One of the key ones is the fiscal side of this. If we don't operate in a sound financial manner we will not continue in the future and both the board and I am very proud that literally from the day we opened to the present each of our annual audits have been very positive and have been accepted by both the tribe and the federal and state governments. Services tend to evolve and the foundation that I described earlier permitted us to - once the nursing facility was open to become Medicare certified. I've learned from other opportunities I've had that each state works a little bit differently and for those of you... I'm assuming most of you... Well, that's not true. You can be calling from anywhere. Arizona does not license facilities by and large on tribal lands as a reflection of sovereignty whereas, for example our adjacent state New Mexico does license nursing facilities. In Arizona's instance, the way it

works is they basically have the facility become Medicare certified and they use that as the tool if you will to assure that there's supervision of the care from an external or third party. Once you receive that certification then the state's Medicaid department will contract you for reimbursement for Medicaid services for many of the residents receive that. And in most instances the Medicare process if done smoothly on your end will take about a year. It's hard to control the other end of it, which is government. So that took place and within that year we received our Medicare certification. So Archie Hendricks provides a list of services that we've included ranging from chronic long-term care to wound care and emergency shelter and respite care. The individuals that are at the nursing home are there for long-term care as well as short-term stays, so many of the short-term...some of the short-term care residents are there under Medicare. But many of them, the long-term care residents as Medicaid patients basically. In order for us to develop these services as I mentioned earlier we tried the foundational approach where we break the service down into small components and then ensure that each of the staff is able to understand and work with those individual components through training and education. A good example of this would be when we had reached a point where we thought that the services were stable, we were then able to look at developing a wound care program which would include post hospital care, rather than wound care. With that as an example, many of our RN's and LPN's weren't able to...were no longer familiar with starting, monitoring, and removing IV's; so we wrote policies and procedures that reflect their scope of practice for them, had sufficient training provided to them and documented that training in their personnel files. And now through a period of time are able to invite IV therapy to residents who are on a long-term or short-term basis, but that's a good example of the program. Integrating services is always a challenge in our type of setting. Individual services often work very well, but then

when you start to integrate them you often see the flaws in those services. So we didn't add services or integrate them until after the current systems that were in place were working smoothly. We operate on a model where we do a small-scale or a trial run for a period of time and then see how it's working and if it's working smoothly we expand it to accomplish what the plan was. If we see there's some problems we'll do some remedial training and education, both on-site and off-site and that also is another key element involving our skilled nursing facility. Wound care, one of the other... For those who are not operating a long-term care facility or those thinking about doing that, some of you have already heard in private conversations with me that sometimes there's a conflict of unintended consequences and when the nursing home was open, while everybody was aware of the level of diabetes on the nation and the complications from diabetes, consideration of how to provide care and service for wound care was considered but at that stage it was premature to prepare to take care of folks with those wounds. So after the foundation was laid and the day-to-day operations were stabilized we began looking at providing a wound care program and the staff began through training and education, including initially one nurse and now we have others who are certified wound care nurses and we began a wound care program beginning with minor wounds and the program evolved to the present where we take care of complex wounds. I'm using a variety of different kinds of equipment and techniques. The same process was used for physical and occupational therapy. We looked at the needs of the residents and then we added our physical and occupational therapy. We now have a full-time OT and PT on staff now and we use the same process for other types of services as we added them. One of challenges and I'll mention this to you for many of the tribes is finding professional staff given the locations of facilities and there are sometimes decisions that are made where a service cannot be provided, or offered at a nursing home or some other type of

health facility because there's not an available staff. The physical therapist took us a couple of years to finally recruit someone and the occupational therapy not much less than that before we were able to find them and candidly at great cost to the nursing home, but the outcome of that is an excellent rehabilitation program that we have in place now. As I mentioned, therapy is integrated with the other departments. The goal of bringing elders home to a culturally sensitive environment where language is spoken and foods that are traditional are eaten all contributes to the quality of care that's provided at Archie Hendricks today. As the nursing home was operating and we had individuals who were receiving the care at the nursing home, there was some hospice being provided from the community hospice in an adjacent city. While they weren't doing a poor job they were really weren't doing a very good job. They were not actually providing some of the services that hospice is required to provide under Medicare. As a point of information, hospice is what is called a carved out service for Medicare. If someone's enrolled in Medicare HMO, for example, or some other program, hospice is not part of that benefit. Hospice remains as a Medicare benefit. So for adults who are eligible, or have enrolled in Medicare they are eligible for hospice care. Younger people might receive it through their Medicaid program depending on the state in which they live. In the instance of the Archie Hendricks Skilled Nursing Facility we were receiving hospice service through a third-party provider, but they did not have anybody on their staff who was O'odham. They didn't have anybody who worked with tribal members and their families with respect to culture and tradition, and we brought this to the attention of the board and they...as they have done in the past that we believe that there's a need there, but we're going to need some information and data about this. So we went out and did our version of a needs assessment and did some data analysis and came to the conclusion that it was very important for hospice care to be offered directly by the tribal

members, not a third-party. So we began to look at hospice and on the slide that I hope some of you can see based on the chat, we looked at residents or members feeling their thoughts about hospice, how many people would use a hospice program and we did that through a needs assessment and what were the Medicare requirements for hospice care within a tribal context? And so we began our dialogue with the board and we provided... The board does have an internal process for new proposals that I recommend to any of you who have programs where you have staff making recommendations. It's very effective to have a sort of new project proposal protocol that would be provided to the board so they have an organized approach to what you're talking about. The reason resulted in a feasibility study, which we conducted and the consensus was that we would move forward with the Tohono O'odham hospice which we have. The board approved to start a budget and our goal was to break even within three years and we're at about that time now and for the most part the hospice program is breaking even. In some instances it's actually showing a little bit of a surplus. There's not a true surplus, because there's additional overhead charges that we should now charge against the hospice. We were giving it a little bit of a financial break if you will so that it could get itself up on its own feet. Currently, I'm acting as the administrator for hospice with... We have an RN who went on to become a nurse practitioner who is actually doing the day-to-day management and deserves the credit for actually operating and seeing the success of the hospice. I'm the figurehead administrator, but don't tell Medicare. So Phase 1 of the hospice included submitting the necessary documents to receive Medicare certification. This is not unlike the process for the nursing home, except actually it took a bit longer. They were backed up, according to the Centers for Medicare and Medicaid and it took a quite a bit of time for them to even come out to do their first visit with us, but moving forward in terms of how this was phased; the second phase

of this was doing the job descriptions, policies and procedures, contracts. One of the key elements for a hospice program is that you must have a contract with or an arrangement with either an acute care or a nursing facility for what are referred to as inpatient beds. There are two portions of hospice that are affected by this. One is if a hospice station requires particularly complex care for a period of time they may be admitted to a nursing home or hospital as it was called an inpatient under hospice. The other circumstance is respite care. If an individual was enrolled in hospice or a patient in hospice and their care givers need respite themselves from care giving then the patient or hospice patient is then resides maybe in assisted living, but most often in a skilled care facility or hospital to give the care givers a break and that's referred to respite care. And there needs to be that kind of ability if one wishes to pursue a hospice. Because of the Archie Hendricks skilled nursing facility, the hospice then contracts with Archie Hendricks to provide that inpatient service when needed. From that point forward as this slide indicates, the program is involved and was inspected at the end of its first year and received Medicare approval. However as we say here, always not perfect. While we did a thorough program of community education and we continued to find some reluctance on a broader basis, this comes from the cultural belief about summoning death through talking about it or discussing it. We had talked with a number of elders and family members prior to starting the hospice program. They felt based on their other family experiences with hospice in the community, in the general community that this would not be a barrier and it didn't stop the use of the hospice program, but it did act as a barrier for some to participate in the hospice program. So what were we to do? Well, we then thought about the idea that was popularly referred to as a palliative care program, which we decided was the route to take and that palliative care program is called Desert Pathways and rather than paraphrasing what I would like to just state was that the Desert

Pathways program was designed to assist community members down the uncertain pathways that arise when dealing with a serious illness. Some communities may call something like the pre-hospice program, but it's not all the individuals that are in Desert Pathways either use hospice or need hospice. This addresses, as the pathways does, exactly what it says is that there are many situations where an individual is confronted with an illness or multiple illnesses and is not clear about what's going on and the medical providers might not give them the time that they need. They may have some difficulty managing their medications and so on and so forth. So Desert Pathways was developed and open to the community and as it notes to the efforts of the hospice nurse manager and subsequently a community education staff, the program has been very widely accepted. Of equal importance it did contribute to the growth of the hospice program, because there were individuals who were in Desert Pathways and then did opt to sort of move into the hospice program. The hospice program literally requires as you might expect doing paperwork and having people sign off on participation. At Desert Pathways it really does not require that because it's not a state or federal program that's under some kind of rules and regulations of reimbursement. As a lesson learned we would've been wiser to start with Desert Pathways and then move into the hospice program; so if any of you are contemplating a hospice program myself and the staff and the board would be happy to talk to you about the approach that we subsequently took. I don't want Frances to be embarrassed that she received a Robert Wood Johnson award as a health leader in the community and through that she was able to facilitate a grant for the Desert Pathways program which permitted us to recruit a community educator and some other support services for over a year and because of that we were able to go to senior centers, district council meetings, community group gatherings, just all the kinds of things you would think of to share information about Desert Pathways and subsequently the hospice and

that had a major impact, not only encouraging people to participate in the program but also gave the staff of the hospice program in Desert Pathways a great deal of insight into the circumstances and situations that community members were faced with respect to serious illness and a series of terminal illnesses. We anticipated that the Desert Pathways programs and hospice will be covered by the hospice reimbursement because we're trying to operate the hospice program very efficiently and keep our expenses very low, and our goal is to have that covered. We'll also be looking at - which is not in this slide. The board formed a 501C3 Foundation, which we will be looking for additional grants through the foundation to help support both the hospice and the Pathways program and to some extent the nursing home program. Our contract continues to fill its mission to programs and services. I mentioned earlier that there were some other unanticipated consequences of operating a nursing home that then became learning opportunities, the cliché of a teachable moment occurred. What was occurring in the nursing facility was individuals who were admitted for care after being in the hospital, after they received that care, in effect were recovered. They no longer required skilled nursing care. They could not live independently in the community because their home was not suitable for them because of any kind of remaining incapacities and therefore they remained at the nursing home in a situation where it probably was not beneficial to them, better than being in an unsafe home environment, but not beneficial for being in a health facility. So we went through a similar process that was done for the nursing home and hospice. We concluded a needs assessment, following the earlier models for the purposes of developing assisted living. The feasibility study was completed by the staff and our first-hand experience of the nursing home validated the information that was in the...or vice versa, validated the information that was in the study. We assessed of the approximately 60 residents in the nursing home anywhere from 10 to 12 were willing candidates

for assisted living and did not require continuous nursing home care. So, as it states here after more than nine years in nursing home operations it was evident that a number of elders were unable to live independently, were not in need of care, level of care in a skilled nursing facility. So, we identified multiple elders who were candidates and we continued with this problem. A key issue for us in the third bullet point on this slide is the state of Arizona reimburses for assisted living provided under the state's Medicaid program. Some states do not reimburse for assisted living. Some states have very interesting formulas. If there's anybody from Montana listening they know that assisted living will reimburse for food and support, but they will not reimburse for their room per se. So there's a limited growth of assisted living in some states under the Medicaid program. It's immensely private. The construction, most of them when we have conversations, people ask about the funding part, so we anticipated a little bit of it. The construction of the assisted living was through tribal funds generated through a part operation of TONCA and investments that had been made by the tribe and TONCA. That's another role that Francis didn't have an opportunity to mention which was being financial stewards of the organization is a key role of the board because of their stewardship of the funds we were able to take those funds that were available and continue to invest them until they were needed to the point where they were able to partnership with the development of the assisted living. We believe that the assisted living will be close to breakeven. In part that comes from the idea of co-locating services. So the hospice offices, the nursing facility, and the assisted living are all on the same piece of land near one another. So there becomes economies of scale. I'm sensitive to and aware of the idea that many community members enjoy and appreciate the distance between themselves and others in terms of their residences or homes or communities. In this situation it's one where the benefit of being nearby may, I say may offset the need for a desire to be separated

of sorts. This *** (31:14) for example, and the obvious is that support services from the nursing home can support the assisted living as the office states supports hospice. So, in conclusion, the program services that TONCA developed resulted in finding healthy new services. There are literally hundreds of Tohono O'odham nation plans. The nursing facility has been open since 2002 and if you give it 12 to 24 months of practical start up and getting everything - going so it's been about eight years and those eight years the home has..is approaching having cared for 1,000 elders in the community and their families through the nursing home. The hospice average census is anywhere from seven to ten individuals at any time and when you think of that you think about it on a daily basis. Importantly, as the slide notes, the services are high-quality to culturally sensitive and importantly they are being provided on the community's land and they are living in the O'odham Himdag which is the way of life. And that concludes my portion of the webinar. Brandon, is there anything we do next?

Francis: This is Francis and I would like to add a couple of things.

Lee: Of course.

Francis: I do want to mention that the facilities would not exist if it were not for our nation's desire to provide for our elder population. Their subsidy provides two thirds of our costs. One third is provided through third-party payment. And as we mentioned our audit this time, we keep clean and that is due to the work of not only the business office, but of each department and how they follow procedure when they spend money. So one thing I think that Lee didn't mention was that we had worked real hard at getting our managers certified. Our DON now has a Masters in Nursing Administration. Our HR person is working toward a certification and our dietary manager also has become certified. So, just a reminder that it took us several years to prepare to open and when we opened in November of 2002, then our real work began. That has been a real

eye-opener I think for all of us. We thought once we opened maybe some of our work would lighten up. Well, it didn't. It became harder. So that's a challenge. So that completes my portion.

Brandon: Well, this is Brandon again at Kauffman and Associates. I would just like to maybe open this up to any questions people may have. Lee, I had noticed you had answered one question in the chat.

Lee: I'm working on it.

Brandon: Okay. If you are interested in asking a question for our presenters, please press star six to unmute your phone and we'll open up for anyone to ask a question now.

Cynthia: Brandon or Lee, this is Cynthia. Maybe you want to read the questions that Lee's just been responding to on the chat line.

Brandon: Absolutely. I'll tell you what, I'll read the first one here. Why would the hospice care be different in the tribal content versus nontribal other than the cultural aspects?

Lee: So my response was, the tribal hospice includes traditional healers, tribal volunteers, and support services consistent with the individual's personal belief systems. The nontribal hospice care were not prepared to do this. We can only go by the hospice programs that were, if you will, adjacent to the nation's land versus in other areas. I know that there are other nontribal hospice programs that have done a very good job at trying to overcome what I've described, but in our experiences and circumstances that was not the case. So that's that answer. The other question was, how is assisted living funded? In Arizona, it is funded under the state Medicaid system. It's a little bit convoluted in terms of the sequence of steps that one takes, but at the end of the process one does contract with the state Medicaid system for reimbursement of the Medicaid beneficiaries that are being taken care of in the assisted living. And that kind of ties to

the second part of it. CMS doesn't license it because it's not a federally reimbursed program. Assisted living is not under... There are no federal funds per se for assisted living other than the match that in part goes on the Medicaid, which I know doesn't go all the way through because of how it works, but basically in some states they are state licensed and in other states like Arizona they are not state licensed. But you request a courtesy inspection by the state and then the state if it meets with their inspection, if it meets with their approval, then they'll accept the request to contract with the Medicaid office for reimbursement.

Cynthia: Thank you.

Lee: You're welcome.

(Pause.)

Brandon: Again, do we have any questions?

Lee: Any other questions?

Brandon: Oh, go ahead Lee.

Lee: No, I was just asking if there were any other questions.

(Pause.)

Francis: No further questions?

(Sound of typing.)

Brandon: Okay. Well, this is Brandon again. If there's no further questions, Lee or Francis do you have anything?

Lee: No. I think I've tried to cover what we had been asked to cover.

Brandon: Okay. There was one question here. Anyway if you get a copy of the PowerPoint presentation, the website for the LTSS, the Long-term Services and Supports can be found at Kauffmaninc.com/LTSS where you can get all of these materials and view the webinar and I will

put that in the chat here in just a moment. If there's no further questions, then we can go ahead and conclude this webinar. I want to thank everybody for joining us today and our presenters for their great presentations. If there's any other questions feel free to visit our website and if there's no other questions we'll go ahead and conclude.

Lee: Thank you.

Francis: Thank you.

(End of webinar - 40:18.)