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Man's Best Friend: Dog Bite Related Injuries on the Rosebud Reservation 1991 – 1998

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Introduction

Dog bite injury has been studied for many years, yet continues to be among the leading public health concerns in the United States. Each year, dog bites result in an average of 20 deaths and at least 2 to 3 million people requiring medical treatment and restricted activity.[1,2] In fact, dog bite victims account for up to 5% of all hospital emergency room admissions. According to the Humane Society of the United States (HSUS), dog attacks are the most commonly reported childhood public health problem in the US, as dog attacks exceed the number of reported instances of measles, whooping cough, and mumps combined.[1-4] Some victims do not seek medical attention or report the incident, yet they still suffer from psychological trauma, anxiety, and the loss of work or school. In addition, dog bites remain a possible mode of rabies infections, requiring post-exposure prophylaxis. Animal bites are dealt with at the local geopolitical level, and reports are not forwarded to the federal government for inclusion into an ongoing national surveillance system.[1]

The Rosebud Reservation is located in rural south central South Dakota, 30 miles north of the Nebraska border, spanning 5,961 square miles. Based on the 1997 US Census, the reservation population is 10,790.

Rosebud's Office of Environmental Health, concerned about the incidence of dog bites, holds free rabies clinics in the communities throughout the reservation each year. The Remote Area Medical Team (RAM), supported by the HSUS, has also provided rabies vaccinations in addition to spaying and neutering services to the residents. The Rosebud Tribe has Animal Control Statutes located within the Law Enforcement Ordinance, but these statues are not consistently enforced.

The purpose of the study reported herein was to epidemiologically characterize dog bite injuries among residents of the Rosebud Reservation. Particular emphasis was placed on the evaluation of medical treatment lag time and investigation lag time, as prompt treatment and receipt of referral for investigation are crucial.

Methods

When seeking treatment at the Rosebud Hospital for an animal bite, the visit is documented on the Emergency Room

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(ER) log, and this triggers the initiation of the animal bite protocol and possibly a call to the Office of Environmental Health (OEH). The animal bite protocol, which was developed by OEH, serves two purposes. First, it facilitates prompt reporting of the animal bite by the medical/clinical staff to OEH, and second it requires the collection of crucial information surrounding the occurrence of the bite while the patient is still at the facility. The protocol form, which is divided into three sections (patient information, animal information, and follow-up), is completed to the extent possible by the clinical staff and is then forwarded to OEH personnel for investigation. At times, the treatment of a serious animal bite may result in the immediate notification of OEH personnel as well as the Rosebud Sioux Police Department.

The study population consisted of all individuals of American Indian descent who resided on the Rosebud Reservation and who utilized the Rosebud Indian Health Service (IHS) Hospital as a source of medical care. The cases were those individuals in the study population who suffered a dog bite between January 1, 1991, and December 31, 1998 and who sought treatment at the Rosebud Hospital or were transferred from the Rosebud Hospital to another facility for further treatment.

Data related to the victim's gender and age, medical treatment lag time, investigation lag time, gender of animal, type of attack, vaccination status, time of year (month), type of medical treatment required, costs, alcohol involvement, ownership status, community where bite occurred, and number of animals involved in bite incident were studied. A dog bite was defined as any attack by a dog resulting in an open wound, fracture, contusion, and/or superficial injuries. In an attempt to characterize attack types, unprovoked attacks were defined as attacks by a dog when the victim is behaving in a non-confrontational way (e.g., individual is standing, walking, or involved in any other activity such as riding a bike or playing in a neutral territory). A provoked attack was defined as anything other than an unprovoked attack. Alcohol involvement was based on documentation in the victim's chart. The presence of an alcohol odor, the victim's admission to alcohol consumption, or any other available documentation (e.g., a blood alcohol level) constituted a positive result. Ownership status was categorized as either owned or stray. Dogs were designated as owned if an individual's name was supplied on the form or if a rabies vaccination certificate was located for the animal, which indicated the owner's name. Otherwise, animals were noted as strays.

Medical treatment lag time was defined as the time between the occurrence of the bite and the receipt of treatment. Investigation lag time was defined as the time between the receipt of treatment and the receipt of the animal bite protocol form for investigation by OEH. Cost estimates in most cases involved medical care treatment costs, investigation/referral costs, and transportation costs. See Table 1 for a summary of cost estimates.

To evaluate animal bites, a data collection form was developed. See page 35 for a copy of the form. These data collection forms are completed through the review of the victim's medical chart and the completed animal bite protocol form. Data from all data collection forms were entered in the EPI INFO Version 5.0 computer program for analysis.

Results

Three hundred and ninety-six animal bite cases were identified through the use of the hospital emergency room log and the animal bite protocol. Of the 396 animal bite cases, 346 involved canines. The rate of dog bite injury was calculated as 431 per 100,000. Subject's ages ranged from 0 to 79 years old. The average age of a case-subject was 11 years. Fifty-three percent (182) of the bites occurred to children age 0 to 13, while 77% (262) of the bites occurred to individuals 26 years or younger. Gender distribution of the cases was 60% male (207) and 40% female (139). Data regarding victims' age and gender were consistent with a study conducted on the Navajo Reservation.[3]

Twenty-four percent (83) of the dog bites were provoked, 49% (167) were unprovoked, and for 27% (91) the attack type was unknown. Among children age 0 to 13, 25% (45) were provoked, 41% (74) were unprovoked, while the attack type was unknown in 35% (63).

Table 1. Cost estimates for emergency room, outpatient visits, response from the police department, OEH, and the ambulance service.

Service	Cost Estimate Per Case (Dollars)	Total (Dollars)
Treatment		
ER/OP Clinic		
• Nursing Services	125	
• Physician Services	154	
Subtotal	279	131,130
Hospitalization		
• Base/Day	180	
• Discharge	104	
• Room & Board	315	
Subtotal	599	5,867
Rabies Vaccine		
• 14 Patients	1,500	
Subtotal	21,000	21,000
Investigation/Referral		
OEH-Min. of 3 hrs.	15/hr. x 3	
Subtotal	65	20,985
RPD	10/hr.	
Subtotal	10	3,307
Transportation		
RAS	365/Base Call	
$5/mi.		
Subtotal	365	19,895
TOTAL		**202,185**

ANIMAL BITE PROTOCOL

Rosebud IHS Hospital

Note: This form is to be ***thoroughly completed*** and signed by the treating physician.

Patient Information: Medical Staff to Fill Out: Chart Number:_____

Date of Incident:_____ Time of Incident:_____

Date of Medical Attention:_____ Time of Medical Attention:_____

Location of Incident:_____

_____

Victim's Name:_____ Victim's Date of Birth:_____

Victim's Address (Include Directions):_____

_____

Victim's Phone number:_____ Parent's Name (If applicable):_____

Did Medical Staff Give the Patient the Option of Immunizations? YES or NO

Was the Patient Immunized? YES or NO

Patient Given Tetanus? YES or NO

Type of Prophylaxis Used: Rabies Vaccine Imovax YES or NO

Rabies Immune Globulin (Human) USP YES or NO

Please **Have the Treating Physician Sign This Form:**_____

Security to Fill Out:

Police Contacted? YES or NO Tribal City County

Officer's Name or DEN#:_____

Animal Information: RPD/OEH to Fill Out:

Type of Animal: Breed_____ Color_____ Markings_____ Size_____

Was the Animal a Stray? YES or NO Animal's Name_____

Owner of Animal:_____ Address (Include Directions):_____

_____

Owner's Phone#:_____

Vaccinated for Rabies? YES or NO Date of Vaccination:_____ Tag#:_____

Was Attack Provoked? YES or NO

Circumstances Surrounding the Incident:_____

_____

Is the Animal Tied-Up (Restrained) for ten days? YES or NO If Yes Where:_____

_____

OEH is available from **8:00 AM – 4:30 PM, Monday – Friday**. Please notify by telephone if victim is treated during regular business hours (**Ext. 307**).

Both male and female dogs were responsible for biting in equal numbers. Two hundred and seventy nine dog bites (88%) occurred from pets, while 42 (12%) were strays. Of those 279 bites from pets, 172 (62%) occurred to male case-subjects while 107 (38%) occurred to female case-subjects. These results are dissimilar to the results of urban area studies, such as the Philadelphia study in which 60% of the dogs were determined to be unowned.[5]

Seven (2%) of the cases required hospitalization and/or extended care; of these 7, 3 (43%) required a 3-day period of hospitalization. One hundred and sixty (46%) of the dogs that inflicted a dog bite had been vaccinated for rabies, 45 (13%) had not been vaccinated, and the vaccination status of 141 (41%) was unknown. Fourteen case-subjects (4%) consented to rabies post-exposure prophylaxis vaccinations, however only one case-subject completed the entire series. The total cost for the vaccine for these 14 case-subjects was $21,000.

Medical treatment lag time ranged from 0 to 36 days, with a mean of 5 days. Of the case-subjects, 283 (83%) were treated within 24 hours, 50 (15%) were treated within 5 days, 5 (1%) within 6–10 days, and 3 (1%) were treated 10 days or more after being attacked. Ownership status (pet versus stray) was not significant when examining how long it took to seek medical treatment.

Investigation lag time ranged from 0 to 85 days, with a mean of 5.1 days. Fifty-four (17%) were referred to OEH within 24 hours, 183 (58%) within 5 days, 41 (13%) within 6-10 days, and 38 (12%) were referred more than 10 days after the attack. Ownership status (pet versus stray) was not significant when examining how long it took to receive the referral. Eleven (3%) of the cases were alcohol involved.

Community N had the highest number of bites, 66 (20% of the total), followed by Community K with 63 (19%), Community A with 53 (16%), and Community F with 31 (9%). These communities have proportionately greater populations than other reservation communities, therefore accounting for the highest number of dog bite incidents.

The majority of the bites, 307 (88%), resulted from a single dog while 18 (5%) of the bites involved a group or pack of dogs.

Discussion

This study is limited by the quality of the information provided on the animal bite protocol forms, found in medical records, and gathered during victim interviews. Of particular concern is the determination of the type of attack. This is subjective, as the victim's perception of an attack may be influenced by misunderstanding the implications of their actions. For example, it is known that the small stature of a child may increase the dog's tendency to establish its dominance over the child. Generally, when a child is confronted with a vicious dog, he/she attempts to run away from the animal.[2,4] Yet, the animal's natural instinct is to chase and catch the fleeing prey.

Another limitation of this study is the non-reporting of dog bites. Not all dog bite victims report incidents or seek medical care. Explanations that might account for the non-reporting include: distance to the hospital, lack of transportation, failure to recognize the importance of reporting the incident, non-recognition of a bite by the treating physician, or a biting dog that is owned by the victim.[5-8] It is acknowledged that a case of human rabies has not been confirmed in South Dakota in the last few years, yet the possibility of canine transmitted rabies cannot be dismissed. State testing of "range animals" (coyotes, skunks, horses, etc.) shows rabies to be present in the environment. Efforts should be undertaken to encourage residents to seek medical attention, or at minimum to report dog bite incidents to OEH.[3-6]

Consistent with other studies, children are the "at risk" group, regardless of the type of attack. The emotional trauma to children can last a lifetime and could handicap a child both emotionally and mentally. Efforts should be undertaken to educate children and the community through educational programs in schools and at community meetings.

For a large percentage of the bites (41%), the vaccination status of the dog was unknown. Possible explanations for this include: the owner may have misplaced the vaccination certificate, the dog may have been given away and given a different name, the vaccination certificate database may not be current, or failure to identify the dog when investigating the incident. When encouraging responsible pet ownership, owners should be reminded to keep their animals' vaccinations current and to keep track of all certificates. Implantable microchips with vaccination and ownership data could be a possible solution.

As noted earlier, the investigation lag time ranged from 0 to 85 days, with a mean of 5.1 days. The prompt investigation of bite incidents is crucial in that it provides information necessary for the effective treatment of the victim, and the isolation and quarantine of the suspected animal. Increased investigation lag time could be attributed in part to confusion regarding the protocol and the filing of the protocol form in the patient chart rather than forwarding it to OEH for investigation. Training of all staff regarding the animal bite policy is warranted. In addition, the animal bite protocol form needs to be reviewed and revised to make it more user-friendly.

Conclusion

Despite the efforts of the Office of Environmental Health to increase the number of dogs that are vaccinated and spayed or neutered, the dog population continues to increase, as does the incidence of dog bites. Based on the results of this study, the following recommendations are made:

1. Review and revise the hospital animal bite protocol.
2. Raise community awareness of responsible pet ownership and dog bite reporting through educational programs in the schools and community meetings.
3. Establish a Dog Control Task Force to implement an animal control program and to enforce current animal control statues.
4. Establish a database of non-fatal dog bite injuries.
5. Continue the coordination of spaying and neutering clinics with RAM. □

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Accuracy of Using PCC Data for Measuring Childhood Obesity

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"GRPA measures," stemming from the Government Performance and Results Act of 1993, are reports that are required of IHS to assure that our agency is appropriately using its budgeted funding to provide a high quality of care to American Indians and Alaska Natives. The GPRA Pilot Study was designed to examine whether or not data already contained in the PCC (Patient Care Component), the IHS clinical information system, could be used to perform GPRA measurements with acceptable accuracy, thus reducing reporting burdens on Areas and local programs. To do this, the study was structured to allow us to compare manual reviews of a facility's paper charts with analyses using data contained within the PCC. This article reports the results of the analysis of a performance measure to assess the prevalence of obesity in children between the ages of 3 and 5 years. This study was conducted at one site – a medium-sized facility that primarily delivers outpatient care.

Methods

In this study, a sample of 181 patients was selected at the identified facility using the PCC application. We then gathered pertinent information (date of visit, weight, height) from that facility's PCC system, on all visits for each of these patients during the study time period (June 30, 1998 through June 29, 1999). We analyzed the data and a detailed report on these visits was provided to the manual chart reviewer. These charts were pulled and manually reviewed. The reviewer compared each of these individual data elements for each visit and patient from the facility's charts with the data provided her from the PCC system. Individual data elements were compared to determine omitted data elements, erroneously entered data, and entire missing visit records.

As we analyzed the data it soon became clear that a small but significant number of visits could not be found in the study facility's charts, but rather could only be found in the separate charts of the service unit's outlying clinics. Resource considerations precluded our chart reviewer from traveling to each of those outlying facilities to manually review those charts, too.

Therefore, to allow us to report these data and their potential impact on the overall accuracy of the measure, classifications were made based on a third, derived method that we termed "best available data." This term was chosen to best represent an artificial concatenation of data. For each patient, if data existed in the facility's chart, we used those data.

For visits to outlying clinics included in PCC data but not the study facility's chart, we used those data available in the PCC. Short of actually reviewing all these charts at all of the other chart-maintaining clinics within this service unit, we believed this would best represent a gold standard for comparison.

Finally, using this information, various results were determined for each data collection method (comparing the facility's RPMS system, the study facility's paper charts, and the "best available data"). For each method of data collection a determination was made for every patient as to whether or not a height and weight had been obtained on the same visit for that patient. If so, the last such visit for each patient was used to calculate a body mass index (BMI) and then the patient was classified as either "overweight," "at risk for overweight," "normal," or "underweight," utilizing the most current table of definitions published on the CDC (Center for Disease Control and Prevention) web site. If the child did not have a height and weight obtained on any visit during the study period, the child's record was classified as "insufficient data." These classifications for each method were compared.

Results

We found that these 181 patients had a total of 559 visits to all facilities within this service unit. Of these 559 visits, 556 (99.4%) were found in the PCC database. Four hundred and ninety-one of the 559 visits (87.8%) were found within the study facility's paper chart. All of the 68 visits (12.2%) not found within the chart were visits to outlying clinics within the service unit, facilities that maintained their own paper charts. In this study, we did not identify any PCC forms missing in the paper chart, or misfiled paper chart forms.

To evaluate the accuracy of individual data elements, we only looked at the 491 visits with a visit record in the study facility's written chart. The pertinent data (date of visit, weight, height) exactly matched for 461 of these 491 visits (93.9%). These individual data elements matched for 1,436 of the 1, 473 individual elements (97.5%). Three visits (0.6%) present in the chart could not be found in the PCC data, and a total of 27 visits (5.5%) had errors in the PCC data elements. Of these 27, a data element was completely omitted for 15 visits (3.1%), and for 13 (2.6%) the data were entered but incorrect. One visit had both omitted data and erroneous data.

Although the differences between classification by chart and PCC were not statistically significant, when compared to the best available data, the classification by PCC was consistently as good as or better than that by chart (See Table 1). The majority of children, 56.9 to 65.2% depending on the method used, did not have both a height and weight on the same day and could not be classified. Chart data corrected erroneous classifications based on PCC data for 5 patients and PCC allowed classification of 15 patients who could not be classified with chart data (See Table 2).

Table 1. Number of patients who were normal weight, underweight, at risk of overweight, overweight, or had insufficient data to make this determination. Total # of Patients = 181.

	Under weight % *(#Yes)*	Normal % *(#Yes)*	At Risk of of Ovrwt % *(#Yes)*	Over weight % *(#Yes)*	Insufficient Data % *(#Yes)*
According to chart data?	1.7%(3)	23.2%*(42)*	5.5%*(10)*	4.4%*(8)*	65.2%*(118)*
According to PCC data?	1.7%(3)	26.5%*(48)*	6.6%*(12)*	6.1%*(11)*	59.1%*(107)*
According to "best available data?"[1]	2.2%(4)	28.7%*(52)*	6.6%*(12)*	5.5%*(10)*	56.9%*(103)*

[1] The definition of "best available data" is detailed in the "Methods" section of this article.

Table 2. Children who had a different classifications based on PCC versus chart data.

	# Yes	%
For how many patients did the chart correct a classification due to erroneous PCC data?[2]	5	2.8%
For how many patients did PCC data allow a classification not otherwise possible because the data was not in the study facility chart?[3]	15	8.3%

[2] Three children who had insufficient data for PCC to classify would have been correctly classified "normal" by chart data. Another child classified "overweight" by PCC would have been correctly classified "underweight" by chart data. One child classified "overweight" by PCC would have been correctly classified "normal" by chart data.
[3] Fifteen children who lacked data in the study facility chart were classified in various categories with PCC data.

Conclusions

Our data showed that at this one facility and for the data elements studied, PCC data have greater than 97% accuracy when compared to the written chart. This is a reassuring finding. Clearly, however, there is ample room for improvement and we, and others, are already working on various initiatives to improve the accuracy of these and other data in the PCC system.

Moreover, it appears that at this facility, PCC does at least as well in classifying patients as we could do manually from the written chart. Actually, the accuracy of these classifications looked better using PCC data than it did using the study facility's paper charts alone, although most of these differences are not statistically significant.

Our data show that chart reviews conducted just at this one facility and not including chart reviews at all chart-maintaining

sites within this facility's service unit resulted in a loss of approximately 12% of pertinent visits and all data they contained. Pragmatically, this has important implications for how we perform GPRA measures for our agency. Although we could consider just using the PCC as a "record locator" to identify all charts for the selected patients at the various chart-maintaining sites within a service unit (and beyond), all charts would then have to be manually reviewed, something that would likely be prohibitively resource intensive.

Fortunately, these data, however, also suggest that the existing PCC data alone (and eventually data from other, non-PCC clinical information systems) could be used to perform these measures with sufficient accuracy to meet GPRA needs, a much more cost-effective strategy.

Finally, this study shows that a majority of 3- through 5-year-old children at this facility did not have both a weight and height measured on the same visit during this one-year period. Besides the potential clinical concerns (although there are understandable reasons why every child presenting to this facility may not have had both a height and weight performed within a year), this raises the question of whether or not there is significant bias in the subset of patients who have had these measurements compared to those who have not. This study was not designed to answer this question.

There are several limitations to these conclusions. This study only provides some of the first formal, empiric data we have on this specific question. In addition, results and conclusions are based on data from only one facility and only on the data elements and measure studied. Finally, our manual chart reviewer looked for data in the paper chart with a PCC report in hand. It is likely that she was able to find more chart data than a typical reviewer would find without the PCC prompts, thus over-estimating to some degree what would have been the accuracy of a manual chart review performed alone.

As we begin to use PCC data for these kinds of measures, we need to continue to evaluate more and different kinds of data and measure their accuracy, in an ongoing fashion, at multiple and varied facilities.

Acknowledgments

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University of Minnesota School of Nursing Announces Internet-based Masters Degree Program

The University of Minnesota now offers a Master of Science Degree with specialization in Public Health Nursing, Women's Health Care Nurse Practitioner, or Nurse-Midwifery through interactive web-based education. Students can pursue graduate education without relocating.

A key goal of this project is to increase the availability of ethnically/culturally and geographically diverse master's prepared public health nurses, nurse-midwives, and women's health care nurse practitioners. The *Native American Nurses Program* (part of the Center of American Indian & Minority Health) offers summer enrichment programs, ongoing academic and cultural support, and counseling. The web-based master's degree program provides an opportunity for American Indian nurses, and nurses who serve American Indian communities, to further their education without leaving their home communities.

The program includes online study with 2 to 3 on-campus sessions per semester. Students may study part or full-time and can finish their masters degree in as little as two years.

Further information is available by calling Trina Lone Hill at (612) 624-0143; toll free (888) 240-8636; or visit *www.nursing.umn.edu*. □

INDIAN AGING CONFERENCES OF INTEREST

American Geriatrics Society Annual Meeting
May 9-13, 2001; Chicago, Illinois

This is a gathering of over 2000 geriatrics professionals, representing the leaders in the field. In addition to special presentations on a variety of topics, there is a core curriculum review in geriatrics that is excellent. This would be an excellent update for physicians, nurses, advance practice nurses and physician assistants. For more information, visit *www.americangeriatrics.org*.

Third Annual American Indian Elders Conference
August 22-24, 2001; Oklahoma City, Oklahoma

The Oklahoma Elder Care Planning Team announces the Third Annual American Indian Elders Conference entitled "Many Faces of American Indian Elders," to be presented in Oklahoma City, Oklahoma. Two goals of this conference are to emphasize healthcare for American Indian Elders and increase the attendance of participants. The target audience includes consumers (elders) and health care providers (nurses, physicians, midlevel providers, social workers, community health workers, etc.).

The meeting will cover a variety of topics such as nutrition, diabetes, pain management, cancer, dementia, exercise/Tai Chi Chuan, end-of-life care, and much more. Partners planning this conference include the Lawton Indian Hospital, Wewoka Indian Health Center, Oklahoma City Area IHS, Southwest Oklahoma Area Health Education Center, American Cancer Society, Association of American Indian Physicians, State Department of Health, Chickasaw Nation, Cherokee Nation, Cheyenne and Arapaho Tribes and the Seminole Nation.

The meeting will be held at the Clarion Meridian Hotel and Convention Center, 737 South Meridian in Oklahoma City. Mark your calendars early! Brochures will be available in June. For more information, contact Mary Jac Rauh, Cameron University at SwOKAHEC (580) 581-2284, e-mail *maryjacr@cameron.edu*; or Carolyn Whitecloud at (405) 951-3716, or toll-free (888) 843-2591, ext. 3716.

UCLA Intensive Course in Geriatric Medicine and Board Review
September 12-15, 2001; Marina Del Rey, California

This is an excellent comprehensive geriatrics review course with faculty who are national leaders in geriatrics.

For more information about the conference contact the UCLA Multicampus Program in Geriatric Medicine and Gerontology, Attn: Catarina de Carvalho, telephone (310) 312-0531; fax (310) 312-0546; e-mail *cprata@ucla.edu*.

In past years UCLA has offered Indian health providers a tuition discount. We will need to provide UCLA with the names of Indian health providers who plan to attend. If you plan to attend this conference, please contact Bruce Finke, MD, IHS Elder Care Initiative, P. O. Box 467, Zuni, NM 87327; fax (505) 782-7405; e-mail *bfinke@albmail.albuquerque.ihs.gov*.

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, 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.*

Clinical Director
Kayenta Service Unit; Kayenta, Arizona

Located in the beautiful "Four Corners" area of Northeastern Arizona, on the Navajo Reservation, the Kayenta Service Unit is seeking a director of clinical services. The service unit offers busy outpatient services and strong preventive programs at two main sites and one field clinic, plus an eight-bed Emergency Department at the Kayenta facility. Board certification in a primary care specialty is preferred, strong interpersonal skills essential, and managerial or supervisory experience desirable. Work is approximately 60% administrative and 40% clinical. Great location for families with young children and for those who enjoy outdoor activities. Send CV or application for Federal employment to Melissa Stanley, P. O. Box 368 Kayenta, AZ 86033; or call Linda White at (520) 697-4000.

Family Practice Physicians
Chapa-De Indian Health Program, Inc.; Auburn, California

Chapa-De Indian Health Program is seeking two additional BC/BE family practice physicians, one to join our Auburn staff and one to join our Woodland staff. Chapa-De is a comprehensive community care system located in beautiful Northern California. We provide medical, dental, behavioral health, optometry, and pharmacy services for 18,000 registered patients in a four-county service area. Join our staff of four family practice physicians, a pediatrician, and a family nurse practitioner. Provide inpatient care at a nearby 100-bed hospital. Enjoy a competitive salary, excellent benefits, every fourth night call, and an opportunity for IHS loan repayment. For more information please contact Darla Clark, Clinical Administrator, at (530) 887-2800; e-mail at *dccdihp@yahoo.com*. CVs can be faxed to (530) 887-2849.

Chief Executive Officer
Native American Community Health Center, Inc.; Phoenix, Arizona

The incumbent would serve as CEO for the Native American Community Health Center, Inc. (NACHC). The CEO has overall managerial responsibility and full accountability for managing all activities of NACHC. The CEO will carry out this leadership responsibility within the agency Board of Directors' guidelines and with full recognition of the professional and technical expertise possessed by subordinate managers and staff. In addition to the executive management of clinical, community health, and administrative activities, this responsibility also includes an implicit charge to identify the unique health care needs of the patient population served, and to plan, develop, and implement a comprehensive health care delivery system tailored to these needs.

Within NACHC guidelines, the CEO develops, establishes, and directs the implementation and execution of overall policies and procedures for the administration and operation of a comprehensive health care delivery system for NACHC; develops, evaluates, and adjusts organization, position and staffing structures and management systems to accomplish the basic mission of NACHC. The incumbent supervises, through subordinate managers and supervisors, employees who engage in performing a variety of health care and supportive activities.

The CEO is responsible to the Board of Directors of NACHC. Salary: DOE. Qualifications and experience: A master's degree in public health, health administration, or related disciplines appropriate to the position, and four years of specialized experience in or related to the line of work of the position, which has provided the applicant with specific knowledge, skills, and abilities to successfully perform the duties of the position. Indian preference will be applied to this position.

For more information please contact the Human Resources Director, at (602) 279-5262 ext. 257 or send your resume to NACHC, 3008 North 3rd St., Suite 310, Phoenix, Arizona 85012; fax (602) 279-5390.

Where to Obtain Magnets

Dear Editor:

In articles in two recent issues of THE IHS PROVIDER ("Do You Have a Magnet in Your Emergency Room?" Volume 25, Number 11, November 2000, page 174; and "Magnets in the Emergency Room Revisited" Volume 26, Number 1, January 2001, page 9), the topic of ophthalmic magnets was discussed. A source for ophthalmic magnets is Wilson Ophthalmic Corp., P.O. Box 496, Mustang, OK 73064; (800) 222-2020. They carry three magnet options. The Firlene Eye Magnet is the largest and most powerful; the cost is $170.48. They also carry a smaller magnet with loop for about $36.00. You can get the smaller loop version with a magnifier for about $77.27.

Tim Strand, O.D.
Chief Optometrist, Santa Fe Service Unit

Editor's note: We appreciate Dr. Strand's sharing this information with our readers, and we encourage others to do the same when they have similar tips that may be valuable to those in Indian Country. □

The 5th Annual Elders Issue

The May 2001 issue of THE IHS PROVIDER, published on the occasion of National Older Americans Month, will be the fifth 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. □

SUMMER 2001 GERIATRIC INSTITUTE:

Major Causes of Morbidity and Mortality in an Aging Population

The New Mexico Geriatric Education Center is pleased to announce the next Geriatric Institute on June 7, 8, 9, 2001 Albuquerque, New Mexico.

Topics will include a comprehensive "best practice" view of major causes of morbidity and mortality in elders, including the following:

End-Organ Disease associated with Diabetes
Coronary Artery Disease/Congestive Heart Failure
Stroke
Common Malignancies
Geriatric Assessment: Strategies and Tools

The second Summer Geriatrics Institute is part of an ongoing series of annual conferences covering the essentials of geriatric practice. This year's conference will emphasize the interdisciplinary practice that is at the core of geriatrics, with interdisciplinary panels addressing topics including the prevention and management of coronary heart disease, stroke, and common malignancies. A half-day will be spent on management of end-organ complications of diabetes. Geriatric assessment will be discussed on the last half day as to tools, methods, and strategies.

Continuing medical education credits will be offered, as well as Pharmacy, Nursing and Social Work continuing education credits for participation in this Summer Geriatric Institute focusing on *American Indian Elders*.

As last year, the NMGEC will be offering scholarships for IHS and Tribal health care providers who work with American Indian elders. Please contact the NMGEC for application procedure.

If you are not on our mailing list, please contact us.
A registration brochure will be mailed in April for the Institute.

Darlene A. Franklin, Program Manager
New Mexico Geriatric Education Center
1836 Lomas Blvd., NE 2nd Fl
Albuquerque, NM 87131
Email: dfranklin@salud.unm.edu
505/277-0911 Fax 505/277-9897

MEETINGS OF INTEREST

American Indian Nursing Education Conference
April 19-21, 2001; Polson, Montana

The American Indian Nursing Education Conference has been canceled.

The 13th Annual IHS Research Conference
April 23-25, 2001; Albuquerque, New Mexico

The broad theme of the 13th Annual IHS Research Conference will be a critical issue: ensuring the benefits of research to American Indian and Alaska Native communities and peoples. The conference will examine in depth research on aging in American Indian and Alaska Native communities. On the opening day, presentations will discuss how to maximize research benefits and minimize harm to elders and communities, and how elders and communities can help plan the research. We will highlight examples of helpful research. We then will form into small groups — each with elders, researchers, Tribal Council or Health Board members, community members, program administrators, and clinicians – to discuss topics in research on aging in Indian Country.

Tuesday and Wednesday morning will be reports of methods and results of qualitative and quantitative research in Indian country. The entire conference will stimulate both seasoned and new researchers with ideas from other researchers that they can use. The conference will also inform clinicians, health program administrators, community members, and Health Board and Tribal Council members about research, programs, or activities that may be helpful in their own communities. People experienced in community-based health programs and participatory research in Indian or other communities will discuss "what problems we had and how we solved them," by presenting their own research and by reviewing results presented by others.

This IHS Research Conference also offers an opportunity for people who have never or seldom presented research results in a national meeting to do so in a friendly, supportive environment. It is an opportunity, as well, for all of us to learn from and with each other.

The meeting will be at the Sheraton Uptown, 2600 Louisiana Blvd. NE, Albuquerque, NM. Rooms at the rate of $65/night have been set aside until March 22 for those attending the "IHS Research Conference." Please make your reservation by calling (800) 252-7772. For more information, contact Cecelia Shorty, Administrative Assistant, New Mexico Tribal Health Care Alliance, Inc., 2309 Renard Place SE, Suite 101, Albuquerque, NM 87106; telephone (505) 764-0036; fax (505) 764-0446; e-mail *ceceliashorty_@hotmail.com*. The IHS Clinical Support Center is the accredited sponsor of this meeting.

Oral Health and Geriatric Dentistry Workshop
April 24-26, 2001; Albuquerque, New Mexico

Non-dentists as well as dentists will learn about oral health issues that concern geriatric patients. Assessment tools for the non-dentist to use in the home or long term care facility will be presented. Geriatric dentistry sessions will include demonstrations on preparing dentures in your rural/field site. A visit to nursing homes will provide actual on-site assessment of dementia patients and other residents. The workshop, cosponsored by the New Mexico Geriatric Education Center and Indian Health Service, will offer geriatric dentistry CDEs and CE for non-dentists. We invite public health nurses, CHRs, and physicians with an interest in providing quality health care to geriatric patients.

Please call (505) 277-0911 for more information or to register for this workshop.

Advances in Indian Health
May 2-4, 2001; Albuquerque, New Mexico

Advances in Indian Health is offered for primary care physicians and physicians assistants who work with American Indian and Alaska Native populations at Federal, tribal, or urban sites. Medical students and residents who are interested in serving these populations are also welcome.

Both new and experienced attendees will learn about advances in clinical care specifically relevant to American Indian and Alaska Native populations with an emphasis on southwestern tribes. Opportunities to learn from experienced, career clinicians who are experts in Indian health will be emphasized. Indian Health Service Chief Clinical Consultants and disease control program directors will be available for consultation and program development.

The conference will be held at the Holiday Inn Mountain View Hotel, 2020 Menaul Blvd. NE, Albuquerque, New Mexico 87107; telephone (505) 884-2511; fax (505) 881-4806. The special conference room rates are $60.00, single occupancy. The deadline for reservations is April 14, 2001. All room rates are subject to state and local taxes which are currently 10.8125%.

For registration information please contact Kathy Breckenridge, UNM Continuing Medical Education at (505) 272-3942 or Julie Lucero, Albuquerque Area Indian Health Service at (505) 248-4016. The conference brochure will be available in January 2001. To be placed on our mailing list, please call the University of New Mexico Office of Continuing Medical Education at (505) 272-3942. The brochure will also be available in January at *http://hsc.unm.edu/cme*.

The National IHS Pediatrics Conference
May 10-12, 2001; Phoenix, Arizona

The National IHS Pediatrics Conference will be held May 10-12, 2001 in Phoenix, Arizona. The conference is intended for pediatricians and primary care providers. Topics include type 2 diabetes in children, seizures/neurology, pneumonia/infectious diseases, obesity, dysmorphology/genetics, rheumatology, and evidence-based medicine. Confirmed speakers include Michael Radetsky, Carol Clericuzio, James Jarvis, Bill Dietz, Ann Bullock,

Lydia Caros, Perri Klass, Leslie Morrison, Roy Teramoto, and Ervin Lewis. The selection of the site of the conference is pending. The IHS Clinical Support Center is the accredited sponsor. Please contact Bill Green at (505) 256-4000 or Dottie Meyer at (602) 364-5175 for more information.

2001 Public Health Professional Conference
May 28-June 2, 2001; Washington, D.C.

This conference will be held at the Marriott Wardman Park Hotel in Washington, DC, and is sponsored by the Commissioned Officers Association (COA) of the U.S. Public Health Service. The IHS Clinical Support Center is the accredited sponsor of this meeting.

Health professionals from all categories are invited to participate. The meeting will address topics of current concern to all public health professionals and will be presented in General, Mini-General and Paper Sessions, as well as discipline-specific tracks. This Conference also provides sessions addressing personnel issues that you can't find at other professional conferences

The agenda has been planned based on the theme, *Public Health in The 21st Century: Expanding Our Mission*. Sessions are scheduled from Monday, May 28 through Friday, June 1. Personnel tracks on Monday and Friday have been planned by the Division of Commissioned Personnel. Sessions scheduled Tuesday through Thursday have been coordinated by the Scientific Program Planning Committee and Category Coordinators. Sessions on Wednesday, May 30 are planned as part of the Discipline-Specific Day. A PHS Retirement Seminar will be held in conjunction with this Conference on Friday, June 1 and Saturday, June 2.

Additional information about the Conference can be found on COA's website at *http://www.coausphs.org*, or through COA's Conference Coordinator, Laurie Johnson, telephone (252) 726-9202; e-mail *lauriej@ec.rr.com*. COA's website includes all the information you need about this conference, including a full agenda, online abstract submission, online registration, travel information, and more. Just click on the "professional conference" button.

The IHS Southwest Regional Pharmacy Continuing Education Seminar,
June 1-3, 2001; Scottsdale, Arizona

The largest annual meeting of Public Health Service pharmacists, technicians, and pharmacists from tribally operated programs, this seminar provides up to 15 hours of ACPE approved pharmacy continuing education credit. This year's program will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258, (480) 949-1414. The conference is hosted by the IHS Phoenix, Navajo, Tucson, Albuquerque, California Areas and the California Rural Indian Health Board, the target audience is made up of pharmacists and technicians working in Indian health system pharmacies. For more information, contact LCDR Ed Stein at the IHS Clinical Support Center, email: *edward.stein@mail.ihs.gov*.

Physician Assistant and Advanced Practice Nurse Meeting
June 4-8, 2001; Scottsdale, 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 4-5 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 5. 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.

NMGEC Summer Geriatrics Institute
June 7-9, 2001; Albuquerque, New Mexico

The IHS Elder Care Initiative has been working with the New Mexico Geriatric Education Center (NMGEC) to develop a geriatrics conference that specifically targets the educational needs of Indian Health Providers caring for Elders. The second NMGEC Summer Geriatrics Institute, scheduled for June 7-9, 2001 represents an active collaboration between the IHS and the NMGEC and is unique in its focus on Indian health care providers.

The second Summer Geriatrics Institute is part of an ongoing series of annual conferences covering the essentials of geriatric practice. This year's conference will emphasize the interdisciplinary practice that is at the core of geriatrics, with panels addressing topics including the prevention and management of cardiac disease, stroke, and selected malignancies. A half-day will be spent on management of end-organ complications of diabetes.

The conference will also include a half-day workshop, specifically for Indian health care providers, covering the processes of comprehensive geriatric assessment in Indian Country. This smaller, less formal session will explore several models of geriatric assessment currently in practice in Indian health facilities. The goal of this special session is to give a firm basis for providers interested in developing geriatric assessment programs at their site. A manual on geriatric assessment in Indian Country is in development with the NMGEC and will be the basis for this workshop.

As with last year's Summer Institute, the NMGEC will provide scholarships to Indian health care providers covering all or part of the tuition.

For more information, contact Darlene Franklin, Manager of the NMGEC, at (505) 277- 0911 or by email at *dfranklin@salud.unm.edu*. You can also contact Bruce Finke, MD, Coordinator, IHS Elder Care Initiative at (505) 782-7357; e-mail *bfinke@albmail.albuquerque.ihs.gov*.

IHS National Council of Nurse Administrators (NCONA) Annual Meeting and Conference "Embracing Change: From Policy to Practice" June 12-15, 2001; Washington, DC

IHS nurse administrators are encouraged to attend the annual NCONA Meeting and Conference, held at the Omni Shoreham Hotel, Washington, DC, telephone (800) 843-6664. This program will take advantage of all that Washington, DC has to offer, including access to legislators and headquarters personnel, and a monument tour. Proposed topics include leadership styles, change theory, legislature affecting IHS, and Medicare funding. Make your reservations early, as rooms are limited. There will be a registration fee of $75. Watch the National Council of Nursing (NCON) web page at *http://www2.ihs.gov/NCON/happenings.asp* for more information.

Anticoagulation Clinic Training Program (ACC) June 25–27; or September 17-19, 2001; Claremore, Oklahoma

Upon completion of this four-day certificate program, the health care professional should be able to provide responsible anticoagulation therapy in a coordinated, systematic manner for the purpose of achieving positive outcomes that may improve patients' quality of life. For more information, contact LCDR Travis Watts at the Claremore Comprehensive Health Care Facility Pharmacy, telephone (918) 342-6581. Registration materials are available at *www.claremoreihs.org*.

2001 IHS Information Technology and Program Support Conference July 9-13, 2001; Albuquerque, New Mexico

The Division of Information Resources is pleased to announce that the 2001 IHS Information Technology and Program Support Conference has been scheduled for July 9-13, 2001, and at the Hilton Hotel in Albuquerque, New Mexico. The theme of the conference is "e-Health, HIPAA, Strategic Partnerships and More."

IHS staff, tribal representatives, "638" tribes, and staff from Federal/state programs and the private sector are invited to a forum where the latest developments in technology will be demonstrated, and roundtable discussions and meetings will be held on the objectives of and concerns about information system policies and issues that affect Indian health.

A call for presenters and presentations will be made in the near future, and the agenda for the conference will be developed soon thereafter. Information about hotel reservations will also be forthcoming.

The contacts for the presentations and workshops are Shirley Lujan, telephone (505) 248-4348; Evangeline Lente, (505) 248-4413; or Jackie Atauvich, (505) 248-4416.

Attendee Registration is available on-line at: *www.ihs.gov/techconf2001.*

American Indian Kidney Conference July 11-13, 2001; Oklahoma City, Oklahoma

The National Kidney Foundation of Oklahoma and the Oklahoma American Indian Kidney Council will sponsor this second annual conference to be held at the Clarion Meridian Hotel and Convention Center in July 2001. Information on prevention of hypertension, diabetes, and kidney disease and coping with kidney disease will be provided over the three days. The target audience included patients and their families, community health providers, medical professionals, and tribal leaders. Continuing education will be available for healthcare providers. For more information, contact Jo Ann Holland, RD, CDE, at the Lawton Indian Hospital, Lawton, Oklahoma; phone (580) 353-0350, extension 560.

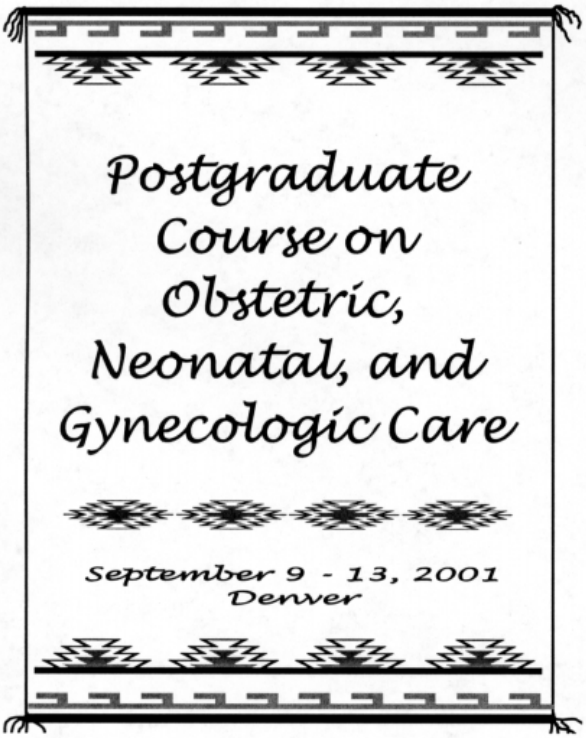
The Pharmacy Practice Training Program: A Certificate Program in Patient-Oriented Practice (PPTP) July 16-19 or August 6-9, 2001; Phoenix, Arizona

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 that include role playing and discussion. For additional information, contact LCDR Ed Stein at the IHS Clinical Support Center, Two Renaissance Square, 40 N. Central Avenue, Suite 780, Phoenix, Arizona 85004, or click on **Pharmacist Training** at *www.pharmacy.ihs.gov*.

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

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

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



TARGET AUDIENCE

This course is directed to primary care providers, including physicians, clinical nurses, nurse practitioners, nurse midwives, and physician assistants caring for women and infants in Indian Health Service settings and tribally-operated health care facilities.

COURSE DESCRIPTION

The curriculum is designed to encourage a team approach to the care of women and their newborns, with a strong emphasis on the realities and limitations of care in the rural, isolated settings that are common to many Indian health facilities. The text gives a clinically-oriented approach to care in facilities where the nearest specialist may be 50 to 800 miles away. Like the course focus and text, the faculty for the course is experienced with care in the Indian health setting.

CONTINUING EDUCATION CREDIT

The sponsors include the American College of Obstetricians and Gynecologists (ACOG), the Indian Health Service (IHS), and the IHS Clinical Support Center. The ACOG is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. The IHS Clinical Support Center is accredited as a provider of continuing education for nurses by the American Nurses Credentialing Center's (ANCC) Commission on Accreditation. This course has been designed in accordance with the standards of the ACCME and the ANCC.

REGISTRATION

The number of participants for the course is limited. Tuition, travel, and per diem expenses are the responsibility of the attendee or the sponsoring Indian health program. ***Send your completed registration form to*** Sandra Dodge, CNP, IHS Division of Clinical & Preventative Services, Parklawn Building Room 6A-44, 5600 Fishers Lane, Rockville, MD 20857 (phone: 301-443-1840; fax: 301-594-6213 or 6135).

POSTGRADUATE COURSE ON OBSTETRIC, NEONATAL, AND GYNECOLOGIC CARE

(Please type or print)

❑ PA ❑ CNM
❑ MD/DO ❑ RN
❑ NP _____ ❑ Other _____

Name _____
Last First Type Specify

Work Address _____

Home Address _____

Telephone (Work) _____ (Home) _____ (Fax) _____

Service unit/health facility name _____ Social Security Number _____

Please register me for the postgraduate course to be held September 9-13, 2001. I have checked the appropriate registration boxes below:*

❑ **IHS employee:** ❑ Physician $200 ❑ Other health professional $150

❑ **I am not employed by IHS:** ❑ Tribally-employed physician $350 ❑ Other health professional employed by tribe $250
❑ Physician not employed by IHS or tribe $450 ❑ Other professional not employed by IHS/tribe $350
❑ Resident $350

* Employees of tribes that have not withdrawn their tribal shares should use the IHS scale. If you are uncertain of share status, verify with Sandra Dodge.

Space is limited. Applications received after session is filled will be placed on alternate list.
Do NOT send fee payment until notified of placement in course.

Geriatric Dentistry and Oral Health for Non-Dentists

Workshop April 24, 25, 26, 2001

Albuquerque, New Mexico

The New Mexico Geriatric Education Center is co-sponsoring with Indian Health Service and University of North Texas, Health Science Center, a workshop with two tracks.

Track one covers geriatric *oral health* issues, assessment tools and hands-on experience for the *non-dentist*. This workshop will give the health care provider an insight into the issues surrounding oral health and their effect on other health systems of the body, especially for elders. A visit to local institutional settings with oral assessment sessions for residents will add to the practical experience for the health paraprofessional or professional. This track will be a two-day workshop and will include geriatric medicine principles and pharmacology considerations in the elderly patient, offering 14-16 hours CE's.

Track two: *Geriatric dentistry* is addressed in this track with geriatric medicine issues discussed, pharmacology and oral medications for the elderly patient, restorative considerations, hands-on experience in an institutional setting, and hands-on segment with selected patients for practice in efficient and cost-effective methods for producing dentures. The dentistry portion will be a 2 ½ day track and offers 16-20 hours CDE's.

REGISTRATION FEES are $40 for the Workshop
FEES WILL BE WAIVED FOR INDIAN HEALTH PROVIDERS
Registration deadline: April 6, 2001

Workshop will take place at the Howard Johnson Hotel and Convention Center,
15 Hotel Circle NE, Albuquerque, New Mexico 87123
Room reservation: 800/877-4852

For more information or to register contact
Darlene Franklin, Program Manager, New Mexico Geriatric Education Center
University of New Mexico, Health Sciences Center
1836 Lomas Blvd., NE 2nd Fl., Albuquerque, NM 87131
Telephone: 505/277-0911, Fax: 505/277-9897
e-mail: dfranklin@salud.unm.edu

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If change of address, please include old address, below, or attach address label.

Old Address _____

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 6000 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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