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Policy Recommendations for Native Elders

Prepared for the National Congress of American Indians 2005 Mid-year Conference

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Connecting resources and knowledge to strengthen the health of people in rural communities.

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The following policy papers are based on the results from the "Identifying Our Needs: A Survey of Elders" needs assessment surveys conducted by the National Resource Center on Native American Aging (NRCNAA) at the University of North Dakota and cooperating tribes spread throughout the nation. The data set contains 9,403 respondents from 171 tribal nations and includes tribes from 11 of the 12 IHS regions. It is the most substantial survey of Native American elders conducted to date and serves as a solid basis for examining the needs of elders and for deriving recommendations for future program development designed to enhance the quality of life, health and well being of the nations' Native elders.

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

Rationale

Thirty-eight percent of Native elders are obese compared to 18% of the general population, ages 55 and older. Body mass index was identified as a factor in the prevalence of arthritis, asthma, diabetes and high blood pressure in Native elders. In addition, some form of exercise was associated with a decreased likelihood of having diabetes, a functional limitation and high blood pressure.

Policy Recommendations

- **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.** Addressing these issues through a community environment perspective, may have the most positive impact on the health of all Native Americans. Wellness programs such as Minnesota's Wisdom Steps represent interventions that could potentially serve as models for the nation's tribes. Further, due to the honored status of Native American elders in their communities, their participation in wellness activities may positively influence the health status for future generations of Native Americans.

  Supportive programs, such as Minnesota's Wisdom Steps, provide an opportunity for tribes to adapt a successful established wellness program to meet the need of their elders. These programs are based on individuals setting personal health goals with the assistance from their physician. Success in the program is about the journey to health, as it encourages elders to improve their health by establishing personal goals.

The primary limitation to implementing a wellness program is engaging Native elders without community support. Success of the intervention rests upon key community Native elder leaders embracing and committing to wellness in their communities.

Overall, wellness programs provide an opportunity to focus on a holistic view of health that includes a community component that is beneficial to all generations. Evidence based wellness interventions are key to learning what works and what does not work; therefore, evaluation of Native elder wellness programs could be used to identify elements that enhance the health of participants and their communities. Best practice models could be identified and an evaluation could be used to discern whether these practices would be cost effective. Researchers/evaluators of Native American descent would be recommended to ensure a culturally sensitive approach is used.

While cost effectiveness of wellness programs may be difficult to assess in the short term (such as a one or two-year study), there is ample evidence regarding the cost of various diseases and their complications that can be used as part of a cost benefit analysis. In addition, outcome data (specific or general) about the success of these types of wellness programs are unavailable; therefore, this data will need to be collected before large allocations are expended to expand programs.

- **An interagency team comprised of the IHS, ANA, CDC, the BIA, the Department of Education, and the Department of Health and Human Services (DHHS) should be created with the charge of developing a collaborative model for health promotion.** Health promotion should become a major goal infused into programs of health care, community education, human services and in-home outreach programs. While the target population of elders is imperative, prevention must also address younger age groups such as those in pre-retirement cohorts.

  The advantage of this approach is that an environmental, multi-disciplinary community approach to health promotion will have the greatest chance of making a lasting impact. Furthermore, implementing successful health promotion strategies across the age spectrum is critical to addressing the poorer health status experienced by the majority of Native American communities.

  A major limitation to this approach is that historically, IHS funding has been unable to meet essential health care needs of Native Americans. Efforts to redirect already limited funding to health promotion would be problematic; therefore, additional funding would need to be earmarked for health promotion efforts.

- **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.** Health screenings, designed for early detection and treatment of chronic diseases, are essential to reduce functional limitations. According to NRCNAA data, these

targeted chronic diseases would include arthritis, diabetes, high blood pressure, congestive heart disease, and stroke.

Health screenings detect disease, limit complications, and improve quality of life; therefore, the primary challenge is to identify funding for health screenings, especially in the current IHS budget. Taking into consideration that current IHS funding is inadequate to meet the basic health care needs of Native Americans, these services should be funded with earmarked funds and should not compete with existing lines of funding.

- **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.** Detection of dental, hearing or vision problems should occur before they contribute to other negative health outcomes, such as fall injuries or poor nutrition. Tribal health entities may want to consider partnering with public health to conduct these screenings.

  Many communities have instituted local screening programs (eg. a mobile dental clinic), thereby diminishing the need to travel outside of the community. Transportation is often a challenge for Native elders, especially those residing in rural and frontier communities. Providing community-screening programs would increase access for people who may not otherwise have access. In addition, partnering with public health provides an excellent opportunity to leverage other resources, such as adult immunizations, that can be provided during the community-screening program.

  All screening programs require a funding source; therefore, collaboration with tribal and other non-tribal entities is essential. This collaboration requires leadership from the tribal community and also requires resources to maximize participation. Designated funding for tribal health, IHS, CMS, and public health would need to be secured to successfully implement a community-screening program.

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

Rationale

Several statistically significant co-morbid relationships were found among six chronic diseases. Chronic disease clusters included: diabetes/high blood pressure; congestive heart failure/high blood pressure; lung/colorectal cancer; and stroke/high blood pressure/diabetes. Among those elders experiencing multiple chronic diseases, their functional status decreased, indicating the need for increased supportive services for the elders to remain independent. Moreover, the decreasing prevalence of diabetes among older elders indicates that those elders with diabetes may have shortened life spans.

Policy Recommendations

- **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**. Adequate disease management prevents premature death, leads to better quality of life, and decreases the development of co-morbid conditions. This demonstration program could include collaborative care and self-management education. Self-management has been found to be effective in improving outcomes and reducing costs among individuals with chronic disease (Bodenheimer, Lorig, Holman, & Grumbach, 2002).

  Current diabetes disease management programs have demonstrated effectiveness; however, there is little information pertaining to disease management programs targeted to Native elders. A demonstration disease management program targeted to Native elders, funded by CMS and IHS, would provide an opportunity to identify effective and non-effective elements that can be used to develop chronic disease management models for Native elder populations. The higher rates of chronic disease among this population suggest transitioning as quickly as possible from a demonstration to a full-scale program.

- **The Environmental Protection Agency's work in air quality and asthma management should target urban Native elders.** Urban Native American elderly were the most likely to indicate they have asthma. The primary goal of this initiative would be to identify successful asthma management programs and locate the factors that contribute to their success.

  Asthma management programs have demonstrated success in helping asthma patients manage their disease. Better self-management of asthma results in fewer emergency department visits and fewer in-patient hospitalizations. Overall, asthmatic Native elders potentially have the opportunity to improve their quality of life. In addition, improving air quality for urban Native elders would improve their respiratory health, and also improve the respiratory health of all the people in those communities.

  The proximity to air pollution sources, such as industrial emissions and heavy traffic, may need to be more closely monitored. In addition, air emission standards may need to reviewed and changed to positively impact respiratory health. Monitoring and changing standards take time, and will require additional funding.

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

Rationale

Significant relationships were found between functional limitations and arthritis, congestive heart failure, stroke, asthma, high blood pressure and diabetes. Increased functional limitations results in the need for home or community based long-term care services. Prompted by new

federally funded research findings from the University of North Dakota's Center for Rural Health, National Resource Center on Native American Aging, the U.S. Senate Committee on Indian Affairs held an oversight hearing to examine the long-term care and health care needs of Native American Elders (July 10, 2002). During the hearing, the Committee Chair, Senator Daniel Inouye (D-HI) noted that "…long term care options for most Native American elders are minimal at best."

Policy Recommendations

- **A special initiative under AHRQ should be established that seeks innovative designs for providing home and community based long-term care services and support for demographically challenged reservations.** This initiative should seek to encourage new provider delivery models designed specifically for isolated and sparse populations, allow for experimentation with reimbursement strategies, and should include funds for evaluation. Special incentives for tribes to develop local solutions should be encouraged with funding mechanisms similar to those offered by states. A three to five year program on four reservation sites selected to represent the diversity in these demographically challenged areas is recommended. Community-University partnerships should be encouraged in this initiative to ensure the adaptation of current materials and state of the art knowledge in the design of new home and community-based care programs.

  Innovative home and community based long-term programs that address the unique conditions of Native elders have great potential to improve the quality of life for Native elders, their families, and their communities. Using a community participative approach in developing, implementing, and evaluating programs is key to successful adoption of culturally appropriate long-term care solutions and should incorporate tele-health and information technology applications to span geographic distances. These programs would require new funding for AHRQ.

- **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 and frontier areas**.

  Collaboration among entities improves the likelihood of support for funding and success of innovative programs. Funding is the major challenge in implementing this recommendation; however, pooling resources by the aforementioned entities may have the greatest potential for implementation. <u>Also, formal policies are needed that recognize traditional Native religions as eligible for faith-based funding</u>.

- **Congress should reauthorize the Indian Health Care Improvement Act (IHCIA).** IHCIA was enacted in 1976 to address findings that the health status of American Indians and Alaska Natives ranked far below that of the general population. IHCIA is the key federal law that authorizes appropriations for IHS programs and

projects, such as the delivery of health services, the surveillance of diabetes, and tools for monitoring the effectiveness of ongoing and future prevention strategies. Failure to reauthorize IHCIA has significant fiscal impact to IHS.

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

Rationale

Access to health care services (e.g. hospitals, clinics, health care providers) was related to several chronic diseases. In addition, eight percent of frontier elders described their unmet health needs as, "unavailable services" in their area. These included access to physicians, nurses, dentists, an IHS representative, prescription medication, nursing homes, medical facilities, pharmacies, plumbing and senior centers. Although this is a small number of elders, no urban or rural elders cited these needs in their areas, thus emphasizing the lack of services in isolated frontier counties.

When asked about unmet health needs, 28% of elders identified a need to make homes handicapped accessible, by having a handicap bathroom and railings installed. Other responses centered on repairs or renovations to the home including having functional heating, plumbing and electricity. Elders, ages 85 and over and those living in frontier areas most frequently requested renovations.

Policy Recommendations

- **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.** Recognizing the vital link in the service delivery network, senior centers function as meal sites, screening clinics, recreational centers, social service agency branch offices, mental health counseling clinics, older worker employment agencies, volunteer coordination centers, and community meeting halls. The significance of senior centers cannot be underestimated. They provide a sense of involvement in the community, offer the opportunity to pursue activities of personal interest, and bring a sense of belonging to elders. Senior centers could also serve as a central location for provision of information technology services. These could include assisted telecommunication links with public services such as Social Security.

  Increasing the availability of senior centers for Native elders residing in frontier counties has the potential of enhancing the network for Native elders, and also providing a common gathering place in which other community members can learn from and interact with Native elders. The inter-generational connections are essential to sharing and preserving culture and community, especially for those most geographically challenged. Additional funding for senior centers and telecommunications, needs to be identified.

- **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.** An implied goal of independent living is embedded in the preceding recommendations. Individual homes should meet the needs of their residents. Home safety audits should become standard practice for the elder population to ensure optimal conditions for independent living. These environmental assessments should be broadly defined to include medical equipment such as safety bars in bathrooms, toilet risers and such items that enable people to function at optimal levels in their home environments.

  By assuring that Native elders live in homes appropriately equipped for their health needs, they are able to remain in their homes and communities rather than be moved to alternative care sites. In addition, maintaining elderly in their home and communities is cost effective, and adds to their quality of life. Communities also benefit by having their elders living among other generations.

  Some Native elders' housing is so substandard that they would require new housing options if their homes were audited for safety. Funds to assist Native elders to upgrade their current living environments would need to be set aside in addition to funds to implement the home safety audit programs.

- **Congress should increase funds for the Native American Housing Assistance and Self-Determination Act (NAHASDA) to improve plumbing and sanitation conditions for frontier Native Elders and all Native Americans.** Plumbing was identified as an unmet health need for frontier Native Elders. Access to plumbing and proper sanitation is essential to maintaining good health.

  As some frontier Native Elders assist in providing care for their children and grandchildren, improvement in their living conditions will translate to improved living conditions for their families. It is a basic public health function that should be available to all Native elders.

  Improvements in plumbing and sanitation require funding which is currently unavailable at the level of need.

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

Rationale

Native elders living in rural and frontier areas most frequently had incomes in the lower income brackets including 36% of frontier elders with an annual income below $5,000 and 40% of rural elders with an annual income between $7,000 and $14,999.

Socioeconomic factors significantly contribute to one's health status over the course of a lifetime. Native elders having the lowest income and lowest educational levels were the most

likely to suffer from high blood pressure, which is a precursor for many other health problems. Therefore, it is imperative to focus efforts on improving socioeconomic conditions in addition to improving access to health care. All Native Americans, including current and future elders, will benefit from improved socioeconomic status.

Policy Recommendations

- **A special initiative under the Department of Education with a three to five year period should solicit model interventions along with evaluation in order to locate cost effective mechanisms for enhancing perceptions of opportunities and improving student retention.** Education and income are both predictors of health and disability, thus it is essential in the overall outlook of Native health to increase support and enhance student retention and Native American students' perceptions of career opportunities. While this recommendation deviates from immediate attention to elders, it is considered critical for the long term. Future generations must realize more of the untapped potential of Native American youth. They are the elders of the future.

  Improving the health disparities of future Native elders begins today with Native youth. Educational opportunities open doors for improved income, and ultimately, improved health. The long-term viability of Native Americans and Alaska Natives is dependent upon the investments in the youth.

  Efforts to provide better quality education and further opportunities for higher education would require investments by the Department of Education and tribal communities. Allocating funds to increase the educational level of future generations will require leadership from the federal and tribal governments.

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