



Elder Visions

Newsletter of the National Indian Council on Aging, Inc.

Winter 2004

by Gary E. Kodaseet, Interim Executive Director

NICOA selects new Executive Director

On October 22, 2004, the NICOA Board of Directors met in Albuquerque, NM to interview and select a new Executive Director to lead the National Indian Council on Aging. The Board met and interviewed the three finalists in a year long search for a director and selected Ms. Traci McClellan (Cherokee) to be the new Executive Director. The following statements have been excerpted from a letter Traci sent to the NICOA Board in August 2004.

Dear Search Committee Members:

The purpose of this letter is to introduce myself and respond to the Executive Director position currently available with the National Indian Council on Aging (NICOA). I am a licensed attorney and enrolled citizen of the Cherokee Nation. I grew up in northeastern Oklahoma where my tribe is located and have since lived near and worked with many other American Indian and Alaska Native (AI/AN) tribal governments and organizations, in addition to federal agencies. I am a professional, self-motivated leader looking for the opportunity to continue my employment experience providing direction to and managing the lead national organization that serves American Indian and Alaska Native elders. With that thought in mind, please regard this letter as a formal request for an interview with your organization.

I have considerable experience working with federal agencies, advocating before Members of Congress and Administration officials, interacting with the media, and being the public face of an



organization as I currently do in my work as Legislative Director for the National Indian Health Board (NIHB). I have been successful in securing extra funding for NIHB from a federal agency and plan to pursue a similar strategic plan for NICOA, in addition to soliciting supplementary resources from private foundations. I work closely with

our 12-member Board of Directors implementing the national legislative and policy priorities of the 562 federally recognized Tribes we advocate on behalf of and anticipate a similar relationship with NICOA's Board. I also provide staff oversight for NIHB's Medicare and Medicaid Policy Committee, comprised of Indian health advocates, administrators, and attorneys, which works to assure that the

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New Executive Director

eligible AI/AN populations - whether elderly, disabled or low-income - receive the benefits to which they are entitled under existing law and in new regulations promulgated under the recently enacted Medicare Modernization Act.

Prior to joining the National Indian Health Board, I created an opportunity to partner with the Northern Plains Tribal Judicial Training Institute, a component of the University of North Dakota's Indian Law Center. I assisted the Institute with its U.S. Department of Justice (DOJ) Tribal Court Assistance Program (TCAP) grant to provide training and technical assistance to 58 grantees for planning, implementation, or enhancement of their tribal courts. By successfully obtaining the fellowship that provided my salary, benefits, and monthly student loan repayment assistance, I demonstrated my grant writing skills. This position further allowed me to develop familiarity with federal grant writing requirements, gain knowledge about various grant cycles and the primary differences between formula and discretionary grants. I also prepared the required reports to DOJ on the Institute's grant activities. I continue to perform these functions in my current position.

As the oldest grandchild on both sides of my family, I spent much of my life surrounded by my grandparents and other elders in my community. I have always had a special rapport with the sagest members of our society and recently spent time volunteering at the Senior Citizens Center in my hometown while visiting relatives. I would welcome the opportunity to relocate to Albuquerque as it would allow me to establish my permanent home closer to Indian Country, family and friends. I look forward to taking personal leave this month to attend your biennial conference and having the opportunity to introduce myself to the Board of Directors.

Please feel free to contact me if you believe an interview is warranted. Thank you for your consideration of my application.

Sincerely,

Traci L. McClellan ■

-- Correction --

Oops! Correction on prior issue of Elder Visions newsletter.

We did not intend to move Milwaukee, Wisconsin to Lake Superior... it is still on Lake Michigan!

Sorry.

by Mary Annette Pember

Indians Scout U.S. Dietary Wasteland

"Indians are like the canaries that miners carried into those coal mines to predict disasters. We may start dropping first, but everyone else is going to follow, even the white man."

I remember hearing an Ojibwe elder make this statement quite some time ago. At the time, I did not fully understand its meaning.

But in light of recent media reports about the huge increases in obesity and diabetes rates for the general U.S. population, and the high incidence of diabetes among American Indians, I continue to marvel at the prescience of the elder's words.

Since the 1940s, Indians have struggled with an unprecedented epidemic of obesity and diabetes in their communities. The incidence of diabetes among Indians is more than double that of non-Hispanic, whites, and more than 80 percent of those diagnosed are obese. They are also more than four times as likely to die of diabetes-related illness than white people.

Before the 1940s, however, type II diabetes, characterized by high blood levels of glucose and closely linked with obesity, was virtually nonexistent in Indian country.

In the overall U.S. population, current studies indicate that diabetes has increased more than 50 percent since 1980, and currently more than 30 percent of the population is classified as obese. The federal government recently

designated obesity as a disease.

When Indians occupied their original lands, they ate a traditional subsistence diet high in lean meats and complex carbohydrates. A typical lifestyle included high levels of physical activity and, perhaps most important, and indefinable spiritual connection to food.

Disenfranchised from land, culture, spirituality and traditional diet and activities, we began to eat ourselves into oblivion.

The government sets the stage for this epidemic by subsidizing processed foods high in empty calories. The fact is that foods full of processed carbohydrates, saturated fats and sugar are cheap and readily available while healthy alternatives are not.

All of this, coupled with a genetic makeup that encourages the body to store fat for times of scarcity, spelled a death sentence for Indians.

Now, ironically, all of us are in the same coal mine.

The World Health Organization reports that for the first time there are as many overnourished as undernourished people worldwide.

Fortunately, Indians are forging the path in recovery. Tribes are taking this health crisis seriously and are developing innovative approaches not only to diabetes treatment but especially prevention.

The Winnebago tribe of Nebraska has declared war on diabetes. It

has created a number of programs, including prediabetes screening for children and adults, free access to fitness equipment and programs, as well as an aggressive campaign touting the wisdom of a subsistence diet.

Wisely, the tribe's health leaders have recognized the peoples' cultural and spiritual ties to food and are encouraging the community to once again see traditional food as medicine. To that end, tribal members are invited to participate in "talking circles," in which they can safely share their emotions about diabetes and the stress of changing their diets.

Slowly, these communities are beginning to see improvements.

Lifestyle and eating habits go to the very heart of who we are as human beings - Indian and non-Indian alike. It should be no surprise, then, that changing these habits is not a simple matter of publishing a few reports declaring that large portions of fast food are bad and exercise is good.

Reversing this current trend in weight gain and diabetes will require a huge cultural commitment from the entire community. Traditional Indian philosophy could be a template for good living. Rather than becoming foretellers of disaster, Indians could be the prophets of recovery. ■

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Medicare Preventive Benefits Begin Jan. 2005

America's seniors will soon have new benefits that will help them live healthier lives, including Medicare-provided medical screenings for heart disease and diabetes, HHS Secretary Tommy G. Thompson announced today in a department-wide campaign to maximize preventive health care.

For new Medicare beneficiaries, the "Welcome to Medicare" physical exam, coupled with an increasingly broad set of preventive benefits including prescription drug coverage, provides Medicare beneficiaries with greater access to more prevention-focused benefits than ever before. These services are key features of the Medicare Modernization Act (MMA), signed into law by President George W. Bush in December 2003.

To support the focus on prevention-oriented health care for seniors, Secretary Thompson launched a coordination of resources between HHS agencies, specifically the Centers for Medicare & Medicaid services (CMS) and the Centers for Disease Control and Prevention (CDC).

"We are committed to healthy aging and to closing the prevention gap so America's seniors can learn new ways to prevent illness and if they do get sick, to treat problems early," Secretary Thompson said. "This new effort will improve the quality of life for seniors and their families."

Medicare recently mailed an updated "Medicare and You" handbook that, for the first time, emphasizes Medicare's new prevention-oriented focus. The handbook informs beneficiaries of what they should do to take advantage of these new services dedicated to early detection and treatment of disease.

"Too many seniors do not use the services that make it possible to find and treat illnesses before

they lead to more serious problems, as well as avoidable increases in health care costs," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The new law gives us the tools to close this 'prevention gap' for seniors, and we're going to do all we can to use these new opportunities to keep seniors healthy."

The difference between the number of seniors who could take advantage of preventive services that include vaccines and screenings and those who actually do is known as the "prevention gap."

CMS will also work closely with the CDC and other HHS agencies to share the prevention message with seniors and their families throughout the nation to broaden the emphasis on prevention and early detection, including the areas of diabetes, elevated cholesterol levels and cancer.

"This new Medicare screening exam will go a long way to help protect our seniors' health and thus help them achieve their full life expectancy," said CDC Director Julie Gerberding, M.D., M.P.H. "It will also provide an opportunity to educate our seniors of the importance of choosing health by eating a diet rich in fruits and vegetables, engaging in regular physical activity and not smoking -- all things that can help prevent chronic diseases which rob so many people of their health."

Medicare's new comprehensive set of preventive benefits includes the "Welcome to Medicare" physical exam and screening for heart disease and diabetes. Coverage also includes screening for weak bones, glaucoma, and cancers of the colon, breast, cervix, and prostate.

The exam is aimed at providing education and counseling about the preventive services that may

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Medicare Preventive Benefits Begin Jan. 2005

be needed. Dr. McClellan said he believes the exam will significantly improve the health prospects of Medicare beneficiaries as they enter the program and learn about preventive measure they may not have known were needed.

Closing the prevention gap, Dr. McClellan noted, could save many thousands of lives and billions of dollars in avoidable medical expenses for preventable complications associated with heart disease, diabetes, cancer, weak bones, high blood pressure, smoking, inactive life-styles, and other illnesses and unhealthy behaviors.

"Medicare's coverage and Medicare's expenses have historically focused on paying to treat costly health problems after they occur," said Dr. McClellan. "With Medicare's new support to help seniors use recommended preventive care and prescription drugs to avoid these costly and debilitating problems, that's going to change."

Dr. McClellan also noted that Medicare Advantage (MA) plans have the flexibility to cover far-reaching prevention services, such as wellness programs, beyond what Medicare covers. MA plans offer prevention benefits including health education services, exercise programs and other services that not only alert patients to potential health risks, but also actually work with them to change harmful lifestyles and encourage healthy behavioral changes. ■

Approximately 1.6 million people reside in 18,000 nursing homes in the U.S.

Nursing Home and Home Care Costs Soar

The average daily cost of a private room in a nursing home in the United States is \$70,080 per year, or \$192 per day, according to the 2004 MetLife Market Survey of Nursing Home and Home Care Costs.

The highest rates were reported in Alaska, where nursing home costs average an astounding \$204,765 per year or \$561 per day. The lowest rates were found in Shreveport, Louisiana at \$36,135 per year or \$99 per day. The average length of stay in a nursing home for current residents is 2.4 years.

The study also found that the cost of a home health care aide average \$18 per hour nationally. Home health care is most expensive in Hartford, Connecticut at \$28 per hour and least expensive in

Shreveport, Louisiana and Jackson, Mississippi where rates are \$13 per hour on average.

Approximately 1.6 million people reside in 18,000 nursing homes in the United States, with just under 10% of the residents aged under 65 and 46.5% aged 85 years and over, according to the National center for Health Statistics.

More than 1.3 million patients received home health care services from 7,200 agencies in 2000, with more than half receiving help with at least one activity of daily living. Seven in ten patients were 65 and older.

The average daily nursing home cost in San Francisco for a private room was \$293. Home care averaged \$21 per hour. ■

CDC REACH Project

The Diabetes Educational Outreach Strategies (DEOS) project is planning a January 19, 2005, Summit Conference at the Indian Pueblo Cultural Center. Aimed at improving Healthy Living Programs and Practices in New Mexico Communities for elders with diabetes, "the goals for this summit will be to raise awareness among New Mexico stakeholders and policy makers on issues related to the health of Indian elders," stated Pete Little, REACH Coordinator. "Collaboration with these efforts involve the fami-

lies and the communities where the elders' reside. Ideally, we'd like to partnership and be proactive in the development of diabetes management and prevention of this disease." Planned activities will include public information, resource sharing and hearing from elders who have the disease and what works best in their maintenance of diabetes. A similar meeting was held in Minneapolis, MN, in October and well-attended by both policy-makers and elders. For further information, contact Mr. Pete Little at NICOA (505) 292-2001.

You'll enjoy this holiday recipe

Spicy Oat Bars recipe for the diabetic

The blend of spices and raisins gives these bars a delectable flavor without a lot of added sugar. Decreasing the sugar can leave cookies less moist, so we've used baking raising to help make the bars moist and chewy; find them in a box right next to the other raisins in the grocery store.

Spicy Oat Bars

Ingredients

Amount

all-purpose flour	1/2 cup
quick-cooking or old-fashioned rolled oats	1/2 cup
baking soda	1/2 tsp
nutmeg	1/2 tsp
cinnamon	1/2 tsp
ground allspice	1/2 tsp
ground cloves	1/4 tsp
salt	1/8 tsp
firmly packed light brown sugar	1/3 cup
stick margarine, softened	1/4 cup
egg	1 each
low-fat (1%) milk	1 Tbsp
baking raisins	1/3 cup

Preparation Instructions

1. Preheat the oven to 350 degrees F. Spray an 8x8 inch pan with nonstick cooking spray.
2. In a medium bowl, whisk together the flour, oats, baking soda, nutmeg, cinnamon, allspice, cloves, and salt. Set aside.
3. In a medium bowl, with an electric mixer on medium speed, combine the sugar and margarine. Blend in the egg and milk until smooth. Add the flour mixture to the margarine mixture in thirds, and blend until smooth. Stir in the raisins.
4. Spread in the baking pan and bake until the edges just start to pull away from the sides of the pan, about 12 minutes. Cool completely and cut into 9 bars.

Time running out for low-income AI/AN Medicare Beneficiaries

More on Medicare Beneficiaries & Drug Card

American Indians and Alaska Native (AI/AN) Medicare beneficiaries who utilize Indian health program pharmacies can now begin taking advantage of two specially endorsed Medicare-approved drug discount cards and the \$600 credit tailored for their needs according to an announcement by the Centers for Medicare & Medicaid Services (CMS) and the Indian Health Service (IHS).

The two special drug cards for Indian health program pharmacies are Criterion Advantage and Pharmacy Care Alliance. The AI/AN Medicare beneficiaries who enroll in these drug cards can use their card at other pharmacies. Both cards have large national networks of pharmacies in addition to the Indian health program pharmacies. The AI/ANs can also choose from any of the other drug cards already participating in the program. More information about the drug discount cards as well as other drug cards can be obtained by calling 1-800-MEDICARE (633-4227) or by going to the Medicare Website at www.medicare.gov.

"These two specially endorsed drug cards are tailored to meet the needs of those accustomed to using special pharmacies," said Mark B. McClellan, MD, PhD, administrator of CMS. "These pharmacies may be the only drug stores serving remote areas where they are needed the most." Providing drug cards through AI/AN pharmacies used by many American Indians and Alaska Natives furthers the Bush Administration goal of providing more affordable, up to date drug coverage for all Medicare beneficiaries. "We want to keep people healthy, prevent illnesses and

reduce health disparities, and these special Medicare drug cards are another step in achieving that goal," said Dr. McClellan.

Low income AI/AN Medicare beneficiaries may also qualify for the \$600 credit for this year and another \$600 for next year. The \$600 credit is available to AI/AN Medicare beneficiaries who do not have other prescription drug coverage, and whose annual income is below 135 percent of the federal poverty limit, which in 2004 is no more than

\$12,569 for individuals and \$16,862 for married couples (in Alaska, no more than \$15,701 for individuals and \$21,074 for married couples). Individuals who qualify for the credit will not have to pay the annual enrollment fee for the discount card. The \$600 credit can be used with any Medicare approved drug discount card and with any pharmacy in that card's network including the Indian health program pharmacies.



"These special drug discount cards will not only reduce the cost of drugs for many American Indians and Alaska Natives," stated IHS Director Dr. Charles W. Grim, "but will also enable Indian health program pharmacies to bill against the \$600 credit for drugs dispensed to beneficiaries, providing a valuable source of third-party collections to the Indian health system. These funds can then be used to provide more health care services to American Indian and Alaska Native people." Deadline is December 31, 2004. ■

Further information on the drug cards can be found at www.criterionadvantage.com and www.pcacard.com. General information on the Medicare program can be found at www.medicare.gov.

Something to do this winter

Upcoming National Events

- **January 18-20, 2005**
Native Diabetes Prevention Conference, Phoenix, AZ
405.325.1316
- **February 25, 2005**
End of Life Care Institute, Oklahoma City, OK
Contact Sheryl Mapes at 405.271.8599 for more information.
- **February 27 - March 3, 2005**
Indian Health Service Combined Councils Meeting, San Diego, CA
Contact Dora Bradley or Gigi Holmes at 602.364.7777 or
Email to gigi.holmes@mail.ihs.gov
- **March 10-13, 2005**
ASA / NCOA Joint Conference, Philadelphia, PA
Call 800.537.9728 for more information.
- **March 23-25, 2005**
Oklahoma Task Force on Minority Aging Conference, Tulsa, OK
Contact Ken Recoy at kenrecoy@eodd.org for more information.
- **April 24-27, 2005**
"Protecting Our Children", Albuquerque, NM
Contact Kim Just at 505.222.4044 x113 for more information or email justkim@nicwa.org ■



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