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Annual Elders Issue

This May issue of The IHS Provider, published on the occasion of National Older Americans Month, is the sixth annual issue dedicated to our elders. We are grateful for the opportunity to honor our elders with a collection of articles devoted to their health and health care. Indian Health Service, tribal, and urban program professionals are encouraged to submit articles for the May 2002 issue on elders. We are also interested in articles written by Indian elders themselves giving their perspective on health care issues. Inquiries can be addressed to the attention of the editor at the address on the back page of this issue.

White Earth Collaborative Elder Home Fire Safety Project

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Among American Indians and Alaska Natives (AI/AN), the elderly are at higher risk of residential fire/burn mortality (Table 1).[1] The most dramatic increases in mortality rates are in people 65 years and older. Among Bemidji Area AI/AN between 1984-1996, the age-adjusted residential fire/burn mortality rate was 8.9

Table 1. Residential fire mortality rates by age group, American Indians/Alaska Natives, 1984-1998.*

AGE	0-4	5-14	15-24	25-34	35-44
AI/AN	6.3	1.2	1.6	1.7	2.2
	45-54	55-64	65-74	75-84	85+
	2.3	2.7	4.9	7.3	7.3

**Source: Office of Statistics and Programming National Center for Injury Prevention and Control, CDC. NCHS Mortality Tapes, 1984-1988. Includes all American Indians and Alaska Natives in the United States.*

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per 100,000, over six times the US All Races rate of 1.4 per 100,000.[2] During this period, the Bemidji Area AI/AN elder (age 55 and over) residential fire/burn mortality rate of 17 per 100,000 was nearly six times higher than the US All Races elder residential fire/burn mortality rate of 2.9 per 100,000.[2]

Risk factors for fire/burn mortality that may be present in some AI/AN communities include lack of smoke alarms; inoperable smoke alarms; alcohol impairment, especially when smoking; poverty; substandard housing; cold climate; rural location; use of wood stoves; and living in mobile homes.[3,4,5,6,7] In addition, the elderly are at high risk because many have limited mobility, and they may be closer to a fire when it occurs, thus having less time to react.[8]

Approximately 800 elders reside on the White Earth Reservation in Minnesota. Most live in rural areas far from health or fire department services. In January 2000, the White Earth Public Health Nurses, Home Health Aides, Community Health Representatives, and Environmental Health teamed up to form the "White Earth Home Safety Collaborative Team." The Team was formed to complete comprehensive health and safety needs assessment surveys and safety device installation in one-fourth of private elder's homes on the reservation. Environmental Health provided Team members with standardization training in conducting home safety surveys, resident education, and smoke alarm installation.

Photoelectric smoke alarms with 10-year lithium batteries were purchased with injury prevention special project funds from the Bemidji Area Office. Ionization smoke alarms are more commonly installed in homes because they are less costly and more readily available from retail stores. However, ionization smoke alarms are more prone to cooking-related false alarms and subsequent disconnection than photoelectric alarms.[9,10,11,12] This is especially a problem in American Indian communities due to common cooking styles such as deep fat frying, and the small size of homes, which may not allow smoke alarms to be installed an adequate distance from the stove.[12,13]

For two weeks starting in January 2000, the Team surveyed 210 homes. They found that over 50 percent of homes did not have at least one operational smoke alarm, either because one had never been installed, or because installed alarms had been deliberately disconnected, primarily due to false alarms from cooking. The Team installed 240 smoke alarms and provided residents with education on how to maintain and test them. Smoke alarms were installed in homes that never had them, as well as in homes in which smoke alarms were over 10 years old or inoperable (due to a problem with the alarm itself).

Within one week of project completion, the Team was notified of a success story involving an 84-year old elder. The elder stated that he had just finished dinner and fell asleep on his couch. Shortly after falling asleep, he was awakened by the sound of his newly installed smoke alarm. A fire had started when a pan of grease left on the stove ignited. The elder was able to extinguish the fire and save his home. Two existing hard-wired smoke alarms in the home never sounded when the fire started. The White Earth Home Safety Collaborative Team was honored in September 2000 with an Area Director's Award for Outstanding Group Performance (Figure 1).

Figure 1. White Earth Elder Home Safety Collaborative Team

Encouraged by the success of this project and the need for additional smoke alarms for the remainder of the elder private homes, the White Earth Environmental Health Officer successfully wrote a Part 2 IHS Headquarters Injury Prevention Grant. These grants allow tribes to fund full-time injury prevention coordinators (Part 1), special projects (Part 2), and conferences (Part 3). The second phase of this project began in January 2001 with follow-up home surveys conducted on a random sample of 20 percent of homes served during the 2000 White Earth Elder Smoke Detector Project. The preliminary results of this effort reveal that the majority of homes (80%) still have an operating smoke alarm.

A spin-off of this project was the development of a community injury prevention committee. The Injury Prevention Committee was selected to pilot development of "Elder Safe," an American Indian-specific fire and fall safety program funded by the US Fire Administration. In addition to addressing the

need for protecting community elders from residential fire injury with reliable smoke detectors, the Injury Prevention Committee is interested in addressing other elder safety concerns (e.g., fall prevention, carbon monoxide poisoning, and motor vehicle passenger safety).

Acknowledgments

Special thanks to Jo Ellen Anywaush, Tribal Health Director; Beverly Moe, Director of Public Health Nursing; and the White Earth Home Health Aides and Community Health Representatives whose dedication made this project possible.

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Adult Day Care as a Viable Eldercare Model for Indian Country

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American Indian and Alaska Native (AI/AN) elders, numbering around 175,000[1] represent a significant segment of the distinctive population of AI/ANs found alongside the larger population. There is a growing crisis in eldercare options for this culturally and geographically diverse people just as there is in the at-large population. However, major divergences in beliefs, health status, history, location, and politics separate the indigenous elder again from those both in the dominant and minority segments of the US populations.

As a nurse in the Santa Fe Indian Hospital for several years, I had clinical contact with elders in New Mexico. It was clear that there was indeed a long term care crisis. The elders (and their families) often used the IHS acute care facility in lieu of structured eldercare on the reservations and Pueblos.[2] Although eldercare options were available in both Santa Fe and Albuquerque, they were not models based on the particular needs and beliefs of the Pueblo, Apache, or Navajo elder. The elders reported that they did not feel they would 'fit in' with programs that were not AI/AN-run.

The author became familiar with the services available in the Albuquerque Area. There were almost no eldercare options designed or located with the AI/AN elder in mind. Two White House Conferences on Indian Aging, hosted by the National Indian Council on Aging (NICOA) in 1992 and 1994, revealed the top priority of Indian elders to be access to long term care.[2] There were available the ubiquitous senior centers with varying capabilities and size (some in shared facilities); two home care agencies, one in its infancy; and the services of one assisted living facility in a southern pueblo. At the time there were no adult day care (ADC) facilities.

For these reasons, hospital discharge options were limited, and the families carried the brunt of the care burden. Although it is reported that 85% of all persons needing long term care receive it from family members nationally, research on aging in an AI/AN population revealed one eldercare model that might be practical and appealing for this population. The adult day care model allows frail elders to remain in the family home during non-operational (evening and nighttime) hours, yet allows families to continue with their daytime routines. This is particularly attractive to both the adult children and the elders.

In AI/AN homes where there is likely to be a multigenerational context, this is even more appropriate.

There have generally been at least two approaches to adult day care. One involves establishing the services in an existing senior center, nursing home, assisted living facility, or a freestanding center. The number of clients that can be served is dictated by the size of the facility and the number of staff available.[3] Currently in New Mexico there is one successful, culturally- relevant adult day care facility operating at Zuni Pueblo.

This ADC component of the elderly services programs was an exceptional 'fit' to the problem of frail eldercare in such a remote and traditionally distinct area. There is a separate room for the clients of the ADC located within the larger facility housing the senior center, congregate meal site, and offices for the foster grandparent and senior companion programs. The facility itself is state-of-the-art for provision of eldercare in Indian country or elsewhere. It is built in a southwest style of architecture and is appointed with paintings done by local artists depicting the land and important cultural symbols.

During interviews with some of the clients, it was apparent that they felt comfortable and "at home" in the facility and with the services offered. The clients interact with and share some of the activities and experiences of the other senior programs. ADC clients keep their staff with them during shared activities. The number of clients being cared for ranges from 10 to 20.

There is a wide range of services available, including transportation, some accompaniment of clients to medical appointments, and a unique association with the staff of the Indian Elder Geriatric Assessment team located in the IHS facility on Zuni. There are also other services available such as grooming, showering, and a meal at the center. The clients do beadwork and weaving activities that are geared to the level of dexterity and eyesight of the client. The products can range from the uncomplicated to the intricate.

Providing for elders in their traditional community setting allows recognition of religious and cultural events, foods, and practices. The Zuni language is spoken by most of the staff members and all of the elders in the program. Recitations and life reviews are conducted in the Zuni language, and exercises are carried out using AI/AN background music and references that are understandable to the elder.

The director of the overall facility, Margaret Dosedo, hopes to expand the program. It is, however, already one of the best in Indian country at this time. There has been some turnover of the day care directors and direct caregivers, as the issue of shortages in eldercare staffing has not spared Indian country. However, with commitment and vision, they have been able to maintain services and are looking ahead to continued success.

Financing of adult day care is always an issue in this country. Nationally, most ADC is paid for out-of-pocket, as it is rare to have any third party payment for these services. The author was able to serve in a consultative capacity to explore additional funding and to assist in infrastructure building. A successful nomination was made, for example, to have the program recognized with a $50,000 SHARE innovation award for providing culturally competent care to an underserved elder population as awarded by the University of Pennsylvania Institute on Aging and SmithKline Beecham.

Success in the tribal setting may depend on the expertise of a grants writer and others able to collect seed money to begin and maintain the operation. The easiest scenario would be to add such a program within existing facilities. It is recognized that many tribes do not have even a senior center, or available extra space when they do have a center. However, other models of ADC may work.

At Zuni the tribe administers the budget for eldercare services. The Senior Programs have been fortunate that in addition to the SHARE grant, monies from the Alzheimer's Association, Title VI nutrition program (Administration on Aging; AOA) monies, and other sources meet operating expenses so that the elders do not have to pay. As is the case in many AI/AN communities, there is a higher prevalence of poverty among the elderly. The ADC component of the Elderly Services Programs at Zuni, however, can be seen not only as successful in fulfilling their mission of providing culturally competent care to frail elders during daytime hours, but as a model to be followed in Indian country where success can be achieved through partnerships, consultation, grantsmanship, and effective leadership.

It is also apparent that there are many others who require care but for a variety of reasons are not accessing the day care facility.[4] Therefore, another approach to adult day care is the home-based ADC where services for four or five elders can be available in an at-home atmosphere. Care could be set up in an existing home to provide for several elders. With very few steps, an applicant for a state license to run a home ADC can provide a safe environment, meals, and supervision. Perhaps creative use of tribal eldercare grant monies can expand to include these types of venues for care, serving the currently unmet needs of some community elders.

It may be feasible on Zuni and other reservation communities to initiate ADC home programs in various locations throughout the community. If even two homes could be established, then up to 10 more elders could be receiving care, perhaps in their own "neighborhoods." The requirements for running ADC homes are easier to meet than full-fledged ADC facilities in most states, and may be the next step in providing culturally relevant eldercare, and allowing for "aging in place."

Finally, there are even more approaches to ADC emerging and being tested in rural communities whose elder population base may not be large enough to support a full-time program. Overall, ADC appears to be a practical program model with enough variations in approach to allow usefulness in a variety of settings. It is a model that can be made culturally relevant with careful attention to both structure and process, such as utilizing community staff members, indigenous language, and continuation of traditional practices.

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Talking Circle: Palliative Care and End of Life Care for American Indian and Alaska Native Communities

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"I Do Not Want to Die the Death of a Thousand Needles" – Issac Macias y Vicam (Yaqui; 1885-1982)

Voices

"There is no death — only a change of worlds."

"The goal is not to prevent death, but to prevent unkindly and untimely death."

"My grandmother taught: it is a hand in and a hand out of this life . . . be there for your family."

"Let me die with dignity, not with pity."

These are some of the ancestral voices, expressed by the participants at the first national "Talking Circle: Palliative Care and End of Life Care for Native American Communities," held in Albuquerque, New Mexico, March 28-30, 2001. Spiritual teachers, physicians, nurses, pharmacists, community elders, American Indian and Alaska Native health program administrators, and behavioral health providers from 18 states gathered to discuss the need for palliative and end-of-life care services for American Indians and Alaska Natives. This gathering was cosponsored by the All Indian Pueblo Council, the Albuquerque Area Indian Health Service, the Palliative, Education, Research and Training Program, and the Office of Continuing Medical Education at the University of New Mexico Health Sciences Center (the accredited sponsor).

Questions Discussed

- Is there a need for palliative and end-of-life care services in American Indian and Alaska Native communities?
- What kind of services are needed?
- Is the time appropriate for bringing up these concerns in American Indian and Alaska Native communities?
- What are the recommendations for proceeding with this initiative?

Discussion

American Indian and Alaska Native elders have enjoyed a 15% increase in life span over the last 20 years. Hand in hand with this increase in longevity has been the experience for some of living longer with chronic illness and disability associated with diabetes mellitus, heart disease, cancer, stroke, liver disease and arthritis. As a result, the dying process for some elder occurs more slowly, extends over time, and is often highly technological. It also frequently takes place in facilities far from family and off tribal homeland. Caregivers are torn between family and work and express lack of adequate skill and knowledge for caring for elders with complex chronic illnesses.

The current legalistic advanced directives requirements can be intrusive, insensitive, and overwhelming to many families

and providers. The process envisioned for advanced directives does not take into account cultural norms and practices of American Indian and Alaska Native communities. Both clinical providers and families are reluctant to discuss the concept of advanced directives, and tribal governments have not yet legislated on this matter. Experienced providers have difficulty knowing when and how to approach families in regards to discussing care beyond cure, pain management, organ donations, autopsy, and "do not resuscitate" decisions. Within the privacy of extended family meetings, "when the time comes," these issues are considered.

However, regarding the issue of what care is desired for the dying person, fewer cultural differences exist than one might expect. American Indian and Alaska Native families express the desire for a system of care that will honor the dying person's individual and family wishes. These wishes include celebrating life, respect for traditional ways, hope for a peaceful death, access to palliative comfort care, being surrounded by family, and being on tribal land. Even in tribes where death is taboo for public discussion, caring for someone during this transition is not taboo, and palliative care concepts are not in conflict with traditional ways. American Indian and Alaska Native communities are open to palliative care services that will respect and support local tradition.

Palliative Care embraces both the western clinical processes of pain and symptom management and traditional medicine and spiritual healing. Families moving through the transition of death do not need to choose between traditional, complementary, alternative and western allopathic therapies. American Indian and Alaska Native communities can develop services based on local values and beliefs. These services could include an active pain management program consistent with Joint Commission on Health Care Organizations (JCAHO) standards, inpatient and ambulatory palliative care, respite care, bereavement care, caregiver support, and home and nursing home hospice care. Collaborative services between agencies could be developed with the goal of maintaining the family as key caregivers and decision makers.

Collective Visions

"American Indian/Alaska Native people will have the opportunity to complete their life circle according to their wishes, with respect to their values."

"Native people will have their values and beliefs respected through the transition of life."

Future Directions

The "Talking Circle: Palliative Care and End of Life Care for Native Communities," sparked national interest and energy for further action. Tribal and IHS provider teams from each IHS Area will have the opportunity to attend an intensive five days palliative care training by Dr. Robert Twycross and his team from the Oxford, England World Health Organization Collaborative Centre for Palliative Cancer Care, September 28 - October 2, 2001 in Albuquerque New Mexico (see details in the "Meetings of Interest" section). With improved clinical skills and strong community-based programs, no elder will have to "die a death of a thousand needles." □

Recommendations

1. Establish a national interdisciplinary peer workgroup to develop national consensus statements/visions for palliative care and end-of-life care for American Indian/Alaska Native communities to include:
   a. Need for services
   b. Training for providers, families, communities
   c. Health Care Financing Administration (HCFA) waiver for Medicare hospice regulations that would reimburse tribally operated hospice services
   d. Interagency collaboration between tribes, Indian Health Service (IHS), Veterans Administration (VA), Health Care Financing Administration (HCFA), and elder programs
   e. Tribal consultation
   f. Funding initiatives
   g. Palliative care standards for the American Indian and Alaska Native health care system
   h. Advanced directives
   i. Palliative care in long term care settings.
2. Continue collaboration with the Robert Wood Johnson Foundation "Promoting Excellence in End of Life Care" initiative
3. Initiate conversations locally with tribal councils, health care facilities, communities, health boards, urban heath clinics.
4. Advocate for local tribal/IHS policies for implementation of palliative care and end-of-life care in facilities.
5. Consider integration of herbal therapies into pharmacy formularies.
6. Provide JCAHO standards of care for pain assessment and management in all settings.

Over there, our spirit is going.
It is good.
I am going over there.
I am happy to go over there.
The sun is going down.
It is good.
Over there, I will be reborn.
From the hoot of the owl, I will fly.

Chant, Rupert Encinas, Tohono O'odham

The Elder Care Initiative in 2001

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

The Elder Care Initiative is based on a vision shared by many and put into words by Dr. Michael H. Trujillo, Director, Indian Health Service, in these pages ("Elder Care," The IHS Primary Care Provider Volume 21, Number 5, page 53, May 1996) and elsewhere. It is the vision that we in Indian health care must provide the very best possible care to American Indian and Alaska Native elders. We do this in spite of limited resources and competing demands. We do this because so much depends on the elders. The only way we can provide the very best possible care is by using all available resources, developing new and innovative models of care, and avidly seeking out collaboration and partnership.

The development of a long term care infrastructure in Indian country continues to be a major focus of the Elder Care Initiative. When most people read or hear "long term care" they think "nursing home." But long term care is much, much more than that. It involves providing the support that elders need to live well, regardless of their health problems or disabilities. For most elders this can and should happen in the home, with their family. But community-based long term care requires supporting systems for the frail elder and his or her family. Much work yet needs to be done to assist tribes and Indian organizations as they plan for the long term care needs of their elders and develop the infrastructure for providing this care. This is an area of intense collaboration between the Elder Care Initiative, the National Indian Council on Aging (NICOA), and tribes. As providers of care for elders we all must work to broaden the discussion of long term care to include all options.

As a part of this effort the Elder Care Initiative collaborated with NICOA last August to present "Innovations in Elder Care, a Participatory Conference" in Duluth, Minnesota. A number of exciting elder care programs were shared, and participants included some of the 1500 elders attending the NICOA national meeting. This conference was funded by the Centers for Disease Control and Prevention and other partners, included the National Resource Center on Native American Aging and the Northwest Portland Area Indian Health Board. Please contact me if you would like a copy of the abstracts presented at this meeting.

AI/AN Aging was also the topic of the theme day of the 13th Annual IHS Research Conference this past April. This day brought together elders, researchers, direct service providers, health care planners, and advocates to listen to the concerns of elders and identify issues of importance in AI/AN aging research. Some of what we learned that day will be presented here in future months. Dr. Bill Freeman, IHS Director of Research, provided key leadership and support in this first ever effort.

Another focus over the past year, and into the next, has been to make available the tools we as providers need to provide quality care to our elders. The long-promised Patient Care Component (PCC) Comprehensive Elder Exam form ("A New PCC Comprehensive Elder Exam Form," The IHS Primary Care Provider, Volume 25, Number 5, pages 73-77, May 2000) is finally available as IHS-865. The RPMS data entry software is also in place to capture functional assessment and develop reports that detail the functional status of our elder patients. These tools will help us to provide state-of-the art geriatric care for our elders.

We have been working with the national network of Geriatric Education Centers to help them make their resources available to Indian country. The Geriatric Education Centers are HRSA funded programs based at universities whose mission is geriatric education of health care professionals, both at the universities and in communities. They can and should be an important resource for our communities and health facilities.

One such center is the New Mexico Geriatric Education Center (NMGEC). The NMGEC is once again offering scholarships to Indian health care providers who attend their Summer Geriatric Institute in June. This year the conference was planned with the input of the Elder Care Initiative with the explicit intent of meeting the educational needs of Indian health care providers. In addition, faculty was recruited, in part, from Indian country.

The last day of this conference will be devoted to geriatric assessment, with a special emphasis on developing programs and approaches in Indian country.

The Elder Care Initiative is also collaborating with the NMGEC to develop a Guide to Comprehensive Geriatric Assessment in Indian country. This handbook will address geriatric assessment as it really happens in Indian health systems and provide tools and approaches currently in use. A number of sites have contacted me over the past year asking for technical assistance in developing geriatric assessment programs. This Guide will be a useful tool for those sites developing geriatric clinics and assessment programs for their communities. It will be available in June of this year.

The dialogue about improved pain management and palliative care continues, nurtured by Judith Kitzes, MD, MPH, Albuquerque Area Chief Medical Officer. In March a "Talking Circle" conference, organized by Dr. Kitzes and funded by the Robert Wood Johnson Foundation, brought together leaders from Indian country and national leaders in palliative care to address some of the unique issues around end-of-life care in Indian country. More discussion and work will follow. In addition, funding has been committed for training for teams from each IHS Area in pain management and palliative care in the coming year.

Every week I hear from providers around Indian country developing new programs and eager for information. By and large these are not major, grant funded projects, but rather small, committed efforts at providing quality care for their elders. This kind of commitment at the local level is what continues to transform vision into reality.

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A More Efficient Way to Provide Dentures to American Indian and Alaska Native Elders

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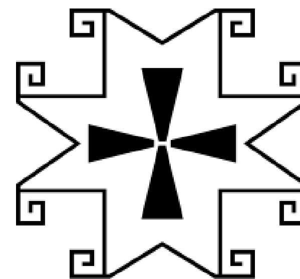
The Indian Health Service (IHS) Dental Program conducted oral health surveys of American Indian/Alaska Native elders in 1991 and 1999. These surveys revealed that the percentage of elders without teeth (edentulous) ranged from 10 percent to over 50 percent in the twelve IHS Areas. The IHS Dental Program is not able to provide removable dentures to all of these elders, due to a lack of resources, particularly dental providers – presently over 25 percent of dentist positions are vacant.

Over the past four years the Navajo Nation Area Agency on Aging has provided dentures to over 550 Navajo elders through the 82 Senior Centers on the Navajo Reservation. A sample of 90 elders was interviewed at least six months after they received their dentures. Over 90 percent of the elders reported they were wearing their dentures, were eating with them, and were satisfied with the dentures. These dentures were made in Senior Centers with a total encounter time for the four visits between the dentist and patient of approximately 70 minutes.

The traditional technique for the fabrication of dentures requires 3 to 4 hours of encounter time between the dentist and patient, and this is the primary reason that dentures are given a low priority in the IHS Dental Program Priority of Services. The impression and bite registration techniques, utilized to make dentures for the Navajo elders, have been developed for use in home-bound elders, senior centers, and elders in nursing homes. They are also being used in two Navajo service unit dental clinics with similar results. The techniques are taught at an annual IHS geriatric dentistry course and also on demand in IHS and tribal dental clinics.

You may receive more information on the Navajo Nation Denture Program and the technique for the fabrication of dentures from David B. Jones, DDS, MPH, by e-mail at *davidbj@earthlink.net*; telephone (301) 230-9375.



Palliative Care and End of Life Clinical Training
September 28 - October 2, 2001; Albuquerque, New Mexico

This is a five-day, intensive, practical, clinical conference on palliative care, pain management, and end-of-life care. The experience will support physicians and nurses for national certification in hospice and palliative medicine boards. Headquarters funding will support one clinical team (either tribal or IHS) from each IHS Area, such as a physician, a nurse, and a pharmacist or behavioral health provider (a total of three). The goal is to develop a provider team in each Area with palliative care and end-of-life care training as a resource for that Area. Those to participate will be chosen by the Area Chief Medical Officers by August 2001. Using Area funds to support travel and per diem, Areas may nominate additional teams to participate; however, the number of participants is limited.

The meeting will be held in Albuquerque, New Mexico. The training will be conducted by Dr. Robert Twycross, Director of the World Health Organization Collaborating Centre on Palliative Care and the Oxford International Centre for Palliative Care. For more information, contact Judith Kitzes, MD, MPH at (505) 248-4500; e-mail *judith.kitzes@mail.ihs.gov*.

Renal Disease in Racial and Ethnic Minority Groups
October 19-20, 2001; Santa Fe, New Mexico

A meeting on Renal Disease in Racial and Ethnic Minority Groups will take place, under the auspices of the American Society of Nephrology and the International Society of Nephrology, at the Eldorado Hotel, Santa Fe, NM on October 19-20, 2001. The meeting will address the following topics in plenary session: 1) The current status of renal disease in minority groups around the world; 2) Pathophysiology and etiology of renal disease in these groups: genetic and environmental considerations; 3) Screening for renal disease in areas of high prevalence: methods of disease registration and prevention strategies; 4) Dialysis and renal transplantation; 5) Health economics, social considerations, role of governments and national and international funding agencies; and 6) Consensus statement development regarding future direction

For more information please contact Andrew S. Narva, MD, FACP, Indian Health Service Kidney Disease Program, 801 Vassar Drive, NE, Albuquerque, NM 87106; e-mail *anarva@albmail.albuquerque.ihs.gov*.

Wisdom Steps Health Promotion Program for Elders

Mary Snobl, Minnesota Board on Aging Indian Elder Desk, St. Paul, Minnesota

The Wisdom Steps health prevention program is a partnership between American Indian communities and the Minnesota Board on Aging. This preventive health program promotes health awareness and encourages Indian elders to visit with their health professionals, set personal health goals, and participate in programs provided by their community's elder, tribal, and Indian Health Service programs and services.

Recently, Wisdom Steps won a two-year, $200,000 SHARE Innovation Award to improve health care access and outcomes for Indian elders in Minnesota. In August 2000 at the National Indian Council on Aging (NICOA) Conference, Wisdom Steps was awarded the NICOA Dr. Patrick Stenger Award. The success of this newly developing program is due to the dedication of community elders working with their Indian health programs and tribal health services, who are encouraging elders to participate in health screenings, health education, and healthy living activities.

Elders who have completed the Wisdom Steps first year incentive plan will be honored at our first Wisdom Steps Conference for getting their blood pressure, blood glucose, cholesterol, weight, and one other of 15 available health screenings; attending a health fair, and walking in an organized walk or being involved in a regular exercise program. Elders will receive their Wisdom Steps pin, first year eagle charm and a certificate. This first year award ceremony will honor our Elders and thank those agencies like our tribal health services and the Indian Health Service for their support.

The Healthy Elder

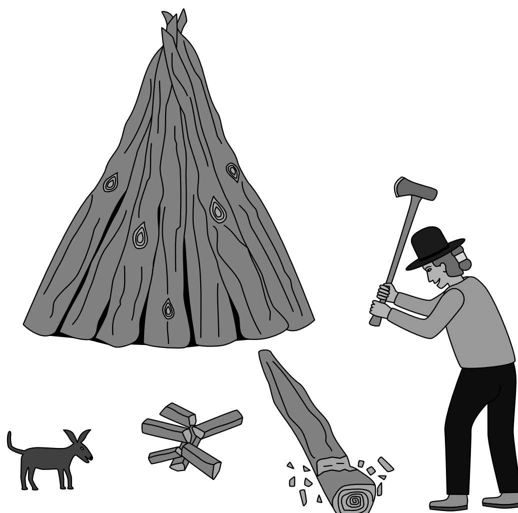
Last week an older man came in to see me for his yearly check-up. He is a very healthy man who takes care of his livestock and hauls wood with his sons and grandsons. He said to me, "I know there are things I should do to stay healthy. What do I need to do?" There are many things that our elderly can do to keep themselves strong and healthy.

Exercise

Exercise is the single most important thing that an older person can do to stay healthy. There are so many good things about exercise that it is hard to know where to start. All of us have heard about how regular exercise can help prevent diabetes or keep our sugars in balance if we have diabetes. But there is much more. Older people who exercise are stronger and less likely to fall and hurt themselves. They sleep better and feel healthier. Regular exercise has even been shown to lessen the pain of arthritis. What kind of exercise is best? Regular exercise – activity every day. It can be walking, running, aerobics or even weight-lifting. It can be bread-baking, chopping wood, gardening, or putting in a fence-line. What is most important is that it is regular, every day.

Eating Well

How we eat and what we eat is very important in staying healthy, whether we are young or old. Staying away from sugar in pop, cookies, and cakes helps keep an elder's sugars in balance. Staying away from fried foods and fatty meats is also important. Most older people eat better if they have company. Meals should be with family or friends. The Senior Center lunches are a great way for elders who are home alone to eat with friends.



Avoid Alcohol and Tobacco

An elder who drinks alcohol is putting his or her health at risk in many ways. Alcohol has a direct damaging effect on the liver and brain. It also makes the older person more likely to fall and break a bone. And drunk people, whether they are old or young, drive their families away. No elder can afford to be without his or her family. Older people are more sensitive to all the bad effects of alcohol.

Cigarette smoking that isn't a part of religious activities is very dangerous for older people. It weakens the lungs and causes cancer and heart attacks. No matter how old someone is or how long they have smoked they will be healthier when they stop.

Seatbelts

A small accident can cause a serious injury in an elder, and wearing a seatbelt can save an elder's life.

Vitamins

Every elder can benefit from taking a vitamin every day. As we grow older, our bodies do not absorb or use vitamins as well as when we were young. A vitamin supplement helps us make up for that.

Calcium

Every elder can benefit from taking a calcium tablet once or twice a day. As we grow older we lose calcium from our bones. Most older people don't eat enough calcium to keep the bones strong. One or two calcium tablets a day helps prevent broken bones.

Screening Test for Colon Cancer

Cancer in the colon or bowels is one of the most common cancers of older people. Testing for tiny bits of blood in the stool is a way to catch growths before they turn to cancer and cancers before they become too big to cure. This is a test that all older people should do once a year.

Mammograms

Breast cancer is another cancer that is more common in older people. The mammogram test, an x-ray of the breast, can catch breast cancer when it is very small and can be cured. Almost every older woman should have a mammogram every year.

Pap Smear

Here is some good news! If a woman has had regular Pap smears she can usually stop having Pap smears when she reaches 65. But if a woman has not had regular Pap smears then she should have a Pap smear no matter how old she is. The Pap smear prevents cancer of the cervix.

Immunizations

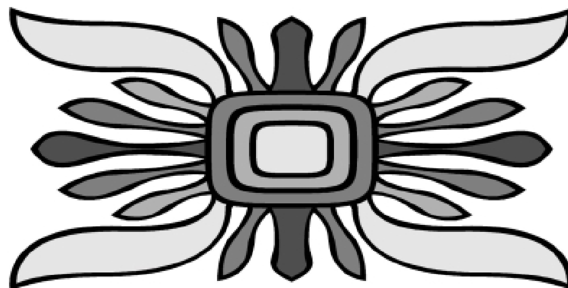
Every fall every older person should have the **flu shot**. Older people are more likely to get very sick from influenza and the shot prevents this illness. Older people are also more likely to get sick from pneumococcal pneumonia, a kind of bacterial pneumonia. Every older person should have the **pneumovax** (***nu**-mo-vax*) at least once with a booster shot after five years have passed. We can't forget the **tetanus** booster every ten years. Believe it or not, most tetanus (lockjaw) in this country happens to older people (who have not had their boosters).

Hearing and Vision Test

Did you know that if you are an elder whose hearing is not good you are more likely to fall and hurt yourself? All elders should have their hearing tested, either by the audiology program or by your doctor, once a year. Every elder should have his or her eyes tested by the optometrist (eye doctor) every year also.

Dental

Regular dental care can help elders keep their teeth healthy. Healthy teeth and dentures that fit well are terribly important to helping elders eat well and stay healthy. Elders should see the dentist at least once a year.



Stay in the Loop Via the New Eldercare Listserv

The number of individuals who have expressed an interest in keeping in touch on elder issues continues to grow. We have set up an e-mail listserv so that we can share information, resources, and ideas. If you would like to subscribe, send an e-mail to *listserver@hqt.ihs.gov* with the following message in PLAIN TEXT in the BODY (NOT THE SUBJECT LINE) of the e-mail:

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After you've subscribed, you can communicate with other participants in the listserv group. Address the e-mail to *eldercare@hqt.ihs.gov*.

Don't forget to check out the Elder Care Initiative website at *www.ihs.gov/medicalprograms/eldercare*.

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This American Geriatrics Society resource combines an excellent clinical reference with relevant self-assessment questions and up to 70 hours of CME. For those who prefer to study at home it is a great way to obtain a firm foundation in clinical geriatrics. For information go to the American Geriatric Society website at *http://www.americangeriatrics.org/products/grs4.shtml*.

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