THE IHS PRIMARY CARE PROVIDER

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The IHS Elder Health Care Initiative in 1997

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A year ago we reported on the Director's health emphasis area, the Elder Health Care Initiative (EHCI).[1] Since then many things have changed, while some remain the same. Herein, we describe this previous years' accomplishments, changes, and frustrations.

Again this fiscal year no specific funds were allocated by Congress to support the Elder Health Care Initiative, although $3.3 million was requested. The Indian Health Service (IHS) did set aside monies for community partnership grants to address child abuse and women's and elder's health issues, and grant solicitation development is underway.

The Elder Health Care Initiative Vision, Mission, and Goals statements have been finalized (see Tables 1 and 2). These statements were drafted by members of the Initiative Team and then submitted for additions or revisions to work groups consisting of Indian elders, individuals active and knowledgeable in elder care issues, members of national Indian organizations, and an IHS-wide interdisciplinary focus group.

The EHCI published the first *National Resource Directory for American Indian and Alaska Native Elders* (NRD) in June 1996 and mailed out nearly 200 copies to health care leaders throughout Indian Country. The NRD is a 98-page compilation of government and non-government agencies, foundations, and funding resources particularly directed to elder Americans and many specifically toward the Native American elder. There is a *Compendium of Grant Resources for Native American Elders Programs* at the end of the directory prepared by the Administration on Aging (AoA) and the Community Resource Center of Denver, Colorado, that identifies resources which provide funding only to Native Americans or that have set aside specific funds for Native American programs. It also identifies organizations that may be of assistance in actually writing a grant proposal. Additionally, the NRD lists Medicaid phone numbers, by state, and also lists 32 nursing homes and alternative long-term care facilities or programs available to American Indian and Alaska Native elders and located in Indian Country.

Each Area Director (or his/her designee) has appointed an Area contact for elder care. These contact people will be known as Area Coordinators for Elder Health Care (see "Summary Report of the Area Coordinators of Elder Health Care" elsewhere in this issue). Many of these Area

Editor's note: This May issue of The IHS Provider, published on the occasion of National Older Americans Month, is the second annual issue dedicated to our elders. Indian Health Service, tribal, and urban Indian program professionals are encouraged to consider writing pertinent articles for the May 1998 issue on elders. Inquiries can be addressed to the attention of the editors at the address on the back page of this issue.

In This Issue...

Table 1. Elder Health Care Initiative Vision and Mission.

Vision

American Indian and Alaska Native elders will achieve and realize the optimum outcome of their health and independence in their own homes and communities.

Mission

To provide quality health services to all American Indian and Alaska Native elders with maximal IHS, tribal, and community partnerships while maintaining the highest level of compassion, dignity, respect, and cultural sensitivity.

Table 2. Elder Health Care Initiative Goals.

1. Work within the IHS/tribal/urban Indian health care system to promote quality health care services and the use of traditional healers for American Indian/Alaska Native (AI/AN) elders.
2. Promote the development of a continuum of comprehensive home and community-based programs which keep elders within their families and communities.
3. Facilitate access of AI/AN elders to timely and appropriate care.
4. Develop the capacity to provide preventive services and functional assessments annually for each elder and comprehensive geriatric assessment for the frail elderly.
5. Foster community health promotion/disease and disability prevention and education programs that address the problems of elders.
6. Develop ongoing continuing education to enhance medical and allied health professional expertise in AI/AN aging.
7. Insure that the ongoing evaluation of health care programs includes those for AI/AN elders.
8. In partnership with tribes and the Bureau of Indian Affairs, develop a process to jointly assess the rate of elder abuse and neglect in Indian communities and encourage implementation of tribal codes for protection of the AI/AN elder.
9. Support a national Indian aging research agenda, including new research projects and health care delivery programs.

Coordinators met in Albuquerque, New Mexico, in September 1996 for a one-day brainstorming session followed by a one and a half-day interdisciplinary education meeting in Geriatrics sponsored by the University of New Mexico and the New Mexico Geriatric Education Center. Plans for fiscal year 1997 include one or two Coordinator meetings in conjunction with further geriatric education. A list of each Area's Coordinator is provided in Table 3.

A first for nurses training in geriatrics/gerontology took place in Albuquerque January 16-18, 1997. Titled "Caring for the Pathfinders" and supported in part by the EHCI, the conference was a huge success judged by the attendance and the participants comments. A review of the meeting by Robin Miller appears elsewhere in this issue (see page 78).

We began building a Geriatrics/Gerontological library from the beginning of the initiative and currently possess or have access to some the latest publications in the field of Geriatric Medicine and the interdisciplinary fields of Gerontology. Information from these sources can be furnished to providers via phone, mail, e-mail, or fax. Questions regarding Geriatric Dentistry or the literature in Geriatric Dentistry should be directed to David B. Jones, DDS, MPH at Headquarters West 505-248-4175. Drs. Jones and Broderick have an article in this *Provider* issue (page 79) on the challenges of providing the highest quality oral health care and education to our Indian elders.

The EHCI is supporting the Elder Resources and Services Survey undertaken by the National Indian Council on Aging. Surveys have been sent to over 650 IHS, tribal, and urban health programs seeking information about elder programs, activities, and expertise in caring for elders in Indian Country. Results will be reported later this year. The information obtained will help the EHCI identify the strengths and needs in the caring network for older American Indians and Alaska Natives, and serve as an information center for programs being planned, in development, or in existence in any IHS/tribal/urban Indian (I/T/U) site.

January 1, 1997 saw the EHCI moving from Headquarters East in Rockville, MD to Phoenix, AZ. Dr. Pat Stenger can be reached at the Phoenix Area Office (phone: 602-364-5188; fax: 602-364-5155; e-mail: pstenger@smtp.ihs.gov) or at the

Table 3. Area Elder Health Care Initiative Coordinators.

Area	Coordinator	Phone	Internet Address
Aberdeen	Steve Scheuermann, RN	605-226-7456	sscheuer@smtp.ihs.gov
Alaska	David Barrett, MD	907-279-6661	
Albuquerque	Susan Gloyd, MD	505-256-4000	
Bemidji	James Bredon, RPh	218-759-3447	jbredon@smtp.ihs.gov
Billings	Mary DesRosier, MD	406-338-2151	
	or Rita Harding, MN, RN	406-247-7133	rharding@smtp.ihs.gov
California	Bev Rodriquez	707-526-3779	
Nashville	Connie Overby, RN-C	615-736-2487	coverby@smtp.ihs.gov
Navajo	Anderson Tso, MSW	520-674-7147	atso@smtp.ihs,gov
Oklahoma	Charles Hays, MD	405-951-3748	chays@smtp.ihs.gov
Phoenix	Wayne Mitchell, EdD	602-364-5135	wmitchel@smtp.ihs.gov
Portland	Dave Daniels, MD	509-865-7879	
Tucson	Lois Steele, MD	520-295-2478	lsteele@smtp.ihs.gov

Phoenix Indian Medical Center in care of the medical secretary, Rose Mendoza (602-263-1537). We hope to develop an IHS Elder Care Home Page on the World Wide Web later this year. A quarterly fact sheet is being published by the EHCI identifying the current projects underway, future planned activities, and new grant or other funding source information. The first issue will contain the EHCI Vision-Mission-Goals statement. To get on our mailing list submit your name, address, and phone number on the voice mail at 602-364-5188. The mailing address is: IHS Elder Health Care Initiative, 40 North Central Avenue, Suite 600, Phoenix, AZ 85004.

When the IHS Director, Dr. Michael H. Trujillo, implemented the Elder Health Care Initiative in October 1995, he charged it with exploring the best avenues of delivering comprehensive home and community-based primary health care to American Indian and Alaska Native elders. In the light of our vision, mission, and goals statements, we have chosen to direct the initial efforts toward provider and consumer education, and improved elder access to and continuity of care with maximal tribal and urban program involvement. The EHCI is forming partnerships with I/T/U entities to share information and expertise in elder issues and is collaborating with government and non-government agencies to locate resources and skills needed in these endeavors. The ultimate goal is to enrich the elder's quality of life and enhance their ability to live independently while maintaining the highest level of compassion, dignity, respect, and cultural sensitivity. Dr. Trujillo has said, "Our elders have always been our pathfinders. They have shown us the way to live, to act, and to be. We owe them a great deal. We owe it to them to do everything we can to ensure that all their health care needs are met."

The Elder Health Care Initiative is available to consult, recommend, and assist sites in the planning, evaluation, or functioning of elder clinics and programs. We are anxious to discuss elder issues in an "Elder Care Talking Circle" type of setting, sharing stories, successes and frustrations, and providing information/resources for all those who labor for our Pathfinders.

Reference

1. Stenger P, Kiger L, Freeman R. The IHS Elder Health Care Initiative. *The IHS Primary Care Provider.* May 1996;21(5):54-55. □

Summary Report of the Area Coordinators of Elder Health Care

Patrick W. Stenger, DO, IHS Senior Clinician for Geriatrics, Elder Health Care Initiative, Phoenix Area Office, Office of Health Programs, Phoenix, Arizona.

The twelve Indian Health Service (IHS) Area Directors were requested to appoint one person in their Area to be the contact with the Elder Health Care Initiative (EHCI) team. These "contacts" have become our Area Coordinators (AC) for Elder Health Care. The current list of ACs appears in Table 3 in the article entitled "The Elder Health Care Initiative in 1997" in this issue (page 69). Three Areas have different coordinators in 1997 than they had in 1996: California, Bemidji, and Billings. Most ACs attended two meetings in 1996 sponsored by the EHCI where "brainstorming elder issues" was the hottest topic of discussion. We asked the ACs for a short report on the elder care activities in their Areas that are currently being planned, those that were up and running, some that had been tried and failed, and others that are just a distant dream. I have combined and summarized the reports for the sake of brevity (not anonymity), and will supply the details and contact names to anyone interested in a particular program or activity.

Three Areas have formed Area-wide elders committees. Committee members come from the Area offices, tribal health programs, the Bureau of Indian Affairs, and medical, nursing, community health representative (CHR), and social service disciplines, among others. One committee has undertaken the task of learning more about elder health care through reading, training, and sharing. Another has conference calls and elder-related continuing education meetings. One committee is currently involved in assessing elder services and needs in their Area; is establishing a state, tribal, and service unit network for the promotion of elder health care; has sent nurses to two workshops in geriatrics or gerontology; and is active as a demonstration site for the swing bed project. Another has two service units with geriatric assessment clinics and another with

an Elderly Case Management team. The third Area elder committee has set forth their objectives as: database development, policy development, resource and service development, and education and training. One committee devotes all the continuing education (CE) for the month of May (Older Americans Month) toward elder care, while another has their education spread out over the whole year, making up about 15% of the total CE hours offered, and attempting to target all disciplines (except pediatrics, of course). Some have developed their version of a resource directory for their particular Area, and one committee has produced two videos, one on caring for the Native American elder and another on elder abuse.

In Areas without an organized elders committee, there still is a lot of activity. One service unit applied for and has received an IHS Office of Planning, Evaluation, and Legislation (OPEL) grant to develop elderly wellness programs for their Area. Many have day care centers, Meals On Wheels, transportation, homemaker, and sitter or companion services. Most Areas don't have the gamut of home- and community-based services. There are few home health agencies run by Indian tribes; fewer still have assisted living or elder housing facilities. In some Areas, IHS and tribal physicians, physician assistants, or nurse practitioners have extended the clinical services of their service units to include local, long-term care facilities. Others are visiting meal sites and screening elders for hypertension, diabetes, and foot, hearing or vision problems. Health fairs are beginning to target the older population around Indian Country. Literature is being produced, often in the native language, by various organizations to increase consumer education about the aging process.

And it's working. Elders themselves are demanding more and better services. It is no longer common to have to coerce an elder into receiving an immunization or screening exam; more and more frequently they are coming in asking for "that pneumonia shot" or "the flu bug shot," or they want their Pap test or their mammogram done or their PSA (prostate-specific antigen) level checked. The age of the sophisticated elder health consumer is upon us.

All over the nation the new buzzwords are "home- and community-based" long-term services and programs, and nowhere in this country are the terms more relevant than among the "First Americans." Indigenous American people have been providing those services within their families, clans, communities, and tribes since settling this land. As I wrote in the above mentioned article, "The ultimate goal is to enrich the elder's quality of life and enhance their ability to live independently while maintaining the highest level of compassion, dignity, respect, and cultural sensitivity," and to do this in their own homes and communities. We don't have the funding to accomplish this goal today, but good people, both inside and outside of IHS, are beginning the processes physically, economically, and politically that are moving us toward the day when we will see elder health care programs funded right along with hospitals and clinics. Most of the elder care activities in Indian Country today were started with no funding, no new positions, very little support, and little hope of success. Now there are dozens of programs all over the nation that target the Indian elder. What will be in place when the post-World War II and "baby-boom" generations enter the aging scene and nearly triple the number of elders we currently serve? That's up to a few good people. Tribal and IHS providers (whether a home health aide, a physician, nurse, pharmacist, driver, CHR, public health nurse, support person, whomever) are here to serve, and will find the ways and the means when so important an issue presents itself to us as the care of our patriarchs, our pathfinders, our elders. □

High Blood Pressure Month

In recognition of *High Blood Pressure Month* (May 1997), the Office of Minority Health Resource Center (OMH-RC) has made a special effort to educate minority communities about high blood pressure. The Center is distributing free copies of a new information packet that provides tips on preventing high blood pressure.

One in four American adults has high blood pressure or hypertension. Though studies have shown a low prevalence of high blood pressure in non-diabetic American Indians and Alaska Natives, the incidence of the condition is increasing in this population. High blood pressure is strongly associated with diabetes among American Indians and Alaska Natives, and there are higher mortality rates when the two diseases occur together. Research conducted by the National Heart, Lung, and Blood Pressure Institute (NHLBI), National Institutes of Health (NIH), shows that the incidence of high blood pressure among American Indians and Alaska Natives increases with age.

Left untreated, high blood pressure can lead to serious health problems, including problems with vision, kidney disease, stroke, and heart disease.

National High Blood Pressure Month is sponsored by the National High Blood Pressure Education Program's Coordinating Committee, and is administered by the NHLBI. High Blood Pressure Information Packets are available now. Call 800-444-6472 and ask to speak with an information specialist. OMH-RC is a nationwide service of the Office of Minority Health, U.S. Department of Health and Human Services.

Editor's note: The editors thought our readers would find it interesting to hear about some successful programs for elder Native Americans. Three programs are described below. The first is an exciting Indian Health Service project taking place at the Zuni-Ramah Service Unit in Zuni, New Mexico. The description of this project was supplied to us by members of the Elder Care Team at Zuni.

Information about the other two projects was found on the Internet site for the Native Elder Health Care Resource Center at the University of Colorado Health Sciences Center in Denver, Colorado (www.uchsc.edu/sm/nehcrc) and corroborated by phone contact with the individuals involved.

An Update on the Elder's Clinic at Zuni

Bruce Finke, MD, Staff Physician; and Lu Del White, RPh, Assistant Chief Pharmacist, for the Elder Care Team of the Zuni-Ramah Service Unit, Zuni, New Mexico.

In the May 1996 issue of *The IHS Primary Care Provider*, we reported on the Zuni Elders' Clinic, a comprehensive, multidisciplinary, geriatric assessment program targeted to the frail elderly. In this report, we will provide an update on the functioning of the Elders' Clinic, a review of our progress, and a look at future plans of the Elder Care team at the Zuni-Ramah Service Unit.

The Elders' Clinic components are essentially the same as described in May 1996. We hold one clinic a month, seeing up to three elders during each clinic. To date, the elders have been referred to us by the medical, nursing, public health nursing (PHN), and pharmacy staffs, and family members. Elders are selected for this specialty clinic based on criteria designed to identify those most expected to benefit from such an evaluation and subsequent recommendations. Prior to the monthly clinic, the elders are visited at home by either a PHN or home health nurse. The nurses do a home safety assessment, answer questions about the clinic, and help arrange transportation if needed. Chart reviews are done by team members prior to the clinic, as well.

The elders come in at 9:00 am and are finished at about 11:00 am (in time to go home for lunch). During the time that they are in clinic, they remain in their respective examination rooms while we, the team members, come to them. Team members evaluate their ability to care for themselves and their home, their bowel and bladder function, sleep, hearing, vision , dentition, nutrition, risk of fall and injury, mental and emotional status, family stress, financial and social resources, medications, health care maintenance, and existing medical problems. After the elders go home, the team meets for one hour to discuss our findings and devise intervention strategies. A clearer picture emerges as we compare our individual assessments. Needed referrals can often be made at that time. From notes taken at the team meeting, a report is dictated that details the findings and recommendations; this report is given to each elder's primary provider.

During the past year, there has been nearly continuous modification of the structure/organization of the Clinic. The reporting format has evolved through several versions to its present outline, and team members have worked to refine the tools used in our brief visits with the elders. The clinic itself is no longer quite so chaotic; the use of a chart taped to the door has helped facilitate clinic flow. In the last several months, the pattern of the clinic has stabilized and the pace of change has begun to slow.

At this point, we have been unable to fully implement the planned evaluation process. It is clear from limited follow-up that we need to review records in a systematic way and assess the implementation of team recommendations by both the elders and their primary providers. This evaluation process is critical to the success of the project in two ways. It serves an important clinical function, ensuring that important interventions actually happen. It is also an objective way for members on the team to know that their work on the project is worthwhile, that we are actually benefiting the elders. The time required to administer the clinic, time squeezed out of our regular clinical duties, has made it more difficult than expected to do this necessary follow-up. We hope to address this within the next several months.

The positive impact of the Elders' Clinic has clearly spread beyond those elders who we have evaluated. One benefit involves the diffusion of information throughout the service unit. The functional assessment model is being adopted by the medical staff in many of their routine encounters with elderly patients. The normal age-related changes in drug metabolism are receiving more attention by pharmacy, medical, and nursing staffs alike. There is increased attention to injury prevention in the home by Public Health Nursing and the tribal Home Health Care Agency.

At the same time, as team members, we are increasing our fund of knowledge and experience by working with these frail elders, and becoming more aware of our own limitations and deficiencies as elder care providers. This has helped us to focus our educational efforts more efficiently as we identify the specific areas in which we need more training.

The process of devising successful intervention strategies

for our patients has pushed us out of the hospital and into the community. This has strengthened our links to the Senior Center, the home health, and the audiology programs, and is making us more aware of the host of community agencies that influence the health of our elderly patients.

An especially important benefit of the Elders' Clinic project has been the effects on the dynamics of the Elder Care Team. The success of this project has given us confidence as a team in our ability to make concrete system changes that will benefit our elderly patients. We have learned to work together and to appreciate each other's expertise and the unique contributions available from each discipline and each individual.

. . . trying to devise successful intervention strategies for our patients has pushed us out of the hospital and into the community.

We are now entering the second phase of our work together as a team. Our initial project, the Elders' Clinic, is established and sustainable. We have begun to look at other projects. Public Health Nursing is taking the lead in collaborating with tribal housing agencies to achieve safety modifications in the homes of the elderly. Behavioral Health is looking into how we work with the Tribal Elder Code. In collaboration with the Senior Center, we are working on a screening strategy for robust elders.

We are encouraged by our experience of the last year and now know that, in spite of the limitations of time and resources, we can bring to life programs that improve the care of the elders we serve.

Acknowledgements

Members of the Elder Care Team include Kent Anderson, DDS (dental); Tina Christie, RN (public health nursing); Robert Currier, PsyD (behavioral health); Bruce Finke, MD (medical staff); Becky Grizzle, RD (dietary); Ernestine Higdon, PT (physical therapy); Robin Miller, RN, CS (nursing); Margaret Mitchell, ACSW (behavioral health, retired); Becky Sellers, PT (physical therapy); and Lu Del White, RPh (pharmacy).

Participating in the organization and implementation of the Elders' Clinic were also Nene Brough, RN (Zuni Home Health Care Association); Carolyn Deysee (Zuni Audiology Program); and Winona Iule, LPN, and Lyda Kallestewa, LPN (outpatient nursing).

The success of this program is the result of the contributions of these individuals and the support of other hospital staff and our service unit administration.

Adopt a Grandparent Program (AGP)

The Adopt a Grandparent Program (AGP) is a unique Native elders assistance program in its tenth year of operation. After three elders were found frozen to death in their cabins on the Pine Ridge Reservation in South Dakota in the winter of 1987, Nellie Red Owl and six Lakota grandmothers sat down together and set out the guidelines for a program to support the elderly people in their community.

Among the Lakota, the word "adopt" has a strong meaning, and "making relations" is a key traditional value; the AGP was born out of this tradition of extended family. These grandmothers understood the many problems confronting the elders and their families, who often lack adequate housing, food, electricity, and heating in winter; basic survival is a daily concern.

Many elders are totally dependent on others to buy food, pay bills, haul water and wood, and help with daily tasks. The AGP provides assistance by coordinating people, resources, and organizations from all over the country, sending material goods such as clothing, blankets, household items, and food directly to elders in need. Food, propane, and electricity assistance are provided through gift certificates paid directly to grocery stores and utility companies.

The AGP is not funded by the government. Money and other support comes from volunteers, memberships, grants from family foundations, and gifts from individuals and businesses. The sponsors come from all walks of life, including people who were adopted out of their native culture who wish to have some connection to their roots, people who never knew their grandparents, non-Indian elders, classrooms of children of all ages, people in prison, church groups, and people who genuinely want to share.

The program provides sponsors with the opportunity to come to know and care for an individually chosen extended family member. The elders are provided with the name and address of their sponsor so they may write letters and communicate directly, resulting in a cross cultural/cross generational exchange. The hope is to connect people who want to share with people who need support, and to facilitate an important exchange of understanding and good will through direct action and cooperation. This coming together of sponsors and elders remains the heart of the program.

The AGP has been contacted by the Cherokee tribes in Oklahoma and North Carolina and even the aborigines in Australia to learn about setting up similar programs in their localities. Part of the plan for 1998 is to do an AGP replication

project. Funding is being sought so that others can try the program in different geographical areas, with their own constituencies. Watch for a handbook that will clearly define the tools, procedures, and training necessary to develop this kind of an organization, so that this program can be replicated in other parts of the country. The AGP also produces a newsletter, currently mailed to its 800 members. Of these 800 members, 190 are Lakota elders and their families from the Pine Ridge reservation. Since many elders find themselves as the primary child care providers for their own grandchildren and great grandchildren, AGP touches about 3,500 people on the Pine Ridge Reservation.

For more information about the Adopt a Grandparent Program, contact Gail Russell, Director, Mountain Light Center, P.O. Box 241, Taos, New Mexico 87571 (phone: 505-776-8474; fax: 505-776-8050; e-mail: agpmlc@aol.com).

Earthstar Project, Inc.

The Earthstar Project, located in St. Paul, Minnesota, is an urban Indian mental health organization that reaches out into the community through various projects. Two programs were developed to provide support and other services to the elderly and to preserve and pass on oral native history: the *Elders Programs Services* and the *Elders Lodge*.

Elders Programs Services

The primary goals of the Elders Programs Services are to coordinate access to needed support services and to strengthen cultural community through the elders. Work is being done to reach elders who are not presently served by any other network or agency in the St. Paul, Minnesota, East Metro area.

Earthstar coordinates and provides transportation services to American Indian elders for congregate dining, shopping, medical and dental appointments, and prescriptions, and support services so elders can receive these needed services and participate fully in the community. Elders are also assisted with crisis intervention and medications.

Earthstar is working in conjunction with several other agencies to help providers become more aware of American Indian elders' special needs and, thus, enable them to deliver culturally sensitive health care that will be accepted by the elders.

Through our assessment program, the extent to which services needed by the elders in the community are not being met, and the reasons why, can be determined. Earthstar coordinates home chore services for elders, like housekeeping, yard work, shopping, errands, and other light chores, provided by American Indian youth. Respect for elders is emphasized. Earthstar organizes and arranges for elders to make field trips to reservations, ceremonies, pow wows, leadership conferences, meetings, and spiritual retreats. Craft supplies (including bead work, basketry, and other materials), books, videotapes, and game equipment are available for use by elders for intertribal and intergenerational educational programs.

Also, the Native American Council of Elders/The Elders Circle discuss various issues with regard to strengthening the elders circle, "Circle of Life." The elders play an extremely important part in completing this circle; elders have the knowledge and wisdom of traditions, and can speak the native languages.

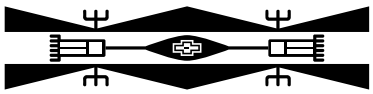
Elders Lodge

The Elders Lodge has been viewed as a center of wisdom, warmth, and strength in the Native American community. Traditionally, elders have held a special position in the tribe. To be a Native American elder is to be respected and revered, and to be honored. The traditional roles of these special people were to be teachers, to carry on the ways of the people, and to pass on oral tradition. As a result of their many experiences (spiritual, philosophical, medical, healing, peace, war, and survival), these special people have much wisdom to share with younger generations.

The Elders Lodge, opened in late April 1997, is nestled in a natural setting within a circle of trees, as in the circle of life in which one lives. The landscape emphasizes the four seasons. These ideas are carried into the community ceremonial room and to the apartments for the elders. The Elders Lodge has 42 one-bedroom apartments in a three-story brick building. The Lodge provides congregate dining in the community room, a full service kitchen, areas for fitness, health screening, crafts, sewing, meetings, a library, and laundry. The community room serves as a center for ceremonies and activities for the elders, honoring their knowledge and desire to pass on cultural traditions and values to their children and grandchildren.

The Elders Lodge will be marketed to Native American Elders, but will be open to all seniors. One family member must be 62 years old or older, and must be able to function independently.

For more information about the Elders Programs Services or the Elders Lodge, contact Frances Hart, Program Services Director, 1500 East Magnolia Avenue, St. Paul, MN 55106 (phone: 612-778-2504). For information about Earthstar Project, Inc., contact Perry Bolin at 612-774-0611. □



What Elders Say About Their Health Care

Jane Ketchin, MA, Manager, The New Mexico Geriatric Education Center, Albuquerque, New Mexico.

The New Mexico Geriatric Education Center (NMGEC),* based at the University of New Mexico in Albuquerque, is dedicated to improving the health care of New Mexico's American Indian elders through education and training. NMGEC programs are designed to enhance the ability of health care providers and lay caregivers to deliver culturally sensitive care. Working in partnership with the Indian Health Service (IHS) and the National Indian Council on Aging, the NMGEC benefits from direct links with Indian Country.

In many efforts to provide services to a particular community, one element is often missing. That element is asking the members of that community what they feel is important for their healthcare and well-being. The NMGEC curriculum committee decided the first step toward providing relevant information to health care providers was first to ask the elders what they thought about healthcare as it pertains to them.

What Indian Elders Say

In the months between January and August 1996, several discussion groups were held at varying locations throughout New Mexico's Indian Country to gather information from Indian elders. Discussions were also held with IHS health care providers, Senior Companions, Title VI Directors, Community Health Representatives (CHRs), and family caregivers, but this article will only discuss the elders' perspectives on their own health care.

The same four questions were asked to each group: (1) What comes to mind when you think about being elderly? (2) What are the most important things about being Indian that health care providers should know? (3) What is the most important thing in health care that can be done for the elderly in your community? and (4) How can the needs of chronic and long-term care of the elderly be better addressed?

For the elders, being healthy involves more than just visits to the clinics and taking medications. Being a healthy elder means staying active physically and mentally and having a strong sense of personal responsibility. It is important for the elders to remain as independent as possible and to be productive within their families and communities.

These elders understand the limitations that come with the aging process. They have a fear of falling and do not want to become a burden to their families. They want health care providers to recognize the diversity within the elderly population. Some have much family support, while others do not. Some will communicate readily while others will not. Some will disclose traditional health practices while others will not. Elders also recognize the problems of elder abuse and neglect, substance abuse, and family fragmentation.

Stresses for the elderly come in many forms. They feel saddened by the loss of language and cultural traditions by the younger generation. They recognize a loss of respect for the elders in the community. The elders also have multiple and conflicting roles, which creates stress. They are caregivers for grandchildren, but there are confusing expectations from both the elder and the children. There are the losses that come with advancing age when friends and family members die. They fear going into a nursing home because that means "sure death," but are concerned with long term care issues and who will take care of them.

Communication is a large concern for the elders. They want clearer explanations and simpler answers from providers concerning medical information and use of medications. They want to be treated with more respect, courtesy, and dignity when in the clinic. More important is the elders' desire for health care providers to listen to their needs, allow silence while they gather their thoughts, and just take the time to be with them when they are in the clinic. They say the health care workers ask too many questions, which then is interpreted as an invasion of privacy. They also want more attention paid to the whole person — emotional, social, financial, and physical.

Elders are reluctant to visit the clinics because of their low expectations of the health care system, the long waiting times, and their sense that they are often overlooked. They prefer continuity of care with one provider, but often see a different provider with each visit. They are concerned about compromised confidentiality and feel that not enough respect is given to traditional and historical knowledge about health, illness, and death.

The elders in the discussion groups all agreed there was not enough follow-up care for the elderly discharged from hospitals, not enough respite care for family caregivers, or enough homemaker services to help keep the elderly in their homes.

Elders are not assertive in voicing dissatisfaction with care or confusion about complicated medications. They want more education for CHRs, for their own family caregivers, and for

* The New Mexico Geriatric Education Center is funded by a 3-year grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions.

themselves. They also want language interpreters in the health care setting to help them better understand what is going on.

Much of what the elders had to say revolved around the importance of their own participation in their health care. Many felt they lacked control of their lives in the health care setting. They wanted continual involvement in the decision-making process about their own care.

Recognizing what American Indian elders say about health care is crucial to this project. This information, combined with information from discussion groups with health care providers and other community members, forms the foundation for the development of educational tools for health professionals and lay caregivers who work with American Indian elders. The NMGEC has designed a variety of curricula to train IHS and tribal providers; these training activities will be initiated this year and continued through next year. For additional information about the NMGEC, contact Jane Ketchin at the New Mexico Geriatric Education Center, University of New Mexico, 1836 Lomas N.E., Albuquerque, NM 87131-6086 (phone: 505-277-0911). □

The Native Elder Health Care Resource Center

The Native Elder Health Care Resource Center (NEHCRC), located at the University of Colorado Health Sciences Center in Denver, Colorado, is one of two national resource centers funded by the Administration on Aging under Title IV of the Older Americans Act. The purpose of the NEHCRC is to conduct research, disseminate information, provide training and technical assistance, and enhance professional education.

The NEHCRC is in the process of developing four interdisciplinary modules regarding common health problems among Native elders, including Cancer, Diabetes, Depression, and Alcohol Abuse. Each of the modules was developed from an interdisciplinary health care perspective. They utilize a case-based scenario to provide culturally relevant information on these diseases in this special population. As a result, the content focuses not only on the disease entity, but also on culturally relevant aspects of the recognition and management of the disease.

Two of the modules, "Cancer" and "Diabetes," are now available for purchase. If interested, please contact Nina Andaloro, the NEHCRC Program Specialist at the NEHCRC, University of Colorado Health Sciences Center, 4455 East 12th Avenue, Denver, CO 80220 (e-mail: Nina.Andaloro@uchsc.edu; phone: 303-315-9244).

The NEHCRC is now on the World Wide Web (WWW) and can be located at www.uchsc.edu/sm/nehcrc. The web site provides access to all nine components of the NEHCRC program including the reception area, library, and gateway. It also provides access to several of the interactive components of the program such as the discussion groups and two searchable databases. Several links to the Native American Office of Technology Assessment sites are provided for easier access. An exit survey is also included in order to provide feedback about the program on the web. Please take some time to complete it so we can continue to improve our site. Information will be updated on a regular basis and new links added to other resources and programs.

Both the Resource Bank and the Exemplar Programs databases are each indexed through keyword searches that cover a full range of health care issues specific to the Native elder population. The information we have chosen to include is meant to improve health care practice standards and increase the cultural competence of health care providers. Moreover, we wish to promote awareness about health issues within this special population.

The first database, the Exemplar Programs, catalogues programs relevant to health promotion, disease prevention, treatment, and rehabilitation of the older American Indian, Alaska Native, and Native Hawaiian. This database is designed so that an individual can search a specific health care issue using four levels of support based upon the needs of the elder. These four levels include: (1) Independent Support, (2) Limited Support, (3) Intermediate Support, and (4) Skilled Support. For example, one may search for "Rehabilitative Services" for an elder who needs "Skilled Support." This search method is especially useful for the health care provider who wishes to obtain information more suited to an individual's specific needs.

The Resource Bank consists of individuals and/or organizations possessing the expertise, materials, and/or resources to promote and prevent health problems among Native elders. This information is particularly beneficial for providers who wish to contact an individual who has exceptional knowledge regarding issues on aging and the aged Native elder.

If you are aware of any model activities that you believe are good candidates for the Exemplar programs, or individuals who should be considered for the Resource Bank, please send us the following information: contact name, address, telephone number, fax number, e-mail address, organization affiliation, position/title, and areas of expertise in aging. Program pamphlets are quite helpful in providing the descriptive information we wish to include within the databases. □

The IHS Oral Health Care Program for Indian Elders

David B. Jones, DDS, MPH, Geriatric Dental Fellow, Baylor College of Dentistry, Dallas, Texas and University of North Texas Health Science Center, Fort Worth, Texas; and Eric B. Broderick, DDS, MPH, Assistant Chief, IHS Dental Branch, Rockville, Maryland.

Mr. Ron Whitefeather,* age 69, recently entered a tribally-run nursing care center. He had suffered a large brain stem stroke that left him unable to take care of himself. He lost his ability to swallow and is being fed with a tube directly into his stomach. Mr. Whitefeather is undergoing rehabilitation to regain his swallowing mechanism as well as his ability to feed himself. His current dentures don't fit well. He would like new dentures so he can chew his food better; he is convinced he can recover from the stroke. Unfortunately, the Indian Health Service (IHS) Dental Program can't help Mr. Whitefeather. He requires treatment in the nursing center by a dentist trained to treat medically-compromised elder patients. This unique type of treatment is not a high priority with the limited dollars available to the IHS dental program.

The IHS developed a "Schedule of Dental Services" to guide dental health personnel in the delivery of oral health services. These clinical service priorities are based on the hierarchy depicted in Table 1, with Level I being the highest priority. Table 2 shows the percent of dental services provided to users of the dental program, by level of care, in fiscal year (FY) 1995.

Since the IHS is only funded to provide about 30% to 40% of the current oral health needs of American Indians and Alaska Natives, a rational and consistent method of prioritizing dental care is essential. The IHS is committed to the delivery of those services that will provide the greatest long-term benefit to the most people. Basic care accounted for 94% of all services provided in FY 1995 (Levels I-III). However, services included in Levels IV through Level VI are legitimate needs that should be addressed by a comprehensive health care program.

In FY 1995, of the over 2 million dental services provided to American Indians and Alaska Natives, only 6% percent were for people over the age of 65. Since much of the need for more complex rehabilitative services is concentrated in Indian elders, such as Mr. Whitefeather, it is not surprising that much of their care needs are not met.

* Not his real name.

Table 1. IHS Schedule of Dental Services.

Level I	Emergency Dental Care	Those services necessary for the relief of acute conditions and defined by the patient to be of an emergent nature.
Level II	Preventive Dental Care	Those activities which prevent the onset of dental disease (e.g., topical fluorides, sealants, and oral prophylaxis).
Level III	Secondary Dental Care	Those procedures which intervene early in the dental disease process (e.g., basic fillings).
Level IV	Limited Rehabilitation	Those services which restore the oral structures to improved form and function (e.g., single crowns).
Level V	Rehabilitation	Rehabilitative services requiring more provider time, skill, or expense than those in Level IV (e.g., dentures and bridgework).
Level VI	Complex Rehabilitation	Those services considered most complex and which often require delivery by a specialist (e.g., implants and comprehensive orthodontics).

Table 2. Percent of services, by levels of care and by age, FY 1995.

	< Age 5	5-19	20-44	45-64	65+	All Ages
Level I	25%	25%	43%	44%	50%	33%
Level II	31%	37%	18%	16%	15%	23%
Level III	40%	30%	29%	29%	25%	38%
Level IV	0%	2%	2%	5%	3%	2%
Level V	0%	1%	1%	3%	2%	1%
Level VI	4%	15%	7%	3%	5%	3%
Total	100%	100%	100%	100%	100%	100%

The IHS is faced with the dilemma of how, with inadequate resources, to meet the complex oral health needs of an increasing number of Indian elders. The IHS Dental Program, in support of the IHS Elder Health Care Initiative, is presently developing and testing several strategies to provide dental services to Indian elders outside of the normal IHS dental clinic setting. These strategies include:

- Training medical and dental providers to recognize and treat oral health problems of the elder Indian patient;
- Training care givers of elders to provide routine preventive oral health services, such as toothbrushing, for those unable to care for themselves;
- Providing oral health assessments for elders in nursing facilities, senior centers, and chapter houses to identify oral health conditions requiring referral and care;
- Providing dental preventive services to Indian elders in nursing homes, senior centers, and chapter houses using antimicrobial agents and fluoride to prevent and control dental caries and periodontal disease;
- Encouraging IHS dental providers to devote more time to providing restorative and rehabilitative treatment for the Indian elder population.

Being able to provide oral health assessment, care, and education to Indian elders is a challenging and valuable part of the IHS dental and primary care practices. It requires an understanding of the normal aging changes in dental structure and function, the pathophysiology of chronic diseases, and the pharmacology and interactions of medications commonly used in American Indian elders. All providers need to be made aware of the interaction of systemic disease and treatments on oral health status and vice versa, and the importance of early, accurate diagnosis and intervention. Finally, it must include a commitment by the IHS to expanding dental care to Indian elders, such as Mr. Whitefeather, to insure them the highest possible quality of life. □

The Elder Female
A Preventative Care Plan and Health Watch

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In a previous article,[1] the state of health of American Indian and Alaska Native elders was described, and statistics about health, socioeconomic, demographic, and environmental status were presented. As this age group (those 60 years of age and older) increases in size, it is imperative that health care givers understand their health needs, optimize their health, prevent future illness or loss of function, as well as uncover any malady in its earliest stages in order to minimize morbidity and prevent mortality. Most of the findings and recommendations in the previous article applied to both male and female elders. In this article, comments will be specifically directed towards the female elder, looking at diseases or conditions that have a predilection to attack the female at different rates than the male, or those that are predetermined by female anatomy. Population data for American Indians/Alaska Natives are presented by ages and by gender in Table 1.

Table 1. Population data, elder age groups, American Indians/Alaska Natives.

Age Group	Gender		Totals
	Male	Female	
55+	59,982	75,148	135,130
60+	43,317	56,030	99,347
65+	26,652	39,921	66,573

This table was derived from IHS service population data, based upon the 1994 revision of the 1990 census data. Multiple population age values were calculated because of lack of a standard definition for "elder," varying from age 50 years (American Association of Retired Persons) through age 65 years (Social Security Administration). There are grants that tribes may become eligible for based upon ages 60 or 65, and some studies may collect data based upon ages 55 and above. Most of the health recommendations in this paper are based upon age 60 years. Regardless of the age criterion used, females exceed males in absolute numbers by 25-30%.

Data Source: P. Acton, MPH, Office of Program Planning and Information Resources, Phoenix Area Indian Health Service.

The 1996 revised U. S. Preventive Services Task Force (USPSTF)[2] recommendations serve as a general guide for screening procedures in the United States. Most of the recommendations look at available national disease data, risk status of various populations, disease incidence/prevalence, and the cost of diagnosis of each case. Specific recommendations are then made about the use of medical screening procedures. Some of the recommendations offered in this article will refer to the USPSTF recommendations; others will specifically cite the absence of any recommendation (or the presence of conflicting recommendations). This article is not a comprehensive treatise on elder care; appropriate references are included for those who wish to learn more. The general theme here will not be treatment of any specific disease or condition, but rather, a preventive health approach, using my personal modification of the World Health Organization's[1] definition of health:

> Health is more than the mere absence of disease, but is a state of complete physical, mental, emotional, spiritual, and social well-being. This implies provision for [potential] achievement of desired financial, family, and career goals. Wellness is a state of optimal health.

Considering the above definition of health, important goals for the elderly would include achievement of optimal health, prevention of illness, and early identification and management of problems.

General Health Measures in the Elder

As with all individuals, a varied, balanced diet, with the proper caloric intake, is imperative in the elder, and forms the basis for general good health. The diet should accomodate existing dentition, avoid foods that have been known to cause digestive problems in the past, and should include foods that are traditional or particularly enjoyed by the elder. Such measures encourage appetite, aid adequate nutrition, and, when properly stimulated with good companionship and healthy conversation, aid digestibility and stimulate the most important characteristic of humans, the intellect. Companionship, and a feeling of being needed and wanted (or worthiness), not only stimulate the appetite, but are important facilitators of good mental health, preventing or ameliorating mental depression as much as or more than many psychotropic agents.[3]

The diet should be watched for excessive fat or cholesterol intake, and should be high in dietary fiber. The caloric need per pound tends to decrease with aging, and elders will tend to gain weight on their average or previous caloric intake ("old age spread"), unless exercise is continued or increased.

There is usually some loss of speed, strength, agility, fine motor control, dexterity, and endurance with aging. When encouraging elders to exercise, it is important to keep these losses in mind. Activity and exercise, however, will temper these losses, while preventing stiffness and contractures, and aiding in the burning of caloric intake. In the prevention of osteoporosis, and the maintenance of cardiovascular health, even simple walking, using both large and small muscle groups, will help, especially when practiced as a regular routine. Care must be taken, however, that falls are prevented, that the paths and walkways used by the elder are safe, and that proper stability is provided for those who are frail, with guiderails and protective assistive grips where needed. Funds are available to equip homes for elders with assistance and safety devices, and such devices can aid the elder in maintaining (or prolonging) independent community living. Once special equipment has been placed, however, periodic inspection and maintenance must be provided to assure that the installed aids have not become safety hazards themselves. Personal safety in the living situation should be evaluated, and observation/inquiry about "elder abuse" should also be made.

The Periodic Health Examination

There is debate in medicine about the cost and/or effectiveness of annual physical examinations. Regular assessment, even via questionnaire, however, has been shown to be highly cost effective in preventing hospital days in the elderly[4] and for promoting health maintenance.[5-7] The IHS Maternal Child Health Chapter prescribes a particular routine for women's health maintenance examination,[8] and can be used as a guide and reference, as can the ACOG (American College of Obstetricians and Gynecologists) age-specific guide[9] for women's health care.

Basic assessment should include an appraisal of the health and functional status (Tables 2, 3, and 4) of the individual. An interval history should always begin the process. The evaluation should include measurements of weight, height, and blood pressure; examination of the heart, lungs, and breasts; and laboratory tests including a complete blood count, blood sugar, lipids, BUN (if specifically indicated), and a urinanalysis.

Actual height measurement without shoes is extremely important in the elderly female, as height loss may be the first physical indication of osteoporosis in someone who is otherwise healthy and asymptomatic. A finding of loss of height should be followed up with a bone density determination for diagnosis and verification. Loss of height in osteoporosis is due to collapse of vertebral bodies secondary to demineralization (in actuality, the dowager hump is a series of a vertebral compression fractures).

Table 2. Goals of the thorough geriatric assessment.

Improve diagnostic accuracy
Avoid iatrogenesis
Clarify functional status and its implications for care decisions
Determine risk factors for functional decline
Identify interventions to preserve or restore functional capabilities
Recommend the optimal care environment
Provide an accurate prognosis for social and medical planning
Help monitor clinical change over time

Adapted from: Kane RL, Ouslander JG, Abrass IB. *Essentials of Clinical Geriatrics.* 3rd ed. New York, NY: McGraw-Hill; 1994.

Table 3. Geriatric problems and syndromes seen in the older woman.

Impaired vision, hearing
Incontinence
Inanition (malnutrition)
Immobility
Instability (falls)
Intellectual impairment (dementia, delirium)
Isolation (depression)
Insomnia
Sexual dysfunction
Iatrogenesis (especially polypharmacy)
Impecunity (poverty)
Frailty and fragility (weakness)

Adapted from: Kane RL, Ouslander JG, Abrass IB. Essentials of Clinical Geriatrics. 3rd ed. New York, NY: McGraw-Hill; 1994.

Table 4. Activities of daily living (classification).

Basic	Intermediate	Advanced
Bathing	Shopping	Strenuous physical activities (hiking, bicycling, sports, etc.)
Dressing	Transportation	Heavy work around house (washing windows, repairs, etc.)
Toileting	Prepare meals	Walk more than 1 mile without rest
Transfer	Take medications	
Continence	Manage money, finances	Capable of self sufficiency
Self-feeding	Keep house	Can assist with care of another person
	Do laundry	Gainfully employed

Assessment of an elder's ability to perform activities of daily living (ADL) will help determine if there is a need for support services (either permanent, temporary, or intermittent) and if the elder can live independently. ADL status (basic, intermediate, advanced) is fluid, and elders can move from one category to another. Those individuals who do not have the capacity for basic ADLs will probably need to be institutionalized or placed in an assisted living environment.

Adapted from: Kane RL, Ouslander JG, Abrass IB. Essentials of Clinical Geriatrics. 3rd ed. New York, NY: McGraw-Hill; 1994.

Some assessment of the status of activities of daily living (ADL) should be made (Table 4) and recorded. A chest x-ray should be done for a specific indication only. Thyroid evaluation should be done every 5 years.[9] There is no specific recommendation on frequency of the electrocardiogram (EKG). The Papanicolaou test (Pap smear) will be discussed later, in the section on cancer screening.

Since elderly women are not menstruating (post-menopausal), a monthly routine for breast self-examination needs to be retaught, to be done on a specified monthly date rather than a specific menstrual day (for example, the "Buddy Check 12" program of a local Phoenix TV station and hospital suggests the 12th day of each month as an "action" day for breast self-exam checks).

Anticipatory guidance should include instructions about danger signs (e.g., breast masses or nipple discharge, blood in stools or urine, vaginal bleeding), as well as appearance of other masses, or symptomatic heart disease. Some dietary and exercise guidance should be provided, and precautions to prevent falls discussed.

Infectious Diseases

Pneumonia and influenza are particularly serious and severe in the elderly, with mortality and morbidity rates significantly higher than in the 25- to 40-year-old age group. The polyvalent pneumococcal vaccine is recommended for any individual (regardless of age) with significant chronic disease (e.g., cardiopulmonary disease, diabetes, alcoholism, cirrhosis, asplenia, immunodeficiencies, etc.), adult residents of nursing homes or other long-term facilities, and for individuals over 65, with a single booster injection considered 5 years after initial immunization.[10]

Annual influenza vaccination is recommended for all individuals over age 60, who are a priority group to receive this vaccine, especially in periods of epidemic or shortage. The vaccine is 80% effective against influenza.[11] This immunization is particularly important for nursing home residents, regardless of age, because of the ease of transmission in settings such as this. The only precaution or specific contraindication to influenza vaccine is allergy to eggs (the vaccine is grown in chick embryos), or a previous adverse reaction to the vaccine.

Reactions to both vaccines are infrequent and mild, and can be easily managed with aspirin, acetaminophen, or non-steroidal anti-inflammatory drugs (NSAIDs). Caution should be exercised in prescribing NSAIDs to the geriatric patient, as serious side effects, especially gastric (peptic) ulceration, have been reported more often in this age group than in younger patients.[12,13] Any deficiencies in immunization status should also be corrected at the same time (e.g., tetanus/diphtheria booster, hepatitis series, TB skin testing). Tetanus immunization deficiencies are found more often in women.[11]

Screening for Cancer

The National Cancer Institute recommends performance of Pap smears every 3 years following three consecutive negative Pap smears. However, because cancer of the cervix has a *higher incidence among Indian females* than in the general U.S. population, the *IHS Manual advises annual Pap smears*.[8,14] Annual exams also provide an opportunity to screen for rectal/colon cancer

by performing a rectal exam and stool guaiac, and for ovarian cancer by performing a bimanual pelvic exam. A palpable ovary on pelvic examination in a postmenopausal woman is abnormal and always demands further evaluation. Much has been written on the "palpable postmenopausal ovary syndrome" with most authorities feeling that ovarian "markers" (CEA and CA125) should be determined, and exploratory surgery done if a definitive reason for enlargement cannot be found. When performing the Pap smear, care should be taken to always obtain an endocervical brush specimen. As part of the normal "aging"/maturation of the cervix, the squamo-columnar junction recedes from the portio vaginalis into the endocervical canal (due to squamous metaplasia), and thus the endocervical specimen is needed in order to obtain a junctional specimen.

As in the general population,[2] it has been noted in many IHS clinic audits that elderly women who are being seen regularly for other problems may not have had a Pap smear for several years; thus the provider should be sure to at least offer such cancer screening. Many elder females believe that such examinations are no longer necessary after they pass childbearing, or they don't wish to be examined by a male provider, and thus will not request such an exam. In a study of elderly minority women at an average age of 75 years, the average number of prior Pap smears since age 65 was 1.7.[2] On the other hand, the USPSTF states that "elderly women do not appear to benefit from Pap testing if repeated cervical smears have consistently been normal." They do note, however, the need to screen those women who have not been regularly screened, and some studies suggest that this is cost effective.[2] Those at greatest risk appear to be those who are least screened. Consideration should be given to using female providers for such exams, if at all possible, as this might facilitate the examination.

In spite of the apparent lower incidence of breast carcinoma in Indian women, and because of the unavailability of mammography equipment in many IHS facilities, Indian women are generally underscreened for breast carcinoma. However, when matched for stage at time of diagnosis, Indian women did not survive as long after diagnosis as did non-Hispanic white women.[15] The present Centers for Disease Control and Prevention (CDC) breast cancer detection projects are mostly for minority women over the age of 50, and state health departments should be approached for grants or services for mammography screening for Indian women, as Indian women are a targeted priority group. Screening mammograms are recommended annually for women after age 50.

Along with screening mammography, elder women should be retaught breast self examination, and should have a clinical breast exam at the time of ordering the mammogram. Because of cost (and USPSTF recommendations), Medicare may not reimburse for routine Pap smears and screening mammograms more often than every 2 to 3 years, and thus the cost may have to be absorbed by the IHS or other sources.

In the northern and central plains, rates of lung cancer in Indian women presently approach those of males.[16] If the woman is a chronic smoker, an annual or biennial chest x-ray should be considered, especially if she is symptomatic (chronic cough or expectoration). A trial of smoking cessation should be encouraged, using both behavioral health and pharmacologic methods (a high priority with USPSTF).[2] While presently less of a problem in the southwest (in women over 60), rates of smoking in younger Indian females are higher than in the older generation, and thus lung cancer and chronic respiratory ailments might become a problem at some time in the future.

The recommendations made for female bowel cancer screening are the same as in the male. The digital rectal exam should be performed annually, as a high percentage of bowel cancers are within reach of the finger (rectum and distal sigmoid). Stools should be screened annually for occult blood, and more invasive diagnostic procedures (e.g., sigmoidoscopy, barium enema, colonoscopy) performed, if indicated.

Hormone Replacement Therapy

Women today have a greater life expectancy at age 50 than do males, regardless of ethnicity[1,11] With the average age of menopause at about age 50, women can expect to spend about one third of their lives without functioning ovaries.[1] The ovary produces both estrogens and androgens; after menopause, the only remaining androgens are adrenal androgens. Among the functions of androgens are facilitation of the deposition and maintenance of bone tissue, and motivation of the sex drive (libido). Bone loss accelerates almost immediately after menopause, and can be markedly delayed by estrogen supplementation (hormonal replacement therapy, HRT; or estrogen replacement therapy, ERT). Estrogen will save bone tissue, but will usually not deposit new bone. With estrogen replacement therapy, a 50% to 60% decrease in fractures of the arm and hip can be expected, and when estrogen is supplemented with calcium, an 80% reduction in vertebral compression fractures can be observed.[17] Supplemental estrogens are also protective against stroke, reducing the incidence by 20-40%.[18-20]

Estrogen is also protective to the cardiovascular system, and the sudden decline in estrogen levels at menopause, along with the concurrent change in the blood lipid profile, is responsible for the gradual increase in heart disease at that time, with rates of coronary artery disease in females approaching those of males within 10 to 15 years after menopause. Heart disease presently kills more elderly Indian females than any other disease.[16]

As the Indian Health Service presently lacks bone density measurement equipment,[1] there are no IHS data or studies on postmenopausal bone loss in Indian women, but specific data may be forthcoming from the Women's Health Initiative (WHI), a 12-year, multi-institutional, National Institutes of Health (NIH) study presently underway nationwide in postmenopausal women. At least two of the research institutions in the WHI are actively recruiting Indian women for participation in the study. It is known that fat tissue metabolizes estrogen differently than lean tissue, mostly via an estrone (E1) rather than estradiol (E2) pathway, with estrone being a more potent estrogen in many of its features. There is a clinical impression that Indian women do not develop osteoporosis; Is this true? And, if so, is the high incidence of obesity in Indian women a reason? Do Indian women have higher or more effective levels of postmenopausal estrogen and/or androgen? Do the generally lower rates of smoking in this population have any influence? Answers to these questions, and others, are expected from the WHI. In any event, until more is known, most clinicians today advise the use of estrogen in all postmenopausal women, including Indian women, for the known cardioprotective and osteoprotective features. The added benefits of a decreased

incidence or later occurrence of Alzheimer's disease, as well as better cognition, recall, and memory retention in women on HRT, have been found in several studies.[18-20]

When estrogen is used, *women who have an intact uterus should always have progestin included* (two approved regimens, cyclic and continuous), *to protect them against unopposed estrogen and potential endometrial carcinoma.* Indeed, several studies have shown a lower risk of endometrial cancer in women who are receiving combined replacement (estrogen/progestin or HRT) therapy than in those women not receiving HRT.[17,20] Any woman on HRT, who has vaginal bleeding at a time when she is *not* expected to bleed, must have an endometrial sampling (this can be done as an outpatient).

Although many physicians are prescribing combined HRT, many women will discontinue the progestin because of side effects, or discontinue the entire regimen.[17] Because of the general feeling of "well being" conveyed while using supplemental estrogen, the estrogen is more likely to be continued, even by those who should be using (or may have been prescribed) combined therapy. It has been demonstrated that frequent inquiry and constant patient education by the provider promotes compliance.

Doses of estrogen replacement known to protect against osteoporosis and cardiovascular disease (0.625 mg conjugated estrogens or 1.0 mg estradiol, daily) are at the present time not known to be associated with any clear-cut increased risk of breast cancer.[17]

Additional benefits of HRT include a decrease in genital atrophy (breasts and genitalia), decrease in vaginal mucosal dryness, maintenance of sexual drive, and decreased urinary incontinence. (See Table 5 for a summary listing of hormonal replacement therapy benefits.)

In addition to these acknowledged benefits of hormone replacement, it has recently been reported that non-insulin-dependent diabetes mellitus (NIDDM, or Type II diabetes) is more easily controlled in women on HRT.[21]

Whether androgens should also be replaced is still a controversial point among gynecologists, who remain fairly evenly divided about this. There are several proprietary products on the market containing combined estrogen and androgen.

Calcium and exercise are also advised to prevent osteoporosis. A daily calcium intake of 1500 mg is advised (the same RDA as for teenagers),[11] with authorities split about whether the intake should be from diet alone or calcium supplements (most feel that dietary calcium is preferable but difficult to attain, especially in a lactose intolerant population). Weight bearing exercise[11] and weight training promote bone deposition and modeling. For those women known to have significant loss of bone density, calcitonin and alendronate (Fosamax®) have been shown to be effective in promoting calcium deposition and reducing fractures. Additional data about the role and effectiveness of Vitamin D and calcium supplementation are expected from the WHI.

Table 5. Benefits of hormone replacement therapy.

Osteoprotective (prevents loss of calcium from bone, lowered incidence of fractures)
Cardioprotective (maintains favorable lipid profile of the premenopausal woman)
Lowered incidence of stroke (thrombotic stroke)
Decreased genital tissue atrophy (breasts and genitalia)
Better cognition and memory
Facilitation of control in non-insulin-dependent diabetes mellitus
Lowered incidence and easier control of urinary incontinence

Urinary Incontinence

Women are ten times more likely than men to suffer from urinary incontinence, but unfortunately, many women do not seek help, either because of embarrassment or personal acceptance. Between 15-55% of females over 65 may have some degree of urinary incontinence; the incidence increases with age, and is higher in nursing home residents.[22,23] Incontinence, either urinary or fecal, is a common reason for ending independent living and being placed in a nursing home (see Table 3). Fewer than half of those affected with urinary incontinence seek treatment. The proliferation of print ads and television commercials for absorbent panties and adult diapers is a vivid demonstration of how widespread the condition is. Incontinence is treatable in a high percentage of cases, and is a quality of life issue.

Specific questions should be asked as to whether incontinence is present, whether such incontinence is acute or chronic; constant or episodic; and whether it is of a stress, urge, neurogenic, overflow, mixed, iatrogenic (i.e., medication or care-change induced), or of an anatomic nature; whether accompanied by other associated conditions (such as urinary tract infection, multiple sclerosis, injury, stroke); as well as the measures presently used for the elder to either control or adjust to the incontinence problem. Realistic goals for correction or amelioration of the incontinence should be sought after proper diagnostic (urodynamic) evaluation. There are now a wide variety of medications, devices, and other treatments available to attain functional continence, or to manage hygiene problems, other than indwelling catheters, diapers, or sanitary pads.[22,23] For additional resources on this subject, see box.

Sexuality and Aging

Sexual interest and activity continues to various degrees in the elder female. As females outlive males (and because women tend to marry men who are older than they are), females may often be without a partner in later life. Additionally, there is a tendency in society to consider the older woman as being asexual since she is no longer fertile. Some of this is paternalistic reasoning, as well as a denial of autonomy. Studies of sexuality in older women are few, with many suffering an "ageist" bias (being done by a different generation, using that generation's values, judgements and references).[24]

Sexuality encompasses sense of self, interaction with others, and many levels of expression and affection, not just the capacity to have sexual intercourse. The major factors that contribute to a diminution in sexual activity in elderly women are ill health and the

absence of a sexually functioning partner.[24] Research on the subject is sparse and riddled with methodological problems. Sexual behavior and practices in the elderly woman form a continuum that ranges from purely mental fantasies to a variety of physical practices that may or may not involve a partner.[25] As in the younger female, assessment of sexual functioning in the elder female is relevant, with medical intervention as appropriate.[9] As in the younger female, the possibility of sexual abuse should likewise be considered in the elder woman.[9]

Women on HRT can and do have sexual activity to a late age, as they usually do not have the genital atrophy, nor the loss of lubrication of genital mucosa that follows declining (or absent) ovarian function. Androgens are mostly responsible for libido in both sexes. A long-term continuing relationship appears to be the best predictor of a person's sexual activity in later life.[25] Indeed, many institutionalized couples who mutually wish to remain sexually active have been subjected to prohibitive institutional rules and norms, negative staff attitudes, and sometimes forced physical separation.[25] It should also be noted that the elder generation grew up in a different sexual climate, with different mores than those that exist today.

Drug Use

Many women have been acculturated by our society to be medication takers/seekers. Women receive twice as many prescriptions for psychoactive drugs as do males. Although older adults constitute 12% of the U.S. population, they use 40% of all prescription drugs, and 69% of older adults rely exclusively on over-the-counter medications for symptom relief, often because of poverty.[26] Alcohol and drug abuse may be the second most common disorder affecting the older adult[27] (with arthritis being the most common). Although comprising only 7% of the population, older women receive 17% of psychoactive drugs, and 20% of the sedative hypnotics prescribed.[26] Older women, like older men, often use multiple medications. This is in spite of the facts that their ability to metabolize or excrete those medications may be declining markedly with increasing age, and that the fat soluble medications may accumulate (because of increasing body fat with

Urinary Incontinence Resources

- **National Association of Continence**
  This organization regularly distributes an educational newsletter to its members and offers patient education literature and audiocassettes for sale. In addition, a thick catalog ("Resource Guide: Products and Services of Incontinence") of all personal products available to help persons with incontinence is updated yearly, and is available for sale.

  For additional information, contact the National Association of Continence, P.O. Box 8310, Spartanburg, SC 29305 (1-800-BLADDER).

- **National Kidney and Urologic Diseases Information Clearinghouse**
  The National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health and a partnership of professional and patient advocacy groups concerned with urinary incontinence have instituted a new campaign, *Let's Talk About Bladder Control for Women,* in January 1997 to make women aware that urinary incontinence is treatable.

  A media kit (including a sample of each of seven patient education pamphlets, a resource list for health care professionals, and a brochure entitled "What Your Female Patients Want to Know About Bladder Control") is available by contacting the National Kidney and Urologic Diseases Information Clearinghouse, 3 Information Way, Bethesda, MD 20892-3580 (phone: 301-654-4415 or 1-800-891-5388; fax: 301-907-8906; e-mail: nkudic@aerie.com). This information can also be downloaded from the Internet, at www.niddk.nih.gov.

- **Agency for Health Care Policy and Research**
  The Agency for Health Care Policy and Research (AHCPR) has responsibility for facilitating the development, periodic review, and updating of clinical practice guidelines. These guidelines assist health care professionals in the prevention, diagnosis, treatment, and management of clinical conditions.

  The AHCPR has developed materials about urinary incontinence for both patients and professionals:

  For professionals: "Clinical Practice Guideline Number 2, 1996 Update. Urinary Incontinence in Adults: Acute and Chronic Management" (AHCPR publication #96-0682) and "Quick Reference Guide for Clinicians Number 2, 1996 Update. Managing Acute and Chronic Urinary Incontinence" (AHCPR publication #96-0686)

  For patients: "Patient Guide: Understanding Incontinence" (AHCPR publication number 96-0684)

  To obtain copies, contact the AHCPR Publications Clearinghouse toll-free at 800-358-9295 or write to AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907 (there may be a fee).

age), producing a longer effective half life. Adverse drug reactions occur in 21% of 70- to 79-year-olds, as compared with 3% of 20- to 29-year-olds. A person age 65 or older usually takes at least four to five over-the-counter drugs as well, frequently concomitantly with prescribed medications. With some drugs, especially psychoactive drugs or medications known to have narrow effective versus toxic ranges, consideration should be given to obtaining drug blood levels; diurnal variations in drug levels must also be taken into account.

Drug-induced illnesses (self-medication and serious errors in taking medications, sometimes induced by reduced mental capacity or complex directions) account for higher hospitalization rates in the elderly (personal communication, P. Acton and R. Arthur). Women 60 and older account for twice as many drug-related emergency room visits as do men (personal communication, P. Acton and R. Arthur).[28] Physicians may prescribe *additional* drugs to counteract the side effects of other drugs, further compounding the iatrogenic illness with polypharmacy. In this age of medical specialization, patients are more likely to be under the care of several physicians, *none of whom might be completely aware of what other providers have prescribed.*

Considering the above, it is obvious that a comprehensive assessment must also include a complete drug history, including both prescription as well as over-the-counter medications. Such a history should detail when each drug was last taken, in what amount, and whether there is a system in place to evaluate all drugs being used, including potential drug reactions and drug errors. One should also ascertain if medications are being taken properly and effectively.

Alcohol and Drug Abuse

As mentioned earlier, elderly women are more likely to be without a partner, and may have less economic resources than the elderly male. After a spouse's death, she may have only a house as an asset (on some reservations she may not have full home ownership as a marketable asset). In this age group, she is less likely to be able to drive, and thus has limited facility in transportation and personal mobility. In the U.S., the average age of widowhood is 56, which for many women leaves potentially 20-25 years or more of living alone. If never married, at age 62 she earns about one third as much as her married female counterpart,[26] and less than her male counterpart.

The older woman is more vulnerable to alcohol/substance abuse because (1) she may live alone, (2) she may be isolated, lonely, and depressed, (3) if in a relationship, she may be unhappy with her relationship, (4) she may be ill or dependent, (5) she may lack money for quality treatment, or (6) she is more likely to be prescribed psychoactive medications or may self-medicate. These problems are magnified even more in the elderly minority woman.[26]

Estimates are that 10-15% of women over 65 years of age suffer from psychiatric, physical, or functional impairment related to alcohol. Currently, problems with alcohol are observed and diagnosed more frequently in older men, in part because drinking is more socially acceptable for men, whereas it still remains socially unacceptable for older women, who may be "closet" drinkers or be in denial. Societal ostracism is still a major factor for women. Older individuals, particularly women, do not present with observable, typical symptoms suggestive of alcoholism. As a result, the provider's index of suspicion and, therefore, ability to recognize a drug or alcohol problem is low. Elderly women tend to drink less but are more likely to abuse drugs along with alcohol, tend to start later in life than men, have smaller livers and thus metabolize alcohol more slowly or less completely, and are reported to seek treatment earlier.[26]

The older woman is more vulnerable to alcohol/substance abuse. . .

A good screening test for both alcohol and prescription drug abuse is the Michigan Alcoholism Screening Test (MAST);[29] three useful questions from this screen are:

1. Do you feel you are a normal drinker and take your medications correctly?
2. Does your family ever worry or complain about your drinking or use of medications?
3. Has your drinking or taking medications ever created problems for you and your family?

These particular questions in the MAST are non-judgmental, relate to *combined* alcohol and medication/substance abuse, and may be more likely to elicit a positive response, which should then be probed further to obtain details. Unfortunately, treatment facilities and beds for females are less likely to be available than for males, and will involve the provider in a major search for care locations, as well as proper aftercare placement. Detoxification in the elderly should usually take place in a hospital (inpatient) setting. Aftercare should always involve the family and significant others(personal communication, P. Acton and R. Arthur).

Conclusion

Comprehensive care of the elder is a challenge to the provider, as well as a challenge for the elder. The goal should be to seek optimum health and wellness, and begins with a proper assessment and an individually formulated care plan. The provider must be aware of and anticipate potential problem areas, including iatrogenesis, so that maximum benefit with minimum risk is achieved for each individual elder.

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Cancer Prevention Fellowship Program

The *Cancer Prevention Fellowship Program*, sponsored by the National Cancer Institute (NCI), offers a unique opportunity for physicians, other clinicians, and PhDs to train in the field of cancer prevention and control. The program offers Master of Public Health training during the first year at accredited universities, followed by independent research opportunities within the Division of Cancer Prevention and Control, NCI, located in the Rockville, Maryland area. The program is 3 years, with the MPH option; up to 3 years without.

Applications for the 1998 Cancer Prevention Fellowship Program must be received by September 1, 1997 (the appointment begins July 1, 1998.

The *Summer Cancer Prevention and Control Academic Course* is a part of the Fellowship Program, but is also open to physicians and scientists from cancer centers, universities, health departments, and industries interested in specialized instruction on the principles and practices of cancer prevention and control. The course is divided into modules that can be attended in their entirety or individually. Prior experience or training in epidemiology is recommended.

To receive a fellowship application catalog or for details on the academic course, contact Douglas L. Weed, MD, MPH, PhD, Director, Cancer Prevention Fellowship Program, Division of Cancer Prevention and Control, Executive Plaza South, Suite T-41, 6130 Executive Boulevard MSC 7105, Bethesda, MD 20892-7105 (phone: 301-496-8640; fax: 301-402-4863).

Alcohol-Related Birth Defects Awareness*

The National Council on Alcoholism and Drug Dependence designated May 11-17, 1997, as *Alcohol and Other Drug-Related Birth Defects Awareness Week.* Indian Health Service, tribal, and urban Indian programs are encouraged to plan prevention activities and to continue these activities throughout the year.

From 1991 to 1995, rates of alcohol use during pregnancy increased, especially for frequent drinking, underscoring the need for renewed attention to advising pregnant women to abstain from alcohol use. Associations between adverse pregnancy outcomes (fetal alcohol syndrome, fetal alcohol effects) and moderate to heavy alcohol use during pregnancy continue to be reported. Health care providers should educate women about the recommendations of the Surgeon General and the Secretary of Health and Human Services regarding the need for women who are pregnant or are planning a pregnancy to abstain from alcohol use.

The IHS Alcoholism and Substance Abuse Branch coordinates issues related to FAS for the Agency. They have a lending library (for IHS, tribal, and urban Indian health professionals) of videotapes and slides on addiction topics and FAS. Videotape materials about FAS include *The Clinical Diagnosis of FAS* (Jon Aase, MD; 30 minutes); *What's Wrong With My Child?* (MTI; 26 minutes); *A Cry for Help: The Fetal Drug and Alcohol Crisis* (MTI; 33 minutes); *A Mother's Choice* (Gryphon; 27 minutes); *Women of Substance* (Video/Action); and the keynote speeches of the *IHS 1995 FAS Conference* (Betty Cooper;, Ken Jones, MD; Ann Streissguth, PHD; and Phil May, PhD). The slide series available is *Alcohol Use and Its Medical Consequences: Unit 5: Alcohol, Pregnancy, and the Fetal Alcohol Syndrome* (2nd edition, 1994). For more information or to borrow any of these materials, contact the IHS Alcohol and Substance Abuse Branch, 5300 Homestead Road N.E., Albuquerque, NM 87110 (phone: 505-248-4121).

Additional information about Alcohol and Other Drug-Related Birth Defects is available from (1) the National Council on Alcoholism and Drug Dependence, Inc., 12 West 21 Street, New York, NY 10010 (phone: 212-206-6770; fax: 212-645-1690; Internet: http://www.ncadd.org) and from (2) the National March of Dimes, Birth Defects Foundation, 1275 Mamaroneck Avenue, White Plains, NY 10605 (phone: 888-663-4637; Internet: http://www.modimes.org). Additional information about fetal alcohol syndrome and other alcohol-related birth defects and developmental disabilities is available from (1) the National Institute on Alcohol Abuse and Alcoholism, 6000 Executive Boulevard - Willco Building, Bethesda, MD 20892-7003 (phone: 301-443-3860; Internet: http://www.niaaa.nih.gov); (2) the National Organization on Fetal Alcohol Syndrome, 1819 H Street, N.W., Suite 750, Washington, DC 20006 (phone: 202-785-4585; fax: 202-466-6456; e-mail: nofas@erols.com; Internet: http://www.nofas.org); and (3) the Fetal Alcohol Syndrome Prevention Section, Division of Birth Defects and Developmental Disabilities, National Center for Environmental Health, MS F-15, Centers for Disease Control and Prevention, 4770 Buford Highway N.E., Atlanta, GA 30341-3724 (phone: 770-488-7370; fax: 770-488-7361; e-mail: ncehinfo@cdc.gov; Internet: http://www.cdc.gov/nceh/programs/programs.htm).

* Source: MMWR. Apr 25, 1997;46(16):345-350.

MEETINGS OF INTEREST □

Association of American Indian Physicians
July 26-29, 1997 Seattle, WA

The theme of this year's annual conference is *Indian Health Issues in the Next Century: The Role of the Indian Physician.* The conference will address the role of the Indian physician in approaching major health problems affecting Native American communities, the many changes taking place in the Indian health arena, facilitating the integration of traditional Indian medicine and modern western medicine, and computer and medical software training.

The meeting will take place at The Madison, A Renaissance Hotel, 515 Madison Street, Seattle, WA 98104 (phone: 206-583-0300; fax: 206-624-8125). For more information and to register to attend the conference, contact Margaret Knight, Association of American Indian Physicians, 1235 Sovereign Row, Suite C7, Oklahoma City, OK 73108 (phone: 405-946-7072).

Advanced Operative Laparoscopy for Obstetricians and Gynecologists
September 22-23, 1997 (and repeated) Bethesda, MD

This two-day course in advanced gynecologic laparoscopy is designed to enhance the specialist's experience and skills in the laparoscopic management of gynecologic problems. Included are seven hours of didactic instruction, The remainder of the time is devoted to two hands-on laboratory sessions in small groups to provide individualized experience and practice in performing laparoscopic surgery with the latest available equipment on the market and under development. Procedures to be performed include salpingostomy, salpingectomy, oophorectomy, and hysterectomy, as well as management of potential

inoperative problems. USUHS designates this activity for 13 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The course will be presented September 22-23, 1997 and, again, December 8-9, 1997 at the Uniformed Services University of the Health Sciences in Bethesda, MD. For additional information, contact HM1 Michael D. Lozeau, USN, Department of Obstetrics and Gynecology, USUHS at 301-295-3777.

Recruitment Conference for IHS and Tribal Recruiters
Dates to be announced. Phoenix, AZ

Recruitment and retention of health care professionals are major concerns for Indian health programs across the country, whether they are operated directly by the Indian Health Service, by tribes, or by urban Indian programs. It is essential that we work together to maximize our exposure to prospective employees and enhance the probability of having them join us in our efforts.

As a means of beginning a dialogue which will result in the construction of a comprehensive and cooperative recruitment effort, we are convening a meeting of as many of the people involved in the effort to recruit health professionals for Indian health programs as possible.

More information and an agenda will be available mid-summer. Please plan to attend this important activity.

Diabetes and Indigenous Peoples
October 8-11, 1997 San Diego, CA

The Native American Research and Training Center (NARTC), the Department of Family and Community Medicine, and the University of Arizona College of Medicine at the Arizona Health Sciences Center are sponsoring the *4th International Conference on Diabetes and Indigenous Peoples* at the Town and Country Hotel in San Diego, California. Topics to be covered include the strengths, opportunities, and challenges that health care providers and Native peoples with diabetes will face in the 21st century; to discuss the needs of individuals with diabetes within the changing climate of "downsizing" and diminishing health care dollars; to share information about the development of community-based holistic approaches that address prevention and treatment; to create networking connections in the development of primary and secondary prevention strategies; and to discuss self-care interventions and prevention strategies among Native people internationally.

For additional information, contact Doug St. Clair, Conference Coordinator, NARTC, 1642 East Helen Street, Tucson, AZ 85719 (phone: 520-621-5075; fax: 520-621-9802).

Safe America: Fourth Annual Injury Control Conference
November 19-21, 1997 Washington, DC

The goals of this conference, sponsored by the National Center for Injury Prevention and Control, the Centers for Disease Control and Prevention, are to highlight effective programs linked to the science of injury prevention and control, develop new and stronger partnerships among national, state, and local organizations working to prevent or control injuries, identify resources that will support injury prevention and control research and programs, and communicate injury prevention and control issues and proven methods to the injury control community, policymakers, and the public.

On November 19th, the *SafeAmerica National Injury Control Conference* will merge with the Department of Transportation's *Moving Kids Safely '97* Conference for joint plenary and breakout sessions involving the participants of both conferences. The purpose of this event is to unite the entire injury control community, thereby stimulating and strengthening partnerships to promote child safety. For information about the *Moving Kids Safely '97* conference, call 1-888-428-KIDS.

For additional information about the *SafeAmerica National Injury Control Conference* and a registration packet, contact Elaine Murray, Prospect Associates, 1801 Rockville Pike, Suite 500, Rockville, MD 20852-1683 (phone: 301-468-6555 ext. 2352; e-mail: emurray@prospectassoc.com).

NATIVE AMERICAN LITERATURE

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

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

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

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CONTINUING EDUCATION MATERIALS AVAILABLE ☐

The IHS Clinical Support Center has continuing education materials available, at no charge, for health care professionals employed by Indian health programs. To make it easier for you to request these materials, we will describe what is available and provide an order form several times a year in *The Provider.*

Individual Format

Most of our "Home Study Modules" are designed for use by physicians, nurses, nurse practitioners, and physician assistants (two are for nurses only). To obtain continuing education credits, an individual must read the materials in the module, take and pass the post-test, and complete the evaluation form. It is expected that each of these learning activities will take participants approximately 2-5 hours to complete. Current topics are listed on the order form (below).

Group Format

Eleven risk management modules, a nurse leadership development course, and modules about clinical evaluation of child physical and sexual abuse (described in more detail below) are designed to be used in a group format. These group format activities, requiring someone on the staff to identify him/herself as the coordinator and discussion leader, include background material for the coordinator, goals and objectives, and ideas to promote active participation of the group. To obtain continuing education credits, the coordinator/discussion leader, after following the format provided, must submit the attendance list and completed evaluations to the Clinical Support Center.

Each of the Risk Management modules includes four unique case histories involving tort claims against the Indian Health Service, as well as background information for the designated discussion leader, and suggested questions to encourage active dialogue about the issues presented. Each module stands on its own; use of all modules is not required to obtain credit. IHS- and tribal-employed physicians, physician assistants, nurse practitioners, and nurses can earn continuing education (CE) credit using these modules.

The Nurse Leadership Development course is designed to be offered over several months' time. Each of the 16 modules in this continuing education activity includes a lesson plan, objectives, background information for the discussion leader, a suggested bibliography that participants may read to enable them to be actively involved in the learning process, evaluation forms, and more. The purpose of this course is to enhance the leadership and management skills of registered nurses. To ensure the success of this activity, it is important to have the Director of Nurses' and nursing supervisors' commitment. In addition, the nursing staff needs to be involved in the needs assessment and initial planning so that they feel this is something they want to be actively involved with. CE credit for this activity is available for nurses only.

The modules on child physical and sexual abuse include slides and an audiotape. Continuing education credit is available for physicians, physician assistants, and nurses.

CE Accreditation

These activities have been planned and produced in accordance with the criteria established by the Accreditation Council for Continuing Medical Education (ACCME) and the American Nurses Credentialing Center Commission on Accreditation (ANCCCA). The Indian Health Service Clinical Support Center is the accredited sponsor.

How to Obtain Materials

Health care professionals employed by Indian health programs may request these continuing education materials by completing the coupon below and sending it to the IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016 (fax: 602-640-2138).

Note: Persons working for tribal programs that have taken Clinical Support Center (CSC) tribal shares may not participate in using these materials unless arrangements are made to return some of these funds to the CSC.

Request for Continuing Education Materials

When ordering materials, please check no more than three items per order.

Individual Format (home study modules)

☐Tuberculosis ☐Sexually Transmitted Diseases ☐Hypertension ☐Headaches ☐Asthma ☐Early HIV Infection ☐Urinary Incontinence ☐Otitis Media
☐Management of Cancer Pain ☐Critical Thinking In Nursing Practice ☐Case Management Using Critical Care Pathways ☐Smoking Cessation

Group Discussion Format (Risk Management modules)

☐Negligence ☐Informed Consent ☐Golden Rules of Risk Management ☐Tort Claims ☐Documentation: The Defensible Medical Record
☐Reducing the Incidence of Medication Errors ☐Medical Malpractice ☐Credentials and Clinical Privileging
☐Federal Government Liability for Contract Providers ☐Issues Involving Contract Health Services ☐Informed Consent Revisited

Group Discussion Format (other)

☐Nurse Leadership Development ☐Evaluation of Child Physical Abuse ☐Evaluation of Child Sexual Abuse

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THE IHS PRIMARY CARE PROVIDER

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