



THE IHS PRIMARY CARE PROVIDER

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



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Annual Elders Issue

This May issue of *The IHS Provider*, published on the occasion of National Older Americans Month, is the eighth 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 2004 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.

Prevention in the Elderly

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Zuni, New Mexico

In an address to the Combined Clinical Councils meeting in February 2003, Dr. Charles Grim, (then interim) Director of the IHS, urged “a renewed emphasis on health promotion and disease prevention” as “our strongest front in the battle to eliminate the health disparities that have plagued our people for far too long.¹”

Where does prevention fit in the care of the elder? In the answer to that question lie some of the fundamental principles of elder care. Our objective is to maintain quality of life, function, and the active involvement of the elderly in the life of the community and family. In the care of the elderly, it is often prevention of new disability, or delaying the progression of existing disability that occupies our attention.

How do we accomplish this? We can start with identifying those interventions that have been proven to reduce risk of death and/or disability in the elderly and ensuring that they are offered to each and every one of our elders. This is the motivation behind the development of the Preventive Care Guidelines found elsewhere in the pages of this issue. Whether adopted as is or modified for implementation in your own clinical and community setting, the Guidelines offer an evidence-based structure for our efforts in preventive care for the elderly. Consider offering a periodic preventive health visit for the elderly as a strategy for implementing these guidelines.² Think

also about community-based strategies for implementation, using Title VI Senior Nutrition sites, CHRs, and Public Health Nursing. These efforts can and should be linked to communi-

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ty-based wellness interventions such as the Wisdom Steps program in Minnesota. Don't forget that the Comprehensive Elder Exam PCC (or PCC+) is a documentation tool that can help us to implement and track these interventions.

Fall and injury is a cause for disability among the elderly and has been described as "among the most common and serious problems facing elderly persons."³ Fall prevention is addressed in the Preventive Care Guidelines with reference to an excellent, evidence-based strategy developed by the American Geriatrics Society and others. This straightforward and inexpensive approach has been adapted for use in Indian health settings and can be found elsewhere in these pages.

Prevention plays a part in the care of even the most frail of our elderly: those with impairment of activities of daily living who require long term care services. Most obviously, prevention of disability reduces the need for these services.⁴ But there is more to it than that. Elders consistently state their preference to remain at home and avoid institutional settings for long-term care and, while that is not always possible, it remains our goal. Models of community-based long-term care such as PACE (Program of All-Inclusive Care for the Elderly) and others have shown that active, coordinated management of the care of the frail, community living elder can often prevent disheartening and expensive institutional placement. Development of tribal and urban community home and community-based long-term care services is the key to providing this kind of care.

Evidence-based prevention strategies in elder care balance up-front expenditure of resources and energy with the promise of improved function and quality of life for our elders and reduced costs for our health system down the road. Whether in clinic or community based prevention efforts as outlined in the Guidelines or in support for the frail elder in the community, an investment in prevention in the arenas of clinical care and community-based wellness efforts offers our elders the promise of improved quality of life and continued active involvement in the life of the family and community. □



References

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Preventive Care Guidelines for the Elderly

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Zuni, New Mexico

The Preventive Care Guidelines for the Elderly represent the efforts of a diverse group of clinicians with experience in geriatric care and Indian health to develop a practical outline for preventive care for American Indian and Alaska Native elders. The Guidelines began with and are based in the recommendations of the United States Preventive Services Task Force (USPSTF).¹ The USPSTF recommendations are age-specific, evidence based, and updated periodically. But the USPSTF recommendations can only recommend interventions for which there is a research base.⁹ Thus the clinicians engaged in this effort have added additional recommendations based on clinical experience. Throughout this effort, the participants were challenged to include the most important elements in the care of the elderly while keeping the “task list” achievable.

Accompanying these guidelines is a one-page chart review form to be used in chart audits on page 105. On page 106 is a list of those who contributed to this project.

The Comprehensive Elder PCC is available, both in standard PCC form (IHS 865) and as PCC+, to help clinicians to work with these guidelines. The Guidelines and chart review are available on the Clinical Guidelines page of the IHS website at www.ihs.gov/NonMedicalPrograms/nc4/nc4-clin-guid.cfm as well as on the Elder Care Initiative website at www.ihs.gov/MedicalPrograms/ElderCare.

Screening

1. Blood pressure
2. Height and weight
3. Colorectal cancer screen

*Currently recommended approaches are:
FOBT annually and/or Sigmoidoscopy every five years
or
Total colon evaluation: Colonoscopy every ten years
or double contrast barium enema combined with sigmoidoscopy every five years.
(recommendations derived from USPSTF¹ and ICSI – Institute for Clinical Systems Improvement²)*
4. Mammogram (every 1-2 years) (for women age 40-70) +/- annual Clinical Breast Exam

There is not consensus about the upper age of benefit for mammography. Women with advanced chronic disease and reduced life expectancy are unlikely to benefit from mammography. The American Geriatrics

Society recommends screening until age 75 and biennially or at least every three years thereafter with no upper age limit for women with an estimated life expectancy of four or more years.³

5. Cervical cancer screen (for all women who are or have been sexually active and who have a cervix)

Consider discontinuation of testing after age 65 if previous regular screening with normal results). Previous regular screening can be defined as 3 normal pap smears within the 10 years prior to cessation of screening. This is based on the cited false-negative rate of 20% for a single Pap smear and 1-2% if three consecutive Pap smears are negative.⁴
 6. Vision screening
 7. Screen for hearing impairment
 8. Screen for problem drinking
 9. Lipid screening
 10. Screen for increased fall risk

*Ask if the elder has fallen in the past year.
Use AGS Fall Prevention Guidelines.⁵*
 11. PPD

High risk only, as defined by the CDC.⁶
 12. Osteoporosis screen

Dexa test or peripheral screening for all women 65 years and older or 55-64 with risk factors.
- Screening issues not addressed by the USPSTF but recommended by an expert panel of Indian Health Providers (annual unless otherwise indicated)**
13. Functional status, including Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
 14. Weight gain or loss over preceding year
 15. Medication review
 16. Oral health examination
 17. Screen for depression
 18. Screen for cognitive impairment
 19. Screen for chronic pain
 20. Screen for elder abuse, neglect, or exploitation, including domestic violence
 21. Screen for diabetes
 22. Screen for urinary incontinence
 23. Discuss the risks/benefits of PSA for prostate cancer screening.

Immunizations

1. Pneumococcal vaccine
ACIP Guidelines for revaccination:
Revaccinate once at 6 years for all persons vaccinated prior to age 65 and once at 6 years for persons likely at highest risk and likely to have rapid declines in antibody level. These persons include: persons with functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), HIV infection, leukemia, lymphoma, Hodgkins disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression (e.g., organ or bone marrow transplantation), and those receiving immunosuppressive chemotherapy (including long-term systemic corticosteroids).⁷
2. Influenza (annually)
3. Tetanus-Diphtheria (Td) boosters every 10 years.

Chemoprophylaxis

1. Discuss aspirin prophylaxis for coronary artery disease in men and in postmenopausal women at increased risk of heart disease (when risk of CAD exceeds 3% in 5 years).

Chemoprophylaxis issues not addressed by the USPSTF but recommended by an expert panel of Indian health providers

2. Ensure adequate calcium and vitamin D intake.
Recommended intake is 1200 mg per day of calcium and 400-800 iu Vitamin D.⁸ Consider supplementation.

Counseling (recommended patient and family education)

Substance Use

1. Tobacco cessation
2. Avoid alcohol/drug use while driving, etc.

Diet and Exercise

3. Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables
4. Adequate calcium intake (women over age 65 and men over the age of 75)
5. Regular physical activity

Injury Prevention

6. Lap/shoulder belts
7. Motorcycle and bicycle helmets
8. Fall prevention
9. Safe storage/removal of firearms
10. Smoke detector
11. Set hot water heater to <120-130 degrees F
12. CPR training for household members

Dental Health

13. Regular visits to dentist (even those with dentures)
14. Floss, brush with fluoride toothpaste daily

Sexual Behavior

15. STD prevention; avoid high risk sexual behavior; use condoms

Counseling issues not addressed by the USPSTF but recommended by an expert panel of Indian Health Providers

16. General information about advance directives.
17. Information about the PSA as a prostate screening exam

Notes:

- a. All recommendations are annual unless otherwise stated.
- b. These guidelines are designed for individuals age 65 and older (consistent with the approach of the USPSTF). □

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8. National Osteoporosis Foundation. Physician's guide to prevention and treatment of osteoporosis. Belle Mead (NJ): Excerpta Medica, Inc.; 1999.
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Quality Assurance Checklist for Preventive Care Guidelines for the Elderly

Within past 18 months if not otherwise noted	Accomplished	Declined	Not Applicable	Not Addressed
Blood Pressure				
Height				
Weight				
Colorectal Cancer Screen (any of below)				
FOBT (w/in 2 yrs)				
Sigmoidoscopy (w/in 5yrs)				
Double contrast Barium enema (w/in 5 yrs)				
Colonoscopy (w/in 10 yrs)				
Mammogram				
Cervical Cancer Screen				
Vision Screen				
Hearing Screen				
Problem Drinking Screen				
Lipid screen (within past 5 years if no CAD equivalent, annual if CAD equiv.)				
Fall Risk Screen				
PPD				
Osteoporosis Screen				
Functional Status Assessment				
Depression Screen				
Cognitive Impairment Screen				
Chronic Pain Screen				
Elder Abuse, Neglect, or Exploitation Screen				
Urinary Incontinence Screen				
Diabetes Screen				
Oral Health Examination				
Discuss Prostate Cancer Screening				
Pneumococcal Vaccination (within past 5 years or twice ever)				
Influenza Vaccination				
Td within past 10 years				
Aspirin if risk for cardiac event is greater than 3% in 5 years				
Adequate Calcium intake or supplementation of Calcium and Vit D				
Patient and Family Education topics addressed				

1. If the elder carries a diagnosis of a condition for which screening is usually recommended, then the preventive measure is not applicable.
2. These guidelines are targeted at the elder without clear life-limiting diagnosis. Clinical judgment must be used in their application.

An Annual Editorial Calendar for *The Provider*

The following annual editorial calendar has been prepared by the IHS Headquarters Public Affairs Staff to encourage the coordination of communication efforts with the rest of the Department of Health and Human Services. By promoting these health focus areas, we hope to encourage potential authors to submit relevant articles for submission to *The Provider* and to highlight media awareness efforts by various agency public affairs activities.

Each month has a designated health focus area that has been selected in line with departmental/national activities and focus areas for that month, thereby helping to coordinate our agency messages. By providing a timely approach to health care reporting, we hope to increase awareness of Indian health issues and enhance respect for *The Provider* as a relevant, topical health care publication. The prototype for this effort, of course, is the annual Elders Issue, now in its eighth year, which is published in conjunction with National Older Americans Month.

It may take time to establish these themes, and we will not unduly delay publication of articles in order to place them in a later issue, but we do encourage you to consider this schedule and look ahead to see what is coming up and how you might want to contribute. Remember that it takes considerable time to get an article ready for publication, so you will want to plan far enough in advance. □

IHS Annual Editorial Calendar

Month	Main Focus Area
January	Mental Health
February	Cardiovascular Disease
March	Nutrition
April	Environmental Quality
May	Elder Care
June	Injury
July	Behavioral Health
August	Immunization
September	Substance Abuse
October	Domestic Violence
November	Diabetes
December	AIDS

Stay in the Loop Via the Eldercare Listserv

The Eldercare e-mail “listserv” has proven to be an invaluable way for those of us committed to improving care of the elderly to share information, resources, and ideas.

To subscribe, send an e-mail addressed to listserv@hqt.ihs.gov with the following message in plain text in the body (not the subject line) of the e-mail:

subscribe eldercare yourfirstname yourlastname
(for example: subscribe eldercare bruce finke)

Evidence-Based Fall Prevention Guidelines

Adapted from the AGS Clinical Practice Guideline, “The Prevention of Falls in Older Persons”*

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Zuni, New Mexico

Fall and subsequent injury represents a major cause of injury and loss of function for the elderly. Not every fall is preventable, but there is a large body of research evidence that points toward effective interventions to reduce the risk of fall and subsequent injury. The American Geriatric Society has published straightforward, evidence-based guidelines for fall prevention. This approach hinges on targeting older adults who have fallen, placing them at highest risk for fall in the future.

Everyone over the age of 65 should be asked once a year if they have fallen. If they have fallen, but have essentially normal gait and balance, no further intervention is required. If they have fallen and have abnormal gait and balance on a simple office test, or if they have fallen repeatedly, or if they have sustained injury, they should have a complete fall evaluation. The evaluation and interventions are based on the clear evidence that falls are multifactorial in nature and that the only effective way to prevent fall (and subsequent injury) is with interventions that target all relevant factors.

These guidelines are also available on the Clinical Guidelines page of the IHS website at www.ihs.gov/NonMedicalPrograms/nc4/nc4-clinguid.cfm as well as on the Elder Care Initiative website at www.ihs.gov/MedicalPrograms/ElderCare.

1. Assessment

All older persons (65 years and older) should be asked at least once a year about falls

- All older persons who report a single fall should be observed as they stand up from a chair without using their arms, walk several paces, and return (i.e., the “Get Up and Go Test”).
- Persons who have difficulty or demonstrate unsteadiness performing this test should have a fall evaluation.
- Older persons who present for medical attention because of a fall, or report recurrent falls in the past year, should have a fall evaluation.

A fall evaluation is defined as an assessment that includes the following:

- A history of fall circumstances, acute and chronic medical problems, and mobility levels (*including the role of alcohol, if any, in the fall*).
- An examination of vision.
- An examination of gait and balance and lower extremity joint function.

- An examination of basic neurologic function, including mental status, muscle strength, lower extremity peripheral nerves, proprioception, reflexes, tests of cortical, extrapyramidal, and cerebellar function.
- Assessment of basic cardiovascular status including heart rate and rhythm, postural pulse and blood pressure and, if appropriate, heart rate and blood pressure responses to carotid sinus stimulation.

2. Interventions

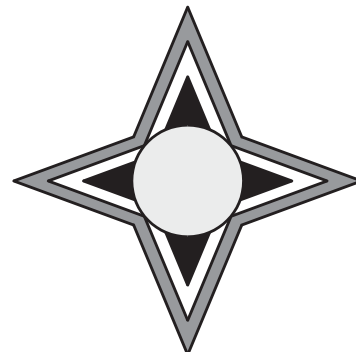
- Gait training and advice on the appropriate use of assistive devices
- Review and modification of medications (medication review by pharmacy).
- Exercise program with balance training as one of the components.
- Home evaluation and modification of environmental hazards.
- Treatment of postural hypotension if present.
- Treatment of cardiovascular disorders, including cardiac arrhythmias if present.
- *Referral for substance abuse evaluation and treatment if indicated.*

3. Additional interventions for consideration, to reduce risk of injury after fall

- *Offer Ca/Vitamin D and MVI if not already taking.*
- *Evaluate risk for osteoporosis and treat accordingly.*

Note: Items in italics are not addressed in the AGS Guidelines

* Guideline for the Prevention of Falls in Older Persons. American Geriatrics Society, British Geriatrics Society, American Academy of Orthopaedic Surgeons Panel on Falls Prevention. *JAGS* 49:664-672, 2001. □



Fall Prevention Guidelines

Robert D. Lindeman, MD, Professor Emeritus, University of New Mexico School of Medicine; Past Director of NMGEC, Past Chief of Division of Geriatrics, University of New Mexico Health Sciences Center, Albuquerque, New Mexico

In May 2001, fall prevention guidelines were published in the *Journal of the American Geriatric Society* (49:664-672, 2001). These guidelines were developed jointly by a panel of experts representing the American Geriatric Society (AGS), the British Geriatric Society, and the American Academy of Orthopedic Surgeons, and endorsed by the AGS Board of Directors.

A panel of experts set out to develop specific recommendations on fall prevention citing various levels of experimental evidence as to the effectiveness of various interventions. Often publications reporting the effectiveness of their fall prevention programs used multifactorial interventions, making it difficult to identify which factor or factors were responsible for the reduction in fall incidence. The numbers of randomized, controlled trials and meta-analyses of randomized controlled trials are extremely limited, making it necessary to rely on less solid evidence of benefits from these interventions. The following are a condensed version of their recommendations:

Assessment

1. All older persons who are under the care of a health care professional should be asked at least once a year about falls.
2. All older persons who report a fall should be observed as they stand up from a chair without using their arms, walk several paces, and return (the "Get Up and Go Test").
3. Persons who have difficulty or demonstrate unsteadiness in performing this test require further assessment, i.e., a fall assessment by a trained professional. This should include a history of fall frequency and circumstances, medications, acute and chronic medical problems, examination of vision, gait and balance, neurological evaluation to include lower extremity peripheral nerves, and cardiovascular status (evidence of postural hypotension).

Interventions

These recommendations were taken from studies of a) fit older persons who had not fallen, b) those considered at risk for falling, and c) those who experienced single or frequent falls. Those strategies that have been shown to be effective in appropriate controlled trials or using other valid experimental approaches are starred:

1. Among *community-dwelling elders* (those living in their own homes), multifactorial approaches should include:
 - *a) gait training and advice on the appropriate use of assistive devices,
 - *b) review and modification of medications, especially for those taking multiple (four or more) and/or psychotropic medications,
 - *c) exercise programs, with balance training as one of the components. Although exercise has many proven benefits, the optimal type, duration, and intensity of exercise for fall prevention remains unclear,
 - *d) treatment of postural hypotension,
 - e) modification of environmental hazards. Specifically, when older patients at increased risk of falls are discharge from the hospital to home, a facilitated environmental home assessment should be considered,
 - f) treatment of cardiovascular disorders, including cardiac arrhythmias.
2. In *long-term care and assisted living settings*, multifactorial interventions should include:
 - *a) staff education programs,
 - *b) gait training and advice on the appropriate use of assistive devices,
 - *c) review and modification of medications, especially for those on multiple (four or more) and/or psychotropic medications.
3. In *acute hospital settings*, there is insufficient evidence to make recommendations for or against multifactorial interventions.

Whereas bone strengthening (calcium, vitamin D, hormone replacement therapy, Fosamax, Miacalcin) does not reduce the risk of falls, it does reduce the risk of fracture. The panel found no evidence to support the use of restraints for fall prevention, noting that they have major, serious drawbacks, and can contribute to serious injuries. The panel ends their report by outlining a research agenda that needs to be implemented to provide answers about which strategies are most effective in fall prevention programs.

The published information on falls in Native American populations is almost nonexistent. Using the National Library of Medicine's PUBMED search system, one has to go back to 1983 to obtain any epidemiological information about falls. In an article entitled "Injuries among Hopi Indians. A population-based survey" (Simpson SG, et al.: *JAMA* 249:1873, 1983), falls accounted for 44 of 218 (20%) injuries resulting in admis-

sion to the hospital and 15% of deaths (this included only deaths during the acute hospitalization with nothing said about premature mortality). Except for the age group 15-34 years, in which the rates for motor vehicle accidents and suicides exceeded those for falls, falling was the leading cause of injury, accounting for three-fourths of injuries in individuals age 65 years and older. Twenty-four of the fall injury cases had fractures, including nine hip fractures, and ten had significant intracranial injury. These authors in their citations quoted one previous study published on injuries in a Navajo population.

The authors noted that most of the fall injuries occurred in or near the home, suggesting the need to assess home premises to identify hazards such as loose rugs, poor lighting, stairways with no handrails, and rocky paths without railings, as they pose serious risk of injury, especially to the elderly. There is nothing to suggest that falls in the elderly are not just as significant a problem in Native Americans as in other populations. This suggests that the above guidelines are just as applicable to Native Americans as they are to others. □

My Personal Experience In An Extended Care Facility

Wayne Mitchell, EdD, Director, Social Services, Phoenix Area Indian Health Service, Phoenix, Arizona

For several years, I was the supervisor of an IHS Extended Care Program. For the most part, the patients served were elderly and in need of skilled or intermediate levels of care. The program's responsibilities were to evaluate patients, recommend levels of care, and place the patients in appropriate extended care facilities. Many years later after leaving this position, I learned that there is no greater experience than personal experience when evaluating extended care facilities.

Not long ago, I had the opportunity "evaluate" an extended care facility from the other side of the bed – as a patient. During the summer of 2002, I became ill and had to be hospitalized. When I was discharged from the hospital, I was sent to an extended care facility, as I was still too ill to go home.

Although this ten-day experience seemed like a nightmare at the time, it provided me with some valuable lessons, which I would like to share.

On my arrival at the extended care facility, I was placed in a double room with an elderly man who was incontinent and should have had a private room. The staff did not attend to his needs as often as they should have. As a result, the room had a constant disagreeable odor, and I was constantly nauseated. It was not until days later that I was allowed to change to another room. I can only imagine how my former roommate must have felt, alone, behind the curtain that separated the two sections of the double room, constantly having to tolerate the same foul odor. *Lesson # 1: Extended Care facility staff should be aware of individual patient needs and problems when assigning rooms.*

One of the responsibilities of a Nurse Aide is to take patients' blood pressures. One aide in my extended care facility was either not properly trained to do so or couldn't remember what to do. Consequently, when he came to take my blood pressure, he could only fumble around until, finally, he called another aide for help. *Lesson #2: Staff are often overwhelmed and don't take the time to train or be trained in basic procedures. Basic training must be a part of the job description and requirements, and staff must be able to demonstrate necessary skills.*

Another Nurse Aide was very "rough" looking. She had pierced her chin with a metal pin and had some small tattoos. I hate to admit it, but when I first met her, I was afraid to have such a strange-looking person taking care of me. Surprisingly, she was actually friendly, kind-hearted, and gentle in her treatment of patients. *Lesson #3: Never judge a book by its cover.*

The day after my placement, I had a discussion with the dietitian about my health circumstances. I advised him that I had recently been diagnosed as diabetic and therefore, I should eat specially prepared diabetic meals. However, in spite of my requests, none of the meals I was given was appropriate for diabetics. All the meals were fatty and high in carbohydrates. *Lesson #4: Proper diet is crucial in an extended care setting. There should be strict adherence to match the patient to his/her dietary needs.*

Before bedtime, a cranky night nurse would bring around medications for all the patients. On one occasion, I dropped one of my tablets on the floor, so I asked for a clean tablet. The nurse replied that she would give me a second tablet, but if I dropped it again, I wouldn't get a third. *Lesson #5: Courtesy, common sense, and cleanliness should be standard rules for all staff.*

When my wife first came to visit, the visitor's waiting area looked dreary, and only a few dated magazines were available to the visitors. The following day, she brought in a stack of current magazines for the waiting room. The day after she brought in the magazines, she noticed that all the magazines she had brought in the previous day had been removed. Not a single copy of anything she had brought was left in the waiting room. *Lesson #6: Were the patients so hungry for "intellectual" stimulation that they took the magazines? Did the staff take them? Did the staff toss them out? Whatever the problem, be prepared to help and help again.*

When I was at last discharged, I thought that my problems with that extended care facility were over. Unfortunately, I was mistaken. After I returned home, I received an initial billing invoice. The invoice contained a rude demand for immediate payment, so instead of sending payment to the business office, I sent the payment directly to the CEO with a complaint about the rude invoice statement. Two days after I received the initial invoice, I had a telephone call from the billing office inquir-

ing why I had not paid the invoice. Additionally, I had accidentally overpaid a different invoice twice, so I asked for a refund. Six months later, still no refund and the invoice matters are still not cleared up. *Lesson #7: For the patient: Keep written records, including dates, of all transactions. For staff: Use common courtesy in all transactions, and make your job easier.*

Extended Care Facilities are needed facilities. They can, and in most instances, do provide good care, and they will grow in numbers as the Baby Boomers age. My experiences in the extended care facility gave me a long look at extended care from a patient's point of view. There are many problems that well-meaning staff are not aware of. Although it is not an enjoyable experience to be a patient in an extended care facility, an advantage of being treated in one is that the experience makes the patient aware of serious problems that they might not otherwise see. □

Art, Age, and Disability

Ernest Griffith, MD, Rehabilitation Medicine Specialist (retired); and Marie Mitchell, MA, Arizona State University Professor Emeritus of Linguistics and English, both member of the Phoenix Area IHS Elders Committee, and both from Phoenix, Arizona

Although we may hate to admit it, many of us still have the idea that old age, illness, poverty, and disability may mark the end of creativity and contributions to the community. As greater numbers of our population — both Indian and non-Indian — approach old age, it is important to dispel this myth by looking into the lives of well-known people who have continued to work and create well into their later years.

Auguste Renoir (1841-1919) was one of the original French Impressionists. He and his young fellow artists, Claude Monet and Alfred Sisley, were impoverished, subject to ridicule by art critics, and denied exhibition of their works by the Paris Salon. Many a day these three went without food. Each received periodic financial support from well-to-do artist colleagues. Not until reaching his early 40s did Renoir begin to receive recognition as an accomplished painter. By then he was a frail, chronically malnourished man who had survived a nearly fatal case of pneumonia.

By age 46, he developed the first acute symptoms of rheumatoid arthritis. This painful, crippling disease steadily

progressed to involve most of the joints of his body. Renoir's fingers eventually became so deformed that he could not grasp or hold a paintbrush. Undeterred, he had the brush strapped to his hand. For the last nine years of his life, Renoir was confined to a wheelchair. Despite advancing age and incapacity, he continued to paint without interruption. A final floral oil painting was completed within a day or two of his death at age 78. He was speaking of his next project on that last day.

What a testimony to the indomitable spirit of this virtuoso! Renoir's art never hints at his suffering and debility. There is no vestige of the depressive episodes occasioned by illness, severe wounding of two sons during the first World War, and the untimely death of his wife. Renoir's technical mastery was barely compromised by the restrictions and weakness of his upper limbs. His paintings, sketches, and late sculptures (executed by aides under his directions) remained joyful affirmations of life, love, and beauty. Nothing would ever impede Auguste Renoir's creativity and bliss.

Claude Monet (1840-1926) was a close friend of Renoir. As a struggling young painter, Monet, too, endured poverty and ridicule as an upstart Impressionist. His young wife died of complications of childbirth, leaving him with two sons. Monet persisted in his painting until, at age fifty, he could afford to purchase a home and property in a picturesque village forty miles from Paris. Monet became a superlative gardener, reno-

vating his property into a group of exquisite flower gardens and, eventually, a water lily pond with a Japanese footbridge.

As he aged, Monet increasingly confined his art to paintings of his gardens. He began to complain of decreasing vision in his late sixties, voicing fears of future blindness. In 1911 his second wife died; three years later, his son succumbed. Monet was further disheartened by the opinion of a Paris eye specialist that he was nearly blind in one eye and severely limited in the other due to cataracts.

Nevertheless, at age seventy-five, he began a remarkable project: the creation of a series of mural-sized paintings of his water lilies. Despite depression and failing vision, he continued the work for ten years. During this period, he destroyed many of his paintings in bitter self-criticism and frustration. His dear friend, the retired statesman Clemenceau, cajoled and demanded that he see his work to its completion.

Monet interrupted the project at age 83 in order to undergo two hazardous surgeries on his right eye. Although his vision improved, he briefly experienced yellow vision, followed by a longer interval in which his visual world assumed a bluish tinge. He doggedly continued to paint. A second fitting of eyeglasses corrected the color defects. By 1926, the eighty-six year old master had completed the mural series. Upon his death in December of that year, these masterpieces were bequeathed to France and installed in the Museum of the Orangerie in Paris. There they remain as the final and eternal gift of a noble spirit.

Many Indian artists also have continued to create in spite of age and disability. Consider Allan Houser, an Indian artist who chose to continue working and creating into his elder years.

Houser was born Allan C. Haozous, a member of the Chiracahua Apache tribe. In 1886 the Chiracahuas, including Houser's parents, were imprisoned and relocated by the U. S. Army for twenty-seven years. Houser was born in 1914, just months after his parents' release; he was their first child born outside of captivity.

At an early age, Houser began to create drawings and carvings. During the following decades, he devoted himself entirely to artistic production. By the time of his death in 1994, Houser had produced almost one thousand sculptures and had displayed nearly fifty exhibitions in museums and galleries in the United States, Europe, and Asia.

Finally, let's consider the famous Hopi artist, Charles Loloma (1921-1991). Loloma succeeded in many areas of artistic production, but he was best known for his ceramics and jewelry creations. Loloma was honored with many awards; he was invited to give numerous lectures; and he was appointed to various prestigious boards.

In 1986 a terrible accident deprived Loloma of much of his energy and vitality. Nevertheless, he continued to create pottery and to paint, and his family continued to operate his studio for many years. In 1996, five years after his death, Charles Loloma was selected for a lifetime achievement award by the Southwest Association for Indian Affairs.

The stories of these four artists demonstrate that creative, vital people in all walks of life can continue to make magnificent contributions in art, in other fields, and to our shared celebration of the daily miracles and beauties of this world. □



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End-of-Life Issues for Native Elders

Katherine Augustine, RN, Council of Elders, *New Mexico Geriatric Education Center, UNM Health Sciences Center, Albuquerque, New Mexico*

The following article is based on a presentation to a class of medical students at the University of New Mexico School of Medicine given by Ms. Augustine (Laguna Pueblo), a retired nurse of 43 years.

Elders are well respected in their tribes; they are the ones who provide the long-ago stories, the unwritten history of families and tribes. They are listened to because of the knowledge they share and because of the time they have given to raising their families, sometimes including the grandchildren. So if an elder refuses treatment, it should be acknowledged.

Show respect; unless you are friends with the patient, do not call them by their first name, especially when working with elders. Even their families do not engage in this; they are called mother, father, grandmother, or grandfather.

Consider the patient's education and their use and understanding of the English language when you explain any procedures that are to take place. Speak slowly and allow time for them to ask questions. Negative aspects of a treatment should be addressed as well as the positive results that may occur, or any trust you have established will be dissolved.

A home visit can tell you a lot, such as an understanding the family life, their place in the community, what their socio-

economic concerns are, and the use of the languages in their home. In the Pueblos the patients are eager to have you come and visit them socially on their Pueblo's Feast day.

Research is a bad word only because since the arrival of the Europeans we have been studied by every means. Autopsy is a very bad word; to use it means having your body dismembered. Our whole body needs to go to the Spirit World.

A patient who has had total care in a health facility may suddenly want traditional care, either by a medicine man or through another native practice of healing. This should always be allowed even if obvious, imminent death is evident.

In the event of a coma or unconsciousness on the part of the patient, and there is the absence of a Power of Attorney, there may be a spokesperson for the family. It may be the elder in that family, or a relative, or even a councilman from the tribe that relays decisive actions made by the family as a whole after much discussion. These are also the people who participate in the burial rituals.

Most of all, do recognize and respect the beliefs and the practices of the Native Americans you may be caring for because they are putting their trust in your hands and heart. When the end has come for them on this earth be aware that they are continuing their journey to the Spirit World and know that you have fulfilled your duty as a truly dedicated doctor. □



Managing Dyslipidemias in Chronic Kidney Disease

Andrew S. Narva, MD; and Theresa A. Kuracina, MS, RD, CDE, both from the Indian Health Service Kidney Disease Program, Albuquerque, New Mexico

This article is the ninth of a series about chronic kidney disease and its management based on the new National Kidney Foundation guidelines. If you missed previous articles in this series, please log onto the IHS website. Archived issues are found at the Clinical Support Center's web page.

The National Kidney Foundation published the Kidney Disease Quality Outcome Initiative (K/DOQI) Clinical Practice Guidelines on Managing Dyslipidemias in Chronic Kidney Disease (CKD) in September 2002. The following summarizes the recommendations.

Patients with CKD are in the highest risk category for risk factor management (CHD risk equivalent)

The incidence of atherosclerotic cardiovascular disease is higher in this population compared to the general population. Survival of end-stage renal disease patients continues to be poor, due in large part to cardiovascular disease (CVD). Besides lipid abnormalities, other "non-traditional" risk factors for CVD include disorders of calcium, phosphorus, parathyroid hormone, and homocysteine, and systemic inflammation. The K/DOQI guidelines focus on managing dyslipidemia.

Evaluation

All adults and adolescents with CKD and all kidney transplant recipients should have a complete lipid profile (fasting):

- At initial presentation with CKD
- 2 - 3 months after a treatment modality change or other condition known to cause dyslipidemia
- At least annually thereafter

The National Cholesterol Education Program Expert Panel on Children (NCEP-C) differs from KDOQI Dyslipidemia guidelines for adolescents in the risk categorization (CKD patients not managed differently versus high risk); frequency of evaluation (every five years versus upon presentation, change and annually); and treatment recommendations (see below).

Evaluate dyslipidemia for remediable, secondary causes.

Treatment

Assess for modifiable risk factors including hypertension; cigarette smoking; glucose intolerance or diabetes control; and obesity, at initial presentation and then at least annually.

Manage these modifiable risk factors according to pertinent existing guidelines.

Adult Treatment Recommendations (> 20 years of age):

- If fasting triglycerides (TG) \geq 500 mg/dL (and no other underlying cause) use therapeutic lifestyle changes (TLC) and a triglyceride-lowering agent.
- If LDL \geq 100 mg/dL, consider treating to reduce LDL to < 100 mg/dL.
- If LDL < 100 mg/dL and fasting TG > 200 mg/dL and non-HDL cholesterol (total cholesterol minus HDL) \geq 130 mg/dL; consider treating to reduce non-HDL cholesterol to < 130 mg/dL.
- Fibrates may be used in Stage 5 CKD if TG \geq 500 mg/dL or if TG \geq 200 mg/dL with non-HDL cholesterol \geq 130 for those who do not tolerate statins.

Adolescent Treatment Recommendations:

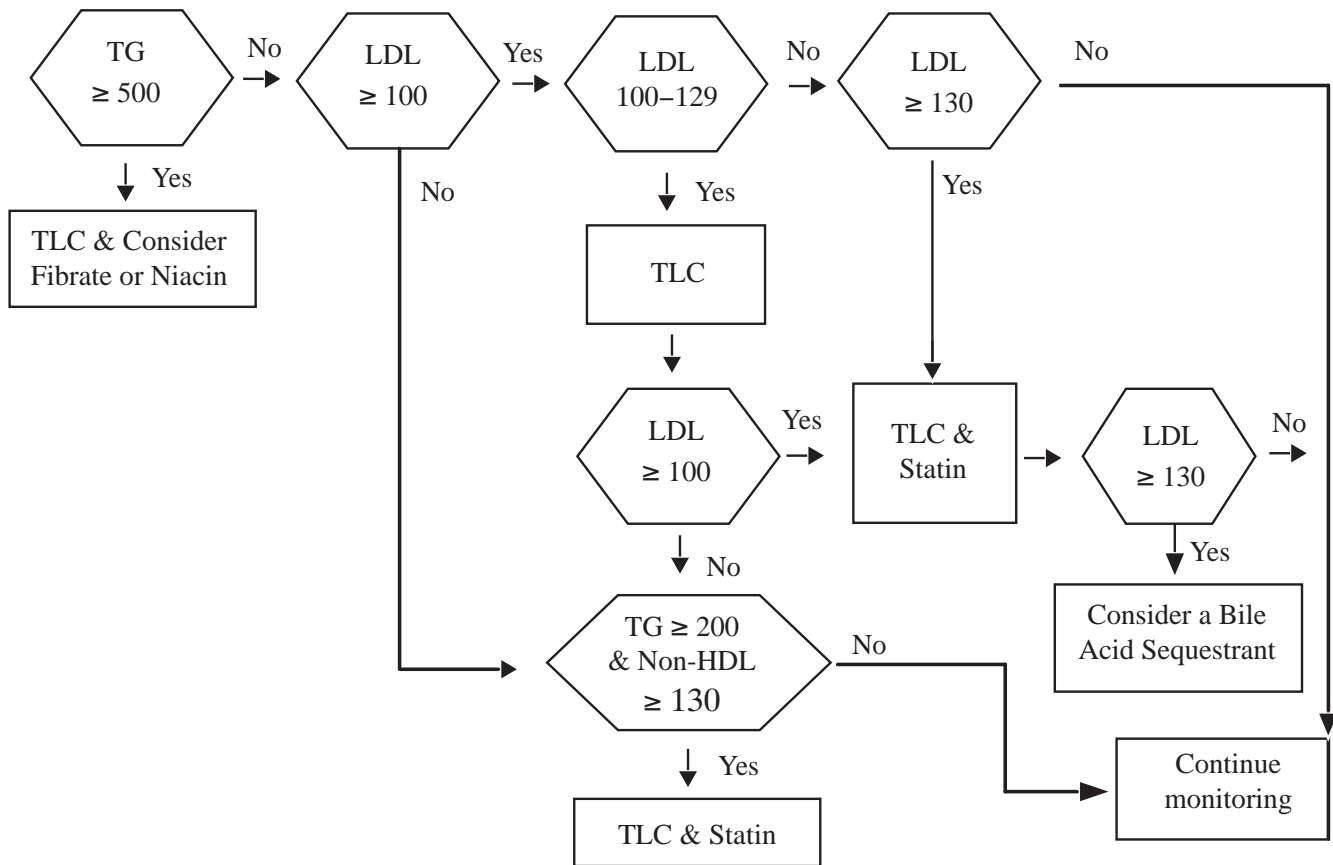
- If fasting triglycerides (TG) \geq 500 mg/dL (and no other underlying cause) use therapeutic lifestyle changes (TLC).
- If LDL \geq 130 mg/dL, consider treating to reduce LDL to < 130 mg/dL.
- If LDL < 130 mg/dL and fasting TG > 200 mg/dL and non-HDL cholesterol (total cholesterol minus HDL) \geq 160 mg/dL; consider treating to reduce non-HDL cholesterol to < 160 mg/dL.

Therapeutic lifestyle changes (TLC) involves diet, weight management, and physical activity. The TLC diet goals include < 7% calories from saturated fat, and cholesterol intake < 200 mg/day. A goal of 10 - 25 grams of soluble fiber and 2 grams of plant stanols/sterols should also be considered. Refer patients to a Registered Dietitian for TLC intervention.

A number of potentially important clinical trials involving kidney patients may provide additional information in the next few years. The KDOQI dyslipidemia guidelines should be updated within three years. This may happen sooner if new information is available. Until that time, consider CKD patients to be high risk for cardiovascular disease and its associated morbidity and mortality and treat accordingly.

An algorithm for treating dyslipidemia in adults appears on page 115. □

KDOQI DYSLIPIDEMIA ADULT TREATMENT RECOMMENDATIONS



LDL = low density lipoprotein
 TLC = therapeutic lifestyle changes
 Non-HDL = total cholesterol minus HDL
 TG = triglycerides.

Recent Changes to Executive Leadership Development Program

Recent changes to the Executive Leadership Development Program (ELDP) reflect current market trends. The registration fee for ELDP now includes all three sessions. The new tuition amount is \$4,500 for all three sessions, and the number of participants is limited to 50.

The participants must complete three sessions within the designated dates. The tuition is due 30 days prior to the start of Session One. There are no refunds for cancellations. However, you or your sponsoring organization may substitute another attendee up to one week prior to Session One without charge. No substitutions are permitted for Sessions Two or Three. Payment may be submitted by HHS 350 approved training form or by tribal organizational check.

SESSION DATES:

Session One – Omaha, NE
June 23-27, 2003

Session Two – Aurora, CO
July 28-August 1, 2003

Session Three – Aurora, CO
August 18-22, 2003

The IHS Clinical Support Center is the accredited sponsor.

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Recent Graduates Comment on ELDP

“...I am now firmly convinced that the Agency is a better organization as a result of this program’s long-term positive influence on the development of its future leaders. In fact, as a recent ELDP graduate, I have strongly recommended that all of the division directors and selected department directors of the Cherokee Indian Hospital consider participating in future program sessions.”

“My attendance at the three program sessions provided me

with valuable information and perspective on the principles of leadership, as well as guidance on the practical application of those principles during everyday work situations. I feel strongly that the interaction with fellow Indian Health Service (IHS) and tribal program managers from throughout the country, the classroom experience, and the professional focus of the entire ELDP add to the tools that participants need to increase their/our effectiveness. The increased effectiveness that individual leaders in the IHS gain from this program, also significantly increases the effectiveness of the Agency, as a whole.”

Edwin McLemore, JD, CEO, Cherokee Indian Hospital, Nashville IHS

“...ELDP builds a strong foundation for the day-to-day operations of IHS and ... prepared me to be a more effective leader. ELDP allows people to see the big picture and mission of IHS.”

Russ Alger, RPh, CEO, Warm Springs

“I attended the SES at MIT for senior candidates. In comparison, I found ELDP more relevant to IHS and comparable to what we deal with on a day-to-day basis. It buys into the IHS mission of executive leadership.”

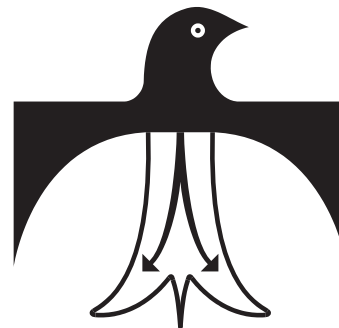
Michael Mahsetky, JD, Director of Legislative Affairs, IHS, Rockville

“...the significant difference was the focus on preparing Indian leaders to work in I/T/U settings.”

Anne Susan, Health System Specialist, Phoenix Area IHS

“I feel the ELDP course has good value for all I/T/Us, and I would recommend it to others.”

Michael Weahkee, California Rural Indian Health Board



Alzheimer's Disease Affecting American Indian Elders

There is a lack of scientific information about dementia among Native American care providers and families. What is Alzheimer's disease? It is one of several disorders that cause the gradual loss of brain cells. Although the disease was once considered rare, research has shown that it is the leading cause of dementia.

Dementia is an umbrella term for a condition made up of several symptoms related to a decline in thinking skills. Common symptoms include a gradual loss of memory, problems with reasoning or judgment, disorientation, difficulty in learning, loss of language skills, or decline in the ability to perform routine tasks.

People with dementia also experience changes in their personalities and behavioral problems, such as agitation, anxiety, delusions (believing in a reality that does not exist), and hallucinations (seeing things that do not exist).

Ten warning signs of Alzheimer's disease are as follows:

- Memory Loss
- Changes in mood or behavior
- Problems with abstract thinking
- Disorientation to time and place
- Difficulty performing familiar tasks
- Misplacing things
- Poor or decreased judgment
- Problems with language
- Loss of initiative
- Changes in personality

Disorders that Cause Dementia

Several disorders that are similar to Alzheimer's disease can cause dementia. These include fronto-temporal dementia, dementia with Lewy bodies, and Parkinson's disease. These disorders involve disease processes that destroy brain cells. Vascular dementia is a disorder caused by the disruption of blood flow to the brain. This may be the result of a large stroke or several tiny strokes.

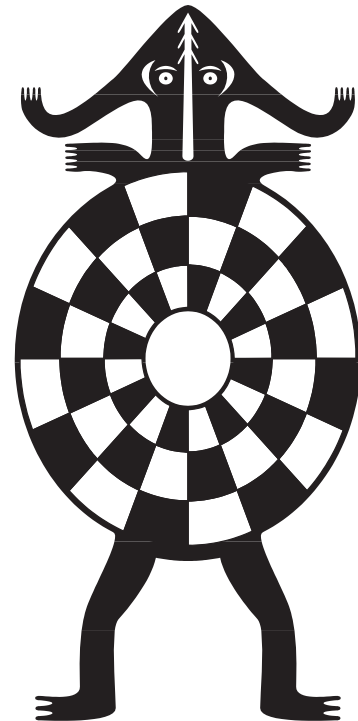
Some treatable conditions such as depression, drug side effects, and thyroid problems can cause dementia. If treated early enough, this dementia may be effectively treated and even reversed.

If you recognize any warning signs in yourself or a loved one, you should consult with your doctor. Early diagnosis is an important step in getting appropriate treatment, care, and support services.

New Research Project

The Arizona Alzheimer's Research Center and the NIH funded Alzheimer's Disease Center seek participants in a longitudinal study of memory impaired and normal elderly Native Americans. This study is being done to learn more about memory disorders in Native Americans. Contact Minnie Jim at (623) 875-6500 for more information. The study is free of charge, meals are provided, and transportation can be arranged.

Additionally a memory disorders clinic has been established at the Native American Community Health Center to diagnose and treat Native American elders with memory disorders, dementia and Alzheimer's disease. For more information, call (602) 279-5262, ext. 246. □





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

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