

# THE IHS PRIMARY CARE PROVIDER



*A journal for health professionals working with American Indians and Alaska Natives*

May 2000

Volume 25, Number 5

## Editor's note:

This May issue of THE IHS PROVIDER, published on the occasion of National Older Americans Month, is the fifth annual issue dedicated to our elders. We are grateful for the opportunity to honor our elders with a collection of articles devoted to their health and health care. Indian Health Service, tribal, and urban program professionals are encouraged to submit articles for the May 2001 issue on elders. We are also interested in articles written by Indian elders themselves giving their perspective on health care issues. Inquiries can be addressed to the attention of the editor at the address on the back page of this issue.

## Healthy People 2010: Reaching American Indian/Alaska Native Elders

*M. Yvonne Jackson, PhD, Director, Office for American Indian, Alaskan Native and Native Hawaiian Program, Administration on Aging, DHHS, Washington, DC*

The number of older American Indians and Alaska Natives (AI/AN) is increasing rapidly. In 1910, the 13,086 elders represented 4.9 percent of the total Indian population. By 1990, the number of elders had increased to 116,000, representing 5.9 percent of the AI/AN population. These numbers are expected to increase to 430,000, or 12.2 percent of the AI/AN population by 2030.<sup>1,2</sup>

As we begin the new millennium and continue to seek improvement in the health of all people in the U. S. through the Healthy People 2010 goals for the nation, we must all work together to assure that AI/AN elders are both participants in and beneficiaries of activities to achieve these goals. Collaborative efforts among elders, health care providers, program planners, and funding agencies will contribute to finding effective solutions for improving health and quality of life.

### **HEALTHY PEOPLE 2010: Goal 1. Increase quality and years of healthy life**

The first goal of Healthy People 2010 is to help individuals of all ages to increase life expectancy and improve their quality of life.<sup>3</sup> Although their life expectancy at birth continues to be lower than that of other ethnic groups, once

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AI/AN reach age 55, they experience a lower death rate than the general population, and many can expect to live well into their eighties and nineties. Unfortunately, increases in longevity are frequently accompanied by disabilities and a declining health status, resulting in a reduced quality of life.

*Functional Limitations and Disability.* There are many definitions for functional limitations and disability and no universally accepted standard for measuring them. A group of commonly used measures of function are activities of daily living (ADL), which include the abilities to eat, toilet, dress, bathe, and get in and out of chair/bed, and instrumental activities of daily living (IADL), such as abilities to prepare one's own meals, do light housework, use the telephone, shop for personal items, and manage one's own money. In assessing the functional status of participants in the tribal elderly nutrition program (Title VI Program), 42 percent of the home-delivered meal participants and 21 percent of the congregate meal participants reported that they had much difficulty with or were unable to perform one or more IADL. Over 31 percent of home-delivered and 10 percent of the congregate meal participants reported that they were unable or had much difficulty to perform one or more ADL. Nearly one fourth of the home-delivered meal participants were unable to walk or had difficulty walking without assistance, and one fifth were either unable to take a bath or shower or had difficulty doing so without assistance.<sup>4</sup>

American Indians and Alaska Natives have the highest rate of reported disability of any racial/ethnic group in the U.S. In 1994-1995, 63 percent of AI/AN elders, age 65 and older, reported having a disability, with 52 percent reporting a severe disability. This compares with 52.5 percent of the general population, age 65 and older, reporting any disability, and 33.4 percent reporting a severe disability.<sup>5</sup>

The presence of more than one chronic disease is related to current disability and to that person's future risk of disability.<sup>6,7</sup> Modifiable risk factors, such as regular exercise, smoking cessation, and maintaining a healthy weight, have been found to help prevent or minimize disability.<sup>8-10</sup>

*Health Status.* How a person perceives her or his own health and functional status is an important measure of health status. A large proportion of older AI/AN perceive their health status as fair or poor. Data from the Behavioral Risk Factor Surveillance System (BRFSS) for 1993-1997 on AI/AN men indicate that self-reported health status declines with age. Ratings of fair or poor health were given by 23 percent of the men age 55-64, 32 percent of those age 64-74, and 49 percent of those over age 75. Although many older AI/AN women rated their health status as fair or poor, their reported health status did not decline with age. The percent of women rating their health as fair or poor health for ages 55-64 was 44 percent, 42 percent for those age 65-74, and 39 percent for those age 75 and older.<sup>11</sup> These percentages are probably conservative, since the BRFSS relies on telephone interviews, and many AI/AN elders do not have telephones and are more likely to be poor and have more health problems.<sup>12</sup>

Over half the Title VI Program participants reported having three or more diagnosed chronic health conditions, with arthritis, hypertension, diabetes, heart disease, and respiratory problems reported most frequently.<sup>4</sup> Older Indians living in Michigan reported having an average of 3.9 chronic conditions, with arthritis, hypertension, diabetes, obesity, and vision and heart problems identified most frequently.<sup>13</sup> These results are similar to risk factors identified for functional status

decline in the general elderly population. A survey of published studies on functional status decline found comorbidity, overweight and underweight, vision impairment, and poor self-perceived health status to be risk factors.<sup>14</sup>

Another measure of health status is access to and utilization of health care services. Available data indicate that AI/AN elders have a fairly high rate of health service utilization. Elders, age 65 and older, comprise 6.1 percent of the IHS user population, but represent 21.7 percent of inpatient days, 14.5 percent of hospital discharges, and 11.0 percent of ambulatory medical clinical impressions.<sup>15</sup> Although AI/AN elders are heavy users of health care services, they use less than the general elderly population. In 1994, Indians age 65 and older had a much lower hospital discharge rate than the general population, 178.5 per 1000 population compared to 341.6, respectively. National data on visits to physicians' offices provide some insight on AI/AN medical care outside of the IHS system. Although the number of physician visits by AI/AN are an aggregate of all age groups because of small numbers, data from the 1997 National Ambulatory Medical Care Survey indicate that American Indians of all ages averaged 1.3 physician visits compared to 3.0 visits for all persons.<sup>16</sup> Nationally, less money is expended for AI/AN health care. The IHS per capita health care expenditure in 1996 was \$1,578, compared to \$3,920 for the U.S. civilian population.<sup>17</sup>

## HEALTHY PEOPLE 2010: Goal 2. Eliminate health disparities

The second goal of Healthy People 2010 is to eliminate health disparities among different segments of the population.<sup>3</sup> Great strides have been made in improving the health status of AI/AN. Within the past 25 years, life expectancy at birth for AI/AN has gone from 8 years less than that of the U.S. general population to 2.6 years less.<sup>15</sup> Additionally, advancements in medical science have improved the diagnosis and treatment of many diseases, thus preventing premature disability and death. Chronic diseases now rank among the leading causes of death in the AI/AN. As shown in Table 1, the leading causes of death in the AI/AN and non-Indian older populations are the same, although the rankings and rates differ between different age cohorts of the same population and the different races. Cancers are the second leading cause of death for all populations over age 65 and Indians between ages 55 and 64, and the leading causes of death for all other populations, ages 55 and 64.

**Table 1. Ten Leading Causes of Death for Decedents age 65 and older (Rate per 100,000 population)<sup>15</sup>**

| DISEASE  | AI/AN* |        | All Races |        |
|--|--------|--------|-----------|--------|
|  | Rate   | (Rank) | Rate      | (Rank) |
| Diseases of the heart                                      | 1,538  | (1)    | 1,891     | (1)    |
| Malignant neoplasms  | 931    | (2)    | 1,134     | (2)    |
| Cerebrovascular diseases                                   | 325    | (3)    | 402       | (3)    |
| Diabetes   | 312    | (4)    | 124       | (6)    |
| Pneumonia & influenza                                      | 265    | (5)    | 225       | (5)    |
| Chronic obstructive pulmonary diseases & allied conditions | 141    | (6)    | 264       | (4)    |
| Accidents  | 114    | (7)    | 85        | (7)    |
| Nephritis, nephrotic syndrome, & nephrosis                 | 108    | (8)    | 60        | (8)    |
| Chronic liver disease & cirrhosis                          | 75     | (9)    | 32        | (10)   |
| Septicemia   | 58     | (10)   | 51        | (9)    |

*Cardiovascular Diseases (CVD).* Although mortality rates vary by age, race, and sex, CVD are the leading cause of death in the United States. Healthy People 2010 calls for improving cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and prevention of recurrent cardiovascular events.<sup>3</sup>

The 1992 age-adjusted mortality rate per 100,000 population was 180.4 for the general population and 132.8 for the Indian population. The rates for the two major components of CVD, coronary heart disease and stroke, were 107.1 and 19.1 in the AI/AN population and 144.3 and 26.2 in the general population.<sup>18,19</sup> Although it appears that AI/AN have lower CVD rates than the rest of the population, these reported rates are probably much lower than the actual rates. The National Center for Health Statistics estimates that death rates for all causes of death combined, corrected for both misreporting of race on the death certificates, and population undercounts in census files, would be 21 percent higher than currently reported.<sup>20</sup> Using this correction for the AI/AN rate, the CVD death rate would be 160, the coronary heart disease death rate would be 130, and the stroke death rate would be 25.

Available data indicate a great deal of variation in the death rates from CVD among the various American Indian tribes.<sup>21,22</sup> While the national death rate from CVD for AI/AN in 1996 was 191.4, the rate varied from highs of 498.2 in Michigan and 384.6 in South Dakota to lows of 173.0 in New Mexico and 146.1 in California.<sup>23</sup> In looking at the CVD death rates for women, researchers at the University of West Virginia found the death rate to be 259 per 100,000 AI/AN women for the period 1991-1995. They also found a great deal of geographical variation, with low rates of heart disease mortality in American Indian women in Oklahoma and New Mexico and high rates in South Dakota, Montana, and Minnesota.<sup>24</sup>

A recent report from the Strong Heart Study compared heart disease incidence data on American Indians with comparable data from two national population studies. They found that the rates for stroke in American Indians appear to be lower for men and similar for women to non-Indians. However, the rates for coronary heart disease for both American Indian women and men were nearly twice as high as the rates for the other study populations. These researchers suggest that American Indians appear to have increasing rates of CVD, most likely due to the high prevalence of diabetes.<sup>25</sup>

The incidence of hypertension, a major risk factor for CVD, is increasing in some AI/AN populations. A 1992 study of the Pima Indians indicated that 40 percent of the Pima males and more than 30 percent of Pima females had hypertension.<sup>26</sup> Data from the Strong Heart Study indicate that hypertension prevalence in Indians in Oklahoma and Arizona, age 45-74, is between 38 and 43 percent, while the rates for Indians living in North Dakota and South Dakota are around 28 percent.<sup>27</sup>

AI/AN elders appear to be vulnerable to the effects of CVD risk factors in the same way as other populations. Diet, physical activity, obesity, diabetes, hypertension, smoking, and low HDL cholesterol have been identified as major, modifiable contributors to the development of CVD.<sup>28,29</sup> Additionally, due to the high prevalence of obesity and diabetes in AI/AN elders and their association with multiple CVD risk factors, prevention and control of obesity and diabetes are vital for reducing the risks for developing CVD.

*Cancer.* Cancer is the second leading cause of death in the U.S. The death rate is higher for men and increases in older age groups. Healthy People 2010 calls for reducing the number of new cancer cases as well as the illness, disability, and death caused by cancer.<sup>3</sup> To help accomplish this, one of the objectives is to reduce the overall cancer death rate to 157.8 cancer deaths per 100,000 population.

The 1992-1994 cancer death rate for AI/AN, age 65 and older, was 931 per 100,000 population; for the general population over age 65, the comparable figure was 1,134.<sup>3,15</sup> However, a study conducted by the National Cancer Institute found that only 60 percent of cancer patients registered with the IHS as American Indians were so identified in a cancer surveillance registry.<sup>30</sup> Thus, the actual cancer death rate for AI/AN elders may be as high as 1,300 per 100,000.

Available data indicate that AI/AN experience higher mortality rates from stomach, liver, kidney, cervical, and gallbladder cancers than the general population, and that the five-year survival rates for AI/AN are among the poorest for all cancer sites combined of any racial group in the U. S.<sup>31-33</sup> Investigators have suggested that AI/AN cancer patients may experience the disease differently from other populations and that more research needs to be done on genetic risk factors, access to screening, diagnostic and treatment methods, and other factors.<sup>34</sup>

Cervical cancer is of particular concern since AI/AN women have one of the highest incidence rates (19.5/100,000) and mortality rates (5.5/100,000).<sup>35,36</sup> Two of the Healthy People 2010 objectives focus on cervical cancer: reduce the death rate from cervical cancer to 2.0 deaths per 100,000 women, and increase the proportion of women who have ever had a Pap test to 97 percent and those who have had one within the preceding three years to 90 percent.<sup>3</sup>

Since the likelihood of cervical cancer survival is almost 100 percent with appropriate treatment and follow-up if it is detected early, it is estimated that regular Pap test screening could reduce cervical cancer mortality by 37-60 percent.<sup>3,37</sup> Several studies have documented the low rate of Pap test screening among AI/AN women. Results from an Indian-specific health risk appraisal completed by members of three Sioux Tribes, age 45 to 74, indicated that one third of the women had not had a Pap test in the last 3 years and 4 percent had never had one.<sup>38</sup> Similarly, Risendal and coworkers found that 39 percent of urban Indian woman, age fifty and older, had not had a Pap test within 3 years and nearly 7 percent had never had one.<sup>39</sup>

Early detection is a major factor in survival from many forms of cancer. However, older AI/AN are infrequent users of early cancer detection programs in comparison with other racial groups.<sup>40</sup> Some barriers to accessing these programs are unique to AI/AN, including health practices and beliefs, such as that talking about cancer will invite the cancer spirit into the body, and other barriers that are common to all populations, such as education, communication, and transportation.<sup>41</sup>

*Diabetes.* Diabetes and its complications are major contributors to morbidity and mortality in AI/AN elders. Healthy People 2010 calls for reducing the disease and economic burden of diabetes through prevention programs, and improving the quality of life for all persons who have or are at risk for diabetes. Among the several objectives aimed at achieving this are: 1) prevent diabetes by targeting and

reducing the number of new cases to 2.5 per 1,000 persons per year; 2) reduce the diabetes death rate to 45 deaths per 100,000 persons; 3) reduce kidney failure due to diabetes to 78 diabetic persons with end-stage renal disease per million population; and 4) reduce the rate of lower extremity amputations in persons with diabetes to 5 per 1,000 persons with diabetes.<sup>3</sup>

Currently there are 8.7 new cases of diabetes per year diagnosed in the AI/AN population, and 197 deaths per 100,000 AI/AN with diabetes.<sup>3</sup> The overall prevalence of diabetes varies among tribes, with Plains tribes having a prevalence of nearly 13 percent, a prevalence of 10.5 percent among tribes in the Southwest, 9 percent among the Woodland tribes, and 4.5 percent among tribes of the Pacific Coast.<sup>42</sup> In 1996 the prevalence of diabetes among AI/AN age 65 and older was 21.5 percent, nearly twice the prevalence among non-Hispanic whites. The diabetes death rate of 312 for AI/AN age 65 and older is 2.5 times the death rate for general population of the same age. The death rate of 160 for AI/AN age 55-64 is 4.5 times the death rate of the general population of the same age.<sup>15</sup>

Diabetes complications, especially end-stage renal disease (ESRD) and lower-extremity amputations (LEA), are major causes of morbidity and mortality among older Indians. In 1993-1997, diabetic ESRD accounted for 65 percent of all ESRD cases in AI/AN. During this time period, the diabetic ESRD incidence for American Indians was nearly five times higher than that for whites.<sup>43</sup> American Indians with diabetes have a higher prevalence of hypertension, which has been found to be a significant predictor of renal disease.<sup>44-46</sup> Evidence continues to show that controlling diabetes and blood pressure can reduce diabetic kidney disease and slow or halt progression of kidney disease to ESRD.

Amputation rates are also increasing. Between 1981 and 1989, the crude rate of LEA increased from 20 to 120 per 10,000 American Indians with diabetes. The proportion of LEA attributed to diabetes was 68 percent among American Indians compared to 45-50 percent in the general population.<sup>47</sup> Controlling diabetes can reduce the need for amputations and increase the quality of life.

Diet, sedentary lifestyle, and obesity are modifiable risk factors for the development of diabetes and its complications. The dramatic changes over the past century in both the types and quantities of food available and the physical activity of American Indians has contributed to the increasing rates of obesity and diabetes.<sup>48</sup>

## Summary

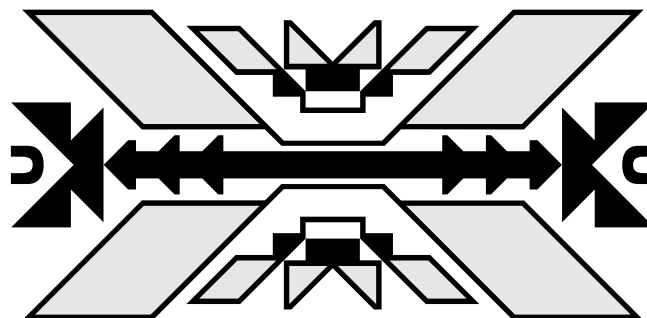
Available data indicate that as life expectancy for American Indians increases, the number of chronic diseases increases and functional ability decreases. From estimates of disability prevalence, Hayward and Heron concluded that AI/AN can expect to live long lives with many years of poor health due to their levels of chronic health impairment.<sup>49</sup> However, current data collection systems are not adequate to report on the health and disability status of AI/AN elders. The lack of national data systems to measure and monitor AI/AN-specific health and disability status data poses a significant barrier to developing and implementing collaborative programs targeted at improving health and eliminating health disparities. Additionally, without adequate data on the extent of disease and disability in the AI/AN elder population, tribes are

disadvantaged when applying to funding institutions and agencies for health promotion and disease prevention programs. As we embark on the Healthy People 2010 initiatives, it is time to put systems in place in order to assure all population groups, regardless of race, are able to participate fully in efforts to increase the quality and years of healthy life and eliminate health disparities among different segments of the population. □

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# The Impact of Arthritis on American Indian and Alaska Native Elders

Robert John, PhD, Biedenharn Chair in Gerontology, University of Louisiana at Monroe, Monroe, Louisiana; Catherine Hagan Hennessy, DrPH, Epidemiologist, Centers for Disease Control and Prevention, Atlanta GA; and Dave S. Kerby, PhD, Assistant Professor of Psychology, University of Louisiana at Monroe, Monroe, Louisiana

It is well established that arthritis is a major cause of functional impairment and disability among all ethnic and racial groups.<sup>1,2</sup> According to the National Arthritis Action Plan,<sup>3</sup> arthritis is the leading cause of disability in people over age 65 and costs the nation more than \$60 billion a year. Based on an analysis of the National Health Interview Survey,<sup>2</sup> among American Indians, arthritis is second only to deformity or orthopedic impairments as a self-reported chronic condition, and is also the second leading cause of activity limitation.

Studies of American Indian health and aging issues suggest that arthritis is an important chronic health problem with significant associated impairments of functional abilities. Research has compared the estimated prevalence of self-reported arthritis and impairment attributable to arthritis among Whites, Blacks, American Indian and Alaska Natives (AI/AN), Asians and Pacific Islanders (API), and Hispanics.<sup>2</sup> According to this study, the AI/AN population has the highest estimated age- and sex-adjusted annual prevalence of arthritis among the groups studied. Moreover, the proportion of AI/ANs who reported an activity limitation attributable to arthritis (22.6%) was second only to Blacks (24.5%). However, the AI/AN population had the highest age- and sex-adjusted self-reported activity limitation attributable to arthritis (4.2%).

Findings from the Survey of American Indians and Alaska Natives (SAIAN)<sup>4</sup> confirmed that arthritis and related conditions are the most common chronic disorders among older American Indians who are part of the IHS service population. Almost half (48.6%) of SAIAN respondents over age 65 reported having arthritis (44.3% among men and 52.2% among women) and 16.3% of American Indian elders in SAIAN experienced rheumatism (19.5% among men and 13.6% of women).

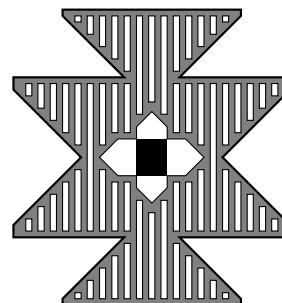
Unfortunately, none of the studies of arthritis among American Indians and Alaska Natives has investigated the burden of arthritis or its social meaning to those so affected. The social meaning and social impact of arthritis have important implications for any public health effort that will address the consequences of this chronic health problem in this population. There is no literature describing how the disease is perceived or experienced, how these perceptions influence self-care practices or preferred treatments for arthritis -- despite the fact that some between-group differences in arthritis

prevalence may be attributable to "variations in cultural thresholds for reporting arthritis"<sup>2</sup> as well as a different distribution of known risk factors (e.g., overweight, physically demanding occupations) or risk markers (e.g., low socioeconomic status or low educational attainment).

Because very little research has been conducted on arthritic conditions and the burden of this illness among American Indian elders, and specifically the cultural issues surrounding illness and disability, the Centers for Disease Control and Prevention is collaborating with the Gerontology Program at the University of Louisiana at Monroe, and the Indian Health Service Elder Care Initiative to investigate the social impact of arthritis on the aging American Indian population. This study will be conducted over the next two years through a combination of secondary analysis of existing data and original research specifically focused on the relationship between arthritis, functional status, cultural values, and the quality of life of American Indian elders. New endeavors will include evaluating and adapting instruments for measuring health-related quality of life and the impact of arthritis among American Indians, and conducting surveys of the prevalence and impact of arthritis among elders in three IHS regions. This study should create baseline data necessary to develop and evaluate effective arthritis interventions in future years. □

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## An Elder's Thoughts on Aging

*"...Right now  
I put that aside  
and see the  
good days..."*

This is about Aging. I have very much experience with aging, and it is the length of time in every human being as a person or part of one's life. Maturity is the years of aging when you reach to an adult status; I am in this status. During my younger years as I was growing up, things, material-wise, were not easy to buy and have. During war, men left home to fight and we lived on rations. And there was no sickness of any kind – seldomly, yes, but not as bad as today.

Today the main issue of sickness is diabetes. People are puzzled how this sickness came about and how it will be cured. In the past years that I have been with the program at Zuni Senior Center, I have known some of the elders during my younger years. This is about aging so I should say some of the elders have aged. Even though they are well and in good spirits, it's a blessing to them that they are taken good care of at the good facilities here at the center. Doctors and nurses are nearby to care for a sick person at Blackrock Hospital, thanks to the professionals.

I live on the outskirts of the village. I work as a volunteer helper; I am a foster grandparent. It is truly good to be with people that you never meet, unless we have our traditional gathering. I work with two dedicated teachers; they are very patient with the children. Being a foster grandparent is a good feeling, and to be recognized by the children, and being called grandma from another person or parent's child, this is part of my experience. Aging is most important in everybody's life. Now days, there are so many things to consider, like our younger generation that are on drugs that are on the reservation. During my days nothing was known as marijuana; today it is a problem.

Hoping our children will be at this age and reach to the aging point, as of this day, I have seen problems and myself have those day. Right now, I put that aside and see the good days and enjoy being at the Zuni Senior Center with my peers at this wonderful place. Just like a second home to everyone. Thank you.

Imogene Epaloose  
Zuni, New Mexico

## A New PCC Comprehensive Elder Exam Form

*Bruce Finke, MD, Director, Elder Care Initiative, and Staff Physician, Zuni-Ramah Service Unit, Zuni, New Mexico*

The PCC Comprehensive Elder Exam is finally completed. This is a brand new Patient Care Component (PCC) encounter form, designed to guide the provider through a state-of-the art geriatric exam. With it comes the RPMS (Resource and Patient Management System) modifications to allow us, for the very first time, to document and track the functional status of our elders. While designed for use in the PCC/RPMS system, it can also be used as a stand-alone form.

There are a number of features that set this PCC form apart from generic exam forms. The first, and arguably most important, is the inclusion of functional status. The role of functional status determination in geriatric care has been discussed previously in these pages ("Functional Assessment in the Elderly," November 1998, Volume 23, Number 11, pp. 149-152). It is an essential component of a quality geriatric exam. Software has been written and is now available which will allow data entry personnel to enter functional status into the RPMS system and report this information on the health summary. These data will also be available for epidemiologic inquiries. Sites that take advantage of this capability will be able to determine the rate of functional dependence in their elderly user population, which is critical information for health care system planning.

The Geriatric Review of Systems (ROS) also sets this PCC apart from a more generic encounter form. The traditional organ

system ROS does not capture high prevalence, multifactorial geriatric syndromes (i.e., falls, incontinence, pain) and overemphasizes disease-finding. The Geriatric ROS emphasizes the most important health issues for geriatric patients while allowing us to ask the kinds of questions that will give us critical information about both function and potentially treatable disease.

Elder-specific preventive care triggers are included on the right hand side bar of the PCC. These can be used both as provider reminders and as a place to note the dates of the last exam or test. In previous articles we have discussed the U.S. Preventive Services Task Force (USPSTF) recommendations for preventive care for older persons ("The USPSTF Recommendations," January 1999, Volume 24, Number 1, p. 8) and the role of the periodic preventive visit as a way to implement these recommendations ("Prevention and the Periodic Health Examination for Elders," December 1999, Volume 24, Number 12, pp 183-184).

On the reverse of the front page are a variety of guides and assists to help the provider who may be less familiar with the geriatric exam. These are just some of the unique features of the PCC Comprehensive Elder Exam form. The form reprinted on page 81 is the beta test version, and you can expect to see a few minor changes in the final form. I will send a notice to all Clinical Directors and urban clinics when the first printing is completed (sometime within the next month). This PCC represents a major step forward in our ability to provide quality care to our geriatric patients. □

PCC COMPREHENSIVE ELDER EXAM

Date: \_\_\_\_\_

Arrival Time: \_\_\_\_\_ AM/PM

Clinic: \_\_\_\_\_

Appt: \_\_\_\_\_

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)

Remove | Move to Inactive | Move to Active

Grid for PROVIDERS, PRIMARY PROVIDER, and OTHER CODE

Functional Status (ADL, IADL), Tobacco/Alcohol/Exercise, Review of Systems, PMH/Surgeries/Hospitalizations, BP, Pulse, Temp, Wt, Vision, etc.

Chief Complaint/Review of System/Physical Exam

Table with columns: Exam (HEENT, Neck, Lungs, Heart, Abdomen, Extremities, Feet, Pulses, Genitalia, Skin, Nodes, Neuro, Breast, Pelvic, Rectal, Mobility, Cognition) and rows for exam findings.

Other Test/Procedures Ordered

Table with columns: A-A1-C #, Purpose of Visit, Problem List Update, and rows for various tests/procedures.

List all Medications, Est. Creatinine Clearance, InSTRUCTIONS TO PATIENT, SIGN RELEASE RECORDS

Medications/Patient Education, INSTRUCTIONS TO PATIENT, SIGNATURE



**Functional Status**

ADL = Activities of Daily Living (Katz)  
 Toileting: getting to the toilet  
 Bathing: maintaining basic hygiene  
 Dressing  
 Transfers: in and out of bed or chair  
 Feeding: getting food from plate to mouth  
 Continence: independence includes management of one's own continence care.

IADLs = Instrumental Activities of Daily Living  
 Finances: paying bills, balancing checkbook, cashing checks  
 Cooking: meal preparation  
 Shopping  
 Housework/Chores: as appropriate to roles  
 Medications: Manages own medications  
 Transportation: Able to get about independently

**Community Services** might include:  
 Senior Center  
 Meals on Wheels  
 Commodities programs  
 Senior Daycare  
 Home Health Nursing  
 Public Health Nursing  
 CHR visits  
 Community based long term care

**Advance Directives**  
 sample questions  
 Many people have an idea of what they want done if they should get sick and not be able to give us instructions. Have you thought about this? Do you have any instructions for us?  
 Have you talked this over with family members? Is there someone we should talk to about this?

**Assistive Devices** might include:  
 Cane  
 Walker (regular or rolling)  
 Wheelchair  
 Crutches  
 Splints  
 Reacher

**Home Equipment** might include:  
 Bathrails  
 Bath Chair (simple or total transfer)  
 Raised Toilet Seat  
 Bedside Commode  
 Incontinence briefs

**Signs of Changing Mental Status**

- Decreasing functional status without obvious cause
- Difficulty managing finances (forgets bills, overdrafts checking account)
- Diminished attention to hygiene or appearance
- Gets disoriented or lost in previously familiar places
- Asks about people who have died
- Accuses family or others of doing harm or stealing things
- Sudden mood changes
- Forgets who people are.
- Loses things
- Restricts activities to home
- Spends more time sitting or in apparently purposeless activity
- Wanders
- Loses track of mealtimes
- Nighttime disorientation
- Bowel or bladder incontinence

**Review of Systems** sample questions

**Hearing:** Do you have difficulty hearing conversation one on one or in a group? Do you have difficulty hearing with background noise? Can you listen to radio or television?

**Vision:** Do you have difficulty seeing well enough to do what you want to do? Is night time difficult? Does glare bother you? Do you have eye discomfort or dryness?

**Dentition/Nutrition:** Do you have any trouble chewing? Are there foods you can't eat? Who prepares your meals? What is a typical breakfast, lunch, dinner? Do you have trouble getting food in the house?

**Sleep:** Do you sleep well? Do you have difficulty falling asleep? Do you wake up during the night? Do you feel rested in the morning? Are you sleepy during the day? Do you take naps? Are you ever short of breath at night?

**Continenence:** Do you lose control of your urine or bowels?

**Prostatism:** Do you have difficulty starting to void? Do you have dribbling at the end? Do you awaken at night to void? How many times?

**Digestion:** Do you have trouble with constipation or diarrhea? Any problems with swallowing? Does it seem to take you a long time to eat? Do you have indigestion, or a sour taste in your mouth?

**Mobility:** Are you having any difficulty or pain with walking? How far can you walk? Does pain or weakness limit your ability to do the things you want to do?  
 Do you have shortness of breath, chest pain or leg pain when you walk?

**Falls:** Have you fallen in the last several months? In the last year? What happened?

**Pain:** Do you have pain? Does it interfere with sleep or activities?

**Cognition:** (Best assessed with observation and collateral information. See Signs of Changing Mental Status)

**Substance Abuse:** Do you use alcohol, marijuana, other drugs? Have you ever drank 5 or more alcoholic drinks on one occasion? Is there alcohol or drug use in the family? How does it affect you?

**Abuse/Neglect:** Are there times that you don't get the help you need from your family? Have you been yelled at or hit? Does anyone use your money in ways you don't approve of?

**Skin:** Do you have dry skin, itching, rash, or bruising?

**Sexual function/Gyn:** Are you satisfied with your sex life? Do you have dryness, discomfort or discharge in the vaginal area? Have you any vaginal bleeding? Do you have difficulty with getting or keeping an erection?

**Office Based Mobility Assessment**  
 (Tinetti)

- Patient gets up from chair without use of hands, walks forward, turns around, walks back to provider.
- Examiner nudges the patient gently on sternum three times, observes the patient with patient's eyes closed.
- Patient turns head, reaches up, bends over
- Patient sits without use of hands.

**Observe:**

- Initiation of movement
- Gait pattern (initiation, step height, step continuity, step symmetry, foot deviation, turning)
- Positional vertigo
- Ability to follow verbal command
- Dynamic and static balance
- Functional range of motion
- Fear of falling

**References**

Tinetti ME, Ginter SF: Identifying mobility dysfunctions in elderly patients, JAMA 259:1190, 1988.  
 Katz S et al: The index of activities of daily living: a standardized measure of biological and psychosocial function, JAMA 185: 914, 1963.  
 Cockcroft DW, Gault MH: Prediction of creatinine clearance from serum creatinine, Nephron 1976, 16:31.

**Estimated Creatinine Clearance**  
 (Cockcroft and Gault)

$(140 - \text{age, yr}) / (\text{lean body weight, kg})$   
 $72 \times (\text{serum creatinine, mg/dl})$   
 for women multiply by .85

\*U.S. GPO: 1999-515-389/94518

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# Elder Health Care: A Challenge for the Provider and the Family

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*Eileen J. Lourie, MD, MPH, Director, Health Promotion/Disease Prevention Program, Phoenix Area Indian Health Service; and N. Burton Attico, MD, MPH, Director, Maternal Child Health Program, Phoenix Area Indian Health Service, Phoenix, Arizona; both members of the Phoenix Area Elders' Committee*

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## Introduction

Elder health care represents a challenge for the provider, the family, and the elder, as well as the entire health care system. As the number of elders increases, the health care system, and other support/care systems, must address numerous vital issues involved with elder care. Too often, our care bypasses the elder, treats him/her as incidental, and neglects common, essential features of the activities of daily living, or even common courtesy. This article will review some of the issues that are uniquely important in elder health care, and suggest some approaches to improved care for this segment of the population.

## Communication

We should always ask elders first how they would like to be addressed. We should not assume that the elder wants to be called by his or her first name. Today's elders grew up at a time when they were expected to address their elders with respect and reverence. The elder usually expects that this same courtesy will be given to him or her. For example, an elder patient might be thinking, "If you don't call me Elsie, I won't call you Sonny."

With an explanation to the elder as to the necessity for this, providers should communicate with the elder's family whenever the elderly patient appears to have problems with comprehension, such as memory loss, dementia, etc. Of course it should not be assumed that a comprehension problem signals dementia; it might be use of unfamiliar terms by the provider, language barriers (either that of the patient or the provider), or hearing loss.

Do not assume that the description of current symptoms, the past medical history, or the social and environmental history given by the patient is complete or accurate. It is possible that although the elder may have dementia or some other condition, the provider may not know this at that first encounter, since he or she may not know the patient and has no way of corroborating the information if family members are not present. Even if a provider is aware of the diagnosis of dementia, the elder's responses may seem perfectly reasonable, when, in fact, they may not be accurate. For example, an

elderly patient may tell the doctor that she is not having any side effects from a specific medication when, in fact, she was forgetting to take the medication, which the family realized, but the provider had no way of knowing.

It is important to obtain an accurate social history and assessment of the home situation, which should usually be corroborated with a family member, particularly when the elder needs to carry out a treatment regimen that will require help, if she or he is being discharged from the hospital and is still recovering, or if he or she is being discharged after ambulatory surgery. For example, consider the case of a relatively independent 86 year-old woman who was being discharged after surgery. No one had ascertained that this woman lived alone. At that point, she would not have been able to care for herself, had no groceries at home, and actually did not have the key for her home with her. Family or friends should have been consulted as a part of coordinated discharge planning.

However, having said all of this, even if the elderly patient does have comprehension problems, we should speak to them about their medical problems; we should not leave them out or speak about them in the third person. When a family member is present, comments should not be directed only to the family member. Unless one is actually aware that the elder is hard of hearing, one should not assume that she or he is so impaired. In other words, don't treat the elder as if he or she is not present or as if they are someone for whom someone else needs to speak. We should preserve their dignity and sense of self-worth, and recognize that they must be involved (to whatever degree they can participate) in making their own decisions. For example, how would an elder feel if the doctor, speaking of a diagnosis of a chronic disease, addresses only the elder's adult son, lowering his voice, as if the elder were not present, or as if this would not concern her or him.

## Drug/Medication Issues

Use medicine bottles that can be opened easily. Specifically ask the elder if there are grandchildren or other small children around, which may make it necessary to use child resistant bottle caps. Ask the elder if she can manage child resistant bottle caps before dispensing medications using them. In fact, you may even want to ask the elder to demonstrate their ability to do this, since it may be embarrassing for the individual to admit that they cannot. Such difficulties, which may not be voluntarily expressed, may impose an artificial, iatrogenic medication compliance problem.

If the medication instructions are to "take one-half of a pill," the pharmacy may need to have the pills prebroken, as

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seniors, who may have arthritis, decreased manual dexterity, tremulousness, or poor eyesight, may have difficulty breaking pills into the proper size, even with pills that are already scored.

Periodically review all medicines for drug interactions and to be certain that the same medicine, under different brand names, is not being taken, especially with patients who are possibly seeing several different providers. For example, a patient who is taking Lanoxin and digoxin, thinking that they were different medicines, is at great risk for dangerous adverse reactions. In this case, the second medication had unknowingly been prescribed by a physician who did not have accurate information about all of the patient's medications.

If the elder is being seen at an IHS facility, the IHS unified medical record (and the computerized medication profile) will help keep all records (and medications) in a single database. The provider should ask if the patient is using herbal or alternative therapies or medications, or over-the-counter medicines. If at all possible, ask the elder to fill all prescriptions at the same location, such that a medication profile may be kept that can be used to check for potential drug interactions. However, as this may not always be convenient for the patient, consider developing a small card (similar to an immunization record), which the elder could carry and have updated every time they have a prescription filled, or whenever they buy an over-the-counter or alternative medicine, so as to have a complete medication list. An example of such a card will be printed in an upcoming issue of THE PROVIDER.

Assure that dosages have been adjusted for age, as well as for associated comorbidities. Remember that a serum creatinine in the "normal" range in someone in their 80s may be misleading; when in doubt, measure or calculate creatinine clearance to see if dosages need to be adjusted. There are also some common drugs that are known for causing cognition problems in the elder patient (e.g., oxybutynin, some analgesics, and many psychotropics); this altered cognition might be misdiagnosed as dementia, which might result in continuing or even increasing the dosage of the drug. Providers (doctors, nurses, pharmacists, nurse practitioners, physician assistants, etc.) need to be cognizant of the facts that: 1) a commonly used medicine may react quite differently in an elderly person; 2) a medication may require a different dosage, or may have different side effects in an elder; and 3) a disease process may manifest itself differently in an elderly patient. Some medications are known to interfere with balance in the elder. For example, alpha- and beta-blockers may precipitate dizziness in elders, thereby causing falls.

Make sure that the minimum number of medications are prescribed, and that the dosing schedules are not complex, especially if the elder is managing the medications by him or herself. This is particularly important if the elder is being seen by several physicians, each managing a different aspect of the elder's medical care, without having direct communication with each other, and each prescribing several different medications. This also points to the need for having one physician in charge; this physician should periodically review the diagnoses and regimens of all physicians who care for the patient. Furthermore, ideally, all elders, and certainly elders who present with a complex clinical picture, should be referred for a comprehensive geriatric assessment, which is usually covered under Medicare.

## Issues of Loneliness/Companionship/Fear

These issues all need to be addressed with elders. Many of the losses they are facing, e.g., loss of a spouse or friends and family of their age, loss of independence, loss of self-esteem, memory loss, loss of control of bodily functions, loss of ability to manage the many tasks of daily living, lack of companionship at mealtime, etc., are problems that can often be anticipated, or if not, can respond to a sympathetic ear or counseling. In many elders, the loss of independence may be a greater challenge than all the other problems. Loneliness and loss of companionship are a common precursor to depression, which is probably undertreated in the elderly. Depression in elders is frequently followed by successful suicidal acts; an older adult commits suicide every 70 minutes in the United States. An article in the February 2000 issue of the *Journal of the American Geriatric Society* reported a study that found that physicians regarded suicidal ideation as being more normal and acceptable in older patients, and they were therefore less likely to refer such patients for treatment.

It is important for all caregivers, e.g., aides, nurses, orderlies, doctors, etc., in a nursing home or hospital to not just perform tasks (for example, assistance with activities of daily living, or patient care procedures) in a perfunctory manner, but to spend time talking with the elder, as well as to explain the procedure, even if the provider does have a "time crunch." In spite of the limited time available to the provider, the elder is entitled to time being spent with him. Otherwise, there is a "depersonalization" and lack of respect for the personhood and dignity of the elder. Even a few minutes can be helpful.

Furthermore, perfunctory performance of tasks eliminates the nurturing human touch. This is vital for all of us, but perhaps even more so for those persons at the two extremes of life, as they are more dependent upon others for care. Human touch, some conversation, a caring attitude, an interest in the elder as a human being who has lived a long and interesting life, has experiences to relate and wisdom to impart – all of these will go far in enabling that individual to feel that she is not a helpless patient but a human being who is worthy of love and who still has something to give.

Think, for example, of the elderly woman with dementia who expresses in a perfectly lucid manner, that she did not like it in the nursing home because the aides did everything in such a brusque manner.

Loneliness is probably one of the most significant issues faced by many elders, particularly if they are living alone or are in a nursing home. Loneliness can lead to fear, anxiety, and depression. It is vital, therefore, that family and friends visit the individual. This is particularly complex for Indian elders, as there are few nursing homes on reservations, often necessitating off-reservation placement. Thus, it may be valuable to arrange for home health care simply for companionship, as well as for addressing health care needs. Involvement with other seniors, as at senior citizen centers or in cultural projects, also helps to fulfill this need. Additionally, intergenerational programs in which elders are interacting with children will go a long way in addressing this problem. Examples of such programs are elders teaching young people the history, art, and spiritual beliefs of the tribe; reading to children in Head Start; a Foster Grandparents' program to visit hospitalized children; or children's classes visiting nursing homes or senior citizens' centers and doing joint activities (singing, crafts, etc.) with the residents.

## Self-esteem

We need to explore ways of helping elders to feel important, to feel that they still have something to give, to offer. To that end, elders should be asked to participate in household tasks, encouraged to spend time with the grandchildren, invited to share the tribal culture with younger people, encouraged to participate in family, community or nursing home projects, supported in their desire to pursue interests, hobbies, classes, new technology, etc.

Activities in senior citizens centers, nursing homes, or elder/senior congregate meal centers, should not be just “busy work.” Preferably, these activities should relate to things that the individuals had been interested in throughout their lives, capitalizing on the wealth of their experiences, as well as the introduction of new activities. However, the activities should not be such as to make the elders feel as if they are being treated as children, or being “warehoused.” Elders should be encouraged to both suggest and lead activities if they desire.

An important activity for elders with dementia can be reminiscing, as it allows them to connect to a time when they were vital and well, and in better control of their faculties and functions. The activities should also allow them to get outside of their home or living situation, and to interface with other individuals. Allowing them to be busy and involved restores and maintains self-esteem, enhances contact with their community and society, and takes their mind away from matters that might be depressing if left alone to ruminate.

## Issues of Alzheimer's and Other Dementias

All providers caring for the elderly (doctors, nurses, physiotherapists, social workers, etc.) should be vigilant about the following specific characteristics of dementia:

- The individual's behavior and mental clarity may vary from day to day and at different times of the day. Especially in the early stages of dementia, the mental clarity may vary markedly.
- It may take a person with dementia longer to follow instructions, such as, for example, those of a physical, recreational, or occupational therapist. That does not mean that the elder cannot do it; it may only mean that he needs more time or that the instructions need to be presented differently. The attitude of the therapist, nurse, or doctor may also affect the elder's willingness to cooperate with a prescribed regimen. Just because the individual has memory loss or behavior change does not mean that she cannot detect impatience or brusqueness in the manner of a staff member. Additionally, the elder may be so disoriented that the procedure will have to be explained to them anew each time it is to be done.
- The behavior of the elder can be very disturbing and upsetting to the provider; we must work with him or her in spite of this. We need to find out who this person was, what they were like, and what they accomplished in life before they became demented. We may need to think of that person (of the past) when we are dealing with this currently demented, disturbing patient.
- Some elders are truly unaware of who they are, much less who the provider is and what that provider is planning to do for them, either on that visit, or as part of a long-term care plan. Furthermore, particularly

with dementia, there is often a degree of paranoia, and the most innocent of statements or actions can be misinterpreted. For example, a patient in the last stage of Alzheimer's may find a shower to be a frightening experience and will, therefore, put up great resistance to being showered.

## "One-Stop-Shopping"

Particularly for elders, who may have multiple conditions, there are often too many doctors, too many tests, and too many places to go to fulfill all of their health care needs. Ideally, there should be geriatric care centers available, where everything can be accomplished in one place. Apart from all medical activities being clustered, there could also be social workers, Medicare and Medicaid workers, Social Security workers, and a senior citizens' facility, all in a central location. Even in the elder who is healthy but who has the normal decreased stamina and limited mobility that may occur with aging, having to go from one place to another can be physically exhausting. To a family, it may also mean that some family member is losing time from work (and losing income) to provide transportation and supervision for that elder to be able to receive health care.

In the meantime (since such centers do not yet exist in most places), are there other ways of doing things? Does the patient always need to come into the clinic? Could a Community Health Representative (CHR), a public health nurse, or a home health care aide be sent out to the home? Could a phone conversation with a family member, to check on progress, perhaps substitute for a visit to the clinic? Could several diagnostic tests be clustered and done at the same visit? Could elder clinics, attended by a variety of specialists, be held at the IHS facility rather than the elder (and the family) having to make several trips to various other facilities/providers?

## Designated Family Member

While the provider should relate directly to his/her patient, it is important to know who the family (and the elder) has designated to be the spokesperson with the health care system and provider. If the provider doesn't follow the proper “line of authority,” she or he may create friction in the immediate care situation, or with other family members. The provider should understand exactly how far this authority (or power of attorney, if one exists) extends in dealing with the affairs of the elder. In those situations in which the elder does not have a “durable power of attorney for medical decisions” properly executed, the provider should specifically note in the medical chart (dated) his or her understanding of what has been discussed with the patient and/or family members, and their response. Some elders will refuse to execute or even discuss a power of attorney, feeling that this is a negative or “witching” experience, and this, too, should be noted, but always fully respecting the patient's own wishes and beliefs.

## Conclusion

In summary, elder health care is complex, with myriad issues that need to be addressed. Only some of these concerns have been mentioned in this article; there are many other topics that still need to be considered. Central to all of these issues is the preservation of the dignity, self-worth, and value of elders, and the goal of making their lives as comfortable and happy as possible. □

## Voices of the Elders: Health Care – More than a Diagnosis

### A New Mexico Geriatric Education Center Video Production

The New Mexico Geriatric Education Center (NMGEC) has created a videotape to educate the community of health care providers working with American Indian elders and for the education of students in medicine, nursing, pharmacy, social work, and other allied health professions.

The primary objective of the videotape production was to provide elders the opportunity to express their thoughts about health care needs, framed in their words and cultural context. Over fifteen hours of interviews were conducted to provide elders with a vehicle to voice their opinions. Their candor speaks to health care providers willing to listen and learn how they can better serve elders.

Some topics covered include communication, cultural sensitivity, elders as patients, life support, women's health, autopsy, death and dying, health promotion, disease prevention, and western versus traditional medicine.

The NMGEC envisions that the videotape will be used to facilitate the development of a culturally sensitive approach to providing health care to American Indian elders. In addition, the production was designed for interdisciplinary team discussion to improve the quality of care to American Indian elders. An educational guide was developed to accompany the video and provide a focus on the questions elders raise and a summary of their major points for team discussion.

The videotape program can be purchased for the price of mailing it to you (\$10, with a check payable to NMGEC/UNM). Contact Darlene A. Franklin, Program Manager, UNM Health Sciences Center, New Mexico Geriatric Education Center, 1836 Lomas Blvd., NE, 2nd Floor, Albuquerque, NM 87131; telephone (505) 277-0911; fax (505) 277-9897; e-mail [dfranklin@salud.unm.edu](mailto:dfranklin@salud.unm.edu). Financial support for this production was provided by a grant from HRSA.

## The New Mexico Geriatric Education Center (NMGEC)

*“They [elders] really don’t care to take those medications, but with encouragement from their children they’ll go ahead and take it and they’ll also return to their traditional medicine way.” (Elder quote from the New Mexico Geriatric Education Center-produced “Trigger Tapes for Discussion About Health Care for the Elderly American Indian.”)*

At the core of New Mexico Geriatric Education Center (NMGEC) activities is the conviction that cultural sensitivity is vital to the effective provision of health care to American Indian Elders. NMGEC education and training programs concentrate on promotion of an appreciation of the richness of Indian culture and traditions, and an awareness of the use of traditional healing practices. Integration of this knowledge with Western medicine becomes the challenge in prevention and treatment of illness and chronic disease among American Indian Elders.

The NMGEC, located at the University of New Mexico (UNM) Health Sciences Center, is dedicated to improving the health care of New Mexico's American Indian Elders through the education and training of health care providers in culturally appropriate geriatrics. The NMGEC serves American Indian elders everywhere, but focuses on all of New Mexico and small portions of Utah, Colorado and Texas, based on the Albuquerque Area geographic designation of the Indian Health Service. Serving a region consisting of 26 Indian communities, the NMGEC benefits from close interactions with Pueblo, Apache, Navajo, Ute, and Mountain Ute Indian communities.

Important to the NMGEC's approach to the provision of health care is its interdisciplinary nature. A core group of faculty from the UNM School of Medicine, College of Nursing, and College of Pharmacy, and from the Veterans Affairs Medical Center, New Mexico State University, and New Mexico Highlands University School of Social Work is responsible for training future care providers in geriatrics and gerontology. Bimonthly Grand Rounds at the Health Sciences Center provide another opportunity for medical students, residents, and professionals to gain continuing education in culturally appropriate geriatrics-related topics. The *Indian Elder Caregiver* newsletter of the NMGEC focuses each issue on a particular aspect of American Indian Elder health care. An up-to-date lending library of resources, articles, books, and over 50 videotapes is available to health care providers, not to mention additional NMGEC-produced videos.

Among the videos produced is one called “Voices of the Elders: Health Care – More Than a Diagnosis.” An interdisciplinary health care team developed the video from interviews conducted with elders from Indian communities in New Mexico. Elders responded to questions regarding their view of the health care they receive. Nearing completion is another video production using different questions gleaned from these interviews. These videos are intended to “trigger” discussions among health care providers to encourage them to look at their own health care system, and how they are perceived by elders. Included with both videos are educational discussion guides for interdisciplinary health care teams.

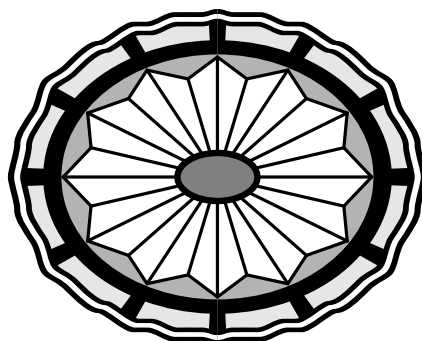
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The NMGEC Council of Elders creates a link with Indian communities, providing information on the status of their health care needs. The Council reviews the cultural content of educational materials and curricula developed by the NMGEC, making the elders an integral part of the program. Their cultural knowledge is an invaluable part of the project.

The next exciting offering by the NMGEC is the Summer 2000 Geriatric Institute, to be held June 29 through July 1, and focusing on American Indian Elders. Using an interdisciplinary approach, the institute will feature numerous geriatric/gerontology topics. Scholarships will be available for tribal and IHS health care providers. Under the current Health Resources and Services Administration (HRSA) grant, the NMGEC, through a train-the-trainer approach, has developed a curriculum for an elder caregivers' training. The train-the-trainer method will allow for those completing the course to take the information back to their community and present it to family caregivers, Community Health Representatives (CHRs), and other health care providers. The train-the-trainer concept allows for the

information to be presented by a member of the community, increasing the likelihood of incorporation of the geriatric content into the provision of health care. The curriculum will emphasize basic in-home care strategies including physical care, mental health evaluation and care, home safety, communication and family relationships and management of medications. If certification is desired, the curriculum will prepare the individual for "personal care attendant" status. After piloting the program in Indian communities, the curriculum will be ready for national distribution.

If you are interested in more information about any aspect of our program, inclusion on our newsletter mailing list, or in networking with the NMGEC to better serve American Indian elders, please contact Darlene A. Franklin, Program Manager, UNM Health Sciences Center, New Mexico Geriatric Education Center, 1836 Lomas Blvd., NE, 2nd Floor, Albuquerque, NM 87131; telephone (505) 277-0911; fax (505) 277-9897; e-mail [dfranklin@salud.unm.edu](mailto:dfranklin@salud.unm.edu). □



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## Sharing Geriatric Patient Education Materials

Dr. Bruce Finke, the coordinator of the Elder Care Initiative, has suggested that we try something new here in the pages of THE PROVIDER. He would like to invite our readers to send him geriatric patient education materials that they have found especially helpful to their elder patients. He will review and format them such that they can be published here for everyone to copy and use. These materials should, like all patient education materials, be written in clear, easy-to-understand language, and should be original, or at least have no copyright protection that would create problems with their duplication. Authorship will be acknowledged, but the materials themselves will be printed without identifying information, for the sake of uniformity. Mail your materials to Bruce Finke, MD, P. O. Box 467, Zuni, New Mexico 87327.

On the following page, we offer the first such patient handout, supplied by Dr. Finke from the Zuni-Ramah Service Unit.

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## The Elder with Dementia or Confusion

**“Doctor, I don’t know what I should do about my mother. She gets mad a lot, and she is mean too. She’s eighty-five years old and has always been very healthy. Now she isn’t the same. She doesn’t want to wash, and sometimes I have to make her clean herself.**



**That isn’t like her; she always taught us to keep ourselves clean. She used to like to go to town, and now she doesn’t want to go places; she just wants to stay at home. She gets after the neighbors for nothing and accuses them of stealing things, and I know they don’t do that. I guess she’s just getting old, but I don’t know why she’s like that.”**

**T**he grandmother in this story probably has a problem called dementia (*dee-men-cha*). Dementia is also sometimes called Alzheimer’s disease (really this is just one kind of dementia), confusion, or senility. When a person has dementia, they do not think right. They cannot remember things; they may be easily confused and also get lost in places they used to know well. Some people (like this grandmother) get frustrated and angry for no reason. Others just do things that don’t make sense, like putting things in strange places, or hiding things. Sometimes they just sit a lot and don’t say or do much.

Dementia almost always gets worse over time. For some people

it gets worse slowly, for others more quickly. In the beginning we may just notice the elder behaving differently than usual. Later, the elder with dementia sometimes behaves in ways that make him or her hard to care for (like the grandmother above).

What we now call dementia has always been a part of aging for some people. Many people just think of it as a part of getting old. But there are important reasons why elders with confusion or dementia should see their doctor. Most importantly, while there is no cure for Alzheimer’s dementia, some other causes of confusion and dementia are curable if they are treated early. Also, depression can look a lot like dementia in an elder, and depression usually gets better with medicines and other treatments. Sometimes confusion or a change in thinking can be a sign that an elder has an infection or other problem. So any elder with behavior change or new confusion or forgetfulness should be checked carefully by their medical provider. An elder who has behaviors that are causing problems for their family should also be checked. There are techniques and medicines that can help those elders and help their families to care for them. The medical provider can be an important help to the family caring for an elder with dementia.

When an elder like this grandmother yells at us or accuses us of something, it can really hurt. We don’t understand why they would treat us this way. Sometimes we get really mad at the elder who won’t listen, or won’t wash themselves, or who keeps asking us the same question again and again. We have to remember that dementia changes the way the elder thinks. Their thinking is not right, and they can’t figure things out. It can be very hard to care for them. If one person is mostly taking care of the elder, he or she will need others to help.

If we try to understand dementia and work together, we can care for the elder who has dementia with the love and honor he or she deserves.

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# A Conversation with Off-Reservation Elders

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*Wayne Mitchell, Director, Social Services Program, and Chairman, Area Elders Committee, Phoenix Area Indian Health Service, Phoenix, Arizona*

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John Saari, MD, a staff family practice physician and geriatrician at the Phoenix Indian Medical Center (PIMC), and I recently met with a number of elders from a group called the Native American Senior Association at the Heard Museum of Native Art in Phoenix, Arizona. This association is sponsored by the Native American Community Health Center, Inc. (NACHCI), an urban Indian health facility located in Phoenix. Although the group's total membership is larger than the approximately 23 people with whom we met, the elders gathered that day had a great deal of spark and enthusiasm.

Initially, when we referred to the group, we used the term "urban" elders. However, it was quickly and clearly pointed out that "off-reservation" is the preferred term. "Most of us are from reservations and we return there often. For many, it's still home," they stated.

Dr. Saari and I met with the group to get a sense of what elders think about health care and health delivery systems. Those present were not reticent about letting us know their opinions and feelings about their health care in general and, in particular, what they thought of the care they receive from the Indian Health Service.

When asked where they received their health care, some said they received their care mostly at PIMC, but others received their care through private physicians and/or at NACHCI. Most of those who spoke felt that they received good services at PIMC, both in general and specialty clinics. They mentioned several favorite doctors who care a great deal about them as patients and about the services they provide. Ida Amiotte, a 77 year old Lakota Sioux from Pine Ridge, South Dakota, said she's lived in Phoenix since 1959 and has always received her care through the Indian Health Service. She has been very pleased with the services, clinics, and ambience at facilities she has used. Phyllis Martin, an "over 60" Hopi, mentioned that she is also satisfied and has few complaints. An 82 year old man from the Nez Perce tribe stated that his care at PIMC is "outstanding."

Some elders also offered suggestions for ways to improve services to their generation. Mary Lomaheftewa, Hopi, stated that she was concerned about dental care. "We were told that the dental department had to concentrate on services to children and we could no longer receive services. We understand this and accept it. We just wanted to let IHS know that elders have special needs, too. Also, we're very glad that dentists are concerned with more than just pulling teeth. For elders, it's care of dentures, bridgework, etc. Hopefully," she added, "it will not be too long before services will open up

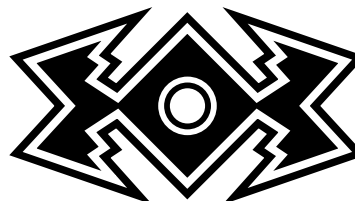
again." (Although PIMC's current dental priorities are children and medically compromised adults, anyone with a dental emergency can also receive treatment.)

Also, several elders spoke about waiting times at PIMC. While Dr. Saari agreed that concerns about long waits are among the most frequent complaints throughout many health care systems, and not just PIMC, he pointed out that PIMC has established a performance improvement initiative to address this issue. Some elders remarked that as they get older, it is more difficult for them to sit for extended periods of time anywhere, not just at PIMC.

Additionally, most of the elders were in agreement that patient courtesy should be an important part of each new employee's orientation and should be stressed to current employees as well. Richard Beyal, a 71 year old Navajo, told us he wanted more information about Contract Health Services (CHS). "I don't understand the whys and wherefores of CHS. It would be nice if someone would explain it to me and other old folks." The group also expressed interest in knowing more about third party billing revenues and where the money goes. The topic of integrated services for elders was brought up. "PIMC has pediatric clinics, maybe someday soon we can have elder clinics" several said. This topic will need further discussion.

It was clear that more discussion time would be needed to address other questions and respond to other comments made by these elders. We hope to visit this group again, perhaps with a series of follow-up meetings with PIMC staff to discuss elder health care issues, to obtain elders' input, and to answer questions they may have.

These elders are no "sit back and wait" group. Smart and articulate, these off-reservation Indians expressed opinions, concerns, and hopes reflecting those of elders everywhere. We, in the Indian Health Service, need to listen to them every chance we get. Dialogues with elders prove to be very beneficial to everyone. The Indian Health Service learns. Elders learn. Our elders have insight and wisdom from which all of us can learn. It may be helpful to service units to take the initiative to meet with local elders in the community to learn what their issues and suggestions may be. □





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# What's New from the Elder Care Initiative

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*Bruce Finke, MD, Director, Elder Care Initiative, and Staff Physician, Zuni-Ramah Service Unit, Zuni, New Mexico*

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The IHS Elder Care Initiative website is up and running and can be found at [www.ihs.gov/medicalprograms/eldercare](http://www.ihs.gov/medicalprograms/eldercare). This website is meant to be useful to the elder and his or her family, as well as to Indian health providers. It has content on the site and links to useful resources elsewhere on the World Wide Web. Please let me know how this site can be more helpful to you and the elders you care for.

This year I surveyed Indian health providers asking for names of and contact information for persons interested in Elder Care. The response has been terrific, with over 300 names currently on the list. I will be relying on these individuals as the Indian Health Elder Care Resource Group. We will build an Indian Health elder care network to share information and resources. If you are interested in adding your name to this Resource Group, e-mail, fax, or mail your name and contact information to me.

There are several exciting educational opportunities coming up this year. The New Mexico Geriatric Education Center (NMGEC) is presenting a Summer Geriatric Institute June 29-July 1 and is offering scholarships for Indian health providers. The NMGEC will also set aside a room for Indian health providers to meet together after the conference. In August the National Indian Council on Aging (NICOA) is holding its biennial conference, "Strengthening the Sacred Circle: 2000 and Beyond," hosted by the Fond du Lac Band in Duluth, Minnesota. Concurrent with that gathering of more than 1500 elders from across Indian Country will be "Innovations in Elder Care, a Participatory Conference." At this conference providers from across Indian Country will have the opportunity to share their innovative elder care programs with each other. See the "Meetings of Interest" section for more information about these meetings.

The Comprehensive Elder Exam PCC (Patient Care Component) encounter form is available now. This RPMS (Resource and Patient Management System) compatible form guides the provider through a comprehensive office-based geriatric exam. It contains a functional status assessment tool, a geriatric review of systems, and health maintenance guides. RPMS modifications now available allow us to track the functional status of our elder patients. We can use these tools to provide state-of-the-art geriatric care for our elders.

We have begun the process of developing recommended standards of care for our elder patients. The Preventive care standards will be introduced in future issues of the IHS PRIMARY CARE PROVIDER and on the ECI (Elder Care Initiative) website. Participants in the Elder Care Resource Group will be key in

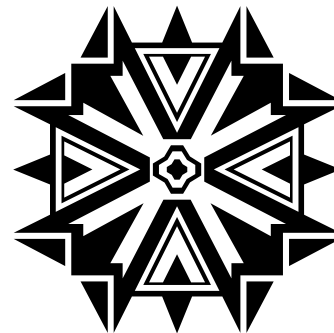
developing these guidelines.

The Albuquerque Area, under the leadership of Chief Medical Officer Judith Kitzes, MD, MPH, has taken a leadership role in addressing issues of improved pain management and palliative care in Indian Health. Model pain and palliative care policies have been developed and shared with sites across Indian Country. These are available on the ECI website. A training opportunity with international and national palliative care specialists is being planned for IHS and tribal providers and leaders, to take place in Albuquerque, October 19-21, 2000. Most importantly, dialogue regarding community desires for "care beyond cure" is increasing nationally.

In this past year we have had several opportunities to present and work with a "Public Health Framework for Elder Care." This is a tool that has proven useful in evaluating local needs and resources in elder care and in setting priorities for program development. The framework is based on the premise that the best elder care integrates acute, chronic, and long-term care and coordinates resources irrespective of institutional boundaries.

Finally, with the support of the Office of Health Programs and through the hard work and dedication of the IHS Clinical Support Center, we distributed over 2000 copies of the handbook *Geriatrics at Your Fingertips* to providers throughout Indian Country. The response to this opportunity was huge and demonstrates the depth of the concern for quality elder care among Indian health providers.

In the coming year the IHS Elder Care Initiative, in partnership with the many dedicated providers throughout Indian Country, the National Indian Council on Aging, Federal, state and tribal programs, and academic centers, will continue to promote quality care for American Indian and Alaska Native elders. Above all, we do this with respect for and in honor of elders and their families. □



## NATIVE AMERICAN MEDICAL LITERATURE □

The following is an updated MEDLINE search on Native American medical literature. This computer search is published regularly as a service to our readers, so that you can be aware of what is being published about the health and health care of American Indians and Alaska Natives.

The Clinical Support Center cannot furnish the articles listed in this section of The Provider. For those of you who may wish to obtain a copy of a specific article, this can be facilitated by giving the librarian nearest you the unique identifying number (UI number), found at the end of each cited article.

If your facility lacks a library or librarian, try calling your nearest university library, the nearest state medical association, or the National Library of Medicine (1-800-272-4787) to obtain information on how to access journal literature within your region. Bear in mind that most local library networks function on the basis of reciprocity and, if you do not have a library at your facility, you may be charged for services provided.

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THE PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; Fax: (602) 364-7788; e-mail: [the.provider@phx.ihs.gov](mailto:the.provider@phx.ihs.gov). Previous issues of THE PROVIDER (beginning with the February 1994 issue) can be found at the CSC home page, [www.csc.ihs.gov](http://www.csc.ihs.gov).

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**Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.**

**Circulation:** THE PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical and nursing schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

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