

# THE IHS PRIMARY CARE PROVIDER

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



August 1999

Volume 24, Number 8

## Analysis of the Indian Health Service Prescription Cost Survey for Fiscal Year 1996

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### Abstract

The objective of this study was to determine the costs associated with outpatient prescription dispensing in the Indian Health Service (IHS), and to compare these costs to national figures. The study began as a written survey sent out to chief pharmacists in five IHS Areas: Albuquerque, Navajo, Oklahoma, Phoenix, and Portland. Participant pharmacists were asked to report a variety of costs, including facilities maintenance, telecommunication expenses, and salaries. Patient volume data were also collected. Data obtained were compared to the 1997 Searle-NCPA Digest data for pharmacies filling 200 or more prescriptions daily.

Total IHS average prescription costs were \$753,637, or 52% less than the Digest average. Average IHS non-drug expenses were \$479,709, or 28% less than Digest average of \$669,197. Total costs were \$1,233,346, or 45% less than Digest average of \$2,226,276. Total annual average prescriptions were 81,201 vs. 91,820 for Digest average. Total average per prescription costs are, therefore, \$15.19 for the IHS pharmacies compared to \$24.24 for the Digest national average. Limitations and implications of the data are discussed.

### Introduction

In August 1997, the Indian Health Service (IHS) Pharmacy Business Committee (PBC) initiated a prescription cost survey to determine the IHS cost of prescription dispensing. Its purpose was to determine costs associated with outpatient prescription dispensing and to compare the findings

to generally accepted national data. The reasons for initiating such a survey were several. First, the information gathered would be used by the PBC to serve as a management planning tool. Second, the IHS accounting system does not provide a cost report associated with outpatient prescription dispensing, so this financial information was unknown. Third, pharmacists throughout IHS could use this information for financial evaluation at their practice sites. Lastly, this information would be available for tribes, should they request an evaluation of outpatient prescription services.

### Methodology

A written survey went out to fifteen IHS chief pharmacists in five IHS Areas: Albuquerque, Navajo, Oklahoma, Phoenix, and Portland. Twelve of the fifteen pharmacists from a diverse sampling of IHS facilities responded. The instructions asked the participant pharmacists to collect data from

### In This Issue...

- 121 Analysis of the Indian Health Service Prescription Cost Survey for Fiscal Year 1996
- 124 Are Antibiotics Indicated for the Treatment of Acute Otitis Media?
- 125 Lead Screening of Native American Children: Targeted or Universal?
- 126 IHS Staff Development Council
- 128 Meetings of Interest
- 129 NCME Videotapes Available
- 130 Position Vacancies
- 131 Native American Medical Literature

specified IHS reports, to provide for consistency in data reporting. All data collected reflect activities from fiscal year 1996 (FY96).

Each participating facility supplied their own data. The FY96 total annual outpatient drug costs, the total number of outpatient prescriptions filled, and the number of weekly outpatient pharmacy hours of operation were taken from the annual IHS Pharmacy Report. The pharmacists also listed other related pharmaceutical costs. These items reflect associated prescription costs such as vials, bottles, computer labels, bags, etc. Also included were pharmacy-distributed patient medication aids such as specialty pillboxes, oral syringes, and insulin supplies. Computer costs other than from the Resource and Patient Management System (RPMS) and any references used to aid dispensing were also reported. Any other associated items not included above were incorporated into their survey response.

Internal costs were identified. Collected from each facility's IHS Hospital and Clinic (H&C) 0101 Report, annual costs for housekeeping, facilities and grounds maintenance, and utilities were obtained. Next, the total square footage of each facility and the square footage of the outpatient pharmacy were reported. Their service unit's maintenance department provided each facility's measurements. Annual costs for these items were calculated on the basis of the proportion of space occupied. Rent expense was not included in this report. Recurring telecommunication expenses and the management information systems (MIS) site manager's time dedicated to pharmacy were included as well. Outpatient pharmacy personnel salaries and benefits from the H&C 0101 were also reported.

Each facility provided their patient volume data. From the IHS 1A Report, each Area provided the number of outpatient provider visits (OPV) and the number of primary care provider visits (PCPV) for FY96. Each facility's medical records department provided the participating pharmacists with the number of active charts. For consistency in reporting, the number of active charts was defined as those charts active during the prior three-year period.

All the provided data were then converted into costs. A mean was determined to report the average FY96 IHS costs for the twelve responding pharmacies. This information was then compared to the 1997 NCPA-Searle Digest (formerly known as the NARD-Lilly Digest). The Digest was selected for comparison because it is considered by the pharmacy profession to be the best source of pharmacy financial information in the United States.<sup>1</sup> It was first published in 1932 by Eli Lilly and Company, and has been published annually ever since, even though the publication is no longer affiliated with Lilly. The 1997 Digest figures reflect information collected from calendar year 1996, collected from independent US pharmacies that filled 200 or more prescriptions daily. The Digest report reflects averages for respondent pharmacies in this prescription volume range.

This data group was selected for comparison for three

reasons. First, most mid- to large- sized IHS facilities fill more than 200 prescriptions daily (although not all surveyed IHS facilities have that large a daily prescription activity profile). Second, non-government pharmacies with large prescription volumes tend to have better economies of scale. Third, many state Medicaid programs allow for prescriptions to be dispensed as only a one-month supply. The Digest pharmacies report an overall 73% prescription volume based on state Medicaid and other third party reimbursements.<sup>2</sup> It is assumed, then, that almost three-quarters of their prescriptions were dispensed as a one-month supply. Since most IHS facilities fill to the next appointment, the average IHS medication quantity is a two to three month supply of medications. It is assumed that any price break received by government contract pricing is offset by the medication quantity the IHS dispenses.<sup>3</sup>

Adjustments were also made to make the Digest information comparable to the reported IHS data. The Digest reports their prescription costs and volume in terms of sales. Since the Digest is a financial analysis publication, it recognizes that retail pharmacies are a for-profit business. As a government agency, the IHS does not sell prescriptions. Therefore, a comparison could not be made between the Digest sales and IHS costs. To make the information relevant, calculations were made to determine cost of prescriptions for both groups. The Digest prescription cost was calculated by taking the Digest's reported Cost of Goods Sold, less the value of non-prescription inventory at cost, multiplied by the inventory turnover rate.<sup>4</sup> The non-prescription inventory cost was subtracted because the IHS does not sell over-the-counter (OTC) items; therefore only the prescription items costs were calculated.

Total expenses were also identified. Ten of the twelve participant IHS facilities reported their other related drug costs, internal costs, personnel salaries and benefits, and all other expenses. A mean was calculated for those reporting facilities. The Digest reports expenses of other related drug costs, utilities, computers, and all other expenses. Since rent was excluded by the IHS facilities, the Digest average rent expense was subtracted for purposes of consistency.

**Table 1. Comparison of IHS and Digest pharmacy cost data**

	IHS Average	NCPA-Searle Digest	% Difference <sup>†</sup>
Total Costs	\$1,233,346	\$2,226,276	45%
Total Rx Costs	\$753,637	\$1,557,079	52%
Cost/Rx	\$9.28	(calculated) \$16.96	45%
Rx Cost/Active Chart	\$33.51	Not available	
Rx Cost/OPD Visit	\$11.43	Not available	
Rx Cost/PCPV	\$17.64	Not available	
Rxs/Hour	30	27.1	-10%
Rxs/Day	222.5	>200	
Total Rxs	81,201	91,820	11%
Square Footage	1,139	4,929	77%
Hours/Week	49	65	24%

<sup>†</sup> Positive percent indicates the IHS figures are lower; negative percent indicates the IHS figures are higher. % difference is calculated as:  $\frac{\text{Digest} - \text{IHS}}{\text{Digest}}$

## Results:

The total average prescription costs per pharmacy for the IHS in FY96 was \$753,637, as compared to the Digest average of \$1,557,079. This is a significant 52% difference in prescription costs between the IHS and the national average. The IHS reported \$479,709 as the average total non-drug expense per pharmacy. The reported Digest average was \$669,197. This reflects a 28% difference in the overall non-drug expenses between the IHS and the Digest pharmacies. Adding the average total drug and non-drug expenses, the IHS total cost is \$1,233,346 while the Digest figure is \$2,226,276. The IHS total cost is 45% less than the national Digest average. Table 1 summarizes these and other data referred to in this discussion.

The FY96 average total number of prescriptions per IHS reporting facility is 81,201, approximately 11.6% lower than the Digest average of 91,820. Five of the reporting IHS pharmacies were smaller facilities that filled less than 200 prescriptions per day, which may account for the lower prescription volume. However, all IHS facilities, regardless of size or volume, use a prime vendor contract to purchase pharmaceuticals. Therefore, it is assumed that the drug prices are the same for each IHS facility. The average cost per prescription for the IHS is \$9.28, which is 45% less than the Digest average cost of \$16.96.

The number of prescriptions processed per hour was compared. IHS facilities average 30 prescriptions per hour, whereas the Digest average is 27.1. IHS fills 9.7% more prescriptions per hour than the national average.

In terms of space, the square footage of the average pharmacy in the Digest report is 4,929 sq. ft., while the IHS reports an average 1,139 sq. ft. The Digest relates square feet in terms of area and sales. It does not report a breakdown of the area represented by prescription, over-the-counter, storage, or other functions.

Last, the average number of hours of operation per week was compared. For IHS pharmacies, the average is 49 hours per week; the Digest reports 65 hours per week, reflecting a difference of 24.6% fewer hours open at IHS facilities compared to Digest facilities. The Digest reports the number of hours open with no allocation of pharmacists' time. Most IHS facilities dedicate one half day per week to the pharmacists'

administrative time for associated pharmacy activities. In addition, most of the field facilities were not open on the weekend, which is reflected in the lower overall IHS average.

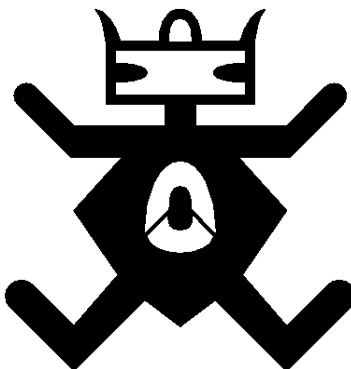
## Conclusion

This report is the first of its kind to compare the IHS to national pharmacy data using the NCPA-Searle Digest. This report provides information for the IHS to consider when analyzing pharmacy financial data. The focus of this report encompasses those outpatient pharmacy-dispensing activities delineated by the third of the IHS Pharmacy Standards of Practice, "to assure the availability, preparation, and control of medications."<sup>4</sup> It does not reflect inpatient hospital pharmacy costs, nor does it look at the value of the other pharmacy services provided by the IHS Standards of Practice. These value added services include pharmacists' assuring the appropriateness of therapy; verifying that patient's understand their medications and their appropriate outcomes; providing drug information, drug therapy consultation, and staff education relating to drug therapy; providing health promotion and disease prevention activities relating to drug use and preventive drug therapy; and managing therapy for selected patients for whom drugs are the principal method of treatment.

In summary, there is a difference in costs for both prescriptions and overall costs associated with operating a pharmacy when comparing IHS to Digest facilities. The Pharmacy Business Committee was able to demonstrate that the IHS pharmacy program could perform a financial analysis of their outpatient pharmacy program. In view of the data presented, this report suggests that the IHS operates a competitive outpatient pharmacy program at substantially lower cost than the US average. □

## References

1. NARD. *NARD Lilly Digest* 1995. Page 2. Alexandria, VA; 1996
2. NCPA. *NCPA Searle Digest* 1996, Page 19. Alexandria, VA; 1997
3. According to a Fiscal Year 1998 Phoenix Area Pharmacy Officer comparison review of government prime vendor contract pricing vs. general pricing schedule, the IHS receives a 47.8% price advantage.
4. United States Public Health Service, Indian Health Service, Pharmacy Branch, Standards of Practice. Manual Appendix 3-7-A, TN 93-11, April 1993. Rockville MD: Indian Health Service; 1993



# Are Antibiotics Indicated for the Treatment of Acute Otitis Media?

Jon Hauxwell, MD, Billings Area Indian Health Service, Billings, Montana

In 1997, the British Medical Journal published a review of available data regarding the effectiveness of antimicrobials in the treatment of acute otitis media (AOM). This article, entitled "Antimicrobials for acute otitis media? A review from the International Primary Care Network,"<sup>1</sup> was distributed to Billings Area IHS providers as part of an ongoing Infectious Disease CME project. Responses from our providers highlighted some fundamental problems we will be obliged to confront.

The authors conclude that "existing research offers no compelling evidence that children with AOM routinely given antimicrobials have shorter duration of symptoms, fewer recurrences, or better long term outcomes than those who don't receive them. It also is not clear that routine compared with selective use . . . prevents complications."

Earlier this century the advent of antibiotic drugs led to widespread optimism that the scourge of infectious disease was soon to become a thing of the past. Faith in technology created the assumption that newer antibiotics could always be developed to counter emerging resistance to older drugs.

But in the late twentieth century, the bugs are winning. Hopes that wholly synthetic antibiotics like the fluoroquinolones, with no counterparts in nature, would frustrate germs' resistance mechanisms proved naive.

Every time we prescribe an antibiotic, we add a selective pressure to the microfloral environment. Germ populations in individual patients are progressively altered, as are those in our species as a population. Excreted and discarded antibiotics are flushed into sewers, where a broader ecological transformation occurs. That enthusiastic antibiotic use makes a major contri-

bution to this microbial evolution is nowhere more apparent than in hospitals, where nosocomial infections take a heavy toll in money and lives.

Physicians, however, must deal with individual cases, weighing the cost to society against the well-being of the individual patient. We naturally tend to side with the individual; but this article suggests that our very notions of what constitutes the individual good may be misguided. If a patient's well-being is not safeguarded by antibiotics, then the supposed conflict with social responsibility disappears.

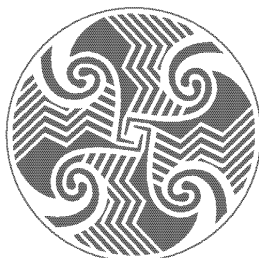
Reluctance to forego routine antibiotic use in AOM might arise from the conviction that it represents a "safer" approach to treatment of the individual, even when the provider might concede the hazards of antibiotic overuse in the population taken as a whole. There is also a common perception that most worried parents will not be satisfied with anything "less than" antibiotics.

It seems probable that bacterial AOM is both over diagnosed and over treated in this country. This is only one aspect of a much broader problem. The routine use of antimicrobials is deeply ingrained in our medical and lay cultures. If we do not undertake to alter this course, we might well see our children succumbing to diseases we "conquered" decades ago. As individual providers and as an organization, we must assume responsibility for considering this issue every time we confront a decision involving antibiotic usage. If our practices do not evolve, the bugs most certainly will.

For every gorillacillin, there is a Godzillabacter. □

## References

1. Froom J, Culpepper L, Jacobs M, et al. Antimicrobials for acute otitis media? A review from the International Primary Care Network. *BMJ* 1997;315:98-102



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# Lead Screening of Native American Children: Targeted or Universal?

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*Michael Bartholomew, Medical Student, Dartmouth Medical School, Hanover, NH; and W. Craig Vanderwagen, MD, Director, DCPS, Indian Health Service, Rockville, MD*

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## Background

Although current studies continue to demonstrate a decline in the prevalence of elevated blood lead levels (BLL) in children, lead remains a common, preventable, environmental health threat. From the recent results of the National Health and Nutrition Examination Surveys (NHANES III Phase 2), it is estimated that 890,000 children (4.4%), ages 0-5, have elevated blood lead levels ( $>10\mu\text{g}/\text{dl}$ ). "These levels continue to vary markedly by age, sex, race/ethnicity, urban status, income, and other socioeconomic factors. Blood lead levels were consistently higher for younger children than for older children . . . for males than for females, for blacks than for whites, and for central city residents than for non-central-city residents. Other correlates of higher blood lead levels included low income, low educational attainment, and residence in the Northeast region of the United States."<sup>1</sup>

In 1997, the Centers for Disease Control and Prevention (CDC), as well as the American Academy of Pediatrics (AAP), revised their policies toward lead screening of children. Based upon data from lead screening studies and cost benefit analyses of universal screening, the CDC and the AAP recommend a targeted screening methodology, utilizing history questionnaires with appropriate blood assays, rather than universal screening of all children. The purpose of the revision was "to help states and communities expand screening and follow-up of children who most need these services and limit screening among children who are not exposed to lead."<sup>2</sup> In addition, it will be the responsibility of state and local health officials to decide on the detailed screening criteria, with the advice of health care providers and other concerned groups.

Recently, the Indian Health Service (IHS) has been asked to reevaluate its Lead Screening Policy for Native American Children by the Environmental Protection Agency (EPA) to determine whether targeted screening or universal screening is more appropriate in Indian Country. IHS currently adheres to a policy that does not dictate targeted or universal screening of lead in Indian children but defers to other knowledgeable agencies. IHS recommends that the service units (SU) design plans and protocols that will be utilized in conjunction with the standards and guidelines established by the AAP and the

individual state's Early and Periodic Screening, Diagnosis, and Treatment Programs.<sup>3</sup> In addition, IHS recommends the use of the AAP's Recommendations for Preventative Pediatric Health Care. To determine which screening procedure is most applicable, this review will examine the current childhood lead screening practices within the past five years and recent BLL studies of Native American children occurring in the 12 IHS Areas.

## Methods

Most IHS Area Offices report prevalence data from BLL studies of Native American children within their Areas. By using the 1997 Native American Child Population Data, an estimate number of children with elevated BLLs was calculated for the same age groups as are used in the submitted IHS Area lead studies. It is assumed that divergence in numbers for child population data from 1997 and that of the time periods used in the individual Area BLL studies would not heavily impact calculated estimates. It must be noted that since there have been no IHS-wide BLL studies, estimates can only be calculated.

## Results

Of the twelve IHS Area Offices, six submitted data. After determining the prevalence of elevated BLL in the studies, it was observed that the Portland Area had a prevalence of 5.75%, which was above the national level (4.4% in NHANES III Phase 2). The Oklahoma City Area had reported a 32% prevalence of children with elevated BLL on initial analysis (TEAL Study). Currently, the Oklahoma City Area reports that the level as been reduced to 4% (screening approximately 30 children a month) through increased lead education and primary prevention practices. All other IHS Area lead studies reporting prevalence data yielded values below the national level.

## Discussion

With the estimated 890,000 children (in the general US population), ages 0-5, with elevated BLL, a very controversial debate ensues over the most appropriate method of screening children for lead, whether targeted or universal. Proponents of universal screening contend that targeted screening in certain locations would not only miss a large portion of children not residing in that locale but further isolate the disease. In addition, targeting regions with a higher prevalence of older housing does not cover older housing scattered in other areas.

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Targeted screening by demographics could potentially exclude environmentally exposed children, while targeted screening using the CDC's 1997 questionnaire lacks symptom-specific questions associated with lead toxicity, and it may not be utilized by practitioners anyway, due to time constraints. Proponents of targeted screening declare that universal screening will waste resources in areas that lack a significant exposure to lead and will reduce these resources available in locations of greatest need, namely high lead exposure areas.

The cost of screening appears to be a major consideration in deciding which method to utilize. Universal screening is economically beneficial in communities where the prevalence of elevated BLL is at least 11% to 17%.<sup>4</sup> In areas with lower prevalence, universal screening may be inefficient and targeted screening preferred.

### Conclusion

In reviewing the data from studies in the IHS Areas, it is reasonable to conclude that the low prevalence of elevated BLL does not warrant a revision of the current IHS lead policy to institute universal screening in Indian Country. From the cost analysis studies, it would appear that the IHS would benefit more by utilizing a targeted screening methodology rather than a universal one. This is not to say that universal screening is not needed at all. IHS still needs to maintain universal screening, as recommended in the 1997 CDC guidelines, in areas known to have a lead problem, either environmental or household. Not

all IHS Areas submitted lead screening study data, thus data are incomplete for Native American children served by the Indian Health Service. In addition, most of the data relate to children in reservation settings and do not necessarily apply to Native American children in urban settings. To determine the true need for revising the current policy for lead screening, lead in urban settings needs to be addressed, as does the design and implementation of a scientific lead screening model. Only estimates and assumptions could be made from the data gathered.

With cost analysis studies favoring targeted screening, and because current data from lead screenings in Indian Country indicate a prevalence near the national level, the Indian Health Service should maintain its current policy until such time as there is evidence suggesting and need for change. □

### References

1. Brody DJ, Pirkle JL, Kramer RA, et al. Blood lead levels in the US population: phase I of the Third Health and Nutrition Examination Survey (NHANES III, 1998 to 1991) *JAMA*. 1994;272:277-283
2. Tips NM, Falk H, Jackson RJ. CDC's lead screening guidance: a systematic approach to more effective screening. *Public Health Reports*. 1998;113:47-51
3. Indian Health Service. Indian Health Manual. Chapter 13 - Maternal and Child Health 3-13.6. 1990
4. Briss PA, Matte TD, Schwartz J, et al. Costs and benefits of a universal screening program for elevated blood lead levels in 1-year-old-children. <http://www.cdc.gov/ncah/programs/lead/guide/1997/pdf/b4.pdf>

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# IHS Staff Development Council

The Indian Health Service (IHS) Staff Development Council is a nationwide group of nurse educators and staff developers employed by the IHS, tribal programs, and Urban Indian programs. The Council's goals include: 1) sharing resources and information, 2) networking with colleagues, 3) collaborating on educational activities, 4) meeting the learning needs of staff developers/nurse educators, and 5) identifying JCAHO criteria regarding competency.

If you are involved in staff development or nursing education, please consider this as your invitation to participate in our recently developed web site and to join us at our next annual meeting.

Through the web site, you can learn more about us and you can communicate with other staff developers and nurse educators on the bulletin board. Our web site is at <http://www.ihs.gov/NonMedicalPrograms/NursingEd>.

Our next annual meeting will be hosted by the IHS Albuquerque/Navajo Area Association of Nurse Educators

(NAAASE). The meeting will be held in Albuquerque, New Mexico on June 15 and 16, 2000, in conjunction with the annual conference of the IHS National Council of Nurse Administrators (NCONA).

During our annual meeting, we conduct a business meeting and offer continuing education on topics of interest to staff developers and nurse educators. Topics from past meetings have included "Developing a Competency Program," "Developing a Web Site," "Conflict Resolution," "Measuring the Impact of Training," and "Developing a Nurse Leadership Training Program." We are in the planning stages now for the June 2000 meeting and would like your input regarding topics for the agenda. Please submit any ideas by posting them on the bulletin board of our web site (see address above) or by submitting them directly to Todd Benson, RN, Nurse Educator (and Chair of NAAASE), Fort Defiance Indian Hospital, PO Box 649, Fort Defiance, AZ 86504; phone (520) 729-3265; e-mail [tbenson@navfda.navajo.ihs.gov](mailto:tbenson@navfda.navajo.ihs.gov). □

# CRAFTING THE FUTURE OF AMERICAN INDIAN & ALASKA NATIVE HEALTH INTO THE NEXT MILLENNIUM



December 9-11, 1999

Westin Horton Plaza

San Diego, California

The conference will focus on creating an environment to strengthen existing relationships and to form new collaborations among tribes, urban Indian health groups, tribal colleges, and academic medical centers and universities.

The conference will include breakout sessions with presentations by leaders and others CURRENTLY or POTENTIALLY involved in crafting the future of Indian Health, such as tribal health directors, urban Indian health leaders, deans and leaders in academic medical centers, tribal colleges, members of the Indian Health Service and other federal and state agencies, and representatives of foundations and other private organizations.

**Co-sponsored by:**

**Indian Health Service**

**Center for Native American Health  
at the University of Arizona**

For more details visit:  
[www.thehillgroup.com](http://www.thehillgroup.com)

For more information contact Susie Warner  
at The Hill Group at 301-897-2789 or  
e-mail: [warner@thehillgroup.com](mailto:warner@thehillgroup.com)

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## MEETINGS OF INTEREST □

### **Creating Health in Tribal Communities: The Nuts and Bolts of Cancer Control**

**September 20-22, 1999; Grand Ronde, Oregon**

This regional conference is for policy makers, administrators, planners, health care providers and others interested in reducing the cancer burden in tribal communities and wanting more information on developing their own community plan. Registration is open to all, with preference given to those representing Northwest tribes. It will be held at the Spirit Mountain Lodge in Grand Ronde, Oregon. For more information, please call Alicia Carson, Regional Trainer, Northwest Tribal Cancer Control Project, Northwest Portland Area Indian Health Board at (503) 228-4185, ext. 27; fax (503) 228-8182; or e-mail [acarson@npaihb.org](mailto:acarson@npaihb.org).

### **Mental Health for the Health Professional: Survival Skills for Caregivers**

**Sept. 21-23, 1999; Reno, Nevada**

The Oklahoma State University Wellness Center will host a conference designed for health professionals who work with American Indians, Alaska Natives, and Hawaiian Natives. The conference will be held in Reno, Nevada at the Peppermill Hotel and Casino, Sept. 21-23, 1999. Among the topics to be presented will be personality characteristics; understanding differences; building unity; the personality of families; dysfunctional families; abuse — not taking care of oneself and others; stress management; and conflict resolution. Special room rates of \$50 plus tax for single or double occupancy and free airport shuttle apply. For more information contact Dr. Mac McCrory at (405) 744-6477; fax (405) 744-7670; or e-mail [macwell@okway.okstate.edu](mailto:macwell@okway.okstate.edu).

### **Seventh National Indian Nations Conference: "Old Medicine/New Voices of the 7th Generation: Reconnecting Partnerships and Reclaiming Traditions"**

**September 28-30, 1999; Tulsa, Oklahoma**

This is a two and a half day conference bringing together Native American victims, victim advocates, volunteers, prosecutors, judicial and law enforcement personnel, family violence and sexual assault specialists, social services and mental health professionals, corrections, crime and justice and juvenile justice personnel as well as tribal leaders to share their knowledge, experiences and ideas for developing programs that serve the unique needs of crime victims in Indian Country. It is conducted by the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center. Sponsors include the Office for Victims of Crime, U.S. Dept. of Justice; the Corrections Program Office, U.S. Dept. of Justice; and the Office of Juvenile Justice and Delinquency Prevention, U.S. Dept. of Justice. The meeting will be held at the Adam's Mark Hotel, 100 East 2nd Street, Tulsa, OK.

For More information, contact the Center on Child Abuse and Neglect, P.O. Box 26901, CHO 3B3406, Oklahoma City,

OK 73190, Attn: Tricia Williams or Janie Braden; phone (405) 271-8858; fax (405) 271-2931; or e-mail [TriciaWilliams@ouhsc.edu](mailto:TriciaWilliams@ouhsc.edu).

### **Cancer Case Management Training**

**October 5, 1999; Pendleton, Oregon**

This training is for health care providers to improve their case management skills to help them improve the lives of their patients living with cancer and their family caregivers. Registration is open to all with preference given to those representing Northwest tribes. It will be held at the Tamastklikt Cultural Institute in Pendleton, Oregon. For more information, please call Alicia Carson, Regional Trainer, Northwest Tribal Cancer Control Project, Northwest Portland Area Indian Health Board, at (503) 228-4185, ext. 27; fax (503) 228-8182; or e-mail [acarson@npaihb.org](mailto:acarson@npaihb.org).

### **Partnerships in Preventing Violence**

**October 15, 1999; Satellite Broadcast**

This is the third in a series of six live satellite broadcasts that focus on providing professionals with a thorough understanding of comprehensive, effective, school centered violence prevention approaches. It is sponsored by the Department of Education, the Indian Health Service, the Centers for Disease Control, and the Department of Justice. The interactive broadcasts are received at 80 Core Facilitated sites across the nation, and may be received at other independent sites. Videotapes of the prior broadcast are available for a nominal fee. For more information, visit the website at [www.walcoff.com/partnerships](http://www.walcoff.com/partnerships), or call (877) 778-4774.

### **Cancer Control Training for Physicians, Nurses, Nurse Practitioners, Pharmacists, and Other Clinicians**

**October 20, 1999; Portland, Oregon**

This training is for clinicians to employ clinical practices that reflect principles for cancer control including 1) early detection and treatment of cancer, and 2) the behavioral aspects of risk reduction. Registration is open to all with preference given to those representing Northwest tribes. The Indian Health Service (IHS) Clinical Support Center is the accredited sponsor of this course, and is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this continuing education for up to 7.25 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the educational activity. This Category 1 credit is accepted by the American Academy of Physician Assistants. The Indian Health Service Clinical Support Center is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation. This activity has been awarded 8.7 contact



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hours for nurses. The course will be held at the Edith Green/Wendall Wyatt Federal Building in Portland, Oregon. For more information, please call Alicia Carson, Regional Trainer, Northwest Tribal Cancer Control Project, Northwest Portland Area Indian Health Board, at (503) 228-4185, ext. 27; fax (503) 228-8182; or e-mail [acarson@npaihb.org](mailto:acarson@npaihb.org).

**Diabetes in American Indian Communities: Creating Partnerships for Prevention in the 21st Century**  
**October 27-29, 1999; Albuquerque, New Mexico**

The partners planning this conference include the Center for Native American Health at the University of Arizona Health Sciences Center, the Indian Health Service Clinical Support Center (the accredited sponsor), the Centers for Disease Control and Prevention, the National Institutes of Health, the American Diabetes Association Native American Design Team, and the Association of American Indian Physicians, as well as several Indian tribes and health care organizations. The conference objectives are to provide a forum for Indian communities to develop partnerships in diabetes related activities; to share information on American Indian community-based activities in diabetes; and to share information on current research on diabetes relevant to American Indian communities.

To meet the objectives the format of the conference will include plenary sessions with joint presentations by community members and researchers, as well as workshops in the following areas: prevention strategies, clinical interventions, research programs, and skills building. The conference will provide networking opportunities, brainstorming sessions, and abstract/poster sessions. The target audience includes the professional diabetes community (scientists, physicians, nurses, community health representatives, health educators, and other health-care workers), tribal health department personnel, and Indian health program workers. For more information, contact Computer Craft Corporation at (301) 493-9674; fax (301) 530-0634.

**American Indian Kidney Conference**  
**May 9-11, 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.

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## 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, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016.*

*These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These CME 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 #750

**Alzheimer's Disease: Primary Care Strategies for Early Intervention** (60 minutes) Until Recently, the symptoms of Alzheimer's disease (AD) were considered difficult, if not impossible, to treat. Now, advances in understanding the etiology and pathogenesis of AD have led to the development of a variety of treatment strategies that can ameliorate functional, cognitive, and behavioral symptoms of this devas-

tating condition. Using actual patient cases, three noted authorities in the management of AD show how these interventions can be applied — effectively and efficiently — by primary care physicians to stabilize or slow the decline in patients' functional abilities, and thus, enhance quality of life for both patients and their families.

### NCME #751

**Complementary Medicine: What Patients Are Doing, What You Should Be Asking** (60 minutes) In 1997, total visits to complementary medicine providers exceeded the total visits to all primary care physicians. Patients spend an estimated \$12.2 billion out-of-pocket for these services. Chances are your patients are seeing these providers and spending for these services. Do you know what your patients are doing? A primary care physician and a complementary medicine provider discuss the current state and future direction of complementary medicine, offer practical advice on how to work with patients seeking these treatments, and review some of the most popular therapies.

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## POSITION VACANCIES □

*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, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016. 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.*

### **Health Educator/Promoter IV Behavioral Health Clinician Sitka, Alaska**

The Southeast Alaska Regional Health Consortium (SEARHC) is looking for a Health Educator/Promoter IV and a Behavioral Health Clinician to work with village residents in communities located in beautiful Southeast Alaska. Both positions are full time with generous benefits packages. Frequent travel will be required. Sitka is a quiet town of 8500 with good schools, clean air, and excellent fishing and other outdoor sports and recreation.

The Health Educator/Promoter will lead the diabetes prevention project and organize and facilitate intervention programs for five rural communities. An MPH or MS in health education is required, with four years relevant work experience and one year experience in rural/bush communities. Samples of health education writing and curriculum will be required. Supervisory experience preferred. Salary \$40,365 to \$44,343, DOE. For more information, contact Stephanie Aird or Nancy Knapp at (907) 966-2451 or e-mail [s\\_aird@yahoo.com](mailto:s_aird@yahoo.com).

The Behavioral Health Clinician will provide clinical and administrative supervision and training to assigned Community Family Service Workers, and will also provide direct clinical services in the villages and to Sitka. Must have a Masters in Psychology, Counseling, Social Work, or other closely related human services field; must be eligible for state licensure as psychological associate or licensed clinical social worker at time of hire and must attain state licensure within six

months of hire. Three years experience in mental health or substance abuse field, one year in clinical supervision and two years in psychotherapy and assessment. Beginning salary \$40,365 to \$48,340, DOE. For more information, contact Iva GreyWolf or Patrick Hefley at (907) 966-2451.

Submit applications/resume to SEARHC Human Resources, 222 Tongass Drive, Sitka Alaska 99835; phone (907) 966-8733; fax (907) 966-2489. Applicants selected will be subject to federal and state background checks. Preference to Alaska Native/American Indian applicants who meet minimum requirements of job description (PL93-638).

### **Family Practice Physician San Jose, California**

The Indian Health Center has an immediate opening for a full-time BC/BE FP to join one FP and excellent support staff in dynamic clinic serving a diverse urban patient population. Comprehensive family medicine from pediatrics to geriatrics. Competitive salary, benefits, and malpractice insurance. Fax CV and cover letter to Dr. Verstraete, IHC, at (408) 269-9273. AI preference (Title 25).

### **Certified Registered Nurse Anesthetist Claremore, Oklahoma**

The Claremore PHS Indian Hospital is seeking a certified registered nurse anesthetist. This is a full time position in a three member department covering two operating rooms. Night call is taken from your home and does not involve trauma or a labor epidural service. Anesthetics are provided for a wide range of both inpatient and outpatient services including general surgery, obstetrics and gynecology, dentistry, and podiatry.

Claremore is a rapidly growing community near a major metropolitan center with convenient access to scenic recreational and cultural opportunities. A warm climate and relaxed practice with congenial staff make this an attractive salaried position.

Send CV to Paul Mobley, DO, Clinical Director, Claremore PHS Indian Hospital, 101 South Moore, Claremore, Oklahoma 74017-5091; phone (918) 342-6433; or fax (918) 342-6517.

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## ERRATUM NOTICE □

In our recent July 1999 issue (Vol. 24 No. 7), the fee schedule for the Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care course was incorrect. The correct schedule is as follows: IHS employees, \$160.00 for physicians and \$100.00 for other health professionals; tribally-employed physicians \$300.00, other health professional employed by a tribe \$200.00; Physician not employed by IHS or a tribe \$400.00, and other health professionals not employed by IHS or a tribe \$300.00; Resident \$300.00.

## NATIVE AMERICAN MEDICAL LITERATURE □

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

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

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

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*The Provider* is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 640-2140; Fax: (602) 640-2138; e-mail: [the.provider@phx.ihp.gov](mailto:the.provider@phx.ihp.gov). Previous issues of *The Provider* (beginning with the February 1994 issue) can be found on the CSC Internet home page (<http://www.csc.ihp.gov>).

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**Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.**

**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 the IHS Banyan electronic mail system.

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 through our fax retrieval service. Call 602-640-2140, ask for the fax retrieval service, and request document #3005. After business hours, press 8, and follow the instructions.

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