DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

JULY 10, 2002

STATEMENT OF THE INDIAN HEALTH SERVICE

OVERSIGHT HEARING ON NATIVE AMERICAN ELDER HEALTH ISSUES

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Mr. Chairman and Members of the Committee: Good morning. I am Dr. Kathleen Annette, Area Director of the Bemidji Area Indian Health Service (IHS). Today I am accompanied by Dr. Bruce Finke, Elder Health Specialist, and Dr. Craig Vanderwagen, Acting Chief Medical Officer, (IHS). We are pleased to have this opportunity to testify on the Native American Elder Health Issues.

The IHS has the responsibility for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN's) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. In carrying out our statutory responsibility to provide health care services to Indian tribes in accordance with Federal statutes or treaties, we have taken it as our mission to raise the physical, mental, social, and spiritual health of American

Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. The mission and goal are addressed through four agency strategic objectives, which are to 1) improve health status; 2) provide health services; 3) assure partnerships and consultation with IHS, Tribal, and Urban programs; and 4) perform core functions and advocacy.

The American Indian and Alaska Native (AI/AN) elder population is rapidly growing and the AI/AN population as a whole is aging (increasing 23% between 1990 and 2000 census). With death rates from diabetes five times the national norms and those of kidney disease three times national norms the prevalence of chronic disease among AI/AN elders continues to increase, contributing to a frail, medically complicated elder population with increasing long-term care needs. You will hear testimony from the National Resource Center on Native American Aging regarding the prevalence rates for functional impairment among AI/AN elders. To our knowledge, this is the best data available on this subject. We know that 1/3 of AI/AN elders 75 years and older have income below the poverty line (over twice that of the national norm). We know that the majority of elders live on or near tribal homelands, while younger family members often move off reservation in search of economic and educational opportunities.

To meet the needs of this rapidly expanding population, the Indian Health Service, through

the Directors Initiative on Elder Health, has focused our efforts in three areas. First, is in the area of infrastructure development for long-term care service delivery for AI/AN elders. Second is the development of improved clinical expertise in clinical geriatric care. Third is in the area of improved palliative and end-of-life care.

Long-term care can be understood as an array of social and health care services which support an individual who has needs for assistance in activities of daily living. These needs range from chore services or transportation to full around-the-clock care. While AI/AN communities continue to provide the majority of care through immediate and extended family, this rapidly growing elder population and these demographic shifts have created an urgent need for both services and systems of care to support families as they care for elders.

An example comes from one of our hospitals. A 95 year old elder, mother of 6, lives in the home her now deceased husband built for their family. Her seventy year old daughter provides around the clock care for her, including bathing and feeding, while still managing the family livestock. Other family members help out. An eighty year old sister stays with the elder while her daughter goes shopping or tends the stock. Grandsons find time between work and home responsibilities to haul wood and water. The elder was recently hospitalized for pneumonia and a small bedsore and on discharge, the family gathered to discuss where she could best be cared for. All of her remaining sisters and many of their

children came, and all agreed that she would want to remain in her home. Her daughter was clear that she wanted to continue to care for her. Equipment was arranged for the home, including a manual hospital bed (there is no electricity to the home), a special mattress, a bedside commode (there is no running water in the home), episodic home health nursing (under the Medicare program), and limited personal care services (three hours a day), funded through the state home and community based care program and provided by the tribal home care agency. Referrals were sent to the tribal housing authority for housing modification. At a recent home visit (done after clinic hours) the primary physician found that the elder had gained weight since discharge and healed her bedsore. Her daughter was still providing the care, assisted by some family members. It has been a difficult time for her, but she still feels that she wants her mother to remain in her own home.

This example depicts the challenging setting in which elder AI/AN's receive their health care. It important to note that this Indian elder has family that can assist with her health care. However, for most Indian elders they do not have family members who can assist with their care.

Long-term care services at the community level are funded through a variety of resources, including IHS, Tribal funds, Medicaid, Administration on Aging (AoA), Department of Veterans Affairs (DVA), state home and community-based care programs, and federally funded housing programs. Each of these resources has unique eligibility requirements

and limitations of scope and none of them provides for coordination of services from disparate sources. An efficient and effective system of long-term care would make use of all available resources, integrating and coordinating services to assist families in the care of their elders.

Long-term care is not culture neutral. The way systems are developed and implemented can have significant impact on the cultural and spiritual health of the community. For this reason and others, planning and infrastructure development for long-term care service delivery must be at the tribal level. The IHS is working to enhance capacity for the delivery of long-term care services and to assist tribes to develop long-term care services and systems in several ways. First by refocusing existing IHS resources to meet elders' long-term care needs. An example of this includes enhanced case management, skilled nursing visits, and family support and education through the Community Health Nursing Program. These efforts are dependent both on local health care priorities and on the degree of organization of local systems to care for elders. Second, through technical assistance and capacity building efforts to support the development of tribally based systems of long-term care. Third, through coordination with other federal agencies to improve access to existing resources and to develop new resources for long-term care services.

Recent efforts include the following: In April 2002 the IHS, with the collaboration of the

Administration on Aging and the National Indian Council on Aging (NICOA), held a Roundtable on Long-Term Care. Experts in Indian health and long-term care from throughout Indian country were invited to identify and address key issues in long-term care. The findings of this Roundtable now help to guide our efforts. A copy of the Roundtable Report can be provided to the Committee.

The IHS is co-leading a working group within the Department of Health and Human Services (DHHS) whose goal is to coordinate federal resources to assist tribes as they develop long-term care services and systems. Participating agencies include IHS, Centers for Medicare and Medicaid Services (CMS), Administration for Native Americans (ANA), and AoA. We intend to involve agencies from outside DHHS such as Housing and Urban Development (HUD), and DVA in this effort as well.

The agency is in the planning stages for the development of a technical assistance center for tribes developing long-term care services. This center will make use of existing expertise throughout Indian country, including the National Indian Council on Aging and the National Resource Center on Native American Aging.

Developing clinical expertise in geriatric care involves special challenges in our decentralized, primary care oriented system. Our strategy is to focus on the provision of excellent geriatric care within primary care rather than on development of specialty

geriatric services. The focus thus far has been on the development of clinical tools (such as the Comprehensive Elder Exam) and training opportunities for Indian health providers. We have collaborated with the Health Resources and Services Administration (HRSA) funded Geriatric Education Centers, the DVA Greater Los Angeles Healthcare System, and the American Geriatrics Society (AGS) in these efforts.

An effort is also underway to develop improved capacity for quality palliative and end-of-life care. Partners in this process include the Oxford International Centre for Palliative Care, and the Robert Wood Johnson Foundation. We are currently developing funding for a three-year program that will train an interdisciplinary cohort of clinicians from throughout Indian country in palliative care.

The blessing of more elders living longer in our communities brings challenges for the Indian health care system. We are committed to providing comprehensive personal and public health for the elders we serve. This means ensuring access to quality geriatric care and coordinated long-term care services that support the elders and their families in their communities.

Thank you for this opportunity to discuss the Native American Elder Health Issues on behalf of IHS. We are pleased to answer any questions that you may have.