

**Community Living for American Indian,
Alaskan Native, and Native Hawaiian Elders**

Jane Tilly, DrPH and Kristen Hudgins, PhD
Administration for Community Living
Center for Policy and Evaluation

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Executive Summary

Part of the Administration for Community Living's (ACL) mission is to assist American Indian, Alaskan Native, and Native Hawaiian Elders to live with dignity and self-determination, while participating fully in their communities. The Administration on Aging, which is part of ACL, implements this mission through its Older Americans Act programs and relationships with other federal agencies and their services. The Administration helps assure successful outcomes in part by recognizing the strengths and resiliency of American Indian, Alaskan Native, and Native Hawaiian Elders and respecting Native communities' sovereignty, culture, and self-determination.

Assisting Elders with respect requires understanding several key concepts. First, is cultural variation among Native communities in the United States.¹ While cultures differ, they typically recognize the importance of connection and harmony among the individual, family, Tribe, community, and land. Second, Native communities are strong and depend upon Elders to maintain and promote their cultural traditions across the generations. Third, Native communities and families care for their Elders and Elders often take on caregiving responsibilities for younger members of their community. While many Native communities share these values, individual cultures and approaches to health and community living vary across the United States. Finally, many Native communities are sovereign with direct government-to-government relationships at the federal level.² However, Native communities may have to work through state governments to access federal programs and this can cause difficulties when States or other organizations do not fully understand a Native communities' sovereign status.

Promoting Elders' health and supporting their community living requires knowing the impact of their historical experience. This experience involves reduction of homelands ceded during treaty negotiations in exchange for medical care, food, education and other essentials. It also includes loss of culture including language, traditional values, and spiritual practices resulting in historical trauma across generations. This trauma contributes to lower life expectancy and higher rates of chronic disease and disability among American Indians, Alaskan Natives, and Native Hawaiians. Fortunately, these populations have used innovative approaches to overcoming the consequences of these problems and there are model programs for Elders throughout the United States. In part, the programs support Elders by weaving together funds from the Older Americans Act, Indian Health Service, Centers for Medicare & Medicaid Services, Veterans Affairs programs, and others.

This issue brief is designed to: 1) assist the Aging Network,³ which includes many organizations serving American Indian, Alaskan Native, and Native Hawaiian Elders; and 2) share information about some of

¹ Native communities is used here to holistically refer to American Indians, Alaskan Natives, and Native Hawaiians. These communities may also be referred to as corporations or consortia.

² This does not apply to Native Hawaiians, who are not currently recognized as a sovereign nation.

³ Under the Older Americans Act, the Administration on Aging provides national leadership, funding oversight and technical support to a federal, state, tribal, and local partnership called the National Aging Network. This network, serving about 7 million Elders and their caregivers, consists of 56 State Units on Aging; over 600 Area Agencies on Aging; 274 tribal organizations; one organization that serves Native Hawaiians; 29,000 service providers; and thousands of volunteers. These organizations provide assistance and services to Elders and their families in urban, suburban, and rural areas throughout the United States.

the innovative programs that promote health and support community living for Elders. The issue brief begins by presenting some broad commonalities in cultural traditions and historical experience among American Indians, Alaskan Natives, and Native Hawaiians, and then documents disparities in health and disability. Next, are descriptions of innovative approaches that Native communities have used to address identified disparities. The brief continues with examples of how Native communities have creatively used the Older Americans Act and other federal programs that aim to promote health and support community living for their Elders. The conclusion highlights common aspects of successful programs for Native people, including embedding the programs within their local context and culture.

Community Living for American Indian, Alaskan Native, and Native Hawaiian Elders

1. Introduction

Part of the Administration for Community Living's (ACL) mission is to assist American Indian, Alaskan Native, and Native Hawaiian⁴ Elders⁵ in living with dignity and choice, while participating fully in their communities. The Administration on Aging (AoA), which is part of ACL, implements this mission through its Older Americans Act (OAA) programs and relationships with other federal agencies and their programs. These agencies include the Indian Health Service (IHS), Centers for Medicare & Medicaid Services (CMS), and Veterans Affairs (VA).

Native communities and their Elders have survived historical trauma, poverty, and other obstacles over the past 500 years through their cultural strength and resiliency. Some communities are thriving and successfully serving their people through innovative programs. Others are struggling to adequately meet the needs of their elders. ACL is committed to promoting health and supporting community living for American Indian, Alaskan Native, and Native Hawaiian Elders through partnership, dialogue, and implementation of Older Americans Act programs that respect tribal culture, self-determination, and sovereignty.

Assisting Native Elders requires understanding the historical experiences of American Indians, Alaskan Natives and Native Hawaiians, as well as these experiences' impact on Elders. Also important to understand are: 1) Tribes' sovereign relationship with the United States and state governments; and 2) Older Americans Act and other federal programs that serve these populations. This issue brief addresses these topics and provides examples of innovative programs that weave together an understanding of American Indian, Alaskan Native, and Native Hawaiian cultures with programs designed to serve Elders.

2. Tribal Sovereignty

Federally-recognized Tribes⁶ are sovereign nations that have direct political relationships with the United States government and the states within which they are geographically located. While tribal members are citizens of all three governments, it is important to note that treaties between Tribes and the United States government take precedence over any conflicting state laws. The federal government

⁴ Although many of the concepts and much of the information in this issue brief applies to Native Hawaiians, little national data is available about this population because of its small size and the fact that the Census combines Native Hawaiians with Pacific Islanders when reporting its data.

⁵ "Elders" in this issue brief are older American Indians, Alaska Natives, and Native Hawaiians.

⁶ A federally-recognized tribe is an American Indian or Alaska Native tribal entity that is: 1) recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and 2) eligible for funding and services from the Bureau of Indian Affairs. Federally-recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States. At present, there are 567 federally-recognized American Indian and Alaska Native tribes and villages. It is important to note that Native Hawaiians do not have tribal sovereignty.

has an obligation to protect tribal self-governance and rights, among other responsibilities (National Conference of American Indians, 2015).

Tribal sovereignty means that tribes have the ability to govern within their territories and protect the health, safety, and welfare of their citizens. Tribal governments can manage the health, safety, and social service programs that serve their people. Many federal programs fund, operate within, or provide services to tribal communities and strive to allow sufficient flexibility for services to be adapted for the specific tribe or cultural group they serve.

3. Elders' Cultures and the Relationship with Health

Native cultures value the importance of family, community, Tribe, and tradition, with Elders playing a key role in maintaining or reviving them (King et al., 2009; Anisko, 2009). Elders connect with the past, safeguard community knowledge, and support its spirit. Elders are the keepers of cultural legacies and have a key role in socializing children and grandchildren in the ways of their communities (Fuller-Thomson and Minkler, 2005). These connections promote health and support community living for American Indian, Alaskan Native, and Native Hawaiian Elders.

Appropriately assisting Elders requires a general understanding of their cultural and spiritual beliefs and practices. Many Native communities believe that social, mental, physical, and spiritual health depend on harmony between an individual's inner and outer environments (Grandbois 2005; King et al., 2009). In other words, people should live in harmony with others; their family and community; and the natural and spirit worlds. Spirituality is important to healing and well-being. As with many cultures, health and healing are not rooted in going to the doctor and receiving Westernized medical care. Many Elders include some traditional medicinal practices involving the use of ceremony, ritual, herbs, and plants alongside or in conjunction with their Western medical care (Rhoades, 2009). Cultural beliefs and practices can vary greatly among Native communities, and even among members of those communities. The key to working well with any Native community is to bring a sense of humility and be open to listening, understanding, and respecting their ways of making sense of the world. Therefore, many of the most effective services are provided by the Elders' own communities.

For mainstream health care workers to interact well with Native people, an understanding and acceptance of traditional healing is essential. In some Native cultures, helpers and healers tend to understand an Elder's health problems through the balances and imbalances in the individual's relational world (Grandbois, 2005; Mohagddam, 2013). Under these circumstances, a healer's first step is to listen to the Elder's story and understand the situation from their perspective. The second step involves helping the Elder create a metaphor for the condition or illness to understand its nature. The healer then builds a ceremony to "fight the illness," which relies on the Elder's description of their chief complaints. Each tribe has its own specific approach to healing and these views and traditions may not be familiar to health professionals from the majority culture..

4. Historical Trauma, Health, and Resiliency

Historical trauma⁷ affects Elders' health. Elders, their parents and grandparents, have experienced traumatic events, with the pain and stories passed down over generations. Traumatic events resulted from a history of Federal policies that led to loss of land; removal to reservations; loss of language, cultural activities, and beliefs; and separation of children from their families and communities.

4.a Historical Trauma

During European immigration to North America in the 1600s and 1700s, immigrants displaced many Native populations (Brown-Rice, 2013). This trend continued into the 1800s when many Native communities lost their land and, in the continental United States, were forced to move west of the Mississippi to reservations that the federal government created (Moss 2010). Next, the federal government implemented an assimilation policy, which began in the late 1880s and ended in the 1930s. This policy involved restrictions on Native people's ability to live their cultures and practice their religions. In addition, government and religious boarding schools took young children from their families and did not allow them to contact their family or communities or practice their languages and traditions for long periods of time. Children were placed in settings where the emphasis was on eliminating cultural connectivity and destroying Native languages. The schools required children to speak, act, and dress like the majority culture and many children experienced a wide range of other abuses. During summers, Native children in boarding schools generally could not return to their communities. Instead, they often provided manual labor for farmers or household assistance for other families (National Resource Center for American Indian, Alaska Native, and Native Hawaiian Elders, 2005). Beginning in the 1940s and ending in the early 1960s, the Federal government decided to terminate its recognition of about 100 Tribes in an effort to promote assimilation; these Tribes lost their Federal benefits. After the assimilation period, the federal government recognized the importance of tribal communities and began the current self-determination era, which promotes Tribes' control over their own affairs.

One chronology⁸ of the federal policy eras is (Moss, 2010):

1. **Removal** 1825-1850, which aimed to move Tribes west of the Mississippi River.
2. **Reservation** 1850-1887, further constricted the areas the Tribes could occupy.
3. **Allotment and assimilation** 1887-1934, allowed individual American Indians to hold land so that they might become like suburban homeowners and blend into the larger society. During this time and later, children were taken to boarding schools to promote assimilation.
4. **Indian reorganization** 1934-1940s, was designed, through The Indian Reorganization Act, to protect Indian lands rather than to promote assimilation.
5. **Termination** 1940s-1961, resulted in 100 tribes losing federal recognition and all access to federal funding for programs.
6. **Self-determination** 1961-present, was designed to promote tribal control over themselves and services.

⁷ Braveheart and colleagues (2012) explain that this term means the complex trauma that a group of people with a specific identity or affiliation experience. This historical trauma is the result of many events a community experiences over generations and includes the population's psychological and social responses to them. The Department of Health and Human Services has a [Resource Guide to Trauma-Informed Human Services](#).

⁸ Another, similar chronology may be found in National Congress of American Indians, *Tribal Nations and the United States: An Introduction*, 2017.

Alaskan Natives and Native Hawaiians had similar experiences to those of their counterparts in the lower 48 states. Many Alaskan Natives: 1) had their land bought and sold without their consent, 2) had to move from their home territories to make way for non-Native settlers, 3) had no right to vote, and 4) faced segregated schooling (Barnhardt, 2001). Native Hawaiians also experienced historical trauma because: 1) their religion was outlawed (1819), 2) land ownership rules changed to favor non-Hawaiians (1848), 3) their monarchy was overthrown (1893), and 4) they were subject to martial law from 1941 until 1945 (Browne et. al, 2009).

4.b Impact of Historical Trauma

The results of this history have been dramatic decreases in Native populations during certain early periods and increases in health problems over time. Many scholars attribute the comparatively poor health outcomes for Native communities, in part, to the historical trauma they have experienced (Brown-Rice, 2013; Evans-Campbell, 2008). Historical trauma affects individuals, families, and communities. Individuals experience post-traumatic stress disorder, guilt, grief, and depression, which, in turn, can affect their family communication and parenting. Communities may experience breakdown of their cultures, values, and traditional rites of passage. Cumulative impacts may result in high rates of illness, alcoholism, and internalized racism. For example, Evans-Campbell (2008) reports on Whitbeck's study of Elders from two large reservations who reported emotionally negative responses to loss of tribal land, forced boarding school attendance, and other historical traumas that occurred years ago. Elders also reported a range of emotions, including depression, anger, anxiety, fear, isolation, and avoidance of triggers that remind them of their losses. American Indian, Alaskan Native, and Native Hawaiian Elders may also experience a deep distrust of government and federal policies due to their experiences. Regardless of their origins or location, Native Communities share a history of domination and trauma, which has contributed to shorter life expectancies and higher prevalence of a number of chronic diseases--diabetes, heart disease, and cancer--when comparing these communities to the majority populations in the United States (Browne et al., 2009).

Despite these challenges, the population of American Indians, Alaskan Natives, and Native Hawaiians is now growing rapidly and has reached over 5 million people. Native people have maintained or rediscovered their traditions, revitalized their cultures and languages, and have implemented creative and innovative health promotion and community service programs honoring their cultural strengths. The next few sections of this issue brief describe population growth, location, and health challenges.

5. American Indian, Alaskan Native, and Native Hawaiian Populations' Growth and Location

Understanding Native history and cultural beliefs is critical to successful service. However, knowing the community's demographic character is important as well. There has been a rapid increase in American Indian and Alaskan Native populations, and their Elders. These populations are concentrated in Western and Southern states. Also, the majority of American Indians, Alaska Natives and Native Hawaiians live outside the reservation system. This can challenge the Aging Network seeking to serve them where they live and requires enhanced outreach for mainstream programs to establish contact and serve urban Elders in a culturally sensitive fashion.

- In 2010, 5.2 million people reported that they were full or part American Indian or Alaskan Native; this population increased 27 percent between 2000 and 2010 (Norris et al., 2012). About 527,000 people were full or part Native Hawaiian (Braun and LaCounte, 2014).
- In 2010, 7.1 percent of the American Indian and Alaskan Native-alone⁹ population was age 65 or over, as was 5.8 percent of the Native Hawaiian and Other Pacific Islander-alone population (West et al., 2014). These populations grew 26.3 percent and 10.7 percent respectively between 2000 and 2010.
- In 2010, about 45 percent of American Indian and Alaskan Native Elders lived in the Western United States, and another 33.5 percent lived in the South (Norris et al., 2012).¹⁰
- In 2010, about 80 percent of American Indians and Alaskan Native Elders live in micro- and metropolitan¹¹ areas (Norris et al., 2012). In the same year, more than 90 percent of Native Hawaiians lived in micro or metropolitan areas of the Western United States.

The rapid increase in the number of Elders is a success story. This increase likely will lead to more demand for services to promote health and support community living, especially in urban areas of the Western and Southern United States.

6. Health, Disability, and Innovative Programs

Although American Indian, Alaskan Native and Native Hawaiian populations are increasing and living longer, they continue to face health disparities. In comparison with members of the overall population of the United States, American Indians and Alaskan Natives have shorter life spans, higher death rates, experience more preventable causes of death, and have more chronic conditions (Espey et al., 2014; Urban Indian Health Institute, 2016). They also experience disproportionately high rates of certain mental health conditions, such as depression and substance abuse (Indian Health Service, 2014). These disparities vary by United States region. Evidence supporting these conclusions varies by data source, definition of American Indian and Alaskan Native populations, and geographic location. Data about Native Hawaiians can be very difficult to obtain, but some research on Elders has shown that they suffer higher rates of disability, and greater issues with self-care and underutilization of services than do non-Hawaiian Elders (Brown et al., 2009).

Evidence shows that:

- American Indian and Alaskan Native life expectancy at birth across Indian Health Service regions was 73.7 years. It ranged from 69.4 in Billings, Montana to 82.3 years in Nashville, Tennessee (Indian Health Service, 2014). The National Center for Health Statistics estimates that the overall life expectancy in the United States is 78.8 years (NCHS, 2016).
- Leading causes of death for American Indian and Alaskan Natives were heart disease, cancer, unintentional injury, diabetes, stroke, and chronic liver disease (Espey et al., 2014; Urban Indian Health Institute, 2016). For the general population these are heart disease, cancer, chronic lower respiratory disease, unintentional injuries, stroke, and Alzheimer's disease (NCHS, 2016).

⁹ "Almost half of the American Indian and Alaska Native population, or 2.3 million people, reported being American Indian and Alaska Native in combination with one or more other races" (Norris et al., 2012). Therefore, statistics that report on American Indians or Alaskan Natives alone are only telling half the story of this population.

¹⁰ [U.S. Census Maps](#) locating these populations are available.

¹¹ Micropolitan areas have an urban core of 10,000 or more people; metropolitan areas have an urban core of 50,000 or more.

- American Indian and Alaskan Natives experience higher rates of obesity (23.9 percent compared to 18.7 percent in other racial/ethnic groups), diabetes (9.7 percent compared to 5.7 percent in all other races), cardiovascular disease (14.7 percent compared to 12.2 percent non-Hispanic whites), and metabolic syndrome (49.8 percent compared to 34.0 percent in the general population) than other populations (Hutchinson and Shin, 2014).
- Data from the 2007–2010 Behavioral Risk Factor Surveillance System show that the prevalence of disability was 31 percent among American Indian and Alaskan Natives as compared to 10.1 percent of Asians (Courtney-Long et al., 2017).

Researchers and service providers have noted these disparities and, working collaboratively with Native communities, have developed some successful programs to address them. One example is the Indian Health Service's *Special Diabetes Program for Indian Diabetes Prevention*, which involved 36 health care programs serving 80 tribes in 18 states with guidance from a Tribal Leaders Diabetes Committee. These programs enrolled over 2,500 American Indian and Alaskan Natives with pre-diabetes into the program. Participants had lower diabetes rates and improved their weight, blood pressure, and lipid levels immediately after the intervention and three years later. Older and retired participants were more likely to complete the program and had fewer problems related to scheduling and moving away (Jiang et al., 2013). Another example is a study of 13 physical activity interventions in Native communities in the United States and Canada. This study demonstrated that strong tribal leadership and inclusion of all age groups were linked to program sustainability (Teufel-Shone et al., 2009). Tribally-led physical activity interventions generally were available to all tribal community members and highlighted communities' unique culture, unity, perseverance, and survival. The most sustainable strategy was training local instructors to lead regular physical activity classes.

7. Caregiving among American Indians, Alaskan Natives and Native Hawaiians

Caregiving often is a cross-generational practice with family caring for Elders, and Elders caring for grandchildren. When Elders have health challenges or need assistance, their families are often their first line of support. A survey of about 5,200 American Indian adults living in the Northern Plains and in the Southwest found that 17 percent of them cared for other adults (Goins et al., 2011). In both geographic areas, caregivers strongly valued traditional activities and healing practices. Being a caregiver of an adult sometimes brings challenges even when support of Elders is considered an honorable activity. Caregivers for adults with physical or mental disabilities in the Northern Plains and the Southwest regions of the United States consistently reported worse mental and physical health than other similar individuals who did not care for adults with those disabilities (Spencer et al., 2013). These challenges are consistent with those of the majority population.

In addition to receiving assistance, Elders often provide assistance to their families and communities. Grandparents play a strong, direct role in caring for their grandchildren and teaching traditional values, language, and behaviors. Seven percent of American Indian and Alaskan Natives age 30 and older were grandparents living in the same household with their grandchildren under age 18 (U.S. Census Bureau, 2007). About 60 percent of these grandparents were responsible for their grandchildren's care.

The Aging Network can build on these interconnections and tribal strengths to serve Elders. Fortunately, innovations provide examples of how that can be done with current federal programs.

8. Service Systems for American Indian, Alaskan Native, and Native Hawaiians

As noted above, Elders experience higher rates of disease and disability and are more likely to be caregivers than members of the majority population. Elders may receive services through programs such as those operated by the Indian Health Service, Administration on Aging, Centers for Medicare & Medicaid Services, and Veterans Affairs, if they qualify for these programs. This section briefly describes each of these programs and related innovations. It is important to note that many Elders may have private health insurance or qualify for Medicare, which allows access to specialists and other practitioners who may not be available at reservation clinics. This issue brief does not address barriers to services such as transportation to health and long-term care providers, which can be far from where Elders live, or service providers who do not understand Native cultures and languages.¹²

8.a. Indian Health Service (IHS)

The IHS provides health care to enrolled members of federally-recognized tribes. It serves about 2.2 million people through a network of hospitals, clinics, and health stations. IHS funding is limited so facilities often must ration and prioritize services and facilities must recover third party payments, including Medicaid (Artiga et al., 2013). American Indian and Alaskan Native people living within an IHS service area may have access to primary care if they are enrolled in a federally-recognized tribe. However, IHS programs may only be able to provide services if the person is at immediate risk of losing their life or having a serious impairment.

Many tribes work closely with states and Medicaid and Medicare to ensure that tribal members' needs are met. Clinics encourage and often help members sign up for federal health programs for which they are eligible. This helps offset the cost of care for clinics and allows for third party payment, thus helping to ensure that IHS funds can be used for tribal members without other coverage.

The IHS aims for maximum tribal involvement in meeting the health needs of its service population, who live mainly on or near reservations. Tribes administer over 60 percent of IHS' appropriation, primarily through self-determination contracts or self-governance compacts; the latter are similar to block grants (Indian Health Service, 2016). These self-governance compacts are known informally as "638 clinics."

The Indian Health Care Improvement Act of 2010 allows IHS to provide hospice, assisted living, long-term care, and home and community-based services, and permits IHS to have agreements with the Departments of Veterans Affairs and Defense to share medical facilities and services (Indian Health Service, 2014). The Act also requires IHS to establish comprehensive behavioral health, prevention, and treatment programs.

IHS, in one of its innovative programs, works with the Pueblo of Zuni to manage a wide range of Elder-care services (Centers for Medicare & Medicaid Services, 2017). The Pueblo provides comprehensive care to Elders within the community through an adult day center for people with dementia, home health services, a federally-qualified health center, and a senior center that offers meals, health promotion, recreation and other services. Funds from the Indian Health Service, Medicare, Medicaid, and the Older Americans Act, among others, support these programs. In addition, the IHS operates a

¹² Please see the HHS report [Barriers to American Indian/Alaska Native/Native American Access to DHHS Programs](#) for more information on barriers.

Hospital Elder Care Program that assesses and manages the needs of Elders, while coordinating with the Pueblo's programs.

8.b. Administration on Aging's Older Americans Act (OAA) Programs

The OAA provides limited grant funding for programs that serve adults age 60 and over. However, American Indian, Alaskan Native, and Native Hawaiian grantees are allowed to determine at what age a person may receive services, which is often under the age of 60. This is permitted because of the differences in health status and life expectancy among Elders, compared to their peers in other groups. The programs provide a variety of services, including nutrition, home and community-based, and caregiver services. The Act has sections called "Titles." The most widely used titles for Native-focused programs are: 1) Title II, which establishes the Office for American Indian, Alaskan Native, and Native Hawaiian Programs; and 2) Title VI, which provides grants for nutrition and health promotion services, home and community-based services, and family caregiver services to eligible tribes or organizations. OAA Title III is important because it provides grants to states for these same services, which are also available to Elders in Native communities who may or may not live on reservations. Congress directed that OAA services to these communities be provided "in a manner that preserves and restores their respective dignity, self-respect, and cultural identities" (42 U S C 3057a).

Title VI has three subsections, which describe grantee eligibility criteria for the Indian Program, Native Hawaiian Program and the Native American Caregiver Support Program. For the first two programs grantees must be: 1) a Federally-recognized tribe or a government (Part A) or non-profit organization able to serve Native Hawaiians (Part B), and 2) represent at least 50 people who are age 60 or older. Grantees receiving Parts A or B grants may also be eligible to receive grants to deliver caregiver support services, which include information and assistance, counseling, support groups, caregiver training, and respite care.

An example of an innovative use of OAA funds is a chronic disease self-management program called Wisdom Warriors, which serves tribal Elders in Washington State and is expanding to serve tribes in Oregon and California (W. Bendixen 2017, personal communication on May 10, 2017). The program is an adaptation of an evidence-based self-management education program developed at Stanford University, which teaches people living with chronic illnesses ways to manage them more effectively. The six-week course follows the Stanford model exactly but encourages participants to incorporate traditional activities into the discussion. For example during a group brainstorming activity about exercise, traditional activities are suggested by the leaders, if they do not come from the group. Exercise with a traditional flare could include subsistence activities (digging clams, picking berries, pulling cedar bark) or games or sports commonly done in tribal communities (pulling canoe, wrestling, high kicks). Once the participants have completed the adapted education program, they become "Wisdom Warriors" and can join others in monthly meetings for the rest of their lives. In the original Stanford program, people do not have this life-long service. The Warriors receive a Wisdom Pouch with a logo pin, and multicolored beads that Elders earn by completing health goals throughout each year. While the Stanford model teaches self-efficacy, in tribal cultures community is deemed more important than the individual. Holding the monthly classes encourages the Wisdom Warriors to continue to support one another using the tools they learned in class.

8.c. Medicaid

Medicaid is a means-tested health and long term care program that states run under broad federal guidelines. States are the direct recipients of Medicaid funding. Thus, Tribal nations must work through their states to obtain Medicaid coverage for eligible members as well as reimbursement for medical services provided in their clinics for eligible individuals. Elders generally must have low incomes and few assets to obtain services. Services include a wide range that promote health and support community living. Medicaid has certain special protections for American Indians and Alaskan Natives who are its beneficiaries (Artiga et al., 2013). These include:

- Certain property cannot be counted toward asset tests or recovered from the estates of beneficiaries age 55 or older.
- Inability to compel American Indians and Alaskan Natives to enroll in a managed care organization unless the IHS or a tribe operates it. These organizations must have sufficient numbers of Native providers to ensure timely access to care.
- Federal match (FMAP) of state Medicaid expenses of 100 percent for the Medicaid services provided to eligible participants.

Note: In 2016, CMS expanded its [definition of services](#) eligible for 100 percent FMAP to include services provided outside of clinics operated with IHS funds. This expanded definition opens doors for enhanced access to services, including long-term services and supports, when specific requirements are met.

An example of an innovative Medicaid program comes from the Oneida Nation, which manages the program under a contract with Wisconsin. In 1994, the Nation began improving Tribal members' access to Medicaid home- and community-based services through that state's Community Option Program (Centers for Medicare & Medicaid Services, 2017). Medicaid prohibits program access by potentially discriminating population characteristics; therefore the services are set up based upon geography. For this reason, Wisconsin treats the Oneida Nation as a county so it can participate in the program. The Nation's program covers Elders and individuals with disabilities who qualify for Medicaid and provides them with a wide range of services, including: assessment, case management, skilled nursing and therapies, and traditional healing. The Nation provides many of these services directly and contracts for others.

8.d. Medicare

Medicare is available for those aged 65 and over who have the necessary work history or those who have a disability and have received social security disability payments for two years. Medicare covers physician, hospital, and related services, as well as medications for those who choose to participate. Native Elders are exempt from cost-sharing for Medicare services. Not all Elders will qualify for Medicare, but this program is an important source of coverage for health care for the American Indians, Alaskan Natives, and Native Hawaiians who do.

8.e. Veterans Affairs

American Indians and Alaskan Natives are proportionately more likely to serve in the military than any other United States racial or ethnic group (Kramer et al., 2009). The IHS and the Department of Veterans Affairs have had an agreement since 2003 to share information and coordinate services for these

veterans. The two government agencies have developed models of Home-Based Primary Care Expansion Programs in collaboration with certain Tribes (Kramer et al., 2015).

Tribal healthcare organizations are the primary care providers and share their information with the Veterans Health Administration (VHA). The VHA system pays the tribes' providers for care of veterans living within reservation boundaries. The care teams provide home-based care or provide telephone consultation to veterans or to the VHA provider. Some tribes or Indian Health facilities provide office space to serve as a base for VHA teams. Teams generally have nursing and social work staff and often use telehealth consultation. These teams also can make use of mobile clinics to provide services in remote areas and team staff can be supplemented through purchase of additional services if required.

9. Conclusions

American Indians, Alaskan Natives, and Native Hawaiians are the peoples whose land the European immigrants appropriated and whose cultures and religions they disrupted beginning 500 years ago. In spite of treaties which guaranteed medical care in exchange for their ceded land, the legacy of this displacement and disruption has caused generational trauma resulting in disparities in life span, disease, and disability.

Despite these disparities, American Indian, Alaskan Native, and Native Hawaiian populations are growing and living longer for several reasons. Starting in the mid-20th Century, the federal government began recognizing and encouraging tribal self-determination. Tribal entities took this opportunity and developed innovative programs to address the challenges.

The successful innovations are those that build on and incorporate the strengths of American Indian, Alaskan Native, and Native Hawaiian communities and their enormous resilience. Examples of innovations exist across the country within programs that Native communities operate under the Older Americans Act, Medicaid, and the Indian Health Service, and through cooperative efforts with the Veterans Health Administration and others. Throughout the nation, Native communities are combining funds from many sources to establish comprehensive service systems to support their Elders as they age in place. Native communities benefit from working together to develop service systems that work well for them. Their ideas and advocacy lay the foundation for innovations which promote health and support community living for Elders.

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