American Indian Elders: Need for Cultural Sensitivity in Health Care and Services

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Overview of Presentation

It is vitally important to know the true history of American Indians and Alaska Natives - FIRST - to provide a platform for success into the future.

• Various definitions of culture
• Discussion of cultural humility
• General cultural implications for health service provision
• Importance of understanding historical factors and legal status about American Indians and Alaska Natives for health and wellness services
• Service suggestions for the aging AI/ANs patients/clients for the future
Understanding American Indian/Alaska Native Basis for Experiences with Health Services: Brief History

- When Columbus arrived it is estimated there were 10 million American Indian/Alaska Native (AI/AN) people in America.
- By 1850 the population decreased to 250,000.
- The three primary causes for decline:
  - Foreign Diseases
  - Starvation
  - Extermination
- Current populations estimates there are presently 3 million AI/AN growing to 4.3 million by 2050.
- AI/ANs have become one of the fastest growing segments of the American population.

Tribal Governance – Cultural Changes

- Currently, there are 573 federally and 74 state recognized tribal governments.
- There remain many tribal communities that are still seeking recognition.
- Historically before colonization overran Indian territories, there were multitudes of governance models:
  - matriarchal
  - patriarchal
  - spiritual
  - warrior
  - inherited
  - conquered
- So could one say that the current tribal governance structure is based on the “colonized/western” model?
- Basically millennia of cultural practices were discarded?
Tribal Governance (cont.)

• Today the 573 federally recognized tribal governments all have Constitutions:
  ➢ Each and every tribe has their OWN Constitution

• Elections are held to elect tribal leadership
  ➢ Election governance is guided by EACH tribe’s Constitution
    ➢ Some elect every year
    ➢ Some have staggered terms

• Each tribal government is directly responsive to their individual members.

Tribal Governance (cont.)

• Tribal governments have a direct government to government relationship with the federal government.

• American Indians and Alaska Natives are identified as a Political Group - NOT a racial group.

• Tribal governments are not governed by states.
  ➢ In fact some reservations have physical boundaries that cross state boundaries.
  ➢ Others may have historical populations that now are divided by international boundaries – Canada & Mexico.

• Some federal funding is only accessible through a state, e.g. Medicaid, various Block Grants.
Legal Foundation

- Treaty of Hopwell actually preceded the Constitution for dealing with the Cherokee Nation
- U.S. Constitution
- 1849 – War Department (Bureau of Indian Affairs) began providing health services
- 1921 – Snyder Act
- 1955 – Transfer Act
- 1975 – Indian Self-Determination & Education Assistance Act (P.L. 93-638)
- 1976 – Indian Health Care Improvement Act

Cornerstones of Federal Indian Policy

U.S. Constitution

- The initial court case that challenged the federal trust responsibility was: Cherokee Nation v. Georgia (1831). Note that in the Treaty of Hopwell actually preceded the Constitution for dealing with the Cherokee Nation. The court ruling further identified tribes with the unique designation of "domestic dependent nations".

- Commerce Clause (Article I, Section 8, Clause 3) authorizes Congress to regulate commerce "with foreign Nations, and among the several States, and with Indian Tribes."
The Indian Health System

- The Indian health system includes the Indian Health Service/Tribal /Urban. system commonly referred to as: I/T/Us
- The Omnibus Reconciliation Act (OBRA) of 1993, added tribal 638, and Title V, urban programs were added to the list of specific programs automatically eligible for FQHC designation

- **Indian Health Service (IHS) federal agency, established in 1955**
- **Federally Recognized Tribes and Tribal Organizations (P.L. 93-638 – compacts and contracts)**
- **Urban Indian Health Programs (UIHP) consist of 34 non-profit 501(3) (c) programs nationwide.**

The Indian Health System (ITU)

**Indian Health Service (IHS, federal)**

- Divided into 12 administrative “Areas”
- 31 Hospitals (Service Units)
- 83 Health Centers (satellite clinics)
- 2 School health centers
- 34 Urban Indian Health programs
- Health facilities are located in 34 states
The Indian Health System (cont.)

Tribes and Tribal Organizations
(compacts and contracts)

- P.L. 93-638
- 15 Hospitals (Service Units)
- 538 Health Centers (satellite clinics)
  - Including 166 Alaska Native village clinics
- 9 School health centers
- 11 Regional Youth Substance Abuse Treatment Centers (both IHS and tribal)

The Indian Health System (cont.)

Urban Indian programs

- Urban Indian Health Programs (UIHP) consist of 34 non-profit 501(3) (c) programs nationwide.
- Programs are funded through grants and contracts from the IHS, under Title V of the Indian Health Care Improvement Act.
- Approximately 45% of the UIHPs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHC) and others receive fees for service under Medicaid for allowable services.
American Indian and Alaskan Native Population for Nonmetropolitan Counties

Source: U.S. Census Bureau, 2018 Decennial Census, Summary File 1

Note: Alaska and Hawaii not to scale.

American Indian/Alaska Native Population - 2016

Note: Racial groups may include people of Hispanic origin.
American Indian/Alaska Native Population Under 25 Years Old - 2016


American Indian/Alaska Native Population 65 and Older - 2016

Key Question

Are we moving the dial on Health Disparities?

AI/AN General Mortality Statistics to US all-races

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<td>Unintentional Injury/accidents</td>
<td>153% Greater</td>
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</tr>
<tr>
<td>Suicide</td>
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Understanding Social Determinants

• Social determinants are conditions in the environments that start at pre-birth and effects health, functioning, and quality of life outcomes and risks.

• Resources that enhance quality of life can have a significant influence on population well being, such as:
  • Availability to have safe housing and nutritious food.
  • Access to cultural activities and traditions.
  • Access to learning within a family or educational system.
  • Access to economic means to support living (job, service).
  • Transportation options or ability to access safe, efficient movement to secure livelihood.
  • Ability to live, work, congregate, and recreate in safety.
  • Social support that embraces culture, language, and well being of all.
What is Culture?

- Is it race?
- Is it ethnicity?
- Is it geographical?
- Does it relate to spirituality/religion?
- Does it have familial ties/history?
- Are there different levels of culture?
- Is it possible to be multicultural?
- Can culture be open or closed? Both?
- Is there more than one culture that governs/guides an individual? e.g. “sub-cultures

Why is Culture Important for Patient Services?

- How do you communicate with Patients or Clients?
  - Verbal
  - Visual
  - Body language
  - Face to Face
  - Gestures
  - Physical contact (e.g. shaking hands, holding hand…)
- How do you listen? What importance is “listening”?
- Does YOUR culture have any affect on communication?
- Do you believe that EVERY patient/client has their own unique culture?
General Cultural Humility

- Are there “general” processes/education for health service providers?
  - Importance?
- What are the current expectations of U.S. citizens in regard to respect/considerations of “culturally appropriate” health services?
  - Can this be generalized?
- Suggested “culturally competent” definition:
  
  *Culturally competent services can ONLY be determined by the Patient or Client.*

Why is it important to have Cultural Humility?

- Does culture affect the quality and effectiveness of services?
- Does culture affect understanding of signs and symptoms?
- Are there some questions/topics that are not parts of various cultures?
- Are there some questions/topics that cultural customs prohibit from being asked?
- Should there be traditions that culture protects?
- Can one become culturally aware, sensitive, respectful?
- Can one become culturally competent?
What are We Trying to do Under the Cultural Humility Umbrella

- Enlighten health service providers?
  - Should health providers also help Patients/Clients to understand how the health services system operates? Or do they even know?

- Are there “prerequisites for culture humility”?

- Are there tools that can be used, e.g. education, mentors?

- The "keepers" of the culture? Who are they?

- How will you know if you practice cultural humility?

How do you become Culturally Sensitive/Attuned?

- Cultural sensitivity is a life long pursuit.

- Cultures are continuously changing - by way of their own acceptable guides to **SURVIVE**.

- Members of cultural groups have a responsibility to be gate keepers, change agents, mentors, and willing to evolve to protect their cultural practices.

- Individuals can learn to be culturally sensitive by first being respectful of their own cultures, and be humbled in other cultures (**NOT** condescending).

- It is important to never assume facts (may be myths) or assume to understand the actions of other cultures.

- When in doubt ask for advise.
Methods for Increasing Cultural Humility

• **Grow your Own** - empower local residents, to be the foundation of a culturally attuned and grounded professional health service workforce.

• **Mentoring** – offer opportunities for professionals to learn from each other – embrace building “cultural capital”.

• **Two way mentoring** – can help reduce culture shock of moving from a rural or village life to urban areas (e.g. college student pairing with high school students).

• **Learning** – all levels of life.

• **Job-based learning** (work a sub-culture? – within a culture).

• Determine who are the "keepers" of traditions and solicit advice from them.

Communication Considerations

• Perceptual barriers – we all see the world differently

• Emotional barriers – withholding thoughts and feelings

• Cultural barriers – misunderstandings, group behaviors

• Age barriers, generational, historical

• Language barriers – not everyone is familiar with all languages or jargon (e.g. subs, hoagies, grinders)

• Learned expectations – often referred to as stereotyping

• Learned dependence – high rate of AI/ANs

• Misinterpretations – misjudgment – dangerous and quickly noted by patients
Cultural Considerations

- Consider historical issues of “trust” of health services providers.
- Consider the individual’s perceptions of “normal aging” (e.g. it is “normal to lose memory”).
- Does the individual’s culture have “stigma” in regard to memory loss?
- What is the individual’s choice of family involvement?
  - what are the cultural expectations
  - family’s responsibility to care for individual
  - does/will the family experience “shame” from others
- Are there cultural impacts for choices of ethical issues, artificial nutrition, life support, autopsies?

Cultural Considerations (Cont.)

- Consider linguistic, economic and social experiences of the individual:
  - What is the choice of communication (self, or family member, advocate)?
  - Are there barriers to access services (including access to culturally sensitive providers)?
  - Do not place all of the family in a single culture or ethnic group.
  - Respect individual choice of:
    - Physical distance
    - Physical contact
    - Tone of voice
    - Eye contact
So What about Direct Service Provision for Mentally Impaired Individuals?

- What is your first step as a health service provider?
- How important is the patient/client history?
- Are there records available to provide history?
- How cognizant is the patient/client?
  - Remembering that individuals generally are aware if they are experiencing memory or cognitive issues.
  - Individuals that have the ability to realize they are having memory issues are quite crafty at “hiding” their impairment.
- Is their family available for consultation (if the patient/client agrees) for cultural, medical and behavioral health history?
- Understand the high likelihood that AI/ANs will have had a history of health services that were not sensitive to their culture.

Cultural Considerations for AI/ANs with Memory Impairments

- Consider each person as an individual:
  - Member of a family
  - A dual citizen
  - With tribal affiliation (if willing to share)
  - Choice of spirituality (Western or Traditional or both)
  - Language preference
  - Historical trauma (100% of all AI/ANs have a history)
- Understand that some elders have histories of horrific racial experiences:
  - Genocide (bounty on dead Indians).
  - Forced assimilation (boarding schools, harsh punishments of using Native language, clothing).
So What does the Data Say About Future Populations?

- Population age 65 and over numbered 49.2 million in 2016.
- 15.2% of the population, about one in every seven Americans.
- Older Americans increased by 12.1 million or 33% since 2006, compared to an increase of 5% for the under-65 population.
- In 2016, among the population age 65 and over there were 27.5 million women and 21.8 million men, or a sex ratio of 126 women for every 100 men. At age 85 and over, this ratio increased to 187 women for every 100 men.

So What does the Data Say?

- People age 65 and over represented 15.2% of the population in the year 2016 but are expected to grow to be 21.7% of the population by 2040.
- The 85 and over population is projected to more than double from 6.4 million in 2016 to 14.6 million in 2040 (a 129% increase).
- Racial and ethnic minority populations have increased from 6.9 million in 2006 (19% of the older adult population) to 11.1 million in 2016 (23% of older adults) and are projected to increase to 21.1 million in 2030 (28% of older adults).
Violence and Poverty Population Concerns

- American Indians are likely to experience a range of violent and traumatic events involving serious injury or threat of injury to self or to witness such threat or injury to others.

- Risk factors derived from various surveys typically show violence and gang involvement. This factor is related to other risk behaviors, such as alcohol and drug use; suicide attempts; and vandalism, stealing, and truancy.

- American Indian children are exposed to repeated loss because of the extremely high rate of early, unexpected, and traumatic deaths due to injuries, accidents, suicide, homicide, and firearms—all of which exceed the U.S. all-races rate by at least two times and directly related to poverty.

Domestic Violence Against Older Women

- There needs to be an increase in knowledge and understanding regarding domestic violence against older women.

- Allow older women themselves to speak about how they define domestic violence:
  - their views about causes
  - reporting, interventions, and consequences for perpetrators

- What are the factors that deter or prevent help-seeking from the justice system and community agencies?

- What are the elements of outreach and intervention strategies they (elders) see as acceptable and/or desirable?
Facts on Violence Against American Indian/Alaska Native Women

- American Indian women residing on Indian reservations suffer domestic violence and physical assault at rates far exceeding women of other ethnicities and locations.
- A 2004 Department of Justice report estimates these assault rates to be as much as 50% higher than the next most victimized demographic.
- These very disturbing findings have been common over the years. And worse in Canada.
- In a 2008 CDC study, 39% of Native women surveyed identified as victims of intimate partner violence in their lifetime, a rate higher than any other race or ethnicity surveyed.

Outcome Possibilities of a Successful Health and Wellness Encounter

- Health and wellness service providers will:
  - Learn the history about the community you serve.
  - Practice and serve with cultural humility.
    - Have abilities to respect individuals and with permission, collaborate with families in “holistic” approaches that have been used for centuries by indigenous peoples.
    - Do not assume all members of a family have the same cultural beliefs or same values of traditions.
    - Provide the highest quality and effective services possible.
- These “fundamentals” are a critical basis for improved understanding of cultural diversity and cultural traditions to reduce unknowing cultural oppression, subconscious racism, gender inequities, and historical dominant culture practices and policies.
So how do we Solve the Issues discussed or How do we Improve

• Develop a new provider type – patient advocate - elders
• Develop methods to improve efficacy of time during professional contact time – list of questions for patients to always ask
• It is imperative that health care and service providers understand the basic historical and governmental influences experienced by all American Indians.
• It is quite impossible to “teach” every cultural scenario, so learn methods.
• Learn tools on how to practice cultural humility.
• Add “cultural humility” classes as a requirement for all health professionals.
• Start teaching cultural humility at very young ages.

American Indian and Alaska Native Health & Wellness

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