

OPERATOR: Welcome and thank you for standing by. At this time, all participants are on a listen-only mode until the question-and-answer session of today's conference. At that time, to ask a question, press star-one on your phone and record your name at the prompt. Today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the call over to Jolie Crowder. Thank you, you may begin.

JOLIE CROWDER: Thank you so much. And thanks to Cynthia for inviting us today to present and to Laura and the staff for coordinating everything and for allowing us to be here. We actually had tried to present some of this content at the Title VI Conference in August and only had a short amount of time and a ton of really great data, and so I'm really excited about the opportunity again today to be able to talk to you folks and share some of the latest information and data that we have from a couple of different projects and sources. My name is Jolie Crowder, I'm with the International Association for Indigenous Aging, and I had hoped—there's a couple photos so you at least kind of have a picture of who's talking today—unfortunately, Dr. Carson had a family emergency and is not going to be able to make it today for our presentation, but we do—we are lucky to have Kendra here with us, who participated in the needs assessment that we conducted with tribal providers, and so she'll be talking with us as we go over content from that presentation.

Here's just a little bit of information about our organization. We're a non-profit that you may or may not be familiar with. We do a lot of work at the national level on policy and program design. We've worked with most of the federal agencies on tribal outreach and efforts involving elders in tribal populations. We've done work more recently in Alzheimer's and dementia, a lot of work in elder abuse, even though the funding is fairly limited, unfortunately, in that particular area, a lot of work in diabetes and the like. And you can find more information about our organization, if you are so inclined, there.

There's really kind of two components to the presentation today. I had the fortune, I guess, if you will, to go back to school after working for a couple decades in health and aging services, to work on my dissertation. I was really interested and had been doing research, but just kind of wanted to formalize my training, and so the first part of the presentation, it really focuses on findings from the work that I did on my dissertation while I was at UVA. So I'm wearing my UVA hat, and the slides that you see sort of in this format and content are my own and not necessarily [unintelligible]. And then, in the second half of today's presentation, we'll talk about findings from the needs assessment that we conducted as part of [unintelligible] with funding. Then we just fortunately received approval to publish that last month.

A little bit of background information; I don't want to assume any like sort of baseline level of knowledge, so this might be a little redundant or kind of common knowledge for the folks on the phone, but I'll assume that there may be some of you on the phone who don't know a lot about elder abuse in the Native American population. In general, in the mainstream population, it [unintelligible] a pretty huge toll on individuals, families, and communities. There's higher rates of hospitalization, healthcare costs have been found to be higher, significant mental and physical health issues, and, unfortunately, there's also higher rates of death for elders who are abused versus those who aren't. And there have been studies that have found that, interestingly, that a lot of those higher rates of death are correlated with types

of abuse such as financial exploitation versus more common types of abuse that you might consider, such as physical abuse.

The estimates are really based on a data [unintelligible] actually which are the most common estimates are that about 10% of older people experience some form of elder abuse. We talked about the consequences, which are significant. We really don't know a lot about the impact of race on the prevalence of abuse. The research that's out there is fairly limited, and at times, the research findings conflict, meaning that some studies have shown that people of a certain race or ethnicity experience higher rates of abuse, and then others have found that race can't be used to predict abuse whatsoever. And then, some have found that it's really about socioeconomic status versus race or ethnicity. And then, some studies or researchers or schools of thought have suggested that there's elements of culture that might serve as a protective factor for some races and ethnicities when it comes to elder abuse. Although, again, we really just don't know a lot about that.

Just again, I don't want to assume that the folks on the phone here are experts in the area, so I will go through a little bit of content about the context of the American Indian and Alaska Native community and how elder abuse occurs and what makes it unique compared to other communities, either minority communities or mainstream population. As you all know, most likely, that there are 573 tribes, everyone is different, there's different sovereign nations, the complexure of [unintelligible] laws, law enforcement systems that vary from tribe to tribe. There's differences in culture and community and geography. There's different cultural beliefs in terms of spirituality or respect for elders.

There is this concept that Dr. Carson, who was going to be on today's call, has talked about in a chapter that she wrote last year, it wasn't about violence, but she talked about this concept of multiple jeopardy experienced by older Native Americans, which means that there's a higher risk of suspected predictors of abuse; poverty, low education, poor health. We have this historical trauma, forced acculturation and relocation, and then institutionalized discrimination and racism sort of compromises that concept of multiple jeopardy. And then there's the lifelong history of violence. There's child abuse rates that are as high as 77%. There have been studies that have found up to 84% of American Indian women and 82% of men have experienced some form of violence in their lifetime, and 40% of women, American Indian women, have experienced violence in the past year.

So for this particular study, I looked at—there's one real seminal study out there, and it still is, it's the 2008 National Elder Mistreatment Study. It's still the largest national population-based study to date. For kind of nerdy, data folks, I did some descriptive analysis and then also did some logistic regressions so that I could identify predictors. So things like [unintelligible]—so I could use math and formulas to figure out, does this particular thing predict the types of abuse that were experienced by the people in the data set? It was a telephone survey. The final sample was fairly unbalanced in that—[unintelligible] was based on census data when we did the original survey in terms of population and age, and my final data set had almost 200 American Indians and Alaska Natives, 437 Black and African Americans, and 5,000 White individuals.

I looked at 16 different abuse variables, sort of the common things, emotional, physical, sexual, and I looked at those at three different timepoints. Potential neglect, which was, do they need help, and no one is available, and then, potential neglect when there has been an

identified caregiver. I also looked at financial exploitation by a family member and by a stranger. And then a new variable that I created for this study was financial exploitation by family amongst people who said they need help with their finances. And then a couple of other variables I added were related to this concept of polyvictimization; so have they experienced more than one type of abuse, either since they were 60 or in their lifetime.

There's a lot of data on this slide, and I've got—just to kind of orient you—if you look at the chart on the left, where I talked about prevalence of financial exploitation by race, just by way of example, you'll see the first set of columns says, Financial Exploitation by Family. If you'll notice—and this is the same for all of the tables—the column that is maroon-ish or brown is the American Indian and Alaska Native Alone population, the yellow column on the charts are the Black or African American Alone, and the green columns are the White or Caucasian alone. I did, just to kind of make things a little bit easier for folks to identify, if you notice, there's like a red circle on a couple spots here, I dropped those in if we found that there was a statistically significant difference in the data, and that means that we used some formulas to say that the percentages are different and it's not just by chance.

And you'll see, for instance, so Financial Exploitation by Family for American Indians and Alaska Natives was 7.1%, and for Whites, it was 5%, but there's not a red circle around that one, and they weren't, even though percentagewise, they're different, they're not statistically different. So for financial prevalence—the prevalence of financial exploitation, the one that was statistically different was Financial Exploitation by Stranger. Some people you convince about statistically significant differences or not, and me personally, I may only be interested in the column that shows the data for the American Indians and Alaska Natives Alone because it's data that doesn't, and heretofore, hasn't existed at a population base level.

So 7% of those in this data set said they were exploited by a family member, 14% said that they were exploited by a stranger, and then 32%, which was one of those new variables, of American Indians who said that they need help with their finances were exploited by a family member, which is just pretty astronomical. So that represents those most vulnerable of the population, the people who need help are the ones who are most likely to be financially exploited. You'll also see the rates, the prevalence of neglect, on this one. You can see the red circle, again, shows you that, statistically-speaking, the difference between the racial subgroups, American Indians had a higher rate of neglect by—potential neglect by an identified caregiver. So there was somebody in their life who was supposed to be taking care of them, and they weren't. They were not attending to one of their needs.

I'm going to move on because we have a lot of data to cover. Another really busy slide here. And, you guys, I think we'll get the slides after this to kind of pick through and figure out the content, and I do have summary slides at the end, but let's start at the top left and look at the Prevalence of Emotional Mistreatment, and that first chart on the top left shows you the first column is Lifetime Emotional Mistreatment, and then the second set of columns are Emotional Mistreatment Since 60, so since they've been an older adult, and then there's Past Year Emotional Mistreatment, and not surprisingly, the rates drop a little bit, which, you know, probably makes sense. If you look back over the history of your life, you may—you should be more likely to have experienced abused.

But even if you just zero in on that past-year emotional mistreatment, so someone who is 65—and it's 65 and older—17% of the American Indians and Alaska Natives in this national

sample had experienced some form of emotional mistreatment. And that, again, every one of these is statistically higher than all of—than those of the other races that we looked at. As well as, if you look at Emotional Mistreatment Since—[audio cuts out]—if you scan over to the right and look at the Prevalence of Physical abuse, the only one that's circled in red is Lifetime Physical Mistreatment. The high rates of abuse, perhaps, aren't surprising, knowing findings in other research that's out there in terms of lifetime rates of abuse of American Indians and Alaska Natives, maybe not even as high as you might have expected to see—[audio cuts out]—while you will notice, to the right, Physical Mistreatment Since 60 and Past-Year Physical Mistreatment aren't statistically significant, but the—[audio cuts out]—and so 4% of—[audio cuts out]—4% of the American Indians experienced some form of Physical Mistreatment Since 60, for instance.

If you go bottom left, we talk about the prevalence of sexual abuse. Our sample was really small, and so, after the Sexual Mistreatment Since 60 and Past-Year Sexual Mistreatment, you should handle with a degree of trepidation, I think, when looking at these numbers, but they're about as accurate, I think, as we might have at this point in time for the national sample. But you can see that, from a lifetime perspective, that the rates of lifetime sexual mistreatment by elders who participated in this study are almost twice that of White participants who reported having experienced sexual abuse in their lifetime. On the bottom right, we talked about that concept of polyvictimization, so experiencing more than one type of abuse. I looked at it at two different timepoints.

So I looked at Polyvictimization Since 60, and I only had four variables that counted that, and then I also looked at the one that's got the red circle, Polyvictimization of Five Different Types of Abuse, and you'll see that there were statistically significant differences, which should be no surprise since these were all different [unintelligible] previous slide. But I think kind of the takeaway on this one is that 30% of the people, the national sample of American Indians and Alaska Natives, said that at some point in their life, that they've experienced one of these five forms of abuse, exploitation, or neglect. That's a large volume of individuals who have experienced some form of abuse in their lifetime, and it is likely underreported.

There was some perpetrator data in here, I'm really not going to do all too much on this, the slide content is in there. There was a really small number of respondents because, by the time you figure out who says they've been abused, and then you get the data about characteristics, it becomes less statistically valid. I think there are some sort of generalities that you could speak in. For emotional mistreatment, the perpetrator was less likely to live with the victim, so they might be a family member or a stranger. And then the perpetrators, about a third of them had substance abuse issues, which was, amongst the different types of abuse, most common for emotional mistreatment. So substance abuse had a connection to emotional mistreatment. For physical abuse, there was really no difference in the percentages of perpetrators of physical abuse. And then, unlike emotional abuse, the majority of perpetrators of physical abuse actually lived with the victim, and then substance abuse issues were also an issue, but not as common with emotional mistreatment.

Sort of the next step in the process was running those statistical tests to say—I looked actually at 20+ different variables and said, does income predict physical abuse, does social support predict physical abuse? So I kind of went through the list one by one, and then I created these models at the end that were a little bit more complex than that to figure out, of

all of the things that I looked at, what do we have a sense of predicts different types of abuse? And the takeaway really is that it differs. It differs by the types of abuse.

Generally speaking, we say some protective factors, which is the first column here, older age is a protective factor for most types of abuse. Higher social support scores for three of six different types of abuse, so the more social support they had, for certain types of abuse, the less likely they were to be abused, but not all. And then, probably not surprisingly, if they were male, it was a protective factor for sexual abuse. Risk factors for abuse; there was a question that folks were asked about whether they were bothered by emotional problems, and that was actually a significant risk factor for five of six different types of abuse. So a question, kind of mental health related, about whether they'd been bothered by emotional problems in the last 30 days, whether they had a history of trauma was predictive of three types but not all six. Help needed was predictive but for only emotional abuse. And then being married or living with someone was predictive only for physical abuse.

Some things that were kind of surprising based on other research is that income and poverty within the American Indian and Alaska Native group was not a significant predictor of abuse. Education was not a significant predictor. Whether they used social services or not was not a predictor. And remember, social support was but not social service use. And then, the poor overall health was not a significant predictor. In other studies that have been done before in mainstream populations and elsewhere, these things have been found to be predictors in different types of studies. So what's social support? In this study, social support would measure, they asked people, in the past month, how often was someone available to help you if you were confined to bed, gave you good advice about a crisis, get together with you for relaxation, talk about your problems, love you, and make you feel wanted? And this is a scaled score, and I actually looked at it a couple different ways in the study to make sure that it was really the scale of the score versus one individual variable that made the difference, and it didn't matter how you looked at it.

And so, I think the takeaway for me, though, is that like, to me, this construct of social support is very different than I have, you know, a neighbor who might bring me a meal, necessarily, having someone who makes you loved and feel wanted or that talks to you on a regular basis, or that concept of social service use, somebody who might bring you a meal but doesn't engage in conversation with you or ask you how you're doing or do any of the other things on the list. And so, if we don't engage in this level of depth of social support, then they are more likely to be abused. Let's see, summary of findings, and I think I have a lot—oh, no, this is it. There's a lot of words on the slide, though, and a fairly small font. I've talked about most of these, but probably not surprising to the folks on the phone, the American Indian and Alaska Native elders in this particular study had a significantly different demographic profile than the White respondents in this profile. There were fewer differences between the American Indians and the Black respondents, though there were still differences.

The prevalence rates of abuse were 1.5 to 7.4 times higher for American Indians and Alaska Natives than Whites for all types of abuse, except for potential neglect. They might not have all been significant, though the majority were. Accumulative rate of emotional, physical, sexual mistreatment, potential neglect, and financial abuse by a family member in the past year was 33%. That's almost double the rate of the original study for the entire population. And that doesn't include every type of abuse or exploitation that we measured in this particular

study. There were high lifetime polyvictimization rates for the elders plus high rates of a history of trauma amongst the American Indian elders, which is, again, probably not much of a surprise to the folks on the phone, but I think those lifetime victimization rates and lifetime history of trauma has major implications for service providers in terms of providing trauma-informed care and the services that you provide and how you approach the people that you provide.

This one is really tricky. The risk and protective factors for different types of abuse vary by race and also vary by type of abuse. So we can't uniformly say, if you are an older White female, then you won't be abused. Or, you know, conversely, there's no one variable that we could say predicts any type of abuse necessarily—universally for all types of abuse, which makes that a little bit challenging. I think, as a provider, when you're trying to think of sort of an easy measure of how to identify potential victims of abuse in your practice, although that social support piece is a protective factor or lack of social support as well as that concept of being bothered by emotional problems, I think, hold potential for future research, as that potential—that emotional problem issue was predicted in five of the six measures of abuse.

Social support wasn't really a surprise as a protective factor because it was the most consistent in previous studies, this study, in other studies, as well as in an analysis that was done of Non-Whites versus Whites in this particular data set. What I caution folks is to make sure you understand, when you're talking about social support, quote, unquote, what that means and what the construct of social support really is as you think about that data and how that applies to your practice. And, again, this may go without saying, but I will say that I think you need to remember that the risk and protective factors that are common to Whites are not necessarily shared by American Indians and Alaska Natives or Black respondents. So when our researchers focused on Whites or has majority Whites and we don't do subgroup and subpopulation analysis of minority populations, that research may not apply, and those findings may not, and often don't, apply to minority populations.

Some implications here for folks, I think, from a practice perspective, this is—it may not be the best, but at this point, it's one of the largest studies of American Indian and Alaska Native elders that included both men and women, it came from a nationally representative sample that included both comparative groups looking at other races and assessed this large of an array of mistreatment types. My hope is that we use this prevalence data as a jumping-off point to increase awareness and start thinking about what we can do and how we can fund more work and research in this particular area and start actually taking some action. We need to recognize and value the strengths and traditions of the diverse array of tribes that are out there, and I think we'll talk about this more in our next presentation as we talk about culture. We also, I think, what's important is to recognize that these things that we believe, these cultural strengths that afford protection to our elders, such as respect, appear to provide little degree of protection, at least when you compare them to mainstream populations who may or may not have these same values of respecting their elders because the rates of abuse are twice as high as that of the mainstream population.

We really need a better understanding of what those elder-specific risk factors are for American Indians, such as trauma and social support and bothered by emotional problems. I think we need to, from a provider and practitioner perspective, we need to be able to predict and identify the folks that we're working with, and we need to be able to use those to develop interventions, such as trauma-informed care and those types of things in our practice. We also

need culturally appropriate and community-specific protocols and policies for elder abuse, and we'll talk more about that [unintelligible]. Also, trauma-informed care; given the high rates of trauma that are experienced and a call for multidisciplinary collaboration and to think about how we can systematically address social support in a meaningful way.

From a research and policy perspective, we need to make elder abuse a strategic priority at all levels in government, at the local level where you work, the state level, and the federal level. When there are calls, for instance, I think the Elder Justice Coordinating Committee was soliciting feedback for comments and directions last month, and hopefully the folks on the phone took the opportunity to submit comments or even your local stories or perspectives. I submitted some recommendations in data, but we really need to center the American Indian and Alaska Natives stories and experiences and needs in the context of the needs of the rest of the population. It's sorely understudied, and without data, I don't think you can drive direction and focus. We desperately need, across all populations, well-designed screening and intervention studies.

For ten years now, the US Preventive Services Task Force has not been able to recommend elder abuse screening because there has not been a single well-designed random or a control trial in this particular area, so it's a huge priority. I also have said this pretty much in everything we do at IA-Squared, we need set asides for research to study minority populations and American Indian populations so that we better understand. We know that we're different, but we're not studying them, and we're lumping in and making assumptions about the population. And then, when we do larger studies, we need to be sure to over sample [unintelligible].

And then Cynthia, who was so kind as I was working on my dissertation and also on the next project, we had a lot of back and forth, had this great quote about—in one of her conversations about just the reality that there's not a home for elder abuse and long-term care anywhere, really, and IHS doesn't have policies in place and there's no one really giving guidance or direction. I think she's picked up the mantle and done the best that she could. And then, sadly, there's just no funding, and that is an experience at large when it comes to elder abuse, unfortunately, compared to other types of domestic violence. And data is really what's going to change policy and drive decision-making, and so, to the extent that we can gather more data and make the case that we need intervention, I think we will be better for that.

I believe actually that we're taking questions at the end, and I know that folks on the phone have to be tired of listening to me speak, and I'm going to zip into the second part of our presentation here. And, good news, I only do the introduction of this and give you some background, and then you get to hear from Kendra, so you get to hear a different—a nice, lovely different voice. This is about a project that we work on at IA-Squared in the previous year with Kendra, myself, and Dr. Carson, with funding from the Veer Institute, which came via the Department of Justice. The objectives of our project were to describe provider, community, cultural, and systematic clinical—at the clinic level factors that contribute to how victims of elder abuse are identified and managed in outpatient clinical settings.

We were looking to find facilitators and barriers to identifying and managing victims of elder abuse in the clinical setting and then just really understand the context of what it means to provide clinical care to elders who are abused. My background, actually, is nursing. I've worked in healthcare for five years before I got my [unintelligible] into management and policy

and programs and moved to D.C., and so, at sort of the core of my work, I've always been interested in that screening and management process for elder victims of abuse. And so the project concept for this actually came out of some coursework that I did while I was at UVA that I was fortunate, through IA-Squared, to write a proposal that got funded.

So methods and participants; we were fortunate that we talked with providers and adult protective services workers, elder services workers, such as Title VI directors and staff, and domestic violence staff from 22 different states. We did phone interviews. We also did an online survey. The survey was primarily focused on health center staff versus APS or elder services workers, whereas the interviews kind of were crosscutting across different disciplines. It was primarily rural clinics and providers who served folks in rural areas and that served patients from multiple tribes, so we did have, in our interviews in particular, we had three urban Indian clinic staff who participated, and I think their insight was really helpful. So I'm going to—I need to turn the ball over to Kendra, which there is literally a ball and there is this odd screen on my thing here now, a video, so I'm trying to figure out how to do that. In the meantime, Kendra, do you want to talk, and I will—

KENDRA KUEHN: I stole the ball from you.

JOLIE CROWDER: Oh, good, I love it!

KENDRA KUEHN: Hi, yeah, so I'm going to switch over to some findings from the project that Jolie described. So this is just our findings from the online survey. We asked about barriers to elder abuse screening among clinical providers, and really, as you might expect, some of the top ones were presence or reliance on a family member in the room, someone needs to, I don't know, just help keep notes, and if that person is also the perpetrator, then of course the victim might not want to talk about it, and then this lack of universal screening tools we'll talk about later as well.

And then we also asked about the abuse seen by providers or the prevalence they've seen, and this actually really mirrors abuse in the larger population as well, financial abuse and exploitation and neglect are highly seen. I think we found that financial abuse, interesting as well since you wouldn't think of that necessarily as something healthcare clinics would pick up given that it's not physical or health related. And then, this we found important was we asked, do you know who to contact to report elder mistreatment, and only a little over half agreed or strongly agreed with that. We think some of the context of that might be the jurisdictional issues of, you know, is it the state or is there tribal protective services.

And further findings, the one we really would like to highlight is that 89% of our respondents really believed that providers should play a role in screening for elder abuse. Regardless of the thoughts or what folks are doing, we found that really encouraging that folks actually do believe they should be playing a role here. Unfortunately, in the survey, 69% said that they don't have adequate training, which this was a result that was very different from the interviews that we discussed, where the majority felt that they did have adequate training, and we think part of this may have been kind of a bias from talking in person versus kind of an anonymous online form. And going along with that, healthcare providers are interested in

receiving additional training, and about half don't have—routinely screen or have a protocol for handling cases.

So then the interviews Jolie described, it really took a deeper dive onto these questions. We had similar kind of basic demographic questions, but then a very—a guide that we also just went further conversations in. So one of the first themes that we explored were the individual level, kind of what the elder's view is, and really one of the top things that came out was the elder's protection of family, not wanting to report abuse by a family member, not wanting to get them in trouble, things like that. And then, going along with the wider family variables, some of the items we saw were elder support of grandchildren, as well as just family in general, really came out, the idea of putting grandchildren first, even if it led to self-neglect or neglect of the elder. And then, also, if children or grandchildren are taking care of the elder, they might take financial advantage of the elder as well since they're vulnerable, but then the elder does not want to report them and lose that only source of caregiving.

And then we also explored some structural variables within the clinics and providers. As came out in the survey, there's kind of a few standardized protocols, a few screenings available, there may also be difficulties with assessing abuse. This is particularly key in areas where, as I'm sure you've seen, there's increased turnover, elders may not trust the providers if they haven't seen them frequently. We also received feedback that providers felt reporting might damage their relationships, and this is kind of a false belief or a myth that most reports show—most reports and studies show that patients still seek care or will come back even if a provider reports. And as seen in the first slide, providers really see all types of abuse, even the physical abuse is the easiest to identify. Why isn't it—sorry having a little difficulty there.

And then, also, one of the themes we explored was cultural variables, which we received some really interesting responses on, I felt. For example, for respect for elders, the cultural variables of family first and community and respect came forward, but we also found these strengths did not always provide protection or providers didn't think they always provided protection. And similarly, the role of acculturation was unclear. We asked about, in your community, would you say they're more traditional or are they more acculturated and mainstream, and there was a variability in whether folks felt that that impacted levels of abuse.

Abuse is generally discouraged as a familial topic; we don't talk about that; we don't report that. And then, as Jolie discussed earlier, things like historical trauma really also provide a different level that might affect abuse or how people report abuse. Additionally, we looked at what's going on in the community and society. We found that abuse really isn't a priority. It's low reporting. And many of the complaints come from the community members rather than providers. Some of the promising interventions that are out there are really things like home health, that's going out and seeing people in the community, seeing what's going on. The staff are often more respected than the providers might be, or more accessible and also can promote community outreach and education, promoting that education of healthy boundaries.

There was a lot of discussion around referral agencies and what's working and what needs to be improved. There was some reactions that tribally run adult protective services might have better outcomes whereas some tribes have to rely on state or local adult protective services. And, again, as Jolie mentioned, jurisdictional issues can be a major challenge; who do you report to, who has jurisdiction over the case can be confusing for many. And then we also looked at the theme of needs and really the main theme was how funding underscores almost

everything; funding for outreach and awareness, funding for elder services, as I'm sure you all know, funding for things like training and development of standardized protocols. Jolie, would you like to move onto the discussion?

JOLIE CROWDER: Why don't you just keep the ball because I don't know how to feel it and I have enough trouble with my old eyes clicking the button that (unintelligible). Yeah, so that was a really quick overview Kendra—quick and awesome overview that Kendra did. We waded through literally hundreds and hundreds of pages of data and research for this project, and as you can tell, it was really hard for us to distill kind of the key findings because we felt like there's just so little known. I do want to go back and say, from a methodological perspective, just to give a little bit of validity to the themes that we identified, we had two researchers who read every interview transcript and individually coded responses, and then we came back together multiple times and said, okay, what are the themes that we're finding. As we went through the interview process, those were iterative, so if we found a theme, we'd add that into our guide. So this is probably one of, we believe, the most structured and rigorous evaluations and assessments that's been done heretofore, even though a lot of the findings might not be absolutely new.

So we recognize that some of these things we've known. There is some new information. I don't think that we knew, and maybe you all did, but I don't think that we knew that screening, like providers were so willing and ready to do screening for elder abuse in the clinical setting. They want to do good things, but they lack the capacity, the skill, the knowledge, and the resources and the support to do them. And so 90% of our providers in the survey said, we want to screen, help us do this, is really kind of the topline finding for us. I think the sort of language that you see there that they're experiencing abuse 70%, I think it was, or have experienced some form of financial exploitation on behalf of their patients, so they're experiencing these cases, and we're leaving them out there to fend for themselves. They have no resources in the office, they have no resources in the community, so they are left dangling in their clinics without the capacity to help their patients or they're doing the best they can.

I think the other pieces that are unique in the American Indian and Alaska Native sort of elder abuse context that came out were the historical and current traumas and sort of that lifelong cycle of abuse and the impact that that still has today that I don't think that we give enough credence to when we think about the provision of services and care, or as other outside providers and services look into tribal communities don't really give enough credence to. The poverty, another social determinant of health, came up a lot in this particular—in our conversations and in the survey. So, if you remember back in my dissertation research, in the American Indian community, poverty really wasn't a predictor of abuse, but I think it's really at the community level that the communities are so impoverished overall that that impacts sort of at the community and the family level, that has impacts on when abuse occurs and doesn't occur.

Caregiving came up, but it wasn't as prominent, and we know that research has said that caregiving, there are a million caregivers out there, and they all do great work, and we can't, by and large, say that caregivers abuse more than not. Oftentimes it was in the context of dementia or Alzheimer's and the challenges that those cases present for people. It was really surprising, for me perhaps, the basic needs that came up, such as housing, food, and

transportation. That came up over and over again in our interviews with healthcare providers and needs for services that these providers and individuals are left fending for. There's also community public health and home health as surveillance and intervention. I feel like community CHRs, we keep people in all walks, all fields keep going, hm, these CHRs could play a really critical role in Alzheimer's and dementia and now in elder abuse or in this particular area, they would keep swiping funding from these public health programs and from the CHR program when, in fact, they're the boots on the ground, and I think we need to invest in that infrastructure. And in this particular case, I think that program in particular really shined in terms for both surveillance and training and intervention.

As we've said before, I think we got a lot about that link between culture abuse from a qualitative perspective, but I don't think we've—no one has ever explored it quantitatively, and I think we still need to better understand that, as an intervention as well, not just culture as a risk factor. MDTs, multidisciplinary teams, is another promising intervention that I'm not sure that we had put on that slide, but there's also a resource center that's been funded to help support tribal MDTs as well as other MDTs that—multidisciplinary teams are sort of burgeoning in—there's a few out there in tribe, but of the tribes that have them seem to do the best job at really crossing disciplines and helping people. Tribes that have funded APS-type person, it doesn't have to be called Adult Protective Services, but somebody that sits as sort of the gatekeeper for elders and abuse seem to be more successful. Self-neglect as a concept was largely absent, and we didn't specifically ask about it, and we know is a big issue in mainstream populations, and perhaps, had we asked, it might have been an issue here as well. It did come up in a couple conversations, but definitely wasn't the focus or a big theme that came out.

Again, we're back to sort of tiny slide font here. Hopefully you guys just get these slides and can take them home or read them at your leisure. We have, also, a slide at the end that gives you links to the reports and then a two-pager that has our policy and practice recommendations. We're really pushing for [unintelligible] testing of elder-specific clinical screening tools in the tribal clinical setting. Whether it's a randomized control trial or quality improvement or under whatever guise you do that. We found two tribes that do it right now and that have done it successfully, but we need to be doing more of that, and we need to be publishing and talking about the work that we're doing because nobody is doing that, and we need to build the body of that research.

We need to develop and test protocols to support the providers, intervention protocols, and we need to train the providers to support them in the work that they're doing. We need training on red flags and grey areas that incorporate trauma informed care approaches. We saw in the first presentation how many elders have experienced trauma or abuse in some form and how prevalent that is. Adaptations of tools or best practices, we need to be affecting what's happening at the community level, what supports and services and assets are available, and we need to be sharing that with our providers because the providers don't know. Maybe we can't assess them because they don't exist, but if they exist, the providers need to know that they exist, and right now I don't think that we're sharing that type of information with healthcare providers.

For tribes that dedicate funding to an APS-type staff person, social worker, case manager, etcetera, they seem to have better outcomes with their elder victims of abuse. I already talked previously on the other slide about community health representatives and the

home health programs and the role that we feel like they could play and the at-risk—the funding issues that they face. We talked about MDTs, and there's just a little bit more detail in terms of our recommendations about multidisciplinary teams, but making sure that we're incorporating health center staff into the MDTs because, oftentimes, they are community supports and services and we forget the health center staff or the health director, and they have eyes on, they see patients with their clothes off in the clinical room, they see things that no one else in the community can see and can really give you a different perspective on dealing with a patient.

We need strategies to enhance outreach and awareness, and I know—you know, I've heard lots of stories at the Title VI Conference of bulletins boards and campaigns and sessions at pow-wows and those types of things, and we need to know what's working and what's not working and what's most effective and not effective, and we just need to keep—we need to be persistent about that and we need to bump up the funding to do those types of activities. And then we need to invest in testing out cultural revitalization programs and other programs that use cultural revitalization or cultural interventions as sort of an intermediary to improve elder abuse outcomes. Those are hard because, downstream, it's sort of a longer term [unintelligible], but we heard some really great success stories or tribes who believe that they're having great success when they are focusing on revitalization and community change and strengthening in those ways, but nobody is measuring that, so we can't say for sure that that's really creating an impact or doing before-and-after type things.

That's it, and this has all of our contact info. The two-page summary, those three things are actually links. So for this report, we have a two-page summary, which is a one-pager summary and then the back page are the recommendations that I just went over. We have a summary research report, which is like 20-ish pages with some attachments, and then, if you are a data nerd or really invested in this topic, our full report is 100+ pages with all of our guides and instruments and tools and full details about methods and measures and stuff like that, and so we welcome you to take a look at those, that content, and reach out to us with any questions you have. So we're done, operator. Oh, sorry, go ahead.

KENDRA KUEHN: And we've received a note that the presentation will be available on the Older Indians website in two weeks.

JOLIEIE CROWDER: Awesome. Operator, can we take questions now?

OPERATOR: Yeah, absolutely! If you would like to ask a question, please press star-one on your touchtone phone. Make sure your phone is unmuted and record your name clearly when prompted. Your name will be required to introduce your question. If you need to withdraw your question, you press star-two. Again, to ask a question, please press star-one and record your name. It will take a moment for questions to come through. Please standby.

JOLIE CROWDER: And, Laura, are they able to put questions in the chat as well, or do you prefer that they only ask them over the phone? I don't know if Laura is on the speaker phone.

LAURA: I'm here. We'd prefer over the phone simply because it's being recorded and that way the recording and transcript will reflect those questions.

JOLIE CROWDER: Okay, awesome.

OPERATOR: And, again, as a reminder, if you would like to ask a question, please press star-one and record your name. [Pause] And I'm currently showing no questions in the queue.

JOLIE CROWDER: Awesome. Well, thank you guys so much for entertaining us and giving us an hour out of your day, which I know is just an incredibly valuable amount of time given all the hard work that you guys do and how valuable that is. And thank you again to Cynthia and the folks at ACL for creating this forum for sharing our research. And we look forward to opportunities to share our findings and do more work with folks in the future. So please reach out to us. You've got our email there. Feel free to contact us if you have any questions or want to talk more.

OPERATOR: That concludes today's conference. Thank you for participating. You may disconnect at this time.