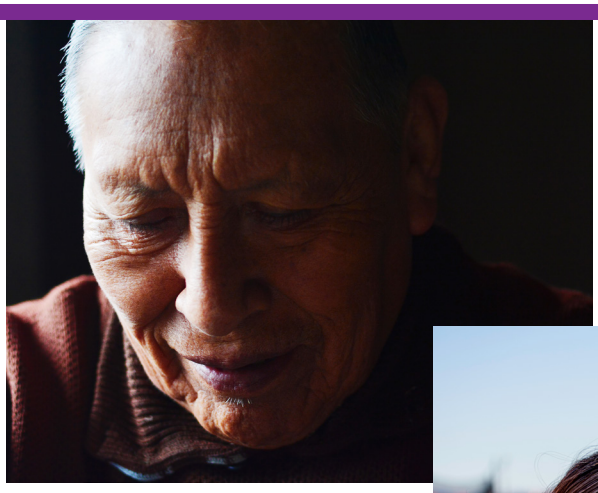
National Resource Center
on Native American Aging
NRCNAA



2025

Native Elders With Functional Limitations: A Profile of Demographics, Health, Caregiving, and HCBS Utilization Trends



Introduction

The National Resource Center on Native American Aging (NRCNAA) is committed to identifying Native Elder health and social issues. Through education, training, and technical assistance, we assist in developing community-based solutions to improve the quality of life and delivery of support services to the Native aging population. Every three years since 1998, the NRCNAA has conducted the "Identifying Our Needs: A Survey of Elders" Needs Assessment.

This work has always been carried out in collaboration with Tribes, villages, and homesteads across the U.S. Participation has grown over time, with the number of Native Elders surveyed increasing from 9,403 in the first cycle to 21,095 in the most recent cycle (Cycle VIII).

With over 25 years of survey data, there is great opportunity to explore the data and uncover meaningful patterns and trends within the aggregate findings.

This brief provides an overview of the methodology used to analyze trending data specific to Native Elders who self-reported higher levels of difficulty with activities of daily living (ADLs). Focusing on this subgroup is essential, as they are at increased risk for chronic diseases, hospitalizations, and overall declines in well-being. Additionally, they often have a greater need for support services to prevent further deterioration in health and quality of life.

This exploration also includes a discussion of the outcomes for each topic area, along with a summary of conclusions and recommendations.

Approach and Outcomes

This review will provide an overview of Native Elders reporting ADL difficulties and have moderate severe or severe scores for the Functional Limitation categories using data from all Cycles I-VIII (1999-2025).

It will also examine professional or skilled caregiver use among this subgroup. A depiction of informal caregiver use will also be reviewed. Further, this brief will provide an overview of demographics and self-reported health status for the Native Elder subgroup.

This work will also look at the distribution rates for this group of Native Elders over time for some of the most common chronic conditions experienced by Native Elders in general, such as arthritis, diabetes, and high blood pressure. It also examined some of the most in-demand support services for Native Elders: home-delivered meals and transportation.

As part of the survey, Native Elders were asked to identify any ADLs with which they experienced difficulty, such as bathing, showering, dressing, or eating. If an individual selected two or more ADLs, they were classified as having a moderate severe or severe level of functional limitation. The figure below depicts the breakdown of this subgroup of Native Elders per survey cycle (I-VIII). Figure 1 shows the number of Native Elders reporting the above mentioned levels of functional limitation per survey cycle, which ranged from 1,683 in Cycle II to 3,940 in Cycle VII. As of the most recent cycle, Cycle VIII, it was 3,595.

Figure 1. Native Elders with Moderate Severe and Severe Functional Limitations

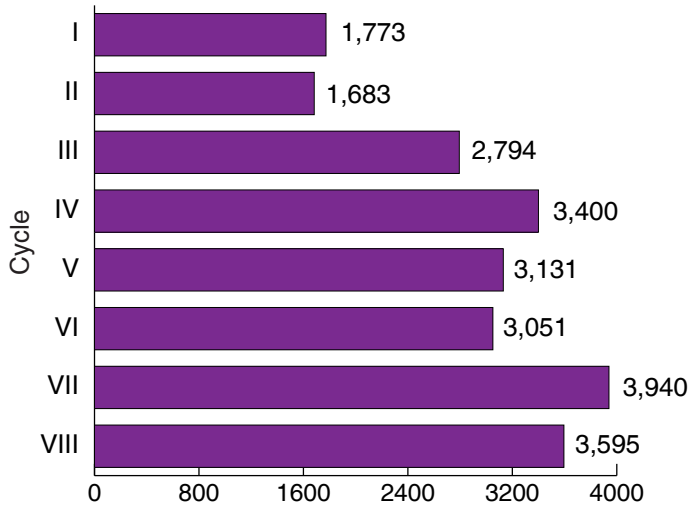
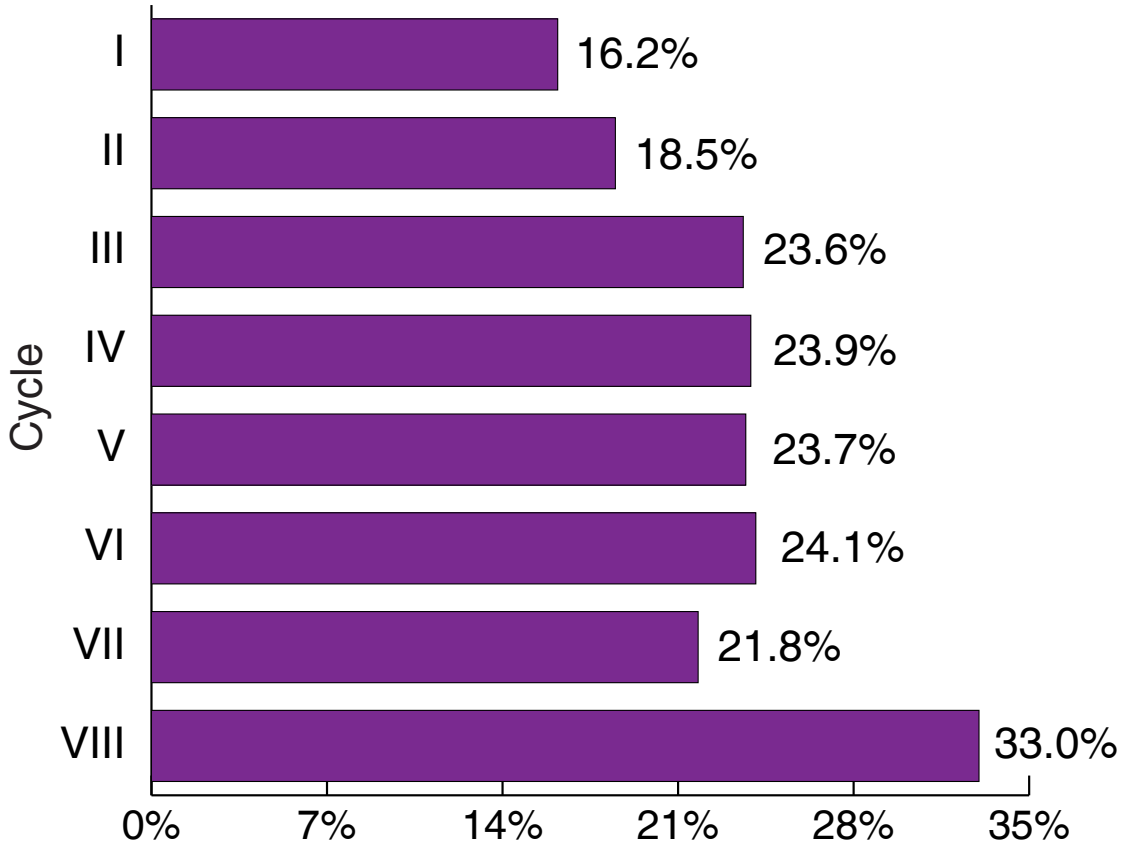


Figure 2. Professional/Skilled Caregiver Use



To assess the use of professional caregiving services, index variables were created for each survey cycle, except for Cycle I. This exception was due to differences in the questions related to support services considered to be professional caregiving services across cycles.

In Cycle I, only personal care services were included. In Cycle II, the survey was expanded to include questions about respite care and home health services. An index variable was created for this cycle to include all three services, which together represented professional caregiving services.

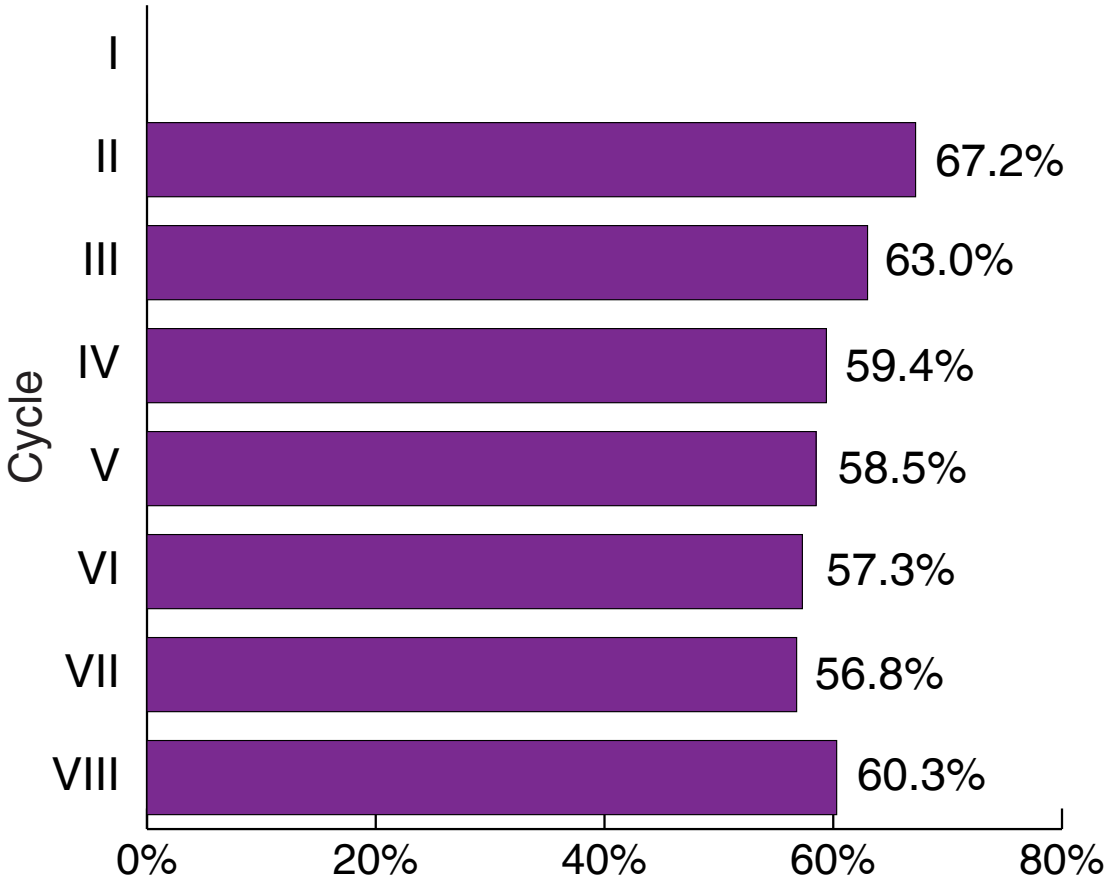
In Cycle III, caregiver programs were added to the list of support services and included in the index variable for that cycle. These four services of caregiver programs, home health services, personal care, and respite care continued to define professional or skilled caregiving services through Cycle VII.

In Cycle VIII, homemaker and chore services were added to the list of support services and incorporated into the index variable describing formal caregiving services.

This approach, using an expanded index, allowed for a more comprehensive representation of the construct of professional or skilled caregiving use, as all relevant support services were included in each survey cycle, even if they were not asked about in other years.

Figure 2 shows the distributions per cycle for those Native Elders self-reporting a moderate severe and severe level of functional limitation who used professional caregiver services, as defined by the index variable specific to each cycle. Use increased slightly in the earlier cycles, remained relatively stable for several cycles, and then showed a substantial rise in the most recent cycle. Overall, it ranged from 16.2% in Cycle I to 33.0% in Cycle VIII.

Figure 3. Family Caregiver Use



Native Elders were asked if a family member provided care to them during each survey cycle, with the exception of Cycle I, as this question was not included in the first cycle of the survey. For the specific subgroup of Native Elders examined in this brief, the majority reported receiving care from a family caregiver in response to this question.

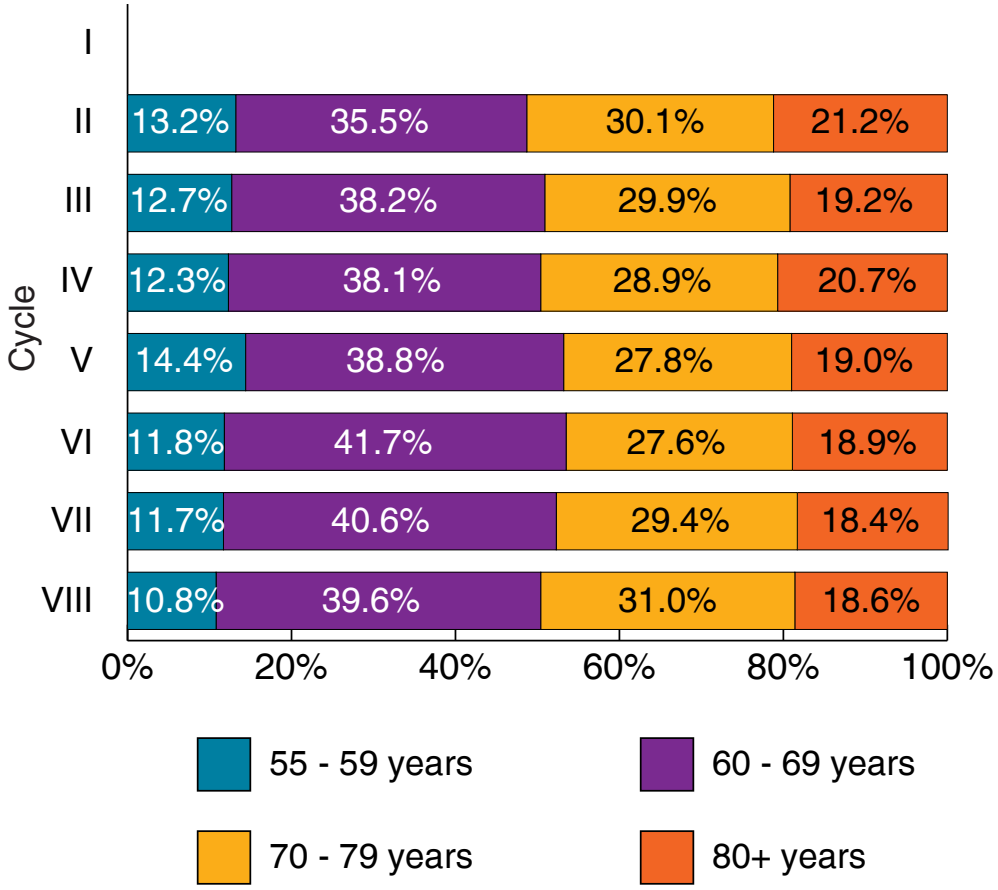
As seen in Figure 3 the highest reported use was during Cycle II (67.2%), followed by gradual decreases in the subsequent cycles with the lowest rate being recorded during Cycle VII at 56.8%. However, the rate of use remained above half of the Native Elders included in this analysis throughout all survey cycles with data available.

Further, the most recent cycle saw a significant increase in reported family caregiving compared to the previous cycle with a nearly 4% increase.

The higher proportions of family or informal caregiver use shown in the figure above are consistent with the limited research that has been done in this area focused on American Indian older adults. Recent studies have indicated that they receive the bulk of their long-term care from informal caregivers.

In addition, how cultural factors impact this outcome have been acknowledged as requiring more study regarding Native Elders. Also, the prevalence of intergenerational families in Tribal communities and group-oriented approach to caregiving needs, rather than a focus on individual needs, may be contributing factors to look into as well.

Figure 4. Age



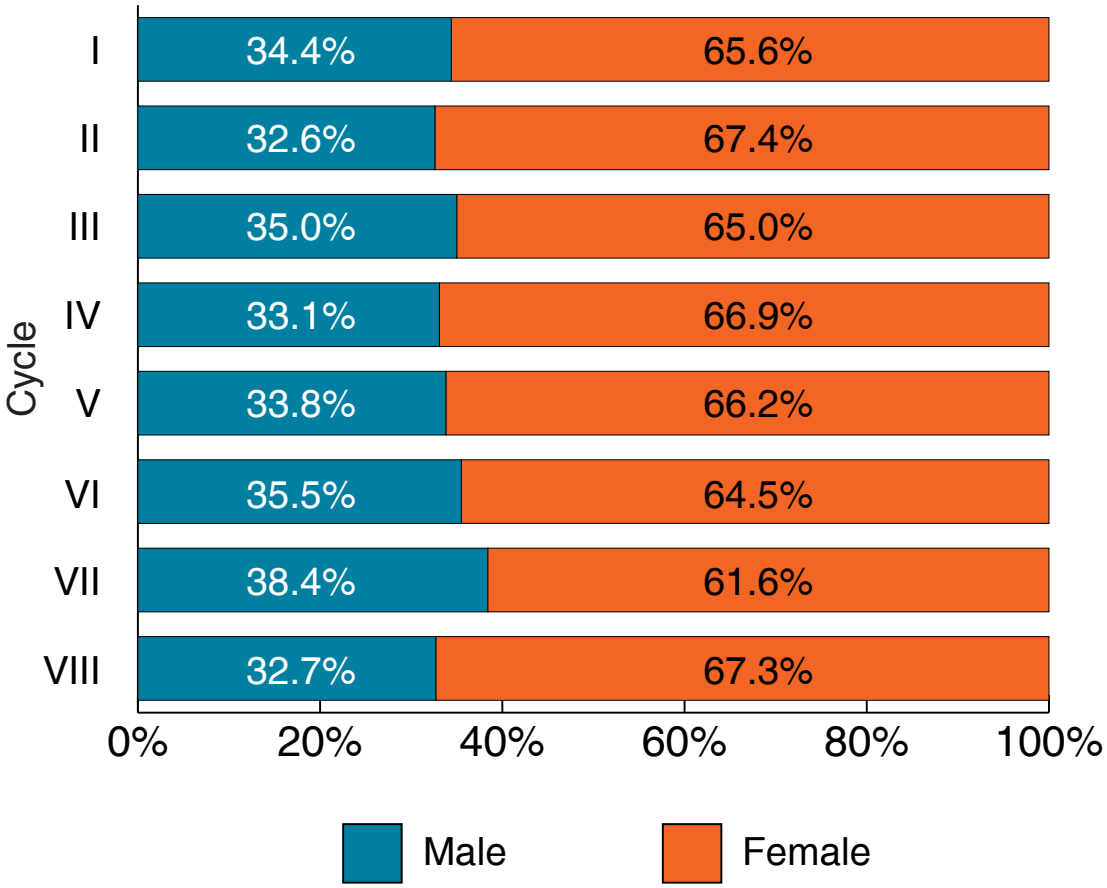
Native Elders who participated in this survey were aged 55 years and older. Figure 4 provides an overview of the different age categories for the Native Elder subgroup that is the focus of this brief.

Across all survey cycles, the highest proportion of this subgroup fell within the 60 to 69 years age range, followed closely by 70 to 79 years. Many individuals of this subgroup were within the 80 years and older category and a notable portion reported being between 55 and 59 years old in each cycle.

This aspect of the demographic profile suggests that the majority of Native Elders with higher levels of functional limitations were between the ages of 60 and 79 years.

This aligns somewhat with previous conclusions made by researchers regarding the relationship between age and caregiving needs. The older the adult, the more likely they are to have assistance needs and have a caregiver, whether it be a family member, friend, or a professional/skilled caregiver.

Figure 5. Sex



Throughout the duration of this survey, the majority of respondents have been female. As seen in Figure 5 above, that remained the case when narrowing down to focus on a subgroup of Native Elders who reported higher levels of functional limitations.

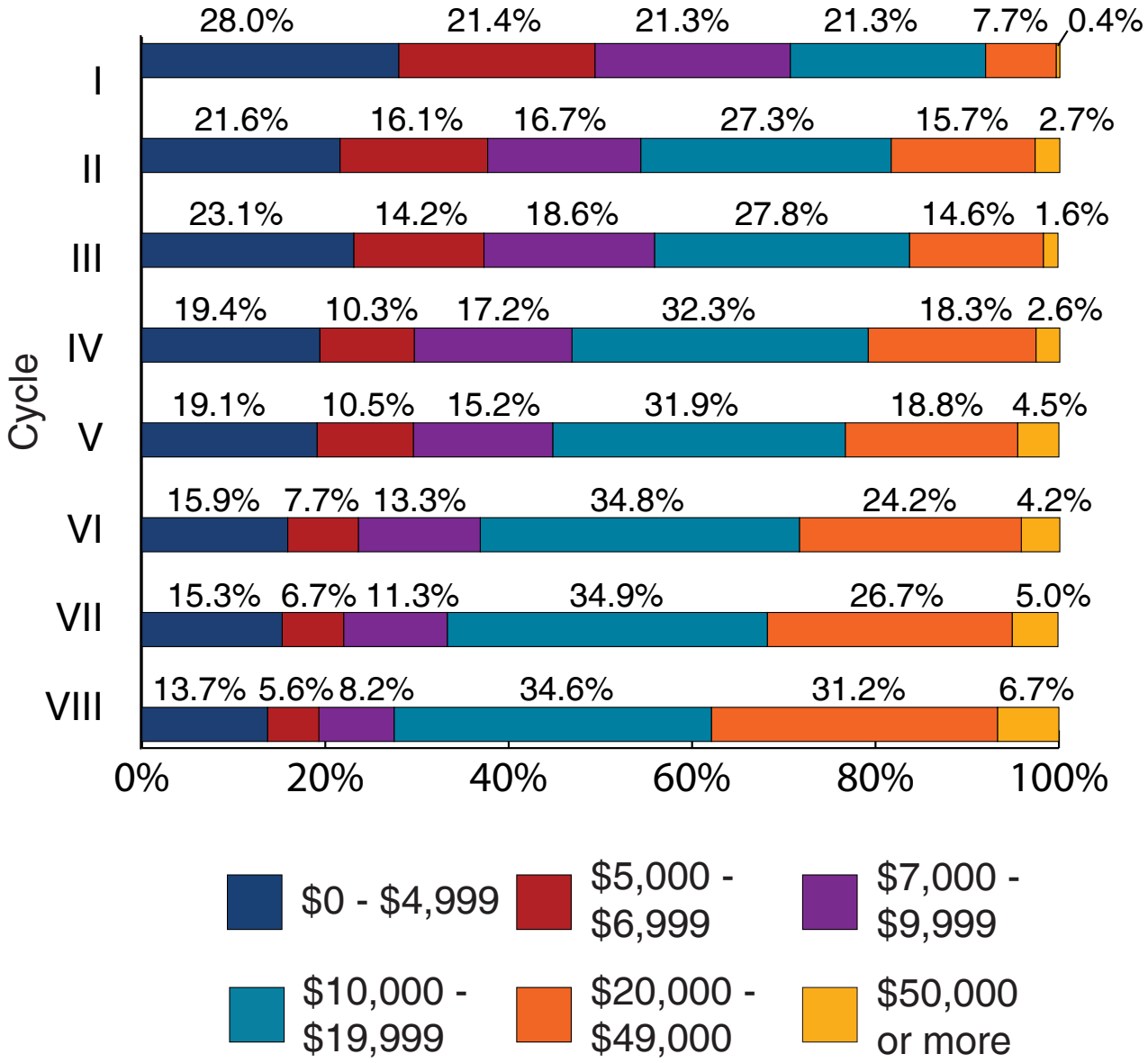
For all cycles, over 60.0% of the respondents were female, with the lower range being 61.6% in Cycle VII and high of 67.4% during Cycle II. Male respondents ranged from a low of 32.6% in the Cycle II to a peak of 38.4% during Cycle VII.

Based on this data, we might assume that, over the lifespan of the survey, women were more likely than men to report having functional limitations.

However, further investigation is needed to account for additional factors that may influence this trend.

That said, the male/female breakdown observed in this subgroup of Native Elders aligns with previous studies showing that older adult women are more likely than men to use both informal and paid caregiving, as well as other home and community-based care services, due to their higher reported rates of functional limitations and other contributing factors.

Figure 6. Income



As state policies have evolved over the years to expand access to paid caregiving and home and community-based services (HCBS) for older adults through Medicaid, it is likely that many of the Native Elders included in this analysis would have met the financial eligibility criteria for Medicaid, as illustrated in the Figure 6 above.

Across all survey cycles, the majority of this Native Elder subgroup reported incomes of $19,999 or less. This suggests many Native Elders of this subgroup would likely have met income thresholds for Medicaid and HCBS waivers, especially during more recent years, which has seen major expansions of Medicaid access across all states.

Figure 7. Marital Status

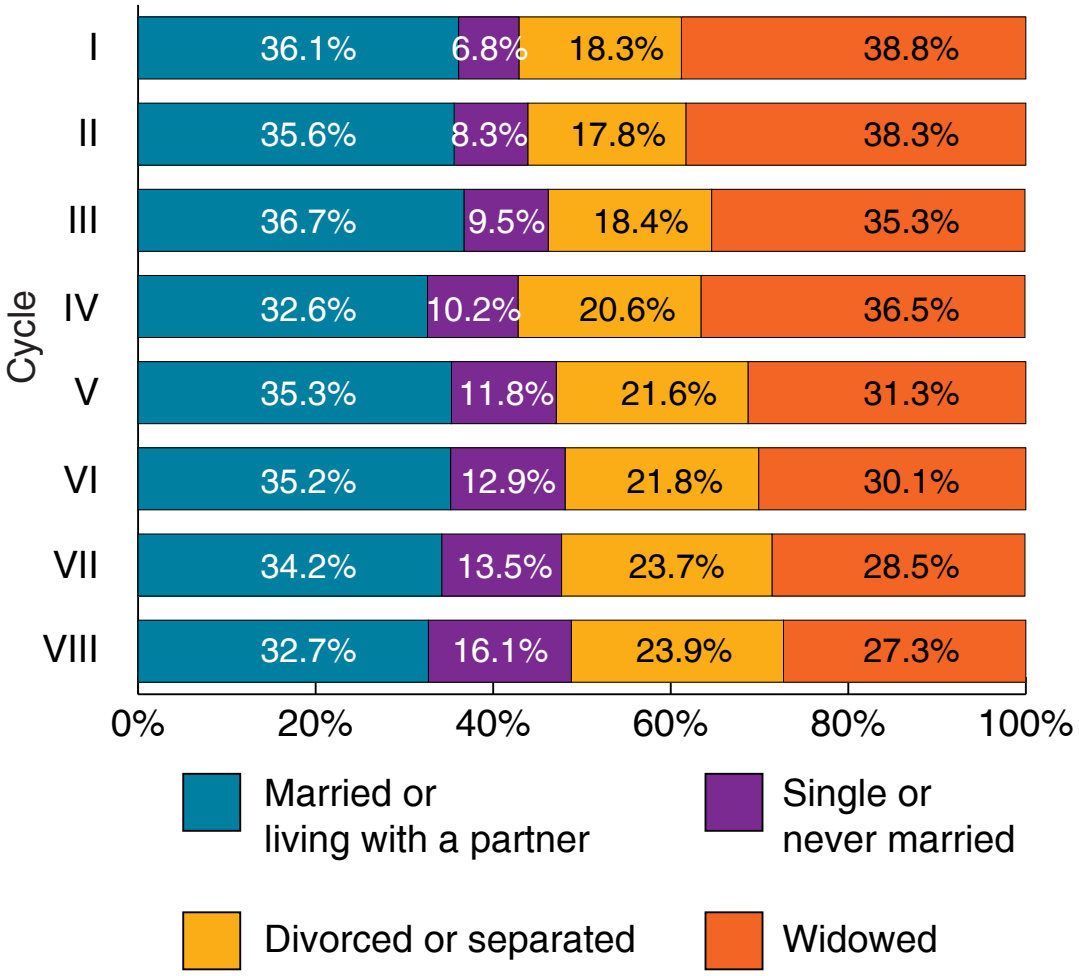


Figure 7 above presents the breakdown of marital status among the Native Elder subgroup highlighted in this brief. Many of the Native Elders reported being married or living with a partner (32.6% to 36.7%) and a substantial portion indicated they were widowed (27.3% to 38.8%) across all eight cycles.

Notable segments of this group also reported being single or never married (6.8% to 16.1%) and divorced or separated (17.8% to 23.9%). However, the majority were either married or living with a partner or widowed.

The outcome of this may suggest that the family caregiver use previously reported may have been more so provided by a spouse or life partner among those who reported they were married or living with a partner.

It could also be considered that those who reported they were widowed received informal care from another family member or used formal caregiving services provided by professional or skilled caregivers. A similar inference could be made for those who reported being single or divorced/separated.

Overall, additional review would help clarify how this marital status breakdown among the Native Elder subgroup relates to the types of caregiving support they reported using.

Figure 8. General Health Status

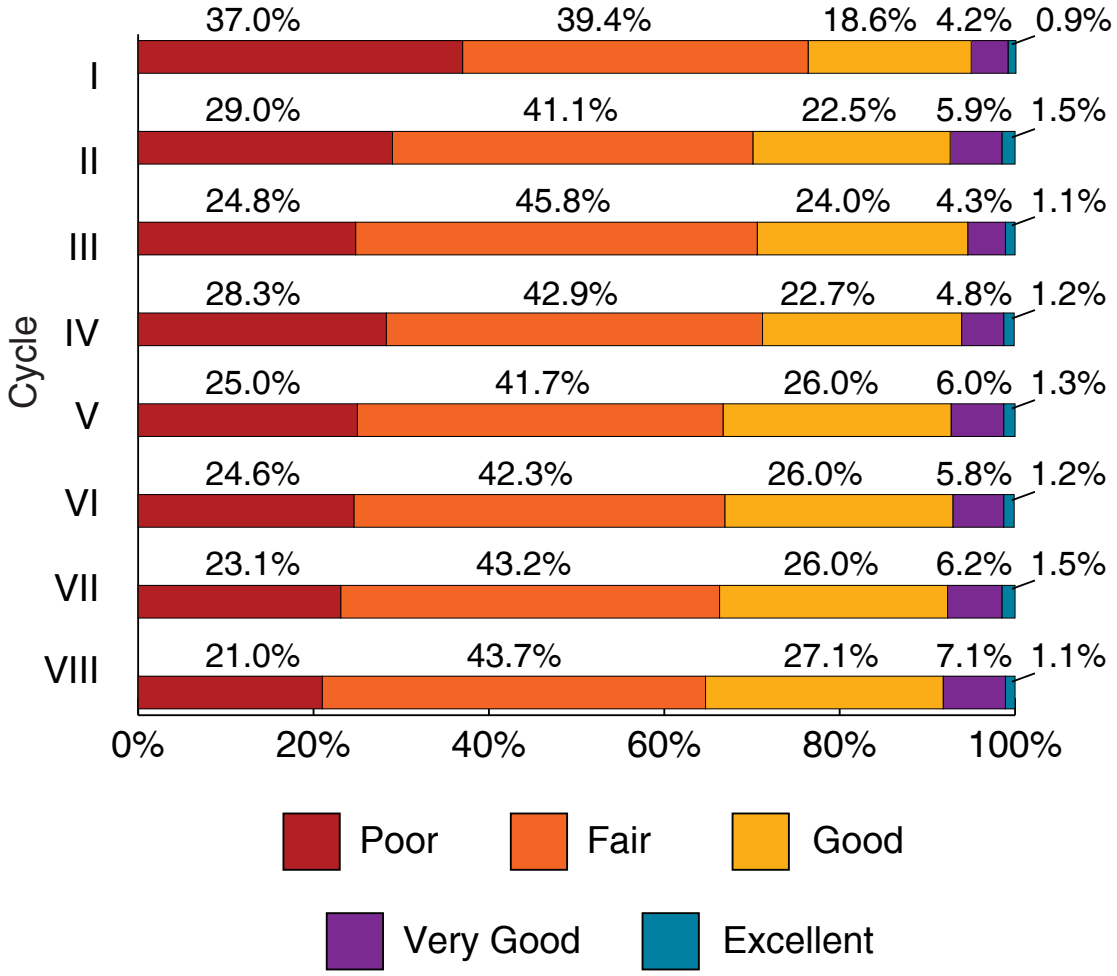
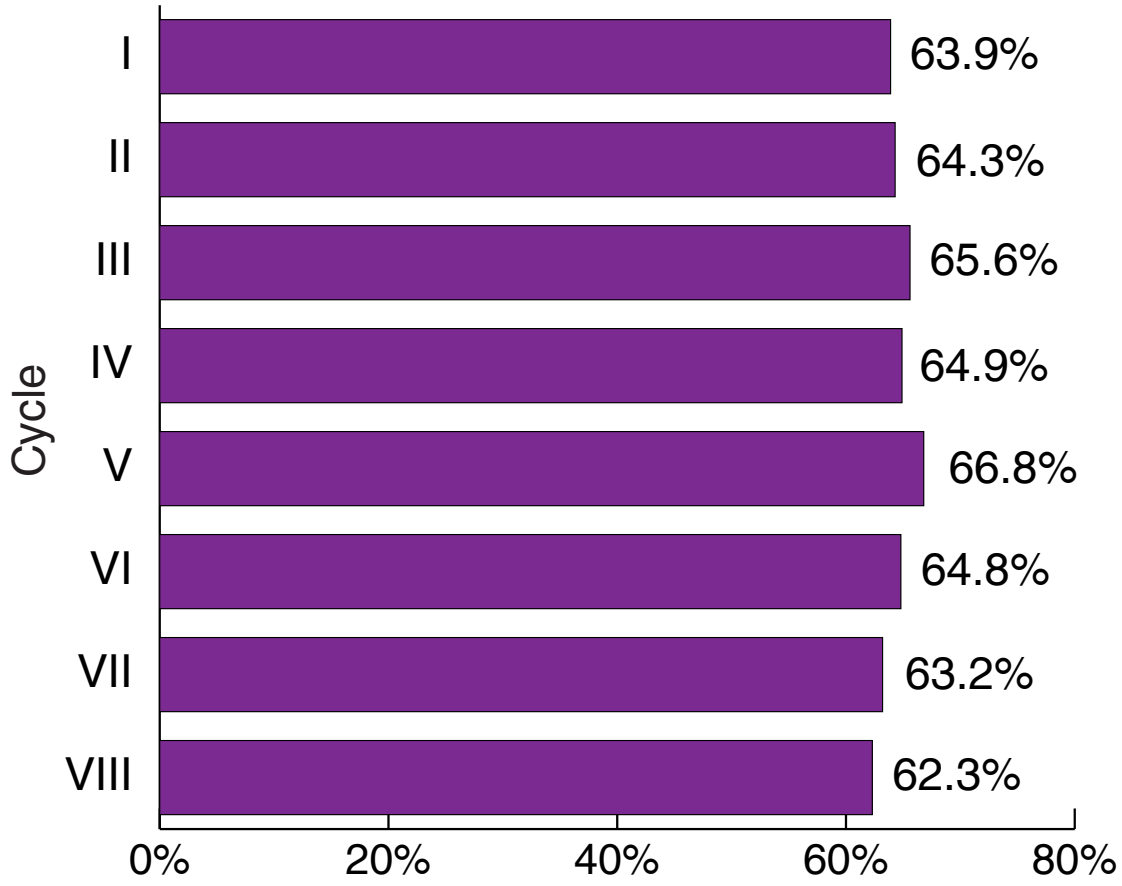


Figure 8 provides an overview of the self-reported general health status for the Native Elders who reported difficulties with ADLs, resulting in their classification as moderate severe or severe functional limitations. The majority of these Native Elders reported their health as fair (39.4% to 45.8%) or poor (21.0% to 37.0%).

A notable number reported a good health status (18.6% to 27.1%) across all cycles, while fewer than 10% of the Native Elders reported a very good or excellent health status.

It is expected that Native Elders experiencing limited functioning would self-report their health status as poor or fair. However, the significant proportion reporting good health suggests that further study, to include other contributing factors, would provide valuable insight into the self-perceived health status outcomes within this subgroup.

Figure 9. Arthritis



Over the 25 years during which this survey has been administered, the three most commonly reported chronic conditions among Native Elders have been diabetes, arthritis, and high blood pressure. This brief includes a review of the proportion of Native Elders in the subgroup who reported being affected by these conditions.

Above, Figure 9 shows the majority of these Native Elders indicated they were diagnosed with arthritis across all eight cycles, ranging from 62.3% during the most recent survey cycle (Cycle VIII) and 66.8% during Cycle V.

This finding was anticipated, given the physical limitations caused by the joint pain and stiffness associated with arthritis. Although this condition is not entirely preventable, it is good that more and more Native Elders are becoming aware of ways to prevent arthritis and such activity needs to continue and increase.

Figure 10. Diabetes

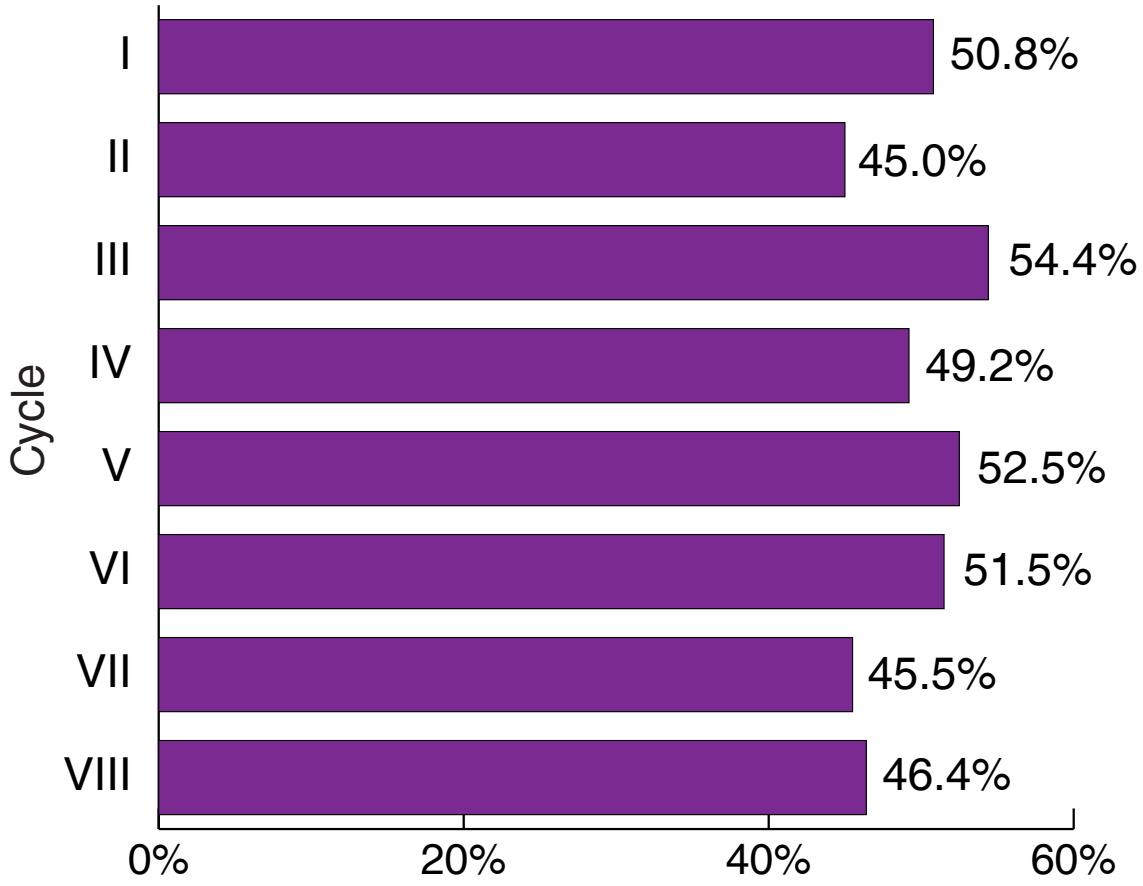
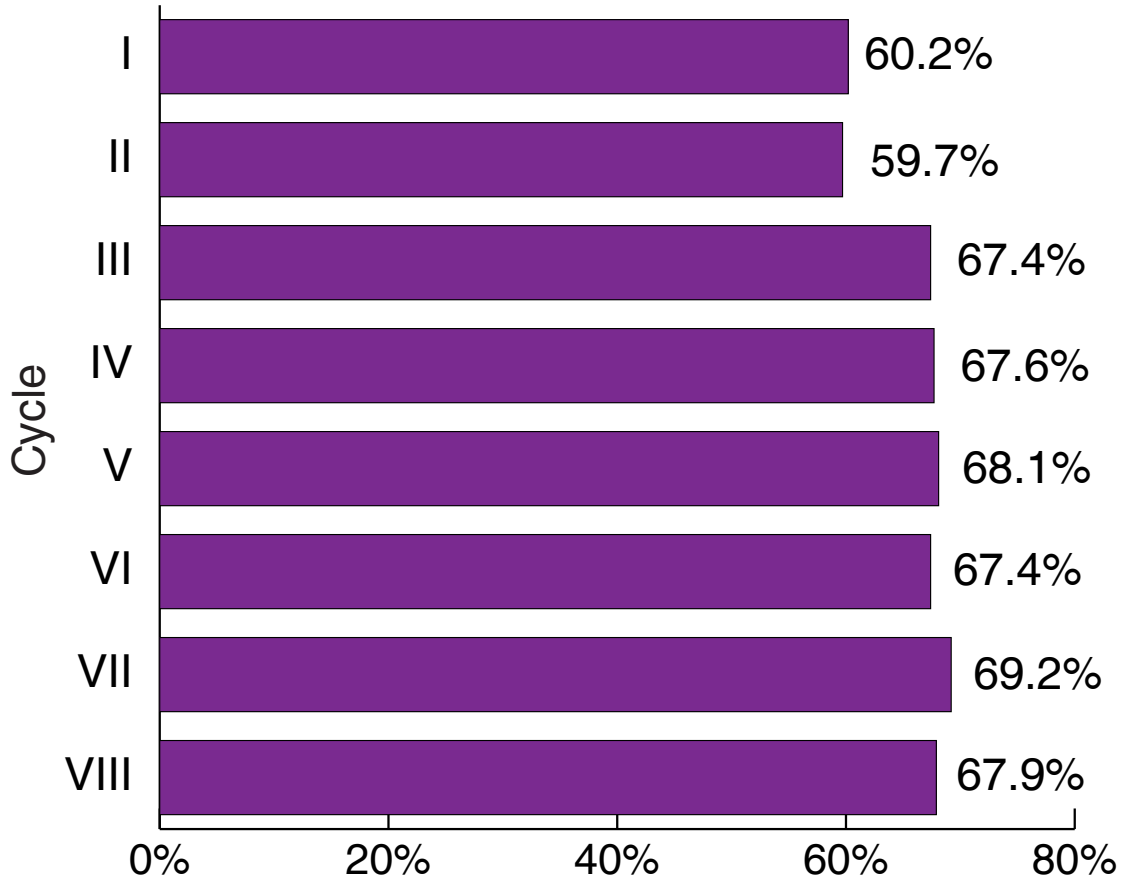


Figure 10 depicts the distribution of a diabetes diagnosis for the Native Elders who met the functional limitation levels to be included in the subgroup highlighted in this brief. All cycles (I-VIII) had a rate of at least 45.0%.

It is well known diabetes is a common comorbidity among Native Elders, experiencing higher rates of diabetes in comparison to the general population. This was evident in the distributions in the figure above, which ranged from 45.0% in Cycle II to 54.4% in Cycle III.

It is hoped that continued efforts to reduce diabetes prevalence among Native Elders, particularly through initiatives such as the Special Diabetes Program for Indians, will help lower the overall burden of this disease in tribal communities. Reducing diabetes prevalence could also lessen the risk of complications and functional limitations that diabetes may contribute to.

Figure 11. High Blood Pressure

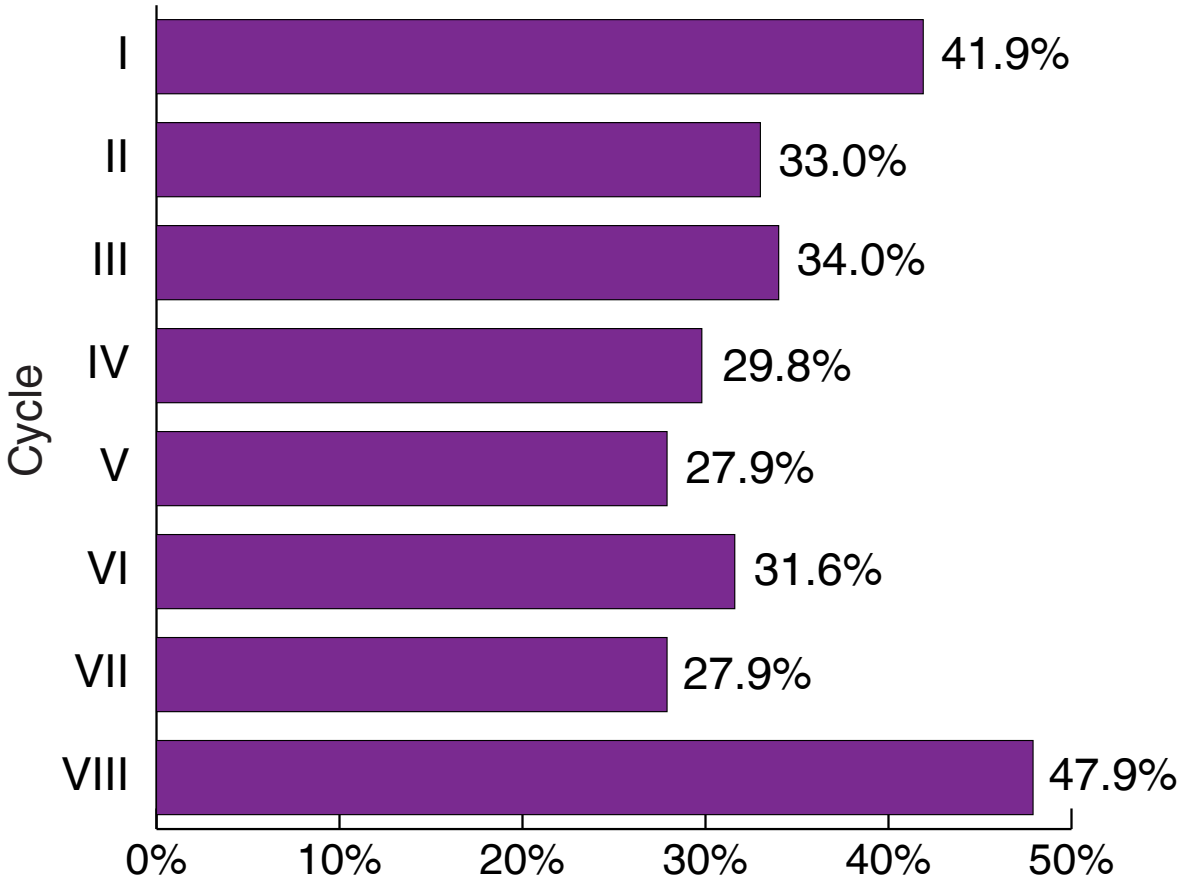


When it comes to high blood pressure, once again there is a significant proportion of Native Elders with a high level of functional limitations being affected by a common condition among older adults that can lead to serious health complications.

The majority of this Native Elder subgroup reported having high blood pressure or hypertension. Figure 11 shows the rates of high blood pressure ranged from 59.7% in Cycle II to 69.2% in Cycle VII.

High blood pressure can also contribute to functional limitations. Fortunately, there are programs in place that educate Native Elders on how to reduce their risk and manage this condition effectively. It is evident such programs need to be sustained and expanded upon.

Figure 12. Home-Delivered Meals



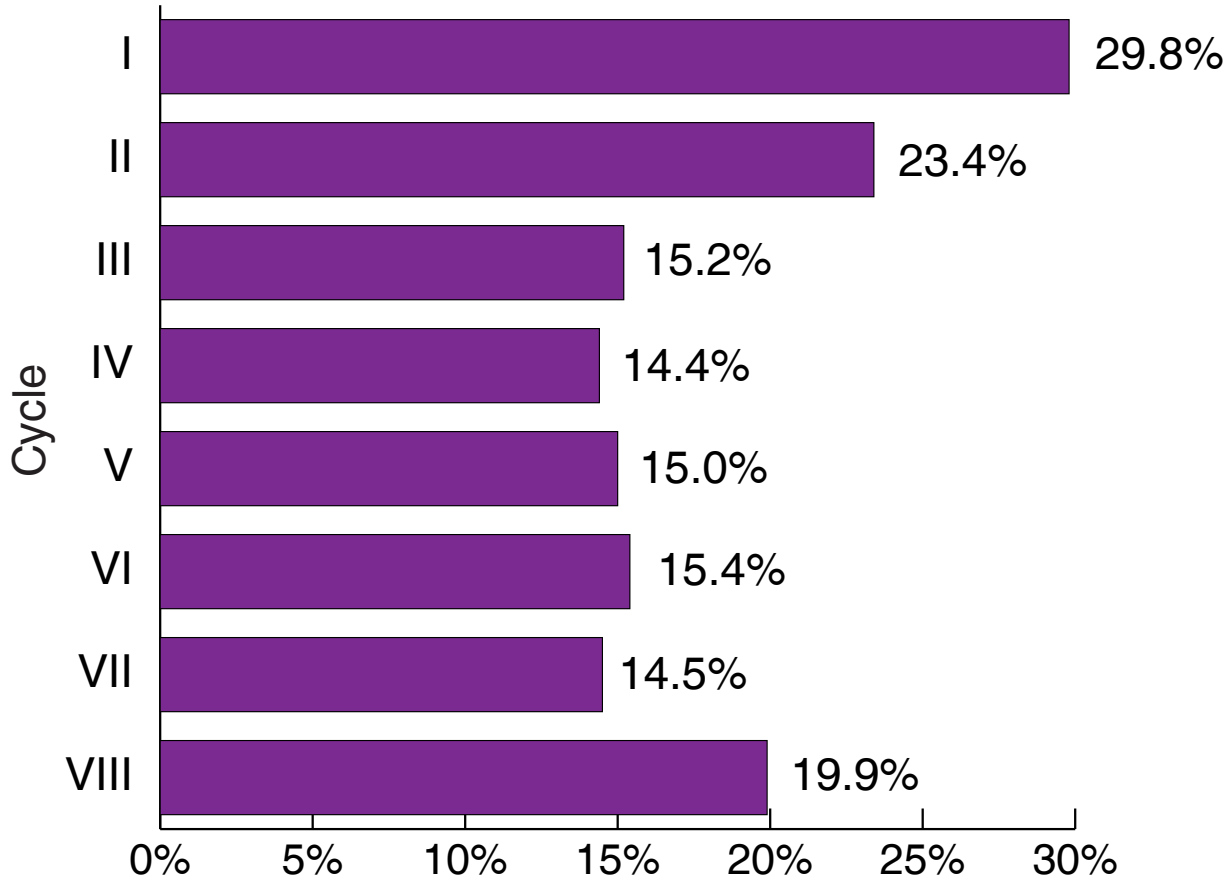
For a look at the use of some of the most needed support services for Native Elders, Figures 12 and 13 depict reported use of home-delivered meals and transportation.

Home-delivered meals are one of the most utilized and needed support services by older adults, especially those experiencing functional or financial limitations.

In the subgroup examined in this brief, Native Elders accessed home-delivered meal services at varying rates over the past 25 years. Figure 12 depicts notable fluctuations occurred throughout this period, with the lowest utilization rate being 27.9% during Cycles V and VII. However, the rate peaked at 47.9% in the most recent cycle.

It is hoped that with this major increase between Cycles VII and VIII, this trend will continue to ensure Native Elders with moderate severe or severe scores for Functional Limitation categories receive this vital support service and benefit from the positive impacts associated with it.

Figure 13. Transportation



Native Elders with functional limitations are likely to need transportation services to attend medical appointments and other essential activities that help maintain a higher quality of life. It also can prevent isolation and other adverse impacts caused by the unmet need of transportation.

Figure 13 depicts the reported utilization rates per cycle for transportation. The lower rates that range from 14.4% to a high of 29.8% further demonstrate how transportation is one of the most unmet needs for Native Elders.

There are many factors that can contribute to these outcomes, such as limited resources in Tribal communities, family or friends providing the transportation, and others. However, this is a concerning outcome that will need to be examined further to best assess how to address any gaps or barriers regarding access to this much needed support service.

Conclusion

This examination of family and professional (or skilled) caregiver use among Native Elders who self-report ADL difficulties and had moderate severe or severe scores for the Functional Limitation categories, revealed the majority of this subgroup received care from a family member. While the use of professional or skilled caregivers was not reported at high levels, a notable increase occurred in the most recent survey cycle, rising from 21.8% in Cycle VII to 33.0% in Cycle VIII.

Across all eight cycles, the majority of this Native Elder subgroup were between the ages of 60-79. As seen in the general Native Elder population throughout the history of the survey, a large majority of this subgroup were female.

The income levels varied widely for this subgroup of Native Elders. However, throughout the survey cycles, many of the Native Elders fell at a level that would be defined as an economic hardship.

For every cycle, most of the Native Elders in this subgroup reported being married/living with a partner or widowed. Additionally, across all cycles, the majority of the Native Elders who reported a moderate severe or severe functional limitations also reported their general health status as either poor or fair.

Most individuals in this Native Elder subgroup reported living with chronic conditions such as arthritis or high blood pressure throughout all eight cycles. Many also reported being diagnosed with diabetes.

This brief also examined the reported use of major home and community-based services, specifically home-delivered meals and transportation. A recent upward trend for home-delivered meals is hoped to continue, while the lower rates for transportation require further analysis.

Additionally, the lower utilization rates of professional caregiver use warrant further focus. A closer look at the demographic profile regarding age, income, severity of functional limitations, and other factors may suggest that many of this Native Elder subgroup were eligible for resources to allow access to these type of support services and further investigation is needed to better understand the trending use of this support service.

Finally, as noted in the earlier review of family caregiving, the consistently high reliance on family members across all cycles requires additional analysis to better understand the underlying reasons for this trend and how best to support Native Elders and their family caregivers.

Overall, these findings emphasize the critical role of family caregivers and it shows a limited, yet increasing use of professional caregiver service for Native Elders with significant functional limitations. Utilizing the information from this brief to guide further investigation into gaps in support services, and how to better understand how demographics and health factors affect the well-being of this vulnerable population, will be essential for driving improvement efforts for this Native Elder subgroup through resource development and policy change.

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