Research Brief

"We See Things Other People Aren't Going to See": Facilitators and Barriers to Screening and Management of Elder Abuse by Tribal Health Care Providers

A National Needs Assessment

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Contents

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Project In Brief

This report describes summary findings the first and most comprehensive national needs assessments designed specifically to identify facilitators and barriers for screening and management of abuse by tribal health care providers among American Indian and Alaska Native (AIAN) elders.

The International Association for Indigenous Aging (IA2), with funding from The National Resource Center for Reaching Victims of Crime, sought to understand the current needs and experiences of tribal health care clinics in recognizing and managing elder abuse. This assessment is part of an overarching goal of promoting and implementing screenings, referrals, and/or interventions for AIAN elders who are victims of abuse. The project was developed based upon the belief that the diverse cultural, social, and health needs of tribal elders who are affiliated with or health care providers who serve the 573 federally recognized American Indian tribes and Alaska Native Villages in the United States (U.S.) (Bureau of Indian Affairs, n.d.) create a unique context in which to understand the recognition and management of elder abuse in outpatient clinical practice.

> The problem is that almost always they'll say, "I'm okay," they'll make an excuse, "No, that's not an injury from being thrown into a wall, I fell into the couch." The problem is a lot of the time, it's the person in the room with that person.
>
> And then, immediately making a report, and trying to determine from there what kind of legal action we can set in place, but it isn't anything we can do from that point if the person denies wanting help, or wanting to report the person who is neglecting or abusing them, and that's pretty much the point where most of them fall down, the person flat out refuses to identify who it is, or to call it neglect or abuse, or to say that they were injured directly by another person. (Registered Nurse, Western Primary Clinic)

The state of the science on elder abuse among AIAN people is similar to that of other minority and vulnerable groups; it is limited, progress has been slow, and solid comparable prevalence estimates are lacking (Jervis & Sconzert-Hall, 2017; Sapra et al., 2014). The available research demonstrates a potentially high prevalence of abuse of AIAN elders that occurs at the intersection of contextual factors that include inter-tribal cultural diversity, tribal sovereignty, complex tribal justice systems, historical trauma, acculturation, urban migration, and demographic and health disparities (Crowder, Burnett, Laughon, & Driesbach, 2019; Crowder et al., 2019).

Little systematic screening for elder abuse occurs across the United States (U.S.), due perhaps in part to a host of barriers faced by health care providers, or related to the continued scarcity of high quality research and availability of victim services geared towards older adults, including AIAN elders. Though, health care providers are uniquely positioned to take an active role in addressing the epidemic of abuse and violence targeting elders. In fact, they likely already are. The information obtained from this needs assessment will fill a gap in practice and policy for tribal providers and perhaps even lend useful insights for mainstream health providers.

Objectives:

- Describe provider, community, cultural, and systematic (clinic-level) factors that contribute to how victims of elder abuse are identified and managed in outpatient clinical settings;
- Identify facilitators and barriers to recognition and management of elder abuse;
- Explore the context of providing clinical care for abused elders;
- Identify phenomena related to care of elders unique to AIAN cultures; and

- Identify existing promising practices for screening and management of elder abuse among tribal health providers.

> …but you're handicapped because you don't know the entire social situation. You see the patient for a very short time, you don't know if that black eye is because they fell, because somebody punched them, or something else, like the dog jumped on them. You're a little bit limited because to have the info you have to have the family that the elder is usually with, and when there is no family it makes it even more difficult to ascertain the issues, there's embarrassment, there's guilt, they may not want you to know because you're not family, you're not the regular doctor that they see, because he's on vacation. Medicine is very fragmented, nowadays, it's hard to see the same person twice. (Physician, East Coast)

Methods:

A multi-phased mixed methods iterative design was employed, that incorporated qualitative and quantitative data collection and analysis across two data sets, including telephone interviews (n = 23) and an online survey (n=90). Between January and May of 2019, a comprehensive outreach effort was conducted to identify health care providers and later domestic violence advocates focused on elder abuse, ACL-funded Older Americans Act Title VI Directors, and tribal Adult Protective Services (APS) workers to participate in telephone interviews, and staff from tribal clinics to participate in the online survey. A subset of tribal health directors, multiple major tribal advocacy organizations and resource centers, and several U.S. federal agencies were contacted for assistance in reaching participants. Personally-identifiable information, tribe, or clinic names were not collected as part of the survey and were redacted from interview transcripts. The assessment protocol was reviewed by the national Institutional Review Board (IRB) for the U.S. Indian Health Service (IHS) and two separate tribal IRBs who determined the project did not require IRB review. Analysis of assessment data consisted of qualitative descriptive and interpretive designs for interviews, and descriptive analysis of quantitative data including frequency counts and percentages and content and thematic analysis of open-ended survey questions.

Sample

Interview participants represent 15 different states including 13 respondents (57%) classified as health care providers (physicians, physician extenders, social workers, nurses, behavioral health counselor, and home health supervisor) and 10 classified as non-health care providers. Online survey participants included staff from tribal health clinics that represent 16 different states. See Table 1 for details regarding health care provider and elder advocate interview demographic and practice location information. See Table 2 for more details regarding survey participant responses.

Results

Key Findings Confirmed by Previous Research

A number of findings from the current needs assessment support previous elder abuse research or expert opinion in AIAN-focused research. For instance:

- financial exploitation and neglect are cited as the most prevalent forms of abuse by health care providers;
- substance abuse and poverty are thought to be the two most common correlates or causes of abuse, which is followed by mental health issues;
- respect for elders is the predominant cultural value discussed in interviews and surveys;
- jurisdictional issues are a significant challenge according to interviews; and
- communities with more traditional views and that are less acculturated are thought to experience lower rates of abuse; conversely, acculturation is thought to lead to higher rates of abuse,

> It's really unfortunate. A lot of it is financial, and a lot of it is drugs and alcohol. Recently, meth has been such an insinuation, we have 160 cases of elders taking care of grandchildren because their parents have either died or been incarcerated.
>
> (Adult Protective Services, Western Tribe)

although there were mixed findings on the part of some health care providers who see instances of abuse regardless of the degree of acculturation or traditionalism.

New and Noteworthy Key Findings

- Screening is widely accepted by not widely accomplished. The majority of tribal health care provider participants (89% of survey respondents) are willing and ready to embrace screening for abuse among their older patients, and their community partners support this role. Only 54% routinely screen for elder abuse and only three clinics report use of an elder-specific screening tool. Eighty five percent (85%) of health care providers agree that they have the capability to identify all different types of elder abuse, including financial exploitation.
- Tribal health care providers are already intervening in cases of elder abuse in clinical settings. For example, 70% of survey respondents have worked with patients experiencing financial exploitation, 60% have experience with neglect or emotional abuse, and 43% have experience with physical abuse.
- More often than not, tribal health care providers indicate that they lack proper protocols for managing cases of elder abuse, have received little training, and either lack information about how to access available community services or supports, or lack the actual community services and supports.
- The top barriers to screening according to tribal health provider survey respondents are the presence of family and caregivers at the appointment, and larger community or agency barriers such as lack of screening tools and lack of services. Additional barriers offered are cultural values, lack of provider trust, and not wanting to report family members who are perpetrators. In interviews, the most commonly discussed barriers to screening include the short amount of time allotted for patient-provider interaction, provider turnover (which diminishes trust in the provider), and the presence of family members during the exam.

- Interventions employed by tribal providers in cases of alleged or confirmed abuse listed in order of frequency mentioned in interviews include: employing additional resources such as nursing care, respite care, food, home repairs or shelter; reporting to APS; Multidisciplinary Teams (MDTs) or formal community cross-collaboration to address cases of abuse; community health representatives (CHRs) and home health as prevention or intervention; availability of additional office staff to make and manage referrals for services; outplacement of elders from their homes, primarily to nursing homes as most shelters cannot accommodate needs of elders; reporting to law enforcement; safety planning; referral to behavioral health; building trust and rapport to facilitate reporting of abuse by clients; and facilitating identification of power of attorney (POA) or guardianship.

> Oh, it's huge, I've seen a lot of that--mental health and trauma, the combination. I've seen it lived in families right left and here and there. A lot of communities are worse than others. The folks who come in for help, to seek housing or whatever, just... The one trauma tool we use the ACEs [Adverse Childhood Experiences] survey, they say if there are 4 indicators or more there is going to be issues and they are mental health issues. Better than 50% of our survey respondents come in with 4 or more. Their minds are abused. More than physically. Or [their] mental health is a side effect of social factors that have taken the brunt of it over the years.
> (Domestic Violence Worker, North)

- Historical and current trauma, which have been discussed in some previous abuse research among AIAN elders, though were not a major theme or aspect, are major themes in our interviews. Boarding schools, the life cycle of family violence, persistent racism, and forced assimilation or acculturation are among the important issues identified by multiple respondents.

- Substance abuse, poverty, and other marked disparities in social determinants of health are thought by tribal health care providers to have a causal link to elder abuse.
- Services essential to the health and wellbeing of Indian elders also face substantial deficits in funding and access. Provider concerns about current funding deficiencies for elder services include community health, behavioral health, and access to other community and health services for elder victims of abuse, access to housing, food, and transportation.
- Caregiving issues or caregiver stress were not as prominently discussed among participants in this assessment. This follows more conventional wisdom and research which has moved to unlink caregiver stress as a single, direct causative factor for elder abuse (Brandl & Raymond, 2012). Discussion of caregiving issues typically arose when health care provider participants shared examples of cases that believe represented potential "gray areas," where it was not always a clear-cut case of abuse or exploitation, rather a question regarding the need for additional services or resources such as home health care, homemaker services, respite care, or food and nutrition services.
- Community health representative (CHR), public health, and home health programs emerged as novel promising interventions for both surveillance and screening as well as an intervention employed by providers and APS workers in cases of alleged or confirmed abuse. Several respondents indicated that standard or mainstream home health resources funded by Medicare, for instance, can be hard to obtain or of such a short duration or intensity they provided little assistance for victims of abuse. Concerns regarding funding cuts to tribal home health and CHR programs were raised.
- There is a need to better understand the link between culture and abuse, specifically the role of acculturation and assimilation at the individual, family, and community level. Most non-health care providers were likely to indicate when asked that acculturation increased the potential for abuse, whereas health care providers were more likely to indicate it had no impact or the impact was unknown. Other than recognition of the issue, we simply know very little about the real impact of the issue on abuse. There are more

questions than answers based upon this assessment findings and existing literature.

- Programs designed to reinvigorate cultural traditions such as language, culture, and food programs are posited as potential promising or best practices. These programs may offer the opportunity to meaningfully engage elders and provide opportunities to reduce social isolation. Validated tools exist to measure acculturation and assimilation among AIANs, as well as elder abuse. There are programs in place focused on re-vitalizing culture. One needs only to invest in a program and related rigorous evaluation that brings all of these concepts and practices together.
- MDTs are another promising practice discussed in our interviews. In those tribes where they exist, they are seen as a very effective tool. Based on brief discussions of MDTS as part of interviews for the current project, we found that what constitutes an MDT and the roles and functions of the teams varies from one tribe to the next. Discussions with tribal staff indicate that membership, function, and outcomes of these MDTs vary.
- Virtually all of the communities who have an existing MDT also have a tribally-funded APS worker or another individual who serves as a single point of contact for alleged cases of abuse. These tribes also appear to employ the most comprehensive response to elder abuse when it occurs, as opposed to relying on county or state APS workers or tribal social services staff member or social worker or department who has dual responsibility for both child and elder abuse complaints.
- Self-neglect was not specifically included in interview or survey questions due to its unique nature and lack of an outside perpetrator. It was an issue raised only by a few interview participants. However, self-neglect is the primary type of elder abuse cases reported to APS and can be the most complex to address (Dong, 2017). Given the high prevalence and association with other forms of abuse such as financial exploitation, providers are likely to encounter self-neglect in their clinical practice.

Summary Interview Themes

The Social-Ecology of Health Model provides the framework for structuring emergent and convergent themes that evolved from interview data analysis. There

are many formulations of the model but all have in common multilevel systems of mutual influence and interaction, moving from the level of the individual through linkages to the larger familial, community, and societal levels. We have organized identified themes into the following categories: Individual, Familial, Structural, Cultural, Community, and Organizational.

Table 3 includes frequencies and percentages for categorical questions asked as part of interviews.

Individual Variables

Theme: Elder protection of family

- Family presence at health care visits can be barrier to screening
- Reluctance to report family even if not present
- Rights to self-determination and need to honor refusal to report family members

Theme: Elder support of grandchildren

- Grandparents put grandchildren first
- Grandparents caring for grandchildren
- Older grandchildren may take financial advantage of the elder, even if elder is impoverished

Familial Variables

Theme: Honor and duty to share resources

- Perceived honor and duty to share by elders
- Entitlement by younger generation

Theme: Caregiving creates vulnerabilities for some

- Elders dependent on family for caregiving may create financial vulnerability
- Gray areas in caregiving for providers; not clear cut cases of abuse versus need for additional
- resources.

Theme: Substance abuse and poverty as contributing factors

- Substance abuse most prevalent causal concern

- Poverty also a major factor

Structural Variables

Theme: Providers see patients who experience all types of abuse

- Physical abuse easiest to identify, but providers see all types of abuse
- Financial exploitation most prevalent followed by emotional abuse and neglect

Theme: Difficulties for providers with abuse assessment

- Time allocated for patient interaction, turnover and family presence key challenges
- Damage to patient – provider relationships a concern, but reports rarely result in patient permanently discontinuing health care

Theme: Few standardized protocols

- Screening and standardized protocols for elder abuse lacking in clinical practice

Theme: Providers can and should play a role

- Building trust and rapport with patients critical

Cultural Variables

Theme: Respect for elders as a function of culture

- Notable strengths: Respect, family first, community, pride, resiliency
- Tradition of respect has eroded and dissolves in face of substance abuse
- Assumption of elder respect due to the elder being "Indian" is not necessarily true "anymore"
- Strengths and culture do not always ensure protection

Theme: Role of acculturation is unclear

- Acculturation increases the likelihood for abuse according to some
- However, this belief is not universal; particularly among health care providers

Theme: Abuse discouraged as community/familial topic

- "We don't talk about that" and "looking the other way" to protect community and the family are common beliefs

Theme: Historical trauma

- Previous experience with forced assimilation and boarding schools, racism, the life cycle of violence, and providers as symbols of white authority continue to plague tribal communities
- Historical trauma is thought by many to increase the probability of abuse, and have a connection to incidence and prevalence of substance abuse in tribal communities

Theme: Cultural renewal as possible intervention

- "Culture as prevention" - Tribal efforts at cultural renewal seen as potential pathway to indirectly (or directly) address elder abuse

Community Variables

Theme: Lack of priority

- Elder abuse is low priority and underreported

Theme: Promising interventions

- Home health staff serve as eyes in the home and are respected resource CHRs, community health personnel, and home health programs instrumental in identification of, and intervention in, abusive situations
- Home health programs at risk due to cuts
- MDTs thought to be effective
- Community outreach and education highest priority

> There are so many strengths from what I see, cultural tradition being one of them. With our agency serving over 120 tribes, that means we have many different spiritual protocols, ceremonies, you name it, so many different cultural things. A huge thing that we implement here, because we see it as a strength of our community, is culture as prevention. So that's why they often go to sweat ceremonies, we also have sage and we smudge clients as needed, we have connections with local spiritual healers, and so cultural identity is such a huge strength here...
> (Licensed Clinical Social Worker, Western Urban Indian Health Center)

Organizational Variables

Theme: Positive interactions with referral agencies essential, room for improvement

- APS and law enforcement important allies
- Some APS programs busy, overwhelmed, or very high caseloads
- Feedback and reporting an issue
- Tribally run APS may have better outcomes

Theme: Jurisdictional issues a challenge

- Jurisdictional issues a major barrier

Needs

Theme: Funding underscores multiple needs

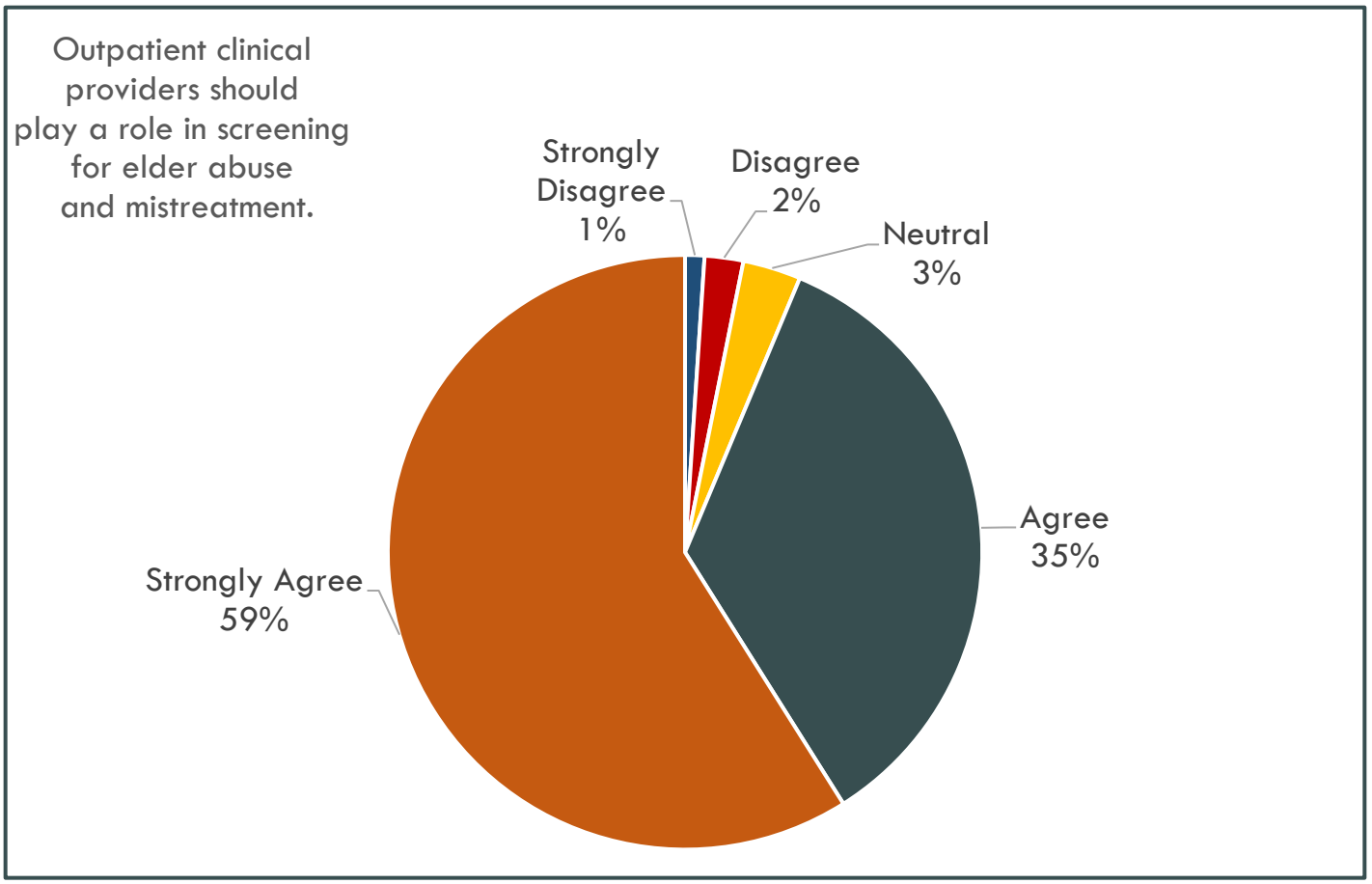
- Outreach and awareness
- Funding to increase all elder services
- Social workers
- Training in screening and intervention
- Standardized protocol for screening and intervention
- Other services: respite care, in-home nursing care, food, safety inspections, transportation, and
- temporary housing for at-risk elders
- Need multidisciplinary / holistic response to prevent and respond

Selected Survey Findings

Survey results reflect responses from 90 tribal health clinic staff serving primarily AIAN patients. Respondents were asked a series of questions regarding their own experience and their clinic's experience with elder abuse including either closed-ended (categorical) or open-ended response options.

The type of abuse tribal health care provider respondents experience most frequently is financial abuse or exploitation (69%), followed by emotional abuse and neglect (61%). While health care providers note financial abuse or exploitation as the most frequent form of abuse seen (70%), non-health care providers cite emotional abuse (67%). Financial abuse or exploitation is thought to be the most prevalent type of abuse in the community (61%).

Respondents commented on screening in tribal clinic settings. The majority (54%) do not routinely screen for elder abuse.



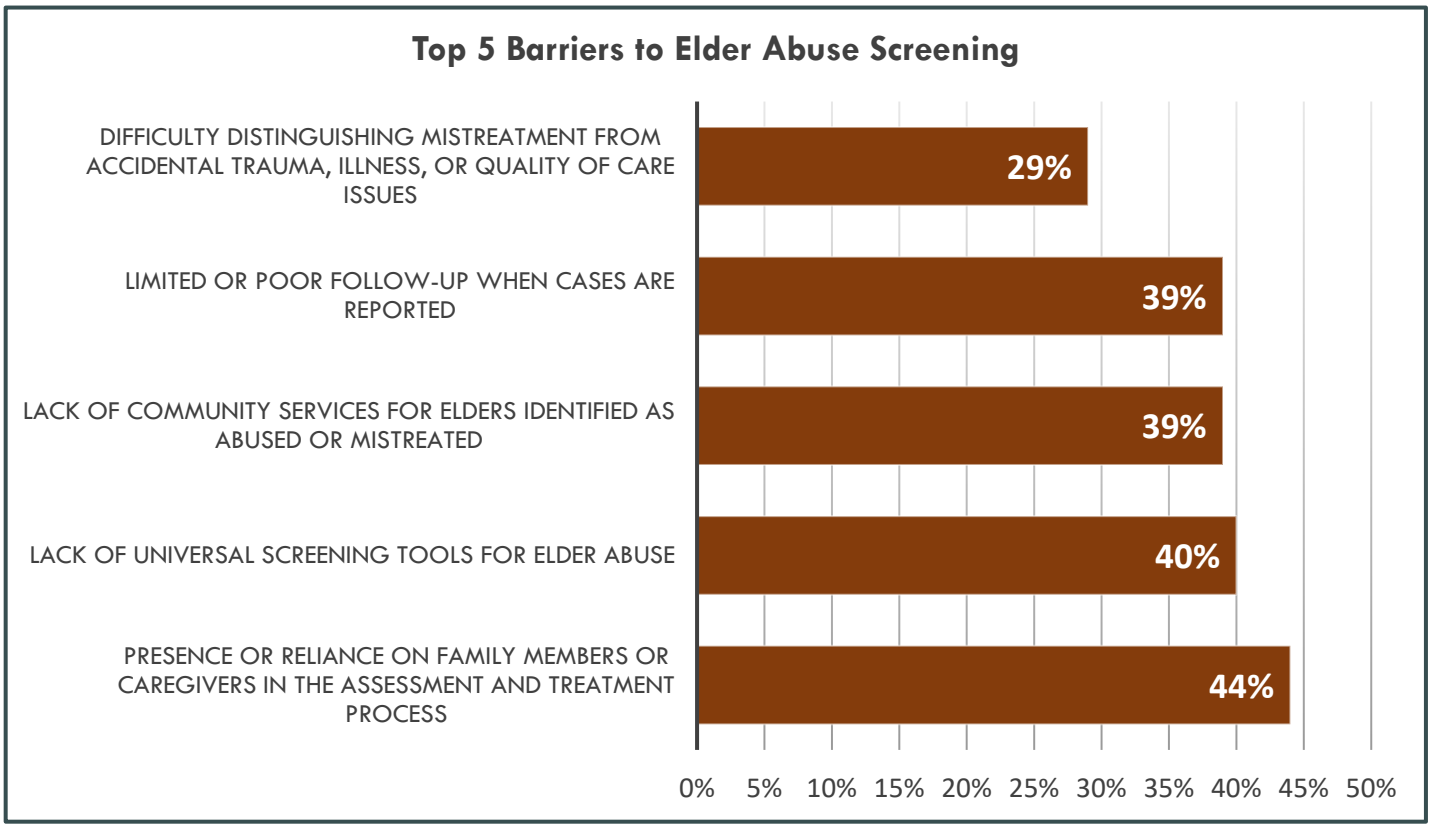
When describing screening, 18 of 29 respondents use informal screening tools while seven identify formalized tools.

Standard protocols and processes for handling suspected cases of elder abuse were reported by approximately half (49%) of respondents' clinics, and half do not have a protocol or staff are not aware of one (24% and 27%, respectively). The majority of respondents note some form of reporting or referral process to APS, tribal police, social services, or other agencies.

Eighty-nine percent of respondents agree or strongly agree that providers in outpatient settings should play a role in screening for elder mistreatment.

When asked to assess their own abilities, only a minority of respondents (43%) strongly agree or agree that they are knowledgeable.

The top barriers to screening (selected from a pre-identified list) are the presence of family and caregivers at the appointment, and larger community or agency barriers such as lack of screening tools and lack of services. Additional barriers offered are cultural awareness, trust, and not wanting to report family members who are perpetrators.



After identifying a case of potential elder abuse, slightly less than half (49%) have referred a case to another agency outside the clinic per protocol, and 45% strongly agree or agree that they know who to contact for reporting elder mistreatment.

Of those who rated the handling of past cases by other entities, slightly more felt the case was handled poorly or very poorly (42%) compared to well or very well (40%).

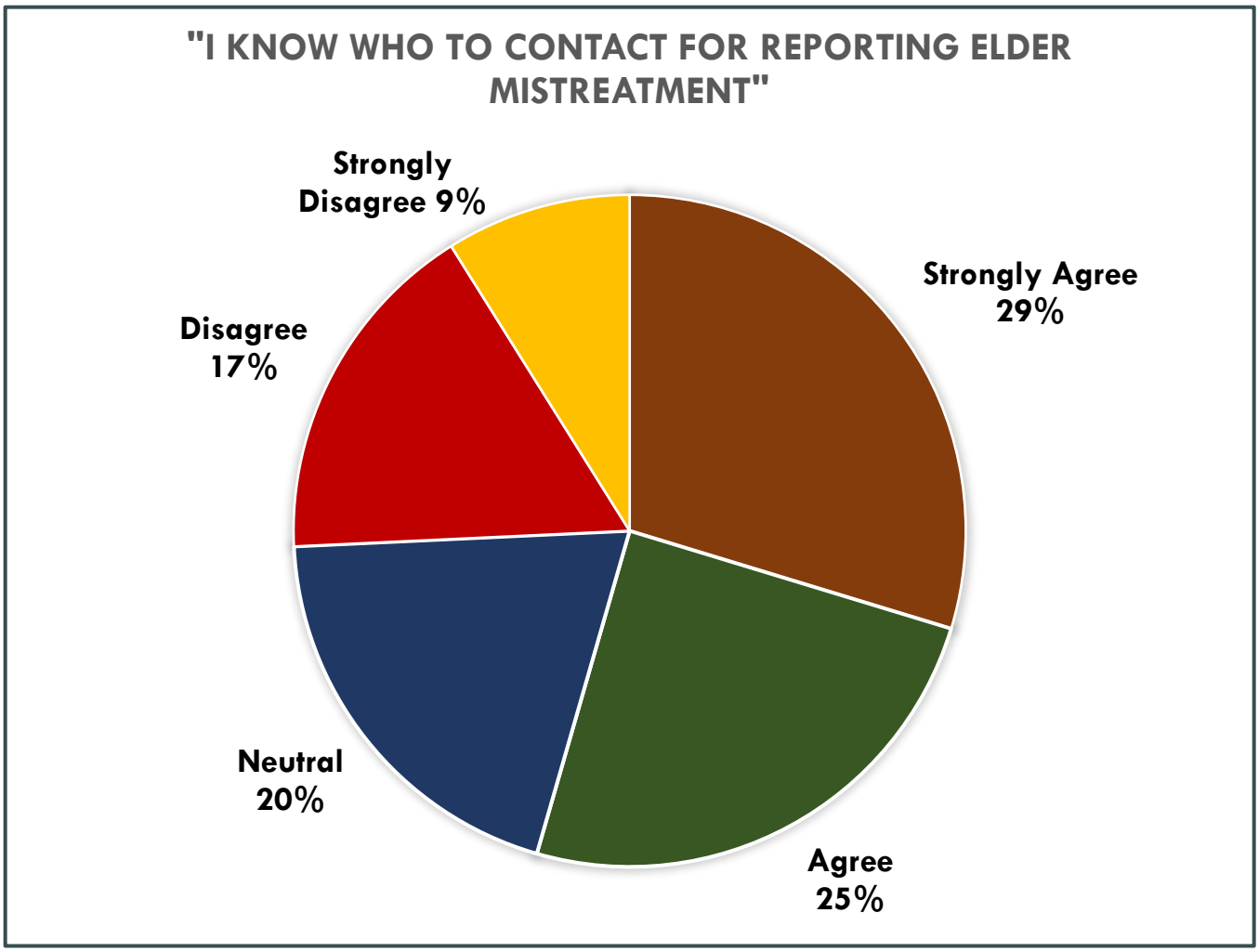
Top responses for why a case was not handled well by an outside agency include

- no follow up (5),

- inappropriate follow-up with elder (4),
- elder was not eligible for the outside agency (3),
- cases took a long time to resolve (2), and
- cultural factors such as distrust, cultural awareness, and attention to native elders needs created barriers (2).

Respondents were also surveyed on a series of questions around needed resources, best practices, and trainings. When asked about resources, tools, or information needed to improve screening, the predominant answer is protocol implementation followed by training, screening tools, and resources. Both health care and non-health care providers feel they do not have adequate training in elder abuse detection, management, and reporting (69%) and the majority express interest in more training (79%).

Forty-seven respondents listed additional significant factors contributing to elder abuse in their community. The most frequently occurring are substance abuse (25) and poverty (17). Other top factors include overreliance by the family on the elder, housing issues, lack of services, trauma history, and unemployment.



To begin looking at how to address the issue, respondents were asked about the community perception of elder abuse. Respondents most frequently note that communities are aware of elder abuse but have done nothing to address it. Others note no community interest, no community awareness, or denial by the community that an issue exists. The majority of respondents feel that there are not adequate resources to address the needs of elder abuse victims (49%) or do not know if there are adequate resources (29%).

Policy and Practice Recommendations

Based upon finding from this needs assessment, with some integration of findings in the existing elder abuse literature specific to AIAN elders, the following set of policy and practice recommendations are offered. Recommendations are offered for consideration by tribes, counties,

state, and federal level policymakers and health care practitioners. The list of recommendations has no particular order of priority, though findings from the present needs assessment indicate that screening tools, protocols, and training are the most pressing priorities for health care providers.

- Development or adaptation of a tool or best practices to systematically assess community supports, services, and assets for tribal health providers and elder abuse victims available within or adjacent to tribes and to tribal-serving health care entities
- Dedicated tribal-funded APS staff person, social worker, case manager, or elder service worker(s) with APS-type roles and responsibilities (in tribes that do not currently have this type of position)
- Enhance or establish relationships between existing tribal and county APS and MDT programs and outpatient tribal health centers to promote regular opportunities for training and ongoing support of clinical staff referrals; incorporate health center staff into existing MDTs
- Initiate or enhance tribal-run CHR and/or home health programs, or identify alternative funding streams to make current programs solvent
- Standardized provider training on elder abuse assessment and management that addresses complicated cases, red flags, and "grey areas" that incorporates a trauma-informed care approach specific to the needs of AIAN elders
- Selection and testing of elder-specific abuse clinical screening tool including short- and long-term outcomes in tribal clinical setting
- Testing/adaption of cultural appropriate, specific tools specific to AIAN elders
- Development of standardized screening protocols for assessing abuse and exploitation in older adults that is adaptable by local tribes and health providers
    - Outpatient clinic settings
    - Home-based care settings
- Training on effective use of standardized screening protocol

- Health centers: health care providers, nursing staff, social workers/case managers, auxiliary health providers situated in clinics that have direct patient contact
- Home-based care programs: CHRs, public health nurses, home visiting nurses and auxiliary staff
- Development of a standardized intervention protocol that is adaptable by local tribes and health providers
    - Training on effective use of intervention protocol
    - Potential interventions identified in the present study include:
    - Assessment of multidisciplinary service and support needs
    - Referral to APS – relationship development, communication, and jurisdictional issues
    - Referral to law enforcement – relationship development, communication, and jurisdictional issues
    - Referral to additional agencies or departments
    - Placement in respite or other facility or shelter for safety
    - Training on roles, processes, policies of other agencies (e.g., depending on statute/regulation APS can't give out information on cases and may not even be able to confirm an investigation is taking place; how providers can and should follow up or documentation needed)
- Support for existing MDTs and expansion to new tribes for assessment, development of an action plan and systematic approach to MDTs as an elder abuse intervention. Consider process specific evaluation or assessment to identify:
    - Membership
    - Frequency of standard meetings of MDT
    - Interventions employed
    - Process to manage follow-up actions (for example, home visits, post-APS or Law referral, additional interventions)

    - Communication and collaboration protocols
- Development and empirical testing of strategies to enhance community outreach, awareness, and reporting of elder abuse
    - Identification of strategies to increase tribal leadership buy-in
- Empirical assessment of the direct and indirect impact on elder abuse and exploitation of programs designed to promote cultural revitalization.

Conclusion

The present project employed a mixed-methods approach to assessment of facilitators and barriers to outpatient tribal health care provider engagement in screening and systematic management of the needs of elder victims of abuse encountered in daily practice. Great congruence between interview and survey findings occurred. However, interviews provided greater depth and opportunities to assess potential promising practices. Interviews also created the opportunity to discuss more complex issues such as acculturation and historical trauma, both issues culturally-specific and significant in the context of tribal communities. Most importantly, we found that, by and large, outpatient health care providers who participated are willing and ready to embrace screening for abuse among their older patients. These same providers are already forced to intervene in clinical settings that frequently lack proper protocols for managing cases of elder abuse, offer little training, and either lack information about available community services or supports or lack the actual community services/supports.

Some findings from this assessment are reflective of previous elder abuse research inclusive of AIAN communities, or support findings from research among mainstream populations, e.g., health care providers' barriers to screening. However, the needs of tribal elders are unique, and the needs

of their respective tribal clinics, villages, and communities are also unique when working to address elder abuse. Systems, protocols, services, and supports must be designed and implemented, ideally by tribes and tribal providers themselves, or at the very least in close collaboration with them. This report offers a set of general recommendations based on the experiences of tribal health providers and non-health care providers from across the country. It addresses the original project objectives identifying multiple factors that contribute to elder abuse detection and management, facilitators and barriers for tribal providers, insights into care provision for AIAN elders, important cultural factors, and several existing and promising practices being employed by tribal health care providers.

To the extent possible, the words of tribal providers and elder advocates themselves are included to substantiate our findings. The project team's hope is that this report provides a stepping stone to future conversations about how to address the epidemic of elder abuse facing tribal communities.

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Table 1 Survey participant demographic information and details about practice location

	Non-health care providers	Health care	Total
	n=10	n=13	n=23
Years working at current location (average)	8.9 (SD 11.0)	13.2 (SD 13.8)	11.8
Provider identifies as AIAN	7 (70.0%)	5 (38.5%)	52.2%
Types of services provided (select all that apply)			

Primary care	0 (0.0%)	9 (69.2%)	39.1%
Behavior health	2 (20.0%)	9 (69.2%)	47.8%
Specialty care/services	1 (10.0%)	9 (69.2%)	43.5%
Non-health care	7 (70.0%)	1 (7.7%)	34.8%
Information and referrals only	2 (20.0%)	1 (7.7%)	13.0%
Other	3 (30.0%)	5 (38.5%)	34.8%
Primarily Rural or urban population			
Rural	8 (80.0%)	11 (91.7%)	86.4%
Urban	1 (10.0%)	1 (8.3%)	9.1%
Suburban	0 (0.0%)	0 (0.0%)	9.1%
Multiple	1 (10.0%)	0 (0.0%)	4.5%
Clinic/practice managed by:			
Indian Health Service	5 (50.0%)	3 (23.1%)	38.1%
Tribe(s)	4 (40.0%)	8 (61.5%)	57.1%
Non-native entity	1 (10.0%)	0 (0.0%)	4.8%
Other	0 (0.0%)	2 (15.4%)	9.5%
Populations primarily served			
AIAN people only	6 (60.0%)	11 (84.6%)	73.9%
AIAN people and non-Native populations	4 (40.0%)	2 (15.4%)	26.1%
Primarily service one tribe or multiple			
One tribe	4 (40.0%)	5 (41.7%)	40.9%
Multiple	6 (60.0%)	7 (58.3%)	59.1%
Approximate % of people seen 60 years and older			
0-30%	2 (22.2%)	5 (38.5%)	31.8%
31-60%	3 (33.3%)	4 (30.8%)	31.8%
61-100%	4 (44.4%)	4 (30.8%)	36.4%

Table 2 Survey participant demographic information and details about practice location

	Non-health care providers	Health care	Total
	n=11	n=79	n=90
Years working at current location (average)	8.09 (SD 6.42)	8.13 (SD 8.38)	8.13 (SD 8.13)
Provider identifies as AIAN	9 (81.8%)	23 (29.1%)	35.56%
Types of services provided (select all that apply)			
Primary care	8 (72.7%)	58 (73.4%)	73.33%
Behavior health	6 (54.5%)	43 (54.4%)	54.44%
Specialty care/services	8 (72.7%)	36 (45.6%)	48.89%
Non-health care	9 (81.8%)	51 (64.6%)	66.67%
Other	6 (54.5%)	19 (24.1%)	27.78%
Primarily Rural or urban population			
Rural	9 (81.8%)	59 (74.7%)	75.56%
Urban	0 (0.0%)	5 (6.3%)	5.56%
Suburban	1 (9.1%)	10 (12.7%)	12.22%
Multiple	1 (9.1%)	5 (6.3%)	6.67%
Clinic/practice managed by:			
Indian Health Service	2 (18.2%)	37 (46.8%)	43.33%
Tribe(s)	8 (72.7%)	39 (49.4%)	52.22%
Non-native entity	0 (0.0%)	0 (0.0%)	0.00%
Other	1 (9.1%)	3 (3.8%)	(4.44%)
Populations primarily served			
AIAN people only	1 (9.1%)	48 (60.8%)	54.44%
AIAN people and non-Native populations	10 (90.9%)	31 (39.2%)	45.56%
Primarily service one tribe or multiple			
One tribe	3 (27.3%)	25 (31.6%)	31.11%
Multiple	8 (72.7%)	54 (68.4%)	68.89%
Approximate % of people seen 60 years and older			
0-30%	3 (27.3%)	34 (43.0%)	41.11%
31-60%	4 (36.4%)	32 (40.5%)	40.00%
61-100%	4 (36.4%)	13 (16.5%)	18.89%

Table 3 Interview Participant Responses on Elder Abuse and Mistreatment Experiences

	Non-health care providers	Health care	Total
	n=10	n=13	n=23
Outpatient providers are capable of identifying all different types of elder abuse			
Strongly disagree	0 (0.0%)	0 (0.0%)	0.0%
Disagree	2 (22.2%)	1 (7.7%)	13.6%
Neutral	2 (22.2%)	1 (7.7%)	13.6%
Agree	4 (44.4%)	8 (61.5%)	54.5%
Strongly agree	1 (11.1%)	3 (23.1%)	18.2%
Have adequate training in elder mistreatment, detection, management, and reporting	3 (33.3%)	9 (69.2%)	54.5%
Would like to receive training in elder mistreatment, detection, management and reporting	8 (88.9%)	10 (76.9%)	81.8%
State requires mandatory reporting of suspected cases of elder abuse			
Yes	7 (70.0%)	7 (58.3%)	63.6%
No	1 (10.0%)	5 (41.7%)	27.3%
I don't know	2 (20.0%)	0 (0.0%)	9.1%
Tribe requires mandatory reporting			
Yes	6 (66.7%)	6 (54.5%)	60.0%
No	3 (33.3%)	5 (45.5%)	40.0%
Clinic has a screening process for elder mistreatment or domestic violence	1 (9.1%)	48 (60.8%)	54.44%
Yes	3 (30.0%)	9 (69.2%)	52.2%
No	1 (10.0%)	4 (30.8%)	21.7%
I don't know	1 (10.0%)	4 (30.8%)	21.7%
Does acculturation make a person/family more or less likely to experience abuse?			
Less Likely	0 (0.0%)	0 (0.0%)	0.0%
More Likely	8 (80.0%)	5 (41.7%)	59.1%
No Relationship	0 (0.0%)	4 (33.3%)	18.2%
I don't know	2 (20.0%)	3 (25.0%)	22.7%
Made referral to APS	-	9 (69.2%)	69.2%
Made referral to law enforcement	-	5 (38.5%)	38.5%

Made a referral to another entity	-	5 (38.5%)	38.5%