Engaging American Indian and Alaska Native Medicare Beneficiaries: Senior Medicare Patrol Toolkit

Prepared by International Association for Indigenous Aging

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Chapter 1: American Indians/Alaska Natives

According to the 2010 Census, the phrase American Indian or Alaska Native (AI/AN) refers to a person having origins in any of the aboriginal peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachments.

However, the widely accepted definition of an Indian comes from the Indian Health Care Improvement Act of 1976 which states, “An Indian is anyone who is a member of a ‘recognized’ tribe, with no mention of blood quantum. An individual may be considered Indian if he or she belongs to a tribe, band, or group that has been terminated since 1940, regardless of whether or not the individual lives on or near a reservation. Another category includes those members of tribes which are recognized now—or may be recognized in the future—by the state in which they reside. In addition, anyone who is a descendent, in the first or second degree, of any one of these individuals also qualifies. Eskimos, Aleuts, and other Alaska Natives are considered Indians. Anyone considered by the Secretary of the Interior to be Indian for any purpose qualifies. And finally, anyone who is determined to be Indian under regulations promulgated by the Secretary of Health and Human Services also is considered to be Indian.”

Overview

The United States has a long-established, special political relationship with AI/ANs due to their tribes’ statuses as sovereign nations, as recognized in the U.S. Constitution. In exchange for land, and in compensation for the forced removal from their original homelands, the government promised, through laws, treaties, and pledges, to support and protect AI/AN people. This is known as the Federal Trust Responsibility.

AI/AN people are a diverse population, with 566 federally recognized tribes based in the rural and urban areas of 35 states. Most tribes are federally recognized, though some are state-recognized or designated by Presidential Order. Still others are unrecognized—meaning that they are not eligible for certain services, such as having access to Indian Health Services (IHS).

- In 2010, there were 324 federally recognized American Indian reservations.
- In 2010, excluding Hawaiian Home Lands, there were 617 legal and statistical AI/AN areas for which the Census Bureau provides statistics.

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* Tribal sovereignty in the United States is the inherent authority of indigenous tribes to govern themselves within the borders of the United States. The federal government recognizes tribal nations as "domestic dependent nations," and has established a number of laws attempting to clarify the relationship between federal, state, and tribal governments.
As a legal category, **Indian Country** includes “all land within the limits of any Indian reservation, b all Indian communities within the borders of the United States, and all Indian allotments.” It also includes all federal trust lands held for AI/AN tribes. Indian Country refers to any of the self-governing American Indian communities throughout the United States; however, Alaska Natives typically reserve the term for use in describing the lower 48 states.

The term Indian Country is also understood by recognizing the many differences among the tribes. It is not a unified country, but many distinctive nations, tribes, and communities. The distinctions between each community may be political, geographic, demographic, economic, or cultural. Such diversity makes it difficult to create an all-inclusive approach for working with AI/ANs.

**AI/ANs rank at, or near the bottom, of nearly every social, health, and economic indicator.** Compared to all other race or ethnic populations, AI/ANs have the highest poverty rates (30%)—twice the national rate. In 2011, the median income of AI/AN (alone) households was $35,192, compared to $50,502 for the entire nation.

**Funding for programs serving AI/ANs has historically been insufficient.** With the passing of more current legislation, federal funding for AI/AN programs has increased. However, this has not been nearly enough to compensate for the decline in spending power or to overcome a long history of substandard community infrastructures. While AI/ANs’ health care, for example, is legally an entitlement—much the same as Medicare and Social Security—federal appropriations for this care are discretionary (approved annually by Congress). The result, historically, has been devastating shortfalls in Indian health care programs. Much the same is true for other socio-economic arenas where unmet needs prevent tribes from raising their standards of living to those of other Americans.

> “At least two rationales exist for ongoing federal commitments to allocate resources to [AI/AN] programs and services. The first is a fundamental desire by the U.S. to address the compelling and often Third World conditions found in many Native communities. . . . In many parts of Native America, economic and social conditions resemble the emergency states associated with natural disasters which require federal intervention. The second rationale . . . is the unique legal and political relationship between the U.S. and Indian tribes nationwide.”

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*An Indian reservation* is an area of land managed by a AI/AN tribe under the United States Department of the Interior’s Bureau of Indian Affairs. There are about 310 Indian reservations in the United States. Not all recognized tribes have a reservation—some have more than one reservation, some share reservations, and others have none. The collective geographical area of all reservations is 55,700,000 acres, representing 2.3% of the United States’ 3.794 million square miles. Twelve reservations are larger than the state of Rhode Island. The majority are west of the Mississippi. Tribal sovereignty allows laws on tribal lands to vary from their surrounding areas. For example, they can allow for legal casinos on a reservation. The tribal council generally has jurisdiction over reservations. Further, different reservations have different systems of government.
Demographic Snapshot

In 2010, there were 5,220,579 AI/ANs (alone or in combination), comprising 1.7% of the total United States’ population of 308.7 million. This is an increase of 39% from the last Census, making it one of the fastest growing populations with a growth rate almost twice that of the total U.S. population. Of the total AI/AN population, 586,629 were 65 or older. The Native population is younger than other races with an average age in 2010 of 29, compared to 37 for the United States overall.

Compared with other racial and ethnic groups in the United States, AI/ANs make up a relatively small proportion of the population. Thus, AI/ANs are often considered an “invisible minority,” which makes recognition by established government-reported tracking scales ineffective and outdated.

Geography of AI/AN Populations

The 566 federally recognized Indian Nations are variously called tribes, bands, nations, pueblos, Rancherias, and Native villages. Approximately 229 of these ethnically, culturally, and linguistically diverse nations are located in Alaska. More AI/AN people live in cities that are situated in the Western, Southern, or Southwestern regions of the United States. However, federally recognized tribes are spread across 35 states in the upper Midwestern, Northwestern, Southwestern, and Western regions of the lower 48 states and Alaska. Many reservations are small and isolated, and even larger ones, like the Navajo Nation, have areas that are extremely remote.

See Appendix for additional map images.

See Figure 1: American Indian and Alaska Native Alone or in Combination - Percentage of County Population
In 2010, the 10 American Indian reservations with the greatest numbers of AI/ANs were the:

- Navajo Nation Reservation (169,321) in Arizona, New Mexico, and Utah;
- Fort Apache Reservation (13,014), Gila River Indian Reservation (11,251), San Carlos Reservation (9,901), and Tohono O'odham Nation Reservation (9,278) in Arizona;
- Pine Ridge Reservation (16,906) in South Dakota and Nebraska;
- Rosebud Indian Reservation (9,809) in South Dakota;
- Osage Reservation (9,920) in Oklahoma; and the
- Blackfeet Indian Reservation (9,149) and Flathead Reservation (9,138) in Montana.

The ten cities with the largest number of AI/ANs included:

- New York, NY
- Los Angeles, CA
- Phoenix, AZ
- Oklahoma City, OK
- Anchorage, AK
- Tulsa, OK
- Albuquerque, NM
- Chicago, IL
- Houston, TX
- San Antonio, TX

Geographic location means that those who reside, attend school, or work on reservations are often isolated from mainstream society. Diversity in cultures and regions, differences between urban and rural settings, and varying levels of access to telephones and electronic connections within the AI/AN population present challenges. For more information, please refer to the accompanying Appendix that contains detailed descriptions of AI/AN populations by region and tribal grouping.
Geographic Fast Facts

- AI/ANs are more geographically clustered than other populations, with 62% residing in 11 states. Forty-eight percent live in the West—more than any of the other three regions of the country. 10

- The largest tribal groups are the Cherokee, Navajo, Choctaw, Sioux, and Chippewa. 11 These five groups comprise almost 40% of all American Indians.

- Eskimo is the largest tribal group among Alaska Natives, followed by Tlingit-Haida, Alaska Athabascan, and Aleut. These four groups combined make up only 3.6% of all AI/ANs who reported tribal affiliation.

- AI/AN migration to urban areas represents one of the most significant demographic shifts in U.S. history. In 1970, 38% of all AI/ANs lived in urban areas 12. According to the 2010 Census, 71% of all AI/ANs live in urban areas, and approximately 30% live on reservations, trust lands or bordering rural areas. 13

- In 2010, the five states with the greatest percentage of AI/ANs (alone or in combination) were California (14%), Oklahoma (9%), Arizona (7%), Texas (6%), and New York (4%).

- The 10 cities with the greatest percentage of AI/ANs (alone or in combination) were Anchorage, AK (12%); Tulsa, OK (9%); Norman, OK, (8%); Oklahoma City, OK (6%); Billings, MT (6%); Albuquerque, NM (6%); Green Bay, WI (5%); Tacoma, WA (4%); Tempe, AZ (4%); and Tucson, AZ (4%). 14

Urban Indians

Prior to the 1950s, most AI/ANs resided on reservations, in nearby rural towns, or in tribal jurisdictional areas, such as in parts of Oklahoma. In the 1950s and 1960s, the federal government passed legislation to terminate its legal obligations to Indian tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs (BIA) Relocation and Employment Assistance Programs, which enticed Indian families living on impoverished Indian reservations to relocate to various cities across the country (i.e., San Francisco, Los Angeles, Chicago, Salt Lake, Phoenix, etc.). BIA Relocation offered job training and placement, and was viewed by Indians as a way to escape poverty on the reservation. Health care was usually provided for six months through the private sector, unless the family was relocated to a city near a reservation with an IHS facility, such as Rapid City, Phoenix, and Albuquerque. Eligibility for IHS was not forfeited due to federal government relocation. The American Indian and Policy Review Commission found that in the 1950s and 1960s, the BIA relocated more than 160,000 AI/ANs to selected urban centers across the country.

In the late 1960s, urban Indian community leaders began advocating at local, state, and federal levels for culturally appropriate health programs addressing the unique social, cultural, and health needs of AI/ANs residing in urban settings. These community-based grassroots efforts resulted in programs
targeting health and outreach services to urban Indian communities. Programs developed at that time were, in many cases, staffed by volunteers, offering outreach and referral-type services and limited primary care, and were maintaining programs in storefront settings with limited budgets.

In response to the efforts of urban Indian community leaders in the 1960s, Congress appropriated funds in 1966, through the IHS for a pilot urban Indian clinic in Rapid City. Later, in 1973, Congress appropriated funds to study unmet urban Indian health needs in Minneapolis. The findings of this study documented cultural, economic, and access barriers to health care and led to Congressional appropriations under the Snyder Act of 1921 to support emerging urban Indian clinics in several BIA relocation cities, i.e., Seattle, San Francisco, Tulsa, and Dallas.

The awareness of the poor health status of all Indian people continued to grow and, in 1976, Congress passed the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. This law is considered health care reform legislation that was created to improve the health and well-being of all AI/ANs. Title V of the IHCIA targets specific funding for the development of programs for AI/ANs residing in urban areas. Since the passage of this landmark legislation, amendments to Title V of the IHCIA have strengthened urban Indian health programs, enabling them to expand to direct medical, alcohol, mental health, HIV, health promotion, and disease prevention services. (P.L. 100-713, P.L. 101-630, P.L. 102-573)

Today, 71% of all AI/ANs identified in the 2010 Census reside off-reservation. This figure includes 427,100 eligible urban Indian active users who reside in geographic locations with access to an IHS or tribal facility.

Currently, urban Indian health indicators underscore the shared challenges of urban Indians and their non-urban counterparts:

- Compared to the general population, urban Indians have:
  - 38% higher rates of accidental deaths;
  - 54% higher rates of diabetes;
  - 126% higher rates of liver disease and cirrhosis; and
  - 178% higher rates of alcohol-related deaths. 15

- Urban Indian women have considerably lower rates of prenatal care with higher rates of infant mortality than even their reservation counterparts within the same state. 16
Indicators of economic stability (or the lack thereof) are also particularly stark for urban Indians.

- The poverty rate of urban Indians is 20.3%, compared to 12.7% for the general urban population.  
  
- The unemployment rate of urban Indians is 1.7 times higher than that of non-Indians in urban areas.  
  
- Urban Indians are 1.7 times less likely to have high school diplomas than their non-Indian counterparts.  
  
- Long-term economic stability is also undermined by the fact that:
  
  - Urban Indians are three times more likely to be homeless than non-Indians.  
  - Homeownership rates for urban Indians are less than 46%, compared to 62% for their non-Indian counterparts.

**Socioeconomic Characteristics**

AI/AN social and economic characteristics vary considerably by area type. In 2010, for example, 34% of the AI/AN (alone) population living in tribal areas was under 18 years of age, compared to 26% in nonmetropolitan counties. The AI/AN (alone) poverty rate ranged from 32% in tribal areas to 25% in the surrounding counties, and the unemployment rate ranged from 16% in tribal areas to 12% in other nonmetropolitan counties.

As might be expected, conditions for Native people worsened significantly during the Great Recession of 2008. The declines in employment and income were similar to non-AI/AN populations, but the AI/AN population, on average, started from a more financially vulnerable situation.

In tribal areas, the new economic activity includes large-scale investments by the tribes themselves, which are reportedly being conducted in a more businesslike manner than previous tribal enterprises.

**Housing**

Housing problems for AI/AN households relate to the quantity, quality, and price of housing.

- From 2006 to 2010, 65,000 AI/AN households (8.1%) were overcrowded, which was much higher than the national average of 3.1%.

- This pattern continues with housing quality, where almost 3% of AI/AN households lacked complete plumbing facilities from 2006 to 2010, which was more than five times the share for all households.

- A similar share of AI/AN households lacked complete kitchen facilities, which was 3.5 times as high as the national average.  

Housing affordability is the most common problem for AI/AN households.
From 2006 to 2010, almost 4 out of 10 AI/AN households were paying more than 30% of their income on housing costs (cost burdened).

Almost 2 out of 10 were paying more than 50% (seriously cost burdened). 23

Unlike the changes in facilities and overcrowding, housing affordability problems are on the rise. The cost-burdened rate went up 5.9 percentage points for AI/AN households from 2000 to 2010. In these areas, the Native American Housing Assistance and Self-Determination Act is the dominant framework for the delivery of housing assistance.

Compared with non-Indians nationally, people living in tribal areas from 2006 to 2010 had a poverty rate and an unemployment rate that were at least twice as high.

Compared with the national average, households in large tribal areas were more than 3 times as likely to live in housing that was overcrowded, and 11 times more likely to live in housing that did not have adequate plumbing facilities. 24

## Education

Much like health and socio-economic disparities, or, perhaps, because of these disparities, AI/ANs also face significant gaps in education and literacy. In addition to deficiencies in the school systems, those living in remote rural areas (which is often the case for people on reservations) have limited access to higher education. In fact, AI/ANs account for less than 1% of those who have earned a college degree, compared to 72% of Whites, 10% of African Americans, 8% of Hispanics and 7% of Asian and Pacific Islanders. 25

Additional notable statistics are:

- Among 12th grade students, 74% of AI/AN students scored below proficient in reading, compared to 53% of Whites and Asian and Pacific Islanders. 26
- According to the National Indian Education Association, AI/AN students have a 7% drop out rate, compared to 2% for whites and 3% for all others. 27
- Statistics from the 2003 National Adult Literacy Survey (the most recent national assessment), found that 32% of AI/AN adults failed to attain basic reading levels, compared to only 13% of White adults. This was a decline from 43% from the 1992 assessment. 28
Table 1: Higher Education Rates and Outcomes for AI/AN students, 2010

<table>
<thead>
<tr>
<th>Higher Education Outcomes and Employment</th>
<th>All Students</th>
<th>White Students</th>
<th>AI/AN Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young adults, ages 25–34, who had a bachelor's degree or higher in 2010</td>
<td>31%</td>
<td>37%</td>
<td>12%</td>
</tr>
<tr>
<td>Young adults, ages 25–34, in the labor force with a bachelor's degree or higher who were employed in 2010</td>
<td>85%</td>
<td>87%</td>
<td>84%</td>
</tr>
<tr>
<td>2010 median full-time annual earnings for young adults, ages 25–34, with a bachelor's degree or higher in any field</td>
<td>$50,300</td>
<td>$50,000</td>
<td>$38,100</td>
</tr>
<tr>
<td>2010 median full-time annual earnings for young adults, ages 25–34, with a science, technology, engineering, and math bachelor's degrees or higher</td>
<td>$58,200</td>
<td>$56,300</td>
<td>$44,100</td>
</tr>
</tbody>
</table>

Source: Ross, Kena, Rathbun, et al., 2012

Closely tied with education and literacy levels is health literacy, which is the degree to which individuals have the ability to obtain, process, and understand basic health information and make appropriate decisions. Unfortunately, AI/AN were categorized as other for the purposes of assessing health literacy in the last National Adult Literacy Assessment, so no specific analysis exists. However, the study did find that only 12% of adults have proficient health literacy and, while rates varied, all racial and ethnic groups performed significantly worse than their White counterparts.

Notably, the study also found that lower health literacy rates are associated with:

- Poverty
- Less education
- Ages greater than 65
- Medicare or Medicaid enrollment

Taking into consideration the socio-economic and educational disparities faced by AI/ANs, this research reinforces the notion that AI/AN elders likely have greater propensity for health literacy issues.
Impact of Acculturation

The history of AI/ANs is filled with traumatic events that impact their lives. After living on the North American continent for 30,000 years as separate heterogeneous nations, AI/ANs were confronted with the arrival of European settlers who invaded their ancestral lands through military intrusions, committed mass murders, engaged in massacres of tribal villages, forced persons to be removed from their territories, and broke treaties. When not engaged in warfare, forced attempts were made to acculturate the population to the colonial lifestyle and eliminate Indian culture and religion, in part by the federal policies of the recent past that removed children from their communities to boarding schools and foster homes. Disease epidemics spread, populations were decimated, and their cultures were violated.

The contemporary state of AI/AN health, wellness, and culture is complex and diverse. While seeking to retain their tribal cultures, not all have been successful. A majority of AI/ANs no longer live on reservations and have blended into the American mainstream. The degree of Native American blood lineage varies by individual. Given the hundreds of tribes and nations that constitute AI/ANs, there is broad variation in cultural beliefs and practices. There are no universal language use, spiritual traditions, or ritual activities. However, all tribes have rich cultural traditions; a literature expressed through oral story-telling; and, as in other cultural groups, unique foods, music, and dance. The loss of culture or acculturation has been described as having the greatest effect on AI/AN communities and a lasting impact that is seen in every disparity that exists today.

Socioeconomic status is often measured as a combination of education, income, and occupation. When considering social standing or class, privilege, power, and control are emphasized. Furthermore, it reflects the inequalities in access to and the distribution of resources. The statistics regarding health, education, housing, and others all point to increasing inequalities in wealth and resource distribution, and the quality of life among AI/ANs (as well as other minorities). For many of these communities, elders and those with disabilities are the most vulnerable. They experience increased barriers to services to improve their quality of life, health, and wellness.
7 Senator Ben Nighthorse Campbell, chair, and Senator Daniel K. Inouye, vice chair, Senate Committee on Indian Affairs, letter to the Senate Committee on the Budget, Feb. 29, 2000, as reported in Concurrent Resolution on the Budget, FY 2001, Report of the Committee on the Budget, United States Senate, Mar. 31, 2000, p. 188 (hereafter cited as Senators Campbell and Inouye, letter to the Senate Committee on the Budget, Feb. 29, 2000).
10 Ibid. p.4. The states with the largest Native American populations, in descending order, are California, Oklahoma, Arizona, Texas, New Mexico, New York, Washington, North Carolina, Michigan, Alaska, and Florida. The census identifies the four geographical regions as Northeast, Midwest, South, and West. Ibid.
11 In 1997, the Office of Management and Budget definition of American Indian or Alaska Native included the original peoples of North and South America, including Central America. Census Bureau, AI/AN Population: 2000, p. 8.
15 Urban Indian Health Institute 2004
20 Ibid


42 USCCR, A Quiet Crisis, Tables 2 and 3 of Chapter 3 (citing the Budget of the United States Government, Fiscal Year 2004, Historical Tables, Table 5.4, pp. 103–04).

43 Ibid

44 Ibid., p. IHS–27.


47 *Ibid.* See also Brosnan, J.


