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Clinic Reminder Cards Based on the US Preventive Task Force Guidelines Available for Your Use

Theresa Cullen, MD, Medical Officer, Division of Information Resources, Tucson, Arizona

For more information, contact the author at IHS/DIR, 300 West Congress 5B, Tucson, AZ 85701; phone (520) 670-4803; or e-mail tcullen@hqt.ihs.gov. □

The US Preventive Task Force (USPTF) has undertaken a major effort to evaluate the current clinical and evidence-based medical literature in a systematic fashion. This review has resulted in the establishment of recommendations for interventions for categorical age groups, as well as for pregnant women. These interventions, which should be used to guide age-specific prevention efforts, are currently under review and will be revised within the next two years.

At the Sells Service Unit in Sells, Arizona, these guidelines were formatted on laminated 4" by 6" cards that could be easily referred to in the clinic setting. The USPTF guidelines have been modified to include some screening interventions that are currently not proven by evidence-based medicine. However, these added interventions (noted by an asterisk on the cards) have been implemented in many primary care practices, and may be of benefit to your community.

Additional information is available in the USPTF Guidelines book. This book includes more specific guidelines for high risk populations, as well as a more detailed evaluation of individual screening interventions. Please refer to this book for further information.

We have reproduced these cards as an insert slightly reduced in size so that they would fit on the page. You are encouraged to reproduce these and use them in your own clinic settings. We hope that the publication of these guidelines will lead to a continued emphasis on prevention strategies within our health care system.

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Zuni Wellness Center Offers Services for the Elderly

Leatrice Lewis, MPH, Manager, Zuni Wellness Program, Zuni, New Mexico

To encourage healthy lifestyles in the community it serves, the Zuni Wellness Center (ZWC) provides a comprehensive program of fitness services and health promotion and disease prevention activities. ZWC staff are trained in the principles of fitness and health. One of the Center's goals is to offer safe and appropriate exercise programs. Services are provided for healthy adults, individuals at high risk, and those with known disease. A screening process includes the completion of a health questionnaire and measurements of blood glucose and blood pressure.

One of the objectives of the Wellness Center is to guide and motivate people with diabetes in controlling their condition with lifestyle modifications as an adjunct to pharmacologic management of their disease. Recruitment for individuals with diabetes occurs at the scheduled diabetic clinic held weekly at the Zuni/Ramah Service Unit. Transportation is provided for individuals referred to the Wellness Center from the hospital or from other community agencies.

Fitness activities include aerobic dance, cardiovascular training, and weight lifting circuits. Aerobic dance activities include low impact and chair aerobics. A variety of music, such as country and western, contemporary Indian, or other appropriate types is used for dance choreography. All fitness classes are instructor-led. Presently, we are working with 76 individuals who are from the Senior Citizen Center. From this cohort, which includes participants in the Foster Grandparents

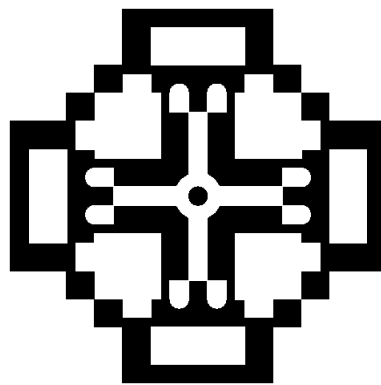
(a school program) and the Community Senior Companion Program, there are 61 individuals with diabetes.

The Wellness Center has three structured fitness classes for the older population held throughout the day on Monday, Wednesday, and Friday. On average, 50 participants attend these classes three times a week. Two ZWC staff members also offer fitness classes at the Senior Citizens Center. Personal flow charts are used to monitor weight, blood sugar levels, and blood pressure. Blood sugar levels are checked before and after exercise. These flow charts are reviewed for current status and for suggested adjustments in medications in consultation with medical staff.

The ZWC staff have seen many exercise benefits for the Zuni Senior Citizens Center participants and the referral group. The physical benefits include improved cardiovascular endurance, strength, flexibility, and balance. Enhancements in the overall sense of well being and quality of life are inferred from the increased participation in many other activities. These experiences include working with school children, taking care of homebound elderly, dancing and enjoying celebrations, traveling to other Indian communities for feast days, and living life with vigor.

During the past twelve years, members of the Zuni Wellness Center staff have appreciated the experience of learning from the elders they serve. With their patience and understanding, the ZWC staff has learned to develop appropriate exercise programs and to explain many health promotion concepts in the Zuni language.

For more information, contact the author at the Zuni Wellness Center at (505) 782-2665. □



Alternative and Complimentary Medicine and Diabetes

Walter O. Scott, RPh, Diabetes Care Specialist, Pyramid Lake Health Center, Schurz Service Unit, Nixon, Nevada

Worldwide it is estimated that only 10 to 30 percent of human health care is delivered by conventional, biomedically oriented practitioners. The remaining 70 to 90 percent of care includes a broad spectrum of practices ranging from self-care in accordance with folk principles to care by an organized health care system based on alternative cultural or traditional practices.¹

Some terms that are used to describe the systems of remedies used in alternative or complimentary medicine are nutraceuticals, botanicals, natural products, micronutrients, herbals, medicinal herbs, dietary supplements, trace elements, orthomolecular medicine and others. Some organized health care systems that practice a holistic approach to complimentary and alternative medicine are traditional Oriental medicine, acupuncture, Ayurveda, homeopathic medicine, anthroposophically extended medicine, naturopathic medicine, environmental medicine, Native American medicinal traditions, Latin American medicinal traditions, and others.^{1,2}

Complimentary and alternative medicine (CAM) is being used by both the general public and health care professionals.³ Several major pharmaceutical manufacturers in the United States have launched their own "natural products" lines. The Journal of the American Medical Association (JAMA) recently devoted an entire issue to the topic of alternative and complimentary medicine (JAMA, Nov. 11, 1998). Regulatory and congressional activities are addressing this widespread interest.^{4,5}

Some products being promoted for and used in the treatment of diabetes mellitus are chromium picolinate,^{6,7,9,12} vitamin E, magnesium,⁷ gamma linolenic acid (GLA),⁸ fenugreek,^{9,11} ricemic,¹⁰ oatmeal, onion, garlic, ginseng, coriander, bilberry leaves, Jerusalem artichoke, prickly pear (Nopal), aloe vera, apple pectin, guar gum,¹¹ fish oils,¹³ and others.

While much factual information is making its way to the general public and health professionals, it is recommended that decisions about products, treatments, and therapies be made using only validated information from credible sources. These sources may include companies producing standardized extracts, exploring methods to ensure superior bioavailability, and conducting or funding research.¹⁴ Because of the current lack of standardization of herbal products, it is difficult to generalize from one product to another.^{15,16} In the absence of

any complete, accepted scientific compendium, the German Commission E Monograph is being relied upon heavily for guidance concerning the use of herbal or natural products.¹⁷ Dietary supplements and herbs are not regulated as "drugs," but their chemical components (phytochemical contents) possess pharmacologic activity.¹⁸ Also, many available products have been analyzed and found to contain adulterants such as undeclared pharmaceuticals and heavy metals.¹⁹ Therefore, caution should be used when considering the use of these products until more standardization and clinical investigation can take place.

Two references available from sources in the United States concerning alternative and complimentary medicines are 1) Herbal Medicine, published by *The Prescribers Letter/The Pharmacists Letter*; 2453 Grand Canal Blvd., Suite A, PO Box 891, Stockton, CA, 95208; Tel. (209) 472-2240; and 2) *The Review of Natural Products*, by Facts and Comparisons, Tel. (800) 223-0554. It is emphasized that neither of these sources is recognized as an official compendium. The Food and Drug Administration (FDA) has established a searchable Special Nutritional Adverse Event Monitoring System (SN/AEMS) database. Reports are received from health professionals or patients/consumers via the MedWatch Program/FDA field offices, other Federal and local public health agencies, or correspondence received by the FDA. Access via the Internet may be found at <http://vm.cfsan.fda.gov/~dms/aems.html>. This site may be helpful in determining the safety of herbal/natural products.²⁰

There are many alternative and complimentary medicine therapies promoted, and some may be shown to be valuable in the treatment and control of diabetes mellitus. It is important to remember that some foods, remedies, and supplements can produce significant effects (some beneficial, some harmful) and that patients or consumers should be reminded to tell their health care providers about any "health" product that they are taking.²¹ □

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 19. Adulterants in Asian patent medicines. *Natural Topics. Drug Facts and Comparisons News*; November 1998, p 48
 20. *Ibid*. p 43
 21. *Prescribers Letter*, January 1999, p 11 (Unpublished review document)

Detection, Evaluation, and Management of Dyslipidemias:

The Santa Fe Indian Hospital Cardiovascular Clinic 1999 Guidelines

Randy Burden, PharmD, CPS, IHS Albuquerque Area Clinical Pharmacy Consultant; and Cardiovascular Clinic Director and Assistant Chief Pharmacist, Santa Fe PHS Indian Hospital, Santa Fe, New Mexico

The Santa Fe Indian Hospital Cardiovascular Clinic has published a much expanded version of its guidelines for managing patients with dyslipidemias on the IHS Pharmacy Intranet. The address is: <http://home.hqw.IHS.gov/pharmacy/clinical/protocols/lipid-sf.pdf>.

These guidelines were derived primarily from the following documents:

1. The Longbeach VAMC Guidelines For the Detection, Evaluation, and Treatment of High Blood Cholesterol in Veterans
2. Adult Treatment Panel II. National Cholesterol Education Program. NIH; Sept 1993. Publication No. 93-3095
3. The Management of Hyperlipidemia, PEC Update. 1995;96(1):1-19
4. The Management of Hyperlipidemia. Department of Veterans Affairs; Nov 1996. Publication No. 96-0003
5. American Diabetes Association: Clinical Practice Recommendations 1998. *Diabetes Care* 21:Supplement 1, Jan. 1998
6. The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of

High Blood Pressure. NIH; 1997 Nov. Publication No. 98-4090

Review of this document and suggestions for improvement were provided by James M. Galloway, MD, FACP, FACC, Native American Cardiology Program; Thomas Richtsmeier, MD, FACP, FACC, Cardiology Program, Gallup Indian Medical Center; Kelly Acton, MD, MPH, FACP, Director, IHS Diabetes Program; Robert Wirth, MD, Phoenix Indian Medical Center; Dennis Toomey, DO, Ambulatory Care Director, Santa Fe Indian Hospital (SFIH); John Fogarty, MD, Staff Physician, SFIH; Diane Pratt, MD, Staff Physician, SFIH; Leeanna Travis, RD, CDE, Chief Dietician, SFIH; and Vicky Chavez, PharmD, CPS, Cardiovascular Clinic, SFIH.

The following is the Index of Topics covered by this document:

Introduction

Summary

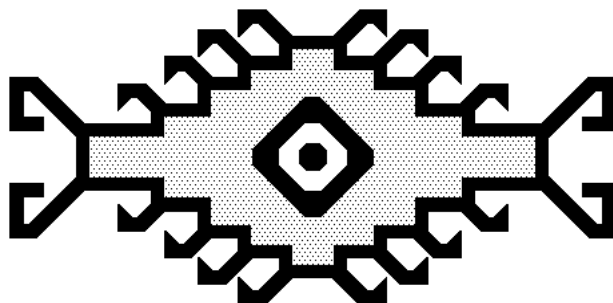
- Rational for Establishing the Cardiovascular Clinic
- Goal of the Cardiovascular Clinic
- Objectives of the Cardiovascular Clinic
- Cardiovascular Clinic Staff
- Patient Referral
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Treatment of dyslipidemias in the elderly

Appendix: Step I and Step II Diet Therapy for Dyslipidemias

Readers are encouraged to visit the website and to use it as a reference or resource. If you have comments or questions, please contact the author by e-mail at rburden@albmail.albu-querque.ihs.gov □



PHS Bicentennial Events in Washington State

CDR Marjorie Slagle, FNP-C, Yakama Indian Health Service Center, Toppenish, Washington

As part of the 200th anniversary of the U.S. Public Health Service, the Regional Health Administrator (RHA) of Region X, CAPT Richard Lyons, and the Evergreen branch of the Commissioned Officers Association (COA) recently coordinated two memorable events in central Washington State. On January 27, 1999, Dr. Lyons, accompanied by the PHS historian, Dr. John Parascandola, and 15 local PHS officers honored the Yakima County Health District for its ongoing role in working with the U.S. Public Health Service in setting and maintaining a national model for community health standards. In recognition of the significant public health accomplishments of these Federal and local government agencies, Mary Selecky, Acting Secretary of the Washington State Health Department, commended the progress that has been made in immunizations and computer-assisted tracking of communicable diseases.

Next on the day's agenda for these dignitaries was a visit to the nearby Yakama Indian Health Service Center in Toppenish, WA. Colleen Reimer, the Service Unit Director, and CDR Marjorie Slagle, Family Nurse Practitioner, hosted an

introduction and tour of this eight-year-old outpatient facility that serves over 20,000 Native Americans. LCDR Sharon John, a Yakama-Umatilla Native American, provided an overview of these tribes' sociocultural backgrounds. Twenty-three PHS officers from all health disciplines comprise an integral component of the 130 member clinic staff.

Luncheon at the Cultural Center featured presentations by PHS members as well as Yakama tribal representatives in testimony to the joint endeavors and accomplishments of the Indian Health Service and the Yakama Nation. The key speakers included CAPT Lyons, Dr. Parascandola, Ms. Reimer, Ms. Selecky, and Ross Sockzehigh, Tribal Council Vice Chairman. COA updates were then provided by CAPT Andy Stevermer, COA's Evergreen Branch President.

These tributes at the Yakima County Health Department and the Yakama Indian Health Service Center truly depicted the diversity and dedication of U.S. Public Health Service officers stationed throughout the country. The Yakama Indian Health Service's mission statement reflects these concepts well: "Our mission is to work in partnership with the people to improve the health and environment and to promote individual wellness within our Native American Community." □

The Public Health Service and Indian Health

John Parascandola, PhD, Public Health Service Historian, Rockville, Maryland

Although the Indian Health Service did not become a part of the Public Health Service (PHS) until 1955, the involvement of PHS in Indian health goes back much further in time. Medical care of Indians was a responsibility of the Federal Government, and was vested in the Bureau of Indian Affairs of the Department of Interior. Charles Burke, Commissioner of Indian Affairs from 1921 to 1929, was concerned about the inability of the Bureau to attract competent medical professionals for career service in the organization. In 1928, he discussed the matter informally with PHS Surgeon General Hugh Cumming, leading to a plan whereby an officer of the

Service was detailed to act as Director of Health of the Bureau of Indian Affairs. The first incumbent in this position was Dr. Marshall C. Guthrie. Dr. Guthrie was assisted by several other officers on his staff in Washington and a number of others serving as medical supervisors in the field service. At about the same time, the Service also began to assist the Bureau of Indian Affairs in dealing with problems of sanitation on reservations. In 1931, Dr. Frank Fellows became the first PHS officer to be assigned by the Bureau of Indian Affairs to Alaska. The assistance provided to the Bureau aided materially in improving the health of American Indian and Alaska Natives.

The PHS continued to provide this kind of assistance to the Bureau of Indian Affairs over the years. PHS officers on Coast Guard ships also sometimes provided health care to

American Indians and Alaska Natives in some areas. In the late 1940s, various health organizations began to press for the transfer of the Indian health program from the Bureau of Indian affairs to the PHS, so that it would be firmly controlled by health professionals. The Transfer Act of 1954 moved all Indian health responsibilities from the Bureau to a new Division of Indian Health in PHS, effective July 1, 1955. On that date, PHS inherited 2,500 staff, 48 hospitals, 13 school

infirmaries, and responsibility for the health care of 472,000 Indians and 35,000 Alaska Natives, with Dr. Ray Shaw as Director of the new Division. In 1968, the name was changed from the Division of Indian Health to the Indian Health Service (IHS), and the IHS achieved Agency status in 1988. Today the IHS provides health care services to more than one million American Indians and Alaska Natives. □



PHS officer Dr. Ralph Carr examines children while ashore from a Coast Guard cutter in Ketchikan, Alaska in 1941.

Bringing Exercise to Elders and Elders to Exercise

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

There is a wealth of information in the medical literature documenting the benefits of exercise and fitness for the elderly.¹ Exercise improves strength, balance, and endurance.² Recent research has demonstrated beneficial effects of exercise on disability from osteoarthritis of the knee³ and on quality of sleep.⁴ Exercise for strengthening also plays a role in multi-dimensional fall and injury prevention programs.⁵ For older persons with diabetes mellitus, exercise lowers blood sugars and improves glycemic control.¹

The article by Lewis in this issue of *The Provider* (page 54) describes the collaboration between a Tribal Wellness Center and a Tribal Senior Citizens Center to bring exercise programs to elders. Wellness Center staff go to the Senior Center to lead exercise classes, and special accommodations (including transportation) are made at the Wellness Center to

bring elders there for exercise. The coordination between these programs brings scarce resources together to benefit the elders of their community. This is the path to wellness for our elders.

□

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Pain and Palliative Care Policy Now Available

Under the guidance of their Chief Medical Officer Judith Kitzes, MD, MPH, the Albuquerque Area has developed and adopted a state-of-the-art policy regarding pain management and palliative care. The policy is brief and contains significant leeway for local modification. It is accompanied by supporting documents that contain the tools needed to implement the policy. The background for this effort has been described by Dr. Kitzes in two articles recently published in the October 1998 and February 1999 issues of *The IHS Primary Care Provider*.^{1,2}

The IHS Elder Care Initiative will provide the policy and supporting documents to all IHS, tribal, or urban programs that

would like to have them. We are eager to see that optimal management of pain and other distressing symptoms be the standard of care throughout the Indian health care system. For copies contact Bruce Finke, MD, Elder Care Initiative, PO Box 467, Zuni, NM 87327; fax: (505) 782-5723; or email: elders@nm.net. □

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NATIVE AMERICAN MEDICAL LITERATURE □

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

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

If your facility lacks a library or librarian, try calling your nearest university library, the nearest state medical association, or the National Library of Medicine (1-800-272-47887) to obtain information on how to access journal literature within your region. Bear in mind that most local library networks function on the basis of reciprocity and, if you do not have a library at your facility, you may be charged for services provided.

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