2026
REPORT

Evidence-Based Health Promotion Programs

Among American Indian, Alaska Native, and Native Hawaiian Communities

National Resource Center on Native American Aging
NRCNAA

ncoa
national council on aging®

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Introduction

American Indian/Alaska Native/Native Hawaiian (AI/AN/NH) Elders are valued members of their families and Tribal communities, revered as wisdom keepers transmitting knowledge for the next generations. AI/AN/NH Elders support the well-being of their communities and deserve to age well and with dignity.

Evidence-based health promotion (EBHP) programs play an important role in this effort and require further exploration to hear from the Tribal communities themselves to ensure access to programs that are not only evidence-based, but also culturally grounded, community driven, and truly responsive to the needs of those they aim to serve.

To gain this necessary insight, the National Resource Center on Native American Aging (NRCNAA) partnered with the National Council on Aging (NCOA) to conduct a national survey of the Older Americans Act (OAA) Title VI directors and staff. The survey included 34 questions related to implementing EBHP programs, with specific areas of focus including organizational needs, familiarity with existing programs, funding resources, partnerships, implementation barriers, cultural factors, as well as information about health promotion programs that had been developed or adapted in their communities.

The online survey was emailed to 256 OAA Title VI directors who were encouraged to complete the survey and share it with their staff as well. Data collection took place from April 13, 2026 to May 25, 2026, which amounted to approximately five weeks of gathering meaningful information from Title VI programs across Indian Country to inform and strengthen evidence-based programming for AI/AN/NH Elders.

There were 95 participants, resulting in a response rate of 37.0%. Responses were collected anonymously, with some providing contact info on a follow-up survey to receive a $25 gift card as an incentive for completing the survey.

This survey built upon a similar survey that was conducted in 2020 to assess information on EBHP among AI/AN/NH communities. That particular survey consisted of 29 questions and was distributed to 241 Title VI directors that resulted in 63 responses. Findings from that assessment are available in the 2021 Evidence-Based Health Promotion Program Report.

This report presents findings on contemporary perspectives, including opportunities and challenges, regarding EBHP in Tribal communities and explores some comparisons with the 2020 survey results. It is also complemented by themes identified through key informant interviews, which provide further understanding for the key takeaways from this work.

2026 SNAPSHOT

256
Title VI programs invited

95
Title VI staff respondents

37%
Response rate

April 13 - May 25, 2026
Survey period

34
Survey questions

WHAT ARE EVIDENCE-BASED HEALTH PROMOTION (EBHP) PROGRAMS?

EBHP programs are research-supported interventions focused on disease prevention and the promotion of healthy behaviors among older adults.

These programs have been shown to improve quality of life, increase self-efficacy and independence, support mental health, and reduce pain and disability.

01

Findings from the 2026 Evidence-Based Survey Report

What's Included In This Section

This section summarizes the findings from the 2026 survey of Older Americans Act (OAA) Title VI directors and staff, providing insight into the current use of evidence-based health promotion programs in Tribal communities.

- Organizational needs
- Familiarity with evidence-based health-promotion programs
- Current program implementation
- Cultural considerations
- Implementation barriers
- Funding sources

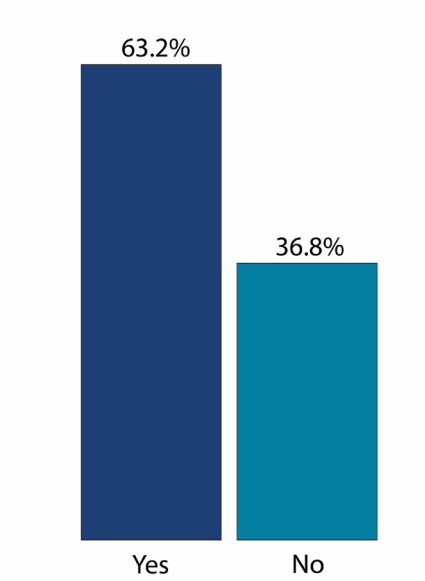
How To Read This Report

Throughout this report, percentages are calculated using the total number of respondents who answered each individual question. In addition, many of the questions allowed participants to select multiple answers; as a result, percentages for some items may total more than 100%.

Figure 1.01

Have you heard of evidence-based health promotion programs before?

(n = 95/95)

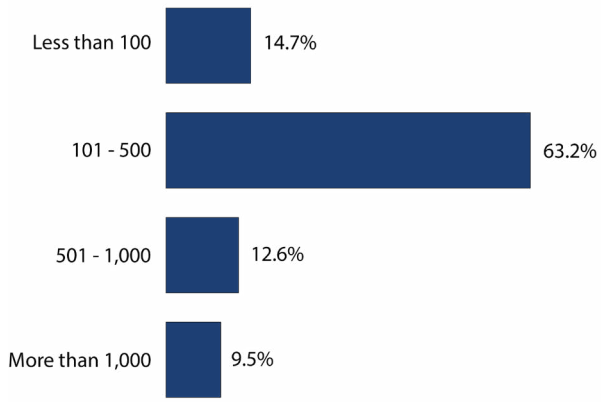


As shown in Figure 1.01, most participants had heard of the term evidence-based health promotion programs before (63.2%).

Figure 1.02

What is the estimated number of Tribal Elders served by your organization?

(n = 95/95)

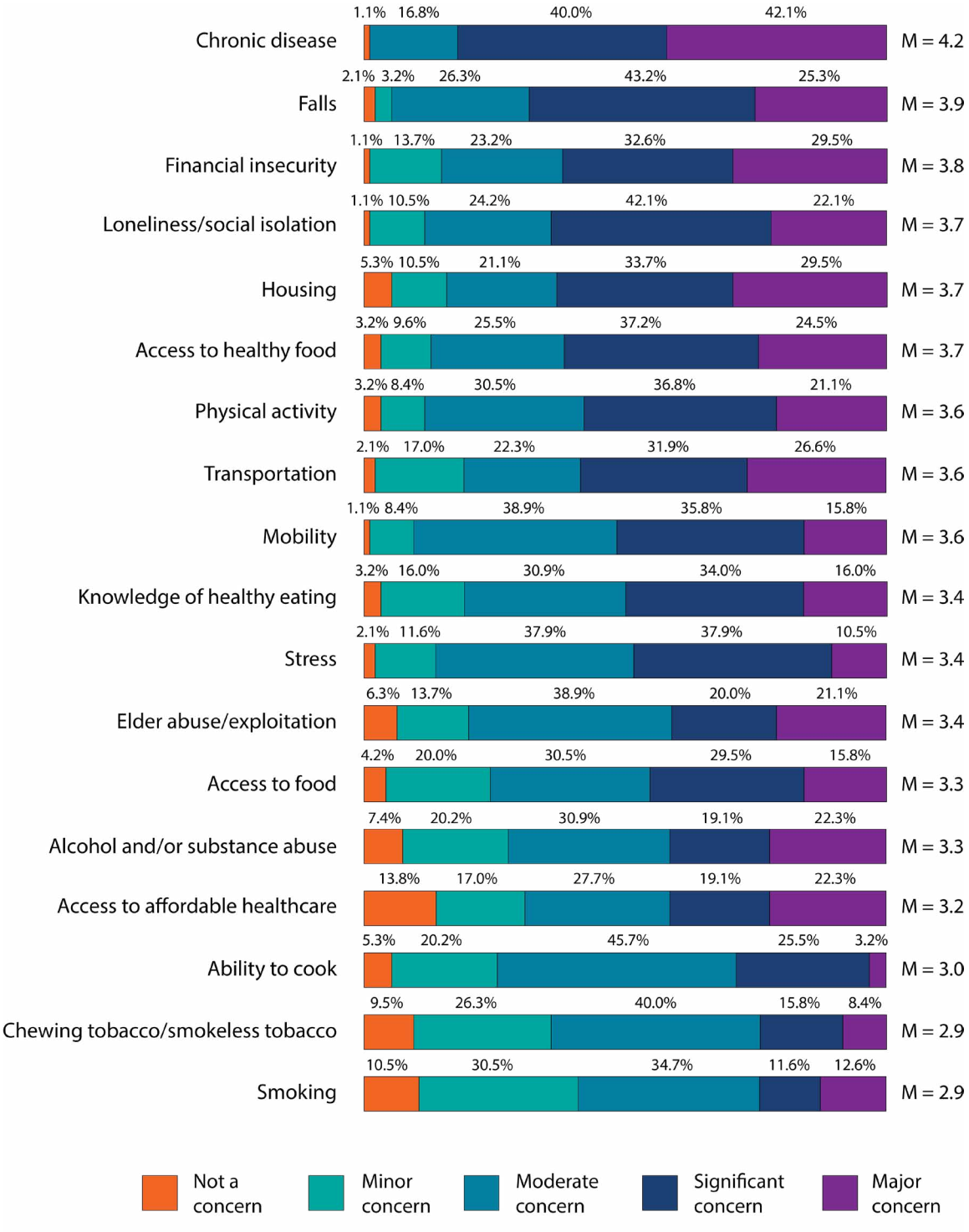


Most participants reported that their organization served between 101 and 500 Tribal Elders (63.2%); this was followed by 14.7% who served less than 100. An additional 12.6% reported that they served between 501 and 1,000 Tribal Elders, and 9.5% who served more than 1,000 (Figure 1.02).

Figure 1.03

Please rate the following items according to their level of concern for the health and well-being of Tribal Elders in your community.

(n = 95)



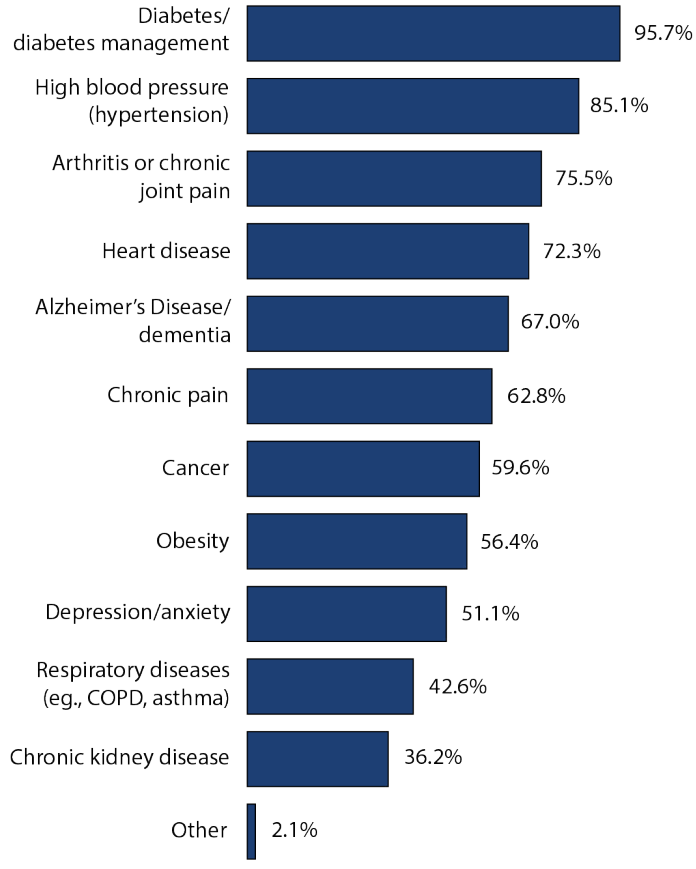
Participants were provided a list of items and asked to rate each according to the level of concern they had for the health and well-being of Tribal Elders in their community (Figure 1.03). Items were ranked on a scale of 1 = not a concern to 5 = major concern. Across all items, chronic disease had the highest overall mean of 4.2, with many participants reporting that it was a major (42.1%) or significant (40.0%) concern. Falls was also frequently cited as a concern with an average of 3.9. Here, 25.3% reported that falls were a major concern, followed by 43.2% who said it was a significant concern. Financial insecurity, loneliness/social isolation, and housing were also commonly selected.

For this question, participants could also write-in a response. Responses included factors such as having assisted living, caregiving, and help in the home; mental health, social interaction, and loneliness; concerns regarding estrangement and violence; family support; and being able to pay for things like food and medication, as well as having appropriate seasonal clothing. Having timely access to healthcare and specialist appointments; cultural connection; transportation, hygiene, and hobbies were also mentioned.

Figure 1.04

Which of the following are the greatest medical concerns for Tribal Elders?

Among those who selected chronic disease (n = 94/94)



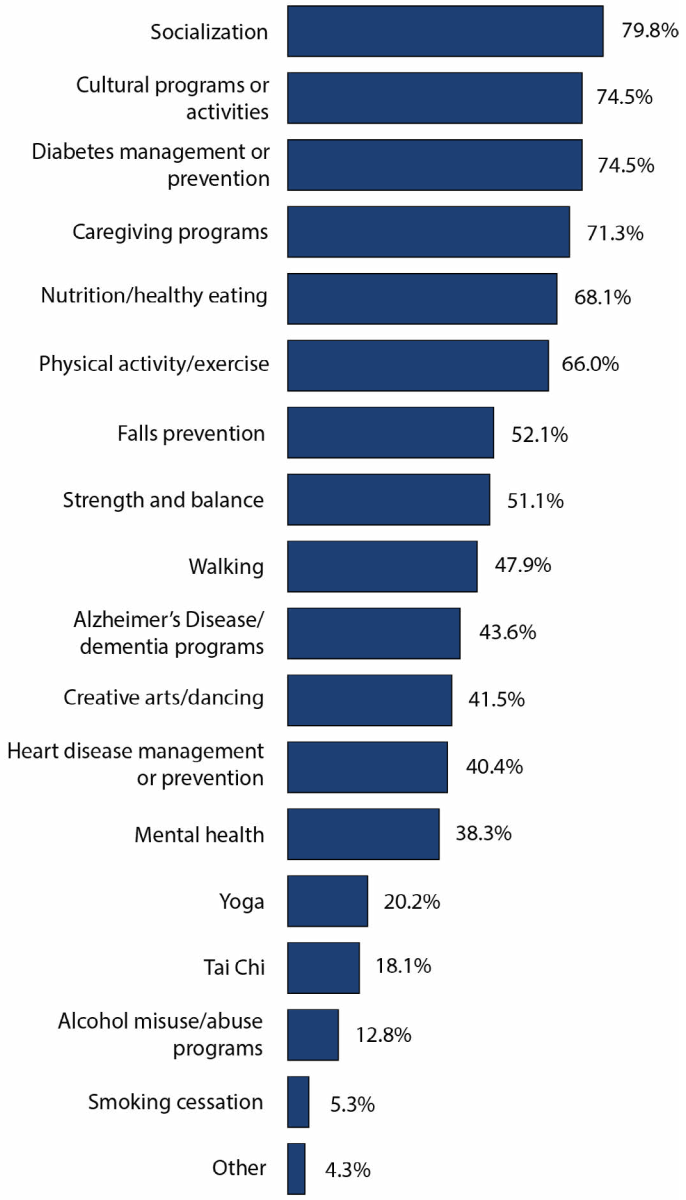
As shown in Figure 1.03, chronic illness was identified as a concern for Tribal Elders by nearly all respondents. Among the 94 respondents who indicated at least a minor level of concern, participants were asked to identify the specific chronic health conditions of greatest concern within their communities; they were able to select more than one. Results are shown in Figure 1.04.

Among these, diabetes/diabetes management was selected by 95.7% of participants, followed by high blood pressure (85.1%), arthritis or chronic joint pain (75.5%), and heart disease (72.3%). Issues such as depression and anxiety (51.1%), respiratory conditions such as COPD and asthma (42.6%), chronic kidney disease (36.2%), and other conditions were reported slightly less frequently. Participants could also write in their own responses for this question - items added here included concerns regarding broken bones and lupus.

Figure 1.05

Based on your experience, which of the following types of physical and mental health-related programs are your Tribal Elders most interested in?

(n = 94/95)

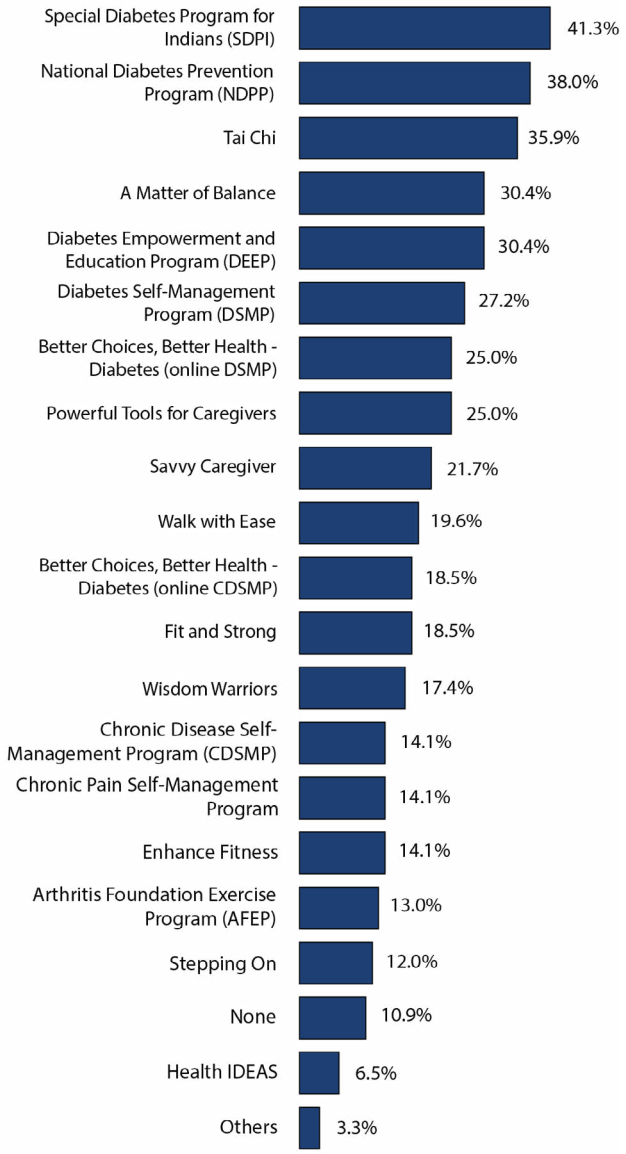


Participants were asked to select physical and mental health-related programs their Tribal Elders were most likely to be interested in; they could select more than one (Figure 1.05). Over three-quarters of participants (79.8%) reported that programs involving socialization would garner the most interest, as well as cultural programs or activities (74.5%), and diabetes management or prevention programs (74.5%). Many indicated that programs involving caregiving (71.3%), nutrition and healthy eating (68.1%), and physical activity and exercise (66.0%) would also be popular. Write-in responses among Elders for this question included options such as Bingocize, nutrition, outdoor fishing, and swimming.

Figure 1.06

What evidence-based healthy aging/ disease prevention and management programs have you heard of before?

(n = 92/95)

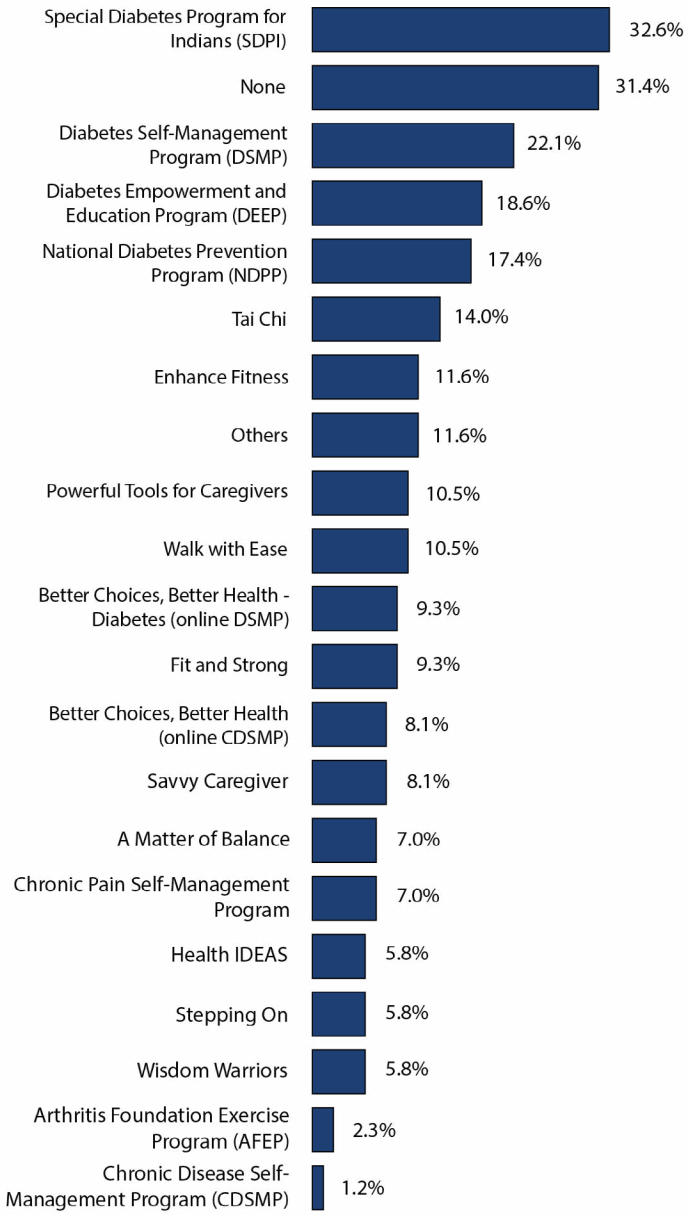


As shown in Figure 1.06, when asked what evidence-based healthy aging and disease prevention and management programs they had heard of before, participants were most likely to report the Special Diabetes Program for Indians (SDPI; 41.3%). This was followed by the National Diabetes Prevention Program (NDPP; 38.0%), and Tai Chi (35.9%). Participants could select more than one choice. Participants could also write-in responses for this question - specific programs listed here included Bingocize.

Figure 1.07

What evidence-based healthy aging/ disease prevention and management programs is your community currently implementing?

(n = 86/95)



In addition to programs that they were familiar with, participants were also asked to indicate which (if any) evidence-based healthy aging/disease prevention and management programs they were currently implementing (Figure 1.07). Approximately one-third reported that they were implementing the Special Diabetes Program for Indians (SDPI; 32.6%), although there was another 31.4% who did not report implementing any programs.

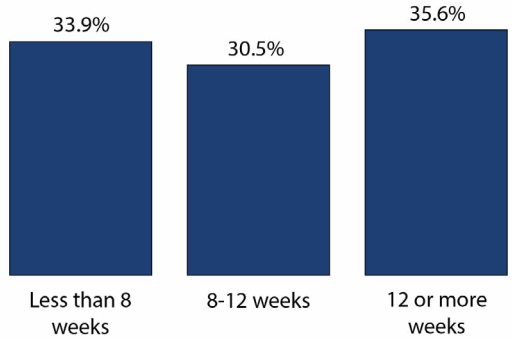
The Diabetes Self-Management Program (DSMP) was also mentioned among 22.1%, followed by 18.6% who reported using the Diabetes Empowerment and Education Program (DEEP). Participants were able to select more than one option.

Participants could also write-in a specific response. These included Bingocize, chair exercise/yoga, Stay Active and Independent for Life (SAIL), StrongBodies, and nutrition, exercise, and socialization/cultural programs.

Figure 1.08

What was the length of the programs?

Among those implementing a program (n = 59/59)



Further questions were assessed specifically among those who reported currently using an evidence-based healthy aging program in their community, in order to learn more about program implementation. Figure 1.08 shows the results when asked about the typical program length. Program timing was fairly distributed, with most reporting that their program was 12 or more weeks long (35.6%), whereas 33.9% reported it was less than eight weeks. The remaining 30.5% indicated that it lasted 8-12 weeks.

Figure 1.09

On average, how many staff members are involved in implementing and sustaining each program?

Among those implementing a program (n = 59/59)

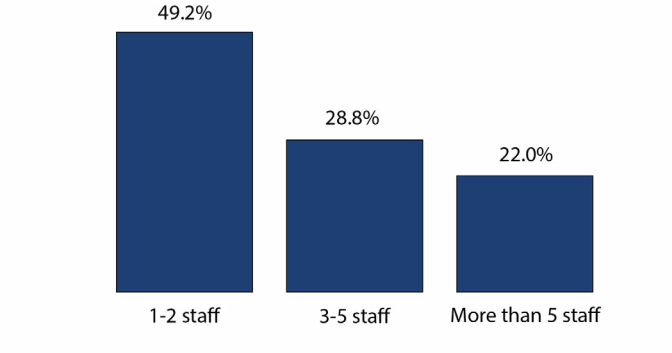
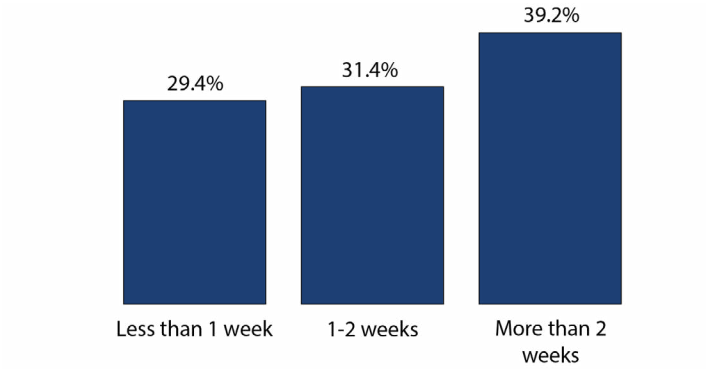


Figure 1.09 shows that most participants reported that when implementing the programs, only one to two staff members were required (49.2%). Just over one-quarter reported needing between three to five staff (28.8%), whereas the remaining 22.0% required more than five staff.

Figure 1.10

On average, how long was the training for individuals to be certified or to coach the program?

Among those implementing a program (n = 51/59)

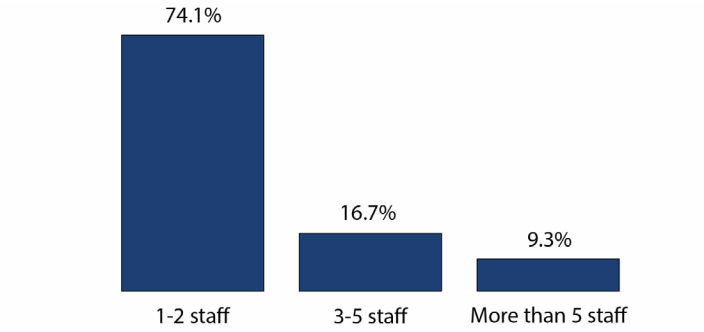


Factors surrounding participants' training and certification process were also assessed, with Figure 1.10 showing the typical length of instruction. Most said that training was more than two weeks (39.2%), followed by 31.4% who reported 1-2 weeks. The remaining 29.4% indicated that their training was less than one week.

Figure 1.11

On average, how many individuals were trained to be certified to facilitate the program?

Among those implementing a program (n = 54/59)



In addition to the number of staff members involved in implementing and sustaining the program, participants were also asked how many were specifically trained to be certified to facilitate the program (Figure 1.11). Most reported it was one to two staff members (74.1%), followed by three to five staff (16.7%), and more than five staff members (9.3%).

Figure 1.12

Please rate your agreement with the following statement: Staff are confident in delivering evidence-based programs(s) as designed.

Among those implementing a program (n = 58/59)

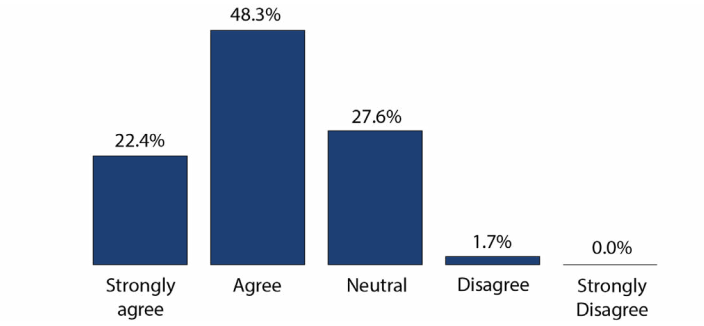
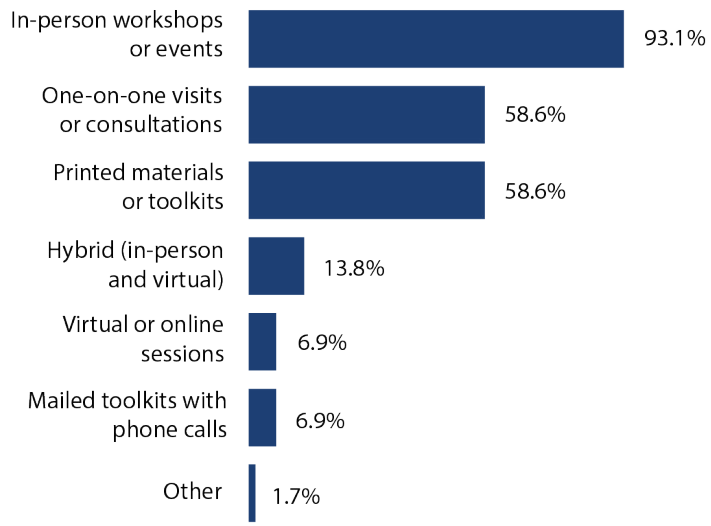


Figure 1.12 shows participants' ratings for how confident staff feels in delivering evidence-based programs. Roughly half agreed (48.3%), followed by 27.6% who felt neutral. Another 22.4% strongly agreed.

Figure 1.13

Which of the following delivery formats have worked best for your community in implementing health-promotion programs?

Among those implementing a program (n = 58/59)



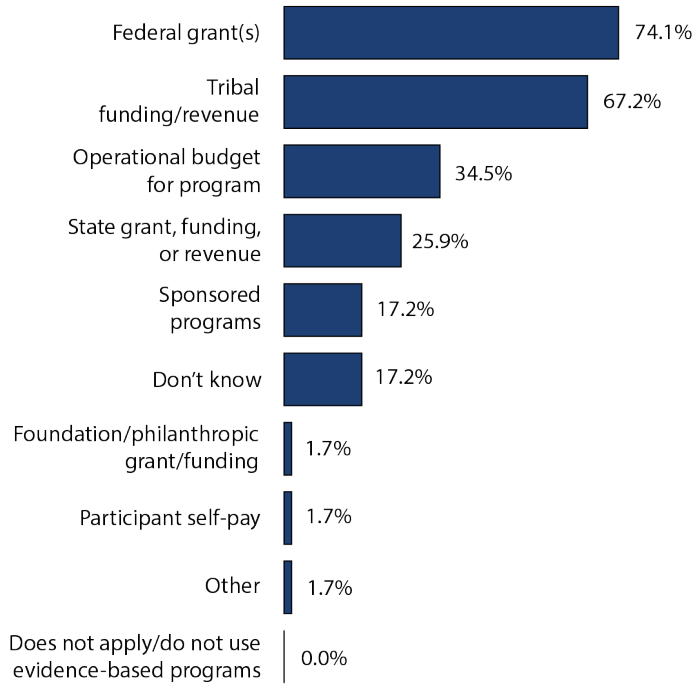
The most effective delivery formats for implementing health-promotion programs was also assessed, with results shown in Figure 1.13. Participants could select more than one choice.

Most reported that in-person workshops or events were preferred (93.1%), although formats such as one-on-one visits or consultations (58.6%) or printed materials or toolkits (58.6%) were also selected. Hybrid, virtual, and mailed toolkits were less commonly utilized.

Figure 1.14

What resources were utilized to implement the program(s)?

Among those implementing a program (n = 58/59)

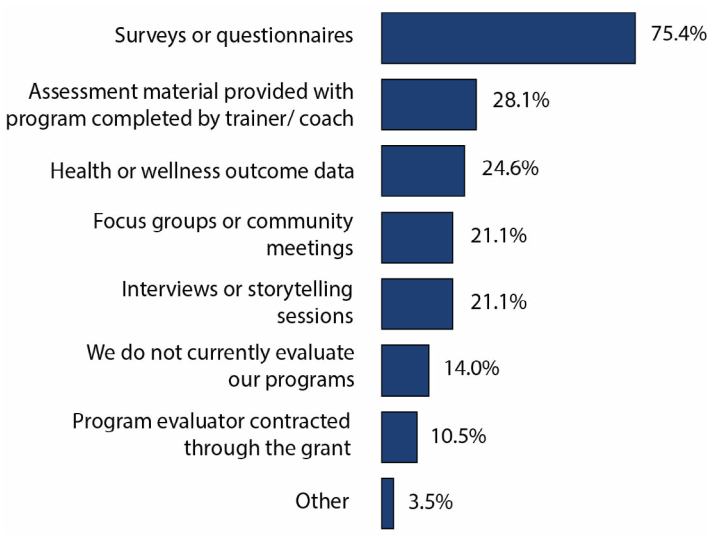


Participants were also asked to indicate which resources were utilized in order to implement the programs. Results are shown in Figure 1.14; participants could select more than one option. Federal grants were the most commonly mentioned resource (74.1%), followed by Tribal funding and revenue (67.3%). Operational budgets (34.5%) and state grant funding or revenue (25.9%) were also reported.

Figure 1.15

How do you currently evaluate your programs for Native Elders?

Among those who reported implementing a program (n = 57/59)

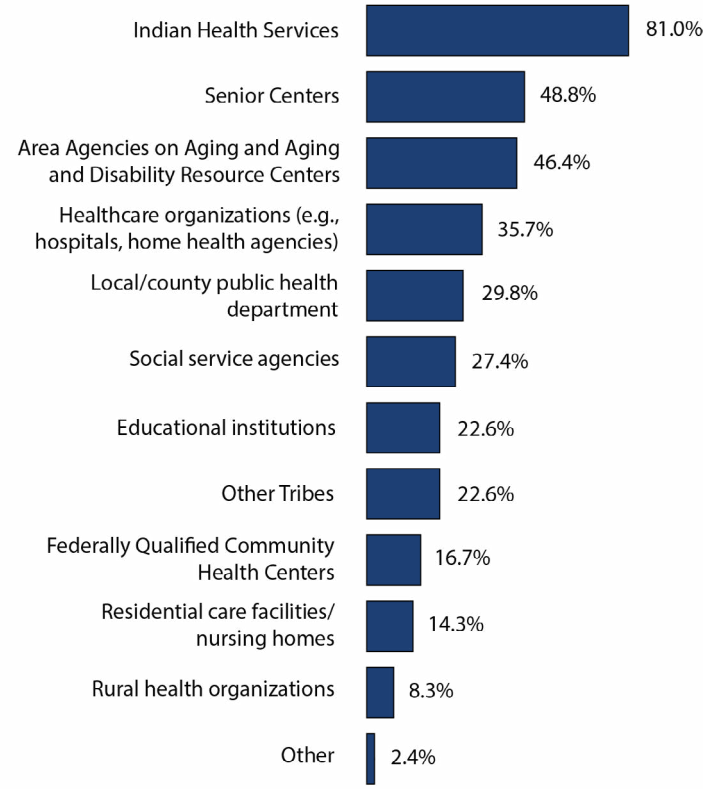


Participants who implemented a program were also asked how they currently evaluated it (Figure 1.15). Three-quarters (75.4%) reported using surveys or questionnaires, although options such as program assessment materials (28.1%), health or wellness outcome data (24.6%), focus groups or community meetings (21.1%) and interviews or storytelling sessions (21.1%) were also sometimes utilized. Participants could also write-in responses for this question - items included doing an evaluation after each session, as well as keeping tabs on participation levels; if participation drops off, the program is discontinued.

Figure 1.16

What partnership(s) do you currently have that assist with delivering healthy aging evidence-based programs to Tribal Elders?

(n = 84/95)

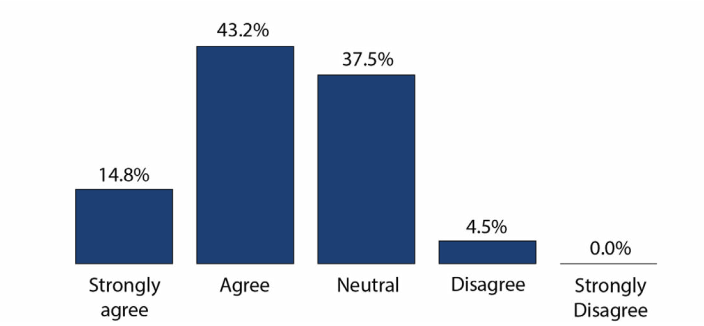


Partnerships that aided in assisting with delivering healthy aging evidence-based programs to Tribal Elders were also assessed. Results are shown in Figure 1.16 across all participants, regardless of program implementation status. Multiple options could be selected. Indian Health Services was the most frequently selected response (81.0%), followed by senior centers (48.8%), and Area Agencies on Aging and Aging and Disability Resource Centers (46.4%).

Figure 1.17

Please rate the degree to which you agree or disagree with the following statement: Tribal Elders are interested in participating in evidence-based programs.

(n = 88/95)

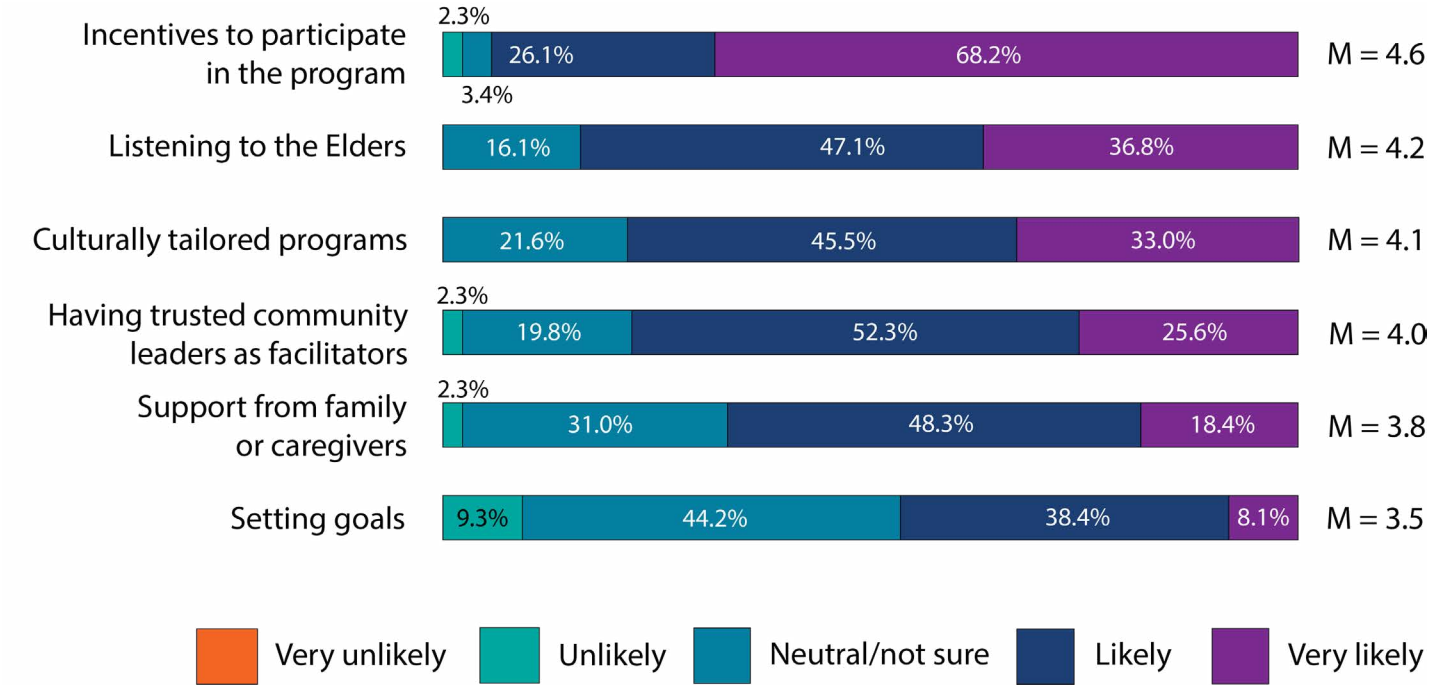


Participants were asked if their Tribal Elders were interested in participating in evidence-based programs. As shown in Figure 1.17, most agreed that Tribal Elders were interested (43.2%), followed by a third who felt neutral (37.5%). Approximately 14.8% strongly agreed.

Figure 1.18

Please rate each of the following items based on how likely they are to encourage Tribal Elders to participate in an evidence-based program.

(n = 88)



Participants were asked to rate to what degree a variety of program aspects might aid in helping to encourage Tribal Elders to participate in an evidence-based program. Results are shown in Figure 1.18; each item was ranked on a scale of 1 = very unlikely to 5 = very likely. Having incentives to participate in the program was rated as being most likely factor to encourage participation, with an average of 4.6. For this item, 68.2% of participants reported that incentives would be very likely to encourage participation, followed by 26.1% who said it would be likely.

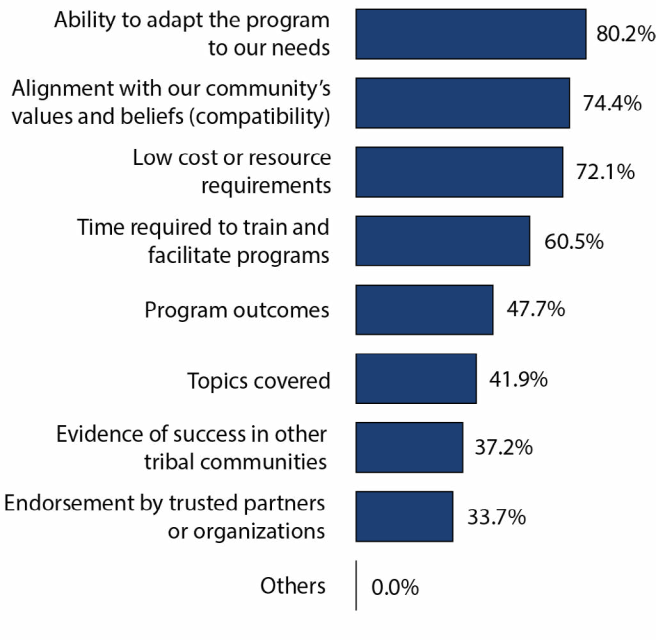
Listening to the Elders was also rated highly, with an average of 4.2. Many reported that this would be very likely (36.8%) or likely (47.1%) to encourage their participation. Other top responses included utilizing culturally tailored programs (mean of 4.1), as well as having trusted community leaders as facilitators (mean of 4.0).

Participants could write in additional responses for this question. These included factors such as not having too long of a class, a shorter time commitment, the time of day of classes, as well as transportation to and from classes.

Figure 1.19

When deciding whether to adopt a new program, which of the following matter most?

(n = 86/95)

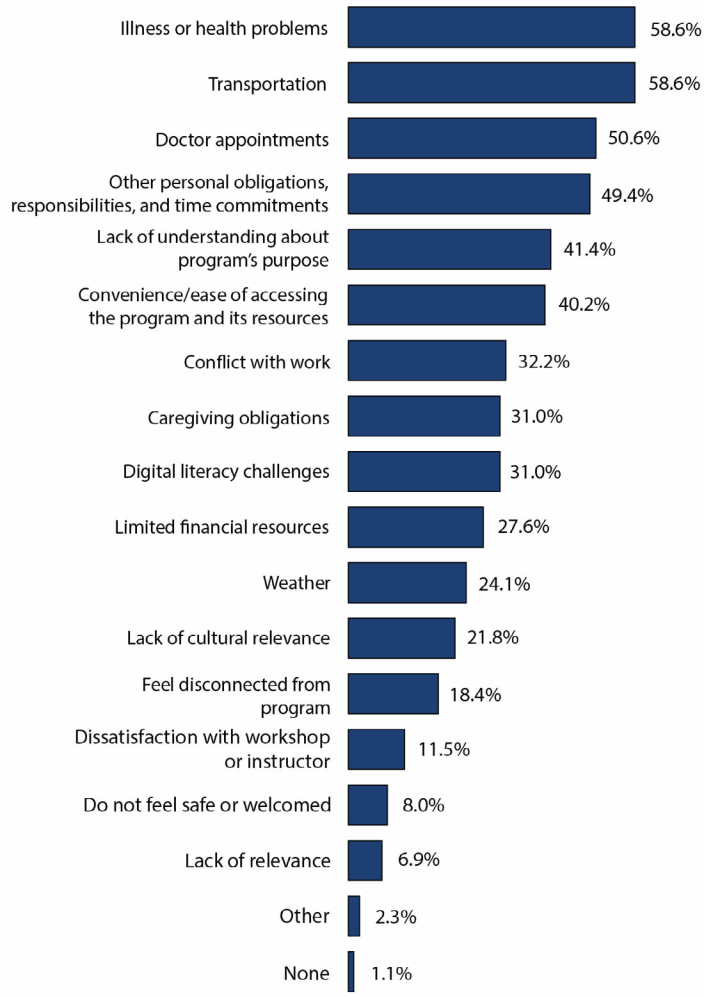


When asked what factors matter most when deciding whether to adopt a new program, participants were most likely to report being able to adapt the program to their own needs (80.2%; Figure 1.19). This was followed by 74.4% who reported that aligning the program with their community's values and beliefs was important, as well as having low cost or resource requirements (72.1%). The time required to train and facilitate programs was also a commonly cited factor (60.5%).

Figure 1.20

Based on your experience, which of the following are the primary reason(s) why Tribal Elders withdraw from an evidence-based program?

(n = 87/95)

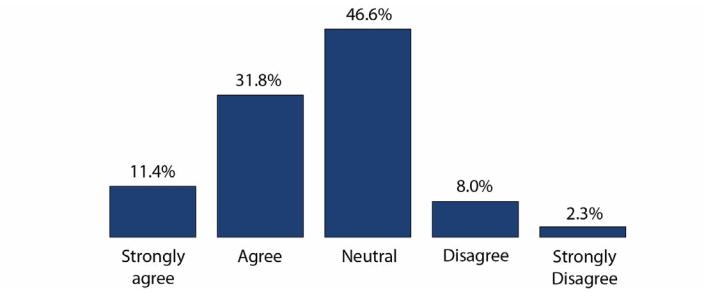


When asked why Tribal Elders typically withdraw from an evidence-based program, most participants reported it was due to either illness/health problems or issues with transportation (58.6%; Figure 1.20). This was followed by 50.6% who listed doctor appointments, 49.4% who reported other personal obligations, responsibilities, or time commitments, and 41.4% who said there was a lack of understanding about the program's purpose. Additionally, 40.2% indicated that the convenience/ease of accessing the program and it's resources played a role in withdrawal. Participants could select more than one option. Write-in responses for this question included lack of desire to change, and lack of willingness to participate without incentives.

Figure 1.21

Please rate the degree to which you agree or disagree with the following statement: Tribal Elders have the support and resources they need in order to participate in evidence-based programs to make the needed behavior changes.

(n = 88/95)



When asked if Tribal Elders had the needed support and resources in order to participate in evidence-based programs and make changes, most participants felt relatively neutral (46.6%; Figure 1.21). Many felt positive about support, however, with close to one-third (31.8%) agreeing, and 11.4% strongly agreeing with the statement.

Figure 1.22

What are the barriers to implementing an evidence-based program in your Tribal community?

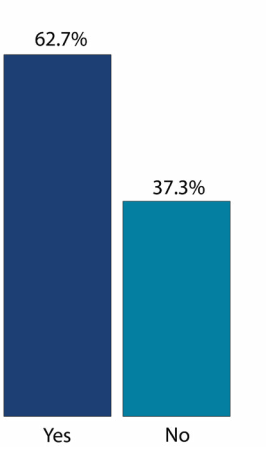
(n = 87/95)

As seen in Figure 1.22, when asked about potential barriers of implementing an evidence-based program into their Tribal community, most participants reported that cost was the main factor (55.2%). This was followed by 54.0% who reported that there were not enough interested Elders, and 51.7% who reported lack of staffing. Participants could select more than one answer choice.

Figure 1.23

Do you feel that most evidence-based programs reflect the cultural values, practices, and needs of your Tribal Elders?

(n = 83/95)

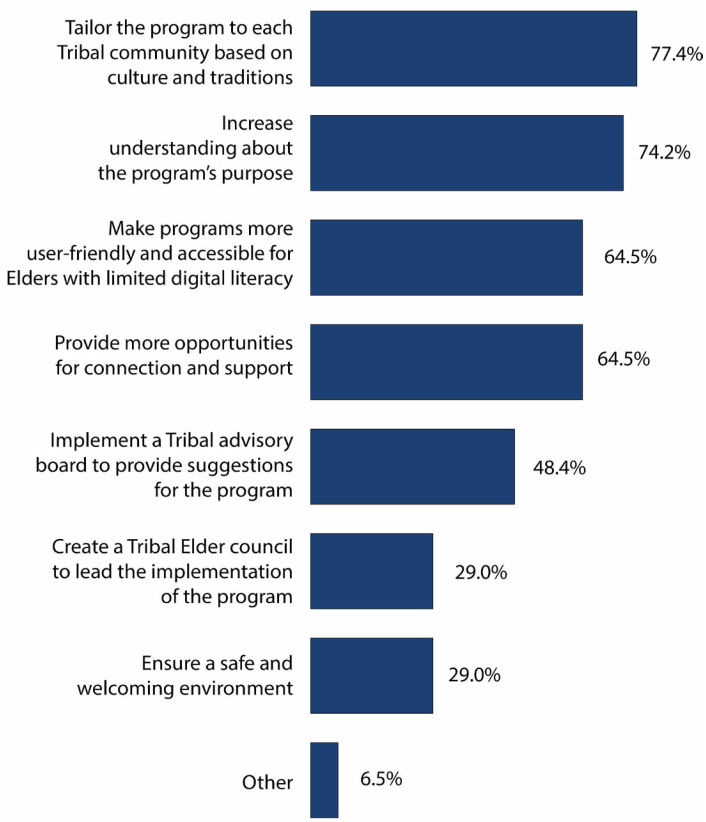


The majority of participants (62.7%) believed that most evidence-based programs reflected the cultural values, practices, and needs of their Tribal Elders. Approximately one-third (37.3%) believed this was not the case, however (Figure 1.23).

Figure 1.24

How would you recommend they become more responsive to your Tribe's culture?

Among those who reported that evidence-based programs were not reflective of cultural values (n = 31/31)



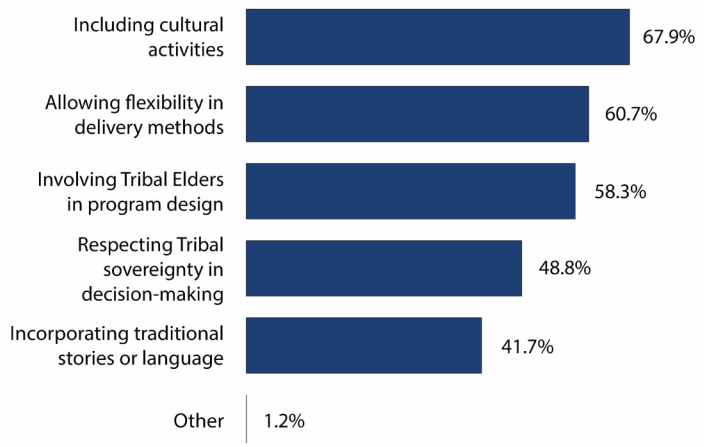
Participants who believed that current evidence-based programs were not reflective of the Tribal Elders' cultural values were subsequently asked to select recommendations on the best ways to increase responsiveness (Figure 1.24). The most commonly selected item was tailoring the program to each Tribal community (77.4%), followed by increasing understanding about the program's purpose (74.2%). Making the programs more user-friendly and accessible for Elders (64.5%) and providing more opportunities for connection and support (64.5%) were also commonly listed. Participants could select more than one response.

Participants could also write-in a response for this question, with one individual writing educational bingo, and another explaining that most evidence-based programs are rooted within a western paradigm that is disconnected from nature.

Figure 1.25

What cultural tailoring practices have you found most effective?

(n = 84/95)

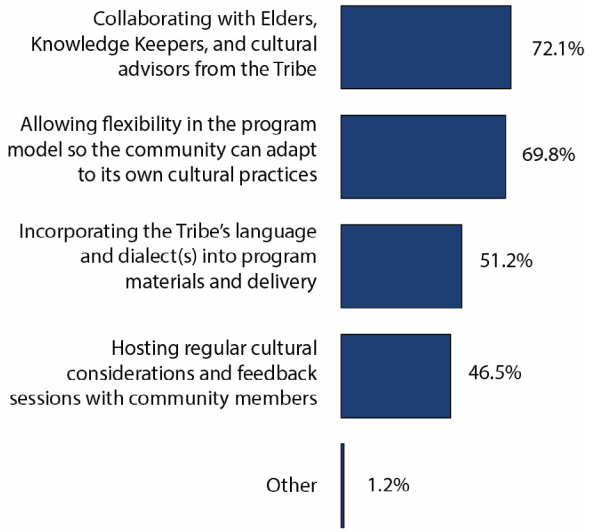


When asked what cultural tailoring practices participants had found most effective (Figure 1.25), 67.9% reported including cultural activities was most helpful. Another 60.7% reported that allowing flexibility in delivery methods was effective, followed by 58.3% who said that it was important to involve Tribal Elders in the program design. Participants could select more than one option. A write-in response for this question suggested making food and snacks an allowable cost, as food brings people together.

Figure 1.26

Which approach do you believe is most important for integrating the unique culture and language of your Tribe into an evidence-based program.

(n=86/95)



When integrating each Tribe's culture and language into the respective evidence-based program (Figure 1.26), most reported that collaborating with Elders, Knowledge-Keepers, and cultural advisors from the Tribe was the most important (72.1%). This was followed by allowing flexibility in the program model to adapt to their unique cultural practices (69.8%), as well as incorporating the Tribe's language and dialect(s) into the program materials and delivery (51.2%). Hosting regular cultural considerations and feedback sessions was also frequently mentioned (46.5%). More than one option could be selected. One write-in response for this question indicated that because they live in an area with multiple other Tribes, they would need the program to be neutral.

Participants were also asked to select from a list of reasons the approach that would most effectively support cultural relevance and long-term impact of evidence-based programs in their communities (Figure 1.27). Close to three-quarters (74.1%) selected that embedding traditional practices into programs as a form of healing from the impacts of colonization, assimilation, and residential schools. Another 58.0% reported centering the program design on historical awareness and trauma-informed approaches that address system barriers. More than one response could be selected.

One participant who left a write-in response for this question indicated it was important to shape the evaluation to Indigenous methods.

Figure 1.27

Which approach would most effectively support the cultural relevance and long-term impact of evidence-based programs for your Tribe, while acknowledging historical and systemic inequities?

(n = 81/95)

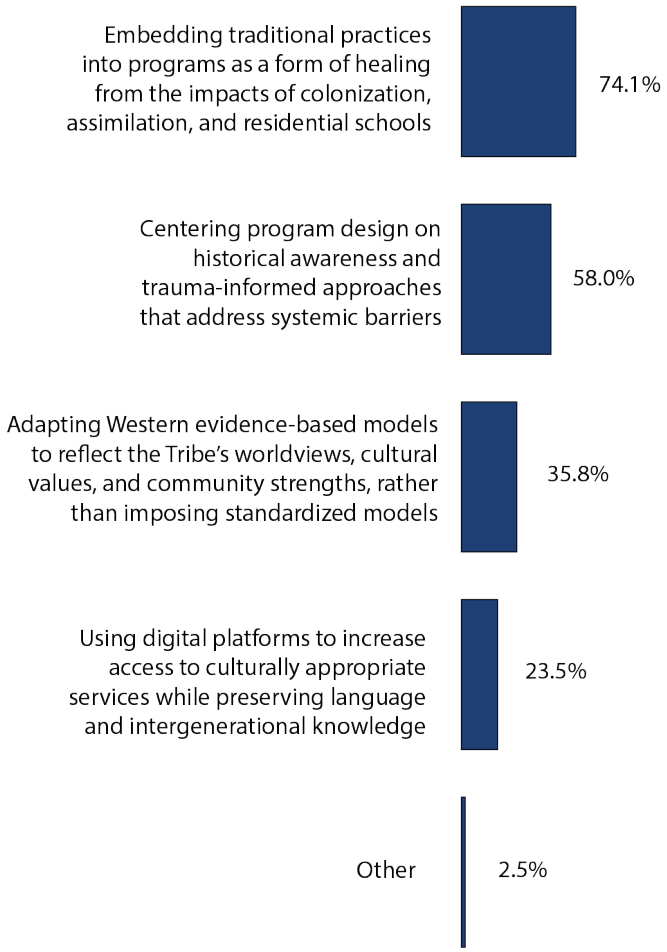
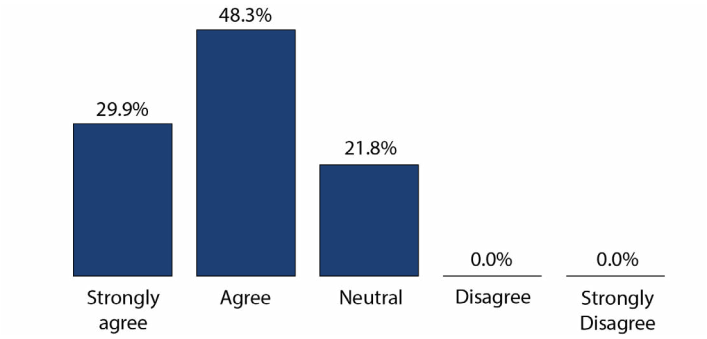


Figure 1.28

Please rate the degree to which you agree or disagree with the following statement: Evidence-based programs can be adapted to meet the needs of the Tribal community.

(n = 87/95)

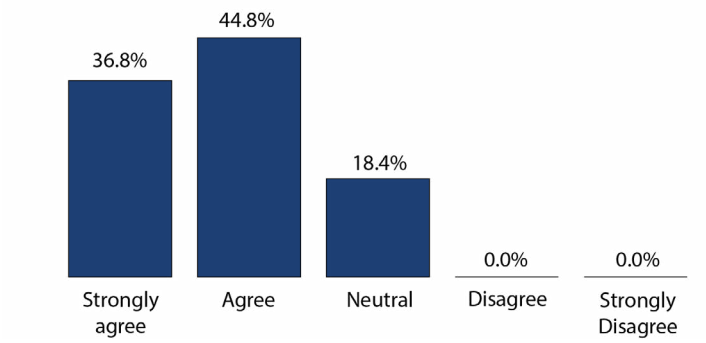


When asked if they believed that evidence-based programs could be adapted to meet the needs of their Tribal community, most participants agreed (48.3%; Figure 1.28). Another 29.9% strongly agreed, while 21.8% were neutral. No participants disagreed or strongly disagreed.

Figure 1.29

Please rate the degree to which you agree or disagree with the following statement: Tribal members should provide input on evidence-based programs before they are implemented into the community.

(n = 87/95)

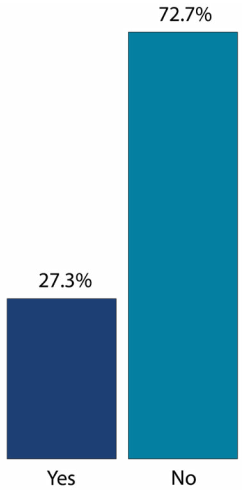


In Figure 1.29, results are shown for participants' agreement regarding whether Tribal members should provide input on evidence-based programs before they are implemented in the community. Approximately 44.8% agreed with this statement, followed by a third who strongly agreed (36.8%), and 18.4% who selected neutral. No participants selected disagree or strongly disagree.

Figure 1.30

Are you currently using a program that has been successful for your Tribal Elders that is not considered "evidence-based"?

(n = 77/95)



When asked if they were currently using a non-evidence-based program with their Tribal Elders that had been successful, most participants reported this was not the case (72.7%; Figure 1.30). Approximately 27.3% reported they were doing so, however.

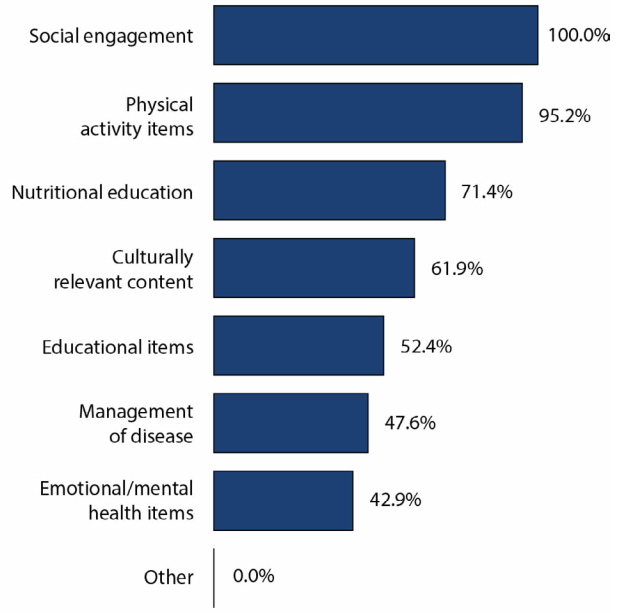
Among those who were, participants were asked to list the specific programs below. These included a variety of programs, including balanced training, cardio drumming, "Chat & Learns" on various health, wellness, and educational topics, as well as educational bingo, and nutritional cooking classes. Other programs included Elder chair exercises, water exercise, strength training, and talking circles. Virtual dementia tours were also mentioned. Senior citizen programs, social gatherings, and trips to have lunch with different Tribes in the area were also listed.

Figure 1.31

Which of the following aspects of the program are most appealing for Tribal Elders?

(Among those using a program that is not evidence-based)

(n = 21/21)

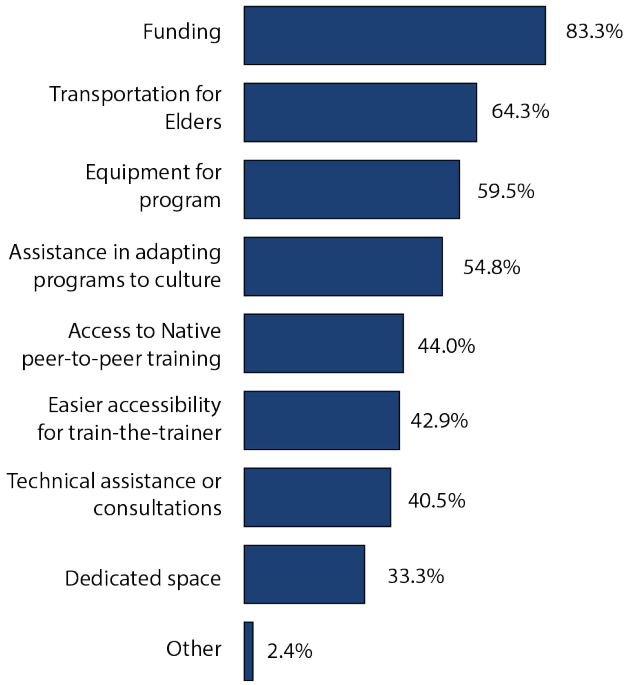


Participants who did report currently using a non-evidence based program were asked to rate the most appealing program aspects for their Elders (Figure 1.31). All participants reported that social engagement was appreciated by Tribal Elders, followed by physical activity items (95.2%), nutritional education (71.4%), and culturally relevant content (61.9%). Educational items (52.4%), information related to management of disease (47.6%), and emotional/mental health items (42.9%) were also selected. Participants could select more than one option.

Figure 1.32

What resources and strategies could be provided to your Tribe that would be helpful in implementing evidence-based programs?

(n = 84/95)

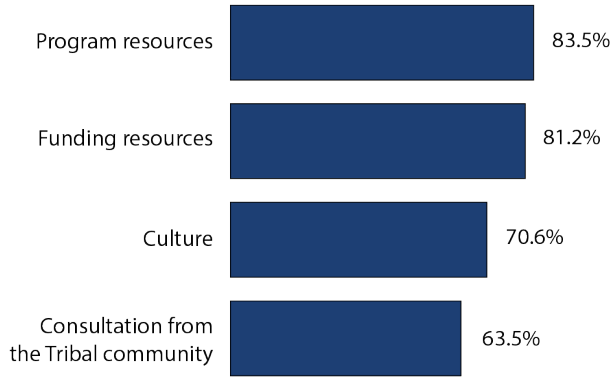


Participants were asked what resources and strategies could be provided to their Tribe that might be helpful in implementing evidence-based programs (Figure 1.32). Funding was the predominant response (83.3%), followed by transportation options (64.3%), program equipment (59.5%), and assistance in adapting programs to their culture (54.8%). More than one response could be selected. Regarding write-in responses for this question, participants listed having trained facilitators, as well as training opportunities.

Figure 1.33

What do you think are the key factors to consider when implementing an evidence-based program into a Tribal community successfully?

(n = 85/95)



Participants were also asked, when implementing an evidence-based program into a Tribal community, what aspects might be most important (Figure 1.33). Most reported that program resources would be a key factor (83.5%), followed by funding resources (81.2%), cultural aspects (70.6%), and consultation from the Tribal community (63.5%). More than one response could be selected. One participant added a write-in response to this question, asking if the program was truly supportive of health, and if it does so holistically.

Write-In Responses: Final Thoughts

At the end of the survey, participants were also asked to provide any additional thoughts, ideas, or recommendations regarding how Tribes could be supported to offer evidence-based programs. Answers were subsequently qualitatively-coded. For this question, there were 20 participants who answered the question, but some listed more than one general topic. As a result, in the process of coding the information, a total of 22 responses were utilized.

Many (31.8%) responded with general or non-specific answers, such as appreciation for the survey, expressing interest, or indicating that they had no specific comments at the time. Approximately 22.7% of participants reported feedback surrounding training and having enough staff. Specific comments within this topic included having enough staff to implement the programs, increasing training, increasing and hiring Tribal individuals. Reducing the frequency of facilitating to not be so stringent was also mentioned – for example, not requiring facilitators to hold a certain number of workshops per year without losing their certification.

Approximately 18.2% listed feedback surrounding engagement or tailoring the program. Specific responses here included incorporating more cultural connection, utilizing one-on-one consultations, as well as working to find ways to get the Elders engaged, such as through factors such as incentives.

Closely tying into the issue of training was that of funding (13.6%), with several saying that they had limited funding to pay for staff to implement the programs; others listed funding for infrastructure and transport as well. The cost of becoming a facilitator was also listed as a concern. One participant said that the cost of implementing an evidence-based program can become unaffordable when it requires multiple facilitators, but the budget doesn't have enough funds for that, in addition to supplies and staff time to hold classes.

Another 13.6% reported increased program awareness and support, with specific responses here centering around reinforcing information and availability of the program in the community, as well as better promotion of programs and training opportunities. Tribal support of the program was also encouraged.

02

2020-2026 Comparisons

What's Included In This Section

This section compares findings from the 2020 and 2026 surveys to examine how evidence-based health promotion programs (EBHP) have evolved among Older Americans Act (OAA) Title VI organizations over time.

Comparisons At A Glance

	2020	2026
Survey Questions	29	34
Respondents	63	95
Programs Invited	241	256
Response Rate	26%	37%

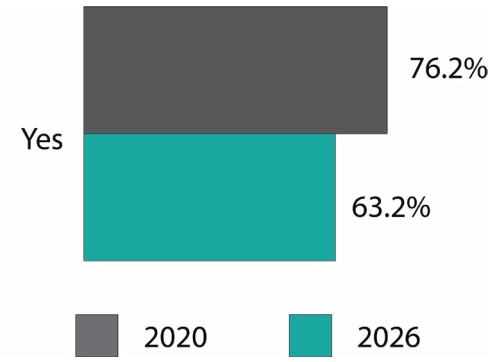
What To Look For

- Emerging trends
- Changes in familarity with EBHP programs
- Continuing challenges
- Areas of growth

When reviewing comparisons between the 2020 and 2026 surveys, please note that many factors can influence the results, such as the sample size, individual participants, as well as the question item wording itself. Because of this, it is important to interpret any conclusions with caution. In addition, in order to showcase accurate comparisons, the charts in this section only highlight answer choices that were present across both survey cycles.

Figure 2.01

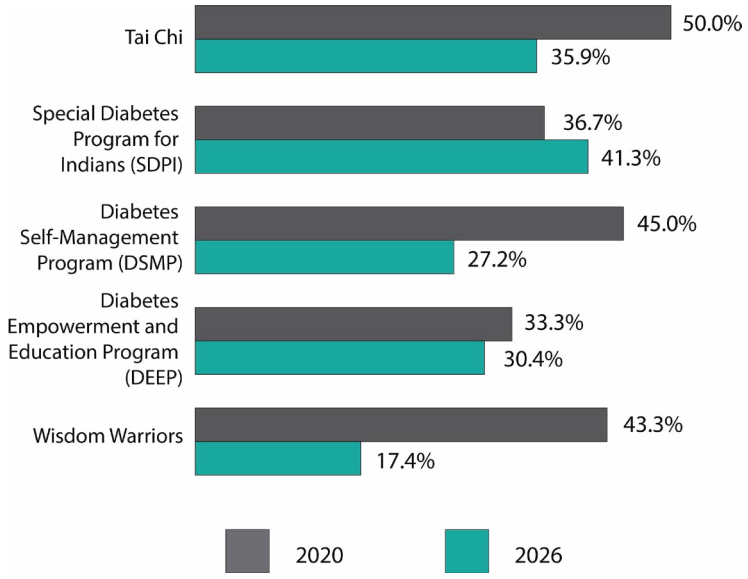
Have you heard of evidence-based promotion programs before?



Compared to the 2020 administration of the survey, the most recent survey collection showed a drop in the percentage of participants who reported hearing of an evidence-based promotion program before (76.2% to 63.2%; Figure 2.01).

Figure 2.02

What evidence-based healthy aging/ disease prevention and management programs have you heard of before?

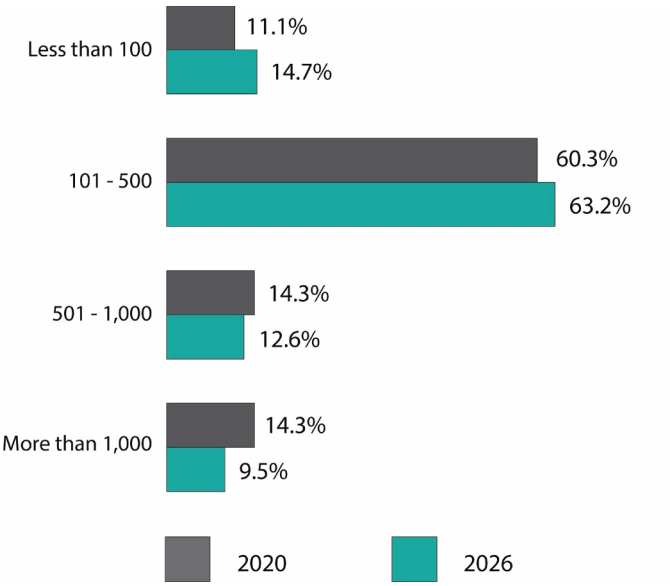


As shown in Figure 2.02, compared to 2020, many participants from the 2026 survey reported being less familiar with some of the disease prevention and management programs, although general trends still held. Awareness of the Special Diabetes Program for Indians (SDPI) was one exception here, which increased from 36.7% in 2020 to 41.3% in 2026. Familiarity with the Wisdom Warriors program saw a considerable decline, from 43.3% to 17.4%.

In 2020, the programs with the most awareness were Tai Chi (50.0%), Diabetes Self-Management Program (DSMP; 45.0%) and Wisdom Warriors (43.3%). In 2026 that had shifted to SDPI (41.3%); Tai Chi (35.9%), and the Diabetes Empowerment and Education Program (DEEP; 30.4%).

Figure 2.03

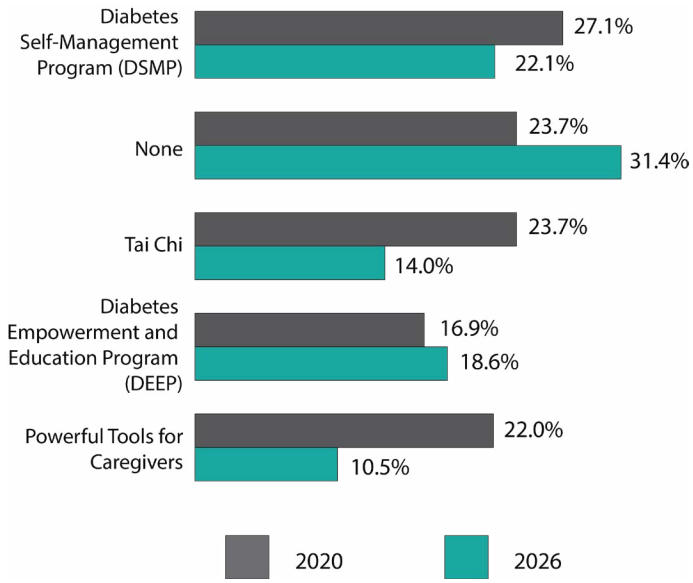
What is the estimated number of Tribal Elders served by your organization?



When looking at overall number of Tribal Elders served by the participants' organizations, overall trends remained the same (Figure 2.03). Most organizations reported serving 101-500 Tribal Elders; this number increased from 60.3% in 2020 to 63.2% in 2026. Compared to 2020, the 2026 survey participants were slightly more likely to report serving less than 100 Tribal Elders (11.1% vs. 14.7%), and slightly less likely to serve 501-1,000 Elders (14.3% vs. 12.6%) and more than 1,000 Elders (14.3% vs. 9.5%).

Figure 2.04

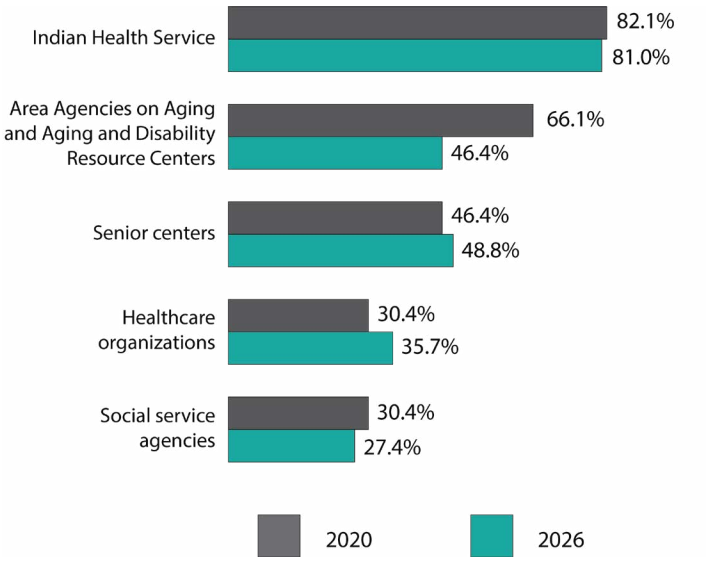
What evidence-based healthy aging/ disease prevention and management programs is your community currently implementing?



When asked what evidence-based or disease management programs their community is currently implementing, results show a general decline across multiple programs (Figure 2.04). Implementation of Powerful Tools for Caregivers dropped from 22.0% in 2020 to 10.5% in 2026; similarly, Tai Chi decreased from 23.7% to 14.0%. DSMP implementation also reduced from 27.1% to 22.1%. Somewhat more participants reported that they were not utilizing any programs in 2026 compared to 2020 (31.4% vs. 23.7%), although DEEP did see a slight increase from 16.9% to 18.6%.

Figure 2.05

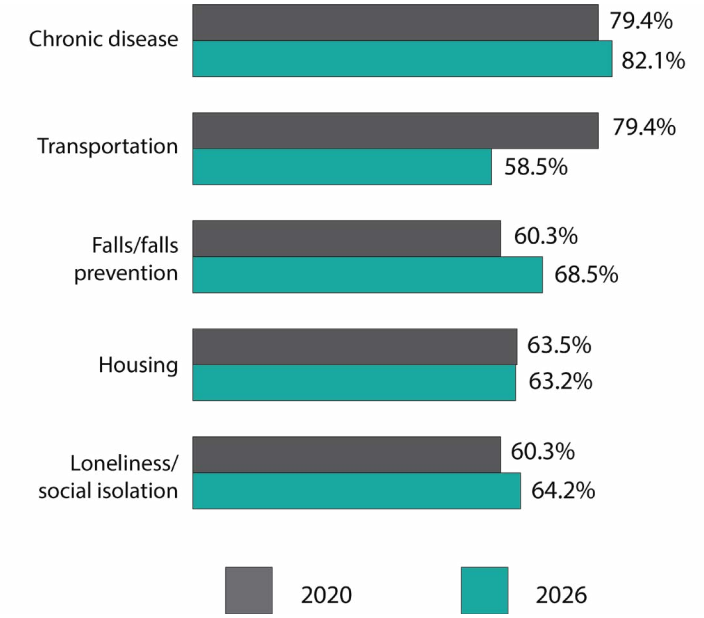
What partnership(s) do you currently have that assist with delivering healthy aging evidence-based programs to Tribal Elders?



When asked to select current partnerships that can assist with delivering healthy aging evidence-based programs, results largely remained the same between the two surveys (Figure 2.05). Indian Health Service continued to be the primary partnership across both surveys (82.1% in 2020 and 81.0% in 2026). A decrease was observed among Area Agencies on Aging and Aging and Disability Resource Centers (66.1% in 2020 to 46.4% in 2026). Percentages for senior centers, healthcare organizations, and social service agencies generally remained similar.

Figure 2.06

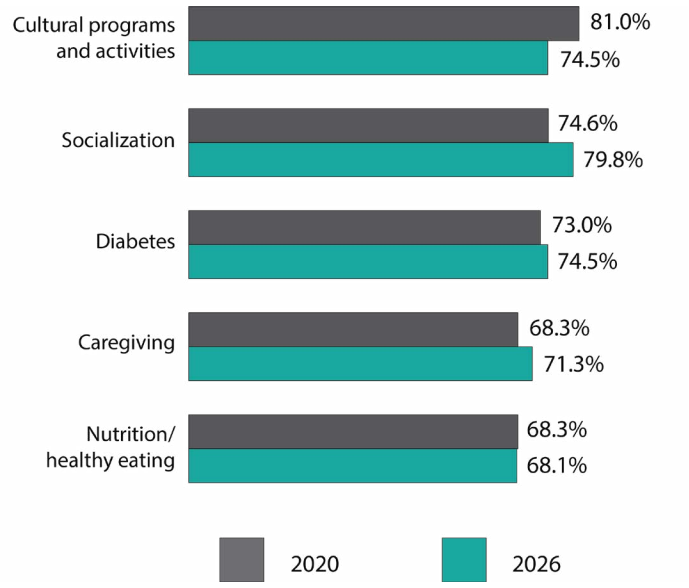
Please rate each of the following items according to your level of concern for the health and well-being of Tribal Elders in your community.



Levels of concern relating to Tribal Elders health and well-being in the community was also assessed (Figure 2.06). For both surveys, chronic disease remained at the top of the list (79.4% in 2020 to 82.1% in 2026). Transportation had decreased to 58.5% in 2026 compared to 79.4% in 2020; in contrast, falls/falls prevention increased slightly in 2026 (68.5%, from 60.3% in 2020. Concern for housing and loneliness/social isolation largely remained the same, although the latter saw a slight increase from 60.3% to 64.2% in 2026.

Figure 2.07

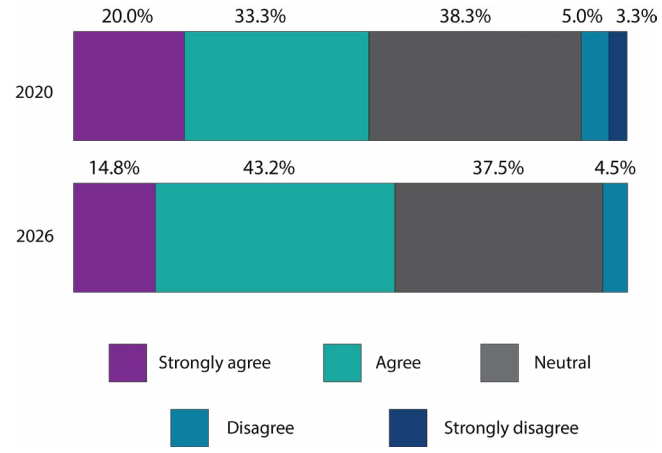
Based on your experience, which of the following types of physical and mental health related programs are your Tribal Elders most interested in?



Participants largely shared similar views with regard to the types of physical and mental health programs their Elders were interested in across both survey cycles. Compared to the 2020 survey, cultural programs and activities saw a slight decrease (81.0% vs. 74.5%), where as socialization (74.6 vs. 79.8%), diabetes (73.0% vs. 74.5%) and caregiving (68.3% vs. 71.3%) all showed slight increases.

Figure 2.08

Please rate the degree to which you agree or disagree with the following statement: Tribal Elders are interested in participating in evidence-based programs.



Participant's agreement with the statement of whether Tribal Elders are interested in participating in evidence-based programs was also assessed (Figure 2.08). Overall trends remained similar, with most participants choosing neutral or agree/strongly agree. There was a slight downshift in those who indicated strongly agree from 2020 to 2026 (20.0% vs. 14.8%), corresponding with an increase in those who agreed (33.3% in 2020 vs. 43.2% in 2026). In 2020, 3.3% of participants strongly disagreed with the statement; in 2026, no participants strongly disagreed.

Figure 2.09

Please rate the degree to which you agree or disagree with the following statement: Tribal Elders have the support and resources they need in order to participate in evidence-based programs to make the needed behavior changes.

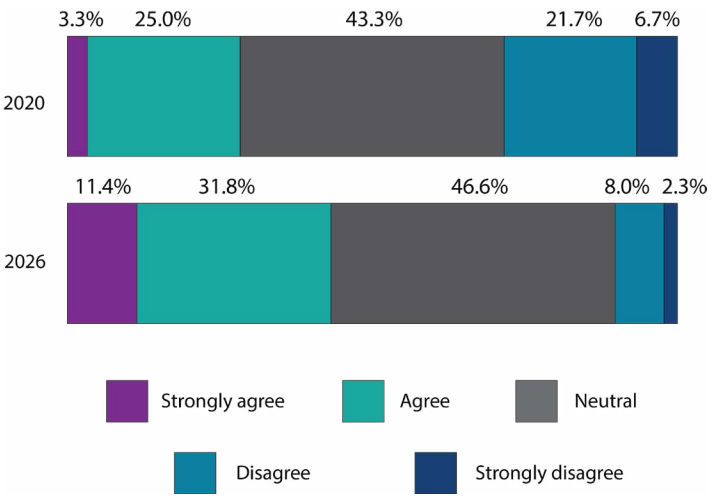


Figure 2.09 shows participants' agreement with the statement that Tribal Elders have the resources they need to participate in evidence-based programs and make changes. Compared to 2020, participant responses show a positive shift to feeling more supported, with strongly agree responses increasing from 3.3% to 11.4%, and agree responses shifting from 25.0% to 31.8%. Similarly, participants were less likely to say they disagreed (21.7% vs. 8.0%) or strongly disagreed (6.7% vs. 2.3%).

Figure 2.10

Based on your experience, which of the following are the primary reason(s) why Tribal Elders withdraw from an evidence-based program?

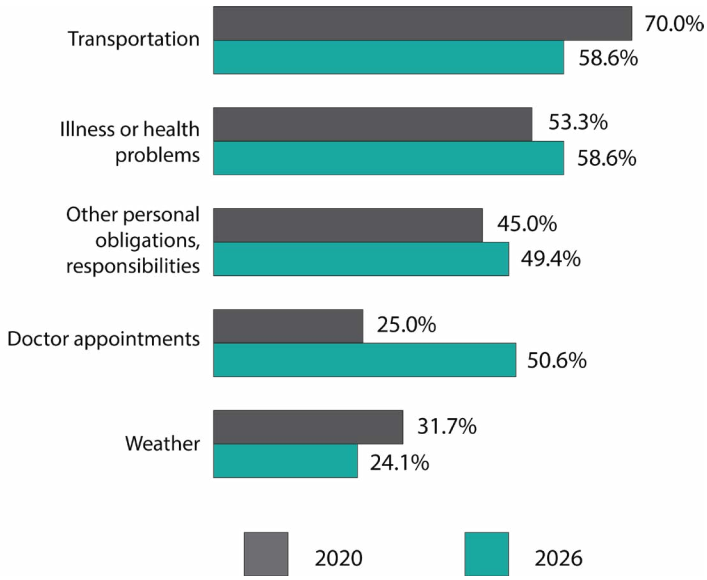
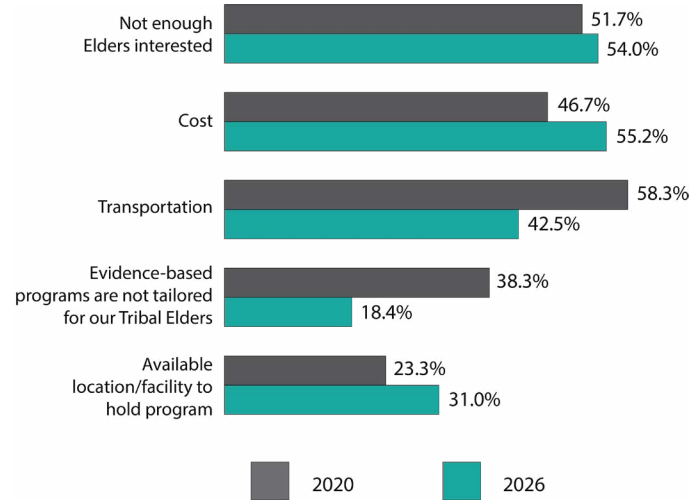


Figure 2.10 shows participants' responses regarding the top reasons why Elders withdraw from an evidence-based program. Top reasons in 2020 included transportation (70.0%), illness (53.3%), and other personal obligations (45.0%). In 2026, participants were most likely to report a tie between transportation and illness (58.6%), followed by doctor appointments (50.6%). In 2020, only 25% of participants reported doctor appointments as being a primary reason.

Figure 2.11

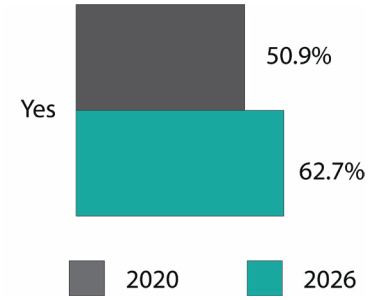
What are the barriers to implementing an evidence-based program in your Tribal community?



Barriers to implementing an evidence-based program in one's community are shown in Figure 2.11. Results generally follow the same trend across both survey cycles. Lack of interest continued to be a common reason. Cost was cited as more of barrier in the most recent survey (46.7% in 2020 vs. 55.2% in 2026), as well as having an available location to hold the program (23.3% in 2020 vs. 31.0% in 2026). Transportation saw a decline, going from 58.3% in 2020 to 42.5% in 2026. Tailored programs for Elders also saw a decline (38.3% in 2020 vs. 18.4% in 2026).

Figure 2.12

Do you feel that most evidence-based programs reflect the cultural values, practices, and needs of your Tribal Elders?

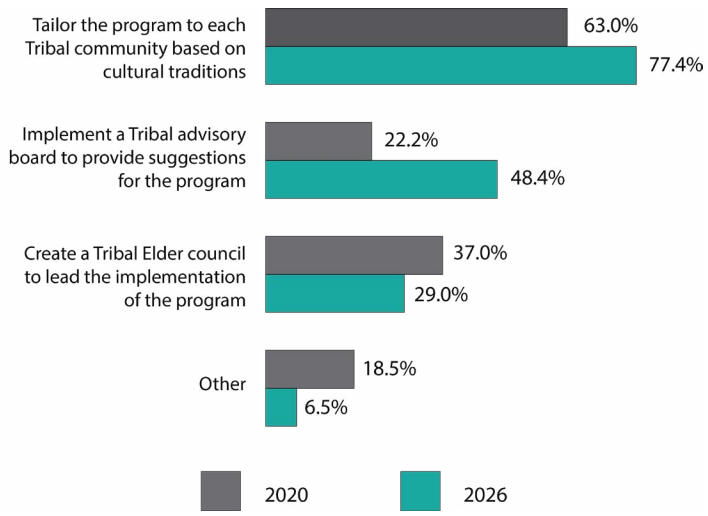


About 62.7% of participants in 2026 reported that they felt evidence-based programs reflected the cultural values, practices, and needs of their Tribes (Figure 2.12). This is a jump from 2020, when 50.9% reported that was the case.

Figure 2.13

How would you recommend they become more responsive to your Tribe's culture?

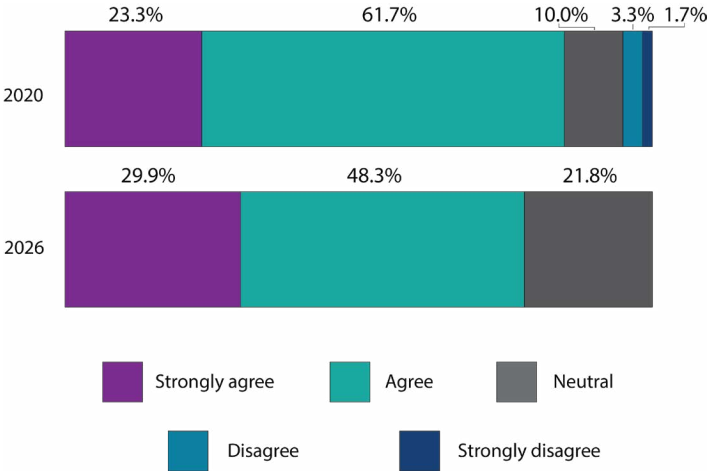
(Among those who did not feel that evidence-based programs are reflective of cultural values).



Those who believed that evidence-based programs did not reflect cultural values were subsequently asked to select potential reasons to help bridge this gap (Figure 2.13). Compared to 2020, participants in 2026 were more likely to report tailoring the program to each Tribal community (63.0% vs. 77.4%). They were also more likely to select implementing a Tribal advisory board to provide suggestions for the program (22.2% vs. 48.4%). Whereas 37.0% recommended creating a Tribal Elder council to lead implementation of the program in 2020, 29.0% did so in 2026.

Figure 2.14

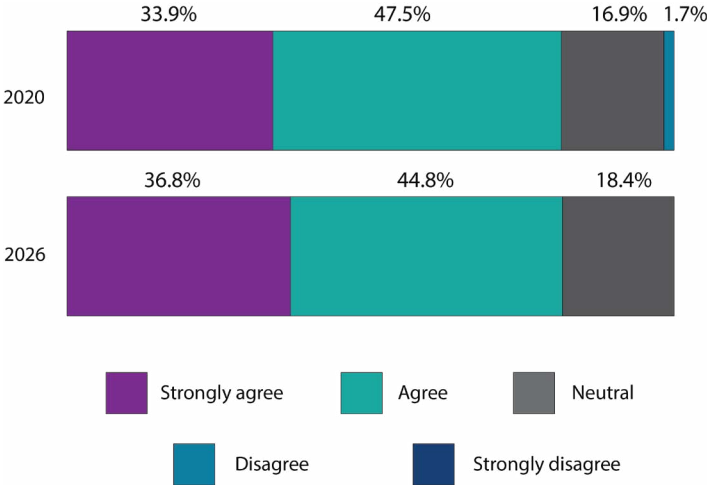
Please rate the degree to which you agree or disagree with the following statement: Evidence-based programs can be adapted to meet the needs of the Tribal community.



When asked to rate their agreement with the statement that evidence-based programs can be adapted to meet the needs of the Tribal community (Figure 2.14), more participants strongly agreed in 2026 (29.9%) compared to 2020 (23.3%). In 2020, 3.3% and 1.7% of participants disagreed and strongly disagreed with the statement, respectively; in 2026, there were no participants who disagreed.

Figure 2.15

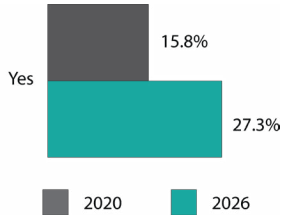
Please rate the degree to which you agree or disagree with the following statement: Tribal members should provide input on evidence-based programs before they are implemented into the community.



When asked to rate their agreement with the statement of whether or not Tribal members should provide input on evidence-based programs (Figure 2.15), results largely remained similar between the two survey cycles. The 2026 administration saw a slight increase in those who strongly agreed (33.9% in 2020 vs. 36.8% in 2026), although there was a marginal decrease in those who agreed (47.5% vs. 44.8%), and slight increase in the percentage who felt neutral (16.9% vs. 18.4%).

Figure 2.16

Are you currently using a program that has been successful for your Tribal Elders that is not considered "evidence-based"?

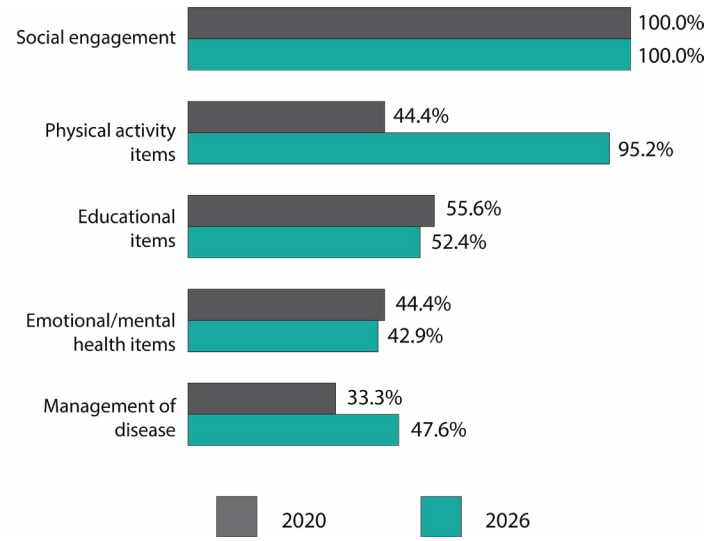


In 2020, approximately 15.8% of participants reported that they were successfully using a program in their community that was not evidence-based. This number saw a considerable jump in 2026 at 27.3% (Figure 2.16).

Figure 2.17

Which of the following aspects of the program are most appealing for Tribal Elders?

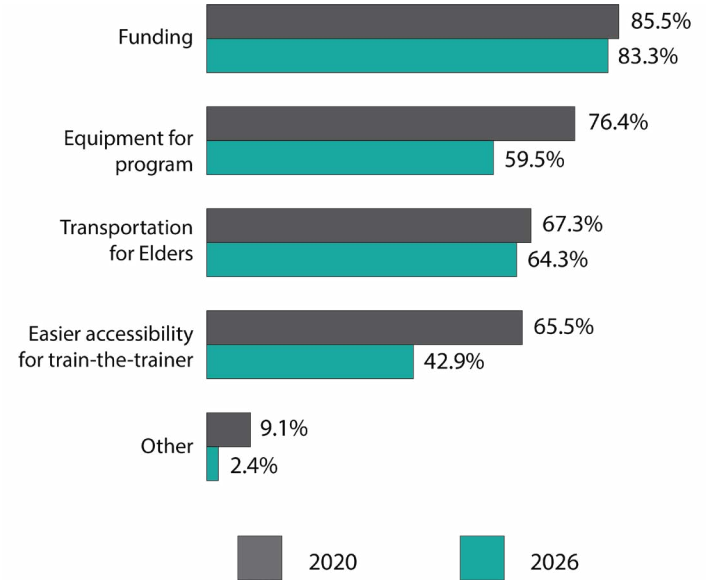
(Among those currently using a non-evidence-based program)



When asked to report the most appealing aspects of the non-evidence-based program they were utilizing, all participants across both survey cycles reported that social engagement was the top feature (Figure 2.17). Physical activity items saw a considerable increase from 2020 (44.4% vs. 95.2%), although it should be mentioned that the number of participants for this question was smaller, which can cause more dramatic swings in percentages. Overall percentages for other aspects, such as educational or emotional/mental health items largely remained the same. Management of disease saw a slight increase, from 33.3% to 47.6%.

Figure 2.18

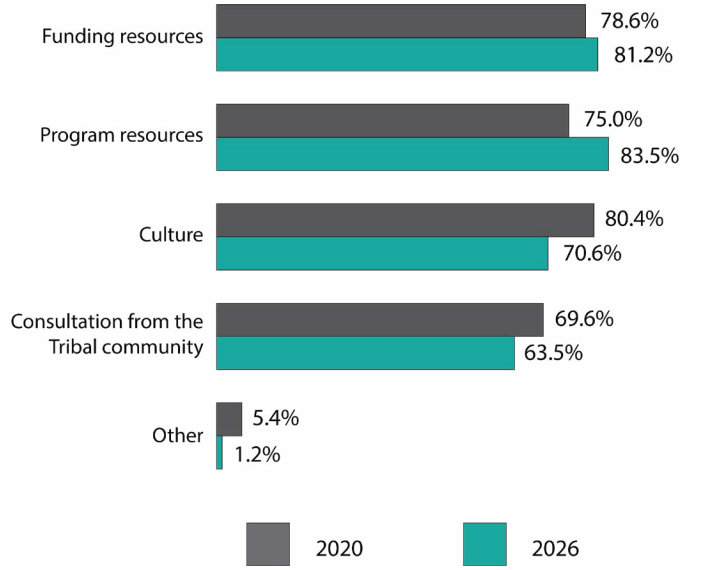
What resources and strategies could be provided to your Tribe that would be helpful in implementing evidence-based programs?



Similar trends across surveys were generally observed when participants were asked what resources and strategies could be provided that would be helpful in implementing evidence-based programs (Figure 2.18). Funding remained the top factor (85.5% in 2020 and 83.3% in 2026). Those in 2026 rated program equipment lower compared to their 2020 counterparts (59.5% vs. 76.4%), as they did for easier accessibility for train-the-trainer as well (42.9% vs. 65.5%). Transportation remained a frequently mentioned resource (67.3% in 2020 vs. 64.3% in 2026).

Figure 2.19

What do you think are the key factors to consider when implementing an evidence-based program into a Tribal community successfully?



When considering key factors in implementing an evidence-based program, results again remained similar across both survey cycles. Funding resources saw a marginal increase in 2026 (81.2%) compared to 2020 (78.6%), as did program resources (75.0% in 2020 vs. 83.5% in 2026). Culture saw some decreases (80.4% in 2020 vs. 70.6% in 2026); this was also the case for consultation from the Tribal community (69.6% in 2020 compared to 63.5% in 2026).

03

Summary of Findings

Evidence-based health promotion programs are an effective tool that can help to improve the lives of Tribal Elders. The 2026 survey administration of the NCOA Evidence-Based Survey highlights a number of key strengths and challenges when utilizing these programs in Tribal communities, as well as collecting valuable feedback surrounding ideas, barriers, and insights into future implementation.

Background and Awareness

The majority of Title VI directors and staff who completed the survey reported that their organization served somewhere between 101-500 Tribal Elders (63.2%). For many, chronic disease was rated as the greatest worry for their Tribal Elders, with 82.1% saying it was either a major or significant concern. This was followed by falls (68.5%) and financial insecurity (62.1%). Among those who specifically rated chronic disease as being a concern, the most cited conditions were diabetes/diabetes management (95.7%), high blood pressure (85.1%), and arthritis or chronic joint pain (75.5%).

Participants were most likely to say that their Elders would be interested in health programs that included socialization (79.8%), cultural programs or activities (74.5%), or diabetes management or prevention programs (74.5%).

Most participants were aware of evidence-based programs (63.2%), although this indicates that another third were unfamiliar with such programs, highlighting the need for efforts to create awareness. Participants reported being familiar with a number of different evidence-based healthy aging/disease prevention and management programs. The most frequently selected programs included the Special Diabetes Programs for Indians (SDPI; 41.3%), the National Diabetes Prevention Program (NDPP; 38.0%), and tai chi (35.9%).

Evidence-Based Program Implementation

When asked about which types of evidence-based healthy aging/disease prevention programs they were most likely to implement, participants were most likely to report programs such as Special Diabetes Program for Indians (SDPI; 32.6%) and Diabetes Self-Management Program (DSMP (22.1%). Many (31.4%) also reported that they were not implementing any programs, however.

Among those who were implementing a program, most reported that it was 12 or more weeks (35.6%), required one to two staff members to be trained (74.1%), and required more than two weeks of training in order to certify staff members (39.2%). On average, one to two staff members were involved in both implementing and sustaining the program (49.2%). Most (70.7%) reported that they either agreed or strongly agreed in feeling confident in delivering evidence-based programs as designed.

With regard to program delivery, most reported that in-person workshops or events worked the best (93.1%), although one-on-one visits (58.6%) or printed materials and toolkits (58.6%) were also options.

In setting up programs, most reported utilizing federal grants (74.1%) and Tribal funding/revenue (67.2%). Most participants reported evaluating programs using surveys or questionnaires (75.4%).

Tribal Elder Interest and Participation

Many participants said that Tribal Elders in their organizations were interested in participating in evidence-based programs, with 58.0% agreeing or strongly agreeing. In general, they recommended incentives (94.3%) and listening to the Elders (83.9%) as being very likely or likely to get them to participate in evidence-based programs.

Participants reported that the top reasons for Elders withdrawing from programs/evidence-based health promotion programs included illness or health problems (58.6%), issues with transportation (58.6%), and doctor appointments (50.6%).

When asked if Tribal Elders had the support and resources they needed in order to participate in evidence-based programs and make changes, 46.6% remained neutral, while another 43.2% agreed or strongly agreed.

Adapting and Implementing Evidence-Based Health Promotion Programs

When deciding whether to adopt a new program, most participants reported that being able to adapt the program to their needs (80.2%) and having alignment with their community's values and beliefs (74.4%) were most important. Cost remained the most commonly listed barrier to program implementation (55.2%), although lack of Elder interest (54.0%) and not enough staffing (51.7%) were also mentioned.

Most participants reported that evidence-based programs reflected the cultural values, practices, and needs of their Tribal communities (62.7%). To become more responsive to their Tribe's culture, they recommended tailoring the program to each Tribal community (77.4%), increasing understanding about the program's purpose (74.2%), making programs more user-friendly and accessible for Elders with limited digital literacy (64.5%), and providing more opportunities for connection and support (64.5%).

When culturally tailoring evidence-based programs, participants reported that including cultural activities were helpful (67.9%), as well as allowing flexibility in

delivery methods (60.7%) and including Tribal Elders in program design (58.3%).

Most (78.2%) participants agreed or strongly agreed that evidence-based programs could be adapted to meet the needs of their Tribal community. An even greater percentage agreed or strongly agreed that Tribal members should provide input on evidence-based programs before being implemented into the community (81.6%).

Successful Community-Developed Programs

Just over one-quarter of participants reported successfully using a program that was not considered evidence-based (27.3%). Among those doing so, all participants reported that social engagement was an appealing aspect of the program for Tribal Elders, as well as physical activity items (95.2%), and nutrition education (71.4%).

Future Program Implementation

When asked about factors that would be helpful in implementing evidence-based programs, most participants indicated funding (83.3%), as well as services relating to transportation (64.3%), equipment for the program (59.5%), and assistance in adapting programs to the culture (54.8%). They cited program resources (83.5%), funding resources (81.2%), culture (70.6%) and consultation from the Tribal community (63.5%) as being the key factors to consider when attempting to successfully implement a program.

Comparisons to Past Survey

When compared to the previous 2020 survey administration, results generally followed similar trends. Because sample size, participants, and question wording, among other factors, can all affect results, findings should be considered in light of such differences.

Across both surveys, most participants had heard of evidence-based health promotion programs before, although there was a slight drop from 76.2% in 2020 to 63.2% in 2026. With regard to familiarity with specific programs, results were mixed, with some programs like tai chi seeing a decrease (50.0% to 35.9%), while others such as the Special Diabetes Program for Indians (SDPI) saw an increase (36.7% to 41.3%).

Participants were also generally less likely to report implementing evidence-based programs in their community, with 23.7% reporting that they were not implementing any in 2020 compared to 31.4% in 2026. Programs such as Diabetes Empowerment and Education Program (DEEP) did see a slight increase (16.9% to 18.6%).

Overall areas of concern for Elders in their community, such as chronic disease, transportation, falls/falls prevention, housing, and loneliness/social isolation remained prominent across both survey cycles. Similarly, participants reported that cultural programs and activities, socialization, and diabetes were top program interest areas for their Elders as well. Many agreed or strongly agreed that their Elders were interested in participating in an evidence-based program (53.3% in 2020 vs 58.0% in 2026), although there was a slight shift in 2026 in the number who strongly agreed (20.0% in 2020 to 14.8% in 2026).

Compared to 2020, participants were also much more likely to believe that their Tribal Elders had the support and resources they needed to participate in evidence-based programs to make the needed behavior changes. In 2020, 28.3% of participants strongly agreed or agreed, whereas in 2026 this value rose to 43.2%.

Top barriers to implementing evidence-based programs generally followed a similar trend. Compared to 2020, cost was more likely to be cited as a barrier (46.7% vs. 55.2%), as well as finding an available location to hold the program (23.3% s. 31.0%), as well as not having enough interested Elders (51.7% vs. 54.0%). Transportation (58.3% vs. 42.5%) and lack of tailoring (38.3% vs. 18.4%) both saw decreases.

Participants in the 2026 survey were more likely to report that the evidence-based programs reflected the cultural values, practices and needs of Tribal Elders (50.9% in 2020 vs. 62.7% in 2026). To improve cultural responsiveness, 2026 participants were much more likely to suggest tailoring the program to each Tribal community based on cultural traditions (63.0% vs. 77.4%) and implementing a Tribal advisory board to provide suggestions for the program (22.2% vs. 48.4%). Most agreed or strongly agreed that evidence-based programs could be adapted to meet the needs of the Tribal community (85.0% in 2020 compared to 78.2% in 2026).

In 2026, more participants reported currently using a program in their community that was not considered evidence-based (15.8% in 2020 vs. 27.3% in 2026), with social engagement remaining the most important aspect for Elders.

Resources and strategies towards implementing evidence-based programs also largely remained the same, with funding being the top priority (85.5% in 2020 vs. 83.3% in 2026). Key factors when implementing the program also followed the same trend, with funding resources and program resources both being frequently mentioned by participants.

Qualitative Interviews

In addition to surveys, interviews were also conducted with a few Title VI directors in order to learn more about their unique strengths and challenges. Full results are shown in Appendix A. All Title VI directors had experience in working with evidence-based programs. Together, they expressed the importance of listening to Elders, not only in determining what is important and of concern, but also in their feedback on the respective program. Ensuring that Elders have a safe space in which they feel comfortable to participate and making sure that activities remain accessible to them were common themes.

Making sure that the evidence-based health program remained culturally relevant was also crucial. Because each Tribe is unique, there is no evidence-based health program that will fit each Tribe without changes and adaptations, but the Title VI directors shared different methods they use to make programs culturally relevant for Elders. This might include involving Elders in implementing the program, using photos of Native Elders in the promotional materials so they recognize themselves in it, or making sure that foods listed are available to Elders. Prioritizing enjoyment and fun, breaking up educational material so it is not overwhelming, and providing incentives for participation are all different ways of increasing engagement.

Barriers remain when instituting evidence-based health programs; many Title VI directors discussed transportation as a significant barrier, especially when living in rural or isolated areas. Time commitment, inconsistent classes, or rescheduling can also impede program progress. From an operational perspective, time and cost remain substantial challenges. Many staff members wear multiple hats, so it can be difficult to find time to implement a new program, especially when taking cost, licensing, and training time into consideration. Forming partnerships with community organizations helps to provide additional resources, but having more flexibility, both in terms of funding and program implementation would be beneficial.

Discussion

Collectively, results indicate that while Title VI staff are familiar with and utilize evidence-based programs, opportunities remain to further increase awareness of available programs in addition to resources to help implement these programs. Programs addressing factors such as chronic disease management, transportation barriers, housing stability, fall prevention, and social isolation continue to remain important priorities.

Being able to tailor evidence-based programs to the specific needs of Tribal Elders is also especially important to ensure the program is useful, although issues such as cost, transportation, or staffing remain a challenge to successfully implementing such programs. Many programs also report incorporating their own non-evidence-based programs to aid health-related issues in their communities, with aspects such as social engagement, incentives, cultural tailoring, and listening to their thoughts and needs being especially appealing to Elders.

APPENDIX A

Title VI Program Spotlights

To provide additional context to the survey, follow-up interviews were conducted with three Title VI program directors. The purpose of these interviews was to better understand how evidence-based health promotion programs are implemented and adapted in Tribal communities, as well as to explore some of the barriers and challenges they face. The information listed here is presented in aggregate form and has been intentionally generalized to protect individuals' privacy. The insights shared are not intended to represent the experiences of all Title VI programs but help to provide perspective on the experiences of specific programs. Key findings are listed below, discussed by theme.

Knowledge and Community Definition

All Title VI directors interviewed indicated that they had direct experience with implementing evidence-based programs, ranging from a few programs to up to six or seven. When exploring the markers of what constitutes a successful evidence-based health program, strong attendance was a frequently mentioned factor – for example, if Elders not only participated in the program and remained engaged, but also if they remained motivated and completed the program in its entirety. Elders' feedback also plays a critical role, such as if the Elders report that they enjoyed it and ask about the program after it ends because they are interested in participating again. Formal survey evaluations are completed from time to time, depending on the willingness of the Elders and resources available.

Needs and Interests of Elders

Elders' needs and interests vary by Tribe and program. Some Title VI directors discussed how their Elders especially like evidence-based programs with physical activity, while others explained that programs incorporating standard physical exercise were not a favorite. Health programs incorporating healthy eating, addressing chronic diseases, caregiving, brain health, hydration challenges, Wii bowling, walking clubs, games and various other programs that promote healthy aging and well-being were discussed throughout the interviews. Variation can occur even among smaller groups within the programs; for example, one Title VI director explained that younger Elders tend to be more interested in prevention aspects of health, while older Elders are not as interested in disease management.

Regardless of the program, Elders are more likely to participate and remain engaged when they feel comfortable. For some, they are more private and hesitant to share information in large groups, preferring to do so in one-on-one environments. For others, establishing a good relationship with their peers and getting to know the trainer plays a larger role. Programs that respect Elders' limitations and boundaries are also important. One example of this can be seen in accessibility; making sure that Elders of any ability level can take part. If that is not possible, they will not offer the activity or program.

Cultural Relevance

Ensuring that the evidence-based program is culturally appropriate is also vital in its overall success. To ensure this, Title VI directors utilize a variety of different approaches. One option is to more directly involve the Elders in the program, as they will help to identify what is and is not culturally appropriate, and ensure that the material is relevant to them. Another director mentioned the importance of adding culturally relevant examples, such as food and activities, that allow Elders to connect more with the material. They also work to incorporate healthy meals and snacks, aspects such as a prayer before eating, or ways to break up the information so that it is more accessible and not as overwhelming.

Using photos of Native Elders in promotional materials can also be useful, as it helps them to connect with the program and increase participation because they recognize themselves in it. Making the program names more accessible and appealing to Elders can also help. The program should also be adapted to what is available to the Elders – for example, if implementing a nutrition program, making sure that Elders have access to the recommended foods is necessary. Ultimately, it is important to respect Elders and meet them where they are at; Elders need to be able to set goals for themselves. This also includes respecting their time and maintaining a safe place where everyone feels comfortable.

Engagement and Collaboration

There are several factors that can increase engagement in evidence-based programs among Elders. Listening to Elders and following their lead is a great strategy, such as learning about the activities they do and do not enjoy. Learning more about the Elders' concerns and finding ways to bring in resources and address them was also mentioned. One Title VI director noted that some Elders have created and run a whole video exercise class by themselves, while others have also served as peer facilitators for a separate program. Getting to know people and developing relationships also plays a significant part.

Another large role in creating engagement is making activities fun. One Title VI director explained that while Elders may not always enjoy standard physical exercise programs, they do like participating in line dancing where the focus is not solely on exercise. Having a visual way of tracking attendance, such as collecting beads or other rewards for each activity attended, was also positively

received. Finding ways to include educational material, such as incorporating it into specific activities rather than providing larger information-heavy teaching, was also appreciated. Another Title VI director discussed their experience with Elders' participation in elder abuse awareness and health-promotion days. At these events, Elders have the chance to get blood pressure and glucose checks, as well as opportunities to connect with speakers, eat healthy meals, gather resources, and socialize with others.

Partnerships are also crucial when implementing evidence-based programs. This can involve collaborating with programs in the community to help deliver services or working together to apply for grants, as well as state units on aging, local universities, among others. Title VI directors also had success in working with interns or students to run evidence-based programs or incorporate student projects, allowing them the opportunity to gain experience while simultaneously fostering relationships with Elders.

Barriers

Transportation remains a large barrier for participation in evidence-based health programs; this was noted across all interviews. Because many Elders do not drive, they must often arrange alternative options to attend health programs, especially when held outside of normal hours. This can be especially challenging in geographically isolated areas. Many of the Title VI directors reported that they did offer transportation services to Elders, but working around multiple schedules can be challenging.

Time commitment and overall participation were also cited as barriers, as it can be difficult for Elders to commit to a several-week program; breaks or family and caregiving schedules may come into play. Inconsistent classes and frequent rescheduling can also add to this and hinder attendance, as it prevents Elders from having a consistent schedule. One Title VI director noted that inflexible evidence-based programs can also create barriers; it is important to ensure that Elders can still participate in programs if they miss a few days due to illness. Lack of access to supplies also plays a role – to participate in the program, Elders must be able to use needed materials such as exercise equipment or books.

From an organizational standpoint, finding instructors remains a significant barrier. Obtaining evidence-based program training for staff can be difficult in terms of time, as trainings are often provided at times when staff are working and fulfilling their essential daily duties. Certifications and licensing costs can also add up. It also takes time to learn the program, prepare for the classes, as well as teach them; because staff already wear multiple hats, it can be difficult to find the time and resources to implement programs. They are already lacking capacity for the services they are currently offering, so there is limited capacity to add additional classes.

Improvements and Supports

The Title VI directors emphasized the importance of listening to Elders, learning about the things that they find fun and that are important to them, and using that as a guide. One Title VI director discussed the importance of including younger generations in the discussion, as the programs currently being designed and implemented may benefit them as well.

Fall prevention was an area of focus for another Title VI director, particularly incorporating balance and exercise activities. They do have an occupational therapist that provides services, but they would like to further increase efforts to reduce falls. Another indicated that they are especially interested in home and community-based services.

In working to get more funding, one Title VI director cited that applying for grants for evidence-based programs can sometimes be difficult. As a smaller Tribe, they sometimes find themselves competing with larger entities with more resources or sometimes are excluded from applying for certain grants. Because of this, as well as coming from a more geographically isolated community, they are interested in seeking out and working with non-profits or smaller programs to help apply for grants and provide resources.

They explained that they would love to be able to give a stipend to facilitators, whether it is community members or staff (in addition to their regular income). Given the choice, facilitators will gravitate toward a paid job over facilitating programs for free, so having funds to offer them would be helpful. Having more funding in general would be beneficial; funding that is not tied to a specific program would also allow for flexibility in program implementation. Less paperwork, additional adaptable ways to collect data, and opportunities to incorporate more cultural aspects were also mentioned, as well as utilizing evidence-informed (versus evidence-based programs) that allow more flexibility.

2026 Evidence-Based Health Promotion Program Report

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