

Evidence-Based Health Promotion Programs Among American Indian, Alaska Native, and Native Hawaiian Communities



A Call to Action to Improve Cultural Relevance and Accessibility

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Foreword from the Administration for Community Living

Evidence-Based Health Promotion Programs Among American Indian, Alaska Native, and Native Hawaiian Communities: A Call to Action to Improve Cultural Relevance and Accessibility provides important information about evidence-based health promotion and disease prevention programs in American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) communities.

This report highlights the:

- Unique disparities in health care access that AI/AN/NH communities face;
- Diversity of services supported by the Older American Act in AI/AN/NH communities, such as nutrition, transportation, caregiver programs, information and referral, and health promotion;
- Current evidence-base for, availability, and acceptability of health promotion programs in AI/AN/NH communities;
- Experience of program administrators in AI/AN/NH communities, and perspectives from elders about what aging well means to them and the extent to which they are aware of and/or have been involved with health promotion and disease prevention programs;
- Results from a survey of Older Americans Act Title VI Directors and Staff, providing information about their experience with health promotion and disease prevention programs, the unique challenges they face in serving their communities, and what resources they think might help; and
- Potential next steps to advance the health and well-being of AI/AN/NH elders.

Through the aging network, ACL funds programs that support nutrition, supportive services, and caregiver services in AI/AN/NH communities, such as congregate and home delivered meals, information and referral, transportation, person care, chore services, and health promotion programs. These services help ensure that AI/AN/NH elders can live independently in the communities of their choice for as long as possible. ACL is committed to exploring ways to enhance our support for the development, implementation, and evaluation of culturally-relevant health promotion programs for—and by—AI/AN/NH communities. The Call to Action in this report identifies many areas of opportunity and creative ways ACL and the aging network can support this work. We would like to thank all the organizations, professionals, and AI/AN/NH community members and elders that lent their time, expertise, and experience to this important effort. We are committed to using these recommendations as we, collectively, chart a path forward.

Executive Summary

American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) communities are less likely than other U.S. groups to have access to public health resources that support individuals and communities in building the skills to manage overall health, including chronic conditions, nutrition, physical activity, self-advocacy, and preventing falls. The lack of access to resources in indigenous communities is especially critical due to both a high prevalence and severity of chronic conditions including diabetes, cancer, heart disease, and unintentional injuries, among others. One strategy to addressing high rates of chronic conditions and unintentional injuries, particularly among Elders, includes implementation of evidence-based health promotion programs. While evidence-based health promotion programs have been implemented for Elders in several AI/AN/NH communities, adoption has not always been successful or sustained due to a variety of challenges.

To better understand the barriers and challenges associated with evidence-based health promotion programs for AI/AN/NH communities, the Administration for Community Living (ACL) funded the National Council on Aging's (NCOA) National Chronic Disease Self-Management Education Resource Center and National Falls Prevention Resource Center to explore the cultural relevance, access, and equity of evidence-based programs (EBP), as well as opportunities for improvement and successful practices. This process called for several steps, including: 1) establishing an advisory council; 2) evaluating the literature already available on this topic; 3) conducting listening sessions with program providers and program participants; 4) conducting a survey of Older Americans Act Title VI staff who administer grants for services for AI/AN/NH Elders; and; 5) identifying action steps and solutions for improving the cultural relevance of EBPs serving AI/AN/NH communities across the United States.

Final Report and Action Plan

Purpose. The purpose of this report is to summarize lessons learned from the literature on how to implement culturally appropriate community-based health promotion programs; share the results of listening sessions conducted with both organizational program coordinators and AI/AN/NH Elders; share the results of a national survey of Older Americans Act Title VI program staff about the use of EBPs; and recommend action steps to collectively work towards solutions for more inclusive programming for AI/AN/NH Elders.

Audience. This report is intended to educate and raise awareness among an array of stakeholders from the public and private sectors with an interest in public health and aging and the capacity to implement action steps outlined in the action plan. Interested audiences may include AI/AN/NH communities; professionals in the fields of health care and aging, such as evidence-based program developers; federal, state, and local agencies; professional associations; consumer and caregiver organizations; and foundations.

Action Steps. This report includes specific action steps intended to be a framework for action to advance the accessibility and effectiveness of EBPs in AI/AN/NH communities. Each of these action items will require collective action from federal agencies, national partners, evidence-based program developers and administrators, local organizations, and ultimately community Elders. See the "Call to Action" section on page 23 for detailed action steps.

There Are Several Steps Toward Solution

Short-Term Actions

- Identify appropriate measures of success as defined by AI/AN/NH communities
- Support expansion of program adaptations that are already developed, like Wisdom Warriors
- Market programs using culturally appropriate names
- Develop guidance to modify content to be culturally relevant
- Increase the number of AI/AN/NH program leaders to ensure programs are led by trusted community members

Mid-Term Actions

- Identify programs developed by AI/AN/NH communities
- Explore collaborations with AI/AN/NH research centers
- Develop guidance on steps needed to meet current evidence-based criteria for programs developed by AI/AN/NH communities

- Identify areas where programs developed by AI/AN/NH communities are most needed
- Identify funding sources to support implementation of programs developed by AI/AN/NH communities
- Build “start-up” phase into funding opportunities where programs are new to the community

Long-Term Actions

- Research process to amend the criteria outlined in the Older American’s Act Title III-D funding and discretionary grant funding
- Determine preferred criteria
- Identify the unique needs and rights of AI/AN/NH communities to develop and implement culturally appropriate programs
- Identify funding for demonstration projects that blend evidence-based programs and culturally appropriate models

Health Disparities and Access to Care

In order to understand the barriers present in effectively using Older Americans Act funding toward evidence-based health promotion and disease prevention programs in AI/AN/NH communities, existing health disparities and lack of access to high quality health care services must be recognized.

According to the U.S. Department of Health and Human Services, approximately 10,000 individuals turn 65 each day (Digital Communications Division (DCD), 2015). Among the general population, 1.7% self-identified as American Indian or Alaska Native (AI/AN) on the 2010 U.S. Census. Nationally, AI/AN communities are younger than the general population, with a median age of 26 (compared to

37 for the general population) and life expectancies that are about 5.5 years shorter than the general U.S. population (73 years compared to 78.5). (*Disparities | Fact Sheets*, 2013).

Until recently, Native Hawaiians, the Indigenous peoples of Hawai’i, were frequently not counted separately but under a category that combined the population of “Native Hawaiians” with other “Pacific Islanders” (NHOPI). In the 2010 census, 1.2 million individuals self-identified as NHOPI, with 540,103 identifying primarily as Native Hawaiian only (Browne et al., 2014). The demographic data reports approximately 36,000 Native Hawaiians over age 60, two-thirds of whom lived in Hawai’i (Browne et al., 2014; Mokuau et al., 2016; *Papa Ola Lōkahi*, 2019). Like

AI/ANs, Native Hawaiians have a shorter life expectancy, typically 10 years less than Chinese and Japanese populations in Hawai'i (Mokuau et al., 2016).

Contributors to the shortened life expectancy for AI/AN/NH communities include a number of social determinants including less access to quality health care and educational opportunities, poor socioeconomic conditions, discrimination, and a series of persistent health disparities. Chronic conditions including heart disease, cancer, diabetes, and alcohol-related health consequences are among the leading causes of morbidity and mortality among AI/AN populations, along with unintentional injuries (*Disparities | Fact Sheets*, 2013). The leading causes of death for Native Hawaiians include cardiovascular disease, cancer, and diabetes.

Disparities in Health Care Services for American Indian and Alaska Native Communities

Historically, access to health care for most AI/ANs has been and continues to be piecemeal, primarily because the federal allocation for indigenous health care is discretionary, not an entitlement. The long history of discretionary funding has never met the needs of the AI/AN populations. Federal health care services for AI/AN communities are rooted in federal treaties that several tribes negotiated in exchange for ceding vast acres of land. In return, the negotiation promised tribes certain services, including education and health care. The first federal agency charged with the responsibility of health care was placed with the U.S. Department of War, an agency without expertise in health care provision. When the Department of Interior was established by Congress, health care services for AI/ANs was transferred to the Interior's Bureau of Indian Affairs (BIA). By the mid-1950s, during the height of Congressional action to remove Indians from federal trusteeship and enacted termination legislation, it also took action to transfer the Indian health program from the Department of Interior's

BIA to the federal Public Health Services. Today, the federal Indian Health Service (IHS) is housed in the Department of Health and Human Services. (Warne & Frizzell, 2014)

Although chronically underfunded since its inception (Warne & Frizzell, 2014), the IHS is the primary health care delivery system for many AI/AN individuals, especially those residing on tribal reservation lands or in Alaska Native villages. The IHS health care systems include several small hospitals, primary health clinics or health stations, and other basic health resources such as behavioral health, public health, dental, sanitation, and a growing number of community wellness programs. While the presence of IHS health resources are predominately on tribal lands, they also provide some financial support to 34 urban Indian health programs located in several major U.S. cities. The Indian Health Care Improvement Act, enacted in 1976, allowed IHS to expand access to services through Medicare, Medicaid, and Children's Health Insurance Program reimbursements (Warne & Frizzell, 2014).

Disparities in Health Care Services for Native Hawaiian Communities

The Native Hawaiian Health Care Improvement Act of 1988, with several subsequent amendments, is a centerpiece of the current health care system serving many Native Hawaiians in Hawai'i (*Native Hawaiian Health Centers*, 2017). The goal of the 1988 Act (similar to the goal expressed by IHS for AI/ANs) is to raise the health status of Native Hawaiians living in Hawai'i. The passage of this legislation did not change the overall structure of Hawai'i's existing health care delivery system, but it established Papa Ola Lōkahi, a nonprofit Native Hawaiian health organization and the Native Hawaiian Health Systems, that consists of primary health care facilities located on five of the eight islands with Native Hawaiian populations. The health care service is not free; Native Hawaiians pay for their health care via multiple sources, including private health insurance, Medicare, and Medicaid.

The Older Americans Act and Evidence-Based Health Promotion Programs

The Administration for Community Living (ACL), an agency in the U.S. Department of Health and Human Services, supports services for older adults and adults with disabilities with the goal of helping individuals live independently. A variety of home and community-based services for older Americans are funded by the Older Americans Act. Services specifically for Native American Elders are covered under the Older Americans Act, Titles III and VI. The latter Act was amended in 1978 to include Native Americans (defined as AI/AN/NH elders). Currently, approximately 1.2 percent of the participants in Title III programs are Native Americans (*Meeting The Needs Of Aging Native Americans | Health Affairs*, n.d.). Federal support from these two legislative actions help participating communities provide nutrition and other community-based support services for AI/AN/NH Elders.

The level of funding received from federal and other sources to support programs serving Elders is formula based and depends on the scope of needs as well as the size of the population to be served. Typically, larger communities with more resources can offer more robust services for older adults, including free-standing facilities like senior centers, while smaller communities often have limited resources. Many tribal communities in rural regions, for example, have smaller programs and are likely to offer fewer options. The same can also be said for AI/AN/NH Elders living in urban communities, who are unable to access existing resources due to transportation barriers as well as reluctance to access programs because the offerings are not always considered culturally appropriate.

Some of the supportive services funded by ACL include nutritional programs (congregate and home-delivered meals), transportation (for medical appointments), caregiver

support, information and referral, and more. In addition, Title III-D of the Older Americans Act supports health promotion and disease prevention programs. Historically, limited support has been available for health promotion and disease prevention programs in tribal communities. Key areas of focus for health promotion and disease prevention programs include chronic disease self-management education, falls prevention, physical activity, behavioral health, and caregiving, among other topics. Since 2003, ACL has encouraged the aging services network to move towards wider implementation of disease prevention and health promotion programs that are based on scientific evidence and demonstrated to improve the health of older adults. The FY 2012 Congressional appropriations law included, for the first time, an evidence-based requirement related to Title III-D funds. In response to the new requirement, ACL defined EBPs as (*Health Promotion | ACL Administration for Community Living*, n.d.):

- Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability and/or injury among older adults; *and*
- Proven effective with older adult population, using Experimental or Quasi-Experimental Design; *and*
- Research results published in a peer-review journal; *and*
- Fully translated in one or more community site(s); *and*
- Includes developed dissemination products that are available to the public.

The listening sessions and survey of Older American's Act Title VI staff conducted for this initiative, identified cultural appropriateness, limited resources, and other factors as barriers to successful integration of evidence-based health promotion and disease prevention programs in AI/AN/NH communities.

Are Evidence-Based Programs “A Good Fit” for American Indian, Alaska Native, and Native Hawaiian Communities?

The motivation for a steady move toward evidence-based programs (EBPs) is a combination of funding only “what works,” which has been defined as programs that are effective based on peer-reviewed research, and more accountability toward ensuring programs lead to health improvements for community participants. This process has been implemented through both state and federal policies. EBPs, when implemented with fidelity to the curriculum, work effectively for participants whose characteristics match those of the EBP research participants. However, these programs have been almost exclusively developed and evaluated for the general U.S. population and with very limited AI/AN/NH community engagement. Consequently, the applicability and translation of EBPs are unproven in AI/AN/NH communities and are often viewed with distrust by community members (Gone & Alcántara, 2007; Larios et al., 2011; Wexler, 2011). Overall, AI/AN/NH communities prefer EBPs that have been developed with or adapted specifically for their communities (Fu et al., 2014; Hirchak et al., 2018; Larios et al., 2011; Mokuau, 2011). But, practices and programs developed and used by AI/AN/NH communities may not meet various definitions of “evidence-based” based on the principles of Western medicine. These concerns have been discussed in the behavioral health field and less so in the health promotion field (Walker & Bigelow, n.d.).

EBPs have roots in evidence-based medicine. Evidence-based medicine requires the consideration of the (1) best research evidence, (2) clinical expertise, and (3) the patient’s unique values and circumstances (Sackett et al., 2000). It appears that in the uptake of EBPs in public health, however, the emphasis has been almost exclusively on the use of the best research evidence. Consequently, the public health literature, overall, has given minimal attention on how to best weigh all three. Here, we suggest that consideration of the targeted participants’ and their communities’ values require greater consideration in the adoption of EBPs in field of aging and public health.

Fortunately, considerable published literature provides important guidance with respect to best and promising practices when delivering programs and interventions in AI/AN/NH communities aimed at improving mental and/or physical health. The most common recommendation is the acknowledgement and incorporation of culture, Indigenous ways of knowing, and existing community strengths (Dickerson et al., 2020; R. D. Walker & Bigelow, 2011; S. C. Walker et al., 2015). In order to do this responsibly, a community-based or tribal participatory research approach is needed (Browne et al., 2017; Dickerson et al., 2020). Walker and Bigelow (2011; 2015) discuss the concepts of evidence-informed culture-based interventions and tribal best practices. These concepts involve respecting and accommodating culture-based knowledge and ways of knowing and practice in these communities, while also supporting the uptake of Western science-based knowledge.

Programs and interventions can originate from the community or they can be developed elsewhere and adapted for a specific community. Strategies for adapting existing EBPs for AI/AN/NH communities fall on a continuum from non-adapted or superficial to culturally grounded or cultural centeredness (Dickerson et al., 2020; Okamoto et al., 2014), but little work has been conducted to evaluate the effectiveness of this range of adaptations. As a result, there has been a recent call to increase the focus on this adaptation research (Alvidrez et al., 2019).

Moving forward, it has been suggested that there is a need to create an American Indian-specific inventory of EBPs, as well as partnerships with funding agencies to develop population-specific EBPs (Warne & Nadeau, 2017).

Despite the concerns with respect to EBPs and AI/AN/NH populations, the purpose of our effort was to review the (1) published literature that discussed experiences in implementing EBPs in AI/AN/NH populations and the (2) published literature that reported on the outcomes with EBPs with AI/AN/NH participants. A scoping review

methodology was employed to identify relevant publications. This design was best suited to address the broad aims of the study and because this design can incorporate a broad range of qualitative and quantitative studies (Colquhoun et al., 2014; Peters et al., 2015). Searches were conducted primarily in late August 2019 and only results emanating from academic and professional journals, conference proceedings, dissertations, government documents, and a limited number of books published within the most recent decade (2009 to 2019) were considered. As the author's primary reading language is English, results were also limited to those published in the English language. (Colquhoun et al., 2014). See the detailed methodology in Appendix A.

Through this search process, a table of 34 publications was compiled to identify information included in our review. The articles covered the following areas: Cancer, caregiving, diabetes, cardiovascular disease, chronic disease (in general), falls, functional fitness, nutrition, substance use/misuse, and elder abuse. Sixteen of these publications concerned diabetes. EBPs included in the literature included, Resources for Enhancing Alzheimer's Caregiver Health (REACH), polarity therapy, Diabetes Prevention Program, Chronic Disease Self-Management Program (CDSMP), So Much Improvement with a Little Exercise (SMILE), the Centers for Disease Control and Prevention's Stay Independent Checklist, Peer Recovery Support, and Family Care Conference. See Appendix B for the table of publications.

Findings from A Literature Review on Evidence-Based Programs and Indigenous Communities

In order for health promotion programs to have an impact on AI/AN/NH populations, programs must either be developed specifically for AI/AN/NH communities or the modifications applied must be culturally relevant with community traditions. Most of the reviewed literature (n=27) evaluated implementation of existing EBPs, with fewer evaluating programs that were developed specifically for AI/AN/NH populations (n=7). Of the publications that reported on efforts implementing existing EBPs, most were adapted. Overall, the reviewed research suggested that AI/AN/NH

populations benefited from program participation. However, it is difficult to determine based on the published literature if adapted EBPs are more effective than non-adapted EBPs for AI/AN/NHs. Also, it is difficult to determine if programs developed specifically for AI/AN/NH populations are more effective than adapted or non-adapted EBPs.

Making cultural modifications to a health promotion program may gain community trust, involvement, and support for the intervention (Jernigan, 2010; Jiang et al., 2015; Kelley et al., 2015; Manson et al., 2011; Martindale-Adams et al., 2017; Popp, 2017). We reviewed the literature on this topic to observe the types of health promotion interventions utilized, methods of recruitment and retention, and types of cultural adaptations used.

Implementation Site. As different programs were implemented in AI/AN/NH communities, researchers took into consideration where the intervention was hosted. For AI/AN groups, workshops were held at reservation communities and facilities including hospitals, clinics, health and senior centers for AI/AN (Jernigan, 2010; Jiang et al., 2015; Kelley et al., 2015; Manson et al., 2011; Martindale Adams et al., 2017; Popp, 2017). Programs for Native Hawaiians were more likely to take place in their homes, senior centers, faith-based organizations, or community-based organizations (Ka'opua et al., 2011; Mau et al., 2010; Mokuau et al., 2012; Tomioka et al., 2012). Health promotion programs implemented at sites that AI/AN/NH participants are familiar with is essential in making them feel comfortable and welcomed, thus increasing the likelihood of community support and participation (Mendenhall et al., 2012).

Recruitment and Retention. Recruitment and retention strategies were essential to the intervention's success. Health interventions focusing on AI/AN communities recruited participants through flyers, word of mouth, and social and cultural gatherings such as health fairs and powwows (Jernigan, 2010; Manson et al., 2011). While recruitment for NH participants also relied on flyers, word of mouth and health events, researchers leaned on networking strategies such as local faith and community-based organizations (Kaholokula et al., 2017; Mau et al., 2010). NH participants were also recruited through digital and print media and aging resource centers (Tomioka et al., 2012, 2019). Recruitment strategies for AI/AN/NH groups

were dependent on community organizations as they have developed a trusting relationship with Elders.

Types of Cultural Adaptations. Specific cultural adaptations incorporated into interventions among AI/AN groups included the use of talking circles as a way for all participants to engage in discussion, as well as creating educational materials in Indigenous languages (Martindale-Adams et al., 2017; Mendenhall et al., 2012). In addition, AI/AN groups were more comfortable when the class trainer was Indigenous and incorporated cultural traditions into the class setting, such as allowing time to socialize and eat before class began and extending the length of the class to accommodate storytelling and narrative discussions (Jernigan, 2010). Other modifications for AI/AN groups were starting and ending class with a blessing, passing trading sticks to designate speakers in a group for Navajo participants, and having flexibility to start class late if a participant emergency arose (Korda et al., 2013).

Native Hawaiian and other Pacific Islander groups had similar cultural adaptations, for instance creating linguistically relevant material and session titles so participants understood the goals of the program (Mau et al., 2010). Other modifications included using images of NH characters on educational materials, disseminating educational materials in a lauhala (a plant fiber) bag, using pule (prayer) at the start of all sessions, utilizing kūkākūkā (talk story) during discussion to exchange information, incorporating ethnic music in class and sharing mea'ai (food) as an entity to fuel the spirit among participants (Mokuau et al., 2012; Tomioka et al., 2012, 2019).

Program Adaptations Identified in the Literature for American Indian Participants:

- Use talking circles for participant engagement
- Create educational materials in Indigenous languages
- Train Indigenous program leaders
- Incorporate cultural traditions into the class setting (e.g. allowing time to socialize and eat before class begins; extending the length of the class to accommodate storytelling and narrative discussions)

- Begin and end class with a blessing
- Pass trading sticks to designate speakers in a group (specific to Navajo participants)
- Have flexibility to start class late to accommodate participant emergencies

Program Adaptations Identified in the Literature for Native Hawaiian and other Pacific Islander Participants:

- Create linguistically relevant material and session titles
- Use images of Native Hawaiian characters on educational materials
- Disseminate educational materials in a lauhala (a plant fiber) bag
- Use pule (prayer) at the start of all sessions
- Utilize kūkākūkā (talk story) during discussion to exchange information
- Incorporate ethnic music in class
- Share mea'ai (food) as an entity to fuel the spirit among participants

Programs adapted to be culturally relevant have higher retention rates than health promotion programs that do not adapt any cultural traditions. Jernigan (2010) observed a Chronic Disease Self-Management Program workshop where the leader was not Native American, who strictly followed the curriculum, and was not understanding to the participants' needs. The intervention lasted three weeks and had to be canceled due to lack of attendance. The tribal community viewed the leader as an outsider and felt the leader was not respectful to the participants with their rigid leadership style, resulting in the workshop failure (Jernigan, 2010). Jernigan (2010) discussed how the workshop was successful when it was offered again with modifications to fit the needs of the Native Americans. The intervention's impact was measured by the increased attendance at the local fitness center (Jernigan, 2010).

Findings and Discussion: Listening Sessions

As a component of our research efforts, 13 listening sessions were conducted to discuss perspectives on evidence-based health promotion programs with tribal elder program staff and Elders in partnership with local organizations. The listening sessions were strategically conducted in different regions of the country, including Hawai'i and Alaska using a standardized discussion guide (Appendix C and D). The guide included prompts asking about the successes and challenges of evidence-based health promotion programs. Notes taken during the listening sessions were shared for further qualitative analysis by two members of the advisory council. The findings and recommendations garnered from the listening sessions were documented and copies were shared with members of the advisory council for their review and suggestions.

Participants

Participants were identified by regions outlined by the Bureau of Indian Affairs map of Indian Lands of Federally Recognized Tribes of the United States (*Map of Indian Lands of Federally Recognized Tribes of the United States*, n.d.). Three listening sessions were held at national conferences, including the 2018 National Council on Aging Healthy Aging Conference and the 2018 National Indian Council on Aging on Aging in Indian Country where participants represented multiple regions including the Eastern, Great Plains, Midwest, Northwest, Pacific, Southern Plains, Southwest, Western. In addition, stand-alone listening sessions were held in Alaska, Hawai'i, and the Eastern, Pacific, and Western regions. One in-depth interview was conducted in Hawai'i.

TABLE 1 • Number of Participants by Region

	Region	Type of Participants	Number of Participants	Male	Female
1	Multi-Regional (Great Plains, Midwest, Northwest, Pacific, and Western)	Professionals	7	2	5
2	Multi-Regional (Midwest, Northwest, Southwest, Western, and other unspecified)	Professionals	14	5	9
3	Multi-Regional (Eastern, Great Plains, Midwest, Northwest, Pacific, Southern Plains, Western)	Elders	19	3	16
4	Pacific	Professionals	22	6	16
5	Alaska	Professionals	6	1	5
6	Alaska	Elders	5	3	2
7	Hawai'i	Elders	15	3	12
8	Hawai'i	Elders	1	0	1
9	Hawai'i	Professionals	9	3	6
10	Eastern	Elders	7	0	7
11	Western	Elders	13	6	7
			118	32	86

Fifty-eight or 49% of the 118 participants in the listening sessions held professional positions responsible for delivering EBPs and other programs for AI/AN/NH Elders in their communities. All but nine of the 118 participants indicated their tribal affiliation or Native Hawaiian heritage. Participants indicated affiliation with 51 different AI or AN tribes. Seventy-three percent of the participants identified as female and most of the participants were age 55 and over. While most Elders in the listening sessions identified as AI/AN, one session held in Hawai'i had participants from other Pacific Islands. Twenty-two participants (14 Elders and 8 professionals) had previously participated in an evidence-based health promotion program.

The Voices of Program Staff

Program Administration. Considerable discussions during listening sessions with program staff centered on administrative aspects of the programs, both successful programmatic initiatives as well as challenges at different phases including introduction, implementation, and sustainability. For small communities with limited resources and fragile infrastructures, several challenges were identified, i.e., 1) lack of space for group activities; 2) transportation barriers; 3) lack of ability to provide a healthy snack or other incentives for participants (due to either lack of funding or restrictions on funding); and 4) short-term funding, which may lead to insufficient time to hire and train staff, as well as recruit program participants. Furthermore, some health promotion intervention programs require data gathering, which can be a challenge for organizations that need approval for data collection from local Institutional Review Boards (IRB). IRB approval processes take time, potentially delaying implementation of the interventions.

Program staff shared that some evidence-based health promotion activities were not successfully adopted by participants. The ability of staff to hire the right (friendly and supportive) staff to coordinate these programs is seen as key to making the programs successful, fun, varied, and sometimes competitive. Most health promotion activities discussed were group-oriented (as opposed to individual-oriented). Program staff found value in personally recruiting participants as well as holding an orientation session to demonstrate planned activities.

Challenges included high staff turnover, short-term funding, restrictions on funding, and/or strict guidelines that accompanied some of the evidence-based interventions. Training new staff in programs also posed difficulties, especially when travel is required. A lack of adequate space or a permanent location for group exercises and/or educational programs remains a key problem in some organizations and many noted a lack of transportation for program participants. Transportation difficulties were cited as a barrier in both rural and urban areas.



Community engagement challenges were mentioned, especially when a new program or a new person is hired to implement a program. Building trust, according to one staff member, takes time. Another staff member explained that a new program cannot succeed without the community's trust and cooperation. Although evidence-based health promotion programs come ready to implement, it takes time for participants to accept them. One program staff compared her idea of implementing a "packaged program" as "fast cooking" compared to traditional methods. She states: "[Starting] an EBP is like using a microwave—fast and quick while traditional approaches take time, like building a fire—it takes time to build relationships; but, building relationships is not a priority in an EBP's 6-week course." In another

instance, one staff member said: “Some Elders don’t care if the program is evidence-based, but rather the program is fun and liked by their friends.”

The specified requirements for EBP delivery could also be a challenge. It is not always possible to encourage participants to commit to a program that meets for a few hours per session for several weeks. Program requirements, some reported, are not only restrictive, but also inflexible. One program staff member indicated that when there is more flexibility to program attendance, more participants remain in the program. Flexibility was also valued since weather can be severe barrier in parts of the country, leaving staff to cancel activities following significant time spent recruiting participants. The required homework that comes with some health promotion programs is also difficult to maintain. Some Elders resist these requests, indicating they didn’t want to revisit their school days.

Importance of Refreshments, Incentives, and Community Celebrations. Staff mentioned several incentives to help retain Elders in programs, including facilitating transportation, providing a friendly environment and/or an enjoyable meal, and using innovative educational methods, such as digital storytelling (a method of capturing the tradition of storytelling in digital media, such as audio podcasts, image slide shows, and videos). Offering snacks or food was emphasized as an important way to maintain cultural courtesies as well as a token of acknowledgement and welcome. When inviting guests to participate in a special activity, the host is expected to welcome guests with some refreshments. Other fun activities mentioned as popular for the Elders included BINGO and educational activities that were engaging and informative. Similarly, supporting local community celebrations that honor Elders was an important way to maintain local traditional practice. It’s also preferable to allow time for Elders to visit with staff, give them an opportunity to discuss their desire to be healthy, and encourage them to share the health information learned with other members of their family. In many instances, however, program staff do not have funds to provide snacks or other incentives for participants.

Cultural Adaptations to Existing Programs. Popular programs integrated local cultural activities such as beading, drumming, dancing, and crafts. Other programs deemed successful included community gardening projects

and group outings that followed popular tribal traditions such as fishing, traditional food harvesting, and camping, among others. Integrating culturally appropriate additions to existing EBPs was mentioned by some staff as a strategy to increase participation. For example, adding drum music to physical activities, and combining activities with popular culturally traditional activities. Some noted the importance of providing programs that fit the age and physical ability of the program participants. Most program staff indicated that it requires more resources to serve Elders who are frail or homebound.

For most programs, there is a need for access to technical assistance to support implementation of program modifications. While some organizations have adapted or modified EBPs to be culturally appropriate, such models are not always shared with others. Making any programmatic changes was also seen as a challenge for program staff; some thought changes would require funding their programs did not have. Lack of funding or not having a helpful model appears to prevent some programs from making evidence-based interventions more culturally relevant or appropriate. In some states, program staff indicated that any modification or changes would require prior approval from either the state or local agencies overseeing implementation or evidence-based program administrators. Even with permission, making modifications could be a time consuming and complex process.

Participant Recruitment. A mixed method of recruitment was mentioned by most of these programs, i.e., mail, radio announcements, flyers, reminders, emails, and/or announcements made at public events. For some staff, personal contact or word of mouth are said to have been successful recruitment and retention methods. Although not directly stated, discussions in the sessions emphasize that the reputation of the program staff as well as the program is an important part of recruiting and maintaining programs for the Elders. The ability of organizations to offer a variety of health promotion activities is important. Smaller programs suffer when their funding forces limited program offerings and/or having to host repetitive activities which is said to add to high drop-out rates.

According to several program staff, many community members who utilized their services were not familiar with evidence-based health promotion activities. Terminology is reported as a factor in whether some health promotion

programs are more acceptable, familiar, or understood. For example, one program staff noted that the terminology “Chronic Disease Self-Management” did not resonate with community members while a more familiar ongoing program, “Diabetes Self-Management” was readily understood. In order to encourage familiarity, one program site renamed the program.

Most program staff reported a need for more educational materials designed specifically for AI/AN/NH Elders. Their list included topics on various chronic diseases, nutrition, long-term care, falls prevention, health insurance, fraud protection, medication management, and resources to maintain enrollment of Elders, i.e., transportation, more classes, incentives, etc.



The Voices of Elders

Definition of Aging Well. In several listening sessions, facilitators started by asking participants what “aging well” meant to them. The replies to this statement varied with discussion on individual attention to self-care, keeping active, and helping others to being more involved with family and group activities. In fact, the most frequent definition of aging well for Elders was cited as “being with family, grandchildren, friends, or engaged in family-oriented activities” such as gardening, dancing, fishing, or group games such as pitching horseshoe or attending sports events with family or friends. Responses to a question on

how programs can support Elders in aging well brought forth an array of recommendations, including provision of healthy food during sessions, engagement in community activities, offering spiritual or religious support, providing opportunities for group activity such as walks, and providing health information and other activities that enhance group socialization.

Evidence-Based Programs. When asked about their participation in evidence-based health promotion programs, there was little mention of evidenced-based programs and/or that they participated in such programs. A few responses mentioned the names of one or two interventions but did not acknowledge the programs to be evidence-based. Instead, participants described the activities of EBPs such as falls prevention, chronic disease self-management, Strong Woman, etc. More frequently, individuals reported that they have not participated in these programs and/or did not know about them.

Most said they liked the programs they had attended in their community because they were able to participate with others they knew as well as having some personal time to socialize with friends. They also mentioned that trusting the staff was what kept them in the program while others reported having an opportunity to learn new types of exercises. In general, one common barrier for lack of participation or limited participation was said to be the lack of transportation and/or the need to attend to personal family priorities. Still for others, either lack of time or a reluctance to commit to multiple classes a week were factors in why they did not participate or had discontinued the program.

Most Elders viewed the programs as an opportunity to help them stay healthy by providing exercise, classes on nutrition and other health topics, and offering a safe place for these activities. Elders named several physical activities they had engaged in, including chair volleyball, lei making, arts and crafts, and walks. Cultural activities were among the list of enjoyable activities although some Elders would like to have more provided. In addition, participants mentioned intergenerational programs and programs that are planned for different levels of ability. One elder mentioned: “Scheduling one physical activity for all is difficult for participants who have physical limitations.” Others agreed that this can be frustrating for some participants and they are likely to drop-out.

Recruitment and Participation. For the most part, Elders who became involved in the health promotion programs were either personally recruited by program staff or were motivated by the incentives included in the program. Some participants indicated that they were motivated to remain in the program because program staff treat them like family. Others mentioned that they appreciate the staff offering a variety of program choices as well as incentives that kept their interest. For those who were in tribal community programs, the inclusion of group outings that involved popular traditional subsistence activities such as harvesting traditional foods, drumming, or beading were mentioned as important motivation for the participants. Giving recognition to Elders who have successfully completed programs was among the recommendations offered by the Elders. A certificate of completion as well as a graduation ceremony to mark the occasion were encouraged. In general, and despite some programmatic shortcomings, most Elders who participated in the listening sessions indicated they welcomed and enjoyed participating in these programs with others from their own communities.

Additional Needs. Input from Elders regarding needed health promotion including similar topics to those listed by program staff, i.e., education on diabetes, heart disease, arthritis, Alzheimer's disease, cancer, and eye health. Elders also asked for more interactive teaching strategies and pointed to activities like healthy food demonstrations and providing opportunities for Elders to learn from each other (exchanging recipes for example). In addition, Elders were interested in presentations scheduled during mealtimes, those that included intergenerational participation, or opportunities to learn more about technology and using computers.

Sources of Health Information. Elders also echoed the program staff when asked where they find health information. The list included Community Health Representatives (CHRs), clinics, family members, church program sources, and the media. It should be noted

that while CHRs are most often mentioned as source of health information for rural-based AI/AN Elders, Pacific Islanders and some urban-based AI/ANs were more likely to add church as an important source for obtaining health information.

Enjoyable Activities. A majority of the personally enjoyable activities mentioned by Elders were similar to those reported by program staff. Most involved doing productive activities or contributing to their household, often with family, including preparing and storing subsistence food, cooking and sharing recipes, cleaning, and producing traditional arts and crafts to help meet family expenses. Assisting with or spending time with grandchildren was also mentioned as a source of personal enjoyment. Others mentioned recreational activities like bike riding, playing pool, chair volleyball, watching TV, or taking walks with grandchildren or family members.

Unmet Needs. Elders shared several unmet needs in their communities, some specific to the Elders' program, i.e., concern about program sustainability, a need for appropriate facilities where programs could be delivered, the need for transportation resources, obtaining designated areas in the community for their community gardens, and the need to have local programs improve health promotion resources for the Elders who are homebound. Other listening session participants noted the need to address language barriers and/or providing courses in literacy. Including some intergenerational activities as well as scheduling physical activity programs to address different functional abilities was mentioned both by the Elders as well as program staff. Although there were no specific examples offered, the need for more cultural activities was suggested by Elders, especially those living in urban areas. The need for special consultants, mainly nutritionists and gerontologists were mentioned in more than one listening session. Adaptive housing was listed as an important need by some AI/AN Elders.

Findings and Discussion: Survey of Older Americans Act Title VI Directors and Staff

The National Resource Center on Native American Aging based at the University of North Dakota conducted a survey of Title VI program staff. The 29-question on-line survey addressed various factors related to implementing EBPs. Survey questions focused on greatest needs, familiar programs, funding sources, partnerships, and barriers, among others. In addition, respondents were asked to provide details surrounding any health promotion programs that they had developed for their older populations. See Appendix E for survey.

The survey was administered to approximately 241 Older Americans Act Title VI directors across the United States; participants were asked to share the link to the survey to any Title VI staff who may also be interested in participating. All survey responses were collected anonymously; however, in an online follow-up survey, respondents had the opportunity to provide their email address if they wanted to be included in a drawing for 50 gift cards in the amount of \$25.

A total of 63 respondents completed the survey between February 11, 2020 and March 17, 2020. Among these 63

TABLE 2 • What are the greatest need(s) for Tribal Elders in terms of health and well-being?

Please mark all that apply. (n = 63/63)

Need	Percent
Diabetes management	87.3%
Chronic Disease	79.4%
Transportation	79.4%
Nutrition	66.7%
Housing	63.5%
Falls prevention	60.3%
Loneliness/social isolation	60.3%
Physical Activity	58.7%
Elder abuse/exploitation	55.6%
Financial insecurity	55.6%
Alzheimer's Disease/dementia	52.4%
Depression/anxiety	49.2%
Access to affordable health care	46.0%
Obesity	46.0%
Mobility	46.0%
Alcohol and/or substance abuse	44.4%
Smoking stress	12.7%
Other	9.5%

TABLE 3 • In your experience, what types of physical and mental health-related programs are your Tribal Elders most interested in?

Please mark all that apply. (n = 63/63)

Program	Percent
Cultural programs and activities	81.0%
Socialization	74.6%
Diabetes	73.0%
Caregiving	68.3%
Nutrition	68.3%
Physical activity/exercise	57.1%
Heart disease	49.2%
Falls prevention	46.0%
Strength and balance	46.0%
Alzheimer's Disease/dementia	44.4%
Walking	38.1%
Creative arts/dancing	33.3%
Mental health	27.0%
Tai Chi	23.8%
Alcohol misuse/abuse	20.6%
Yoga	19.0%
Smoking cessation	6.3%
Other	6.3%

participants, 58 completed the survey in its entirety, while 5 individuals started the survey but did not finish. The response rate is 26%.

In the following graphs and tables, the percentages are listed for each respective question; these percentages are based on the total number of individuals who answered that question. In some cases, respondents could select more than one response, so totals may add up to greater than 100%. For the purposes of this survey, the Administration for Community Living’s definition of EBPs was used, described on page 8.

TABLE 4 • Which evidence-based health aging/ disease prevention and management programs (i.e., health promoting programs that are backed by research) have you heard of before?

Please mark all that apply. (n = 60/63)

Program	Percent
Tai Chi	50.0%
Diabetes Self-Management Program (DSMP)	45.0%
Wisdom Warriors	43.3%
Special Diabetes Program for Indians (SDPI)	36.7%
Chronic Pain Self-Management Program	33.3%
Diabetes Empowerment and Education Program (DEEP)	33.3%
Powerful Tools for Caregivers	31.7%
Chronic Disease Self-Management Program (CDSMP)	26.7%
Better Choices, Better Health	25.0%
Arthritis Foundation Exercise Program (AFEP)	23.3%
Stepping On	23.3%
A Matter of Balance	21.7%
Fit and Strong	21.7%
Savvy Caregiver	21.7%
Enhance Fitness	18.3%
Better Choices, Better Health - Diabetes	15.0%
Walk with Ease	13.3%
Healthy IDEAS	11.7%
None	5.0%
Other	3.3%

Most respondents (60.3%) indicated that they served between 101-500 Tribal Elders; several also reported serving 501-1000 Tribal Elders, or more than 1,000 (14.3% for each). Respondents were least likely to report serving tribes with less than 100 Tribal Elders (11.1%).

The greatest reported needs were for diabetes management (87.3%), chronic disease (79.4%) and transportation (79.4%). Additionally, 6 respondents (9.5%) reported other needs that were not listed on the survey. These responses included caregiver issues, including caregiving for children, the importance of physical therapy after surgery, lack of dry goods in the home, long term care, and sharing of oral cultural stories.

TABLE 5 • What evidence-based healthy aging/ disease prevention and management programs (i.e., health promotion programs backed by research) is your community currently implementing?

Please mark all that apply. (n = 59/63)

Program	Percent
Diabetes Self-Management Program (DSMP)	27.1%
Tai Chi	23.7%
None	23.7%
Powerful Tools for Caregivers	22.0%
Diabetes Empowerment and Education Program (DEEP)	16.9%
Chronic Disease Self-Management Program (CDSMP)	13.6%
Other	13.6%
Arthritis Foundation Exercise Program (AFEP)	11.9%
Chronic Pain Self-Management Program	11.9%
Enhance Fitness	11.9%
National Diabetes Prevention Program (NDPP)	11.9%
Wisdom Warriors	11.9%
Stepping On	8.5%
Better Choices, Better Health - Diabetes	6.8%
Better Choices, Better Health	5.1%
Savvy Caregiver	5.1%
A Matter of Balance	3.4%

TABLE 6 • What funding sources do you use to implement evidence-based programs for Tribal Elders? Please mark all that apply. (n = 59/63)

Funding Source	Percent
Administration for Community Living Older Americans Act - Title VI	76.3%
Tribal funds/revenue	55.9%
Other federal funding	25.4%
Other state funding or state revenue	18.6%
Administration for Community Living Older Americans Act - Title IIID	15.3%
Don't know	10.2%
Does not apply (do not use evidence-based programs)	5.1%
Foundation/philanthropic funding	1.7%
Other	1.7%

When respondents were asked if they had heard of EBPs, approximately 76.2% reported hearing of them before, whereas 23.8% had not. Most respondents said their Tribal Elders were most likely interested in programs involving culture and activities (81.0%), socialization (74.6%), and diabetes-related issues (73.0%). Other commonly-reported programs included caregiving (68.3%), nutrition (68.3%), and physical activity/exercise (57.1%). Four respondents (6.3%) wrote in their responses and included programs involving quilting, canning, gardening and painting; sharing and transferring the oral cultural traditions to ensure they are not lost; and traditional native leather and beadwork.

FIGURE 1 • 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 needed behavior changes.

Please mark all that apply. (n = 59/63)

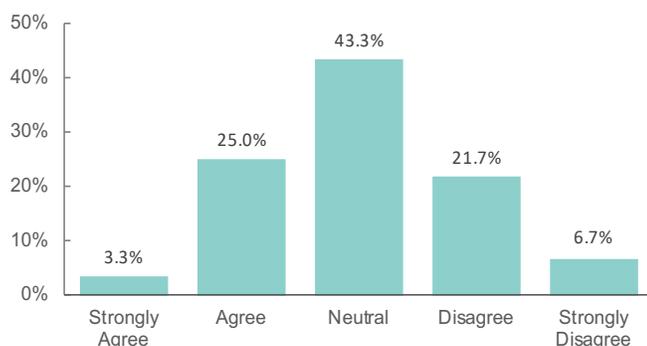


TABLE 7 • What partnerships do you currently have that assist with delivering healthy aging evidence-based programs to Tribal Elders?

Please mark all that apply. (n = 56/63)

Partnership	Percent
Indian Health Service	82.1%
Area Agencies on Aging (AAAs) & Aging and Disability Resource Centers (ADRCs)	66.1%
Senior Centers	46.4%
Healthcare organizations	30.4%
Social service agencies	30.4%
Local/county public health department	26.8%
Other tribes	23.2%
Educational institutions	16.1%
Federally Qualified Community Health Centers	12.5%
Residential care facilities/nursing homes	12.5%
Rural health organizations	12.5%
Other	1.8%

One respondent indicated they had offered programs in the past, but Tribal Elders were set in their ways and subsequently had difficulty keeping them in a program.

Tribes were most likely to be implementing the Diabetes Self-Management Program (DSMP; 27.1%) or Tai Chi (23.7%), although many reported not implementing any EBPs (23.7%). Eight respondents (13.6%) wrote in responses indicating other programs or activities, such as having an elder chair exercise and fitness center; gardening, quilting, painting, and canning; Wisdom Steps; peer-assisted learning strategies; and low-impact stretching exercises. One reported that they were in the process of applying for a falls prevention program utilizing Tai Chi, as well as the Wisdom Warriors program. Two individuals indicated that it was not applicable, or they were unsure.

Among the 17.7% of respondents who reported implementing a program not listed in the survey, most indicated the program was 12 or more weeks (50.0%), involved 1-2 staff members (90.0%) that were trained for less than one week (50.0%), and involved training 1-2 staff members to coach the program (88.9%). Most utilized tribal funding (66.7%) and none indicated that federal or

TABLE 8 • What factors do you think would increase the likelihood that Tribal Elders would participate in an evidence-based program?

Please mark all that apply. (n = 59/63)

Factor	Percent
Incentives to participate in the program	89.8%
Culturally-tailored programs	67.8%
Listening to Elders	66.1%
Setting goals	33.9%
Other	3.4%

foundation grants were used. Most respondents indicated the program was evaluated through assessment material that was provided by the program (55.6%). Approximately one-third reported they did not evaluate their program (33.3%), whereas 11.1% reported that a program evaluator was contracted through the respective grant.

If participants had implemented other programs, they were asked to provide the program name. Responses included Active Living Every Day, Go4Life, Harvest of the Month, Healing of the Canoe, Yoga, and Stay Strong Healthy Program. Others mentioned exercise, that they had their own routine, or programs involving diabetes.

TABLE 9 • Based on your experience, what are the primary reasons why Tribal Elders withdraw from an evidence-based program?

Please mark all that apply. (n = 60/63)

Reason	Percent
Transportation	70.0%
Illness or health problems	53.3%
Other personal obligations, responsibilities	45.0%
Weather	31.7%
Lack of relevance	28.3%
Doctor appointments	25.0%
Conflict with work	23.3%
Dissatisfaction with workshop or instructor	20.0%
Caregiving obligations	13.3%
Other	13.3%
None	3.3%

For those implementing programs listed in Table 5 most respondents reported using the Administration for Community Living Older Americans Act – Title VI as their main funding source for EBPs (76.3%), as well as having partnerships with Indian Health Service (82.1%) to help assist and deliver the programs. One individual (1.7%) wrote in that they collaborated with tribal programs for funding and one respondent (1.8%) wrote that they partnered with their tribal health maintenance program.

Most agreed that Tribal Elders were interested in participating in EBPs (53.3% strongly agree/agree), but had mixed results with regard to having the support that was needed (e.g. the ability to buy nutritious foods, opportunity for regular physical activity, etc.) in order to make behavior changes as a result of the EBPs (25.0% agreed they had the support, whereas 21.7% disagreed). Neutral was the most common response (43.3%). Approximately one-quarter of respondents agreed that Tribal Elders had the resources they needed, whereas 21.7% disagreed with this statement. Close to 7 percent of respondents strongly disagreed that Tribal Elders had the support they needed.

Incentives to participate in the program was the most commonly chosen response as to how to get Tribal Elders to participate (89.8%) in EBPs. More than two-thirds of respondents also indicated that culturally tailoring programs is an important factor for Tribal Elder participation.

Transportation was the primary reason Elders withdrew from a program (70.0%) with illness/health problems and personal obligations being the second and third most common reasons, respectively. Eight respondents indicated “other” (13.3%), writing in responses such as lacking cultural relevance (n = 2), losing interest, lack of incentives, the type of training (e.g., classroom), lack of meeting frequently due to distance, or being unwilling to change/lack of awareness.

Slightly over half of respondents indicated that evidence-based practices were responsive to the tribe’s culture. Participants who indicated that current practices were not responsive (49.1%) were subsequently asked to provide potential recommendations to improve programs. Most indicated it was important to tailor the program to each respective tribe (63.0%). Creating a tribal elder council to lead the implementation was the next most common

TABLE 10 • What aspects of successful non-evidence-based programs are most appealing for tribal Elders?

Please mark all that apply. (n = 9/9)*

Program Aspect	Percent
Social engagement	100.0%
Educational items	55.6%
Physical activity items	44.4%
Emotional/mental health items	44.4%
Management of disease	33.3%
Other	11.1%

response (37.0%), followed by implementing a tribal advisory board (22.2%). For programs implemented that were not evidence-based, respondents indicated that having social engagement (100.0%) was especially appealing. Five individuals (18.5%) had write-in responses such as tailoring it to specific needs; determining what would work best for each pueblo, tribe, and nation; and lack of relevant programs/tribes wanting to create their own programs. One suggested educating caregivers, as they may have an influence on those whom they provide care.

When asked what the most common barriers were to implement an evidence-based program into their community, transportation was the most commonly listed reason (58.3%). Many also responded that there were not enough Elders interested in participating (51.7%), whereas others said that cost was a factor (46.7%). Nine individuals marked the “other” category; these write-in responses included access to training; Elders wanting “fun” classes and not feeling like they are doing work; lack of local resources; and traveling distance. The additional five responses centered around staffing, such as having a staff shortage, lacking a program coordinator, or not having an outside person to train the trainer.

Most respondents (84.2%) reported that they were not currently using a non-evidence-based program that was successful for their Tribal Elders. Among the nine respondents (15.8%) who did report success using a non-evidence-based program, all indicated that social engagement was most appealing (100.0%). Having educational items (55.6%) (e.g. workbooks, manuals) and physical activity items (44.4%) (e.g. weights, resistance

TABLE 11 • What resources and strategies could be provided to your tribe that would be helpful in implementing evidence-based programs?

Please mark all that apply. (n = 55/63)

Program Aspect	Percent
Funding	85.5%
Equipment for program	76.4%
Transportation for Elders	67.3%
Easier accessibility for train-the-trainer	65.5%
Other	9.1%

bands) were also frequently reported as being appealing to Elders, followed by emotional/mental health items (44.4%) and management of disease (33.3%). One respondent (11.1%) indicated having a really good instructor was also useful.

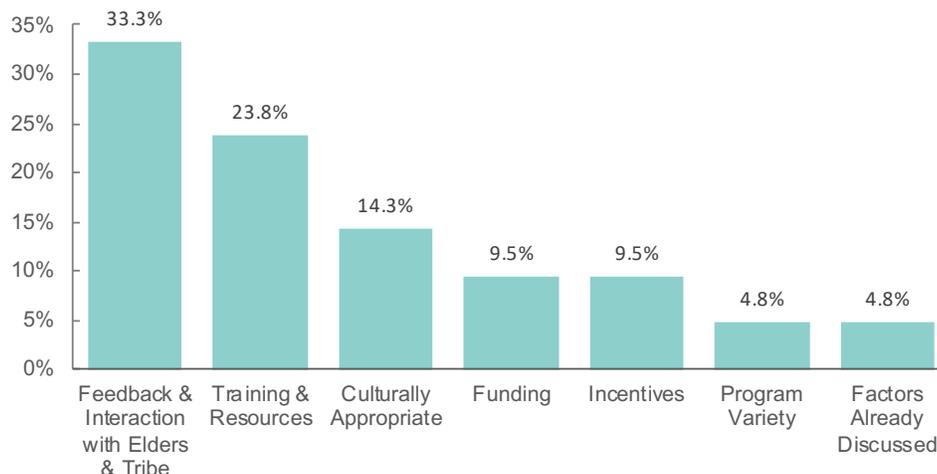
All respondents were asked to indicate which resources or strategies would be most useful in helping to implement an evidence-based program for Tribal Elders. Funding was the most common response (85.5%), followed by equipment (76.4%), transportation (67.3%), and accessibility for train-the-trainer models (65.5%). There were five other responses, including write-in answers of using the funding to provide materials and supplies for moccasins, ribbon skirts and shirts, as well as incentives; culturally appropriate advertising; educational materials such as muscle/body illustrations; and advance planning and notification of future training.

Most respondents agreed (61.7%) or strongly agreed (23.3%) that EBPs could be adapted to meet the needs of the tribal community. Additionally, respondents were most likely to agree (47.5%) or strongly agree (33.9%) that tribal members should provide input on EBPs and appropriate adaptations before they are implemented into the community.

When asked what the key factors were in successfully implementing an evidence-based program within a tribal community, the majority of respondents indicated that culture was especially important (80.4%). Funding resources (78.6%) and program resources (75.0%) were also particularly important, as is consultation from the tribal

FIGURE 2 • Please share any additional thoughts, ideas, or recommendations on how tribes could be supported so as to offer evidence-based programs in their communities.

(n = 19/63)



community (69.6%). Three respondents (5.4%) added write-in responses of identifying gaps, obtaining “buy in” from the Elders such as incorporating Elders as leaders in the program, or indicating that each tribe is unique so it is very difficult to implement each tribe’s culture, customs and traditions.

Out of the 63 survey respondents, 19 respondents provided additional thoughts on how to further support tribes regarding EBPs. These responses were broken down by overall theme, with some reporting more than one topic, resulting in a total of 21 different answers. Seven different themes were broadly consolidated based on their responses, each of which is discussed in detail below.

The first overarching theme was **utilizing feedback and interaction with Elders and tribes**. Within this category, responses included showing the Elders that the program worked in another tribal community and had the support of the Tribal Council; having a good response from the community about how fun the program is; and listening to community members and Elders and asking for their advice and input in order to allow for ownership. Creating digital stories, featuring noted leaders, as well as incorporating tribal members into the training were also discussed.

Training and resources were also commonly listed. Within this category, responses included having a summit to learn about best practices; having state aging departments provide more training and support, such as how to seek funding; having regional staff educate about “Funding Opportunity Announcements” and “Notice of Funding

Opportunities;” and sharing ideas and strategies. Additional responses included having various trainings available on a more consistent basis, as well as providing more information on evidence-based programming.

Making sure programs were **culturally appropriate** was also a common theme. Responses involving this topic centered around having advertising and language that Elders would be responsive to and tailoring it to each tribe so Elders would feel more comfortable participating. One respondent indicated tribes take an eclectic approach in building programs that may or may not include EBPs, and that requiring EBPs does not honor the tribe’s sovereignty and allow them to create and manage their own programs.

Funding was also mentioned among respondents. Respondents indicated funding was a major issue resulting in a lack of many programs and services. **Incentives** was another theme that emerged; respondents reported that Elders were influenced by incentives, which would help to bring them to the table and help to realize how important they are.

One respondent indicated having **program variety** would be helpful so Elders are not doing the same thing all of the time; they found that if a program goes over 8 weeks, the attendance tends to drop off. Additionally, one individual indicated that all of the **factors previously discussed** would be helpful to address. These include items mentioned in the previous question (i.e., culture, funding resources, program resources, consultation from the tribal community).

Discussion

Agencies and organizations advocating for health promotion services for older adults place importance on services which are determined to be “evidence-based” according to Western medicine. However, through the listening sessions conducted with Elders and professionals as well as the survey of Older American’s Act Title VI staff members, we learned that health promotion models that have been proven effective for other populations do not always carry over to AI/AN/NH communities or may not be feasible to implement with the resources available. In order to make interventions more meaningful, steps are needed to ensure that culturally appropriate interventions honor tribal sovereignty and take into consideration the deep history of discrimination towards and health disparities among AI/AN/NH communities. Each community will have their own preference for how to serve their Elders—whether that be in adaptations to existing EBPs, new programs developed by AI/AN/NH communities, or a focus on traditional activities that more closely reflect Indigenous wellness.

The program participants’ view of successful aging included maintaining personal independence, staying physically active, providing self-care, being socially active with grandchildren, helping others, providing family support, enjoying humor, and doing fun activities such as line dancing. The theme of kin or community connectedness was central in many comments made by the elders. The notion of connectedness for some elders included participating in their tribal ceremonies or other personal or group spiritual activities, showing that perception of health and wellness activities encompasses a broad range of traditional events.

In general, and despite some programmatic shortcomings, most elders who participated in the listening sessions indicated they welcomed and enjoyed participating in these programs with others from their own communities. Elders found comfort in a program model where they are treated like family and given the opportunity to engage in familiar cultural group activities. In describing successful components of the programs for AI/AN elders, program

directors mentioned providing interventions that are fun, varied, and competitive.

Some of the recommended program modifications were minor, such as altering the name of the intervention or substituting tribal music for packaged program music. Ultimately, these changes can be accomplished by many organizations, but may require permission from program developers and/or funding to test modifications. These modifications may help address some of the barriers shared by elders. For example, identifying areas of flexibility so elders can continue to participate despite other demands (e.g., unexpected family emergencies, childcare, or other disruptions due to bad weather conditions and/or lack of transportation).

For small communities with limited resources and fragile infrastructures, there are several challenges that need to be considered, i.e., 1) lack of space for group activities; 2) transportation barriers; 3) lack of ability to provide a healthy snack or other incentives for participants; and 4) short-term funding, which may lead to insufficient time to hire and train staff, as well as recruit program participants. For most programs, there is a need for access to technical assistance to support implementation of program modifications. While some organizations have adapted or modified EBPs to be culturally appropriate, such models are not always shared with others. In addition to improving the provision of culturally appropriate interventions, allowance in program budgets for incentives and food is especially needed by programs with limited resources.

The way the elders were recruited or chose to participate in their local health promotion programs varied. Some were personally recruited by program staff while others heard about the program or were encouraged to participate by family members or friends. Still others indicated at the listening session that they had not heard about local programs. When asked to name some of the EBPs in which they participated, few gave the official name of the programs but described the activities of EBPs such as falls prevention or chronic disease self-management. Most also said they liked the programs because they were able to

participate with others they knew as well as having some personal time to socialize with friends. They also mentioned that trusting the staff was what kept them in the program while others reported having an opportunity to learn new

types of exercises. Most elders viewed the programs as an opportunity to help them stay healthy by providing exercise, classes on nutrition and other health topics, and offering a safe place for these activities.

Call to Action

The authors and contributors of this report developed the following short-, mid-, and long-term action steps based on their expertise, the literature review, listening sessions with elders and professionals, and the survey of Older American's Act Title VI staff. Each of these action steps will require collective action from federal agencies, national partners, evidence-based program developers and administrators, local organizations, and ultimately community Elders to ensure health promotion, disease prevention, and falls prevention programs are accessible and culturally appropriate for AI/AN/NH Elders.

Each action step was developed with the following assumptions in mind:

- An elder's choice to participate is not generally influenced by whether a program is "evidence-based" or not.
- Federal funding for health promotion and disease prevention programs frequently requires using EBPs. Criteria for evidence-based status varies among federal organizations.
- Programs that currently meet the Administration for Community Living's criteria do not include options that were researched specifically for AI/AN/NH communities.
- Elders would be better served with health-focused programs developed by AI/AN/NH communities.
- Existing evidence-based programs may be adapted to be more culturally relevant.
- Many AI/AN/NH communities lack resources and/or infrastructure to develop a program that meets **ACL's evidence-based criteria**. (Defined on page 8.)

- AI/AN/NH communities may not want to or may not be able to pursue adherence to ACL's evidence-based criteria—either due to the high cost of research or desire to keep program knowledge within the community.
- An overall increased focus on the health disparities faced by AI/AN/NH communities at the local, state, and national level will be instrumental to improving health and working toward health equity.

Action Steps

1. Provide guidance and support for tribal organizations to implement programs that currently meet ACL's evidence-based criteria in AI/AN/NH communities.

Timeline: Short term/currently in progress

Action steps:

- Explore culturally appropriate measures of success for AI/AN/NH communities when choosing or implementing health promotion programs.
- Increase research efforts examining the efficacy of adapting existing EBPs for AI/AN/NH communities and develop formal guidance and best practices.
- Identify strategies to market programs with culturally appropriate names and descriptions.
- Adapt program leader training programs for AI/AN/NH communities and develop guidance for program leaders on how to maintain program fidelity, while also making adaptations to ensure content is culturally appropriate (for example: Wisdom Warriors adaptation for the Chronic Disease Self-Management Program).

Modifications identified include name, marketing, use of AI/AN/NH music, and references to culturally relevant food and activities.

- Identify funding sources to support development and testing of program modifications, general program implementation, and increase the number of program leaders from AI/AN/NH communities to ensure programs are led by trusted community members.
- The majority of respondents to the listening sessions and survey for this initiative identified as female. Moving forward, seek input from male Elders on how best to make the programs work for them, including factors that would increase their participation.

2. Support AI/AN/NH communities in developing NEW culturally appropriate health promotion, disease prevention, and falls prevention programs.

Timeline: Mid-term/Long-term

Action steps:

- Explore or identify culturally appropriate measures of success for AI/AN/NH communities when choosing or implementing health promotion programs.
- Identify programs focused on health promotion, disease prevention, or falls prevention developed by AI/AN/NH communities and create a public inventory.
- Create a list of funding sources to support AI/AN/NH communities in developing population specific EBPs.
- Develop guidance on the steps needed to meet the ACL evidence-based criteria and support AI/AN/NH communities that have developed health promotion, disease prevention, and falls prevention programs in meeting them.
- Explore collaborations with research centers focused on AI/AN/NH communities.
- Identify areas where AI/AN/NH-developed programs are most needed.
- Identify resources for tracking program participants served by programs developed by AI/AN/NH communities.

3. Support AI/AN/NH communities in implementing health promotion, disease prevention or falls prevention programs developed by native communities.

Timeline: Mid-term

Action steps:

- Identify programs focused on health promotion, disease prevention, or falls prevention developed by their own or other native communities.
- Identify funding sources to support implementation of programs developed by native communities, including those with and without evidence-based criteria.
- Pursue recommendations above to increase the number of programs developed by native communities available for implementation.
- Consider allowing a 6-month start-up phase for new, small programs to enable them to hire, develop programs, and recruit Elders.

4. Advocate for changes to ACL's evidence-based criteria to develop separate evidence-based program criteria for AI/AN/NH communities based on different cultural needs and values.

Timeline: Long-term

Action steps:

- Research process to amend the evidence-based criteria for Older Americans Act Title III-D and discretionary grant funding.
- Determine preferred criteria and recommend changes to funding mechanisms that require adherence to evidence-based guidelines. Preferred criteria to include increasing the value placed on the implementer's expertise (community-based organizations serving AI/AN/NH communities and existing infrastructure) and the Elder's unique values and circumstances.
- Identify the unique needs and rights of AI/AN/NH communities to develop and implement culturally appropriate programs.
- Fund demonstration projects that blend EBPs and culturally appropriate models.

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Appendix A: Literature Review Methods

Sources of information: Health care, education, and social sciences-focused research databases searched included the EBSCOhost and PubMed interfaces to MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Education Source, ERIC, SocINDEX, and PsycINFO, as well as multidisciplinary resources such as Academic Search and Google Scholar. Where possible, the full text of articles was also searched to detect additional relevant results not found through general controlled vocabulary searching.

Additional searches were also run in the U.S. federal, tribal, state, and municipal search tool USA.gov and in generic Google. These additional searches were conducted to, as much as possible given the restrictions of time and search capability, identify relevant programs/initiatives/interventions not already found within searches of the more formally published literature.

Search terms: These resources were searched using terms related to Elders and indigenous populations of the United States. Resource-specific subject headings were mined for additional applicable terms. An example of just one of the search phrases used is:

(elder* OR "older adult*" OR geriat* OR geront* OR "old age" OR "older people*" OR "older Native American*" OR "very old" OR "65 years" OR "65 yrs" OR "senior citizen*")

Publications Review

700+ title and abstract reviewed

44 entire article reviewed

34 met criteria for inclusion

AND ("American Indian*" OR "Native American*" OR "Native Hawaii*" OR "Hawaii* Native*" OR "Alaska* Native*" OR "Native Alaska*" OR "Indians, North America*" OR "indigenous peoples of the Americas") AND (program OR programs OR programming OR interven* OR ((community OR tribal OR tribe OR tribes OR social) N3 service*))

Article review: After initial broader searches, over 700 publications were reviewed at the title and abstract level. From the more general web searching, we located 11 more publications and standard websites about programs being carried out. Coupling relevant results located in initial searches with those identified from the narrower search, a total of 44 publications were identified to be reviewed in their entirety. Of those, the programs/initiatives/interventions detailed in 34 publications met inclusion criteria for this review.

Appendix B: Table of Literature Review Results

This table lists the 34 publications that were included on our review, which covered the following areas: Cancer, caregiving, diabetes, cardiovascular disease, chronic disease (in general), falls, functional fitness, nutrition, substance use/misuse, and elder abuse. Sixteen of these publications concerned diabetes. EBPs included in the literature included, Resources for Enhancing Alzheimer's

Caregiver Health (REACH), polarity therapy, Diabetes Prevention Program, Chronic Disease Self-Management Program (CDSMP), So Much Improvement with a Little Exercise (SMILE), the Centers for Disease Control and Prevention's Stay Independent Checklist, Peer Recovery Support, and Family Care Conference.

Table 12 • Literature Review Results

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Cancer						
Ka'opua, L. S. I. et al. (2011). Testing the feasibility of a culturally tailored breast cancer screening intervention with Native Hawaiian women in rural churches. <i>Health & Social Work</i> , 36(1), 55-65.	Ka lei mana 'olana	Developed specifically for targeted population	Randomized site (church), two-group pre-post control group comparison	N/A	Rural churches	Rural Hawaii
Mokuau, N., Braun, K. L., & Daniggelis, E. (2012). Building family capacity for Native Hawaiian women with breast cancer. <i>Health & Social Work</i> , 37(4), 216-224.	N/A	Developed specifically for targeted population	Randomized control wait-listed design	Cancer knowledge, self-efficacy, coping, follow-up care use	Rural and urban areas on the Hawaiian Islands of O'ahu, Hawai'i, and Moloka'i	Native Hawaiian women who had been diagnosed with breast cancer within the prior 10 years
Caregiving						
Martindale-Adams et al. (2017). Implementation of the REACH model of dementia caregiver support in American Indian and Alaska Native communities. <i>Translational Behavioral Medicine</i> , 7, 427-434.	Resources for Enhancing Alzheimer's Caregivers Health (REACH)	Yes	Description of implementation process	N/A	N/A	American Indian communities in the United States
Korn, L. et al. (2009). A randomized trial of a CAM therapy for stress reduction in American Indian and Alaskan Native family caregivers. <i>The Gerontologist</i> , 49(3), 368-377.	Polarity therapy	No	Randomized trial	Stress, depression, quality of life, sleep quality, worry	Rural and urban western Washington	American Indian caregivers of persons with dementia
Diabetes						
Dill, E. J. et al. (2016). Psychosocial predictors of weight loss among American Indian and Alaska Native participants in a diabetes prevention translational project. <i>Journal of Diabetes Research</i> , 2016, article ID 1546939.	Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre/post survey design	Weight loss	36 American Indian/ Alaska Native local health care programs, serving 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	American Indian/ Alaska Native adults aged ≥18 years that met specific clinical eligibility requirements

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Jiang, L. et al. (2012). Latent class analysis of stages of change for multiple health behaviors: Results from the Special Diabetes Program for Indians Diabetes Prevention Program. <i>Prevention Science</i> , 13, 449-461.	Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Comparative assessment design	Exercise, diet, weight	36 American Indian/ Alaska Native local health care programs, serving 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	American Indian/ Alaska Native adults aged ≥18 years that met specific clinical eligibility requirements
Jiang, L. et al. (2015). Socio-economic disparities in weight and behavioral outcomes among American Indian and Alaska Native participants of a translational lifestyle intervention project. <i>Diabetes Care</i> , 38, 2090-2099.	Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre-test/post-test design	Weight and weight loss; healthy activities	36 American Indian/ Alaska Native local health care programs, serving 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	American Indian/ Alaska Native adults aged ≥18 years that met specific clinical eligibility requirements
Jiang, L. et al. (2018). Neighborhood characteristics and lifestyle intervention outcomes: Results from the Special Diabetes Program for Indians. <i>Prevention Medicine</i> , 111, 216-224.	The Diabetes Prevention Program – Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre-test/post-test design	Development of diabetes; BMI; physical activity	36 American Indian/ Alaska Native local health care programs, serving 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	American Indian/ Alaska Native adults aged ≥18 years that met specific clinical eligibility requirements
Jiang, L. et al. (2013). Translating the Diabetes Prevention Program into American Indian and Alaska Native communities. <i>Diabetes Care</i> , 36, 2027-2034.	Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre-test/post-test design	Completion rates, diabetes incidence, weight, physical activity, fasting blood glucose, blood pressure, lipid levels	36 American Indian/ Alaska Native local health care programs, serving 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	American Indian/ Alaska Native adults aged ≥18 years that met specific clinical eligibility requirements
Jiang, L. et al. (2015). Participant and site characteristics related to participant retention in a Diabetes Prevention Translational Project. <i>Prevention Science</i> , 16, 41-52.	Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre-test/post-test design	N/A	36 American Indian/ Alaska Native local health care programs, serving 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	American Indian/ Alaska Native adults aged ≥18 years that met specific clinical eligibility requirements
Manson, S. M. et al. (2011). Special Diabetes Program for Indians: Retention in cardiovascular risk reduction. <i>The Gerontologist</i> , 51(S1), S21-S32.	The Special Diabetes Program for Indians Healthy Heart Demonstration Project (SDPI-HH)	Yes	Pre-test/post-test design	Sociodemographics, Body mass index, blood pressure, lipids, hemoglobin A1c, self-administered comorbidity questionnaire	30 health care programs participated, which served 138 tribes in 13 states and each of the 12 IHS administrative areas	American Indian/ Alaska Native adults aged ≥18 years who have diabetes

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Mau, M. K. et al. (2010). Translating diabetes prevention into Native Hawaiian and Pacific Islander communities: The PILI 'Ohana Pilot Project. Progress in Community Health Partne+A16:F16rships, 4(1), 7-16.	Diabetes Prevention Program - Partnerships for Improving Lifestyle Interventions 'Ohana Lifestyle Intervention (PILI POLI)	Yes	Qualitative focus groups and informant interviews, pretest/posttest for assessing effectiveness		Honolulu, HI	Native Hawaiian, Filipino, or other Pacific Islander adults, aged ≥18 years in the Honolulu area
Mendenhall, T. J. et al. (2012). The Family Education Diabetes series: Improving health in an urban-dwelling American Indian community. Qualitative Health Research, 22(11), 1524-1534.	The Family Education Diabetes Series (FEDS)	Developed specifically for targeted population	Qualitative (Talking Circles)	N/A	St. Paul, MN	Prior FEDS participants
Mendenhall, T. J. et al. (2010). The Family Education Diabetes Series (FEDS): Community-based participatory research with a midwestern American Indian community. Nursing Inquiry, 17(4), 359-372.	The Family Education Diabetes Series (FEDS)	Developed specifically for targeted population	Pre-test/post-test design	Diastolic blood pressure and HbA1c	St. Paul, MN	American Indian individuals with Type 2 diabetes
Moore, K. et al. (2014). Case management to reduce cardiovascular disease risk in AI/ANs with diabetes: Results From the Special Diabetes Program for Indians Healthy Heart Demonstration Project. American Journal of Public Health, 104(11), e158-e164.	Special Diabetes Program for Indians Healthy Heart (SDPI-HH) Demonstration Project	Yes	Pre-test/post-test design	CVD risk factors	30 SDPI-HH programs, serving 138 tribes in 13 states and each of the 12 IHS administrative areas: included 7 Indian Health Service hospitals or clinics, 21 tribal health care programs, 2 urban IHS-contracted programs). 4 were in urban settings, all others were on reservations	American Indian/ Alaska Native adults aged ≥18 years who have diabetes
Kaholokula, J. K. et al. (2014). Translating the Diabetes Prevention Program in Native Hawaiian and Pacific Islander communities: The PILI 'Ohana Project. Translational Behavioral Medicine, 4, 149-159.	Diabetes Prevention Program - PILI Lifestyle Program (PLP)	Yes	Pre-test/post-test design	Body mass index, systolic and diastolic blood pressure, physical functioning, exercise frequency, and eating habits	Honolulu, HI with four community-based organizations	Native Hawaiian, Filipino, or other Pacific Islander adults, aged ≥18 years in the Honolulu area

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Kaholokula, J. K. et al. (2012). A family and community focused lifestyle program prevents weight regain in Pacific Islanders: A pilot randomized controlled trial. <i>Health Education & Behavior</i> , 39(4), 386-395.	PILI Lifestyle Program (PLP)	Yes	Piloted randomized control trail	Weight loss maintenance	Honolulu, HI	Native Hawaiian, Filipino, or other Pacific Islander adults, aged ≥18 years in the Honolulu area
Pratte, K. A. et al. (2019). Recruitment and effectiveness by cohort in a case management intervention among American Indians and Alaska Natives with diabetes. <i>Translational Behavioral Medicine</i> , 9, 749-758.	Special Diabetes Program for Indians Healthy Heart (SDPI-HH)	Yes	Pre-test/post-test design	BMI, waist circumference, blood pressure, HbA1c, lipids, aspirin use, smoking status, dietary choices, and physical activity. Goals for behavioral outcomes were set as smoking cessation, daily use of aspirin, and ≥150 min/week of physical activity.	30 SDPI-HH programs, including 7 Indian Health Service, 21 tribal, and 2 urban Indian health programs	American Indian or Alaska Native adults with diabetes and aged ≥18 years
Pratte, K. A. et al. (2019). Regression to normal glucose regulation in American Indians and Alaska Natives of a diabetes prevention program. <i>Diabetes Care</i> , 42, 1209-1216.	Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre-test/post-test design	BMI, weight, waist circumference, systolic and diastolic blood pressure, LDL cholesterol, HDL cholesterol, triglycerides, FBG and 2-H glucose, previous or current diagnosis of hypertension, comorbidity, family history of diabetes, healthy lifestyle choices	36 SDPI-DP projects at Indian health care programs throughout the nation	American Indian or Alaska Native adults with diabetes and aged ≥18 years and having either impaired fasting glucose or impaired glucose tolerance
Teufel-Shone, N. I. et al. (2015). Changes in food choices of participants in the Special Diabetes Program for Indians–Diabetes Prevention Demonstration Project, 2006–2010. <i>Preventing Chronic Disease</i> , 12, E193.	The Special Diabetes Program for Indians Diabetes Prevention Program (SDPI-DP)	Yes	Pre-test/post-test design	Sociodemographics, fasting blood glucose, blood pressure, body mass index, lipid levels, physical activity, and food intake	36 AI/AN local health care programs participated that served 80 tribes in 18 states and 11 of the 12 Indian Health Service administrative areas	

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Cardiovascular Disease						
Kaholokula, J. K. et al. (2017). Ka-HOLO Project: A protocol for a randomized controlled trial of a native cultural dance program for cardiovascular disease prevention in Native Hawaiians. <i>BMC Public Health</i> , 17(321), 1-12.	Ola Hou i ka Hula (Restoring Health Through Hula)	Developed specifically for targeted population	2-arm randomized controlled trial with a wait-list control design	Systolic blood pressure, improvement in risk for cardiovascular disease, psychosocial, and sociocultural measures	Various Hawaiian communities	Across Hawai'i via 5 community-based organizations
Chronic Disease						
Gellert, K. S. et al. (2010). Ke `Ano Ola: Moloka'i's Community-Based Healthy Lifestyle Modification Program. <i>American Journal of Public Health</i> , 100(5), 779-783.	Ke `Ano Ola (KAO).	Developed specifically for targeted population	Pre-test/post-test design	Weight, blood pressure, cholesterol, blood sugar	Moloka'I, HI	All community members
Korda, H. et al. (2013). Racial and ethnic minority participants in chronic disease selfmanagement programs: Findings from the Communities Putting Prevention to Work initiative. <i>Ethnicity & Disease</i> , 23(4), 508-517.	Chronic Disease Self-Management Program (CDSMP)	Yes	N/A	N/A	45 states, the District of Columbia, and Puerto Rico	Older adults with chronic disease
Jernigan, V. B. B. (2010). Community-based participatory research with Native American communities: The Chronic Disease Self-Management Program. <i>Health Promotion Practice</i> , 11(6), 888-899.	Chronic Disease Self-Management Program (CDSMP)	Yes	Post test	N/A	Santa Clara, CA	Patients of the Indian Health Center of Santa Clara Valley, CA who had diabetes
Falls Prevention						
Popp, J. et al. (2017). Using the Centers for Disease Control and Prevention's Stay Independent Checklist to engage a community of American Indians and raise awareness about risk of falls, 2016. <i>Preventing Chronic Disease</i> , 14, E05.	Stay Independent Checklist	No, confirmed cultural appropriateness of the Stay Independent Resource as well as the self-assessment tool via focus groups	Focus group	Falls	Zuni Pueblo, NM	Community Health Representatives

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Overall Fitness						
Kochevar, A. J., Smith, K. L., & Bernard, M. A. (2001). Effects of a community-based intervention to increase activity in American Indian elders. <i>Journal of Oklahoma State Medical Association</i> , 94(10), 455-460.	So Much Improvement with a Little Exercise (SMILE)	No	Pre/post assessment	Emotional health, blood pressure, heart rate	Community-based medical clinic in Oklahoma City, OK	American Indian adults aged 55-75 years old, and diagnosed with at least one of the following conditions: arthritis, heart disease, obesity, and/or non-insulin dependent diabetes
Sawchuk, C. N. et al. (2011). Does pedometer goal setting improve physical activity among Native elders? Results from a randomized pilot study. <i>American Indian and Alaska Native Mental Health Research</i> , 18(1), 23-41.	N/A	No	Randomized trail	Self-reported physical activity, health-related quality of life, objective measures of physical activity and fitness	Seattle	Outpatients from an urban clinic between 50 to 85 years
Sawchuk, C. N. et al. (2017). Changes in physical activity barriers among American Indian elders: A pilot study. <i>American Indian and Alaska Native Mental Health Research</i> , 24(1), 127-140.	N/A	No	Randomized trail	Self-reported physical activity, health-related quality of life, objective measures of physical activity and fitness	Seattle	Outpatients from an urban clinic between 50 to 85 years
Tomioka, M., Sugihara, N., & Braun, K. L. (2012). Replicating the EnhanceFitness Physical Activity Program in Hawai'i's multicultural population, 2007-2010. <i>Preventing Chronic Disease</i> , 9.	EnhanceFitness	Yes	Pre-test/post-test design	Chair stands, arm curls, up-and-go, and falls	Kaua'i County, HI	Older adults
Tomioka, M. et al. (2019). Twelve-month retention in and impact of EnhanceFitness on elders adults in Hawai'i. <i>Journal of Aging Research</i> , 2019, Article ID 9836181, 1-7.	EnhanceFitness	Yes	Pre-test/post-test design	Chair stands, arm curls, and up-and-go	Kaua'i and Maui Counties, HI	Older adults

Citation	Program Name	Program Adaptation	Study Design	Health Outcomes	Community Setting	Targeted Community
Nutrition						
Kattelman, K. K., Conti, K. & Ren, C. (2009). The medicine wheel nutrition intervention: A diabetes education study with the Cheyenne River Sioux Tribe. <i>Journal of the American Dietetic Association</i> , 109, 1532-1539.	Medicine Wheel Nutrition Model for Nutrition	Developed specifically for targeted population	Randomized control trial	Weight, body mass index, HbA1c, fasting blood glucose, cholesterol, triglycerides level, circulating insulin concentration, blood pressure, 24-hour diet histories, and physical activity	Cheyenne River Indian Reservation	Tribal members with Type 2 diabetes
Substance Use Disorders						
Kelley, A., Snell, B., & Bingham, D. (2015). Peer recovery support in American Indian communities: A qualitative intrinsic case-study approach. <i>Journal of Groups in Addiction & Recovery</i> , 10, 271–286.	Peer Recovery Support (PRS)	Yes	Qualitative case study design	N/A	2 American Indian reservation communities located in a rural Northern state	Individuals who were partaking in the PRS program
Kelley, A., Bingham, D., Brown, E., & Pepion, L. (2017). Assessing the impact of American Indian peer recovery support on substance use and health. <i>Journal of Groups in Addition & Recovery</i> , 12 (4), 296-308.	Transitional Recovery and Culture Program	Yes	Pre/Post Assessment	Drug and alcohol use, depression, anxiety, suicide attempts, psychological and emotional impacts	Tribal chemical dependency programs, tribal health programs, community social service agencies, and self-referral from the Northern Plains American Indian Tribes	American Indian adults in recovery or a recovery program
Elder Abuse						
Holkup, P. A., Salois, E. M., Tripp-Reimer, T., & Weinert, C. (2007). Drawing on wisdom from the past: An elder abuse intervention with tribal communities. <i>The Gerontologist</i> , 47(2), 248–254.	Family Care Conference	Yes	N/A	Reduction in family conflict and elder abuse	An American Indian reservation (not named) in the Northwest	Families referred for participation via need for intervention around family conflict and potential for elder abuse

Appendix C: Listening Session Discussion Guide (Professionals)

Introduction / Welcome (script)

Good [morning/afternoon], <introduce yourself>

We are grateful that you have volunteered to participate in this listening session to help us develop concrete solutions and identify best practices for developing and adopting health promotion programs for native Elders—programs that will motivate Elders and help them create meaningful change to improve or to maintain their health and well-being.

It is well known that health promotion programs have greater impact when they incorporate the culture and values of the local community. If there is a mismatch between these cultural values and the programs, you lose people quickly.

Our goal here is to learn what types of best practices you've utilized to ensure that health information and/or health promotion activities are well received by native Elders. These listening sessions are hosted by the National Council on Aging in partnership with an Advisory Council representing 13 organizations, consisting of experts in the field of health, aging, and native communities.

Any information gained from this listening session will be compiled with others conducted in several other sites around the country. Any information shared during this session will be reported anonymously. The findings from the listening sessions will help guide the work of the national advisory committee in developing creative solutions and identifying best practices for the delivery of evidence-based health promotion and falls prevention programs for older American Indians, Alaska Natives, and Native Hawaiians.

Group Agreement

The guidelines for our discussion today are simple.

1. We want to hear from everyone, so please speak up!
2. If you need to stretch your legs, you can step out at any time.
3. What you share today is confidential. We ask that everyone respect each other's privacy and keep any sensitive information within this group.
4. This listening session is about your personal reflections, there is no right or wrong here.

[Introduce co-moderator and their role (e.g. notetaker, etc). Ask the group to introduce themselves, give a brief introduction with name, tribal affiliation, office affiliation.]

Ice Breaker

[Listening session moderators are encouraged to begin the session with a 5-minute brief activity to break the ice. Participants can be invited to take turns in answering questions about healthy aging. Feel free to use any of these questions or make up your own or modify these.]

- What does aging well mean to you, personally? [try to explain in one or two words (keeps it brief)]
- What wisdom do you want your children to take to heart about what it means to be a healthy elder? Your grandchildren? Your great-grandchildren? The generations beyond?
- Name one thing you do on a regular basis to help you stay or get healthy?

Guiding Questions

- 1. Let's do a quick round-robin, and share which evidence-based health promotion, disease prevention, or falls prevention programs you've been involved in delivering (either as a program leader/facilitator or coordinator). Some examples of evidence-based programs include (full list of "evidence-based programs" provided):**
 - **Chronic Disease Self-Management Program (a.k.a. Wisdom Warriors)**
 - **Diabetes Self-Management Program**
 - **Matter of Balance**
 - **Stepping On**
 - **Tai Chi for Arthritis**
- 2. What aspects of the evidence-based program(s) do you feel were effective and worked well for older participants in your classes? What did not work well?**
 - **Do you recall any aspect of the class that did not match with the beliefs or practices of community Elders about healthy living or aging?**
 - **If or when participants stopped going to the program after a few sessions, what was the usual reason(s)?**
- 3. Modification is often necessary to make the program contents relevant to your participants.**
 - **Can you provide specific ways that you modified class activities, content material, or other components of the workshop to ensure the program captured the needs of native Elders?**
 - **Which of these modifications seemed to work?**
 - **What else would you change about the program that you delivered to make it more meaningful and relatable to native Elders?**
- 4. Are you implementing other health promotion, disease prevention, or falls prevention activities instead of evidence-based programs? Are there reasons that they work better? [Use full list of current "evidence-based programs" for reference.]**
5. What type of health information that you don't have now would be good for your Elders? What health topics are of highest priority to the Elders you serve?
6. Generally, tell us about the types of activities that Elders in your community enjoy doing, for recreation, with family or alone?
 - Are there certain programs or services in your community that draw big crowds of older adults?
 - What do you believe makes them successful?
7. In addition to the questions above, are there any other topics that should be raised at future listening sessions? Any final comments?

*Bold text denotes priority questions.

Appendix D: Listening Session Discussion Guide (Elders)

Introduction/Welcome (script)

Good [morning/afternoon], <introduce yourself>

It is fortunate that in many native communities there is a growing number of resources to help native Elders. However, it is difficult sometimes to determine which programs attract and keep Elders participating in these programs. For example, how Elders receive information can determine whether they enjoy participating in health promotion programs and falls prevention classes. Some Elders prefer to take written information home. Others might want to talk to professionals face-to-face or on the phone about program information. And as Natives, we do enjoy coming together as a group, especially to discuss and learn about our health and the health of our community.

We are humbled to have you here today, and delighted that you have volunteered to be a part of this listening session to share your experiences and information so that we can learn more about what types of health information and activities are most valuable to you and other Elders in your community. These listening sessions are hosted by the National Council on Aging in partnership with an Advisory Council representing 13 organizations, consisting of experts in the field of health, aging, and native communities.

The information gained from this listening session will help us learn more about how to develop programs that will keep you and other Elders coming back these local programs in order to create and maintain meaningful change in your life and your community. Your shared information knowledge will also help us identify creative ways to resolve some of the issues that get in the way of Elders participating in health promotion programs.

The information you share today will be grouped from other listening sessions conducted with native Elders from other sites around the country. Together, the lessons learned from these listening sessions will guide the work of a national advisory committee, designed to help improve the delivery of evidence-based health promotion and falls prevention programs for older American Indians, Alaska Natives, and Native Hawaiians.

Group Agreement

The guidelines for our discussion today are simple.

5. We want to hear from everyone, so please, speak up!
6. If you need to stretch your legs, you can step out at any time.
7. What you share today is confidential. We ask that everyone respect each other's privacy, and keep any sensitive information within this group.
8. This listening session is about your personal reflections, there is no right or wrong here.

[Introduce co-moderator and their role (e.g. notetaker, etc). Ask the group to introduce themselves, give a brief introduction with name, tribal affiliation, etc. and ask if there are any questions before proceeding]

Ice Breaker

[Listening session moderators are encouraged to begin the session with a 5-minute brief activity to break the ice. Participants can be invited to take turns in answering questions about healthy aging. Feel free to use any of these questions, make up your own, or modify these.]

- What does aging well mean to you, personally? [try to explain in one or two words (keeps it brief)]
- What wisdom do you want your children to take to heart about what it means to be a healthy elder? Your grandchildren? Your great-grandchildren? The generations beyond?
- Name one thing you do on a regular basis to help you stay healthy?

Guiding Questions

8. **By a show of hands, how many of you have participated in a formal health promotion / disease prevention program or falls prevention program at any time in your life? Some examples include Matter of Balance, Chronic Disease Self-Management Program (a.k.a. Wisdom Warriors), Stepping On, Tai Chi, Diabetes Self-Management Program, or others like it. [provide names of programs that you know are used in the community or provide an additional description, if participants don't recognize any of these]**
9. **For those of you that said YES...**
 - Which programs did you participate in, attending even for at least one class/sessions?
 - How did you learn about the program(s)?
 - With many demands in your daily home life, what was the biggest motivator for attending the first class?
10. **For those of you that said NO...**
 - Have you heard of any of these programs advertised or promoted in your community?
 - What would motivate you to attend one of these programs?
 - What is your biggest challenge in attending a program like this?
11. **Tell us about the types of activities you enjoy doing that bring you joy, for recreation, with family or alone? What do you do for fun?**
12. **What else seems to be working in your community toward helping Elders age well?**
 - Are there programs or services in your community that draw big crowds of Elders?
 - What do you believe makes them successful?
 - What seems to be working?
13. **What type of health-related information would be especially valuable to you right now to help you live a better quality of life? If you could create any type of program to improve the health and well-being of Elders in your community, what would it look like? What would it focus on?**
14. **Where do you usually look for information on health or aging?**
 - In your opinion, what is the best way to promote health promotion programs to others like you?
 - What are some ways that these programs could be incorporated into other aspects of your daily life and activities?

15. For those of you that had at least one encounter with the class...

- What did you like best about the program?
- In what ways did the class content attract you personally?
- If you stopped going to the program after a few sessions, what was the primary reason?
 - What could the instructor or program leaders have done differently to help you stay engaged?
 - Did you find a rapport with other participants? With the instructor(s)?
 - How confident were you in the quality of the information presented? Did you trust the information shared?
 - Do you recall any aspect of the class that did not support your beliefs or practices about healthy living or aging? Please explain.
 - ◆ Was there anything about the program that was not especially meaningful?
 - ◆ Were there any program materials offered by the program that were not especially useful for you?

*Bold text denotes priority questions.

Appendix E: Title VI Directors and Administrators Survey

Introduction/Welcome

We've gathered you to help us develop concrete solutions and identify best practices for developing and adopting health promotion programs that will keep Native Elders coming back to create meaningful change in their lives and improve their health and well-being.

Any information you share today will be compiled in a final report, but reported anonymously. Together, findings from the survey will help inform the work of a national advisory committee dedicated to developing creative solutions and identifying best practices for the delivery of evidence-based health promotion and falls prevention programs for American Indians, Alaska Natives, and Native Hawaiians Elders.

According to the National Council on Aging (NCOA), evidence-based programs are interventions focused on disease prevention and encouragement of health behaviors in older adults. Backed by research, these programs can have positive effects on health, such as a better quality of life, self-efficacy, and mental health, increased levels of independence, as well as lower amounts of pain and disability. (<https://www.ncoa.org/center-for-healthy-aging/basics-of-evidence-based-programs/about-evidence-based-programs/>).

1. Have you heard of evidence-based programs before?
 - a. Yes
 - b. No

2. What is the estimated number of tribal Elders served by your organization?
 - a. Less than 100
 - b. 101-500
 - c. 501-1000
 - d. More than 1000

3. What are the greatest need(s) for tribal Elders in terms of health and well-being?
(Please mark all that apply.)
 - a. Access to affordable health care
 - b. Alcohol and/or substance abuse
 - c. Alzheimer's Disease/Dementia
 - d. Depression/anxiety
 - e. Diabetes management
 - f. Elder abuse/exploitation
 - g. Falls prevention
 - h. Financial insecurity
 - i. Housing
 - j. Loneliness/social isolation
 - k. Nutrition
 - l. Obesity
 - m. Chronic Disease (e.g., heart disease, high blood pressure, high cholesterol, arthritis, diabetes)
 - n. Physical activity
 - o. Smoking Stress
 - p. Transportation
 - q. Mobility
 - r. Other(s): _____

4. In your experience, what types of physical and mental health related programs are your tribal Elders most interested in? (Please mark all that apply.)
 - a. Alcohol Misuse/Abuse
 - b. Alzheimer's Disease/Dementia
 - c. Caregiving
 - d. Creative Arts/Dancing
 - e. Cultural Programs and Activities
 - f. Diabetes
 - g. Falls Prevention
 - h. Physical Activity/Exercise
 - i. Heart Disease

- j. Mental Health
- k. Nutrition
- l. Smoking Cessation
- m. Socialization
- n. Strength and balance
- o. Tai Chi
- p. Yoga
- q. Walking
- r. Other(s): _____

5. What evidence-based health aging/disease prevention and management programs (i.e., health promoting programs that are backed by research) have you heard of before? (Please mark all that apply.)

- a. A Matter of Balance
- b. Arthritis Foundation Exercise Program (AFEP)
- c. Better Choices, Better Health (online Chronic Disease Self-Management Program)
- d. Better Choices, Better Health – Diabetes (online DSMP)
- e. Chronic Disease Self-Management Program (CDSMP)
- f. Chronic Pain Self-Management Program
- g. Diabetes Empowerment and Education Program (DEEP)
- h. Diabetes Self-Management Program (DSMP)
- i. Enhance Fitness
- j. Fit and Strong
- k. Healthy IDEAS
- l. Special Diabetes Program for Indians (SDPI)
- m. Powerful Tools for Caregivers
- n. Savvy Caregiver
- o. Stepping On
- p. Tai Chi
- q. Walk with Ease
- r. Wisdom Warriors
- s. Other(s): _____
- t. None

6. What evidence-based health aging/disease prevention and management programs (i.e., health promoting programs that are backed by research) is your community currently implementing? (Please mark all that apply.)

- a. A Matter of Balance
- b. Arthritis Foundation Exercise Program (AFEP)
- c. Better Choices, Better Health (online Chronic Disease Self-Management Program)
- d. Better Choices, Better Health – Diabetes (online DSMP)
- e. Chronic Disease Self-Management Program (CDSMP)

- f. Chronic Pain Self-Management Program
 - g. Diabetes Empowerment and Education Program (DEEP)
 - h. Diabetes Self-Management Program (DSMP)
 - i. Enhance Fitness
 - j. National Diabetes Prevention Program (NDPP)
 - k. Powerful Tools for Caregivers
 - l. Savvy Caregiver
 - m. Stepping On
 - n. Tia Chi
 - o. Wisdom Warriors
 - p. Other(s): _____
 - q. None
7. Have you implemented any other evidence-based programs that were not listed above in Question 6? (If NO, skip to question 9.)
- a. Yes
 - b. No
- If yes, please list: _____
8. What was the length of the programs?
- a. Less than 8 weeks
 - b. 8-12 weeks
 - c. 12 or more weeks
9. What was the number of staff involved in implementing and sustaining the program?
- a. 1-2 staff
 - b. 3-5 staff
 - c. 5 or more staff
10. How long was the training for individuals to be certified or to coach the program?
- a. Less than 1 week
 - b. 1-2 weeks
 - c. More than 2 weeks
11. How many individuals were trained to be certified or to coach the programs?
- a. 1-2 staff
 - b. 3-5 staff
 - c. 5 or more staff
12. What resources were utilized to implement the program (check all that apply)?
- a. Federal Grant
 - b. State Grant
 - c. Foundation Grant

- d. Tribal Funding
- e. Other(s): _____

13. How was the program evaluated?

- a. Program Evaluator contracted through the grant
- b. Assessment material provided with the program completed by trainer or coach
- c. Program was not evaluated
- d. Other(s): _____

14. What funding sources do you use to implement evidence-based programs for tribal Elders?

- a. Administration for Community Living Older Americans Act – Title VI
- b. Administration for Community Living Older Americans Act – Title IIID
- c. Foundation/Philanthropic funding
- d. Other State Funding or State Revenue
- e. Other Federal Funding (e.g., Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), etc.)
- f. Tribal Funds/Revenue
- g. Don't Know
- h. Other(s): _____
- i. Does not apply (Do Not use evidence-based programs)

15. What partnership/s do you currently have that assists with delivering healthy aging evidence-based programs to tribal Elders? (Please mark all that apply.)

- a. Area Agencies on Aging (AAAs) & Aging and Disability Resource Centers (ADRCs)
- b. Educational Institutions (e.g., universities, community colleges, tribal colleges)
- c. Indian Health Service (IHS)
- d. Federally Qualified Community Health Centers
- e. Healthcare Organizations (e.g., hospitals, home health agencies)
- f. Local/County Public Health Department
- g. Other tribes
- h. Residential care facilities/nursing homes
- i. Rural health organizations
- j. Social service agencies
- k. Senior Centers
- l. Other(s): _____

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

- a. Strongly Agree
- b. Agree
- c. Neutral

- d. Disagree
 - e. Strongly Disagree
17. What factors do you think would increase the likelihood that tribal Elders would participate in an evidence-based program (Please mark all that apply).
- a. Culturally tailored programs
 - b. Incentives to participate in the program (t-shirts, water bottles, pedometer, etc.)
 - c. Setting goals
 - d. Listening to the Elders (ideas, concerns, suggestions, etc. about the program)
 - e. Other(s): _____
18. Based on your experience, what are the primary reasons why tribal Elders withdraw from an evidence-based program? (Please mark all that apply.)
- a. Caregiving obligations
 - b. Other personal obligations, responsibilities
 - c. Conflict with work
 - d. Dissatisfaction with workshop or instructor
 - e. Doctor appointments
 - f. Illness or health problems
 - g. Transportation
 - h. Lack of relevance
 - i. Weather
 - j. Other(s): _____
 - k. None
19. 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 needed behavior changes.
- a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly Disagree
20. What are the barriers to implementing an evidence-based program into your tribal community? (Please mark all that apply.)
- a. Cost
 - b. Transportation
 - c. Not enough Elders interested (number of participants)
 - d. Evidence-based programs are not tailored for our Tribal Elders
 - e. Available location/facility to hold program
 - f. Other(s): _____

21. Do you feel that evidence-based practices are responsive to your tribe's culture?
(If YES, skip to question 23.)
- Yes
 - No
22. If not, how would you recommend they become more responsive to your tribe's culture?
(Please mark all that apply.)
- Tailor the program to each Tribal community based on cultural and traditions
 - Implement a Tribal advisory board to provide suggestions for the program
 - Create a Tribal Elder council to lead the implement of the program
 - Other(s): _____
23. 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.
- Strongly Agree
 - Agree
 - Neutral
 - Disagree
 - Strongly Disagree
24. 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.
- Strongly Agree
 - Agree
 - Neutral
 - Disagree
 - Strongly Disagree
25. Are you currently using a program that has been successful for your Tribal Elders that is not considered "evidence-based"? If so, please list the program/s below. (If NO, skip to question 26.)
- Yes
 - No
- If yes, please list: _____
26. What aspects of the program are most appealing for the tribal Elders?
(Please mark all that apply.)
- Social engagement
 - Educational Items
 - Physical Activity Items
 - Emotional/Mental Health Items
 - Management of Disease
 - Other(s): _____

27. What resources and strategies could be provided to your tribe that would be helpful in implementing evidence-based programs? (Please mark all that apply.)

a. Easier accessibility for train-the-trainer

b. Funding

c. Transportation for Elders

d. Equipment for program

f. Other(s): _____

28. What do you think are the key factors to consider when implementing an evidence-based program into a tribal community successfully? (Please mark all that apply.)

a. Consultation from the tribal community

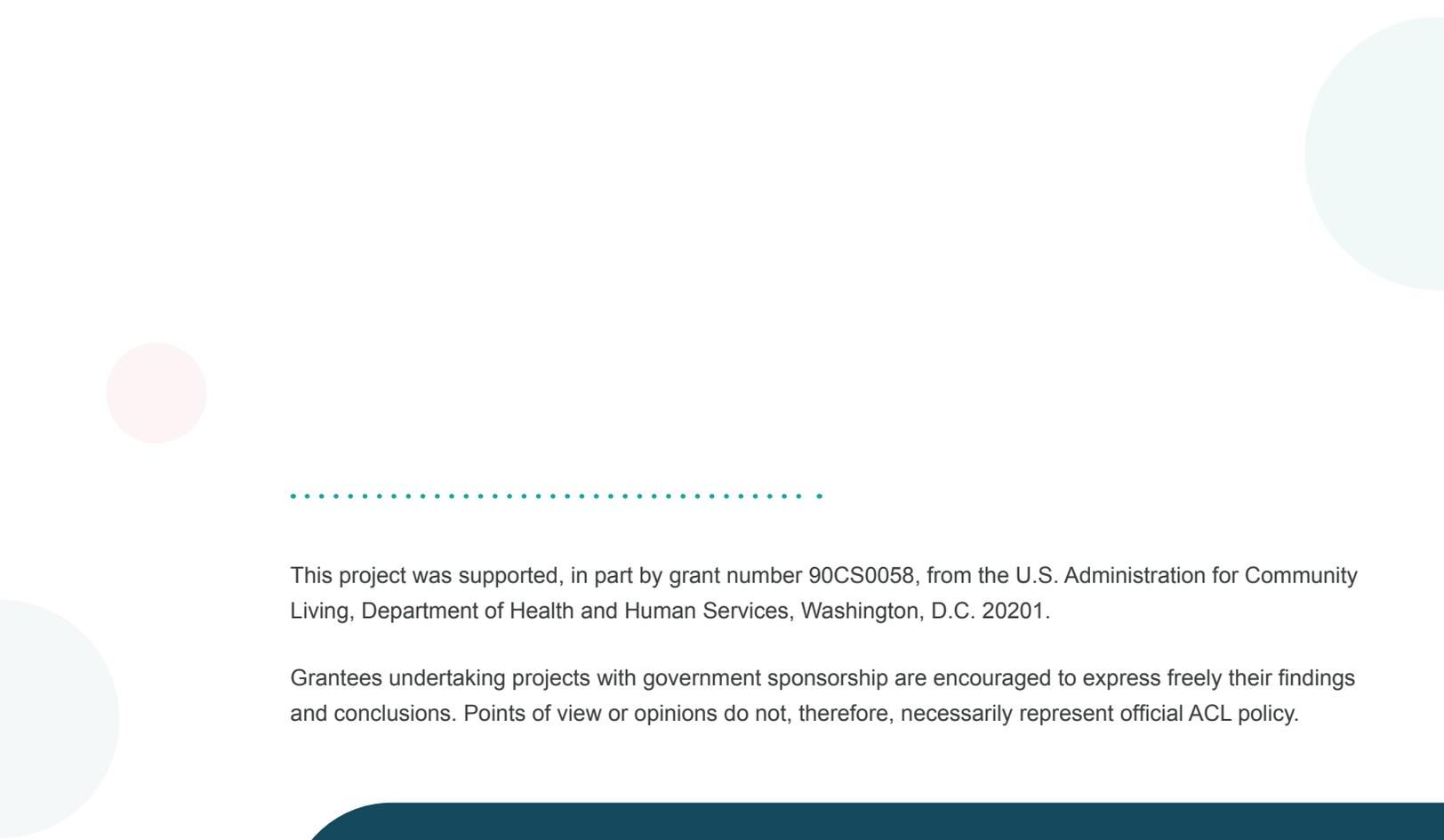
b. Program Resources

d. Funding Resources

e. Culture

f. Other(s): _____

29. Please share any additional thoughts as to ideas or recommendations on how tribes could be supported so as to offer evidence-based programs in their communities.



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