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PREVENTIVE HEALTH CARE FOR THE NATIVE AMERICAN ELDERLY

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PREVENTIVE HEALTH CARE FOR THE NATIVE AMERICAN ELDERLY

WEDNESDAY, NOVEMBER 13, 1991

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, in the Dirksen Office Building.

Staff present: Portia Porter Mittelman, staff director; Mia Masten, professional staff; Anna Kindermann, counsel; Andrea Boldon, legislative correspondent; and Katherine DeCoster, minority professional staff.

WELCOME REMARKS BY DAVID BALDRIDGE, NATIONAL INDIAN COUNCIL ON AGING

Mr. BALDRIDGE. Good morning. My name is David Baldridge, of the National Indian Council on Aging. I welcome all of you to our workshop today and thank you for coming.

I especially want to thank the Senate Special Committee on Aging and its chairman, Senator David Pryor of Arkansas, for making this forum possible.

Since Senator Pryor has a number of other commitments today, I would like to introduce him now and ask him to say a few words before he has to leave.

OPENING STATEMENT OF SENATOR PRYOR, CHAIRMAN

Senator PRYOR. Good morning, and thank you for that introduction.

I welcome you all here this morning for this workshop on Native American health care, an area that we have not concentrated on in the past. We think that with your panel and the information and the thoughts and suggestions that you give to us, we can share this information with our colleagues in the Senate that will be very, very constructive.

In doing research in preparation, our staff has not only enjoyed this, but they have found additional challenges in these areas that relate not only to health care, but also health status between American Indians and the majority of our population.

They found life expectancy statistics reveal an 8-year difference, for example, between Indian elders and elderly whites. Some of the leading causes of death of the American Indian elders—pneumonia, influenza, diabetes, liver disease, cirrhosis, tuberculosis—affect the American Indian at much higher rates than the general elderly population.

These are just a very few of the issues we hope to address this morning and throughout this staff discussion.

We have found in formal hearings that very few people get an opportunity to exchange thoughts in that setting. This is why we have chosen this type of visitation where we can constructively share ideas and have a better exchange across the table and a little franker exchange where there doesn't seem to be quite the posturing and the formality that a formal hearing engenders about.

So we are glad that you are willing to participate in the informality of a meeting like this. We have held several workshops during the past 2 years on different subject matters, and we are going to continue in 1992 using this forum as a means of gathering information and sharing ideas. We find it to be very, very constructive.

We want to thank you. We appreciate your attendance. Some of you have come from a long way.

I was just telling a story about Senator Inouye. We have one of Senator Inouye's staff people today with us. I had the privilege about 2 years ago of attending George Washington University's graduation. One of my sons was in the graduating class. Senator Inouye was the speaker.

He started talking about all the challenges that graduates have and all the things that they are going to be faced with in this generation. All of the sudden he stopped after 3 or 4 minutes, sort of threw his speech away, and said, "I don't want to talk about that. I'd rather talk about the American Indian."

All of the sudden, 12,000 people in the audience were hypnotized. From his heart, Danny Inouye just started talking about the American Indian, what we have done and what we have not done as a society, and what we need to do. I don't think I've ever heard a warmer, more heartfelt speech, or seen an audience that was more receptive to any speech I have heard in recent years. It was truly a moving experience, and educational for me.

I want to thank all of you for participating.

I'm going to now leave so you can have a good discussion. Thank you very much, Dave, and all of you.

Mr. BALDRIDGE. Thank you, Senator.

Our purpose this morning—the goals for this series of discussions by the Senate Special Committee are: To raise consciousness, to promote ongoing discussion, and to highlight some effective strategies and programs to reach the ethnic elderly. We are talking preventive health care for Native American elderly.

We'd like this, as the Senator said, to be an informal discussion. Our presenters here will each talk to you briefly, and then we want to open the floor to your comments. We most certainly want your participation.

There is, by the way, a notebook circulating. Please leave us your name and your affiliation, or a business card. As you speak, we'll recognize you from here. As you take the microphone, please tell us who you are and who you represent.

With everyone's permission, I have gathered a brief history here of health service to American Indians. I'll open the discussion with this presentation.

It began in the early 1800's when Army physicians took steps to curb smallpox and other contagious diseases among tribes living near military posts.

Another milestone, 1832. Federal treaties were introduced, committing the Government to provide health services.

In 1882 the first Federal hospital for Indians was built, and a concentrated movement was underway to establish hospitals and infirmaries on reservations and at boarding schools.

In 1910 health education programs were established for American Indians.

In 1913 dental services were initiated.

In 1921 the Snyder Act established that the U.S. trust responsibility to American Indians includes health care.

In 1928 PHS sanitary engineers began assisting the BIA in surveying water and sanitation systems.

In 1934 the Johnson-O'Malley Act authorized the Federal Government to contract for medical services to Indian people.

In 1950 there was the beginning of an expanded program to improve individual home sanitation.

In 1955 Congress transferred responsibility for Indian health from the Department of the Interior to the Public Health Service.

A key landmark in 1975, the Indian Self-Determination and Education and Assistance Act emphasized the right of Indian tribes to become fully functioning governmental units similar to State governments. Indian employment preference was initiated for the BIA and IHS.

In 1976 the Indian Health Care Improvement Act reaffirmed the Nation's commitment to improve Indian people's health status and provide for increased tribal involvement.

The preamble for this act identifies the goals of the IHS as: (1) To raise the health status of American Indians and Alaska Natives to the highest possible level; and (2) to encourage the maximum participation of this population in the planning and implementation of IHS services.

The Indian Health Service has subsequently established three program objectives: first, to assure American Indians and Alaska Natives access to high quality, comprehensive health services appropriate to their needs; second, to assist this population in developing their capacity to staff and manage health programs, and to assume operational authority for IHS programs serving their communities; third, to act as Indian people's advocate in health-related matters, and to help them gain access to other Federal, State, and local programs to which they are entitled.

Today, if I am correct in this, the Indian Health Service is one of seven administrative units comprising the Public Health Service in the Department of Health and Human Services. With a staff in excess of 11,000, the IHS in 1989 included 834 physicians, 325 dentists, and 2,200 registered nurses.

In addition to these personnel, Indian Health Service staff includes field health physicians, registered record administrators, public health nurses, registered dieticians, public health nutritionists, community health medics and aides, practical nurses, dental assistants, maternal and child health specialists, environmental specialists, and auxiliaries.

The IHS has built 30 hospitals, 90 health centers, and more than 200 clinics. Each year Indian Health Service negotiates more than 1,250 contracts with outside health care providers, contracts for 1,000 hospital beds in local hospitals, and operates with tribes 51 hospitals and 400 outpatient facilities.

I would like us all to consider, as we look at Indian health issues, that they need to be viewed in a larger context. I don't think America's Indian elderly health issues can be considered apart from a very complex and an unprecedented relationship that is now more than two centuries old between the U.S. Government and American Indians. Health care is only one facet of this relationship; others include: education, housing, land ownership, law enforcement, and religious freedom.

Interrelated in odd ways, seemingly disconnected, the intangibles and the emotional considerations of Indian elders simply cannot be reduced to simple answers.

Throughout this Federal/Indian relationship, though, there is a single issue—that of tribal sovereignty—that recurs again and again, and it has emerged as a basis for understanding almost every other Indian issue.

Tribal sovereignty means self-determination, and it is the single-most important right sought by American Indians. Self-determination allows a group to determine its own future by determining its own form of government.

This brief summary I give is based on a book, "American Indian Policy in the 20th Century," which was edited by Vine Deloria, Jr.

Relations between American Indian tribes and the Federal Government are as old as the United States, itself. We are told that the first Congress of the United States passed three Indian laws in its first week of existence. And few of us would dispute the substantial attention paid by the Federal Government to Indian issues over the years.

Still, Federal recognition of tribal rights to self-determination have vacillated wildly over the past 150 years between acknowledgment of the principle and attempts to eradicate tribal existence.

In the late 1700's, the very first Federal response to Indians was naive—to move them westward, to presumably separate the tribes from interfacing with this young republic.

The tactic did not address issues of political or economic primacy. Within this context, however, some care was taken to preserve the legal rights of Indians and the cultural integrity of their tribes. Both European powers and the early U.S. Government dealt with Indian nations through the treaty process, treating them as international sovereigns.

It quickly became apparent that the tactic of separation of tribes wouldn't work, that it wouldn't resolve the problems posed by these two radically different ways of life.

In 1831, Chief Justice John Marshall referred to tribes as "domestic dependent nations." "Indian nations," he said, "Were a distinct political community, having territorial boundaries within which their authority is exclusive."

Federal efforts, though, soon turned toward economic and social assimilation. In 1871, Congress ended its policy of making treaties, which laid the groundwork to deal with tribal members as individ-

uals. The decision was based on testimony such as, "We see nothing about Indian nationality or Indian civilization which should make its preservation a matter of so much anxiety to Congress or to the people of the United States."

The new direction was shortly followed by Federal Indian schools, police forces, and court systems, all based on the theory of assimilation.

I think probably the greatest example of Federal ambivalence about Indian nations and Indian people are the dates of this. In 1882, I mentioned the first Indian hospital was established at Carlisle, PA, at the Indian school. Eight years later, in 1890, 300 Indians—mostly women and children—were killed at Wounded Knee, SD, 8 years after the construction of the first hospital.

In 1887, the most dissimilationist policy of all, the Dawes Act, was passed. It was heralded by President Theodore Roosevelt as, "A mighty, pulverizing engine to break up the tribal mass." The act subdivided reservations, allotting tribal lands to individuals in 40- or 160-acre parcels, with the Federal Government purchasing the remainder of tribal lands.

As a result of that policy, two-thirds of tribal lands had passed into white ownership by 1934. By 1900, half of all Indian languages had become extinct.

A policy shift occurred again in 1934, when BIA Commissioner John Collier convinced Congress to restore tribal rights. The Indian Reorganization Act of 1934 halted further allotments and established tribal governments and courts. Even here, though, the Constitution's drafted were Anglo and didn't always reflect Indian values.

By the 1950's, assimilation had again gained strength.

By 1961, under President Eisenhower, Congress had terminated its relationship with 109 tribes. The policy of termination was an abject failure. Its effects, including the loss of land, tribal identity, language, and culture, are being painfully experienced today by the tribes affected.

In the 1970's, Government policy changed again as President Nixon announced a new era of self-determination, an era in which an Indian future is determined by Indian acts and Indian decisions. Hopefully under that era we gather here today.

Whatever answers we look for for Indian health won't be easy. America has treaty-based reservations, executive order reservations resulting from the Indian Reorganization Act. We have State-created reservations. We have hundreds of bands of Indians who do not have Federal recognition. We have terminated tribes. We have a high percentage of urban and rural Indians not served by the reservation system. We have 500-plus federally recognized tribes, which established their own criteria for membership according to degree of Indian blood and/or other considerations.

Yet, amid all this complexity, we must begin. We need to start at once. We can't wait for the year 2000. We can't wait until 1995. America's Indian elders are in crisis now.

With that introduction, I would like to recognize Doctor Yvonne Jackson, who is the Administration on Aging's Associate Commissioner on American Indian, Alaska Native, and Native Hawaiian Aging.

We are very pleased that Doctor Jackson could attend today, and we look forward to working with her on these health issues with great success over the next few years.

Doctor Jackson.

DR. YVONNE JACKSON, ADMINISTRATION ON AGING, ASSOCIATE COMMISSIONER ON AMERICAN INDIAN, ALASKA NATIVE, AND NATIVE HAWAIIAN AGING

Dr. JACKSON. Thank you.

I'd first of all like to thank the organizers of the workshop, Senator Pryor, and especially Mia Masten, for all the work that she put into getting this all together to talk about this very vital issue.

I'd like to share with you today some of the preventive programs the Administration on Aging is pursuing in Native American communities.

As many of you know, the Commissioner on Aging, Doctor Joyce Berry, has initiated a national eldercare campaign. This multiyear, nationwide effort is a call to action to broaden the base of societal involvement and commitment and assisting today's vulnerable elderly, and also to mobilize resources for older people at risk of losing their independence.

The campaign has three basic goals:

First, to alert the public to the need for individual and collective action to address the unmet need of today's elderly and to prepare for the challenge of an increasingly aging society.

Second, to broaden the base of existing public and private involvement and support for addressing the need for in-home and community-based services for older people at risk now and in the future.

Third, to encourage communities across the Nation to use the full range of public and private resources available to them in responding to the needs of older people at risk of losing their independence.

In order to achieve these goals, the eldercare campaign is utilizing three major strategies.

The first strategy is to create public awareness. A broad-based national media and public awareness campaign has been initiated in order to promote a change in basic attitudes about older people at risk and create a positive environment for action on their behalf. As part of this strategy, the Administration on Aging has funded the National Title VI Directors' Association, which is the group that operates the Indian and Alaska Native and Native Hawaiian programs funded by Administration on Aging in Indian communities.

The Title VI Directors' Association has been funded to conduct a public awareness campaign in Indian Country. They will be developing tools and resources, and training a corps of liaison volunteers for conducting a public awareness campaign aimed at individuals, agencies, organizations, and businesses on the needs of at-risk American Indian, Alaska Native, and Native Hawaiian elders. They plan to develop information packets, brochures, and videotapes to be used in, first, 50 Native communities, as well as for

presentations to public service agencies, private businesses, churches, professional associations, and other interested groups.

They will be working with the American Association of Retired Persons to present this information to non-Native groups.

A second strategy for accomplishing the goals of the national eldercare campaign is to increase organizational commitment to eldercare. A wide variety of agencies and organizations representing Government, businesses, labor, and voluntary religious and civic communities, will be encouraged to adopt an eldercare agenda.

These organizations will be asked to provide guidance and assistance to local affiliates in developing a variety of approaches in communities across the Nation to address the unmet needs of older people at risk.

In this upcoming year, we will be working with AARP, the American Medical Association, the American Red Cross, Families USA, the National Association of Mail Programs, the National Easter Seal Society, and many other aging and nonaging organizations.

The third strategy is coalition building. This will be used to demonstrate that coalitions of organizations at the national, State, tribe, and local levels can be an effective approach to enhancing home- and community-based services for older people at risk.

The vehicle we are using to promote coalition building is what we are calling "Project CARE." CARE stands for Community Action to Reach the Elderly.

The goal of Project CARE is to optimize participation of organizations and constituencies which have not had a predominant focus on aging issues before. Implicit in the strategy underlying Project CARE is the important need to develop a local indigenous leadership.

Under Project CARE, the Commissioner on Aging has funded three demonstration projects in each State for the next 3 years to support the development and operation of community coalitions. These demonstration projects are to examine effective approaches to working with coalitions involving many organizations and individuals whose primary agenda has not been aging.

The primary purpose of the community coalitions is to develop and implement local action plans to address the unmet home- and community-based service needs of older people at risk. The community coalitions are expected to heighten public awareness at the local level to the need for individual and collective action to address the unmet need, and to marshall support for older people at risk in the community; broaden the base of public and private support by involving organizations which have not traditionally participated in efforts to address the unmet needs; encourage public and private organizations within the community to adopt an eldercare agenda; and participate in local planning efforts to develop and deliver services to older people.

Five American Indian and Alaskan Native communities have received Project CARE community coalition grants, including the Bristol Bay Native Association in Dillingham, AK; Fort Belknap Tribe in Montana; the Devil's Lake Sioux Tribe in North Dakota; the United Houma Nation of Louisiana; and the Indian Family Services of Minneapolis, MN.

In addition to the specific strategies for reaching the goals of the national eldercare campaign, the Commissioner on Aging has established 12 national eldercare institutes, including a National Eldercare Institute on Health Promotion and Aging. The focus of this Institute will be on encouraging older people to adopt lifestyle habits and risk-reduction behaviors that will lead to improved well-being and reduce the need for eldercare.

One goal of the Institute will be to improve the transfer of knowledge about health promotion to appropriate audiences around the country. They are also charged with identifying barriers to reaching low-income, minority populations and to develop and implement health promotion strategies for overcoming these barriers.

We in the Office for American Indian, Alaskan Native, and Native Hawaiian Programs look forward to working with the Institute on Health Promotion on identifying the barriers and developing implementation strategies for Native communities.

In the brief time I have this morning, I hope to have highlighted some of our programs ongoing in the Administration on Aging.

I look forward to hearing from the rest of the panel and from you in the audience.

Thank you.

Mr. BALDRIDGE. Thank you, Doctor Jackson.

Doctor Robert John is from the Gerontology Center at the University of Kansas in Lawrence. He has had more than a decade of distinguished research about Indian elderly.

Robert.

DR. ROBERT JOHN, GERONTOLOGY CENTER, UNIVERSITY OF KANSAS AT LAWRENCE

Dr. JOHN. Today what I want to talk to you about is the four essential preventive health care priorities for American Indian elders.

Perhaps you all know that the American Indian population is growing very rapidly. It was 1.4 million persons in 1980, and now it stands at 1.9 million persons.

American Indian elders 60 years of age and over increased from 108,000 individuals in 1980 to 166,000, a 52-percent increase over the decade. I think we can predict that over this coming decade the population will increase substantially, as well.

One of the difficulties in trying to establish priorities for American Indian elders is the fragmented, incompleted Indian health care service system that we have. Essentially what you have is two populations. You have an urban population and a rural reservation population.

If I can just generalize, the rural reservation population is served by Indian Health Service and the urban population is not.

What we know is largely limited to what the Indian Health Service does and the information it collects.

Approximately 61 percent of all American Indian elders live in Indian Health Service areas. That doesn't mean that they use it. I think the figure is something like 85 percent of elders or people

who live in Indian Health Service areas actually use Indian Health Services at some point.

But you have this problem of the bifurcation of the population into urban and rural reservation groups. We know next to nothing about how to deliver preventive health care to urban American Indian elders.

Another one of the difficulties that confronts the Indian Health Service, as well as policymakers is that the health care problems of the American Indian population are changing.

What we have witnessed over the last 40 years is a very dramatic increase in life expectancy at birth from 51 years in 1940 to 71 years in 1980. Some observers—and I agree with this characterization—have said that the health problems of American Indian elders or the American Indian population is undergoing what is known as an epidemiologic transition. The health care problems are shifting from acute and infectious diseases to chronic and degenerative diseases and, to some extent, the Indian Health Service has recognized this.

However, I would add as a policy note that the Indian Health Service needs to shift its focus to devote more efforts to the prevention and treatment of chronic and degenerative diseases.

I would add that extensive training activities for all IHS personnel needs to be conducted. Some revision of the way in which health care resources are allocated needs to take place in order to devote more resources to these chronic and degenerative diseases.

One other policy note, before I get on to the specific points I want to make, is that there is a special problem, too. I don't know how aware people are of it here in Washington, but since the Indian Health Service has responsibility for much of Indian health care, other Federal agencies tend to think that they should not do anything in terms of improving the health or studying the health of American Indians. There is something of a turf issue here.

I have talked to other health care agencies within Public Health Service, and their response is, "Well, Indian Health Service should do this," or "We probably wouldn't fund that since Indian Health Service is supposed to do this." So there is a special policy issue here. Somehow, more interagency cooperation to meet the needs of American Indian elders is needed.

I think that, in terms of specific health care priorities, first of all there needs to be greater targeted efforts to reduce or eliminate specific diseases. The leading causes of mortality among American Indian elders are heart diseases, malignant neoplasms, cerebrovascular diseases, pneumonia and influenza, diabetes mellitus, and accidents.

A few of these disproportionately afflict American Indian elders. In particular, diabetes mellitus is epidemic. Accidents occur at a very much greater rate among American Indian elders than among the general population of elders. Pneumonia and influenza, liver disease and cirrhosis, and tuberculosis all need special efforts.

If targeted efforts to take place, I think that it would be wise to have a policy that independent health evaluation of the programs take place. I think that we need to understand how best to eliminate or target efforts toward these particular diseases, and I think

that independent health effectiveness program evaluations are a means to do that.

The second major issue, I think, in terms of preventive health care, is to determine why it is that American Indian elders underutilize services. They underutilize social services. They also underutilize medical services. They use fewer in-patient and out-patient medical services than the general population of elders.

There are a number of reasons, if you are interested, I could suggest for their underutilization of medical care services, but I think that issue needs to be studied and we need to figure out ways to get around these barriers.

The third point that I would like to make is that I think we need to greatly expand prevention, health promotion, health education, and screening for health problems.

Most of the major causes of illness and death among American Indian elders are preventable, and certainly they are amenable to early medical interventions.

The primary risk factors for the six leading causes of mortality are smoking and diet, including consumption of alcohol. If I were to pick two programs that I would like to target in particular, it would be some sort of smoking prevention/cessation effort, and also some diet modification.

I think each of those risk factors—smoking and diet—could be greatly reduced through culturally appropriate disease prevention and health promotion programs and health wellness education.

J.T. Garrett has written a chapter in a book that has been published that talks about traditional medical practices among American Indians, and he describes it as a wellness path. We need to highlight and emphasize that sort of approach to these issues.

The last example of this third point I will provide is that we need better and more extensive health screening. This would greatly reduce mortality and increase longevity among American Indian elders.

There is a recent study—results are starting to appear from the Survey of American Indians and Alaska Natives. It is part of the National Medical Expenditure Survey. In there quite clearly they document that American Indians' health screening is far below that of the general population.

For instance, in terms of mammograms, 17 percent of American Indian elders have had a mammogram, compared to 38 percent of the general elderly population; or breast exams, 66 percent of American Indian elders have had a breast exam, compared to 86 percent of the general elderly population; or pap smears, 64 percent among American Indian elders, 83 percent among elders in general.

So you can see that more thorough health screenings would greatly reduce mortality and increase longevity among American Indian elders.

The last issue that I'd like to raise is the issue of long-term care for American Indian elders. We need specific authorization to assign responsibility for long-term care to particular Federal agencies. Currently, no long-term care system exists.

I think that American Indian elders would like to have, as all American elders would like to have, comprehensive, community-

based services, supportive or rehabilitative and social services, available to them in their communities so they can remain independent in their homes for as long as possible. But we do need to explore institutional-based long-term care options.

I think that in terms of long-term care, whatever we do to promote health will reduce the need for long-term care, and certainly reduce the need for institutionalization. The object of long-term care services should be an appropriate level of care to maintain elders in the least restrictive environment.

Thank you for your attention.

Mr. BALDRIDGE. Thank you, Robert.

I'd like to reinforce your comments about long-term care. I've got a note here that the Indian Health Service Office of Planning, Evaluation, and Legislation about a year ago sponsored a roundtable here on long-term care. The draft report from that roundtable found that "services for Indian elderly, especially long-term care, are fragmented, uncoordinated, and sometimes nonexistent on reservations."

It continues: "Responsibility for long-term care lacks a focal point and has yet to become the source of meaningful dialogue among policymakers."

The report concluded: "The issue lacks definition and most basic work on it is yet to be done."

That roundtable felt that an opportunity exists—and a good one—to begin defining and developing before we are overwhelmed with a long-term care problem.

I think this may be a legislative issue. I'd like to talk about it some more with our people here.

Ms. Nicky Solomon—having just met you, I don't have stories to tell about you yet, but, in directing the Community Health Representatives Program for the Indian Health Service, we are very grateful that you could be on our panel, and we look forward to your comments.

NICKY SOLOMON, COMMUNITY HEALTH REPRESENTATIVES PROGRAM, INDIAN HEALTH SERVICES

Ms. SOLOMON. Thank you very much.

I guess I am kind of a fill-in for our Associate Director of the Office of Health Programs within Indian Health Services.

Dave, as I was listening to what you were reading about the history of Indian health over the past few hundred years, I think that there should be one other date and notation made in there, because IHS just happens to have the distinction of having a very special, one-of-a-kind community health program, and that program is called the Community Health Representative Program. That program has been in IHS' budget since 1968.

Until the early 1980's, we had approximately 2,400 health workers serving on Indian reservations and in remote Alaska villages. When the early 1980's came, there was a drastic reduction in the budget, and we are now at a little over 1,500 community health representatives in IHS.

The CHR program is an Indian Health Service funded, tribally contracted, and directed program.

The CHRs are indigenous, community-based, well-trained, medically guided health care providers who provide health promotion, disease prevention, and outreach services in their communities.

The CHR program, within this past fiscal year, provided over 4.2 million services to individual persons, and nearly half of those services were provided to grandmothers and grandfathers.

Of those individually served, 25 percent were in the health area of diabetes, Doctor John.

The CHRs are also in the process of providing screening, as mentioned by Doctor John. But when I think about the strides that have been made by this program and where we were 10 years ago, and where we are now, and look at the statistics that we have, I realize that there is so much work and so many more people to be working with, and yet we have less staff to do it.

The CHRs provided these services at a cost to the Federal Government of $9.12 per person served. You can't beat that cost-effectiveness.

I did bring some hand-outs that have all of these data, and what have you. I won't proceed to read it, because I thought that I would like to share this and pass this out to all of you. I brought 30 copies.

A good share of our time is spent in transporting grandmothers and grandfathers to services, to the grocery store, to health services. I have come to the conclusion that CHRs do provide this service, but at the expense of not then being able to make the home visits and doing more direct health care in people's homes and providing the Health Promotion disease prevention HIP/DIP services that we are charged with doing.

There are so many—I do realize that transportation is a need in Indian Country. People live miles and miles away from where the primary health care is provided.

I also wanted to mention that on the hours spent on gerontological care, half were spent providing case management and homemaker services.

I didn't want to take too much of your time but, like I was saying, I can't make a pitch strong enough for what Indian Health Service has been providing through this program. The tribes look at it as their program. They do not look at it as an Indian Health Service program because they administer it, they direct it, they hire, they fire. They have complete control of this program.

CHRs also do a lot of interpretation for grandmothers and grandfathers. A lot of them may understand English, but they don't care to speak it. In clinics they are interpreting between the doctors and nurses, the laboratories, the pharmacists. They have become liaisons and advocates. In a sense, like I said, it is a very special, one-of-a-kind program, possibly in the Nation, but it certainly is in Indian Country.

Mr. BALDRIDGE. Thank you, Nicky.

The Navajo Nation is our country's largest tribe, and I admire the number of programs they have set up. It is a very proactive administration, and they are doing some nice things for their people.

Tulley Mann is instrumental in operating those services from the Navajo Division of Health in Window Rock, AZ. Tulley has agreed

to come here to talk about some of the health promotion efforts underway with the Navajo Nation.

Tulley.

TULLEY MANN, NAVAJO DIVISION OF HEALTH, WINDOW ROCK, AZ

Mr. MANN. Thank you, Dave.

As you know, the Navajo Tribe is one of the largest Indian tribes. We have what they call the Navajo Area Agency on Aging, which extends into the three States—Arizona, New Mexico, and Utah, and one of the few that is designated as Area Agency on Aging.

We have been able to provide services to a little over one-third of our 15,000 Navajo elders through Federal, State, and tribal funds. We do work with the Navajo Nation Council on Aging representatives, an advocacy body for elderly citizens, a 10-nember council comprised of members who are mostly people that are 55 years of age and over. They are elected from the local council.

We have five different geographic locations identified as agencies. From there, we have two representatives to be advocates for their problems at their level.

Under the auspices of the Navajo Area Agency on Aging we have four programs that we run. We have adult in-home care, elderly home care, foster grandparents, and senior citizen centers. In the urban areas, the senior centers are called multipurpose facilities. On the reservation that I come from, which is Navajo, we call them senior centers, primarily because our elders congregate on a daily basis in those locales.

In my review of some of the materials written on behalf of other Indians and non-Indian organizations, we are concerned with the same issues regarding our elders. I appreciate this opportunity to cite you some of the problems that we have and a way to address some of these problems that we have.

We have over 300 Indian tribes throughout the Nation with a variety of languages and practices, different ethnic customs. Despite our uniqueness, we have the same goals, and we have a common concern for our elders because we have experienced poverty, hunger, isolation, abuse, and many other social ills. Such problems were identified in Public Law 100-175, which is a part of the Older Americans Act of 1987.

Some of the findings that were identified which have not been alleviated thus far—poverty state of existence, which is estimated to be as high as 61 percent through Indian Country. As you are aware already, the life expectancy of a Native American is 8 years less than an Anglo American.

Lack of nursing homes, no long-term care or inadequate long-term care, inadequate number of facilities and other health care facilities, lack of sufficient area agencies on aging—the reason I'm saying it is because the Navajo is one of the only agencies that is recognized as an Indian area agency on aging.

We frequently find Native Americans in substandard and overcrowded housing. At this point the conditions are—the grandmothers are taking care of their grandkids, which is maybe a one-room

house with a building, with three or four kids in each of the households. They frequently live in substandard housing.

They are underserved by Title VI, which is a part of the Older Americans Act at a rate of 19 percent of the total national Indian elderly population living on the Indian reservations, and are served under Title III at a rate of less than 1 percent of the total participants under that title.

We have two fundings—Title III and Title VI under the Older Americans Act. Although there have been slight increases in Title VI, it does not totally address the needs of the older Native Americans.

More specifically, in 1985 the Navajo Nation has compiled a health status report on distinct diseases and conditions characterizing the Navajo Nation as follows:

It remains undeveloped and underserved, with basic socioeconomic conditions characteristic of many Third World countries.

Its population continues to grow, although the growth rate at a national level is declining. Along with this, mortality rate is expected to climb, fertility rate will remain high, and age distribution changes.

The changes in disease occurrences are expected, which Doctor John has alluded to.

Age-specific mortality analysis indicates that accidents and violence are the primary causes of male deaths. The reason that is so prevalent in Indian Country is because of alcoholism and elder abuse.

Elder abuse is also prevalent because there is so much underdevelopment, lack of jobs, and also a lot of our elders exist or dwell in isolated areas.

Infectious diseases, although in decline, are still a major public health problem, and attributed to inadequate sanitation.

Malnutrition is evident in the high incidence of upper respiratory infections, particularly among infants and young children unable to fight off otherwise benign diseases.

Degenerative diseases such as cancer, strokes, heart disease, diabetes, hypertension, retinal failure, gall bladder, et cetera, are on the rise on the reservation.

Some people may ask why you have sanitation problems. Well, the infrastructure does not exist to alleviate waste as we have in urban settings or concentrated dwelling areas.

Some steps have been taken to address some of the above-cited health problems, to include: sanitation, nutrition, hygiene, water availability, and addressing housing needs, which are part of the Navajo Nation's long-range, and social and economic development.

Some prevailing health conditions of Navajo elders are, as I said, tuberculosis, cancer, et cetera. One of the major problems that we are dealing with, not only in elders, but also in young people, is obesity. That is a big problem because of the diet that we are experiencing, like McDonalds, junk food, and things like that and also high cholesterol food distribution commodities.

In combatting such health conditions, barriers to appropriate treatments are language, use of traditional medicine—which is preferred by many elders, and the denial that health conditions exist are attributed by lack of transportation, poor road conditions, lack

of family support. Other factors include poor housing and lack of employment. This also is correlated with lack of adequate income.

Much of the health care is provided by Indian Health Service on the Navajo Nation. The Navajo area Indian Health Service headquarters is in Window Rock, AZ. In extensive review of some of the materials, I did not find that provision of health care to the elderly is a priority, nor a specialized area of Indian Health Service.

It was explained by one representative that this was due to lack of funds.

Encouragingly, Indian Health Service has proposed a task force on geriatrics to begin addressing the special health needs of the elders.

Unfortunately, the Older Americans Act does not fully address many of the above-cited problems, although it is a fine legislation. Nonetheless, it is through the Older Americans Act which funds our senior citizens program that some preventive health issues have begun to be addressed.

First the Title III and Title VI permit us to provide nutritious meals on a daily basis to Navajos who otherwise would not eat at all simply because they are isolated, alone, and may not be able to prepare wholesome foods that are properly prepared.

The Navajo Area Agency on Aging programs—the services that we provide are nonmedical, community-based programs established to prevent unnecessary institutionalization of elders and to maintain them in their communities at home as long as possible.

As I said before—I alluded to it a little bit—the food distribution, provides a 52,000 annual food distribution case load. Elders represent at least 60 percent of that food distribution. We find that collaboration and coordination do not exist at the local level where we are trying to develop a comprehensive health care network.

I just gave you a little outline of the profiles of the Navajo Nation Area Agency on Aging. There are a lot of problems, but we also are aware there are answers. But many times answers require a lot of monetary appropriations, and also a lot of manpower. Manpower has become very expensive.

But if we can work together with all of the Federal agencies, I'm sure some sort of resolution will come about.

Thank you, Dave.

Mr. BALDRIDGE. Thank you, Tulley.

One comment you made really struck home with me, and that is the CHRs are doing a marvelous job out there in many cases, Nicky, I congratulate you. These are fine people trying to cover a lot of bases. But I'm somewhat shaken and astounded that the Indian Health Service at this point has no geriatric policy whatsoever, and apparently no funding for geriatric training for staff or individual case management. I'm very troubled by this, and again I compliment the CHRs who are filling that gap and doing a very fine job as best they can.

So here we sit with this huge and difficult issue in front of us, and not a great deal of time to talk about it today.

If I could, I would like to structure our comments for the remaining part of this hour perhaps in trying to define what the top two or three or four barriers are to Indian elderly receiving health care.

We have some very articulate, knowledgeable, and competent people here at the table. Again, we welcome and solicit your comments.

As you speak, please introduce yourself and whom you represent.

With that, panelists, please feel free to join in. Let's open this up and see if we can make some progress.

What do you consider to be a major barrier at any level? Yes, sir?

DR. STEVE HEATH, INDIAN HEALTH SERVICE

Dr. HEATH. I'm Steve Heath. I'm a physician. I've been with the Indian Health Service for almost 14 years now. Eleven of those years were spent out in the field, prior to coming to headquarters a couple of years ago. I have dealt with providing health care to Native Americans in Arizona, New Mexico, and Oklahoma over that period of time.

I am an internist, so I have at least a fair amount of training in caring for adults, in general, and elderly people, as well.

I am impressed in my travels around Indian Health Service regarding the difficulty of getting elderly Native Americans to come to clinic at times when it is best for them to come, in the early stages of their disease process, and to maintain regular appointments and those type of things.

We spend a great deal of our time emphasizing preventive measures in the Indian Health Service—physicians do—but we don't have specific targets, as has been mentioned, of the elderly population. One of those reasons is that we have been unable to encourage them enough to come to clinics to hear our message.

I guess there are three reasons why a person doesn't come to the clinic. One of them is they don't have transportation. The second one is that they don't know they should come, they don't understand the reasons why they need to come because they don't feel sick. And the third reason is they don't want to come. They just don't want to come. There is not a good trust relationship, there's not a good understanding, or whatever.

I think all three of those reasons can be worked on through programs such as Nicky Solomon has so nicely laid out before us, and as I believe Doctor Jackson and Doctor John have already emphasized, and Mr. Mann as well—community involvement.

I think the main barrier for access for elderly people is an understanding issue, and I think we need—the Indian Health Service needs to really open its doors and get more into the community, get more involved with the resources that are there already, such as CHRs, tribal programs, and become intimately involved with those, and hopefully improve funding for those needs, get out into the community. If Mohammed won't come to the mountain, we have to take the mountain to Mohammed.

We need to really get into the community, understand the reasons why these elderly people can't come or won't come to the clinic, address those, and overcome that barrier.

If I can say one more thing, one of the big disabilities we have in the Indian Health Service as far as physicians are concerned is turnover. Physicians come to the Indian Health Service for a lot of

reasons. I came because I wanted to. I never owed a commitment. But a lot of physicians come through programs where they have a commitment to serve, serve that commitment—which is usually 2 years—and then they leave.

Turnover is a killer when you are trying to develop a program at a local service unit. It takes a physician 6 months to a year just to get his or her feet on the ground and understand how the Government process of providing health care works. Then that person would have a mere year left to really finish his commitment, and then leave before he or she really has an interest in developing programs such as working with the elderly people.

I think this is a real hindrance when a local service unit is interested in providing a particular service or improving a particular service to a segment of its population.

Efforts remain ongoing to try and improve our recruitment and retention efforts, and I could—there is a whole bunch of things being considered, but, of course, money remains a major problem.

I think the other issue as far as physicians wanting to get more specifically involved in individual programs is we need to have—the Indian Health Service needs to work on its turnover problem and have more stable staff, develop people that have interest in geriatrics from the top down, and get these people out there in the community where they can provide the services that are needed.

Mr. BALDRIDGE. Thank you, Doctor.

It is interesting that IHS, as you pointed out, is only one component of trying to serve Indian elderly. Does anyone know if there have ever been initiatives between IHS and the AOA? As Doctor Jackson pointed out, they are capable of doing some very fine things in outreach, but I don't know if a link has ever been made. Anyone?

RAMONA ORNELAS, INDIAN HEALTH SERVICE

Ms. ORNELAS. I'm Ramona Ornelas with Indian Health Service.

Several years ago we did establish a memorandum of agreement with the Administration on Aging to sponsor a major study of the elderly to try to develop a descriptive profile of the services, of the health status, the functional status, from a number of perspectives.

I think there were some earlier discussions on how they might address some of the health promotion/disease prevention initiatives. I think there was also some discussion with the substance abuse program as to how there might be better coordination.

That study will be available, and much of the resource for the long-term care roundtable that you spoke of was background information, so that will be available very soon. It is probably the only study that will compile all known sources of information to develop a profile of this particular population.

Mr. BALDRIDGE. Thank you.

Ms. ORNELAS. I have another comment on the barriers to health care.

I think there are two of them that are prime. One is resources. They simply are not sufficient to address all needs of Indian people, so there are some tough choices that have to be made. And I think the primary focus of coordinating resources and services

has to be tribal governments. There are a number of Federal resources available that are not yet now being tapped.

Transportation, for instance—most tribal governments do not apply for grants from the Department of Transportation, and they will provide capital cost and training for drivers. And there are other services, as well.

For instance, there is funding for home health care. They can seek HCFA waivers to fund home health care through using CHRs, the public health nurses. Skilled nursing is Medicare reimbursable under Part A. There are just a number of resources that are not now being tapped.

But the reality is, even if they are tapped, resources will still be scarce.

So I think that it behooves everybody involved, all the policymakers, to take a very, very careful look at what those rational choices are.

The other one I think—and I alluded to it—was the lack of awareness, the ignorance—that may be a very strong term—on the part of a lot of policymakers, including tribal governments. It just simply hasn't had the focus. The coordination doesn't exist down there as yet. I think there are attempts now to address that, but that's the state of things right now—it is just in the developmental phase.

Ms. MITTELMAN. Dave.

Mr. BALDRIDGE. Portia.

PORTIA PORTER MITTELMAN, STAFF DIRECTOR, SPECIAL COMMITTEE ON AGING

Ms. MITTELMAN. Dave, if I could just follow up, I'm Portia Mittelman with the Senate Aging Committee.

A lot of you heard Senator Pryor speak to the need to sensitize the Congress a bit more about different ethnic elderly populations. That really is our fundamental mission with this series of workshops that we are having.

But, to follow up on what both of you were saying, it is going to be very important for us to understand more fully a little bit more about the psyche, if you will—if I can use that term—of American Indian elders, some of the reasons why they respond to things in the way they do. I think we need to start from that point so policymakers can develop effective approaches and strategies to some of the things that both of you have pointed out.

If there are ineffective ways to reach this population, and policymakers are not aware of more effective ways, then we will be spinning around in circles. So if the panel or any of the other participants today could speak to that just a little bit, if you could help us understand some of those special concerns, special needs, special responses that the elderly part of this population has to health care treatment, or any other aspect of what we are talking about today, that would be helpful.

Mr. BALDRIDGE. Thank you. We'll switch directions here. We'll open this discussion to comments especially on the Indian elderly, or any other issues you may have.

Yes, sir?

ED O'DONNELL, DEPARTMENT OF VETERANS AFFAIRS

Mr. O'DONNELL. I'm with the Department of Veterans Affairs. My name is Ed O'Donnell. I was going to speak of the problems of access to services for Indian elderly people and a number of other issues as to why they don't seem to take advantage of those programs that might be available by Federal agencies or other agencies.

Back in 1986 we formed the VA Advisory Committee on Native American Veterans. That came to us as a result of an act of Congress, and we had that committee going for approximately 4 years.

We have a report from that committee. Unfortunately, I do not have a number of copies for everyone, but that committee found that, for one thing, you just cannot open up a program and tell Indian people that it is available and they'll come and get it.

The members of that committee who weren't Native Americans—a number of them—plus representatives of the major Federal agencies serving Native Americans, found out very quickly that you really have to outreach to Native Americans, and that you have to use the local tribal people to gain access to that community if you are going to have any credibility with Indian people.

Indian people, we found from our committee hearings, were very suspicious of the Federal sector and of non-Native Americans, and basically they stood back and waited sometimes for things to happen.

So I would certainly encourage those who are trying to serve Native Americans to reach out to them through whatever means are possible on the reservations or elsewhere, perhaps in the urban areas through the Indian associations that are operating there, and not to kind of set up shop like perhaps even the VA did many, many years ago, putting up a hospital and expecting everyone to come and get services, when really they had no intention of doing that, and they were very fearful of what that might mean.

We found also that, among the Federal agencies serving Native Americans, there was really not very good communication and, in fact, a lot of duplication of services.

We have since established some sharing agreements, for example, with Indian Health Service, so that their resources are being used better and the VA's health care system is being used much more effectively.

We have also set up in the Albuquerque area and in the Northwest regional coordinating councils involving VA, Indian Health Service, and Bureau of Indian Affairs that cross State boundaries and, in fact, move into the Navajo Nation, as I understand.

We do have some health care personnel—VA-paid health care personnel—who are working on the Navajo Reservation who provide access to the VA health care system for Native American veterans.

So there are some really tremendous opportunities out there for more cooperation from the Federal sector, more sharing agreements, more community-focused activities.

VA is moving very strongly toward a presence in the community away from an acute health care system to a community integrative

health care mode. We are very interested in developing community resources that will serve Native Americans, veterans, and the larger members of that community, and we are looking at ways that we can share, through formal agreements or otherwise, both VA's resources and the communities' resources to serve older Americans.

I'm looking forward to further activities in this arena and would be pleased to discuss initiatives with anyone.

Thank you.

Mr. BALDRIDGE. Thank you. Good comments.

YVETTE JOSEPH, SELECT COMMITTEE ON INDIAN AFFAIRS

Ms. JOSEPH. I want to ask a couple of questions, because I work here for Senator Inouye with the Select Committee on Indian Affairs. But first I want to respond to what Portia was talking about—the reasons why Native Americans may not access services.

We were talking about the reasons why, and it seems that, because there is a whole avalanche of paperwork that is required for virtually every Federal program that a senior citizen may want to access services, however when they go into an Indian Health Service facility they are required to fill out whatever Medicaid or Medicare paperwork that is needed to be completed, plus note whatever insurance coverage they might have if they have any. And then they have the whole collection of health information that they have to fill out for the Indian Health Service.

Because you have a State-controlled agency working within a Federal facility, oftentimes even that relationship doesn't exist. And so it is individuals like the Community Health Representatives that interpret many times what the paperwork is all about.

In terms of nutrition programs, the same thing applies for food commodities or food stamp related programs. Many times it is hard to clarify what your financial resources and your income might be.

And then you have the Bureau of Indian Affairs who has their own battery of paperwork, as well, for general assistance, for any kind of benefit program.

And so there is a tendency not to want to do more paperwork, and so I guess those programs that Ramona was talking about don't usually tend to be accessed because there is so much work just trying to keep up with what you have in front of you.

I was wondering—and this is more of a question for Yvonne. Were you formerly with the Indian Health Service?

Dr. JACKSON. Yes.

Ms. JOSEPH. OK. So you are familiar with the fact that there are no eldercare outreach programs on reservations. It seems like the emphasis in outreach has been to go out to the Junior League kinds of systems like the Red Cross or the American Medical Association or the Association of Retired Persons.

When I think of those organizations, I think they may be effective in places like Phoenix or Fort Lauderdale, but they are not necessarily in existence in the basic Indian community where there are relatively no phones and no transportation. So that's probably one of the key barriers to effective eldercare outreach.

You don't have those kinds of systems, and it sort of seems like, if you are trying to develop local plans, you need to probably be more tribally focused.

What typically happens is there is an effort that focuses on State-related programs and not necessarily tribal-related programs. Maybe through Title III or Title VI programs, if the Tribes had some resources available to them to do a lot of the local planning, I think it would probably be more effective.

I had a question. I was wondering—and I know, just from working on the appropriations in trying to increase the funding for Title VI programs, I believe they ended up being funded at probably about $484,000 more over the fiscal year 1991 appropriation, which is around $15 million. But it is my understanding that this appropriation should actually be funded at the authorized level of $24 million in fiscal year 1992.

I was wondering, in terms of the way the budget process works, are there Native American representatives that work with the Administration on Aging to offer their comments or opinions about how the budget should be formulated? And are they engaged in that process? I know that it happens within the Indian Health Service, but I don't know if it really happens in the Administration on Aging, if there really is truly representation from the Native American community on budget decisions.

Dr. JACKSON. For appropriations? Dave Baldridge is our primary representative. We calculated to bring all the tribes up to the funding level that they were funded at in 1980 would take $30 million. So we are still funded half of what we should, to have them at the 1980 level, not even at the 1992 level.

Mr. JOSEPH. Does the same apply for other seniors programs? Are they all funded at their full authorization levels, or half of what they should be receiving?

Dr. JACKSON. I don't know about that. I pay attention to Title VI.

But I did want to comment about your eldercare comment you made about the agencies I talked about. That point was, I think, very important.

Within the agency, we are working with the large, national organizations, but within Indian communities we realize this isn't going to hit the target. So we have established an Indian Eldercare Work Group, and we've got a person from Navajo and Pascua Yaqui, and all over the country. We have got about 12 representatives. We're working on target in an eldercare campaign for the Indians that will work within the Indian structures outside of the national organizational structure to address those specific issues that you raised.

Ms. JOSEPH. So that's just started then? That's new?

Dr. JACKSON. Yes.

Ms. ORNELAS. Could I comment on the Title VI programs?

One aspect of the study that we did looked at the comparison of services under Title III and Title VI. The finding was that fewer services were available through Title VI. Also, that State units on aging did not provide much focus to Title VI programs. They pretty much left them alone.

That was several years ago, and I understand that that's changing now, but, by and large, Title VI programs are really just meals programs. They don't do much else. They do other things informal-

ly, but they are not formally structured the way the Title III programs are. They may not have an ombudsman or a legal services or a social service or a formal transportation service. By and large, they are just meals programs.

Ms. JOSEPH. How underfunded is Title III?

Dr. JACKSON. I wish I had a Title III person here to address Title III. Title III gets a lot of State funding.

Fran, correct me if I'm wrong.

Title III has to have State matching funds, where Title VI does not require State matching funds. So Title III is a combination of State and Federal and local funding, where Title VI is primarily Federal funding with some tribal funds.

Some tribes have developed different avenues for augmenting funding for Title VI. Some require a certain percentage of their bingo money to go directly to the elderly program. A lot of the tribes have fundraising programs where the elderly people will produce handicrafts and sell them to supplement the funding of the Title VI program.

But Ramona was very correct: Title VI is a very bare-bones program.

The legislative mandate is different from Title VI and Title III. Title III requires ombudsmen, requires many, many services that the Title VI doesn't. The legislative mandate of Title VI only requires meal service and referral. So anything the tribe does beyond those to required services needs to be funded by the tribe.

FRAN HOLLAND, ADMINISTRATION ON AGING

Ms. HOLLAND. Hi. I'm Fran Holland. I work for Yvonne.

I would just like to add that the tribes can also go for the Title III funds even though you have the Title VI services, so that they can begin to work together. While Title VI is not funded at the same level as Title III, it does have more freedom for tribes to develop the programs that they want to. So there is a way that you can interweave it, although in no way am I implying that there is enough money out there or enough resources out there.

Dr. JOHN. I also would like to address Title VI.

Title VI programs are aging services in Indian country, and yet not even half of all Indian tribes are served by Title VI, so you can see that even with the existing programs at least half of Indian elders are not served by any kind of program.

Right now I just asked Yvonne what the average grant was—$57,000 is the average Title VI grant. That is better than it has been in a few years past, but it is inadequate. Title VI programs struggle to provide nutrition services, and with that level of funding will never be able to develop the kind of professional staff that is typical in Title III.

So you have not only the quantity of services that is very much reduced in Title VI, but I think that the quality issue is another one that has to be addressed. Title III typically has trained professionals to deliver the services.

Now, your comment about bureaucracy is a really important one, and the only agency—typically the only agency in Indian country that is dealing with the issue of how to overcome the bureaucracy,

processing papers for Medicare or Medicaid, or whatever, is the Title VI program. If I were to pick one single thing that needs to be improved within Title VI, it would be information referral services broadly conceived, because information referral services do just that—they broker, they give information, they do follow-up—in other words, case management.

Mr. BALDRIDGE. We have 311 tribes not served by Title VI. I think the latest statistics showed that fewer than 20 percent of our elders are served by Title VI.

I'm not surprised that not too many people back here know a great deal about Indian elderly. I went to NARIS, the University of Oklahoma's database on Indian affairs. It is the largest national database available exclusively for Indian studies. I believe the IHS uses it and probably funds it.

Out of either 11 or 14,000 studies they had on hand, they could cross-reference 125 to Indian elderly. We have such a huge gap in research that I'm surprised that anyone knows anything.

I would think that a prime focus for research might be the levels of Title VI service. It seems so apparent, and yet it hasn't been done. It has not been funded.

Ms. SOLOMON. I don't purport to speak for all of Indian country, but for my tribe—I am a Winnebago from Nebraska. Generally, when you tell people you are a Winnebago they think of the recreational vehicles. But I just want to inform you that you are looking at a real, genuine Winnebago.

But talking about elder and grandfather's and grandmother's psyche, within my tribe part of the belief is that you don't speak unless you say something good. I think sometimes when I think of the background that many of our grandmothers and grandfathers have come from, and the things that they have been promised, Indian people have been probed, assessed, surveyed, and many promises made that have never materialized. So they are reluctant to say anything.

They are very skeptical. They want to see and have you prove first before making a commitment or making a statement. But that's the background that I come from.

JO JO HUNT, LUMBEE INDIAN FROM NORTH CAROLINA

Ms. HUNT. My name is Jo Jo Hunt. I am a Lumbee Indian from North Carolina. Who do I represent? I represent my 67-year-old widowed mother. We lost my father earlier this year.

I have listened to you here today talk about the various kinds of services available. I want to remind you that some 64 percent of the Indian population, according to the 1990 census, now resides off reservation. I certainly don't want to take anything away from the reservation programs, because they desperately need everything they can get, but I think we have to have some foresight.

Often we deal in Indian affairs from one crisis to the next with no planning at all. But with that large a percentage of the population off reservation, you are going to have more and more seniors off reservation, too.

My tribe has never been on a reservation. I dealt with my father's 61-day hospital stay, his 5-day nursing home stay, his stroke,

his Alzheimer's, his pneumonia, and his death without a CHR, without the assistance of the Indian Health Service.

That 64 percent of the Indian population will deal with these kinds of events without the Indian Health Service unless they are in a city that happens to have an urban health program, but still they won't have the CHRs.

I would hope that we start looking at Indian people as American citizens, as well, as eligible and entitled to all the other services that everybody else in this country is entitled to.

Those folks who are off reservation can start to have access and not feel isolated and not apart from the things that are available for everybody else.

I'm not quite sure how the conversations can begin. Certainly, Doctor Jackson and Mr. Baldridge, I would hope that you would look at some of these issues rather than concentrate on one segment of the population, which is a very important segment but, again, it is not the entire population of Indians.

I had hoped that some folks from Baltimore—there is a Baltimore American Indian Center. There is a large concentration of people from my tribe and from other tribes in North Carolina who migrated to Baltimore for jobs. They have, as I understand, a very active senior citizen group there. I had hoped that they would be here to talk about some of these things so that I, a 41-year-old, didn't have to speak for seniors—but I'm not that far away from it. The years pass quickly.

But there ought to be some way that all of us can get some of these needs met. I realize that senior care, long-term care, health services, housing, nutrition, and all those issues are important to seniors wherever they are. They are important to Indian senior citizens wherever they are, too, including off-reservation areas.

I'd like to have some comment, perhaps from Mr. Baldridge, as to whether or not the National Indian Council on Aging looks at these issues, and also from Doctor Jackson as to how her program interacts with other parts of the Older Americans Act to look at this additional population.

Mr. BALDRIDGE. With more than 500 federally recognized tribes, trying to serve Indian elderly is a very complex problem to begin with. And then we look—my figures show 48 percent of our elders, nearly half—and you say now over half—living off reservation and in the cities. I think of this neglected population. Those are the single portion that falls through the cracks the most.

Indian elderly are less than 1 percent of the people Title III serves. These people are as isolated—possibly often more so—than anyone living on a reservation. It is very disturbing to me that we are having such a tough time even identifying them.

The AARP, in their Title V jobs program—wants to try to serve Indian elderly in the cities. We are not sure to tell them who they are. We are going to the Indian Health Service. We have provided a list of the clinics, and hopefully we can work with IHS and, through their files of enrollees and people receiving services, we can identify this Indian urban population.

California is our second largest Indian State, and I think they have few, if any, large reservations. There are rancherias and urban populations there, and yet it is the second largest population

in the Nation. I'm very discouraged to tell you that at this point we are taking no programs to them. I'm not sure how to get to these people.

The AARP is doing a nice SSI enrollment outreach that is going to focus on urban Indian elders, but it is a pinpoint in a big map. And yes, there is a tremendous amount to be done, and yes, it is very troubling.

Dr. JACKSON. The Title VI program is specifically for reservation Indians, so when I'm dealing with Title VI I am dealing only with reservation Indians, and only the 211 tribes that we have funded. However, part of my role as Associate Commissioner is to work with all the American Indians, Alaska Natives, and Native Hawaiians, so we have been trying, as Dave said, to get a fix on the urban Indians, where they are.

A couple of years ago we funded a researcher in Los Angeles to identify the elderly Indian population in Los Angeles, since they have such a very high Indian population where maybe we could target some resources to a central location where the Indian elderly would feel comfortable in coming.

What the researcher found was that there was no central location. They were so scattered around Los Angeles—and Los Angeles is such a large area—that it was not a viable option. Los Angeles is hard to deal with.

Also, as a part of my role, I chair an interagency task force on older Indians. A number of the task force members are here this morning. What we have done this past year—one thing we are looking at is to work with our own programs, all the people on the task force work in a program where a focus is on the Indians. We are looking at the paperwork. Is there a way that we can change the paperwork between the agencies so two agencies—one piece of paperwork will suffice for two or three agencies?

Within this discussion in the task force, most of the other programs work with all Indians, not just reservation Indians, so we have broadened the focus of this task force.

Last year we had two hearings. One was on urban Indians, and we brought urban Indian elderly in from cities around the Nation and heard about their problems. I remember the lady from Chicago talked about not going to the Title III site because she was not welcome there. The Indians in her part of Chicago—the Title III site was primarily hispanics, and the Indians were not welcome there, so the Indians in that part of Chicago did not participate in AOA programs.

We heard from people in Baltimore, how they get State funding. They get no funding from Title VI.

We also had another hearing where we heard from State-recognized tribes. They are suffering the same problems as the urban, and probably even more because they are rural, isolated tribes that don't have many Title III services that they can even access. So it is not that they feel discriminated against; it is that those services aren't available to them.

So I guess I am in the same boat as Dave. We know the problems are out there. We are looking at the problems. And we are really groping with how to deal with them. We certainly would welcome any input you have on assisting us on that.

Ms. HUNT. Thank you.

Mr. MANN. Dave, I'd like to say something.

Mr. BALDRIDGE. Sure.

Mr. MANN. We are experiencing the same problem on Navajo. We have a lot of Navajos in California, Phoenix—even Washington and Canada. We are trying to get them to be aware of the services that are available. They have an Indian Health Service facility in Phoenix, in Albuquerque. At the same time you go about to how long it takes for one Indian or one elder to see a physician because of the manpower that is not adequate. The facility may be there, but you don't have the manpower to address the health needs of the elderly.

Our experience has been the simple fact that we get the individual to the hospital, but the individual stays there until all hours of the night, and the physician that he or she is supposed to see goes home, and then they have to come back the next day.

That situation exists whether the facility is in Albuquerque or whether the facility is in Window Rock, because Indian Health Service does not have the manpower nor the funding to make those people available—the physicians and the nurses—because, like I have found out, the tenure is usually just maybe 2 years, and the physicians are gone.

Over the years, there has been a lot of mistrust developed because of that. How do you alleviate that? You do away with IHS? Or do you hire medicine men to address the health needs of Native Americans? What do you do?

You can access the Department of Transportation for vans, but the vans they give you are going to last maybe 2 years at the most because of the type of road conditions you have in the rural areas.

A lot of our Native Americans live more than 3 or 4 miles apart without any type of sanitary facility. If you have ever been to a Third World country, you know the conditions. It is very sad.

Sure, we can talk about resources availability, accessing resources, but we always run up against stringent Government regulations. That's where our bureaucratic red tape has to be reduced and the avalanche of paperwork has to be reduced.

To access any type of Medicare or Medicaid facility—I have asked my mother, who is about 80 years old, to utilize some of that. She says, "It is very unimportant when I go to public health facilities. The first thing they ask me is whether I have a card. I sit there after they take my card for hours, and sometimes I don't get seen. And when I do get seen, the only thing I'll get is pain pills, and I don't get examined. And when they look at me, all they do is touch me here and there and say, 'Well, you're okay. Just take the pills and you'll be all right.' "

It is evident. The competency level of some of those physicians is sad.

But how do you alleviate those problems? Do you hire physicians that are paid comparable to a private practitioner? What do you do? Do you reduce/consolidate health facilities and make it a comprehensive health facility to address the needs of the Native Americans instead of having a bunch of facilities throughout Indian country that are totally inadequate, instead of helping the Native Americans?

They are doing less than adequate job. What do you do?

We have funding for Title VI and Title III. We contract Title III. What we do is pump in money from the three States and also local funding, which is Navajo Nation funding. Also, we have Title VI. We also combine that and match funds with the State, local, and tribal funds.

So it is flexible, yet, at the same time, the level of funding is not adequate. The type of facility and the infrastructure upkeep is tremendous.

Thank you.

Ms. SOLOMON. Doctor Heath, I would just like to ask you a question. What is the number of shortage of number of physicians that IHS now has? Is it like 150 or something?

Dr. HEATH. About 150 to 170, somewhere around there. Of course, it fluctuates.

Mr. BALDRIDGE. Albuquerque Indian Hospital told me there that they, in the last year or two, I believe, have had an average vacancy in their beds of 43 percent. It is so ironic that our elders can't get served, and IHS is very painfully aware that they don't have staff to serve them. So the Indian people get referred out. It is a very difficult situation all the way around with funding, and it certainly seems to be one thing we've got to look at here.

More comments, please?

KATIE JOHNSON, NATIONAL ASSOCIATION OF STATE UNITS ON AGING

Ms. JOHNSON. I'm Katie Johnson with the National Association of State Units on Aging.

I would just like to comment on Mr. Mann's identification of the barrier—lack of family support. I think that one of the things we need to do is look at the whole family. We can't look at the elderly without looking at the rest of the family.

I say this to say that we should have some flexibility to be able to support and help family members. Helping an adult in the family get a job is going to help the elderly person. Helping the family to get food stamps, or other kinds of assistance is going to ultimately help that elderly person.

For example, I think we need to consider the needs and concerns of each family member and have more flexibility to utilize program resources to counsel not only the victim of elder abuse, but also family members, and to be able to provide support or the kind of assistance to them which deals with other family problems that often contribute to the abuse.

Why can't certain youth program services, for example, be made available to help the elderly persons. If there is a young person who is living with his grandparent and being provided transportation to the doctor, why can't the youth program worker also take the elderly person to the doctor? I think we tend to say, "This is my program, that is their program. I can't use my money and resources to do this for them." I think we need more flexibility, or for someone to say it is okay, because helping a family member in the household is ultimately going to help the elderly person or likely alleviate a concern that affects their well-being.

I think that coordination, linkage, and collaboration between programs also need to be strengthened so that assistance may be provided to the family as a whole.

Mr. BALDRIDGE. Thank you, Katie.

Oklahoma has a fine initiative going between Title VI directors and Title III directors, and NASUA has been very supportive of efforts like that. We will be working to try to build coalitions like that, but it appears to be a very small effort in the face of a very huge problem.

We do have the room for a few minutes longer, so let's keep the floor open here. I would ask you again to please leave us your name and your address so we can send you all results of the meeting today, or a transcript.

Mr. MANN. Dave, I'd like to further comment on what you said on family support.

We have an intergenerational type of program out on the Navajo Nation, but I think that needs a little more concentration, not only in terms of manpower, but funding, so that we reduce that generation gap, because a lot of us are aware that our generation and the generation before me have supported elderly without nursing homes, and that concept has not only died in the Anglo-American society, but it is also dying on the Navajo Reservation, as well as other ethnic groups.

So that intergenerational relationship philosophy, the "being youthful in your elder years," has to be promoted, because when you become old you have a lot of degenerate types of faculties, whether it is your faculties, your physical use of hands, or whatever.

When you are young you need help in development of intellectual abilities and things like that. When you get old, your mobility is very limited. So we have to complement each other, no matter how old or how young we are. That needs to be promoted. Keep the American dream alive—the old days. It is not going to change.

Thank you.

Mr. BALDRIDGE. S. 243, the Senate bill on the reauthorization of the Older Americans Act, has some real implications for Indian health and many other Indian issues that are very important to us.

Anna Kindermann is here from Senator Pryor's staff. She's an attorney who has dealt with the reauthorization, so I'm going to ask Anna if she will fill us in on the latest.

ANNA KINDERMANN, SPECIAL COMMITTEE ON AGING

Ms. KINDERMANN. I'm very happy to be here. I'm sorry that I missed the majority of this morning's session. It sounds like it has been very informative.

I am pleased to report that S. 243 did pass the Senate last evening. Of particular interest to you all, there was an additional amendment added by Senator Bingaman which would establish grants for Native American rights protection activities.

I have not seen the language for this amendment—it was tacked on at the last minute and passed without any problem. When I have an opportunity to review the language, I would be happy to inform you of those. You can call me at the Committee.

There are, as Dave said, a number of provisions with respect to Title VI that are of particular interest to you. In addition and there is a little bit of an increase in the authorization for Title VI.

I have not seen the final appropriations for Title VI. It has been through conference, but I have not seen the final appropriations. I can; however, give you the authorization levels in the Senate bill that passed last night, if that would be helpful.

For Title VI there would be, for fiscal year 1992, $23.3 million; for fiscal year 1992. That's $21.733 million for Part A and $1.5 million for Part B.

For fiscal year 1993, $24.6 million. That's $22.9 million for Part A and $1.6 million for Part B.

For fiscal year 1994, $25.9 million—$24.1 million for Part A and $1.7 million for Part B.

Finally, for fiscal year 1995, $27.3 million—$25.5 for Part A and $1.8 million for Part B.

It is my understanding that the House reauthorization bill, H.R. 2967, and the Senate bill, S. 243 will go to conference within the next couple of weeks. It is our hope that it will be reported out by the Thanksgiving recess, if that is, indeed, when Congress does recess.

Mr. BALDRIDGE. Thanks, Anna.

I have heard that there is a possibility of $5 million being appropriated for tribes to deal with elder protective services. We think that's marvelous. It is a great step. We hope it is true.

Let's look at spending another 10 or 15 minutes, not necessarily in summarizing or in conclusion, but continuing to look at this population of Indian elderly.

Ms. JOSEPH. Dave, we are working right now on the introduction of the Indian Health Care Improvement Act, which predominantly sets the foundation for the whole of the Indian Health Service. One of the things that I know that we were thinking of here on the Senate side—and this is more specific to meeting the needs of children—is possibly doing something to enhance the availability of specialized care in terms of pediatrics, being able to address otitis media and hearing problems, being able to do whatever we could to enhance breast feeding and that type of thing, and just having lactation specialists available, but trying to make a team of specialists available in every area either through contract or through some staffing availability to go out to do better well-child clinics, particularly in outpatient settings.

The tendency in Indian Health Service is to have those services available in hospitalized areas, but I think there are only about 50 hospitals out of about 543 different health facilities in the Indian Health Service, and that's where that kind of care is available.

I'd imagine the same may hold true for geriatric types of care, but I was wondering—and it sounds like there is relatively none—if we took the same concept where you have this team of specialists available at every outpatient clinic to do pediatric care, if you could do the same where maybe once a month in an outpatient clinic somewhere in the far reaches of wherever—Navajo Country, or in the Billings area, or Aberdeen—having this team available to do what might be needed for eldercare.

I was wondering what that model would have to include to really address seniors' needs.

I think a part of the problem is that you have so many people waiting in line. If senior citizens knew that there was a day where they could have all of their various health care needs addressed, I was wondering if that is really too far out to consider, rather than well-child clinics, having well-elder clinics, that type of thing. How would that be received?

Mr. BALDRIDGE. Someone from IHS?

Dr. HEATH. I think that would certainly have significant potential. I think when you have one-stop shopping any time it helps, no matter what you are shopping for. If an elderly person could come in and have their feet attended to by a podiatrist, they could have their preventive health needs looked at by a physician or registered nurse, or whoever was knowledgeable of those areas, have their nutritional concerns addressed by a dietician familiar with the nutritional needs of the elderly, and so on and so forth, I think that would potentially have a significant impact.

Again, if someone comes on a clinic once and spends 4 hours there, if all they do is get to see a doctor for 5 minutes they go away unhappy. If they come in and they wait or are there for several hours but they get several things done, they get a lot of needs taken care of, they tend to leave more satisfied, and for good reason. They have accomplished a lot more.

I can't say off the top of my head that I know of a facility—maybe Ramona does—that has concentrated on providing that particular comprehensive service on a regular basis. There are certainly physicians such as from Anchorage, internists, or what have you, who will fly out to small clinics or hospitals in Alaska, for example, for a day or a week and hold specialty clinics. Some of those are particularly targeted for diseases that affect the elderly, such as cardiovascular diseases and that type of thing. But a comprehensive—I can't think of a good example where a comprehensive well-adult or well-elderly clinic exists within the Indian Health Service. But certainly there——

Ms. ORNELAS. Yes. There is one area where they are making an attempt to take a multidisciplinary attempt, and that's at the AIDA service unit. It is not just a clinical focus; it is also social services, a strong emphasis on prevention, and health education.

There are also other tribal programs that combine the meals programs with specific kinds of services, like foot care. Maybe once a week the public health nurse will come to visit the meal center and give instruction on foot care and provide some services.

I think there is a lot happening out there that we don't know about, but certainly not enough.

Dr. HEATH Many of these things, as Ramona mentioned, don't necessarily target elderly alone. They will target the adult population. Certainly examples of those exist.

I do want to mention before we come to a close that the Indian Health Service has put together a work group on aging. We have asked approximately a dozen individuals—Doctor Jackson being one of them. I believe she'll be sending a representative to our first meeting, as well as individuals from the Bureau of Indian Affairs, tribal individuals, the National Institute on Aging—to participate

in this work group, where we will be looking at a lot of these issues that have already been discussed here around this table today, particularly as to how the Indian Health Service can develop a geriatric agenda for its programs over the next year in a strategic planning process.

Our first meeting is December 2 and 3 in Albuquerque. That's coming up in a few weeks. We hope to develop this agenda over the course of a few meetings over a period of no more than 6 months.

We don't want to concentrate on asking for more research or information. We want to concentrate on developing action items that the Indian Health Service can incorporate into its strategic plan for the next several years to address some of these issues.

I do want to say that, unfortunately, a lot of these discussions will probably concentrate on reservation Indians.

Ms. HUNT. But since you have urban health clinics funded by Indian Health Service, could you add to that working group some representatives from those urban clinics? That's a simple way to start talking about it.

Dr. HEATH. I think that that's a very, very important thing that we will need to add to that group, because it is, as has been mentioned here very eloquently today, a subgroup of Native American elders that are probably in even more need than a lot of the people on the reservations.

Ms. SOLOMON. Excuse me. I just wanted to kind of share some information that I am aware of.

In Alaska, the Kodiak Area Native Association—they call it KANA—are in process of establishing what they are referring to as "village response teams." In Alaska the villages are hundreds of miles away from any kind of health care. They have established these teams in their villages that respond to anything or everything, because villages are so small. Maybe there is a population of 35 people in one village. You can't specialize in that particular case. They are just getting started with that.

I know that in the Aberdeen area they were also thinking of establishing what they were referring to as community response teams, but those teams were going to be focusing on fetal alcohol syndrome.

But when you get into small, remote, rural communities, you can't specialize. You've got to be generalists. You've got to be able to handle somebody that has a heart attack, or somebody that is going to deliver a baby.

I think the concept is good, but most of our reservations are very small. They are remote. Even Navajo districts are miles away. You can't really specialize that much. You have to keep it very general and do everything.

Mr. ORNELAS. I think that raises the issue of a need for targeted training programs not only of CHRs, but all the providers, as well, including social services.

Mr. BALDRIDGE. I want to thank you all for coming and participating with us.

Senator Pryor's staff, would you like to close? We are very grateful for this forum.

Ms. MITTELMAN. Let me speak on behalf of my staff.

First of all, Mia Masten has done a fabulous job of bringing us all together, and I'm very, very pleased and proud of the work that she has done.

Also, Anna Kindermann, who is our Older Americans Act expert, has done a wonderful job.

And Andrea Boldon, who is back in the corner, has been helping in a lot of different ways today. I really thank her.

Dave, I just have to ask one question before we close.

Mr. BALDRIDGE. Certainly.

Ms. MITTELMAN. This really is a little bit off of our general subject, but it has been interesting for us, when we were doing the research about this workshop, to discover that Native American is not always the phrase of choice. I wonder if someone could just speak to that for just a bit, because we were intrigued. We want to be politically correct in this.

Mr. BALDRIDGE. To try to find any single thing that is politically correct throughout Indian country, you could be seeking a first.

My board of directors prefers the term American Indian to Native American. On an informal basis we use that term throughout all of our documents and our conversation, so you are safe in doing that. That's what the Indian elders recommend that I work with. Tulley may have a different feeling in Navajo Country.

Certainly the Older Americans Act continues with "Native Americans," and the clock won't stop if any of you use that term, but we do use American Indian.

Ms. MITTELMAN. Thank you, Dave, for that.

And thank every one of you very, very much for coming and participating. This is not the end. This is only the beginning. We thank you.

[Whereupon, at 12:13, the workshop was concluded.]

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