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*Editor's note: This May issue of The IHS Provider, published on the occasion of National Older Americans Month, is the fourth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for the May 2000 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.*

## The Health Status of Urban Indian Elders

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### Introduction

A decade ago, the Senate's Committee on Aging published the proceedings of hearings on the needs of American Indian and Alaska Native elders under the title, "The American Indian Elderly: The Forgotten People." Omitted even from the "Forgotten People" were Indian elders living in urban areas. Today, nearly equal numbers of elders live in urban and in rural reservation areas. For over a quarter-century, community-based surveys of elders living in urban areas have indicated that few people intended to return to their natal reservations after retirement. Instead, these elders who have spent their adult lives in cities planned to remain in their homes and near their urban families and friends. Even though urban American Indians and Alaska Natives (AI/AN) may not currently benefit from special federal or tribal health and supportive services, increasing numbers can be expected to seek health care and community-based long term care services.

A ground breaking study by the National Indian Council on Aging (NICOA) found that even in middle age, AI/AN suffer physical, emotional and social impairments that are more characteristic of the general U.S. population age 65 or older. Most of the information available on the overall health

of urban AI/AN elders was collected in surveys conducted in Los Angeles (Barker and Kramer 1996, County of Los Angeles 1989, Kramer, 1992), in Phoenix (Eck and St. Louis, 1972), and in a multi-site survey of Pittsburgh, Tulsa, Denver, Minneapolis, and Tacoma (NICOA, 1981). The Los Angeles County survey, conducted from 1987-1989, is the largest database. It contacted over 300 persons who self-identified themselves as AI/AN, who were recognized by the AI/AN community as elders, and who participated in AI/AN

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community activities. The median age for both men and women who were considered elders was 58 years (range 38 to 91 years). Health data reported in this article is largely based on that survey.

### Health and Human Service Needs of Indian Elders in Los Angeles

*Health is the #1 Priority.* Elders living in Los Angeles, ranked health care as their number one concern and number one priority for service. Their self-reported prevalence of chronic diseases compared unfavorably to both reservation and urban populations sampled by NICOA. Elders in Los Angeles reported higher rates of problems with eyesight, hypertension, diabetes, asthma, stroke, speech pathologies, liver disease, amputation, and cancers. In contrast, lower rates were reported for some conditions, notably hearing problems, breathing problems, kidney stones, tuberculosis and sleep disorders. Although no comparable data were collected by NICOA, a high frequency of dental problems was noted in Los Angeles; these comprised the third most frequently identified health problem.

**Table 1. Selected self-reported diseases or symptoms, AI/AN age 45 and older, by percentage of population.**

Health Problems	Los Angeles (n=283)*	National (n=712)**
Eyesight	65.9	54.6
Arthritis/rheumatism	36.4	42.6
Dental problems	33.2	NA
Hearing problems	21.0	44.4
Diabetes mellitus	19.8	12.5
Sleep problems	17.0	30.4
Breathing problems	13.1	34.0
Headaches	11.0	28.5
Asthma	8.1	4.3
Stroke	4.9	3.2
Speech problems	4.6	1.4
Liver problems	3.5	1.6
Kidney stones	3.2	8.9
Amputation	2.8	1.2
Cancer	2.5	1.1
Tuberculosis	0.4	5.0

\* From County of Los Angeles (1989); excludes homeless elders.<sup>3</sup>  
 \*\* From NICOA (1981), includes both rural and urban elders.<sup>7</sup>

Self-reported health status, a good marker of morbidity and mortality, crosscuts inter-tribal variation, age, sex and psychosocial factors among the elders of Los Angeles. Nearly half the elders reported their health as only fair (33%) or as poor (15%). The number of elders evaluating their health as poor is disturbingly high and about twice what was expected. A step-wise regression model related these fair-to-poor self-assessments with three predictors: low weight, low income, and use of cigarettes. While these findings may not be surprising, no systematic intervention strategies were in place to identify

vulnerable elders at the time of the survey.

*Behavioral health: typical bimodal patterns.* Behavioral health was also assessed. About one-third of elders habitually smoked cigarettes and, of that group, 54% smoked no more than one-half pack per day. About one-fourth of smokers were heavy cigarette users (or 5% of the total population). A bimodal distribution of behaviors was also found for consumption of alcohol. While 73% of elders did not drink alcohol, 8% consumed alcohol several times a week or daily. The proportion of heavy drinkers is consistent with patterns of alcohol consumption in this age group among the general population. Self-reported physical function and health status were not associated with current alcohol use. However, people who reported depression were more likely to drink alcoholic beverages more than once per month. In general, cigarette smokers were significantly more likely to consume alcohol than non-smokers.

*Activities of Daily Living.* Table 2 shows that, similar to other Americans age 65 or more years (National Health Interview Survey 1986 Functional Limitations), the majority of elders reported no impairments in either Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). Mobility disorders were the most common problem reported. Those who reported any limitation tended to report multiple impairments. The greatest number of impairments and the strongest correlation with age (i.e., older than 60 years) related to IADL, especially ability to use a telephone, handle finances independently, and prepare meals. Increasing age was also associated with limitations in ADL, with the strongest correlations found in bathing, transfer, and mobility. In relation to health conditions, IADL impairments were associated with heart disease and depression, while ADL impairments were significantly associated with shortness of breath.

**Table 2. Impairments in functional status by self-report for AI/AN elders, Los Angeles\***

Activities	% reporting any impairment (n=294)
<b>Activities of Daily Living</b>	
Bathing	7.7
Dressing	5.9
Toileting	4.9
Transfer	8.1
Feeding	2.4
Mobility	13.1
<b>Instrumental Activities of Daily Living</b>	
Using telephone	5.4
Handling finances	7.2
Shopping	19.0
Using transportation	19.2
Preparing meals	15.2
Doing housework	19.7

\* From County of Los Angeles (1989); excludes homeless elders.<sup>3</sup>

In Los Angeles, where nuclear households were common, frail elderly typically lived in multigenerational households. In particular, older women with ADL impairments tended to live in households with three or four generations of family members. Most frail elders had informal or formal assistance to remain at home, but most also noted that it was insufficient. While the family support system is an essential component of care, its effectiveness may be limited by lack of stable financial and other resources. Across the nation, about half the urban American Indian population age 75 or older lives with family members and these families are three times as likely to live in poverty as their white counterparts.

*Health risks of older women.* Significant health risks emerged for women. Compared to elder men, women reported significantly higher frequencies ( $p \leq 0.05$ ) of hypertension and of heart disease, as well as impairments of the ADLs bathing and grooming. Women also tended to report higher levels of limitations in IADL, in particular with housework, laundry, and using the telephone. As many as 37% of community-dwelling women over age 60 lived alone. Social isolation is a risk that has long been noted for urban elders, and few programs have addressed the need for socialization.

*Health and social services needs.* The Los Angeles project also documented the services which elders deemed important. First and foremost was the need for health screenings, particularly for eyesight, blood pressure, cardiovascular conditions, and diabetes. Exercise classes, rehabilitation, and health counseling were also highly desired. Elders also wanted to enhance the quality of their lives with cultural activities. The top five activities were potlucks, pow wows, crafts, games, and recognition of American Indian history. The types of activities that elders volunteered to lead generally coincided with traditional social roles of peer and intergenerational counseling, teaching American Indian history, crafts, and language, and providing day care to school-age children and youth. In addition, elders wanted to participate in activities offered at other senior centers in the area (e.g., field trips, legal aid, large-print library). Elders strongly supported the hope that an AI/AN senior center would one day operate in Los Angeles. They preferred delivery of health and human services at a centralized AI/AN senior center even if regular transportation would be a challenge.

## Discussion

*Limited available data: causes and implications.* Since AI/AN represent about 1% of the total U.S. population, sampling strategies are difficult and costly. Existing studies are cross-sectional and narrowly focused on cohort segments. Special large scale surveys have focused on populations concentrated on reservations. With 60% of the AI/AN population residing in other locations, generalizations must be made with caution. Unlike black and Hispanic populations, AI/AN populations are not routinely oversampled to account for variation.

No systematic data are collected on diagnostic patient care, vital statistics, or population characteristics for urban

AI/AN. The data collected by the Indian Health Service on this population is derived from aggregated national data for reservation states. A pilot study demonstrated a method for systematic collection of data from urban IHS clinics using ICD-9 diagnoses (American Indian Health Care Association, 1989). Conclusions based on such data should be tempered with the recognition that resources and access focus on younger populations, and so skew the epidemiological profile.

Urban AI/AN cannot be distinguished from the general population in cross-sectional national surveys, such as the National Health and Nutrition Examination Surveys (NHANES). Nor can urban AI/AN be distinguished from rural and reservation dwelling persons on longitudinal surveys, such as the Health and Retirement Survey. Other unique problems of data collection deter the use of typical large scale sampling methods: 1) random population sampling is impeded by poverty-related or seasonal instability of telephone accounts or places of residence, and by withholding of an "official" address due to distrust of authorities, experiences with aggressive collection agencies, and for other personal reasons, and 2) the validity of random population sampling is also compromised by a preference to avoid identification as Native American on census and other documents for fear of discrimination, by inflation of reservation or association enrollment for political or financial benefits, and by erroneous self-identification as AI/AN by non-Indians for a variety of personal reasons (Westermeyer 1996).

To date, there has been little comparability between sampling methods or survey instruments assessing the health status of urban AI/AN populations. Despite these methodological problems, the take home message is clear. Urban dwelling AI/AN, from the time of birth (Grossman, Krieger, Sugarman, Foquera 1994), experience greater disparities in health risks and morbidity than urban-dwelling whites. Table 3 shows the relative risk of chronic disease for middle age AI/AN (all residential locations) in comparison to other census subpopulations.

**Table 3. Relative risk of health problems for persons 51-61 years old; odds ratio for minority groups compared to whites (from the first wave data of the Health and Retirement Survey)**

	American Indian	Black	Hispanic	Asian/Pacific Islander
Diabetes	2.52	2.46	2.00	1.01
Cancer	2.42	0.77	0.66	0.23
Congestive heart failure	2.24	1.43	0.82	0.37
Angina	2.17	2.05	1.14	0.63
Heart problems	2.00	1.07	0.71	0.51
Head injury	1.95	0.60	0.89	0.04
Psychological problems	1.76	0.98	1.38	0.26
Lung disease	1.74	0.74	0.75	0.44
Broken bones after age 45	1.64	0.76	0.76	0.55
Hypertension	1.59	2.33	0.79	0.99
Stroke	1.48	2.03	1.43	0.72
Arthritis	1.42	1.08	0.98	0.68

Even less is known about the health of urban AI/AN elders. Generalizations from these cross-sectional studies are limited by the lack of consistency in defining terms, by the use of unique survey instruments, and by methodological inconsistencies. Regional variation noted in the IHS service areas may be even more complex in urban areas, where an astonishingly wide range of native cultures has converged, particularly on the west coast. In Los Angeles, for instance, 92 tribal affiliations were claimed by 328 elders. Although born on reservations, most of these elders have aged in urban, not reservation, environments. Their knowledge about aging and cultural roles for elders may reflect the reservation social life of their youth, but their own experiences of aging reflect urban living conditions. In addition to tribal variation, health-seeking and health-promoting behaviors vary by individual in adherence to traditional and/or western beliefs, by access to a variety of health care providers, and by ability to pay for health services or enrollment in a health plan through an employer or pension plan or through Medicare. Further complexity derives from competing definitions of aging used by the AI/AN community, service providers, and policy makers.

The final problem in data collection is the sparse distribution of elders over urban landscapes. For instance, the 1990 US Census (STF3) reports that 2,886 AI/AN elders (60 + years) lived in the Los Angeles County Area Agency on Aging (AAA) planning and service area, which provides community-based services to over one million older adults. Although AI/AN represent only 0.2% of the population of adults age 60 + years, they live in about half of the 310 incorporated cities, communities, and unincorporated areas in this 4000 square mile county (excluding the City of Los Angeles AAA service area). For 31% of these communities where AI/AN elders reside, they number no more than one to four individuals. In 83% of the communities in which elders reside, they number no more than 25 persons. This distribution poses challenges to developing cost competitive programs based on strategies for culturally appropriate targeting and service delivery. It also poses significant challenges to scientific sampling strategies. The survey of elders in Los Angeles tried unsuccessfully to structure a probabilistic sample based on census tract data, door-to-door canvassing in neighborhoods which historically were known to have high AI/AN populations, and AI/AN community organization membership lists or referrals.

For all these reasons, convenience sampling has generally been the most practical method of data collection. Indeed, when sufficiently broad and well-structured the method achieves good results (Westermeyer 1996), matching census data for population structure, reflecting cultural values (i.e., definition of elderhood and self-identity), and identifying persons who would avail themselves of services that were targeted especially for AI/AN elders' needs. This latter point is of particular importance because 1) elders' needs differ from those of general population older adults, 2) resources designed for general population older Americans are tied to chronologi-

cal age criteria, and therefore cannot be accessed by a substantial portion of elders, and 3) design of culturally competent health and human services would reflect the interactional basis of the pan-Indian community as well as the needs, utilization patterns, and values of individuals who interact within that ethnic framework.

*Future research.* The sparse literature available suggests a population at risk for poor health, particularly from cardiovascular disease and diabetes. Increasing numbers of older urban AI/AN, typically with high rates of chronic diseases, will be seeking medical care in urban areas. To date, however, there has been no systematic comparison of the health needs and utilization patterns of urban elders cared for by IHS clinics, or by other emergency or primary care providers.

Salient questions for serving the health needs of urban elders remain unanswered. Most obvious is the need for a systematic and efficient database to assess morbidity and mortality and to develop projections for demands on health care systems. These projections should address policy-related issues of allocating services based on a diversity of needs rather than age-eligibility. Other policy issues are access, resource allocation, and potential partnerships with third party payers to serve urban elders.

Equally important is the need to develop health services models that will optimize care for aging urban elders. These models might examine outcomes based on the health care institution (IHS, county clinics, private providers, managed care models), on the level of care (primary care, specialty care, geriatric primary care), on cultural competency in delivery of health services, or on the integration of human services in health delivery systems. Demonstration partnerships with non-Indian, community-based health care programs to deliver preventive health care also merit evaluation of best practice models.

Little attention has been given to community-based long term care. The literature indicates greater utilization of nursing homes among urban AI/AN families, but little is known about the factors that contribute to the family decision about placement. Consideration might also be given to examining cultural biases embedded in assessment instruments. For instance, the instrumental activities of daily living model strongly reflects a metropolitan lifestyle.

The month of May, 1999 marks both Older Americans Month in the United States, during the United Nations International Year on Aging. This is a time when the provision of health and human services to older adults is a prominent consideration for many providers and policy makers. Given the demographic imperative, it is a fitting time to include urban AI/AN elders in our considerations to optimize their health and quality of life. □

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# Incontinence in Elders: A Practical Diagnostic and Management Schema

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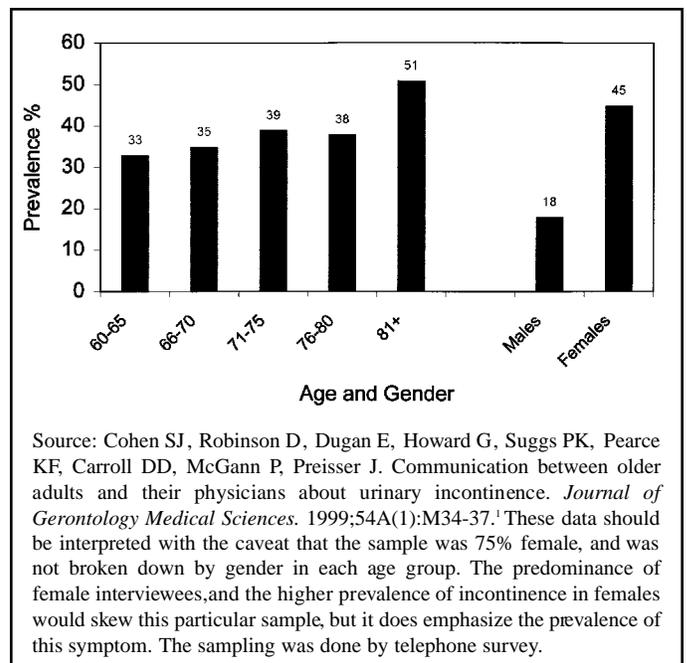
## Introduction

Incontinence is common in elders, and is more common in the elder female than in the elder male (see Figure 1).<sup>1</sup> Many elders have come to think that incontinence is inevitable with aging, and therefore they don't mention this problem to their doctors, or even to family.<sup>1</sup> It is a condition feared by many elders, because it is often a primary reason that they may cease community living to be placed in a nursing home, with their independence now sacrificed. Incontinence is an ailment so much a part of our everyday life, and yet one we want so much to hide,<sup>2</sup> that adult diapers now often fill entire aisles in a supermarket, while these products were uncommon just a decade or so ago. Approximately 15-30% of community dwelling elders, and 50% of nursing home residents suffer from urinary incontinence.<sup>3,4</sup> The June Allyson Incontinence Foundation even has a web site on the Internet, as do other incontinence self-help groups. Incontinence is closely related to an elder's risk of falling, especially when it is combined with nocturia.<sup>4</sup> Incontinence is the second most common reason for nursing home placement of the elder.<sup>3,4</sup>

*Incontinence is not inevitable for elders, nor is it untreatable if it occurs.* Providers need to specifically inquire of their patients about incontinence, and let them know that diagnostic studies can be done to find the cause. They must reassure them

that most incontinence can be successfully treated, so that these elders may regain their dignity and improve their quality of life. Unfortunately, both medical and nursing education programs devote too little attention to urinary incontinence.<sup>3</sup>

**Figure 1. Prevalence of incontinence in elders**



## Types of Incontinence

Incontinence is defined as the involuntary loss of urine which is sufficient to be a problem,<sup>4</sup> and can be divided into specific types (see Table 1), according to when or how it occurs, and its precipitating or associated factors. The type of

incontinence is closely associated with the etiology.<sup>5</sup>

**Table 1. Types of urinary incontinence and their characteristics**

<b>Stress</b>	Leakage of small amounts of urine during physical movement or activity (coughing, laughing, sneezing, running, exercising, lifting)
<b>Urge</b>	Leakage of a large amount of urine at unexpected times, including during sleep
<b>Functional</b>	Untimely urination because of physical disability, external obstacles, or problems in thinking or communicating that prevent a person from reaching a toilet in time
<b>Overflow</b>	Unexpected leakage of small amounts of urine because of a full, distended bladder
<b>Mixed</b>	Mixed etiologies of incontinence, usually the occurrence of stress and urge incontinence together
<b>Transient</b>	Leakage that occurs temporarily because of a condition that will pass (infection, medication)

Source: Adapted from National Institute of Diabetes, Digestive and Kidney Diseases. Urinary Incontinence in Women. NIH Publication No. 97-4132. National Institutes of Health, Bethesda, MD, 1997.<sup>5</sup>

*Stress incontinence*, the most common type of incontinence in women, is associated with initiation of strenuous activity and a sudden increase in intra-abdominal pressure (true stress incontinence). Stress incontinence is uncommon in males, occurring usually only post-prostatectomy. The leakage is usually episodic and of small amounts, and is commonly accommodated or hidden by wearing perineal pads, pieces of facial or toilet tissue, adult diapers, or by frequent voiding so that the bladder is usually almost empty. The stress may be as minor as picking up a small grandchild or a package, coughing, laughing or sneezing, or running to catch a bus. In the female, stress incontinence is most often due to pelvic relaxation and/or damage associated with childbirth, with additional relaxation and atrophy of the pelvic tissues occurring at menopause, related to the loss of endogenous estrogen.

*Urge incontinence*, also called detrusor instability, occurs because of contractions of the bladder detrusor muscles that are often irregular; these decrease the bladder capacity and increase intravesicular pressure. On cystometry, detrusor instability is marked by sudden rises in pressure accompanied by the urge to void (usually uncontrollable), and decreased bladder capacity. Interstitial cystitis and acute or chronic cystitis are among its causes, but the cause may also be idiopathic. Even with infection, the reduced bladder capacity and increased vesical irritability may persist long after the infection has been treated. Behavior is an overlying factor that

often contributes negatively.

*Functional incontinence* is seen in those individuals with neurologic conditions, such as stroke; post-prostatectomy (with destruction or ablation of the internal sphincter); Alzheimer's and other dementias; motor weakness or inability to get to the toilet in time (insufficient time between sensation of the need to void and the ability to get to the bathroom); or due to a bladder stone obstructing or interfering with vesical sphincter function. Whenever possible, the primary cause should be treated, and attempts should be made to determine if environmental changes will suffice to keep the elder dry. These causes are to be distinguished from neurogenic etiologies, such as diabetes mellitus and spinal cord lesions.

Medications such as thiazide diuretics or furosemide (Lasix) that are prescribed for hypertension or edema may transiently increase the total urine production. Caffeine containing beverages may also result in diuresis. If diuretics are used late in the day or at night, this may contribute to nocturia, which may result in incontinence. Administering these medications in the daytime may minimize this problem (see also Table 2). There is also a tendency of the kidney to lose some of its usual nocturnal antidiuresis with aging (the usual nighttime concentration of the urine with recumbency or sleep); as well the kidneys may produce more urine at night as a homeostatic response to renal failure. Restriction of total fluid intake is best avoided, however, as maintaining adequate intake is essential to the elder's hydration.<sup>4</sup> Studies have shown that many elders may produce larger volumes of urine during the nighttime than the daytime hours,<sup>6</sup> contrary to what is the expected norm.

**Table 2. Drugs with an adverse effect on continence**

<p><b>Drugs causing urinary retention:</b>  Opiates  Alpha-adrenergic agonists (including OTC decongestants, e.g., phenylpropanolamine, pseudoephedrine) especially in males  Calcium channel blockers (e.g., verapamil)  Anticholinergics (atropine/belladonna, propantheline, bentlyl)  Some antihistamines (especially the older agents)  Some anti-Parkinson agents</p> <p><b>Drugs causing female urinary incontinence:</b>  Alpha-blockers (prazosin, terazosin, doxazosin)  ACE inhibitors (only if they cause cough)</p> <p><b>Drugs causing sedation/confusion</b>  Benzodiazepines (Valium )  Sedatives (Dalmane )</p>
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### Evaluation

Much of the evaluation and treatment of incontinence can be done by primary care providers, with only a few items

requiring specialty procedures or consultation. Since this is often a “secret” or hidden ailment, the provider must inquire directly about incontinence in the elderly client.<sup>2,3,4,5</sup> If incontinence exists, a thorough, detailed history then needs to be taken, inquiring about the amounts of urine lost, under what specific circumstances, and what is being done (or has been done in the past) for control, hygiene, avoidance, or amelioration. Although there is frequently a mixed etiology, this type of information is essential to understanding the problem and the impact of the problem on the elder’s quality of life. The provider should also inquire about the elder’s specific goals relating to the incontinence, for example, to prolong the times between urination so that they can go to a movie, decreased nocturia so they can sleep better, or to be able to ride in the car with their family or friends (see Table 3, Goals of incontinence management).<sup>7</sup>

**Table 3. Goals of incontinence management**

<p>Preservation of the upper urinary tract          Maintain or regain adequate bladder capacity with good compliance          Promote low-pressure micturition          Avoid bladder overdistention          Prevent urinary tract infection          Minimize use of Foley catheters          Choose therapy that minimizes the patient’s risks while maximizing his/her social, emotional, and vocational acceptability*</p> <p>*Major goal</p> <p>Adapted from: Kenelly MJ, Rudy DC. Incontinence caused by neurologic disease. In: O’Donnell PD, ed. Urinary Incontinence. Mosby-Yearbook, St. Louis, 1997; chapter 47, page 341.</p>
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A detailed physical exam should be done by the provider, including a pelvic exam in the female, and a digital rectal exam in the male. A post void residual urine volume should be measured (by catheterization); this residual should be less than 100 ml and should also be less than 1/3 of the volume of urine that was voided.

Typically, in overflow incontinence, there is a large residual, with small amounts of urine voided. The sensation of bladder fullness is lost. This may even cause retrograde pressure on the kidneys, with hydroureter, hydronephrosis, and, eventually, decreasing kidney function. In the patient with prostatism (benign prostatic hyperplasia), there is hesitancy, dribbling, nocturia, and urgency, with an associated sense of incomplete emptying of the bladder. The volumes passed are usually small (overflow, with the bladder left fairly full), with a decreased force of the urinary stream. In the female, overflow incontinence sometimes occurs, as with an atonic bladder or as a result of overly vigorous surgical correction of stress incontinence (iatrogenic overflow).

Looking for actual stress leakage with the patient having a full bladder, or examination in the standing position may be necessary in the diagnostic evaluation. When the bladder is catheterized for residual urine, a urine culture should also be done, looking for a cryptic bladder infection.

A simple cystometric study can be done with minimal equipment, using a three way stopcock (or a Y tube) and a water manometer. Fill the bladder with incremental amounts of water via a catheter attached to the manometer. Fluctuations in bladder pressure are manifest as changes in the manometer pressures, which should stay low (less than 10 cm) until at least 300-350 ml is reached. A utero-fetal monitor (electronic fetal monitor) can be converted for use for the same purpose, and will give a graphic record of the procedure. Voiding can usually be suppressed by most patients until a bladder volume of about 500 ml is reached, at which time the intravesical pressure will rise sharply.

In a patient with urge incontinence, there is a sudden and uncontrollable urge to void, accompanied by increased bladder pressure and voiding, but at a low volume. There are few patients who need complex cystometry, and these patients can be referred to either a urologist or a urogynecologist for evaluation with urodynamics.<sup>4</sup>

In patients with urge incontinence, small amounts of urine are passed, due to spasmodic contractions of the bladder, usually without the stimulation of stress or increased intra-abdominal pressure; the bladder may empty completely (small residual), and usually there is a small total bladder volume/capacity. Since small amounts of urine are passed often, urinary frequency is a common complaint. Cystometry helps to establish the diagnosis, showing frequent spikes in intravesical pressures at low bladder volumes. Patients with urge incontinence have usually practiced avoidance by urinating often so as to avoid a full bladder, further compromising the bladder capacity (a negative behavioral change in the long run). Strict bladder training with timed voidings, increasing the elapsed time between voidings over several weeks or months, can be successful in as many as 75% of patients with detrusor instability. For those who do not respond to this treatment regimen, the use of bladder antispasmodics such as oxybutinin (Ditropan) or tolteradine (Detrol) can reduce the involuntary contractions (relaxation of bladder muscle, increased tone of the vesical sphincter). Imipramine (Tofranil) given at bedtime, with its anticholinergic activity, can reduce the involuntary nighttime voiding and enuresis. (More about this later under “Treatment.”)

While cystometry is the most useful diagnostic tool for urge incontinence, it should be stated, however, that this procedure can miss as much as 20 - 25% of detrusor instability (false negatives). Another caution: surgical correction of stress incontinence in a patient who has both stress and urge incontinence, can make that patient miserable.

A voiding cystourethrogram in a male with stress incontinence may show funneling of the bladder neck (into the

prostatic fossa), and loss of the internal sphincter. In the female, various types of descensus, with displacement of the urethrovesical junction may be found. Electromyography can demonstrate the involuntary bladder contractions in urge incontinence. Cystoscopy can show interstitial cystitis, intravesical calculi, and vesical, urethral or bladder diverticuli. Ultrasonography is usually not very helpful in this condition, although it may show large residual volumes with incomplete emptying, hydroureter, hydronephrosis, or overflow incontinence, and it is a non-invasive diagnostic procedure.

**Table 4. Criteria for further evaluation or referral\***

<p>Uncertain diagnosis and inability to develop a reasonable treatment plan based upon the basic diagnostic evaluation.</p> <p>Uncertainty in diagnosis may occur when there is a lack of correlation between symptoms and clinical findings</p> <p>Failure to respond to the patient's satisfaction to an adequate therapeutic trial, and the patient is interested in pursuing further therapy</p> <p>Consideration of surgical intervention, particularly if previous surgery failed or the patient is a high surgical risk</p> <p>Hematuria without infection</p> <p>The presence of other comorbid conditions, such as: incontinence associated with recurrent, symptomatic urinary tract infection; persistent symptoms of difficult bladder emptying; history of previous anti-incontinence surgery, or radical pelvic surgery; symptomatic pelvic prolapse beyond hymen; previous pelvic radiation treatment; prostate nodule, asymmetry, or other suspicion of prostate cancer; abnormal post-void residual urine; neurological conditions, such as multiple sclerosis or spinal cord lesions or injury</p> <p><i>* Some patients who meet these criteria may not be appropriate for further evaluation and treatment if such evaluation and/or treatment is not desired by or feasible for the patient.</i></p> <p>Source: Fantyl JA, Newman DK, Colling J, et al. Urinary Incontinence in Adults: Acute and Chronic Management. Clinical Practice Guidelines Number 2 (1996 Update), Agency for Health Care Policy and Research, DHHS. AHCPR Publication No. 96-0602, Rockville, MD, March 1996.</p>
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**Treatment**

In general, treatment is based upon using the least invasive or intrusive therapy first, progressing to more aggressive therapy as necessary or as tolerated. Treatment strategies include exercises, biofeedback, behavioral therapy, avoidance, pharmacotherapy, devices or appliances, surgery, or any combination of therapies. The treatment should not be worse than the disease, and a paramount goal should be to preserve the dignity of the individual. The elder should be involved in making the decisions about the treatment strategy, and should be informed about potential side effects and the length of time before changes/improvements would normally be noted. They should be fully informed about "staged" treatments, so that they know what to anticipate. Treatment should fit the elder's

own goals, and not those of the family or other caretakers (see Table 3).

*Behavioral.* Kegel's exercises can be effective for stress incontinence in 70% of females, and 50% of males. This modality should be tried for at least six weeks before it is deemed a failure, since the earliest positive results are usually noted only after about three weeks. In those with combined or mixed stress/urge incontinence, a combination of timed voidings, antispasmodics, and Kegel's exercises may be effective, along with "mapping" out the location of accessible bathrooms along the planned path of the elder's trip or day's activities. Kegel's training should be retried in those for whom it has been previously used with success, but whose stress incontinence has recurred. Electrostimulation of the pelvic diaphragm (see below) may strengthen the levator muscle, and takes at least three to five weeks to achieve positive results.

Therapy using vaginal cones of varied and increasing weights can help to restore sufficient pelvic diaphragmatic muscle support to alleviate stress incontinence. In some elders, the use of pessaries can elevate and support the urethrovesical angle sufficiently to relieve stress incontinence.

*Electrostimulation.* Electrostimulation of the sacral autonomic or somatic nerves and pelvic musculature can improve both stress and urge incontinence; it is especially valuable in stress incontinence. While there are large amounts of literature (including some meta-analyses) showing improvement,<sup>8</sup> there is not much known about the actual mechanism of improvement. In stress incontinence, high frequency current is utilized (50-100 Hz), while in urge incontinence, low frequency stimulation is used (5-20 Hz). Probes are placed intra-vaginally and/or intra-anally, with the frequency attuned to the type of muscle fiber being stimulated. While this can be done in either a clinic or home setting, many older clients have difficulty using this therapy at home. Reports show approximately 35 - 40% are either improved or completely dry.<sup>8</sup> There are few contraindications to electrostimulation.<sup>8</sup>

*Biofeedback.* Biofeedback is used by many therapists to make patients aware of sensations in the urinary bladder, training them to suppress behaviors triggered by urinary sensations, in order to increase storage. Training induces an automatic response, which extinguishes the abdominal, sphincter, and detrusor instability causing the incontinence. It is one of the therapies used successfully with urge incontinence, usually combined with behavioral therapy. It has varying degrees of success, with reports of complete control in 20 - 25%, and improvement in an additional 30%. It must be recognized that biofeedback requires sophisticated equipment, and training of the provider, who must then be able to train the patient to have specific responses to stimuli from the bladder. Long term follow-up data are not available.

*Pharmacotherapy.* There are presently no drugs that are effective for true stress incontinence. In benign prostatic hyperplasia (prostatism), medical therapy is more often used today than surgery, the previous mainstay. Because of the high con-

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centration of alpha receptors in the prostate gland, both alpha-blockers and alpha-reductase inhibitors are now widely used to treat prostatism, and can reduce the size of the prostate gland dramatically. Thus, the obstruction of the urinary stream that occurs with benign prostatic hypertrophy can be managed medically. These medications vary in their rapidity of action, some acting within a few weeks, others taking as long as three to six months to show maximal effect. Finasteride (Proscar, Propecia), doxazosin (Cardura), tamsulosin (Flomax), terazosin (Hytrin), and prazosin (Minipress) are all used clinically, with 90% of prostatism in 1999 now being managed medically. *Not all are FDA approved for prostatism* (most do not have specific labeling, and therefore this amounts to an "off label" use). The PSA (prostate specific antigen) should be measured before and during treatment (the baseline PSA value may be changed by as much as 50%). As alpha-blockers are also effective agents in managing hypertension, control of hypertension may also be achieved simultaneously. In some individuals, there may be excessive sensitivity, producing orthostatic hypotension (and occasionally syncope). Tamsulosin is more prostate specific than some of the other drugs, with less blood pressure effect. Bedtime administration of the alpha-blocker should be considered, to avoid hypotension, but one must be aware that if the individual experiences nocturia, syncope may occur during nighttime trips to the bathroom.

Oxybutinin, tolteradine, and imipramine are widely used to control urge incontinence. Side effects include dry mouth, dry eyes, constipation, and aggravation of closed angle glaucoma (a contraindication to use). The least expensive agent that will do the job without causing disturbing side effects in each particular patient should be utilized. Medications that require fewer doses per day (tolteradine requires only BID dosing; oxybutynin, TID or QID) yield better patient adherence (a cheaper medication that is not taken is a false economy). Although oxybutynin is less expensive and is considered first line, be aware that it may have an adverse effect on cognition in elders,<sup>9</sup> which side effect has not been reported with tolteradine. The cognitive side effects of oxybutynin may cause some elders to decompensate dramatically,<sup>9</sup> and should be observed for closely. Dry mouth may interfere with appetite, and dry eyes may interfere with the wearing of contact lenses.

Estrogen replacement has a profound beneficial effect on female incontinence symptomatology, because the female urethra is highly dependent upon estrogen. In some cases, topical estrogen (estrogen topical cream or estrogen urethral suppositories) will have a more profound and more dramatic effect on the urothelium. Imipramine, with actions on the detrusor muscle (relaxation), the urinary sphincter (contraction), is used in both children and adults with enuresis and involuntary voiding.

*Surgical procedures.* Various surgical procedures are used for the treatment of stress incontinence. Commonly used by gynecologists is anterior colporrhaphy, which, although usually

immediately successful in reconstructing both the pelvic and perineal diaphragm, has a 25 - 40% return of symptoms within five years. The many suspension and sling procedures (Marshall-Marchetti-Krantz, Pereyra, Burch, rectus or fascia lata sling, Raz) each have their proponents, but they all offer good results with infrequent recurrence of stress incontinence (less than 10 - 20% after five years). These latter procedures lengthen the urethra, displace (elevate) the urethro-vesical junction, and, additionally, fixate the urethro-vesical junction to a bony anchor independent of the muscular pelvic diaphragm.

*Collagen injection.* Collagen injected around the base of the bladder may help in the formation of an artificial sphincter, or reinforce a weakened sphincter. After this procedure, the patient must be closely monitored for the post injection occurrence of acute retention or for gradual absorption of the injected collagen and the return of incontinence (necessitating a reinjection). Collagen injection is rarely a permanent cure, but can yield temporary relief from incontinence for the elder. It can often be done as an office procedure under local anesthesia.

*Intermittent self-catheterization.* In cases where overflow incontinence has not been relieved in any other manner, intermittent self-catheterization can be used in both the male and female.<sup>10</sup> This is usually performed as a clean (not sterile) procedure, and can be done over prolonged periods without causing excessive urinary tract infection. Certainly the bladder tolerates intermittent self-catheterization better than overdistention or an indwelling Foley catheter, whereby the urine is usually infected within 48-72 hours of catheter placement. An indwelling catheter is also a potential nidus for the formation of bladder stones, and should be avoided if possible. Intermittent self-catheterization is contraindicated in the patient who lacks either the mental capacity or the manual dexterity to perform the procedure. For some males, an external catheter (condom catheter) with a leg bag may be a useful alternative.

*Mechanical plugs and appliances.* Introduced in the last couple of years is a rubber plug device (Reliance) which can be introduced into the female urethra and used to control incontinence. The plug is removed for voiding and replaced into the urethra after voiding. The device should not be worn for more than six hours at a time. There is a high incidence of bladder infection after one year of use. Also newly available is a triangular pad that is actually glued across the meatus, closing it (Miniguard). This is removed for voiding and a new pad is placed afterwards.

*Neuroimplantation.* A new device/procedure is available for the spinal cord injured patient with incontinence. This is an electrical stimulator device that is implanted in patients who have intact and functional spinal nerves. The NeuroControl VOCARE Bladder System requires special training in its placement, but does result in urination on demand, with low residual volumes. It delivers low levels of electrical stimulation to the intact sacral nerve roots enervating the bladder, causing the bladder detrusor muscle to contract, and the bladder to

empty.

**Appliances.** Functional incontinence may often be managed by simply providing a urinal, bedpan, bedside commode, or a condom catheter for the elder to use during those times when they are unable to get to the bathroom. These are all preferable to placing an indwelling catheter, which predisposes to infection, increasing the elder's risk of sepsis. In some cases, the provision of handgrips, or an elevated toilet seat as an assistive device may suffice to improve self-toileting. There are also non-tipping male urinals, and urinals specifically designed for females that can be used. While not an appliance but a nursing procedure, timed reminders may assist in keeping the elder aware of the need to use the bathroom.

**Avoiding iatrogenic incontinence and managing the side effects of pharmacotherapy.** Complaints of dry eyes or dry mouth in the patient on oxybutynin should be managed by switching the patient to tolteradine, since its actions are almost entirely confined to the bladder. New onset confusion in the patient on oxybutynin should be initially ascribed to the drug rather than to dementia.<sup>9</sup> In the patient taking alpha-blockers, fainting or dizziness when arising from bed, particularly with nighttime dosing, should be initially managed by changing the time of administration, or next by reducing the dosage; if none of these measures work, then the medication may have to be changed.<sup>11,12</sup> Tamsulosin has the least effect on blood pressure. It should be noted that alpha-reductase inhibitor drugs (primarily finasteride) are contraindicated for women, and produce hirsutism (they are also used for treating male pattern baldness). These drugs may also induce a specific birth defect, hypospadias, but reproduction is generally not a concern in the geriatric patient. Calcium channel blockers, when used for hypertension, may cause undesired effects on the urinary system, occasionally causing retention (see Table 2). Always in elders, a fundamental goal is to reduce the total number of drugs being used to avoid potential drug interaction and/or adherence problems.

**Other modalities.** Other modalities used include artificial sphincters, urinary diversion, and implantation of other special devices, all of which have varying degrees of success in the proper, specialized hands.

## Conclusions

- Urinary incontinence is very common among elders, and is epidemic among elderly nursing home residents.
- Of all those with urinary incontinence, more than half have had no evaluation or treatment.
- Urinary incontinence is not a part of normal aging, but age-related changes predispose to its occurrence.
- Urinary incontinence leads to stigmatization and social isolation.
- Every person with urinary incontinence is entitled to evaluation and consideration for treatment.
- Many health care professionals ignore urinary incontinence and do not provide adequate diagnosis and

treatment.

- Providers must take a proactive approach to the problem of incontinence in elders, and not just assume that the elder is continent if they don't specifically mention incontinence as a complaint.
- Contrary to prevailing opinion, most cases of urinary incontinence in the elderly (90%) can be cured or substantially controlled. □

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# Administration on Aging Programs and Services for Indian Elders

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*M. Yvonne Jackson, PhD, Director, and Margaret C. Graves, LCSW-C, Native American Aging Program Specialist, both from the Office for American Indian, Alaskan Native, and Native Hawaiian Programs, Administration on Aging, Washington, DC*

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Today, one in every twelve American Indians and Alaska Natives (AI/AN), or about 166,000 persons, is 60 years of age or older. This number is expected to increase over 225% in the next 30 years. Given this welcome trend, AI/AN who are now in their 40s and 50s can expect to live well into their 80s and 90s.

While most AI/AN elders are active members of their families and communities, others need some type of assistance, ranging from help in preparing meals to total care. To help meet the diverse needs of the growing number of older persons in the United States, the Older Americans Act of 1965 (OAA), as amended, created the Administration on Aging (AoA) as a primary vehicle for organizing, coordinating, and providing community-based services and opportunities for older Americans and their families.

The AoA is the federal focal point and advocacy agency for older persons. It provides funds for programs and services for older persons and assists in protecting the rights of vulnerable and at-risk older persons. Working in close partnership with the national aging network — 57 State Units on Aging (SUA), more than 661 Area Agencies on Aging (AAA), 225 Indian tribal organizations representing nearly 300 tribes, and thousands of service providers, senior centers, caregivers, and volunteers — the AoA supports the development and coordination of community-based systems of services designed to meet the needs of elders and their caregivers.

## **Office for American Indian, Alaskan Native, and Native Hawaiian Programs**

The OAA established the Office for American Indian, Alaskan Native, and Native Hawaiian Programs. This Office is responsible for administering and evaluating grants to tribes, providing training and technical assistance to grant recipients, coordinating activities between other federal departments and agencies to assure a continuum of improved services, developing research plans, conducting and arranging for research in the field of AI/AN aging, and collecting and disseminating information related to problems experienced by Indian elders. Most importantly, this Office is responsible for serving as the effective and visible advocate on behalf of

AI/AN elders.

## **Title VI Grants for Native Americans**

Under Title VI of the OAA, grant awards are made directly to tribal and Alaska Native organizations to provide supportive and nutrition services, including both congregate and home-delivered meals. In 1999, a total of \$16.6 million was awarded to 225 tribal organizations.

Nutrition services are a major component of tribal Title VI programs. Nearly 3 million congregate and home-delivered meals are provided annually to elders participating in the Title VI program. An evaluation of the Title VI nutrition program conducted during 1993-1995 found that, on average, more women than men participate in both the congregate and home delivered meals programs; and participants were not currently married, were living with others, and were poor. The average age of congregate meal participants was 68 years and the average age of the home-delivered meal participant was 71 years. The home-delivered meal participants were in poorer health, more functionally impaired, got out of their houses less often, and needed in-home supportive services more than the congregate meal participants.

Most Title VI program sites provide hot congregate meals 4 to 5 times a week. For elders unable to leave their homes, a hot meal is delivered 5 times a week. Most programs provide modified diets for diabetics, or others who might be on low fat, low cholesterol, and low sodium diets. A few programs provide special nutrition services such as meals for homeless elderly, an evening meal option for home-delivered meals, and weekend home-delivered meals.

In March 1997, the AoA and General Mills Foodservice funded 20 demonstration projects to test the benefits of providing vulnerable elders with a breakfast to supplement their noon meal. The Rosebud Sioux Tribal Elderly Program in South Dakota was selected to participate in the project. Their goal is to help prevent diabetes and to assist those elders who have diabetes in controlling their blood glucose. The program has provided 3,000 low-fat, low-sugar breakfasts to homebound elders in the first four months of 1999.

In addition to providing meals and nutrition education and counseling, Title VI programs are important sources for social interactions. The congregate meal program provides opportunities for meetings with friends, participating in recreation and other activities, and taking trips to other elders programs or state and national meetings. The meal delivery person is an important contact for home-bound elders. When asked what

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they like most about the program, over half the home-delivered meal participants stated that interaction with the delivery person was as important as the meal.

Another major component of the Title VI program is the provision of supportive services. Information and assistance about other programs and services for elders are provided by Title VI program staff. Information is provided about social security, food stamps, and energy assistance, to name a few programs. Title VI program staff often assist in making appointments for the elder and arrange for transportation, if needed. Program staff then follow up to assure that the elder was served. Transportation to meal sites, doctors appointments, and grocery shopping is a vital supportive service component of many Title VI programs. Other services provided by some Title VI programs are personal care and homemaker services, health aide services, case management, and family support. Many programs offer health related screenings, such as podiatry screening, and monitoring, such as blood pressure monitoring.

#### **Title IV**

The AoA's discretionary grant program, Title IV, provides opportunities to test program initiatives, support for innovative demonstration projects, and training and technical assistance to grant recipients. Although recent budget reductions have curtailed many discretionary programs, the AoA continues to provide funding for two National Resource Centers for Older Native Americans (see "National Resource Centers on Native American Elders" in the following article in this issue of *The*

*Provider*). The Resource Centers serve as focal points for developing technical information and expertise for Indian organizations, Title VI grantees, Native American communities, educational institutions, and professionals and paraprofessionals working with elders.

Title IV funds are also provided to the National Indian Council on Aging (NICOA) to assist in their efforts to improve the lives of AI/AN elders.

#### **Title V**

The Senior Community Services Employment Program, Title V, is administered by the U.S. Department of Labor. This program offers part- or full-time employment to low income persons who are 55 years of age or older.

#### **Conclusion**

The Older Americans Act is currently being considered for reauthorization. In field hearings for the reauthorization earlier this year, Sydney Bird, Chairperson of the National Association of Title VI Grantees, summarized the AoA programs for AI/AN elders as follows: "The Older Americans Act is of great importance in Indian Country. Title VI of the OAA is a major source of support for social services for elders, especially in the provision of meals. The OAA provides an essential source of employment for low-income Indian elders through Title V of the Act. Title IV has been instrumental in providing research and training opportunities to benefit our elders and those who serve them." □

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## **National Resource Centers on Native American Elders**

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*M. Yvonne Jackson, PhD, Director, and Margaret C. Graves, LCSW-C, Native American Aging Program Specialist, both from the Office for American Indian, Alaskan Native, and Native Hawaiian Programs, Administration on Aging, Washington, DC*

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The 1992 amendments to Title IV of the Older Americans Act (OAA) required the Administration on Aging (AoA) to establish two National Resource Centers on Native American Elders. The functions of these Resource Centers are to gather information, perform research, disseminate the results of the

research, and provide technical assistance and training to service providers. Cooperative agreements were provided to the University of Colorado and the University of North Dakota to establish these Resource Centers in 1994. Additional funding was provided for breast cancer education in 1997.

#### **Native Elder Health Care Resource Center**

The Native Elder Health Care Resource Center (NEHCRC) is located in the Department of Psychiatry at the University of Colorado. According to Dr. Spero Manson, Director of the NEHCRC, "our prime emphasis is on developing and disseminating culturally competent health care

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for Native American elders and promoting relevant health materials to Indian communities nationwide through the use of computer networks, telecommunications, and printed media.”

The NEHCRC is developing a series of educational modules addressing some of the most prevalent and impairing illnesses, both physical and mental, among elders. “Each module, while focusing on a given health problem, emphasizes the social and cultural contexts that are inextricably linked to its cause, epidemiology, assessment, treatment, and prevention. As much as possible, case-oriented material is presented to ground the discussion in the Native elder life experience,” stated Dr. Manson. Two modules have been completed, “Diabetes Mellitus (Type 2) in American Indian/Alaska Native Elders: Cultural Aspects of Care” and “Cancer Among Elder Native Americans.” Other modules are being developed on depression and alcohol abuse/dependence.

The NEHCRC is currently developing and piloting a model tribal colleges and universities distance learning program. Through agreements between NEHCRC, Sinte Gleska University, Rosebud and Pine Ridge, telehealth equipment has been installed and continuing education classes are being developed. The classes are targeted to CHRs, EMTs, and other human service personnel. All participants will receive academic credit through Sinte Gleska University/University of Colorado Health Science Center.

To learn more about the NEHCRC, visit their web site at: [www.uchsc.edu/sm/nehcrc](http://www.uchsc.edu/sm/nehcrc); or contact them at 4455 East 2 Ave. AD 11-13, Denver, CO, 80220; telephone 303-315-9228.

### **National Resource Center on Native American Aging**

The National Resource Center on Native American Aging

(NRCNAA) is located at the University of North Dakota. The NRCNAA is a collaboration between the Office of Native American Programs, the Center for Rural Health, and the Resource Center on Gerontology. “The Center is committed to increasing awareness of issues affecting American Indian, Alaskan Native, and Native Hawaiian elders and to be a voice and advocate for their concerns. We work closely with the local service providers throughout the nation to address the needs of American Indian, Alaska Native, and Native Hawaiian elders,” states Alan Allery, the Center’s Director.

Several Geriatric Leadership Seminars will be held throughout the country during 1999. Training will focus on elder issues, identification of service needs, and the aging process. Each seminar participant will develop a “change project” that will create positive changes in the lives of American Indian elders. The seminars are open to health and human service providers, tribal government officials, family members, and elders.

The NRCNAA has developed culturally appropriate breast self-exam shower cards. These cards were sent to all individuals who attended their Breast Cancer Conference in 1998 and will be provided to participants in the Geriatric Leadership Seminars.

The NRCNAA has pilot tested a “Health and Social Needs Assessment for Native Elders” for use at the community level. They are now conducting workshops on its use.

To learn more about NRCNAA, visit their web site: [www.und.nodak.edu/dept/nrcnaa](http://www.und.nodak.edu/dept/nrcnaa); or contact them at 317 Cambridge St., Room 110, University of North Dakota, Grand Forks, ND 58203; telephone 800-896-7628. □

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## **PERSONAL COMMENTARY** □

Not too long ago in Zuni, when a person began to age and became unable to take care of him or herself, family members would take the elder into their home and care for them. Today, there are many changes within our pueblo, which have affected the way we treat our older Zuni members.

With so many people in the community working at professional jobs, and having to be away from their homes, there are not many Zunis who have the time to take care of the older ones in the family. Often they are left at home alone to try and care for themselves, or they are looked after by someone who might not understand their needs. In some homes, family members with money problems might give seniors a home just because of benefits they might be getting. In some families, there are problems with domestic violence, or drug and alcohol abuse. These problems often cause people to take out their anger or frustrations on elders living with them, by abusing them.

One other major concerns we have is the problem with

diabetes and diabetes-related sicknesses. Our changes in diet, from what our ancestors used to eat, to what we eat now, has caused many of us to develop health problems.

I feel there is one way that we could start solving many of these problems and give our elders a chance to live in a safe, clean, healthy place. A nursing home, with a qualified staff would be one way to help the elderly. All their needs could be taken care of in the nursing home. Those with health problems could be better looked after by people familiar with their medications, illnesses, and diet. Those in abusive homes could have a safe place away from drinking and fighting.

I feel very happy and lucky that I live with my son and daughters. I know they will take care of me with love and understanding, if there comes a time when I can’t. To me, it is very important that we find ways to help and keep our elders with us as long as we can.

— Cornelia Bowannie (Zuni). □

# An Update on the IHS Elder Care Initiative

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

In this issue of *The Provider* we will give an update on the IHS Elder Care Initiative (ECI) and an overview of the status of Elder Care in the Indian Health Care System.

The ECI continues to operate out of the Zuni-Ramah Service Unit of the Albuquerque Area. Dr. Bruce Finke coordinates the effort with the active participation of providers from IHS, tribal, and urban programs (I/T/U) and collaboration with academic centers, other Federal agencies, and nonprofit organizations. Last year we outlined a set of priorities in these pages.<sup>1</sup> Over the past year the priorities have shifted somewhat, as we've worked with and listened to providers and elders in Indian Country. In broad terms, the Elder Care Initiative focuses on three main areas. These are support of local efforts throughout the I/T/U to enhance elder care, support of planning efforts at the tribal level for comprehensive, integrated systems of elder care, and advocacy for additional resources for elder care.

While the elderly make up a relatively small percentage of the American Indian and Alaska Native (AI/AN) population compared to national averages, their numbers are, thankfully, increasing rapidly.<sup>2</sup> Across Indian Country people are feeling that change. Elders and their families are looking for ways to meet the needs of aging, and tribal governments are faced with

increasing demand for services. There are not a lot of resources. What we do have in Indian Country are a true sense of the important role of the elder in the community, strong family commitment, and a collective, community-wide sense of responsibility to the elders.

Improvement in the medical care of elders occurs at the point of service: the clinic or hospital where the elder receives his or her care. Eldercare teams can be a tool to accomplish this as we strive to provide the highest quality care and enhanced services.

The key to improving overall elder care is at the community or tribal level. This requires careful planning and coordination and the wise commitment of scarce community resources. Advocacy efforts should focus on bringing additional resources to tribes to assist them in these planning efforts, and on bringing more services into the home to help elders to stay in their homes and communities.

The increase in our elderly is a blessing and a challenge. Across Indian Country dedicated people are working to meet this challenge as we enjoy the blessing. □

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## INDIAN AGING CONFERENCES AND RESOURCES OF INTEREST □

### **Geriatric Pharmacy Mini-Residency Training Program September 22-25, 1999; Santa Monica, CA**

This will be at the Miramar Sheraton Hotel, Santa Monica, CA. For more information, call (310) 312-0531; e-mail: [larruda@ucla.edu](mailto:larruda@ucla.edu).

### **Gerontological Society of America, 52<sup>nd</sup> Annual Scientific Meeting November 19-23, 1999; San Francisco, CA**

The GSA is the nation's largest multidisciplinary society dedicated to aging issues. For more information, call (202) 842-1275; fax (202) 842-1150; e-mail: [geron@geron.org](mailto:geron@geron.org); or visit the website at: [www.geron.org](http://www.geron.org).

### **Geriatrics Review Syllabus, Fourth Edition 1999-2001**

The GRS4 is now available. This contains a core curriculum in geriatrics, and is sponsored by the American

Geriatrics Association. The previous editions have been excellent reference works, brief and clinically oriented, and also very useful as a comprehensive review of geriatrics. There is a CME program linked to the Syllabus, offering up to 70 hours of CME credit. The entire package is quite affordable. This is highly recommended for anyone wanting to strengthen their skills in the care of older patients. For more information, contact Kendall/Hunt Publishing Company at (800) 338-8290. They do accept government purchase orders.

### **American Indian Elders . . . Following Their Ways August 3-5, 1999; Oklahoma City, OK**

The theme of the meeting is "Aging Successfully Through Life's Journey." This conference will have something for everyone, with content geared toward elders, caretakers, and professionals. It will be held at the Clarion Meridian Hotel and Convention Center, Oklahoma City, OK. For more information

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