AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-24)

Introduced by: Medical Student Section

Subject: American Indian and Alaska Native Language Revitalization and Elder Care

Referred to: Reference Committee B

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1 Whereas, American Indian and Alaska Native (AI/AN) elders ages 65 and over are expected to
2 increase from 13% of the AI/AN population in 2012 to 20% by 2030[1]; and
3
4 Whereas, AI/AN elders are considered essential to community identity, as extended family and
5 clanship leaders are valued as protectors, mentors, teachers, and intergenerational transmitters
6 of cultural knowledge, a well-recognized protective health factor for AI/AN youth[2-5]; and
7
8 Whereas, AI/AN elders experience significant health and socioeconomic disparities including
9 the lowest life expectancy of all racial/ethnic groups in the US, a 25% uninsured rate, and a 25%
10 rate of having at least one documented disability[1]; and
11
12 Whereas, a study in Canada of AI/AN elders found that Indigenous-led health service
13 partnerships improve holistic health outcomes, as well as access to care, prevention uptake and
14 adherence to care plans for First Nations[6]; and
15
16 Whereas, a survey with southwestern Tribal Nations found that AI/AN elders consistently shared
17 themes of healthcare insecurity due to failed systems and IHS underfunding[7]; and
18
19 Whereas, while AI/AN elders receive primary care through the IHS, underfunding and
20 understaffing has forced IHS to rely on non-IHS facilities for more specialized elder care,
21 including hospice and respite care, forcing AI/AN elders to navigate unknown health systems
22 not respective of their cultural values and traditions[8]; and
23
24 Whereas, despite the well-documented comorbidities AI/AN people carry into elderhood, AI/AN
25 elders are less likely to create end-of-life care plans compared to non-Hispanic Whites and
26 remain one of the least studied populations regarding their use of advance care planning[7-9]; and
27
28 Whereas, terminally ill AI/AN elders are less likely to receive hospice and palliative care than
29 other racial/ethnic groups, with fewer than a third receiving these services compared to over
30 45% of the non-Hispanic white population[10]; and
31
32 Whereas, according to data collected by the Mayo Clinic Spirit of Eagles program, Tribal Health
33 Directors reported pain management, advanced care planning, hospice contracts, care for the
34 dying, and bereavement support as their most pressing needs, with 60% reporting limited
35 access to end-of-life care[11]; and
36
37 Whereas, by 2060, the number of AI/AN elders with memory loss is expected to increase by
38 400%, requiring additional resources for the IHS to provide dementia services[12]; and

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Whereas, language and cultural barriers severely restrict AI/AN elder access to federal and state programs, such as Social Security, Medicare, and Medicaid[13-14]; and

Whereas, over 20% of AI/AN elders mostly speak their native language, and in several counties on the Navajo Nation, over 40% speak their native language as their primary language[15]; and

Whereas, the National Indian Council on Aging considers Native languages as key for improving health and social services and well-being for AI/AN elders[16]; and

Whereas, the White House Office of Science and Technology Policy (OSTP) has directed the Department of Health and Human Services, Centers for Medicare and Medicaid Services, IHS, and other federal agencies to value and prioritize Indigenous knowledge, including languages and knowledge holders, in federal grantmaking and other funding opportunities[17]; and

Whereas, the Biden-Harris Administration's 2024 budget request for Indian Affairs programs makes significant investments in Tribal native language revitalization[18]; therefore be it

RESOLVED, that our American Medical Association recognize that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors (New HOD Policy); and be it further

RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 4/5/2024

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RELEVANT AMA POLICY

H-295.897 Enhancing the Cultural Competence of Physicians

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

[CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18; Modified: Res. 322, A-22]

H-350.976 Improving Health Care of American Indians

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

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(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
[CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

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