THE IHS PRIMARY CARE PROVIDER

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

January 2000 **Volume 25, Number 1**

Marking our 25th Year of Publication

This issue marks the beginning of the 25th year of publication of what is now *The IHS Primary Care Provider*. It started out as a photocopied amalgam of clipped articles and occasional original contributions, often with hand-drawn artwork on the cover, distributed to a few dozen. Now, with a circulation of more than 8000, it is widely regarded as a unique source of original articles about the health and health care of American Indians and Alaska Natives. For this endurance and growth, we have only to thank you, our readers, and the countless authors who have taken time away from their primary responsibilities to share their knowledge and wisdom.

DIABETES MELLITUS
Palliative Care Strategies

Judith A, Kitzes, MD, MPH, Chief Medical Officer, Albuquerque Area Indian Health Service, Albuquerque, New Mexico

Diabetes mellitus, type 2, has emerged over the past 50 years as a leading cause of morbidity and mortality for American Indians and Alaska Natives (AI/ANs). Prevalence rates show that this population group suffers disproportionately from diabetes mellitus (DM) compared with other populations.[1] The report *Prevalence of Diabetes in American Indians and Alaska Natives 1997* states that "the age-adjusted prevalence of diabetes among AI/AN was 3 times that among non-Hispanic whites. However, the prevalence of diabetes among AI/AN women aged 45-64 was 4 times that among non-Hispanic white women, and the prevalence of diabetes among AI/AN men aged 20-44 was 5.8 times that among non-Hispanic white men." [2]

The emerging epidemiology of type 2 DM in AI/ANs identifies a population experiencing an excess burden of chronic disease and its distressing symptoms. Unfortunately, at this time, prevalence rates for AI/ANs for symptoms and illness often associated with diabetes or its complications, neuropathic pain, gastroparesis, atonic bladder, diarrhea, impotence, and candidiasis, have not been published. One study conducted in 1998 suggests that AI/ANs who have diabetes mellitus experience a threefold increase in the prevalence of depression compared to the non-Hispanic white population.[3]

Preventive strategies that may be directed toward diabetes and the ensuing symptoms are receiving greater attention in many AI/AN communities. At the same time, there is a clear need to improve the quality of life of those who already experience chronic symptoms. Evidence-based palliative care measures that can alleviate the physical, emotional, psychological and spiritual aspects of suffering have been published and can be utilized for patients and their affected family members. This article will focus on the following symptomatic problems and the applicable palliative care strategies: neuropathic pain, gastroparesis, diarrhea, impotence, candidiasis, autonomic hypotension, depression, and end-of-life care.[4-12]

Neuropathic Pain

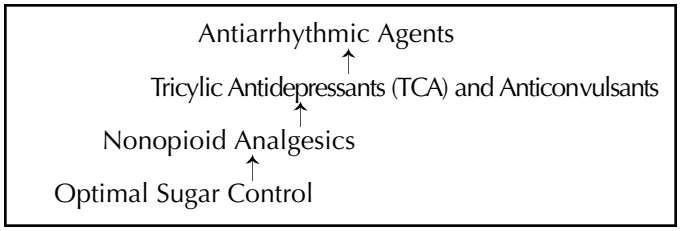
Neuropathic pain may have a metabolic or an ischemic origin, and the pattern of nerve involvement varies by cause. A strategy for evaluating and diagnosing neuropathic pain can be found in Staged Diabetes Management, Complications and Hospitalization, 1999.[7] Treatment should attempt to address the underlying cause. An acute onset of neuropathic pain associated with rapid fluctuations in blood glucose levels may signal a temporary condition. However, chronic pain may develop with progression of disease; this is often most severe at night. Management of such symptoms is best pursued by an interdisciplinary team.

Available treatment modalities include relaxation techniques such as biofeedback and visualization, optimal blood glucose control, use of analgesic medications, adjunctive therapies, surgical decompression of, for example, carpal nerve entrapment, psychological and spiritual counseling, and Traditional Medicine approaches. Definitive therapy is elusive at present, and patients should be offered therapies in a stepwise fashion, trying one therapy at a time, documenting the effectiveness of each, before changing approaches. This paper emphasizes the pharmacologic strategies for palliation because they are the most widely available in the Indian Health Service. Certainly, nonpharmacologic strategies should be aggressively pursued to the extent that they are available at your location.

Optimal Blood Sugar Control. Combinations of oral or parenteral hypoglycemic agents, exercise, or proper diet can delay the development of peripheral neuropathy and may offer reduction in chronic symptoms. Staged Diabetes Management, 1999 or the IHS diabetes mellitus management standards of care are useful references for strategies for optimal blood sugar control.[7]

Analgesic and Adjuvant Medications. Use the World Health Organization (WHO) stepwise approach, trying one class of medications before moving on to another, or combinations of medications, all based on the patient's self-report of pain (see Table 1).

Table 1. The WHO stepwise pharmacologic approach to neuropathic pain



Nonopioid analgesics, of course, refer to acetaminophen and nonsteroidal antiinflammatory drugs (NSAIDS). Tricyclic (TCA) and other antidepressants may be useful as well, although the ability to titrate to an effective dosage is dependent on tolerance of side effects. Table 2 describes some

of the antidepressant medications that have been found to be effective.

Table 2. Antidepressants useful for pain control

Nortriptyline	Starting dose 10-25mg PO hs; titrate to 50-150 mg PO hs Recommended for elders because of fewer anticholinergic effects
Amitriptyline/ Imipramine	Starting dose 10-25 mg PO hs; titrate to 50-150 mg PO hs Amitriptyline is contraindicated in the elderly
Desipramine	Starting dose 10-25 mg PO hs; tritate to 50-150 mg PO hs
Fluphenazine	May be added to above TCA if needed at a dose of 1 mg PO TID

Anticonvulsants such as gabapentin (starting dose 300 mg PO hs; titrate to 300-600 mg PO TID) or carbamazepine (starting dose 200 mg PO BID; titrate to 200mg PO QID) have been helpful for some patients. Antiarrhythmic medications such as mexiletine (150-200 mg PO TID) may be used when all else fails, although it is recommended that you seek consult with a specialist before using these agents. Localized pain may respond to capsaicin cream applied topically 3 or 4 times daily.

Other measures may include traditional medicine, acupuncture, massage, biofeedback, surgical decompression of entrapped nerves (usually carpel tunnel syndrome), spinal cord stimulation, transcutaneous nerve stimulation, relaxation techniques, psychological support, spiritual support, and art/music therapy.

Depression

Routinely assess for signs of clinical depression. Tricyclic antidepressants or selective serotonin reuptake inhibitors (SSRI) may be prescribed in the same dosages as are used for the nondiabetic patient. Psychological counseling, spiritual support, and family education and support are very important.

Impotence

When nonpharmacologic methods have been unsuccessful, sildenafil (25-50 mg PO based on efficacy and tolerance) may be useful for patients with diabetes, although it is contraindicated in patients with unstable cardiac disease or who are on nitrates.

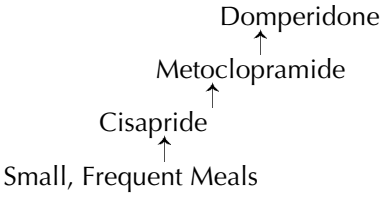
Candidiasis

Improved glycemic control is crucial to treating candidiasis. While improving glycemic control, therapy for oral candidiasis can include fluconazole tablets (200 mg first day; 100 mg/daily for 2-3 weeks; monitor liver functions and sulfonylurea levels), clotrimazole lozenges (1 lozenge, 5 times a day for 2 weeks; monitor liver function tests), or nystatin liquid (100,000 units/ml; 4 to 6 ml QID daily for 7 days. Vaginal infections usually respond to fluconazole tablets (150 mg PO once) or to a variety of vaginal preparations containing clotrimazole, micronazole, or nystatin.

Gastroparesis

Nausea, vomiting, early satiety, and anorexia may be symptoms of gastroparesis. To treat these symptoms, encourage frequent and small meals, avoid high fat foods and carbonated beverages,and consider use of cisapride (10 mg PO before meals and at bedtime; may be increased to 20 mg; this is preferred in elder patients), metoclopramide (10 mg PO before meals and at bedtime; may be increased to 15 mg if required; has extrapyramidal effects in elders), or domperidone (20 mg PO BID). Refer to Table 3.

Table 3. A stepwise approach to gastroparesis



Diarrhea

Diarrhea may respond to loperamide (start with 4 mg PO, then 2 mg after each bowel movement, with a maximum use of 16 mg/24 hours), diphenoxylate (2.5 mg PO QID), or codeine phosphate (60 mg PO TID or QID).

Orthostatic Hypotension

This can be difficult to treat. One must consider discontinuing antihypertensive medications, prescription of elastic stockings, or elevating the head at night.

Palliation of the above symptoms needs to be individualized, and treatment must be monitored for potentially harmful side effects. Always be mindful of the risk to benefit balance in attempting to improve the quality of life.

End-of-life Care

End-of-life care for a person with diabetes mellitus is very similar to that for a nondiabetic person. Palliative care continues to focus on the physical, emotional, psychological, and spiritual needs of the patient and the family — not on the disease state. Pain, dyspnea, anxiety, restlessness, and other symptoms can be addressed using accepted, specific palliative therapies.

However, a diabetic patient may experience a change in their need for glycemic medications, and tight glucose control may no longer be necessary. Specific goals may shift to include the following: 1) avoid symptomatic hypoglycemia and hyperglycemia, 2) relax dietary restrictions, 3) provide optimal care of the skin and feet, and 4) offer early treatment of symptomatic oral and vaginal candidiasis.

As the end of life approaches, the patient may have a diminished desire to eat or drink, and accompanying weight

loss may require a gradual withdrawal of oral hypoglycemics or insulin. Metformin has many side effects, and is best stopped. A longer acting sulfonylurea, if providing good control, must be monitored carefully, and consideration must be given to tapering the dose downward. There is less risk of hypoglycemia if a short acting drug, (e.g., tolbutamide) is used. Maintenance intravenous fluids are not usually required at this time of life, especially if there is reduced kidney function. All palliative medications need to be dosed with the consideration of potentially decreased renal function. As the person progresses through their final days and becomes unconscious, blood glucose monitoring may not be necessary if it causes discomfort to the patient. Depending on the patient's or the family's desires, insulin may be stopped. As the entire family unit moves through this life transition, interdisciplinary, supportive care is the ultimate goal.

In summary, the palliative care strategy for patients with diabetes mellitus is a dynamic mix of evidence-based therapies and evolving new pharmaceutical and nonpharmeceutical approaches. Palliative care is never static. A fundamental principle of palliative care is to tailor each therapeutic approach to an individual patient and their family and to continue to provide care beyond cure. □

Acknowledgments

The author wishes to express appreciation for assistance in the development of this article to Dr. Robert Twycross, Macmillan Clinical Reader in Palliative Medicine, University of Oxford; Dr. David Matthews, Clinical Director, Oxford Diabetes and Endocrinology Centre; and Ms. Meg Roberts, Librarian, WHO Collaborating Centre for Palliative Care, Oxford, England.

References

1. Valway S, Freeman W, Kaufman S, Welty T, Helgerson SD, Ghodes D. Prevalence of diagnosed diabetes among American Indians and Alaska Natives,1987. *Diabetes Care* 1993;16(suppl 1):271-276
2. Burrows N. Prevalence of Diabetes in American Indians and Alaskan Natives, 1999. Division of Diabetes Translation. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. February 1, 1999
3. Warnock J, Mutzig E. Diabetes mellitus and major depression: considerations for treatment of Native Americans. *Journal of the Oklahoma Medical Association*. 1998 Dec;91(9):488-93
4. Benbow S, Cossins L,MacFarlane I. Painful diabetic neuropathy. British Diabetic Association, *Diabetic Medicine* 1999;16;632-644
5. Beers MH. Nortriptylline usage in the elder population. *Archives of Internal Medicine*. 1997:157:1531-1536
6. Sallout H, Mayoral W, Benjamin SB. Cisapride useage in elder population. Clinics in Geriatric Medicine.1999:15:439-456
7. Mazze R,Strock E, Simson G, Bergenstal R, Etzwiler D. Complications and Hospitalization Quick Guide. 1999 International Diabetes Center, Institute for Research and Education, Minneapolis, Minnesota. Pp1-21 through 1-28
8. Price D, Gingell J, Gepi-Attee S, Wareham k, Yates P, Boolell M. Sildenafil: study of a novel oral treatment for erectile dysfunction in diabetic men. *Diabetic Medicine* 1998 Oct;15(10):821-5
9. Rendell M, Rajfer J, Wicker P, Smith M. Sildenafil for treatment of erectile dysfunction in men with diabetes:a randomized controlled trial. Sildenafil Diabetes Study Group. *JAMA* 1999 Feb 3;281(5):421-6
10. Twycross R, Wilcock A, Thorp S. Palliative Care Formulary 1998, Radcliffe Medical Press, Oxford, England
11. Kingery W. A critical review of controlled clinical trials for peripheral neuropathic pain and complex regional pain syndromes. *Pain* 1997; 73:123-139
12. Boyd K, Diabetes mellitus in hospice patients: some guidelines. *Palliative Medicine* 1993;7:163-164

Pharmacy Practice Training Program

Editor:

In August 1999, I attended the Pharmacy Practice Training Program sponsored by the Clinical Support Center, and I wish to provide a brief commentary on this excellent training experience. I had attended this course on two previous occasions, the last time in 1990, and was concerned that I would gain little by going again. I discussed this matter with Ed Stein, the program's coordinator and one of the instructors, and was assured that I would indeed benefit from participating in the program, especially since it had been over five years since I last attended. Not only was he correct in this assessment, but with the manner in which this training has evolved over the years and with the new knowledge that I acquired, I wish I had not waited so long to involve myself with it once more.

For readers not familiar with this course, the Pharmacy Practice Training Program was started in the early 1980s. Indian Health Service pharmacists were rotated through every few years,with the costs being fully paid by the Clinical Support Center. For pharmacists new to the Indian Health Service, the training provided an excellent introduction to IHS pharmacy practice. It taught a set of skills, many unique to the Indian Health Service, that could be utilized in their daily practice. Chart screening, patient education and counseling, conflict resolution, and laboratory test monitoring were some of the topics covered. For mid-career and senior pharmacists, the course provided a first-rate refresher of these skills. It also allowed them to pass along their acquired knowledge to the new pharmacists.

Funding for the Clinical Support Center became progressively tighter in the early 1990s. One consequence of this was that the cost for supporting the Pharmacy Practice Training Program shifted to the service units, by asking them to fund the travel expenses for their pharmacists who attended. Unfortunately, the June 1999 session had to be canceled due to a lack of registered participants. After participating in August, I realize what a missed opportunity this was for pharmacists who had never taken the course or who had not attended for several years. I also saw it as a loss for the collective wisdom of Indian Health Service and tribal pharmacy programs, as the course imparts a great deal of knowledge and insights about practice styles all acquired over many decades. Fortunately, the July and August sessions were well attended, and plans are underway to offer several sessions again this year.

There are a couple factors, I believe, which make this program unique and worthwhile. The first is the content. True to its roots, the course continues to emphasize the skills that pharmacists in the Indian Health Service and tribal programs need to use every day. The curriculum, in its evolution, has incorporated a large measure of case review and role playing. Typical IHS pharmacy situations are presented in a way that gets everyone involved in practicing and improving their patient care competence. A day of physical assessment training has also been added. This brings a whole new dimension to the decision-making aptitude that the course strives to engender. Pharmacists are encouraged not only to think in terms of supplying drug therapy, but to also be active in identifying and assessing non-drug factors that affect this therapy and in making recommendations based on their findings.

The quality of the instructors is another reason this course is so successful. The instructing pharmacists have established clinical programs at their own service units and have the ability to share what they know with those in attendance. As participants, I think we all felt we were being taught by some of the best pharmacists in the Indian Health Service. I personally left with a sense that there is a lot more that I can do as an IHS pharmacist, and that the teachers had given me the tools and a renewed desire to implement what I had learned.

While I have always found the Pharmacy Practice Training Program practical and stimulating, this latest offering was definitely the best. After attending it, I am impressed by the course's continued relevance to pharmacists of varying skill and tenure within the profession. Since lifelong learning is now a requirement of every health profession, the Pharmacy Practice Training Program is an ideal way for IHS and tribal programs to meet this need for pharmacists. I hope the Clinical Support Center continues to offer and develop this program in a way that maintains its exceptional nature. I also hope that pharmacists and service units recognize its value and commit to supporting it through regular participation.

Tony Kuyper
Chief Pharmacist
Inscription House Clinic
Shonto, Arizona

Geriatric Handbook

We have received more than FOUR TIMES the expected number of responses requesting free copies of the *Geriatrics at Your Fingertips* handbook. This is a terrific expression of interest in the health and health care of Indian elders. We are currently doing our best to obtain additional copies of the handbook, and we hope to begin the distribution process within two weeks.

The Annual Elders Issuse

The May 2000 issue of *The IHS Provider*, published on the occasion of National Older Americans Month, will be the forth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. 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.

POSITION VACANCY □

Editor's note: As a service to our readers, The IHS Provider *will publish notices of clinical positions available. Indian health program employers should send brief announcements on an organizational letterhead to: Editor,* The IHS Provider, *The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix,Arizona 85004. Submissions will be run for two months, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Family Practice Physician
Wind River Indian Reservation, Wyoming

The Wind River Service Unit has an opening for a BC/BE family physician to join a seven physician group in a non-obstetrics practice. We admit to a private hospital in Lander, Wyoming; call is 1 in 7. It is a great practice in a stunning setting. The opening is available in July 2000. For more information, call John Klinkenborg at (307) 332-7300 (work) or (307) 332-7753 (home). CVs can be faxed to (307) 332-7464.

Call For Papers

12th Annual IHS research Conference

The Twelfth Annual Indian Health Service (IHS) Research Conference, sponsored by the IHS Research Program and the IHS Clinical Support Center (the accredited sponsor) will be held April 24 - 26, 2000 in Albuquerque, New Mexico.

Papers are invited for oral or poster presentation in the following categories: Aging, AIDS, Alcohol and Substance Abuse, Cancer, Cardiovascular Disease, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Injury Prevention, Mental Health, Nutrition, Oral Health, and Women's Health. Research that measures the effectiveness of innovative environmental health or health care interventions, or that involves exemplary partnerships between researchers and tribes, is especially welcome.

Abstracts must be received no later than close of business March 10, 2000 to be considered for review (see "Instructions for Preparing Abstracts" below). Notice of acceptance of abstracts will be mailed no later than March 27, 2000.

For abstract consultation (style, etc.), contact Louis J. Lafrado, PhD, All Indian Pueblo Council, 3939 San Pedro NE, Suite E, PO Box 3256, Albuquerque, NM 87190; (505) 856-2539; fax [same telephone number]; e-mail: *LandD@.att.net.*

Instructions for Preparing Abstracts

1. YOU SHOULD SHARE YOUR RESEARCH RESULTS WITH THE TRIBE(S) INVOLVED IN THE RESEARCH AND GET THEIR APPROVAL TO PRESENT THE RESEARCH BEFORE DOING SO.
2. All abstracts that are accepted for either oral presentation or poster presentation will be reproduced in a book of abstracts for distribution. Therefore, all abstracts should have an identical format. On the following page is a sample of that format. Please follow the directions below carefully.
3. All abstracts should be submitted in electronic format only. They may be sent as an attachment to e-mail or mailed on a PC formatted diskette, using the addresses below.
4. Use the sample abstract form on the next page as a guide for size as you prepare your abstract. All copy must fit within this frame.
5. The abstract content should be structured as follows:
   - Title [bolded]
   - Authors [first name, middle name/initial, last name] Note: Do not include degrees after the author's names. Place an asterisk before the name of the presenting author.
   - Skip one line after the Title and Authors.
   - The text of the abstract. It should be one single-spaced, continuous paragraph, with no new lines. The text should be no more than 250 words. Use a type size no smaller than 12 pitch typewriter type or a 10 cpi font in a word processor. The text should not have figures, tables, equations,mathematical signs or symbols, or references. The organization of the paragraph should be as follows:
     - a brief statement of the Purpose of, or Background to, the study;
     - a statement of the Methods used (including number of subjects and other pertinent data);
     - a summary of the Results presented in sufficient detail to support the conclusion;
     - a statement of the Conclusions reached. (It is not appropriate to state, "The results will be discussed.")
     - Bold the four headings: Purpose or Background; Methods; Results; Conclusions.
     - Skip one line after the text of the abstract.
     - Add "For further information:" in bold, followed by the primary author's full name, official title, organization, address, telephone number, fax number, and e-mail address.
6. Please also check the desired form of presentation: oral, poster, or either one.
7. Please fill out the biographical sketch on the next page and fax or mail it to the address below. Do not submit a curriculum vitae or resume.
8. Send your abstract:
   - on a diskette with the abstract in a PC-compatible WordPerfect 5.x or 6.x file, or Microsoft Word file, Rich Text Format file, or ASCII text file; or
   - as a copy in the one of the above formats as an attachment to an e-mail at the address below.
9. Abstracts must be received by close of business, March 10, 2000.
10. Authors will be notified of the acceptance or rejection of their papers no later than March 27, 2000.

All abstracts should be sent to: Research Conference Coordinator / All Indian Pueblo Council
Louis J. Lafrado, PhD
3939 San Pedro NE, Suite E, PO Box 3256, Albuquerque, NM 87190
(505) 856-2539; fax [same telephone number]; e-mail: *LandD@att.net*

Indian Health Service Research Program 12th Annual Conference

ABSTRACT TEMPLATE and BIOGRAPHICAL DATA FORM

Using "avoidable hospitalization" indicators to assess adequacy of primary care: the Indian Health Service (IHS) 1980-1990. Blessing Yazzie, Eudora Welty, *Thomas Whitehorse.

Background. Major needs in assessing care include: use existing data; and assess primary care. We used "avoidable hospitalization" indicators to assess how well IHS primary care prevented avoidable hospitalizations. **Methods.** The avoidable hospitalization indicators were: TB, pertussis, cervical cancer, rheumatic heart disease, asthma, complications of hypertension, influenza and pneumococcal pneumonia in 65+ year olds, infant gastroenteritis, otitis media, uncontrolled diabetes, lower extremity amputations, hypoglycemia, pyelonephritis, cellulitis, stomach or duodenal ulcer, and newborn hemolytic disease due to isoimmunization. The IHS inpatient database for years 1980-1990 provided the count of cases. The denominator was the IHS Service Population, derived from the 1980 and 1990 census of American Indian and Alaska Native residents in IHS service delivery areas. We accounted for changes in hospitalization practices by Observed:Expected ratios ("observed—the change of hospitalization rates for each avoidable condition from 1980 to 1990; "expected"—the change that had occurred for all hospitalizations. We calculated the all-U.S. rates using the National Hospital Discharge Survey. **Results.** Hospitalization rates for most avoidable conditions decreased more than had all hospitalizations. However, the rates of four conditions both decreased less than all, and worsened relative to the change in the US: pneumococcal pneumonia for 65+, newborn hemolytic disease, hypoglycemia, and asthma. IHS hospitalization rates for the latter two conditions had increased. **Conclusions.** The IHS should investigate the epidemiology and primary care of pneumococcal pneumonia, newborn hemolytic disease, hypoglycemia, and asthma. Avoidable hospitalization indicators may detect changes in primary care or epidemiology rapidly and with good sensitivity.

For further information: Blessing Yazzie, MD, MPH. Director, Tribal Health Program, 4300 Haxton Way, Tucson, AZ 85746-9352. 520-263-8500, fax 520-263-8516. *blessing@tribe.gov*

Biographical Sketch

(Please Type)

Primary Author/Presenter: _____
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Mailing Address: _____

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City/Zip/State: _____

Telephone Numbers: Work: ( ) _____ Fax: ( ) _____ Home: ( ) _____

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Secondary Authors: (Name/Title/Place of Employment): _____

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If this abstract is not accepted for oral presentation, would you consider a poster? ☐ Yes ☐ No

Indicate the major content area of your abstract:

☐ Nursing ☐ Medicine ☐ Environmental Health ☐ Community Health ☐ Nutrition

☐ Behavioral/Mental Health ☐ Dentistry ☐ Epidemiology ☐ Other _____

Call For Papers

INNOVATIONS IN ELDER CARE

A participatory Conference

We invite you to submit a proposal for presentation at the upcoming conference, Innovations in Elder Care, a participatory conference. This conference is scheduled to run concurrently with the National Indian Council on Aging (NICOA) 2000 conference in Duluth, Minnesota, August 20-22, 2000.

The goals of the conference are to:

- Further the development and implementation of creative programs designed to enhance care for American Indian and Alaska Native Elders.
- Further develop the resource network of personnel within the Indian health care system working on issues of concern for American Indian and Alaska Native elders

The conference will achieve these goals by bringing together providers of care from throughout the Indian health care system to share experiences in the development and implementation of programs to enhance care of elders. We will learn from each other. Elders will be involved throughout this process, in the selection of programs for presentation, and as active participants in the conference. We will ask them to share their wisdom and to keep us on track. Presentations will be between 20 and 30 minutes each, including time for discussion.

While we are interested in any programs that enhance the health and well-being of our elders, we are emphasizing programs designed to improve preventive care services, reduce disability, and improve delivery of community-based long term care services.

Partial travel support may be available for presenters. All presenters will be eligible for the NICOA Patrick Stenger Award recognizing excellence and innovation in elder care programs.

The conference is sponsored by the National Indian Council on Aging, the Indian Health Service Elder Care Initiative, the North Dakota National Resource Center on Native American Aging, the Centers for Disease Control and Prevention, and the IHS Clinical Support Center (the accredited sponsor). The deadline for submission is February 29, 2000.

Please join and the Elders in August 2000 as we share our vision with each other and work to create better care for our elders.

Instructions for Preparing Abstracts

1. Use the abstract form on the next page to prepare your abstract. All copy must fit within this frame. This form may be copied.

2. Accepted abstracts will be reduced and printed in the conference program. Remember that you are producing camera-ready copy. Submit your abstract in a type size no smaller than 12-pitch typewriter or a 10-cpi font on a word processor. Single-space all copies. Do not include figures, tables, equations, mathematical signs or symbols, or references in the abstract.

3. The abstract content should be structured as follows:
   - Title of paper or program
   - Topic Relevance: specifically what problem are you trying to address. Why would other providers of services to elders want to attend this session?
     - Program/Paper Description
     - Define the problem and state what led you to undertake your study or project
     - Describe the objectives of your program or project
     - Describe the study or service population
     - Describe your methods and state why they were chosen
     - Describe your evaluation results and/or key findings or conclusions

4. Fill out the contact information; it must accompany the original abstract. Do not submit a curriculum vita or resume.

5. All abstracts should be sent to the National Indian Council on Aging, 10501 Montgomery Blvd. NE, Suite 210, Albuquerque, NM 87111. Phone (505) 292-2001; fax (505) 292-1922; e-mail: *evagdpe@nicoa.org.*

6. Abstracts must be received by close of business, February 29, 2000.

Innovations in Elder Care

Call for Abstracts

ABSTRACT FORM

Contact Information

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Primary Author/Presenter: _____
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Mailing Address: _____

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Abstracts must be received by February 29,2000.

Call For Abstracts

NCONA 2000 Conference

RISE TO THE CHALLENGE: FEEL YOUR POWER

The National Council of Nurse Administrators, NCONA 2000 Conference, sponsored by Navajo and Albuquerque Area Nurse Administrators and Nurse Educators and the Indian Health Service (IHS) Clinical Support Center (the accredited sponsor), will be held the week of June 12-16, 2000 in Albuquerque, New Mexico.

Papers are invited for oral presentation or for consideration for publication in *The IHS Primary Care Provider*, in the following categories: Leadership, Stress Management, Motivation, Nursing Informatics, Power of Education, Teamwork, Marketing, Recruitment and Retention, Population-Based Care, Healthy Community 2000, Multistate Licensure, and Experiences with the 638 Process.

Abstracts must be received no later than close of business, February 29, 2000 to be considered for review (see "Instructions for Preparing Abstracts," below). Notice of acceptance of abstracts will be mailed no later than April 5, 2000.

For Abstract consultation (style, etc.) contact the Navajo Area Nurse Consultant at (520) 871-5842; fax (520) 871-1365; e-mail *rzunie@gimc.ihs.gov.*

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3. The abstract content should be structured as follows: title, author, affiliation (with degrees), purpose/background, methods, results, and conclusions. Place an asterisk next to the name of the presenting author. Conclude your abstract with the sentence "For further information: [Name and address of author serving as point of contract]." The abstract must fit within the frame on the single abstract form and be no more than 250 words in length.
4. Check the desired form of presentation: oral, consideration for publication in *The Provider*, or either.
5. Please fill out the biographical sketch below; it must accompany the original abstract. **Do not submit a curriculum vita or resume.**
6. All abstracts should be sent to: Navajo Area Nurse Consultant, P.O. Box 9020, NAIHS Complex, Window Rock, AZ 86515-9020; telephone (520) 871-5842. **Submit one original signed by the author. Please submit a diskette with the abstract in a PC compatible Word for Windows text file.**
7. Abstracts must be received by close of business, February 29, 2000.
8. We will notify authors of the acceptance or rejection of their papers no later than April 5, 2000.

Biographical Sketch

(Please Type)

Primary Author/Presenter: _____
(As you would like it printed in the final conference program)

Mailing Address: _____

_____

City/Zip/State: _____

Telephone Numbers: Work: ( ) _____ Fax: ( ) _____ Home: ( ) _____

E-mail Address: _____ Position/Title: _____

Secondary Authors: (Name/Title/Place of Employment): _____

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Send abstract and biographical data sketch to: Navajo Area Nurse Consultant, Navajo Area Indian Health Service, P.O. Box 9020, Window Rock, AZ 86515-9020. Fax (520) 871-5842; e-mail *rzunie@gimc.ihs.gov.*

NCONA 2000 CONFERENCE

Call for Abstracts

ABSTRACT FORM

Submitted for.

☐ Oral Presentation ☐ Consideration for Publication in *The Provider* ☐ Either

If this abstract is not accepted for oral presentation would you consider submission for publication in *The Provider*?

☐ Yes ☐ No

Indicate the major content area of your abstract:

☐ Multistate Licensure	☐ Stress Management	☐ Motivation	☐ Nursing Informatics
☐ Power of Education	☐ Recruitment/Retention	☐ Marketing	☐ Teamwork
☐ Population-Based Care	☐ Healthy Community 2000	☐ Leadership	☐ 638 Process

Abstracts must be received by February 29, 2000

Signature of primary author: _____

Colposcopy: Basic and Refresher Courses
April 10-13 (Basic) and April 12-13 (Refresher), 2000; Albuquerque, New Mexico

The Indian Health Service Cancer - Epidemiology Program announces its 2000 basic and refresher colposcopy courses. The basic course will be held April 10-13; the refresher course April 12-13. Both courses will be held in Albuquerque, New Mexico. The basic colposcopy course forms the foundation of a colposcopy training curriculum that also includes a supervised preceptorship at the service unit.

The refresher course is targeted at IHS, tribal, or urban program colposcopists desiring a review and update of colposcopy and management of lower genital tract neoplasia. It is ideal for colposcopists still in their preceptorships and those practicing colposcopists who don t have the opportunity to see a large volume of high grade dysplasia or cancer in their practices. For more information or application materials, contact Roberta Paisano, IHS Cancer Prevention, 5300 Homestead Road, NE, Albuquerque, New Mexico 87110; phone (505) 248-4132; e-mail *roberta.paisano@mail.ihs.gov.*

CDC - Diabetes Translation Conference 2000
April 17-20, 2000; New Orleans, Louisiana

The CDC - Diabetes Translation Conference 2000 will bring together a wide constituency of local, state, Federal, territorial, and private sector diabetes partners to explore science, policy, education, and planning issues as they relate to reducing the burden of diabetes. The main constituents are the Diabetes Control Programs and their various partners. The target audience includes Federal, state, and local public health professionals; managers, directors, and executives from the affiliated health professional associations; health professional association and consultant partners in prevention and control activities and programs; managers, directors, and executives from health management organizations; physicians, nurses, nutritionists, and health educators; other non-government health professionals; representatives from special interest groups; and academic and research staff from educational institutions. Submission of papers in the following categories is encouraged: Health Systems; Surveillance Activities; Evaluation; Early Detection; Health
Communication; Community Intervention; and Coordination.

For more information, contact Norma Loner at (770) 488-5376 or by mail at CDC/DDT, 3005 Chamblee-Tucker Road, Atlanta, Georgia 30341-4133.

Twelfth Annual IHS Research Conference
April 24-26, 2000; Albuquerque, New Mexico

The 12th Annual Indian Health Service Research Conference will be held in Albuquerque, New Mexico. This is an opportunity for people who have seldom or never presented research results in a national meeting to do so in a friendly, supportive environment; it is also an opportunity for all of us to learn from each other. Please see the Call for Papers elsewhere in this issue.

Blending Traditional and Modern Methods of Care
April 27-28, 2000; Albuquerque, New Mexico

The 13th Annual New Mexico Indian Nurses Association National Symposium will be held at the Albuquerque Marriott Hotel in Albuquerque, New Mexico. To obtain more information or a registration form, contact Erma Marbut, RN at Crownpoint, NM at (505) 786-6262 or Rose Mason, RN, in Albuquerque at (505) 248-4047.

American Indian Kidney Conference
May 8-10, 2000; Oklahoma City, Oklahoma

This two and a half day conference will provide information on prevention of kidney disease and coping with kidney disease. The target audience is patients and families, community health providers, medical professionals, and tribal leaders. For more information, contact Jo Ann Holland, RD, CDE, Lawton IHS Hospital, Lawton, OK; phone (580) 353-0350, ext. 560.

Project Making Medicine
May 2000; Oklahoma City, Oklahoma

Project Making Medicine is recruiting Indian Health Service and tribal mental health providers and substance abuse counselors from the Alaska, Nashville, Navajo, and Billings IHS Areas to attend specialized training in the treatment of physically and sexually abused Native American children.

The Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center, through funding from the National Center on Child Abuse and Neglect and the Indian Health Service, Mental Health Division, has established a training program to provide specialized training to IHS and tribal mental health professionals in the treatment of child physical and sexual abuse. The purpose of Project Making Medicine is to increase the number of mental health providers available to serve child victims, using a “train the trainer” model. Upon acceptance into the training program, each enrollee will receive forty hours of training in treatment of child physical and sexual abuse, forty hours of training in clinical supervision and consultation, ongoing follow-up phone consultation, and one on-site visit. The program requires at a minimum a 12-month training obligation, and each person selected must make a commitment to implement a similar program at their site that will offer training, specialized treatment, and consultation.

The training is specific to Native American populations and the unique characteristics of tribal communities. Core and Consulting Faculty include traditional native healers and clinical and counseling child psychologists who have expertise in treatment and prevention of child maltreatment in Native American communities.

Funding was established for approximately sixty mental health professionals from the twelve IHS Areas to be trained over the three year period of the project (1998-2000). Each year the IHS will select twenty professionals from four IHS Areas to participate in the training. Licensed tribal and IHS mental health professionals (PhD, LMSW, LPC) are encouraged to contact their respective IHS Mental Health Branch Chief to be considered as a nominee. Certified alcohol and drug abuse counselors who work with adolescents may also be considered.

The initial application consists of 1) a letter of intent from the applicant that includes the commitment to provide specialized services to Native American children for at least two years following completion of training; 2) a letter of commitment from their immediate supervisor stating that the applicant will be allowed to participate in the training for the duration of the program and will be supported in the requirements as outlined above; 3) a letter of support from the tribe or IHS agency stating the applicant will be allowed to participate in the training for the duration of project, that the agency supports the requirements as outlined above, and the agency will sponsor a Project Making Medicine on-site visit; 4) a copy of the applicant s current license; and 5) a curriculum vitae.

The initial training for the next cycle will be held in May and October of 2000 in Oklahoma City, OK. The deadline for applications is March 1, 2000.

For additional information regarding Project Making Medicine, please contact Dolores Subia BigFoot, PhD, or Sonja Atetewuthtakewa at 405-271-8858; or e-mail: *dee-bigfoot@ouhsc.edu.*

Physician Assistant and Advanced Practice Nurse Meeting
June 13-16, 2000; Phoenix, Arizona

This conference for physician assistants, nurse practitioners, certified nurse midwives, and pharmacist practitioners employed by the Indian Health Service or Indian health programs will offer 20 hours of discipline-specific continuing education designed to meet the needs of those providing primary care to American Indians and Alaska Natives. An agenda will be available in March. This year there will be a business meeting June 12-13 open to all advanced practice nurses, before the beginning of the continuing education portion of the meeting, which will start at 1 pm on Tuesday, June 13. There will be a registration fee of $200 of those employed by compacting tribes or those in the private sector. For additional information, contact the IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004; phone (602) 364-7777; fax (602) 364-7788.

Rise to the Challenge: Feel Your Power
June 12-16, 2000; Albuquerque, New Mexico

This is the annual meeting of the National Council of Nurse Administrators and is sponsored by the Navajo and Albuquerque Nurse Administrators and Nurse Educators and the IHS Clinical Support Center (the accredited sponsor). Please see the Call for Papers elsewhere in this issue for more details.

The Pharmacy Practice Training Program (PPTP): a certificate program in patient-oriented practice
June 19-22, July 17-20, August 7-19, 2000; Phoenix, Arizona

The goal of this four-day training program for pharmacists employed by the Indian Health Service or Indian health programs is to improve the participant's ability to deliver direct patient care. This program encompasses the management of patient care functions in the areas of consultation, communication, interviewing techniques, laboratory test interpretation, conflict resolution, physical assessment and disease state management. These techniques are taught utilizing case studies, which include role-playing and discussion. For additional information, contact the IHS Clinical Support Center, Two Renaissance Square,, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004.

Innovations in Elder Care: A Participatory Conference
August 19-22, 2000; Duluth Minnesota

Planned to run concurrently with the National Indian Council on Aging(NICOA) 2000 conference, this meeting is intended to bring together those who from throughout the Indian health care system who provide care to elders to share experiences in the development and implementation of programs to enhance care of elders. See the Call for Papers elsewhere in this issue for more information.

Cancer Training for Physicians, Nurses, Nurse Practitioners, Pharmacists, and Other Clinicians
October 2000; Location to be announced

The first Early Detection and Treatment of Cancer Conference, held in October 1999, received very positive evaluations from clinicians who attended. Breast, prostate, cervix, colorectal, and lung cancers were covered, along with behavioral aspects of smoking, and palliation and pain management, in this one-day training. Leading experts in each area presented on current issues and technology regarding each site and subject. This training emphasizes interaction between the presenters and participants. The Indian Health Service Clinical Support Center is the accredited sponsor. For more information about the coming year's program, contact Alicia Carson, Regional Training Specialist, at (503) 228-4185, ext. 27 for more information, or read about current Northwest Tribes Cancer Control Program activities at *http://www.npaihb.org/cancer/ntccp.html*.

NCME VIDEOTAPES AVAILABLE □

Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004.

These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These NCME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in The IHS Provider *on a regular basis.*

NCME #756

Good Travel, Good Health *(60 minutes)*

Although a new and modern millennium is upon us, travel to remote and exotic locations still carries inherent dangers. Having just returned from the Sixth International Conference on Travel Medicine in Montreal, two experts in emporiatrics (from the Greek emporos [to go on board ship] and iatrike [medicine]) provide an up-to-date report on contemporary issues in travel medicine.

NCME #757

Post-Stroke Rehabilitation: Promoting Recovery Through a Team Approach *(60 minutes)*

Stroke is the third leading cause of death in the United States and the leading cause of a disability among adults. Approximately 550,000 people suffer a stroke each year; nearly 150,000 of these individuals die. Those remaining are part of the 3 million people who live with varying degrees of neurological impairment. Critical to its success is an interdisciplinary approach that requires the active participation of the patient and family. Dr. Kushner give the viewer an insider's perspective into the daily activities of a cutting-edge stroke rehabilitation program, where dedicated professionals offer expert assessment and management of these patients.

NCME #758

Seizure Disorders: Classification and Treatment *(60 minutes)*

Seizure disorders can take on a variety of manifestations, making classification critical to selecting correct treatment interventions. The ideal situation is to treat each patient with one agent that eliminates his or her seizures with no drug-related side effects. Although the goals of treatment are simple, finding effective therapies can be challenging. New drug and surgical therapies are offering patients hope for controlling their seizures. Dr. Trouth reviews the classification of seizure disorders in adults and children and outlines the proper management of these patients.

NCME 759

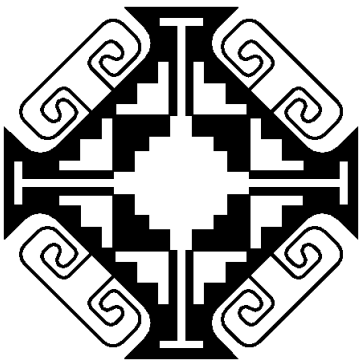
Recognizing and Treating Anxiety: Clinical Observations, Practical Advice *(60 minutes)*

When does anxiety cross the line from being part of everyday living to a disorder that requires intervention? What are the clinical features that distinguish generalized anxiety from disorders such as panic attack? In this candid, live presentation, Dr. Murray uses case examples to describe diagnostic clues and treatment options.

NCME 760

Expert Perspectives on Contemporary Clinical Issues in Hepatitis C — Part One *(60 minutes)*

The potentially serious consequences of chronic hepatitis C and the need for treatment are more widely recognized by physicians than ever before. In part one of this 2-part video series based on information from the acclaimed CD-ROM, "Clinician's Companion III," you'll learn about the dramatic progress that has been made over the past year in managing hepatitis C – including new evidence about the natural history of the disease that may help identify more asymptomatic patients with chronic hepatitis C virus (HCV). A challenging case study illustrates how previously untreated patients with HCV infection are most likely to achieve sustained virologic, histologic, and biochemical benefit when treated with interferon/ribavirin combination therapy compared with interferon alone.



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THE IHS PRIMARY CARE PROVIDER

The Provider is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; Fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov*. Previous issues of *The Provider* (beginning with the February 1994 issue) can be found at the CSC home page, *www.csc.ihs.gov*.

Circulation: The Provider (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical and nursing schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at *www.csc.ihs.gov*

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