Center for Rural Health

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Successful Physical Activities for Title VI Programs

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Technical Assistance Forum &
30th Anniversary Celebration of the Title VI Program
Prior Lake, MN
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Connecting resources and knowledge to strengthen the health of people in rural communities.

Center *for* Rural Health

- Established in 1980, at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, ND
- Focuses on:
  - Education, Training, & Resource Awareness
  - Community Development & Technical Assistance
  - Native American Health
  - Rural Health Workforce
  - Rural Health Research
  - Rural Health Policy
- Web site: http://ruralhealth.und.edu

National Resource Center on Native American Aging

- Established in 1994, at the Center for Rural Health, University of North Dakota School of Medicine and Health Sciences
- Focuses on:
  - Education, Training, and Research
  - Community Development & Technical Assistance
  - Native Elder Health, Workforce, & Policy
- Web site: http://nrcnaa.org

Native Elder Issues

- Growing elder population with Boom generation
- Lower life expectancy
- Higher chronic disease rates
- Higher health risk factors
- Lack of screening
- Lack of long-term care services in Indian Country
- Changing family structure

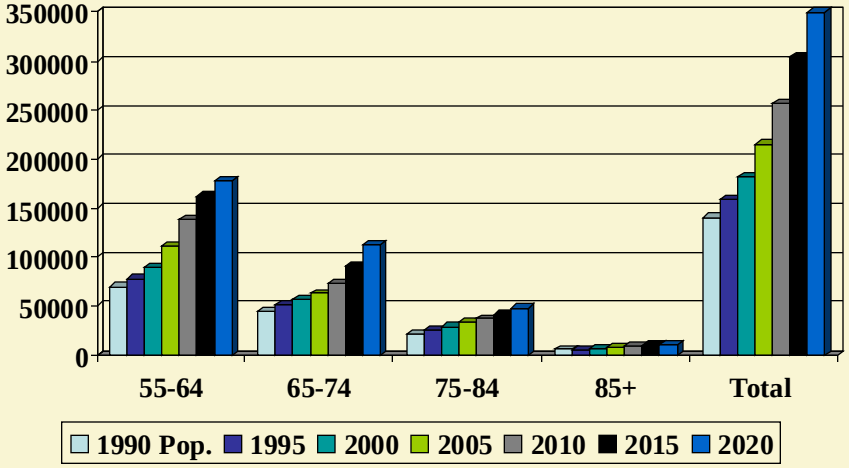
The Framework

- *Identifying Our Needs: A Survey of Elders I-III*, funded by the Administration on Aging, provides technical assistance and training opportunities to conduct a needs assessment using an established model.
- The NRCNAA model uses:
  - Academically accepted design and methodology
  - Random sampling ensures fair subject selection
  - The results are independent from political influence
  - Informed consent, tribal approval, and tribal ownership ensure tribal sovereignty is protected
  - The model developed with input from Native elders and Native elder providers ensures respect for Native elders.

Data is collected on

- General health status
- Activities of Daily Living (ADL's)
- Instrumental Activities of Daily Living (IADL's)
- Indicators of chronic disease
- Cancer screenings
- Access to healthcare
- Indicators of vision and hearing
- Tobacco and alcohol use
- Nutrition and exercise
- Weight and weight control
- Social supports

Native Elder Population Projections 1990-2020



Regional Variances

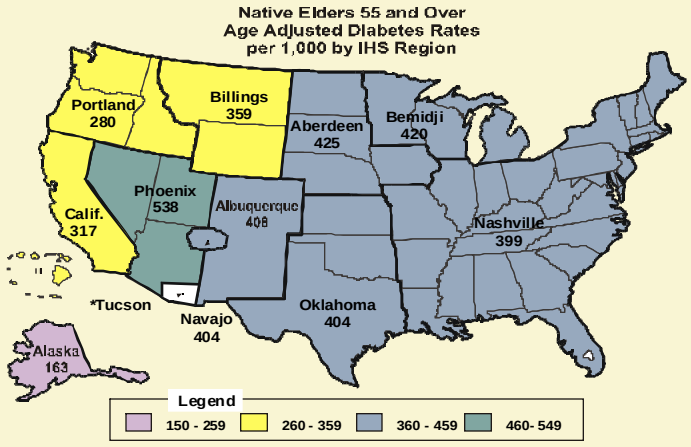
- One size does not fit all
- Variation in regard to life expectancy and chronic disease
  - Ex. California Indian Health Service Area life expectancy is close to the nations; however, Aberdeen Area is 64.3, a difference of 12.5 years.
  - Ex. Alaska Area has diabetes rate close to the general population at 14%; whereas, the majority of other regions are at 37% or higher.
- Once you seen one tribe you've only seen one tribe

Life Expectancy at Birth, ages 55, 65 and 75 by IHS Area

IHS Area	At Birth	At Age 55	At Age 65	At Age 75
Aberdeen	64.3	18.9	13.2	8.5
Bemidji	65.7	18.7	12.7	10.1
Billings	67.0	20.2	13.9	8.9
Alaska	68.0	21.3	14.7	9.2
Tucson	68.4	22.2	15.8	10.0
Phoenix	69.8	22.6	16.1	10.6
Portland	71.7	23.1	16.0	10.1
Navajo	71.9	24.9	17.7	11.7
Nashville	72.2	22.8	16.3	10.5
Albuquerque	72.7	25.4	19.6	12.2
Oklahoma	74.2	25.7	18.2	13.1
California	76.3	26.9	19.4	13.3
All Indians	71.1	23.5	16.7	11.2
**U.S. All Races	76.8			

Source: I.H.S. Division of Statistics (1998); **National Center for Health Statistics (2000)

Diabetes Rates by Region



Source: NRCNAA Needs Assessment Data, UND Center for Rural Health.
* No data are available.

Current Status of Project

- **Cycle I**
  - 190 tribes from 87 different sites are represented in national file
  - 9,403 Native elder participants have filled out the survey
  - At least one tribe from 11 of the 12 I.H.S. Regional Areas were represented in the national file
- **Cycle II**
  - 254 tribes from 75 sites representing 10,521 Native elders have completed Cycle II
  - All 12 I.H.S. Regional Areas were represented in the national file

Demographic shifts influencing health

- Baby Boomers are changing the age distribution for elders
- Length of last residence is shorter
- Educational levels are improving
- More people age within marriages
- Incomes are gradually improving

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Functional Limitations

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Functional Limitations

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

Component Changes in Functional Limitations: IADLs AND ADLs

- IADLs declined significantly for all age groups – an across the board gain
- ADLs declined significantly **only** for the 65-74 cohort

Functional Limitation Levels Applied to Services and Personnel

Level Functional Limitation	Service Goals	Services with best fit	Personnel required
Little or none (65%)	Health promotion, preventive care, maintaining vitality	No caregiver services required Health Promotion/Prevention	Health educators, physical trainers, therapists
Moderate (18%) This category represents entry level functional limitations and requires assistance usually consistent with remaining in one's home.	Supportive services to aid persons in remaining in own domicile. Train and support informal providers and buffer them with respite and contact services for a range of possible tasks.	Informal care – w/supports Chronic Disease Management Home & community based •Day/night care* •Durable medical* equipment •Home health care* •Homemaker services* •Physical therapy •Occupational therapy •Medication assistance* •Speech therapy •Mental health services •Transportation services* •Nutritional services* •Personal care* •Respite care* * Require local providers	Family and friends Trainer for skills Facility staff – LPN/CNA Rental source RN, LPN, CNA, PT, OT… Cleaning and chore assts. PT, PT aides, tele-health OT, OT aids, tele-health Medication aide Speech therapist Psychologist, Psychiatrist, Psych. Social Worker, Van driver Dietician, aide Trained attendants Trained respite providers or institutional site

Functional Limitation Levels Applied to Services and Personne

Level Functional Limitation	Service Goals	Services with best fit	Personnel required
Moderately Severe (6%)	The goal for this level of care is to provide housekeeping and meals along with a modest level of oversight. People may contact for services from the home and community based services in addition to the basic services found in these settings. Assisted living establishes the goal for this cluster in that it seeks to maintain resident control over services.	Congregate care Basic care facilities Assisted Living	Institutional staff as required by state regulations
Severe (12%) With 3 or more ADLs, this level tends to become prime candidates for skilled nursing care. They represent care needs with relatively high levels of acuity.	Skilled nursing care is the most fully institutional and is reserved for those with medical needs necessitating this level of care.	Skilled Nursing Care	Institutional staff as required by state regulations
Terminal as special category	End of life care occurs at all points on the above continuum, but is concentrated at the higher levels of limitation. The goal is physical and emotional comfort.	Hospice Care	*Hospice volunteers and coordinator

Exercise Change and Age

- Weight Lifting – Down for 55–64 age group
- Powwow – Down for 55-64 & 65-74 age groups
- Biking - Down for 55-64 & 65-74 age groups
- Jogging - Down for 55-64 & 65-74 age groups
- Walking – **Up dramatically for all ages!!**
- Gardening – Down for 55-64 & 65-74 age groups

Growing Problem of Weight

- The average BMI score increased from 29.1 to 29.6 from cycle I to cycle II
- Age is related to BMI with the younger elders having the highest BMI scores – the 55-64 age group's average BMI fell in the obese category

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Data Use Examples

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Community Level Data Uses

- Documentation of health disparities
- Documentation of need for health promotion, home and community based services, and assisted living
- Renewal of Title VI Native Elder Nutrition and Caregiving Grants
- Strengthening of grant proposals

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Policy Recommendations

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Policy Recommendation # 1: Disease Prevention Efforts Including Health Promotion, Screening and Wellness Programs

- Federal agencies including the Indian Health Service (IHS), Administration on Aging (AoA), Centers for Disease Control (CDC), Health Resources and Services Administration (HRSA), Bureau of Indian Affairs (BIA), Administration on Native Americans (ANA) and the Agency for Healthcare Research and Quality (AHRQ) should allocate resources to develop and evaluate wellness programs that focus on healthy eating choices and physical activity for Native Americans using a multigenerational approach.

Policy Recommendation # 1 Continued: Disease Prevention Efforts Including Health Promotion, Screening and Wellness Programs

- An interagency team comprised of the IHS, ANA, CDC, BIA, AoA, and the Department of Education should be created with the charge of developing a collaborative model for health promotion.
- Health screenings not already supported for elders (55 years or older) should become the responsibility of IHS and the Centers for Medicare and Medicaid Services (CMS) as a part of targeted health promotion programs.

Policy Recommendation # 1 Continued: Disease Prevention Efforts Including Health Promotion, Screening and Wellness Programs

- **Designated funding within Health and Human Services should be provided to enable tribal health organizations and IHS to implement coordinated community screening and referral programs for Native American elders. These programs should be designed to remedy access to dental, hearing, and vision screenings.**

Policy Recommendation #2: Chronic Disease Management Programs to Prevent Co-morbidity and Increase Access to Services

- **A joint CMS, CDC, ANA and IHS disease management demonstration program should target the most prevalent chronic diseases in Native elders including diabetes, arthritis and high blood pressure.**
- **The Environmental Protection Agency's work in air quality and asthma management should target urban Native elders.**

Policy Recommendation #3: Increase Availability of Home/Community Based Long-term Care Services in Rural Areas

- The health and human services community and faith based programs along with the Office of Rural Health Policy (ORHP) and AHRQ should support initiatives that seek innovative designs for providing home and community based long-term care services and support for Native elders living in rural areas.
- Congress should reauthorize the Indian Health Care Improvement Act (IHCIA).

Policy Recommendation #4: Increasing Availability of Health Care and other Services in Rural Reservation Areas

- The AoA Office for American Indian, Alaska Native, and Native Hawaiian Programs should advocate with states and other federal agencies to increase senior centers for frontier Native Elders.
- A special initiative under Housing and Urban Development (HUD) should provide assessments, on a regular basis, of Native elder's current housing environment in relationship to their health needs.
- Congress should increase funds for the Native American Housing Assistance and Self-Determination Act (NAHASDA) to improve plumbing and sanitation conditions for rural Native Elders.

Policy Recommendation #5: Increase Incomes and Access to Health Insurance and Medicare for Future Generations of Native Elders'

- **A special initiative under the Department of Education to create and evaluate model programs to increase student retention and academic success in American Indian children.**
- **The IHS should provide a evidence based demonstration project focused on encouraging healthy lifestyles among American Indian youth.**

How can we collaborate to make better use of the data set?

- Our agreement with tribal government is not to give the raw or aggregate data to other agencies…..however, we can query our data for other agencies, do cross tabulations with other agency data, etc.
- We want to enhance/encourage data driven decision making by tribes, agencies, etc. regarding older American Indians.

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