



Elder Voices

Newsletter of the National Indian Council on Aging, Inc.

Winter, 1997

Title VI increases probable

Older Americans Act Update

As Congress adjourned on November 11 for a Veteran's Day recess, a last-minute compromise between Senate and House leaders resulted in a \$2.4 million increase for Title VI (Native American programs). Serving 229 reservation senior programs, Title VI is known as the cornerstone of Older Americans Act programs serving Indian Country. The funding increase represents a 14.9% increase from the current funding level of \$16.1 million.

The increase represents a split between a proposed House mark (no increase) and the Senate's recommendation of a \$20.1 million increase. The budget now awaits the President's signature.

"We had high hopes that the Senate numbers would prevail," said NICOA executive director Dave Baldridge, "because we believed the Senate leadership strongly supported the larger increase. Still, it's a larger increase than we've seen in recent years."

In 1995, the current appropriations level (\$16.1 million) was established. At that time, the 10% reduction from previous funding levels was the first decrease the title had undergone since it was established in 1980.

OAA Funding Levels

Appropriations for other Older Americans Act programs serving Indians are faring relatively well. Title V, the Senior Community Service Employment Program (SCSEP), will be funded at its current level, \$440 million. NICOA, one of ten national SCSEP sponsors, operates nearly 800 employment training positions for elders in a dozen states.

Title IV, which historically has provided funding for training Title VI directors, NICOA's activities, and two Native American Resource Centers will be increased from \$4 million to \$10 million. The increase is especially welcome since Congress reduced the title's \$26 million to \$4 million last year.

FY98 OLDER AMERICANS ACT FUNDING PROPOSED BY CONGRESS (in millions)

	<u>Current Levels</u>	<u>New Levels</u>	<u>Increase</u>
Title III Grants to States	\$795.4	\$821.8	\$26.4
Title IV (Discretionary grants)	4.0	10.0	6.0
Title V (Employment training)	440.0	440.0	-0-
Title VI (Native Americans)	16.1	18.5	2.4

**The National Indian
Council On Aging, Inc.**

10501 Montgomery Blvd., NE, Ste. 210
Albuquerque, N.M. 87111
505/292-2001
FAX 505/292-1922
e-mail: nicoa@swcp.com

**NICOA
Board of Directors**

Pat Woods (Muskogee Area)
(Chair) 405/332-8624

Tammy Sixkiller (Phoenix Area)
(Vice Chair) 602/846-7991

Iva Brant (Central Area)
(Secretary) 716/532-9459

Frank Chee Willetto (Navajo Area)
(Treasurer) 505/655-3221

Sydney Bird (National Title VI)
402/878-2487

William Burke (Portland Area)
541/966-9830

Jean Campbell (Billings Area)
402/878-2929

**Helen Cummings (Minneapolis
Area)** 218/35-6500

Georgia Gallegos (Anadarko Area)
405/247-2448

Janet Guthrie (Juneau Area)
907/886-7191

**Lorenzo Jojola (Albuquerque
Area)** 505/869-4236

Gloria LeftHand (Aberdeen Area)
701/766-1244

Vacant (Sacramento Area)

August 23,24,25

'98 Conference set for Bismarck

NICOA's 1998 national conference on Indian aging is scheduled for August 23-25 (Sunday through Tuesday) in Bismarck, North Dakota. According to Patricia Woods, NICOA's board chair, the '98 event is scheduled for three days instead of two so that conferees can enjoy the host city. "In past years," she said, "NICOA's conferences have included two full days and evenings of meetings and events. In order for our elders to go sightseeing or shopping, they had to miss some conference sessions. This year, with an extra conference day, our schedule will be a lot more relaxed. We hope our elders won't get so tired, and that conferees will have good opportunities to enjoy Bismarck and the surrounding area."

Woods indicated that special events will include a pow wow, traditional fashion show, and buffalo feed, as well as an evening election of new board members. "As usual," she said, "NICOA will provide buses between hotels and conference events." Since 1992, NICOA's aging conferences have steadily grown. That year, 1,550 attended the event in Green Bay, Wisconsin. In 1994, 1,650--including more than 1,000 elders from 130 tribes--attended NICOA's conference in Spokane, Wash. In 1996, 1,850 attendees came to Albuquerque, New Mexico, for the largest Indian aging conference in history.

"We expect another attendance record in Bismarck," Woods said. "A local planning committee has been working hard to create an exciting, productive event."



"I think we finally got a handle on it!!"

F a c t S h e e t

National Indian Council on Aging Managed Care: "A Voice for Minority Elderly"

- WHO** Led by the National Hispanic Council on Aging, a team of four minority aging organizations is conducting a three-year project for the Kellogg Foundation. NICOA will conduct the Indian portion.
- WHAT** The project is designed to inform minority elders about Managed Care options and to give them a grassroots voice in determining their managed care future.
- WHERE** In its first year, NICOA will conduct the project with demonstration sites in New Mexico, Denver, Colo., and Washington, D.C.
- WHEN** This project began in March, 1997 and will conclude in March, 2000.
- WHY** 1) The fragmentation of the Indian health care (I/T/U) delivery system; 2) tribes are contracting and compacting to become health care providers; 3) the implementation of managed care is now a state responsibility, not a federal one; 4) The I/T/U system is or has been negotiating its managed care role in more than 30 states. Both Indian providers and consumers (elders) are frequently confused about their fast-changing options.
- HOW** Year 1 activities include partnerships with New Mexico Indian organizations to create a series of state-wide dialogues involving elders, service providers, and tribal leaders. NICOA is also creating partnerships with the Denver-based National Indian Health Board and with the IHS to create a structured national examination of managed care and its effects on Indian Country.

F a c t S h e e t

National Indian Council on Aging Indian Health Data Bureau

- WHO** The *Indian Health Data Bureau* is funded by grants from the Administration on Aging, the Administration for Native Americans, and the Indian Health Service.
- WHAT** The *Indian Health Data Bureau* is being created by NICOA to acquire and supply health information about Indians to all three parts of the Indian health care (I/T/U) delivery system: the IHS, compacting and contracting tribes, and urban Indian health clinics.
- WHERE** The *Indian Health Data Bureau* is located in Albuquerque, New Mexico at NICOA headquarters.
- WHEN** The Bureau was established in Spring, 1997. Its final year of scheduled federal funding is 2002.
- WHY** 1. The Indian Health Care Delivery (I/T/U) system is fragmenting;
2. Tribes, urban clinics, and IHS Service Units lack critical information as they negotiate Medicaid Managed Care and other health care issues with states;
3. Because of our small population, Indian client data is not being provided to the I/T/U system by the federal government;
4. In the new health care environment, data means money. The I/T/U system must have accurate data to succeed;
5. Elders' health needs are best met by helping assure the continuation of the I/T/U system that serves them.
- HOW** NICOA will access Health Care Financing Administration (HCFA) Medicare and Medicaid data for Indians, the IHS "RPMS" patient database, the U.S. Census, Housing and Urban Development (HUD) data, and other sources. Data will be compiled, analyzed, and provided upon request to meet the needs of Indian health care providers.

“Assessing Geriatric Resources”

**A 1997 Report to the Indian Health Service
by the
National Indian Council on Aging**

This report describes the results of a two-page questionnaire to survey geriatric resources, both services and staff, at 684 Indian health care providers. These providers included 219 tribal health directors, 257 tribal leaders of P.L. 93-638 contracting tribes, 43 tribal leaders of P.L. 93-638 compacting tribes, 125 IHS service unit directors, and 40 urban Indian health clinic directors.

The initial questionnaire was sent out on November 12, 1996, with a cover letter from NICOA (attached), along with a self-addressed-stamped envelope. The mailing requested responses by December 7, 1996. This sweep generated 124 responses, an 18% rate.

The second sweep, posted on December 15, 1996, targeted the 560 providers who did not respond to the first mailing. Accompanied by a letter from NICOA (enclosed), this mailing was followed up by telephone calls on December 19-20 to request participation in the survey. From this effort, an additional 114 completed questionnaires were returned by the January 6, 1997, deadline.

The final sweep was sent out on February 1, 1997, with a February 31 deadline. This mailing was accompanied by a flyer, generating a total of 31 completed and returned questionnaires.

In total 269 questionnaires (39.3% of total sample) were completed and returned. This report presents the results from this survey.

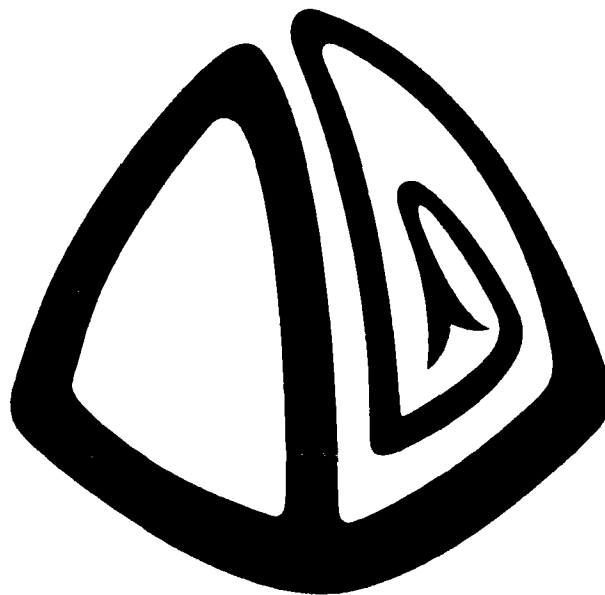
Introduction

The Indian Health Service Elder Health Care Initiative (IHS/EHCI), in collaboration with the National Indian Council on Aging (NICOA), identified the need to survey every available geriatric and gerontological resource within the entire IHS/Tribal/Urban health care delivery system in the nation.

The survey tool was developed in collaboration by IHS/EHCI and NICOA and contained two sections which covered both human and programmatic resources. Part A asked about medical/support staff with degrees, certificates, or other evidence of training or expertise in geriatrics or gerontology. Part B sought to identify programs which address the needs of elders. Part A contained 25 questions with multiple choice and open-ended response formats. Part B contained 33 questions. In addition to these two sections, an additional question was asked to identify how each provider defines an elder within their program on the basis of age.

The mailing list was provided by IHS. It included 219 tribal health directors, 257 tribal leaders of P.L. 93-638 contracting tribes, 43 tribal leaders of P.L. 93-638 compacting tribes, 125 IHS service unit directors, and 40 urban Indian health clinic directors. In total there were 684 providers in the list which was up-to-date as of October 1996.

The analyses performed for this report were based on 269 total returns, which comprised a 39.3% return rate from the original sample list of 684 Indian health care providers.



Personnel/Staff in Geriatrics or Gerontology

Most providers under the I/T/U service reported some of their staff having geriatric or gerontological speciality training. Overall, the following reported specialists were identified by job title (more detailed tables, specifying number and Area Office are provided in Appendix 1).

Table 2: Number of providers with reported geriatrics/gerontology training by job title

Job Title	Number with Specialization
Administrators	47
Community Health Medics (CHMs)	15
Community Health Reps. (CHRs)	205
Dentists	55
Gerontologists	4
Home Assistance Aides	60
Nurses	
- Certified Nursing Assistants (CNAs)	190
- Certified Practical Nurses (CPNs)	58
- Registered Nurses (RNs)	139
- Public Health Nurses (PHNs)	65
- Nurse Practitioners (NPs)	39
Nutritionists/Dieticians	37
Occupational Therapists	3
Pharmacists	36
Pharmacy Practitioners	7
Physical Therapists	10
Physician Assistants (PA)	24
Physicians	99
Podiatrists	9
Psychiatrists	12
Psychologists	16
Rehabilitation Therapists	4
Social Workers	92

Most of the returned surveys did not specify the type of degree or certificate. With a few individual exceptions, the majority did not report the degree or simply reported the generic degree and not the speciality (eg. RN).

The majority of providers tended to choose 55+ as the age definition of an elder within their program. Nevertheless there are exceptions as 17% chose 60+ as the definition of elder. There were no variances among Area Offices in their definition of an elder.

Programs for elders

Most providers offered some programs for elderly clients. No provider reported a total absence of services for the elderly. The most common program reported by providers was "transportation to the clinic." Considering that Indian elders, more than the general population, reside in rural areas, transportation to health services emerges as a significant factor. The second most frequent program reported was "Health Education/Promotion" with more than 40% of the providers reporting that "most" elders benefited from this program.

The following table summarizes the results by program. A more detailed analyses by Service units can be gained from Appendix 1.

Table 3: Number of Providers reporting operating elderly programs by the level of benefit to the elders.

Program	Providers operating program	% of Providers report main benefit
Abuse Protection Services	119	57% few benefit
Adult Day Care	24	79% none benefit
Assessment Clinic	76	45% most benefit
Assisted Living Program	54	63% few benefit
Companion Services	53	64% few benefit
Congregate Meals	195	43% most benefit
Chore Services	95	62% few benefit
Exercise Classes	89	64% few benefit
Nutrition Education	193	61% few benefit
Health Education/Promotion	208	43% most benefit
Hearing Care/Screening	150	43% most benefit
Home Health Agency/Care	130	59% few benefit
Home Delivered Meals.....	182	46% few benefit
Home Repair Services	91	65% few benefit
Home/Respite Care.....	47	70% few benefit
Homemaker Services	89	70% few benefit
Hospital	138	46% most benefit
Mobile Diabetes Checks	88	42% few benefit
Mobile Heart Checks	29	38% few benefit
Mobile Mammogram	79	43% few benefit
Nursing Homes	68	
- on reservation.....	29	45% few benefit
- tribally operated	21	52% few benefit
- off reservation	130	58% few benefit
Podiatric Services	111	43% few benefit
Senior Citizen Center	157	46% most benefit
Social Services Counseling		
- Medicare	186	38% most benefit
- Medicaid	184	42% most benefit
- SSI	174	42% few benefit
Transportation to Clinic	232	41% most benefit
Visual Care	187	48% most benefit

Every provider surveyed identified at least one program reported to be beneficial to all elderly. However, in contrast with "all" elders benefit, and "none" benefit, most of the responses fell within the middle ranges of "few" and "most" elderly benefit.

Programs in order of frequency:

1. Transportation to Clinic	232	17. Chore Services	95
2. Health Education/Promotion	208	18. Home Repair Services.....	91
3. Congregate Meals	195	19. Homemaker Services	89
4. Nutrition Education	193	20. Exercise Classes	89
5. Visual Care	187	21. Mobile Diabetes Checks	88
6. Social Services Counselling - Medicare	186	22. Mobile Mammogram	79
7. Social Services Counselling - Medicaid	184	23. Assessment Clinic	76
8. Home Delivered Meals	182	24. Nursing Homes	68
9. Social Services Counselling - SSI	174	25. Assisted Living Program.....	54
10. Senior Citizen Center	157	26. Companion Services	53
11. Hearing Care/Screening	150	27. Home/Respite Care	47
12. Hospital	138	28. Nursing Homes - on reservation	29
13. Nursing Homes - off reservation	130	29. Mobile Heart Checks	29
14. Home Health Agency/Care	130	30. Adult Day Care	24
15. Abuse Protection Services	119	31. Nursing Homes - tribally operated	21
16. Podiatric Services	111		

Conclusion

Although there seems to be a growing awareness of geriatrics/gerontology throughout the Indian health care delivery system, there is some evidence that this awareness stops short of knowledge. The fact that most respondents did not complete the degree or certificate information applicable to their staff indicates some ignorance of these certificates or degrees. Continuing education for these providers might include descriptions of the different types of degrees/certificates/qualifications that can be awarded with a specialization in geriatrics and gerontology. This survey identified at least 32 different acronyms of qualifications.

Furthermore, the fact that all providers provide some elderly programs indicates that there elder services are being administered to American Indian and Alaska Native elders to a larger extent than was previously known. This implies that elder care initiatives, services or programs directed to the national constituency of Indian elders should have a broad exposure at the local level. The response rate of just under 40% also implies that there should be more elder services and geriatrically-trained individuals out in the field which have yet to be counted.