Caregiving for Native Elderly with Health Problems
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The needs for caregiver services are related to functional limitation or the ability of the elder to physically get around. The majority of functional limitation assessments include activities of daily living (ADLs) and instrumental activities of daily living (IADLs). According to McDonald and Ludtke (2002), ADLs including eating, walking, toileting, dressing, bathing, and getting in or out of bed, are crucial to survival as the inability to conduct these tasks on a daily basis limits the elder's ability to live and remain independent. Whereas, difficulty with IADLs such as cooking, shopping, managing money, telephoning, doing housework, and getting outside, may decrease the elder's quality of life, they can still remain independent with minimal assistance.

Functional limitations are determined by a number of factors such as increased age, declining health status, and increases in chronic diseases. As populations age, they become more susceptible to the need for long-term care and require care at higher rates than the young elder (Jenson & Friedman, 2002). Increased age has been shown to be positively correlated to functional limitation with elders 75 and older having the highest rates of physical disability (Agree, 1999; Chakravarthy MV, Joyner MJ, Booth FW, 2002). With aging, there is a rapid increase in the prevalence of a number of chronic diseases, which in turn can increase the possibility of functional limitations and disability. Native elders have higher rates of chronic disease when compared with their U.S. general population counterparts (McDonald, Ludtke, & Allery, 2002).

For Native elder populations age 65+, the top three health disparities when compared with their U.S. general counterparts were: high blood pressure at 50%; arthritis at 47%; and diabetes at 37% (Moulton, McDonald, Muus, Knudson, Wakefield & Ludtke, 2005). Significant relationships were also found for those experiencing multiple diseases or co-morbidity, and those experiencing co-morbidity reported higher rates of functional limitation. Native elders who had arthritis or a stroke were the most likely to indicate having functional limitations.

The following co-morbid relationships were found to be statistically significant for the Native elder population:

- diabetics were more likely to have high blood pressure
- those with congestive heart failure were more likely to have high blood pressure
- those with lung cancer were more likely to have colorectal cancer
- and, those experiencing a stroke were more likely to have either, or both, high blood and diabetes

In other words, Native elders experiencing multiple chronic diseases were more likely to have functional limitation. This is important information for those elders receiving home and community based services (HCBS) in our tribal communities. Presently, the majority of these services are being provided by community health representatives (CHRs), tribal health, and county public health services. For those tribal communities with larger elder populations and older elders ages 75+, they are experiencing the impact of the *Baby Boom* generation more than other communities as they have more elders eligible for

services and fewer resources for those elders. The increase in our elder population is expected to continue well into 2050, so we need to develop our programs to maintain, or expand, our level of care to increase our elder's quality of life by keeping them independent as long as possible.

The good news is that we will have an abundance of elders in our communities, but we will need to have our elder agencies work together to ensure quality services are coordinated and available. One idea would be to provide case managers for each elder, so when they become eligible for services, they will have a one stop resource to guide them through the maze of forms needed to access benefits. In regard to caregiver services, the case manager would be sure the elder received an initial assessment of their physical and mental status to determine if any current or future caregiver services are needed. Most elders would be assessed on the previously mentioned ADLs and IADLs measures and would be reassessed on a periodic basis depending on their difficulty with the tasks.

Family members or informal caregivers usually provide the majority of caregiver services to elders and these rates are higher among Native elder populations (Ludtke, McDonald, & Vallestad, 2004); therefore, supportive services are needed to train family on how to provide quality care to the elder. The responsibility for training family members would most likely fall on the professional caregivers who stop by regularly to care for the elder. In most cases, these professionals have received training as certified nursing assistants or quality service providers and have years of experience to share with family members. Although they work hard at providing caregiver services, personnel and funding shortages exist and they have difficulty in reaching all elders requiring services. When budget cutbacks occur for our community, we must come up with innovative solutions to increase outside funding to provide services. One way is to get everyone certified that we can apply for third party reimbursement from Medicaid and Medicare to fund these services.

Another idea in regard to workforce would be to develop initiatives to increase the number of aging professionals to address the future demand for aging services for our growing elder populations. Tribal communities are in a unique situation compared to other rural communities in that our population is still having babies at a high rate when compared with non-Native populations, and these youngsters are staying home. One goal would be to provide education incentives to this future workforce that they might consider going into aging careers such as doctors, nursing, home health aides, physical therapy, health promotion, and social work, then return to their communities to provide these services. The more degrees and credentials we have available, the more eligible we are for reimbursement for services. Utilization of our young men and women from the community to staff these efforts also ensures culturally appropriate care to our elders.

Indian way, we are supposed to respect and care for our elders in recognition of their contributions to our communities. These contributions may have been service to the tribe through tribal government, keeping our culture alive through language and songs, or just being examples in how we should live. At the individual level, regardless of the

contribution, family and professional caregivers must work together to care for our elders. At the administrative level, directors should be seeking out any possible funding sources to bring in additional funding to provide services to support both their workers and the family caregivers. The overall goal would be to coordinate services to assess, plan, provide, and evaluate the care for each elderly, and when we have provided care to all of the elders in our community, then we have a caregiver model that truly encompasses our Native value of caring for our elders.

Hau' Pidamiya!

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