THE IHS PRIMARY CARE PROVIDER

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Innovative Software Links Microsoft Excel® and Access® to RPMS Databases for Clinical and Epidemiological Applications

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The Santa Fe Indian Hospital Cardiovascular Clinic (CVC) has been in existence for almost two years. Since its inception, health care providers have felt a need for easier access to, and applicability of clinical Resource and Patient Management System (RPMS) data. In October 1997, the CVC obtained a grant from the McCune Charitable Foundation to support the expansion of the clinic, as well as the development of methods that would make the RPMS database more user-friendly.

An innovative software program was created that allowed the direct linkage of Microsoft's Excel® and Access® (spreadsheet and database software) to the RPMS databases. This program consists of a small portion of original "M" or RPMS programming, combined with a major portion of two commercial off-the-shelf applications: KB-Systems' SQL-ODBC® and Fileman Mapper®.

CVC clinicians are now able to request in graphical form any laboratory or anthropometric data (such as weight or blood pressure) over time by completion of an Access® "window" (see Figure 1). Therapeutic goals can be entered to aid the patient's understanding of their progress. Figure 2 depicts an example of an LDL cholesterol profile of a patient with coronary artery disease for whom a goal of 100 mg/dl has been set. Figure 3 is a graphic display of blood pressure readings. Figure 4 is an example of a glycosolated hemoglobin (HgA1c) profile with a goal of 7 %. Figure 5 is a graph of weight with a goal of 108 pounds.

Figure 1. Microsoft Access "window" used to obtain data

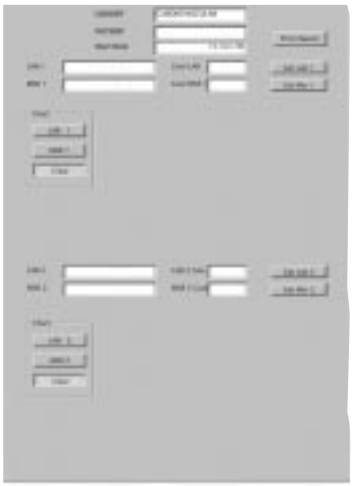

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Figure 2. LDL Cholesterol profile display

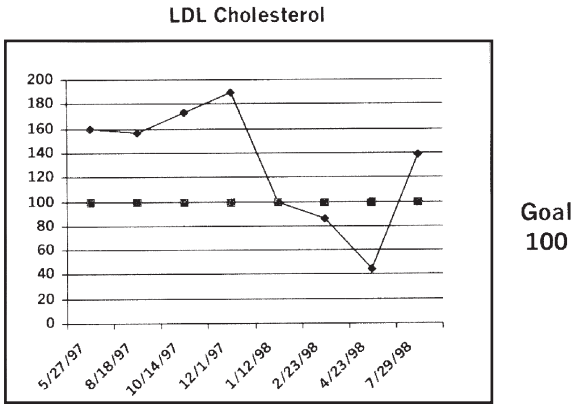


Figure 3. Blood Pressure display

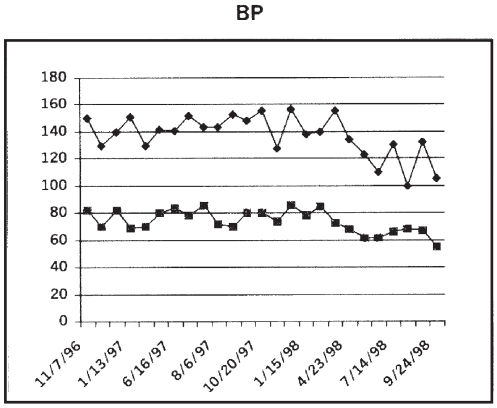


Figure 4. Glycosolated Hemoglobin display

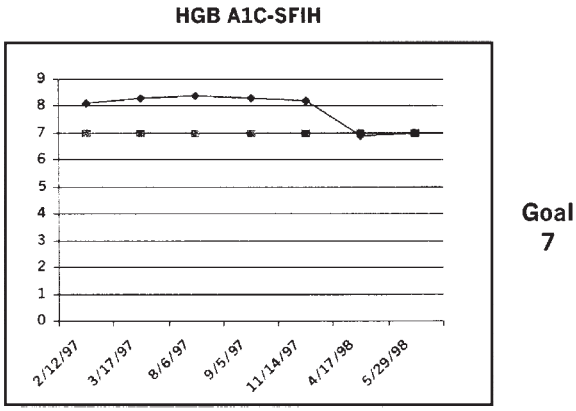
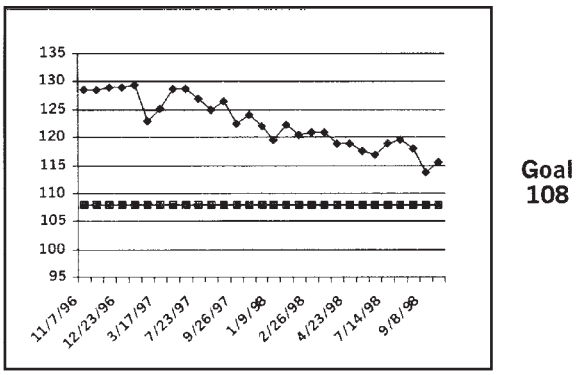
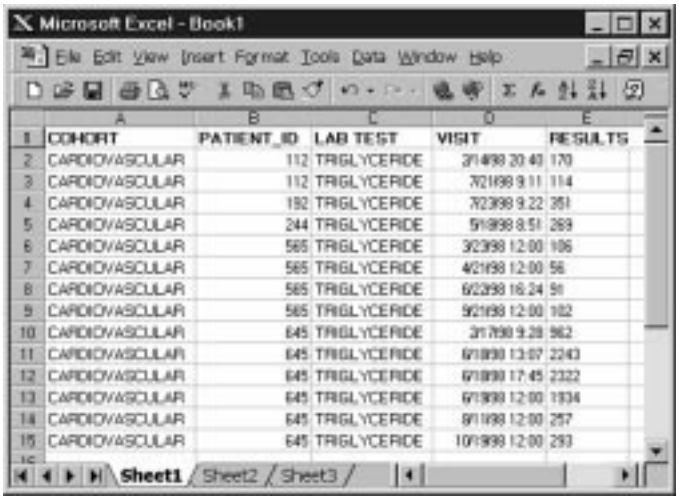


Figure 5. Weight display



Indian Health Service Evaluation and Research funds are supporting an evaluation project in which interventions made through the CVC are compared to usual care of patients over time. In order to evaluate the effects of these interventions, a rapid data retrieval process was needed for statistical analysis. The Excel® spreadsheet program is being used to access the RPMS patient cohorts, sub-divide patients into specific treatment cohorts, and retrieve requested information according to the evaluation format (see Figure 6).

Figure 6. Microsoft Excel® spreadsheet display of patient data



This software program was developed because of the need to present graphs with treatment goals to patients for feedback, as well as the need to access data for epidemiological purposes. Our experience with this approach has been positive, and is supported by excellent patient reception. □

IHS Research Conference Addresses Genetic Research

Observations of One Participant

Virginia Hood, MB, BS, MPH, University of Vermont, Burlington, Vermont

"The Promises and Perils of Genetic Research" was the topic for the forum that occupied the first day of the 10th Annual Indian Health Service (IHS) Research Conference held in April 1998 in Albuquerque, New Mexico.

The purpose of the annual Research Conference is to provide a forum for researchers, health care providers, community members, administrators, and students to share information and ideas about research projects involving Native American people, including ways to ensure the benefits and reduce the risks of the research to both individuals and communities. In recent years, in addition to individual presentations describing specific recent investigations, sessions addressing the benefits and risks of research in general have been introduced. In previous years, topics such as developing partnerships in science and research, and establishing guidelines for presentation and publication of research findings have sparked lively discussions and useful exchanges of approaches. This year's forum topic was particularly pertinent for Indian communities whose members and cultures have long been favorite subjects for researchers, but who have become appropriately cautious about involvement with any research initiatives that have not originated within their communities or with their input.

The daylong program consisted of formal presentations from representatives of the Human Genome Project (HGP), the IHS, Native American researchers, and community members, as well as small group discussions among all participants at the conference. There was an interesting discussion of the differences between the HGP, designed to map the human genome, and supported by National Institutes of Health, and the Human Genome Diversity Project, an independently funded project devoted to the genetic characterization of racial, ethnic, or other defined groups.

Support for the benefits of genetic research rests on the assumption that defining genes will lead to better understanding of disease. This can be translated into actions that will lead to better health through advances in prevention, with earlier diagnosis for those at risk, and therapy, with specific gene, gene product, or drug therapy. There followed an outline of what is currently understood about the genetic and environmental influences on the development or expression of human disease and the complexity of their interactions. It was stated that even those excited by the prospects of understanding the genetic determinants of disease acknowledged that the current emphasis on investigation of genetic rather than environmental factors may be more related to their being simpler to unravel than to their being of greater importance. Many of us present agreed with this analysis, feeling that, especially with respect to disorders such as diabetes and vascular disease, greater efforts should be made to examine lifestyle influences, as they are most likely to be amenable to treatment or prevention.

The discussion of the perils of genetic research highlighted issues in two areas; those affecting the individual and those affecting the community. Consideration of the consequences of research for the community, as well as for the individual, has always been a critical concern for Native American people. The need for community, as well as individual consent for any research is always emphasized. In both these areas the adverse effects resulting from loss of confidentiality, discrimination in private life or the workplace because of identifiable individual characteristics, or reinforcement of stereotypes were causes for concern.

Also at issue were the possible adverse legal and political consequences of defining cultural groups by genes. The greatest concern for many individuals was the concept of using personal biological material to generate "for profit" products (genetic patenting). Perhaps the strongest sentiment expressed in opposition to pursuing genetic research was the lack of currently available, demonstrable benefit to communities. People certainly felt that they did not need genetic information to know who they are or from where they have come. As stated by one distinguished speaker, although in recent years researchers have increasingly "allowed" Indians to participate in research and "allowed" them to object to aspects of a project, Indians are asking why they should be involved at all in research, particularly research that does not benefit them directly.

When considering approaches to these complex issues, attitudes varied from those who were totally opposed to any kind of genetic research to those who felt that specific questions relevant to the tribe and potentially beneficial to the community, families, and individuals could be considered for investigation. However, all emphasized that the basis for any investigation must be honesty and respect among all those participating so as to ensure genuine safeguards for the use of all materials and information collected, examined, or retained.

One issue not raised was the consequences of siphoning resources from other important investigations to accommodate the insatiable appetite for genetic research. Such efforts seem particularly futile when seeking understanding of disease by

genetic characterization of racial or ethnic populations. Given the lack of homogeneity in such populations in North America, there is likely to be more variability within than among the groups.

The discussion of the benefits and perils of genetic or any other research in communities is still in its infancy, and we all have a great deal to lose if we don't continue and foster it. We have much to learn from those who have been taught repetitively by history and experience that even researchers with good intentions do not always do what is right for individuals or communities. □

Optimal Medication Dosing in Older Adults

Lu Del White, RPh, Assistant Chief Pharmacist, Zuni PHS Indian Hospital, Zuni, New Mexico

Providing appropriate therapy for older adults and avoiding adverse drug reactions is becoming a greater problem as the percentage of elders in the population increases. In 1986 51% of adverse drug reactions (ADRs) resulting in death occurred in patients over 60 years of age; 39% of hospitalizations resulting from ADRs occurred in the same age group.

One of the most important ways to assure optimal therapy for older adults is to adjust medication dosage based on renal function. The easiest way to do this is to calculate an estimated creatinine clearance (CrCl) based upon the serum creatinine, using the Cockroft and Gault equation, as follows:

$$\text{CrCl (males)} = \frac{(140\text{-Age}) \times \text{IBW}}{72 \times \text{SCr}}$$

$$\text{CrCl (females)} = \text{CrCl (males)} \times 0.85$$

Where: CrCl is the creatinine clearance in ml/min
Age is the age in years
IBW is the ideal body weight in kilograms
SCr is the serum creatinine in gm/dl

Renal function generally declines with age, but it is extremely important to remember that serum creatinine, by itself, is not a reliable indicator of renal function in the elderly; age and weight must be taken into consideration. This is due to a decrease in lean body mass in the elderly and a resultant decrease in the daily production of endogenous creatinine. Thus, although the serum creatinine remains within the "normal range," in fact, creatinine clearance is falling. In some cases it may be necessary to obtain a 24-hour urine collection when a more exact value is needed, but in most cases the calculated CrCl will suffice as a starting point as a guide for therapy.

Figure 1 clearly illustrates the decline of CrCl with age for a variety of individuals with a "normal" serum creatinine.

Figure 1. Variation in creatinine clearance as a function of age and sex

Age (years)	Sex	SCr	IBW (Kg)	CrCl (ml/min)
65	M	1.2	75	65
	F	1.2	52	38
75	M	1.2	75	56
	F	1.2	52	33
85	M	1.2	75	47
	F	1.2	52	28

All of these patients described in Figure 1, with the exception of the 65-year-old male, should have doses of, for example, ticarcillin, ticarcillin/clavulanate, and cefixime adjusted. At a CrCl below 50 ml/min, dose adjustments for cefixime and ciprofloxacin (and all the newer fluoroquinolones) are recommended. A CrCl below 40 would require reductions in the dosages of cefaclor, cefazolin, and cephalexin. Below 30 ml/min ampicillin/sulbactam and cotrimoxazole dosages need adjustment. Of course, aminoglycosides levels must be monitored regardless of what the renal function is. Antiviral agents such as acyclovir, famcyclovir, and valcyclovir require dosage adjustment, and hydrochlorothiazide is not effective at CrCl less than 35 ml/min, just to give a few more examples of drug dosages affected by decreased renal function.

All of these medications are frequently used in our facility, and since several of them are expensive, it is advantageous to

tailor dosages so that optimal therapy is achieved at the lowest possible cost.

The Zuni Hospital's Pharmaceutical Formulary now contains a listing of all formulary antibiotics with dosage adjustment for decreased renal function and dialysis. A calculated CrCl is done for all adult inpatients and for outpatients older than 65 years of age or those with renal insufficiency.

It is important to note, however, that while glomerular filtration rate generally declines almost linearly with age, approximately 1/3 of older individuals maintain normal renal function until late in life. This underscores once again the need to individualize therapy in this patient group more than any other.

It is also important to remember that elderly patients, as a general rule, have a low reserve capacity. A side effect or adverse reaction caused by an excessive dose that might have had minimal impact on a younger patient can cause major problems for elderly patients simply because their bodies cannot accommodate the additional stress.

Commonly used references list most of the dosing information needed to make adjustments for our elderly patients based on calculated CrCl. The majority of the information we used to develop our formulary came from *ASHP Drug Facts and Comparisons*, the *Handbook of Dialysis* by John Daugirdas and Todd Ing, and the *APhA Geriatric Dosage Handbook*. These are all references that I would recommend acquiring if they are not already in your reference library. □

FOCUS ON ELDERS □

Bruce Finke, MD, Staff Physician at the Zuni-Ramah Service Unit, and Director of the Elder Care Initiative, Zuni, New Mexico

In last month's issue of *The IHS Provider* we proposed marking May 1999, which is Older American's Month, in the International Year of the Older Person (IYOP), by developing and nurturing interdisciplinary elder care teams at our Indian Health Service, tribal, and urban program (I/T/U) sites. In this and next month's *Provider* we will discuss the function and composition of elder care teams.

Why teams?

The task of building the best possible elder care in our hospitals, clinics, and communities requires the consistency and long-term commitment only achievable through a team effort. Staff turnover and the pressure of competing demands often hamper change within our systems. The team approach allows us to proceed with our work without relying on the energy or efforts of a single individual.

Why interdisciplinary teams?

Elder care is, by nature, an interdisciplinary process. The elder's needs cross boundaries of profession and setting. We each bring our own expertise and perspective on the needs of the elderly and we can learn from each other. We each understand how to work within our part of the system to improve the care of elders, and we can help each other.

Who should be on these interdisciplinary teams?

The team make-up will vary from site to site, depending upon the availability of personnel representing various disciplines and their own level of interest in elder care. Use whomever you may have. We would all think of the direct service clinical personnel (nurse, pharmacist, physical and occupational therapists, optometrist, audiologist, nutritionist, dentist, physician assistant, nurse practitioner, and physician). We need to think also of the many others who have specialized knowledge and who can help us better care for our elders (housekeeping and maintenance, ward clerk, business office representative, medical records and laboratory personnel).

We must also think of those in the community who work with elders. These again include the obvious direct service providers (CHRs, and those working in programs such as the Senior Center, Title VI/Meals on Wheels, Elder Day Care, Home Health, Social Services and others). It should also include the other agencies in the community that have impact on the elderly (housing, transportation, commodities, employment, and others).

Let's not forget the elders themselves. They can be a powerful source of wisdom, guidance, and inspiration for our teams.

Won't the group be too big?
Do we include all of these people?

These are your resources. Within these groups you will find the committed, passionate, and caring people who will join together to improve care for our elders.

Now is the time to commit to set aside an hour or two each week in May 1999 to build and nurture your interdisciplinary elder care team.

Next month: How to set up the Interdisciplinary Elder Care Team. □

Indian Health Programs in the New Millennium: The 1999 Meeting of the National Councils
January 5-8, 1999 Phoenix, Arizona

The National Councils (Clinical Directors, Service Unit Directors, Chief Medical Officers, and Nurse Consultants) of the Indian Health Service will hold their 1999 annual meeting January 5-8, 1999 in Phoenix, Arizona. This year's theme is "Indian Health Programs in the New Millennium." An exciting and informative program is planned to address Indian Health Service/Tribal/Urban program issues and offer solutions to common concerns throughout Indian country. Indian Health Program Chief Executive Officers and Clinical Administrators are invited to attend. The meeting site is the Hyatt Regency Phoenix at Civic Plaza, 122 North Second Street, Phoenix, Arizona; phone (602) 252-1234. The Clinical Support Center (CSC) is the accredited sponsor for this meeting. Please contact Gigi Holmes at (602) 640-2140 for more information or to request a registration packet.

Facing the Challenge
January 14-16, 1999 Albuquerque, New Mexico

"Facing the Challenge: Developing Native American-Specific HIV Research, Care, Treatment, and Intervention Services in Tribal, Indian Health, and Urban Health Systems" will be held in Albuquerque, New Mexico on January 14-16, 1999. This is an HIV continuing education activity for physicians, nurse practitioners, physician assistants, registered nurses, dentists, ophthalmologists, dietitians, psychologists, psychiatrists, social workers, case managers, community health representatives, substance abuse counselors, and providers to urban Indian and tribal health programs. It is sponsored by the Phoenix Indian Medical Center HIV Center of Excellence in collaboration with the IHS Clinical Support Center (the accredited sponsor) and the National Institutes of Health Office of AIDS Research. For more information or a registration brochure, call (800) 749-9620.

Fetal Alcohol Syndrome
Two identical sessions: February 10-12, 1999, and June 2-4, 1999 Seattle, Washington

This conference is cosponsored by the University of Washington Fetal Alcohol and Drug Unit, the University of Washington FAS Diagnostic and Prevention Network, and the Indian Health Service. Native Americans or those working with Native Americans are eligible, including professionals (physicians, psychiatrists, psychologists, social workers, nurses, teachers, CHNs, chemical dependency counselors, lawyers, judges, etc.) as well as advocates and parent activists. Six trainees will be selected for each session by the IHS Alcohol and Substance Abuse Program, HQW. Costs for lodging and most meals will be paid for by the UW Fetal Alcohol and Drug Unit. Costs for travel to and from Seattle, airport transfers, and some meals are the responsibility of the attendees or their organizations.

The curriculum includes 1) preventing and overcoming secondary disabilities in people with FAS and FAE across the lifespan (1 day); 2) preventing FAS with the Birth to Three Advocacy Model for working with very high-risk mothers and their families (1 day); and 3) demonstration of a multidisciplinary FAS Diagnostic Clinic and its relevance for community interventions, parent advocacy, and prevention (1 day).

The faculty includes Ann Streissguth, PhD; Sterling Clarren, MD; Robin LaDue, PhD; Therese Grand, PhC; and others from the Fetal Alcohol and Drug Unit and the FAS Diagnostic and Prevention Network. To apply, provide a description of past experience related to FAS and plans for the utilization of this training in Indian communities. Send your application to Timothy Taylor, PhD, Health Researcher, Alcoholism and Substance Abuse Program, IHS Headquarters West, 5300 Homestead Road, NE, Albuquerque, NM 87110. For more information, please contact Timothy Taylor at (505) 248-4125; fax (505) 248-4129; or e-mail *tltaylor@smtp.ihs.gov.*

Advances in Indian Primary Care
April 14-16, 1999 Albuquerque, New Mexico

This is the second annual continuing medical education course designed for primary care physicians who work in Indian health at federal, tribal, and urban sites. The course is intended to be an opportunity for new and experienced primary care physicians to learn about advances in clinical care specifically relevant to American Indian and Alaska Native populations, with an emphasis on southwestern tribes. The course will serve well as a clinical orientation for primary care clinicians new to Indian health. Medical students and residents who are interested in serving Indian populations are also welcome; it would be an excellent opportunity to seek placement at practice sites.

The course is presented by the IHS Senior Clinicians in Family Practice, Internal Medicine, Pediatrics, and Obstetrics and Gynecology; the University of New Mexico Health Sciences Center School of Medicine Area Health Education Center (AHEC); and the IHS Clinical Support Center (the accredited sponsor). The IHS Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians.

The course will begin Wednesday afternoon, April 14 and end at noon on Friday, April 17. More information will be published in future editions of *The IHS Provider*. For more information or a registration form, contact Chuck North, MD, Senior Clinician for Family Practice, PHS Indian Hospital, 801 Vassar Drive NE, Albuquerque, New Mexico 87106; phone (505) 256-4065; fax (505) 256-4093; e-mail: *north.chuck@IHS.gov.*

IHS Research Conference
April 26-28, 1999 Albuquerque, New Mexico

The Eleventh Annual Indian Health Service (IHS) Research Conference, sponsored by the IHS Research Program and the IHS Clinical Support Center (the accredited sponsor) will be held April 26-28, 1999 in Albuquerque, New Mexico. Papers are invited for oral or poster presentation in the following categories: Aging, AIDS, Alcohol and Substance Abuse, Cancer, Cardiovascular Disease, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Injury Prevention, Mental Health, Nutrition, Oral Health, and Women's Health. Research that measures the effectiveness of innovative environmental health or health care interventions, or that involves exemplary partnerships between researchers and tribes, is especially welcome. The theme of the first day's seminar will be environmental health in a community context. Abstracts must be received no later than close of business February 26, 1999 to be considered for review. Notice of acceptance of abstracts will be mailed no later than March 31, 1999.

Physician Assistant and Advanced Practice Nurses Meeting
June 7-11, 1999 Phoenix, Arizona

This conference for mid-level providers (physician assistants, nurse practitioners, certified nurse midwives, certified nurse anesthetists, and pharmacist practitioners) employed by the Indian Health Service or Indian health programs will offer 20 hours of continuing education designed to meet the needs of those providing primary care to American Indians and Alaska Natives. Note the date change from the November announcement in *The IHS Provider*. An agenda will be available in spring. This year there will be a business meeting open to all advanced practice nurses June 7-8 before the beginning of the continuing education portion of the meeting, which will start at 1 pm on Tuesday, June 8. Additionally, there will be a CE track for certified registered nurse anesthetists during the entire conference. There will be a registration fee of $150 of those employed by compacting tribes or those in the private sector. For additional information, contact the IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016; phone (602) 640-2140.

For abstract consultation or registration information, contact Ms. Linda Arviso-Miller at (505) 248-4142; fax (505) 248-4384; or e-mail *linda.arviso-miller@mail.ihs.gov.*

POSITION VACANCIES □

Editor's note: As a service to our readers, The IHS Provider *will now publish, on a space available basis, 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. At this time we do not plan to run ads for "positions wanted." The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Family Physician
Espanola (Santa Fe) New Mexico

The Santa Clara Health Center, Santa Fe Service Unit, has an immediate opening for a job sharing (half time) Civil Service family practice physician. The practice is in an ambulatory setting providing care to Pueblo Indians. The current physician/partner would like a colleague who is interested in considerable schedule flexibility and minimal night call (currently one night every two months, possible less in the future). For a physician interested in working part time, this is an outstanding practice opportunity in a culturally diverse and beautiful area. For further information, please contact Len Shulman, MD at the Santa Clara Health Center, RR5, Box 446, Espanola, New Mexico 87532; telephone 505-753-9421 (Health Center), or 505-989-9342 (home).

Clinical Director
Belcourt, North Dakota

The Quentin N. Burdick Memorial Health Care Facility has an immediate opening for a Clinical Director. The Turtle Mountain Area is a wooded area with hundreds of lakes and ponds located in north central North Dakota. This well-equipped medical facility offers a competitive salary, including Title 38 bonuses. There is no overhead; housing is available. The Quentin Burdick Hospital is JCAHO accredited, has an excellent surgery program and CT scan availability, and is an IHS loan repayment site. For more information, please contact Lancelot R. Azure at (701) 477-8658, or you may mail your curriculum vitae to Quentin N. Burdick Memorial Health Care Facility, attn.: Service Unit Director, P. O. Box 160, Belcourt, North Dakota 58316. No J-1 applicants, please.

Clinic Administrator
Pauma Valley, California

Seeking individual to assume the key role of administrator of a health center. Minimum five years executive level experience in a health care environment, tribal health administration experience required. Financial and analytical background desirable. Will be responsible for overseeing the development of the program and so must possess superior interpersonal and leadership abilities, Master of Public Health or Business Administration. Send resume and salary history to IHC, attn.: HR, P. O. Box 460, Pauma Valley, California 92061. Phone (760) 749-1410, ext. 304; or fax (760) 749-1564.

Clinical Nurse
Whiteriver, Arizona

Come to the beautiful White Mountains of Eastern Arizona. Opportunities for skiing, hunting, fishing, and other activities abound. The Whiteriver Service Unit, on the Fort Apache Indian Reservation, provides care to eligible patients requiring health care services. We are a progressive unit with several new services added within the past year. We want to make you part of our team! Positions for RNs exist on the pediatric, obstetrics, and adult care units, and are rotating day and night, with 12 hours shifts the primary tour. Employment is Federal Civil Service on the General Schedule scale and the positions are graded GS-7 and 9. Salaries range from $35,446 to $49,428 (pending scale). Federal benefits are part of the employment package. For information, contact Donna Huber, RN, Nurse Executive, P. O. Box 860, Whiteriver Arizona 85941; or telephone (520) 338-4911.

House Nurse Manager/Supervisor
Whiteriver, Arizona

The Whiteriver Service Unit has an immediate opening for a house manager/house supervisor. This position provides administrative supervision to the Nursing Department and other ancillary departments, primarily after normal business hours. To be considered, each applicant must have experience in a variety of nursing settings, including emergency, obstetrics, and inpatient medical. The incumbent coordinates patient care activities, including arranging transport of patients to referral facilities. This position is a GS-10 Nurse Specialist, with a starting salary of $42,208. For more information, please contact Donna Huber, RN, Nurse Executive, P. O. Box 860, Whiteriver, Arizona 85941; or telephone (520) 338-4911.

INDIAN AGING CONFERENCES OF INTEREST □

American Medical Directors Association 1999 Annual Symposium
March 4-7, 1999 Orlando, Florida

The theme of this year's meeting is "Our vision for long term care: preserving integrity and promoting innovation" in the context of the physician's dual role as caregiver and administrator. This is an excellent meeting for physicians who serve as Medical Director or attending physician in extended care facilities. The meeting will be held at the Disney World Dolphin Hotel in Orlando, Florida March 4-7, 1999. For more information, call (410) 740-9743.

Geriatric Medicine for the Family Physician
October 7-10, 1999 Albuquerque, New Mexico

"Geriatric Medicine for the Family Physician," a conference sponsored by the American Academy of Family Physicians (AAFP), will be held October 7-10, 1999 (Balloon Fiesta weekend) in Albuquerque, New Mexico. This course is billed as an update in geriatric medicine as well as a way to help prepare physicians to sit for the Geriatric module of the ABFP recertification examination or the Geriatric CAQ recertification exam. For more information, call (800) 926-6890, or Fax: (816) 822-8372.

Geriatric Medicine for the Family Physician Audio CME

This is comprehensive geriatrics review course on audiotape, approved for 32.5 hours of CME credit. It is available from the American Academy of Family Physicians (AAFP) by calling (800) 926-6890 or Fax: (816) 822-8372.

YEAR-END INDEX □

Major Subjects and Titles, Volume 23, January through December 1998

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 (1-800-272-47887) 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.

Kasprow WJ, Rosenheck R. Substance use and psychiatric problems of homeless Native American veterans. *Psychiatric Services.* 49(3):345-50, 1998 Mar. 98184708

Powers DR, Wallin JD. End-stage renal disease in specific ethnic and racial groups: risk factors and benefits of antihypertensive therapy. [Review] [79 refs] *Archives of Internal Medicine.* 158(7):793-800, 1998 Apr 13. 98213407

Pedersen SC, Anton SC. Bicoronal synostosis in a child from historic Omaha Cemetery 25DK10. *American Journal of Physical Anthropology.* 105(3):369-76, 1998 Mar. 98204639

Nagi DK, Foy CA, Mohamed-Ali V, Yudkin JS, Grant PJ, Knowler WC. Angiotensin-1-converting enzyme (ACE) gene polymorphism, plasma ACE levels, and their association with the metabolic syndrome and electrocardiographic coronary artery disease in Pima Indians. *Metabolism: Clinical & Experimental.* 47(5):622-6, 1998 May. 98252431

Newbold KB. Problems in search of solutions: health and Canadian aboriginals. *Journal of Community Health.* 23(1):59-73, 1998 Feb. 98187474

Long CR, Curry MA. Living in two worlds: Native American women and prenatal care. *Health Care for Women International.* 19(3):205-15, 1998 May-Jun. 98263595

Imperatore G, Hanson RL, Pettitt DJ, Kobes S, Bennett PH, Knowler WC. Sib-pair linkage analysis for susceptibility genes for microvascular complications among Pima Indians with type 2 diabetes. Pima Diabetes Genes Group. *Diabetes.* 47(5):821-30, 1998 May. 98247870

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