THE IHS PRIMARY CARE PROVIDER

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

March 2002 Volume 27, Number 3

Scratching the Surface: Evolving Domestic Violence Screening in One Service Unit

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Problem Definition

Women in the U.S. are more likely to be injured, raped, or killed by a current or ex-male partner than by all other types of assailants combined.[1] During the 1990s, it became increasingly clear that the medical community should be on the front line in the identification of and intervention in domestic violence (DV).[2] In 1991, the American College of Obstetricians and Gynecologists developed the first informational packet on domestic violence that was to be distributed by a national medical society.[3] The Joint Commission on Accreditation of Hospitals and Health Care Organizations (JCAHO)[4] has required hospitals to have protocols for the identification and treatment of abused women since 1992. By 1996, the American College of Emergency Physicians published guidelines for both emergency physicians as well as for Emergency Medical Service providers encouraging a formal response to domestic violence patients.[5]

Other medical professions, from primary care physicians to registered nurses, soon followed suit. Professional associations established formal guidelines and policies for their members to screen, treat, and refer patients for assistance related to domestic violence. However, education and training regarding domestic violence was generally lacking in medical education.[6] Education is essential: providers need to recognize warning signs as well as know how and what to ask. Education and training efforts presume that the single, most valuable contribution a medical provider can offer is to identify and acknowledge the abuse.[7] Within the past decade, however, it became clear that while education may initially raise awareness, without formalized policies to screen and refer for domestic violence, recognition and response to domestic violence would falter over time.[8] Protocols make the education substantive; content becomes *need to know* instead of just *nice to know.*

By the mid-1990s, the Family Violence Prevention Fund (FVPF) had created a model based on the premise that training, policy, and protocols are three equally important compo-

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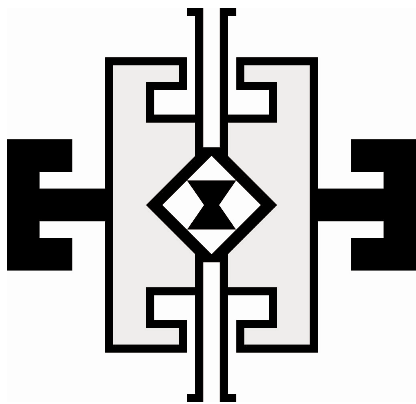
nents in establishing a long-term, sustainable program to address domestic violence in the medical setting.

Background: New Mexico

Domestic violence-related activities at the Indian Health Service (IHS) Hospital in Albuquerque (referred to as Albuquerque Indian Hospital, or AIH) occurred concurrent with many of the state and national DV activities. One team member (DC) became concerned about this issue working in the AIH Urgent Care Clinic and began researching this topic. Research in New Mexico indicates that Native American women are at significant risk for domestic violence. According to the U.S. Census, Native American women comprised 3.14% of Albuquerque's female population in 1990; however, Native American women made up 14.2% of the residents at a local Albuquerque domestic violence shelter in 1996.[9] A study conducted by the University of New Mexico's Department of Emergency Medicine found that New Mexico Native American women are at higher risk for domestic-violence related homicide than Hispanic and non-Hispanic white women.[10]

Evolution of AIH Domestic Violence Activities

Discussions with two nurses with similar concerns led to the formation of a DV team at AIH. Formal invitations were sent to each AIH department head with the hope that each department would send one representative to form a multidisciplinary team. Many of the individuals who initially expressed interest in belonging to the domestic violence team had a personal desire to know what to do and what to say when they encountered signs of violence and abuse.



The initial team consisted of a doctor, a social worker, two nurses, a health educator, an x-ray technician, a nurse administrator, and a security officer (five women and three men). They began monthly meetings in May 1997, and spent part of most meetings with a guest speaker from one of several advocacy groups in Albuquerque and the surrounding pueblos. Turnover in the team has lead to the loss of some members and the gain of others from other departments, e.g., pharmacy and lab, as well as a Masters in Public Health graduate student (CM). The core group, consisting of the original doctor, social worker and two nurses remains. They are Donald Clark, Kathy Manygoats, Marlene Lamebull, and Terry Williams .

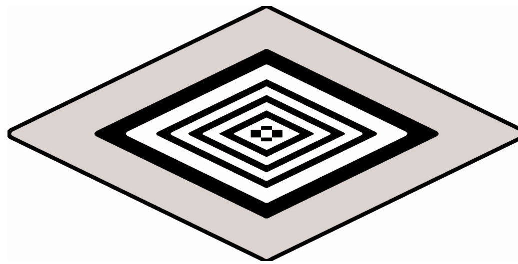
Members of the team wanted to institutionalize the service unit's (SU) response to DV, that is to make DV screening as natural as taking blood pressures and temperatures in triage. To that end the team chose three goals: to make AIH a safe place to talk about and obtain information regarding DV, to develop formal methods of identification and referral of DV, and to learn about available community resources. We restricted ourselves to the patients visiting the hospital and excluded those visiting the Albuquerque Service Unit's field clinics, recognizing that different methods may be required in rural settings.

The initial months were busy with several simultaneous activities. The team:

- Invited a guest member from a local DV advocacy group
- Struggled with the definition of domestic violence and whether and how to include other forms of family violence in our committee's efforts
- Developed a screening tool
- Wrote policies and procedures for DV screening and referral with an evaluation component
- Discussed the details (when and where) of screening.

At about the same time, New Mexico was chosen as one of ten states to introduce the Family Violence Prevention Fund's National Health Initiative. Two AIH staff members (DC and KM) joined the state task force and underwent training in this model in October 1997. The information obtained at this training included copies of hospital and emergency room policies and procedures and samples of screening instruments. These templates helped the team to finish the initial tasks much more quickly.

Two major decisions are critical in any domestic violence screening program. One is how to screen, i.e., verbally or with a written questionnaire, and the second is determining which women to screen. Although some literature suggests that verbally screening patients for violence is more effective than a written history form,[11] the AIH team selected the written tool, reasoning that a written screen would be more consistent to implement across the SU and would provide documentation for quality control evaluation. The other major decision was



whether to screen all women who come to the facility at each visit or to screen only at specific times and in certain clinical situations. These two approaches are known as universal and targeted screening, respectively.

Over 7,500 women 18 years of age and older made about 47,000 outpatient visits to AIH for their own concerns in 1996; these estimates do not include times that adult women brought children or elders to the clinics, nor does it include any visits to field clinics. Our initial plan was to screen adult women in targeted situations, specifically at visits for well woman care, contraception counseling, pregnancy, or any injury. But a Resource Patient Management System (RPMS) review of visits during 1996 showed that only half of the women visiting AIH in 1996 came for these reasons. This realization changed the focus of our screening efforts to universal screening.

As a result of this change we dropped our previous screening tool, which was lengthy and meant to be educational. Instead we adapted McFarland's three-question screen[12] because of its brevity and proven sensitivity and specificity. This screen was described in the October 1993 *IHS Provider*.[13] The three questions relate to physical abuse in pregnancy, physical violence in the past year, and a question regarding unwilling or forced sex in the past year. Specific guidelines for administering the tool include:

- The screen is not to be administered if it might increase a woman's danger. Therefore it is only administered if someone old enough to talk does not accompany the woman.
- Nursing staff administers the screen when the patient is placed in an exam room while waiting to see the medical provider. The nurse explains that the screen is voluntary, that it is part of her confidential medical record, and that the medical provider will follow up any positive responses to the screen.
- The nurse verbally administers the screen if reading or language barriers preclude an individual from responding to the written screen.
- If the screen had been administered at a recent prior visit, the nurse asks if there's been a change since the screen.
- The nurse notes on the Patient Care Component (PCC) if the screen was given, declined, declined because there is no change from recent screen, or if the screen was not given because the patient is not alone. The nurse initials these notations.
- The intervention for a positive response includes acknowledgment of the abuse and its probable continued escalation, discussion of a safety plan, and offering information regarding resources and advocacy within AIH and the local community. Referrals are made only at the patient's request.

The team's main concern was that the screening process would offend patients. We initiated a two month pilot period (January and February, 1998) using this screening tool in different primary care settings: Urgent Care, a well woman and prenatal practice, and in an internist's and a family doctor's primary care clinics. Four providers performed these screens, two male, two female; three physicians and one nurse practitioner. We were relieved that no patient expressed anger or offense, and that several expressed gratitude for the screen. The service unit formally adopted the DV screening policies and procedures on March 1, 1998.

Two problems became apparent almost immediately. The Albuquerque Area went through JCAHO accreditation in April 1998. During the second DV team meeting in June 1997, the administrative nurse coordinating the service unit's JCAHO recertification activities directed the team to develop policies and procedures as soon as possible in preparation for recertification. This pressure turned out to be both good and bad. It forced the team to focus on the policies and procedures; however, we neglected staff education due to time constraints, and did not keep other staff informed about our activities and proposals. The idea of DV screening was generally well received by the medical and nursing staffs, but universal screening was initially opposed as just one more thing to do, and as competition for other public health priorities such as alcohol abuse screening.

We did not appreciate the lifetime prevalence of DV among the friends and families (extended or immediate) of our staff, and the resulting discomfort experienced in asking about this particular problem. The team members quickly learned

how to refer staff to the Employee Assistance Program (EAP), if they desired; however, most of these discussions took place off the record between the two nurse team members and staff who expressed personal difficulty with this subject. Both the nurses were approachable and willing to conduct one-on-one training for those who wanted it. Over time, most staff members came to feel comfortable and competent in screening for domestic violence.

The medical staff's initial comments fell into two general categories. Universal screening was thought to be impractical because of competing public health priorities; it should be targeted at certain times or for certain types of visits. There was also a feeling that if the nurses do not administer the screen, then it just won't get done; routine aspects of a clinical visit should be addressed by nursing standards of care.

Concurrent with these AIH domestic violence-screening activities, AIH was one of a dozen sites in New Mexico competitively selected to participate in the FVPF model domestic violence program training. Five members of the AIH team attended a three-day training in June 1998. Each NM team was at a different stage of DV intervention, some just starting, others with well-developed policies and procedures. The teams applied the model to the unique concerns of each site's service population and each team's stage of development. This training helped the AIH team members to be on the same page and provided goals for further development of DV activities, such as the staff seminars.

As a result of the resistance encountered among service unit staff, and with information obtained in the statewide training, the team placed more emphasis on AIH staff education in service unit-wide and department-specific training activities. Seminars included information learned during the monthly committee meetings, and used several community advocates as speakers. These training activities included general information about DV and resources, including EAP. They provided a forum for staff to raise issues, such as the portability of temporary restraining orders on and off of reservations, and legal obligations to report DV for adult and teenage victims. Seminars were tailored to specific department's needs; for example, some seminars included role-playing exercises to decrease discomfort with this topic, while others addressed documentation of domestic violence in the medical record, the use of diagrams like the SF 531 body map (available through medical records), and Polaroid cameras for documentation.

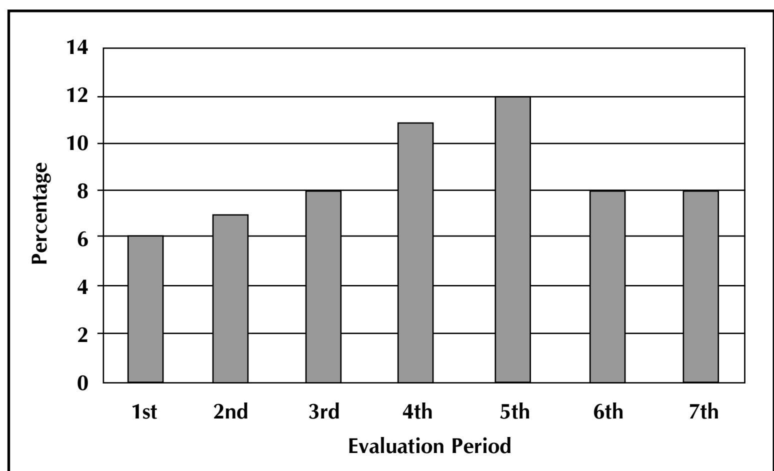
No informational packets for victims of DV available locally contained Native American-specific information. We developed a wallet-sized trifold with a brief safety plan, as well as phone numbers of DV agencies and resources, to distribute to patients and to place in exam rooms and bathrooms in the clinic.

We expected DV screening to catch on more quickly than it did. We thought that we could decrease discomfort around this issue with education and concrete recommendations regarding what to say and do when providers encounter a positive screen. We confidently believed that everyone would see the importance of this issue once they had identified a few victims of DV and capably handled the encounters. We thought a kind of virtuous circle of positive feedback would result once a critical mass of nurse and medical providers began to see the positive effects of their efforts.

In keeping with these preconceptions, the team developed a periodic quality assurance review to identify which nurses and physicians administered the domestic violence screen and to provide periodic reminders and information to the hospital management regarding the team's sustained activities. DV team members meet every six months for an intensive four hour review of medical charts, which reflects a random selection of 10% of charts of female patients ages 18 years and older from the AIH patient data base, resulting in a review of about 700 charts. Each member tabulates which physicians and nurses utilize the domestic violence screen. The results are compiled and reported at medical staff and nursing meetings.

The virtuous circle has yet to occur. Granted, more providers were screening patients for domestic violence. During the first six-month period, only 6% of visits by female patients 18 years and older were screened for domestic violence. By the fifth six-month review, the percentage of visits of adult female patients screened had increased to 12%. While the concept of positive feedback was not entirely abandoned, we hoped that we would reach a critical mass of providers when the implementation of the screen became a part of the nursing evaluation in June 2000, 2½ years from the time the screen was first pilot tested. Despite this, by the 6th and 7th evaluation periods, i.e. at the end of 3½ years, the percentage of visits screened for DV had dropped back to 8% (see Figure 1).

Figure 1. Percentage of visit screened for domestic violence



We believe other factors contributed to this decline in screening, including the fact that AIH has been going through downsizing since December 1995, with accelerating changes

since May 2000. This has impacted staff morale in many ways, but the main effect this has had on DV screening is in nursing personnel turnover. Since May 2000, the service unit has relied heavily on contract nurses who may not be familiar with our protocols. In addition, the number of nurses staffing Urgent Care is fewer, whether contract nurses or not. On busy days, there is barely enough time for nurses to call patients to rooms, let alone to spend a minute orienting the patient to the screening tool. Further changes in the AIH outpatient delivery system expected over the next one to two years may have even greater effects on DV screening. Lastly, it is doubtful whether domestic violence screening at AIH would survive if the DV Team lost its core members. No other staff members have expressed the commitment to carry on the Team's activities, despite the interest and participation in the Team's activities shown by many employees at Albuquerque Indian Hospital.

Two other DV-related activities have occurred at AIH. The DV team hosted a meeting of field clinic DV teams and community DV advocates in June 2001, which resulted in the sharing of information among the different programs, and members attending each other's meetings and workshops. This has already benefitted patients, since many DV victims from surrounding Native American communities seek care at AIH. Knowledge of local community resources helps staff advise these patients.

In addition, the Service Unit's Maternal Child Health (MCH) committee revised the Prenatal form in April 2000 to include DV screening at the first prenatal and 28 weeks visits. The revised form includes a reminder to screen for DV and alcohol/drugs. Screening in this fashion has proved remarkably successful. The percentage of prenatal patients screened for domestic violence at least once during pregnancy rose from 58% to 87%. The MCH committee chairman feels the success is due to the routine nature of the screening, and the fact that the reminder to screen is printed on the prenatal form.

Such routine inclusion of reminders on the PCC form may be possible with PCC+ with an option to include a printed reminder to screen for domestic violence on a service unit's visit form in the near future. PCC+ is undergoing final testing at this time before widespread implementation throughout the IHS.

AIH Accomplishments and Challenges

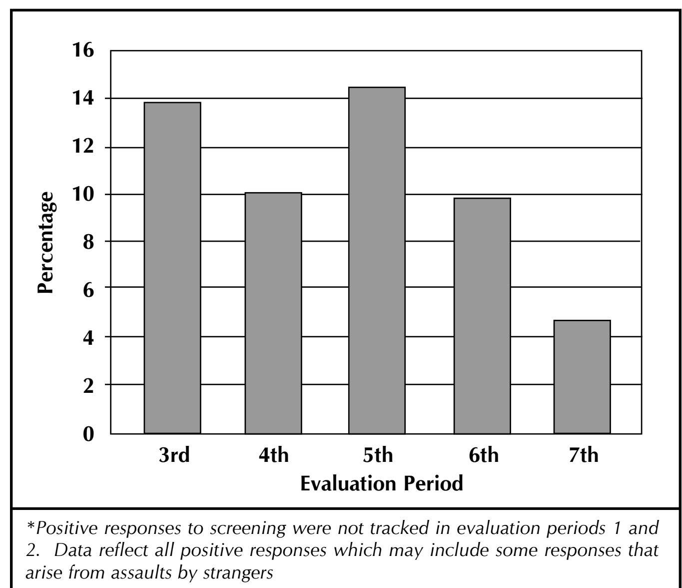
In the general sense, the AIH team's three broad goals have been accomplished. AIH is a safe environment for patients to ask about and be referred to resources for domestic violence. The team has also made significant inroads in establishing a system-wide approach throughout the outpatient clinics in addressing domestic violence. Policies and procedures for DV screening are in place, and an evaluation mechanism has been used consistently. Lastly, each member of the team has learned about issues and local resources to identify, treat, and refer patients with problems related to domestic violence. This information has been folded into the treatment and referral of patients, and shared with other staff.

In the more particular sense, AIH can document success in the following:

- Providing training on domestic violence for medical and nursing providers and raising awareness at departmental and staff meetings
- Making materials and resources available in waiting areas, exam rooms, and women's bathrooms

The overarching goal to institutionalize the identification and treatment or referral of victims of DV remains elusive. This is especially frustrating because all preliminary information indicates that screening is effective in identifying victims of domestic violence. At least 4% of the screens, usually more, come back positive. Figure 2 shows the percentage of positive responses to the domestic violence screens identified in the periodic evaluations.

Figure 2. Percentage of screens that were positive*



**Positive responses to screening were not tracked in evaluation periods 1 and 2. Data reflect all positive responses which may include some responses that arise from assaults by strangers*

Suggestions and Recommendations

As mentioned previously, policies without actions are meaningless. Most IHS facilities have policies for DV.[14] What might be missing is education about DV for staff, along with periodic review mechanisms to monitor the implementation of the policies.

The good news is that several model DV policies and procedures are available to choose from. You do not need to reinvent the wheel, but some thought should be given to what is feasible in your facility. A cookie-cutter DV policy cannot be applied to all hospitals and clinics.

If your facility is large enough to have a multidisciplinary team to coordinate DV efforts, this would be helpful. The perspectives of various departments guided our planning of the logistics of DV screening. Teamwork has other values, too. As individual team members come and go, the team itself can

retain institutional memory regarding what has been done, what has worked and not worked. A team is also good for moral support. A project of this nature is hard work, emotionally difficult, and often discouraging. Team members offer each other support in this emotionally charged issue. Throughout the process, the community advocate is an invaluable source of information to community resources.

Invite your hospital or clinic's administration to send a team member. If that is not possible, take time to keep the administration informed of the team's activities and obtain their support. One of our team members became the Albuquerque Service Unit Director. Her understanding of our activities has helped smooth the way at several steps. For example, our team was concerned that evening clinic staff would not come to morning training activities. The Service Unit Director instructed department heads to offer overtime for this event.

If your facility is a small clinic or health center, consider a larger service unit-wide team that includes representatives from the field clinics. Pooling resources, even if only clerical assistance, can go a long way toward lightening the workload. Field clinic staff can also develop or join teams that include other community agencies.

Talk and listen to your colleagues. Keep them apprised of the team's work and progress, and listen to feedback.

It is clear that screening for DV will have to change as the system changes. Flexibility and adaptation are critical as we continue to find how best to screen for domestic violence with the resources available and in whatever situations we work in. □

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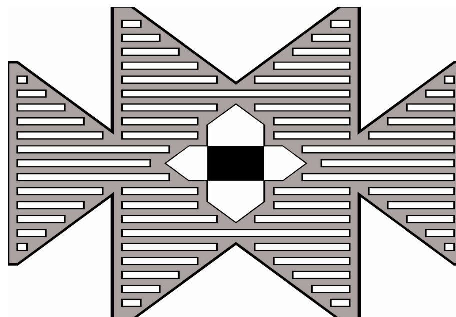

The Native American Cardiology Program: A Collaborative Approach to Subspecialty Cardiology Care

James M. Galloway, MD, FACP, FACC; Eric A. Brody, MD, FACC; Beth Malasky, MD, FACC; Neil Freund, DO, FACC; all from the Native American Cardiology Program, Tucson, Arizona

Cardiovascular disease has emerged as the most common cause of death for American Indians and is now the focus of a major initiative for prevention activities for tribes and urban programs, as well as for the Indian Health Service. Cardiovascular disease has also become a major cause of disability and hospitalization, as well as an indication for both inpatient and outpatient procedures, resulting in increasing expenditures of our limited Indian Health Service (IHS) and tribal Contract Health Service funds. As a result, a need for aggressive treatment and prevention activities has been recognized by the tribes as well as by the IHS.

Prior to the initiation of the Native American Cardiology Program (NACP), the only specialized cardiology care available for American Indian patients throughout much of the country, including the southwest, was from private cardiology groups, generally available at great distances from the patients' homes and reservation-based clinics. The care was not comprehensive and often consisted of a single visit, typically lacking continuity of care, cultural sensitivity, and a vision of coordinated prevention activities. Services obtained from multiple providers were poorly coordinated and lacked a systematic approach to the development of prevention activities; as well, there were few incentives to control medical costs.

Recognizing these needs, the NACP was started in 1993 at the University of Arizona as a collaboration between the Navajo, Phoenix, and Tucson Areas of the Indian Health Service. The program was developed to provide direct cardiovascular care to Native Americans on-site at reservation clinics, as well as to provide tertiary care for complex cardiovascular disease in Tucson. It has evolved to become a unique collaboration between the Indian Health Service, the University of Arizona, the University Medical Center, the Flagstaff Medical Center, the Southwestern Arizona Veterans Administration Healthcare System, as well as Native American tribes and communities. Many of the staff comprising the NACP are employed by our partner organizations and are subsequently assigned to the NACP under the direction of Dr. Galloway and staff.

The mission of the NACP is to promote cardiovascular health and wellness through state-of-the-art treatment, education, and prevention for Native American patients throughout the southwest. The NACP employs primary and secondary prevention measures in an effort to stem the rising epidemic of cardiovascular disease and diabetes now afflicting Native American communities. The research arm of our program focuses entirely upon tribally requested evaluations related to the epidemiology of cardiovascular disease among Native Americans, prevention strategies for decreasing cardiovascular disease and diabetes in Native Americans, as well as evaluations of the effectiveness of these strategies.

The NACP has realized significant benefits through its association with the Sarver Heart Center at the University of Arizona, including the availability of additional manpower support, programmatic support, recruitment potential, and the increased academic vigor derived from an academic center. The NACP has also achieved many similar benefits through its association with the the Southwestern Arizona Veterans Administration Healthcare System, enjoying the additional advantage of the cost savings realized from the utilization of another federal facility for subspecialty services performed by IHS physicians. The recent association and partnership with the Flagstaff Medical Center has expanded these benefits as well as the diagnostic and therapeutic interventions available to our patients through this program. Generous private donations have provided support for diagnostic and other equipment related to direct patient care as well.

The NACP now supports over 30 hospitals and clinics in Arizona, Nevada, New Mexico, and Utah. We hold clinics, including on-site echocardiography, in field hospitals on a regular basis. The program offers multiple services from a distance, including both telephone consultation and telemedicine services. The latter include distance cardiology clinics through real-time telemedicine, Doppler, two dimensional, and color tele-echocardiography, as well as dobutamine stress echocardiography provided at a distant field site, which we can oversee real-time from our offices in Tucson and Flagstaff.

The NACP actively supports primary care providers in the field through continuing education sessions held in conjunc-

tion with cardiologist visits, by teleconferences in the hospitals where this is available, and through the annual IHS cardiology conferences hosted by the NACP. Project staff serve as faculty at conferences throughout the country discussing cardiovascular disease and its risk factors and prevention in Native Americans. The NACP regularly hosts rural physician and mid-level provider training for IHS and tribal employees at the university, where participants can learn about stress testing, pacemakers, ICU management, cardiac evaluation and treatment, and echocardiography.

The NACP focuses on the provision of exemplary health promotion and disease prevention activities while providing high quality, culturally sensitive and appropriate cardiology services to our American Indian patients and their families. This includes the integration, when desired, of traditional healing services. The program orchestrates individual and regional cardiology prevention services and publishes guidelines, including primary, secondary, and tertiary prevention services, and registries. National IHS cardiovascular prevention guidelines on lipid management have recently been released and are available on the Internet at *http://www.ihs.gov/MedicalPrograms/Cardiology/LipidGuidelines.pdf*. Other guidelines are currently under development.

Continuity of care is a vital component of these services, and this is managed in Tucson and in Flagstaff as well as locally at reservation and urban facilities. Contract Health Service expenditures for cardiology care have been significantly reduced through assurance of the appropriate utilization of diagnostic studies, patient evaluation, and medication use. However, the major benefit has been a marked improvement in the quality of care provided to the Native American patients we serve.

The NACP maintains several Area registries, including a Pacer Registry for all Native American patients with pacemakers throughout Arizona. There are over 150 active patients in the Pacer Registry. Physicians at multiple sites in the field have been trained to evaluate and analyze pacemakers using facilities at the local and neighboring hospitals and clinics, and we assist in their oversight. The on-site pacer checks in Tucson and Flagstaff are provided through NACP medical staff and emphasize direct communication with the patients' primary care physicians on the reservations. The program also provides patient assistance with logistics and cultural issues.

Perspectives on Native American Cardiology

Despite the historical absence of significant levels of coronary artery disease in Native Americans,[1] cardiovascular disease is now the leading cause of death in Native American people. Recent data confirm the clinical impression of a dramatic increase in coronary artery disease recognized by many of us in the field caring for adults in Indian country, whether we are in the field of family practice, internal medicine, emergency medicine, or cardiology.[2] Indeed, data from the Strong Heart Study reveal that the incidence of cardiovascular disease among Native Americans is now almost twice that found in the general U.S. population.[3] In addition, other studies clearly indicate that this worrisome trend is significantly increasing,[4] placing higher priorities on aggressive acute management and prevention.[5]

Furthermore, few areas of clinical medicine are evolving as quickly as the clinical management of cardiovascular disease. This rapid change demands considerable effort in order to remain current with the emerging literature, guidelines, and recommendations being developed by a multitude of sources. Therefore, we at the Native American Cardiology Program feel that we may be able assist by offering succinct reviews of some pertinent cardiovascular issues on a periodic basis in The IHS Provider, covering such topics as primary and secondary prevention, diagnosis, acute and chronic therapy, as well as the epidemiology of cardiovascular disease in Native Americans.

In our first article, we present an introduction to the Native American Cardiology Program, a successful regional subspecialty program. This, then, is the first of a number of articles and reviews we at the Native American Cardiology Program, as your partners in Indian health, will offer for your review. We hope you will find this series helpful to you and the patients we mutually serve.

James M. Galloway, MD, FACP, FACC

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Patients at high cardiovascular risk due to valvular disease, severe coronary artery disease, or other cardiovascular disease, but who are not yet at the point of needing invasive intervention, are also maintained on high risk registries to assure they do not get lost to follow-up.

Anticoagulation levels of affected Native American patients are monitored by the NACP nursing staff. The nurses work directly with the medical and laboratory staff on the reservations, monitoring anticoagulation levels and initiating intervention activities, if necessary, through the public health nursing staff. We are proud that many facilities serving Native Americans have now developed their own anticoagulation clinics for the patients they serve.

Rural public health nursing (PHN) services following hospitalization are coordinated by the Native American Cardiology Program staff in concert with service unit or tribal staff. Upon discharge of our inpatients, the PHN staff is advised by our program of the patient's present status and is instructed about follow-up procedures to ensure they receive the appropriate medications and specialized treatments they need.

The staff of the Native American Cardiology Program is comprised of Dr. James Galloway; Dr. Eric Brody; Dr. Beth Malasky; Dr. Neil Freund; Dr. Robert McNamara; Laura Koepke, ANP-C; Betsy Painter, FNP; Terri Wilson, RN; Phyllis Sanderson; Carol Locust, PhD; Diane Steuart; Lin Lawson; Julie Bursell; and Juanita Ortegas.

Ms. Donna Shalala, then Secretary of the Department of Health and Human Services, awarded the Native American Cardiology Program and its staff the "Secretary of Health and Human Services Award for Distinguished Service" for its "innovative delivery of comprehensive cardiovascular care for Native American people through exceptional teamwork and collaboration with academic, federal, state, private and tribal institutions." Dr. Galloway and the NACP have been recognized by the Hopi Tribe for the "Outstanding Provision of Health Services" and by the Tucson VA Medical Center for "Distinguished service in the delivery of healthcare to Native people."

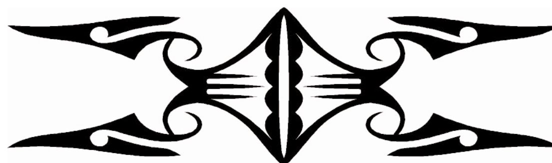
The program has also been honored by two Exemplary Group Performance Awards from the Phoenix Area of the Indian Health Service. Most recently, the Arizona Hospital and Healthcare Association awarded the prestigious Salsbury Award to Dr.Galloway in recognition of his dedication, leadership, and outstanding contributions to the health of the people of Arizona through his efforts with Native Americans.

The Native American Cardiology Program serves as an example of regional subspecialty care provided by the Indian Health Service and offers a model for the development of other focused, subspecialty services that could be shared between Indian Health Service Areas and tribal and urban programs, providing optimal services to a clinicians, hospitals, and clinics through coordinated and culturally sensitive Indian health care.

The Native American Cardiology Program is broadening its efforts to combat cardiovascular disease through a national initiative, with integration of its efforts with Indian communities and tribal prevention activities as well as the IHS Diabetes Program and other agencies such as the National Institutes of Health and the Centers for Disease Control and Prevention. Efforts to increase the awareness of the impact of cardiovascular disease in Native American communities, as well as the general medical community, are underway through publications and seminars.

Within Indian country, a series of intensive one-day seminars for clinicians focusing on the prevention, diagnosis, and treatment of acute coronary syndromes is being offered. The initial conference will be held in Flagstaff, Arizona on May 17, 2002. Another five conferences will be held in other parts of the country; the dates and locations will be publicized well in advance here in The Provider, as well as by direct notification of the nearby clinics and hospitals. We invite your participation in any of these conferences. All are presented at no charge to the participants.

We at the Native American Cardiology Program are available to you through our offices in Flagstaff at (928) 214-3920 or at the University of Arizona at (520) 694-7000. □



The Indian Health Service
14th Annual IHS Research Conference

WHEN: April 29, 2002 - May 1, 2002, Monday through Wednesday
WHERE: Sheraton Old Town Hotel, 800 Rio Grande Blvd.
Albuquerque, New Mexico 87104
FOR WHOM: People in Indian health systems and others in health system who are: Researchers, Health Care Professionals (including CHRs), Administrators, Health Board members, Tribal Council members, Traditional Healers and interested community members.

The 14th Annual IHS Research Conference, "Caring For All," will enhance our ability to ensure benefits of the research to Native communities and peoples. The conference will also examine in depth the impact of caring on research in American Indian and Alaska Native (AI/AN) communities.

Monday's presentations will focus on the impact of caring and discuss how to maximize research benefits and minimize harm to AI/AN individuals and communities, and how those involved can help plan the research to ensure benefits. We will highlight examples of helpful research by forming into small groups -- each with researchers, Tribal Council or Health Board members, community members, program administrators, and clinicians -- to discuss research in Indian country.

Tuesday (all day) and Wednesday morning sessions will focus on methods and results of current qualitative and quantitative research in Indian country.

The entire conference will stimulate both seasoned and new researchers with additional ideas they can use. The conference will also inform clinicians, health program administrators, community people, 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 problems they encountered and how they solved them, by presenting their own research and by reviewing results presented by others. This is an opportunity for people who have never or seldom presented research results to do so in a friendly and supportive environment at a national meeting. It is also an excellent opportunity to learn from one another.

The IHS has blocked 80 rooms under the "IHS Research Conference" at the Sheraton Old Town. Reservations must be made by March 29th by calling (800) 325-3535 or (505) 222-8700. The first 40 reservations will be a rate of $65/night plus tax, on a first-come, first-served basis. Thereafter, the rate will be $90/night, plus tax, which reflects the IHS conference allowable rate.

Individuals who want to present their research should prepare an abstract and send it to Orie Platero by March 29, 2002 (see Call For Papers). For those attending the conference and who will not be presenting research, please send or e-mail your registration form to: Orie Platero, at 801 Thompson Avenue, TMP 450, Rockville, MD 20852, telephone (301) 443-1492, e-mail *oplatero@hqe.ihs.gov*, or fax (301) 443-1522.

Certificates will be awarded to all attendees who register. The IHS Clinical Support Center is the accredited sponsor of this meeting. The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education, the American Nurses Credentialing Center Commission on Accreditation, and the American Council on Pharmaceutical Education.

The Sheraton Hotel has building accessibility for people with disabilities. If you need special accommodations, please call or note on the Registration/Abstract Form April 12.

14th Annual IHS Research Conference
Call for Papers - Abstracts

The 14th Annual Indian Health Service (IHS) Research Conference, sponsored by the Office of Program Support and the IHS Clinical Support Center (the accredited sponsor), will be held April 29 - May 1, 2002 at the Sheraton Old Town Hotel in Albuquerque, New Mexico.

Submit your oral or poster presentation for the following categories by March 29, 2002: Aging, AIDS, Alcohol and Substance Abuse, Alternative Healing Practices, 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, Women's Health, and Traditional Medicine. Research that measures the effectiveness of innovative environmental health or health care intervention, or that involves exemplary partnerships between researchers and tribes are encouraged.

Instructions for Preparing Abstracts:

1. You should share your research results with the tribe(s) involved in the research for tribal review and approval before presenting the results at the IHS Research Conference.
2. All abstracts accepted for either oral presentation or poster presentation will be reproduced in an abstract book for distribution. Therefore, all abstracts must have an identical format in a Word or WordPerfect file. Please follow the directions carefully on the following page.
3. Use the sample abstract form, next page, as a guide for size as you prepare your abstract. All copies must fit within the frame.
4. The abstract content should be structured as follows:
   - Title [bolded]
   - Authors [First name, Middle Initial, Last name] Note: Do not include degrees after the authors' names. Place an asterisk before the name of the presenting author.
   - Single space after the Title and Authors.
   - Single-space the text of the abstract with one continuous paragraph using Times New Roman 12 CPI.
   - The text should be no more than 250 words. Do not include figures, tables, equations, mathematical signs or symbols, or references.
   - Organize the text in the following manner and bold the Purpose, Methods, Results, and Conclusions
     - A brief Purpose statement or Background of the study
     - A statement of the Methods used (including number of subjects and other pertinent data)
     - A summary of the Results presented in sufficient detail to support the conclusion and
     - A statement of the Conclusion. (It is not appropriate to state, "The results will be discussed.")
   - Single space after the text of the abstract.
   - Add "For further information:" in bold, followed by the primary author's full name, official title, organization, address, telephone number, fax number, and e-mail address.
5. Please check the desired form of presentation: oral, poster, or either one.
6. Please fill out the biographical sketch on the next page and fax or mail it to the address below. Do not send a CV or resume.
7. **Abstracts must be received by close of business March 29, 2002.**
8. We will notify authors of the acceptance or rejection of their paper no later than April 5, 2002.
9. All abstracts should be sent to: Orie Platero, Conference Coordinator
   801 Thompson Avenue, TMP 450
   Rockville, Maryland 20852
   Telephone: (301) 443-1492; Fax: (301) 443-1552
   E-mail: oplatero@hqe.ihs.gov

Indian Health Service

14th Annual Research Conference

ABSTRACT TEMPLATE AND BIOGRAPHICAL DATA FORM

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

Background: Major needs in assessing care included: using existing data; and assessing primary care. We used "avoidable hospitalization" indicators to assess how well IHS primary care prevented avoidable hospitalizations. **Methods:** The avoidable hospitalization indicators were: TB, pertussis, cervical cancer, rheumatic heart disease, and asthma, complications of hypertension, influenza and pneumococcal pneumonia in 65 + year olds, infant gastroenteritis, and newborn disease due to isoimmunizations. The IHS inpatient database for years 1980-1990 provided the count of cases. The denominator was the IHS Service Population derived from the census 1980-1990 of American Indian and Alaska Native residents. We calculated the all US rates using the National Hospital Discharge Survey. **Results:** Hospitalization rates for most avoidable conditions decreased more than had all hospitalizations. However the rates of four conditions decreased less than all, and worsened relative to the change in the US: pneumococcal pneumonia for 65+ year olds, newborn hemolytic disease, hypoglycemia and asthma. **Conclusions:** IHS should investigate the epidemiology and the primary care of these conditions. Avoidable hospitalization indicators may detect changes in primary care or epidemiology rapidly and with good sensitivity.

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

Biographical Sketch (Please Type)

Primary Author/Presenter: ______________________________

As you would like it in the Conference Program

Mailing Address: ______________________________

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____

City/State/Zip: ______________________________

Phone Numbers: Work: ______________ Fax: ______________ E-mail: ______________

Secondary Authors: *(Name, Title, Place of Employment)* ______________________________

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Submitted for: [ ] Oral Presentation [ ] Poster Presentation [ ] Either

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

Indicate the major content area of your abstract:

[ ] Nursing	[ ] Medicine	[ ] Environmental Health
[ ] Community Health	[ ] Nutrition	[ ] Behavioral/Mental Health
[ ] Dentistry	[ ] Epidemiology	[ ] Other______________

IHS 14th Annual Research Conference
"Caring for All"

REGISTRATION FORM

The broad theme of the 14th Annual IHS Research Conference will be the impact of caring during research activities among Native communities and people. The conference will address caring and empathy issues by providing a forum for learning about American Indian/Alaska Native research activities; discuss research methods and research findings to improve the health of the people involved; involve American Indian/Alaska Native people in the research process; allow for dialogue between American Indian/Alaska Native participants of the research activity; and promote caring and sincere concern for human safety throughout the research process.

The conference will be held at the Sheraton Old Town, 800 Rio Grande NW, Albuquerque, NM, 87104, (505) 222-8700 or (800) 325-3535. Please reserve your room at the Sheraton by March 29 by referring to the "IHS Research Conference." The first 40 reservations will be a rate of $65/night, plus tax, on a first come-first-served basis. Thereafter, the rate is $90/night, plus tax, which reflects conference rate allowable charges. All government travelers must complete the actual subsistence form to be reimbursed the $90 rate.

NAME:____

TITLE: ____

ADDRESS: ______________________________________

____

PHONE: ________________ FAX: ________________ E-MAIL: ________________

Whom are you representing? (Check one):

[ ] Tribe Name:____________________________
[ ] University :____________________________
[ ] IHS Location:____________________________
[ ] Other Federal Government Agency:____________________
[ ] Other :____________________________

I will be attending the IHS Research Conference on the following days:

[ ] Monday, April 29, 2002
[ ] Tuesday, April 30, 2002
[ ] Wednesday, May 1, 2002

No registration fee to attend the Conference

IHS Research Conference Coordinator:

Orie Platero
801 Thompson, TMP 450
Rockville, MD 20852
Ph: (301) 443-1492
Fax: (301) 443-1522
E-mail *oplatero@hqe.ihs.gov*

The Sheraton Old Town is providing full access to attendees with disabilities. If you need special accommodations, please note on the Registration Form, or call us before April 12, 2002.

Diabetes Prevention Conference and Expo
April 4-5, 2002; Gallup, New Mexico

This meeting is sponsored by the Southwest Diabetes Prevention Research Center, the Gallup Indian Medical Center Diabetes Program, the RMCHCS Wellness Institute and Diabetes Management Program, the Navajo Area IHS, the Navajo Nation Special Diabetes Program, and the IHS Clinical Support Center (the accredited sponsor). The target audience is diabetes health care workers, health care professionals, and allied health care providers. Day one will highlight the results of the Diabetes Prevention Project, including an examination of the Lifestyle Balance curriculum; DPP principal investigator William Knowler, MD will be the keynote speaker on April 4. The conference will emphasize the use of motivational techniques to make diabetes prevention an achievable goal for patients. Day two will focus on the prevention of diabetes complications, with emphasis on motivational factors to help patients effectively control their diabetes. The Diabetes Expo will feature fitness demonstrations, the latest in diabetes education, and more.

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this continuing education activity for up to 9¾ hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the educational activity. This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse Midwives.

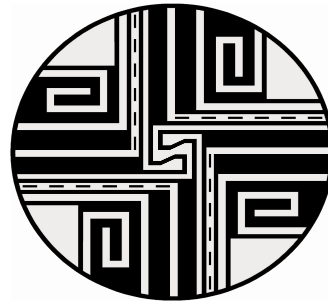
The Indian Health Service Clinical Support Center is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation, and designates this activity for 11.7 contact hours for nurses.

This conference is complemented by a partner conference taking place April 6; see below for more information.

There is a registration fee of $75; $100 after March 15 or on site. Exhibitors are invited to the Diabetes Expo; call for exhibit fees. For more information contact Rebecca Gray at GIMC; telephone (505) 722-1464.

Diabetes, the Dysmetabolic Syndrome, and Atherosclerosis 2002: Focus on Preventive Therapy
April 6, 2002; Gallup, New Mexico

This meeting is sponsored by the University of New Mexico Office of Continuing Medical Education, the Gallup Indian Medical Center, the Navajo Area Indian Health Service, the Navajo Nation Special Diabetes Project, the RMCHCS Wellness Institute and Diabetes Management Program, ant the



Southwest Diabetes Prevention Research Center. The target audience is licensed health professionals.

Featured speakers and topics include "Pathophysiology and Progression to Type 2 DM" and "Overview of Glycemic Therapies" by Patrick Boyle, MD; "The Dysmetabolic Syndrome" and "Lipid Therapy in DM and DMS" by Thomas A. Hughes, MD; "Diabetes, Endothelial Function and Vascular Disease" by Jonathan Abrams, MD; "Anti-Hypertensive Therapy in Diabetes" by Norman Kaplan, MD; "Diabetes, DMS, and Atherosclerosis in Native America" and "Treating Coronary Disease & CHF in Diabetics" by James Galloway, MD; and "Renal Diseases in Type 2 DM" by Andrew Narva, MD.

For more information contact Shawna at the UNM Office of Continuing Medical Education; telephone (505) 272-6568.

Education for Physicians on End-of-Life Care
April 5-7, 2002, Santa Fe, New Mexico; October 8-10, 2002; New Orleans, Louisiana

EPEC is Education for Physicians on End-of-Life Care. The goal of the EPEC Project is to educate all U.S. physicians about the essential clinical competencies required to provide quality end-of-life care. At the heart of the Project is the *EPEC Curriculum*. It provides physicians and other members of the interdisciplinary team with basic knowledge and skills needed to appropriately care for dying patients.

EPEC is now offering a 2 1/2 day program specifically designed for physicians and other members of the health care team to become EPEC trainers. Approaches to teaching the full *EPEC Curriculum* will be demonstrated, and the issues in the curriculum will be discussed so that you will be able to fulfill your obligation to implement EPEC in your organization or community. Each attendee will receive the two-volume Curriculum (Trainers Guide and Participant's Handbook).

Courses will be held April 5-7, 2002 in Santa Fe and October 8-10, 2002 in New Orleans. The Cost of the confer-

ence is $500. For more information call (312) 503-3732, or go to the EPEC website at *www.epec.net*. EPEC is supported by Northwestern University Medical School and the Robert Wood Johnson Foundation.

Colposcopy: Basic and Refresher Workshops
April 8-11, 2002 (Basic) and April 9-11, 2002 (Refresher); Albuquerque, New Mexico

The Indian Health Service Epidemiology Program announces its 2002 Basic and Refresher Colposcopy Workshops in Albuquerque, NM. The basic course will run from 7:30 am on April 8 until 1:30 pm on April 11. The refresher course will run from 1:30 pm on April 9 until 1:30 pm on April 11.

The Basic Colposcopy Workshop forms the foundation of a colposcopy training curriculum that also includes a supervised preceptorship at the service unit. The Refresher Colposcopy Workshop is a review and update of colposcopy and management of lower genital tract neoplasia. It is ideal for colposcopists still in their preceptorships and those practicing colposcopists who don't have the opportunity to see a large volume of high grade dysplasia or cancer in their practices.

Both target IHS, tribal and urban program providers. Tuition is $500 for the Basic workshop and $250 for the Refresher workshop. For more information or application materials, please contact Roberta Paisano, IHS National Epidemiology Program, 5300 Homestead Road NE, Albuquerque, NM 87110; phone: (505) 248-4132; e-mail *roberta.paisano@mail.ihs.gov*.

A Team Approach to Diabetes in Native Americans
April 9-11, 2002; July 9-11, 2002; and September 10-12, 2002; Claremore, Oklahoma

These diabetes workshops are offered by the Claremore Indian Hospital Model Site Diabetes Programand are designed for physicians, nurses, pharmacists, dietitians, and certified health educators who want to obtain continuing education units and enhance their knowledge about type 2 diabetes education. They are sponsored by the Claremore Indian Hospital and IHS Clinical Support Center (the accredited sponsor). Early registration is required due to limited enrollment; there are no registration fees. For more information, contact Eileen Wall, Diabetes Coordinator, at (918) 342-6446; or e-mail at *Frances.Wall@mail.ihs.gov*.

Geriatric Dentistry and Oral Health for Non-dentists Workshop
April 15-17, 2002; Albuquerque, New Mexico

The Indian Health Service, the New Mexico Geriatric Education Center, and the University of Texas will be cosponsoring a workshop featuring David Jones, DDS, MPH, the IHS Dental Consultant, who will teach the unique techniques of 'rural site' denture making. Geriatric principles, oral assessment in the nursing home setting, patient-based case presentations, and difficult denture patients are just a few of the topics in this 2½-day workshop. For those choosing the Oral Health for Non-dentists track, along with the geriatric principles, case presentations, and other topics will be home care assessment, and nutrition and oral health. A visit to a local Alzheimer's-specific skilled nursing facility will take place with oral assessments of patients.

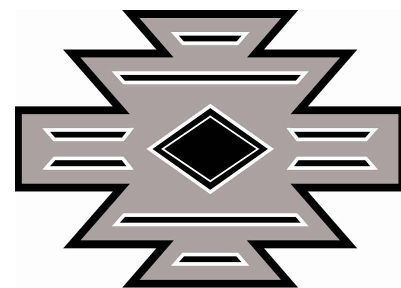
For more information or an application to register, contact Darlene Franklin at the NMGEC, telephone (505) 277-0911; fax (505) 277-9897; or e-mail *dfranklin@salud.unm.edu*. Those IHS or tribal providers who work with elders are eligible for a tuition waiver for the workshop; for all others, the tuition is $100. CDE and CME credit will be offered.

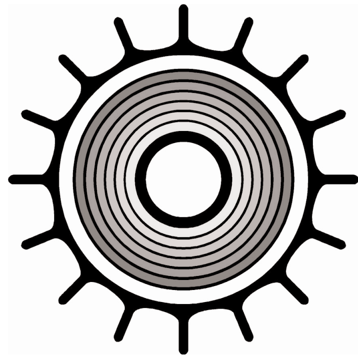
2002 Public Health Professional Conference
April 21-24, 2002; Atlanta, Georgia

This year's conference will be held at the Sheraton Atlanta Hotel in Atlanta, Georgia and is sponsored by the Commissioned Officers Association of the U.S. Public Health Service. The IHS Clinical Support Center is the accredited sponsor of the 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, *"Leading the Public Health Response to Disease and Disaster: Global Vision, National Action*." Sessions are sched-





uled from Monday, April 22 through Wednesday, April 24, and have been coordinated by the Scientific Program Planning Committee and Category Coordinators. The sessions on Wednesday, April 24 are structured as discipline-specific tracks. The Division of Commissioned Personnel, Program Support Center, is offering several personnel sessions on Sunday, April 21, including a Basic Officer Training Course (BOTC). The BOTC continues on Thursday and Friday, April 25 and 26, and a PHS Retirement Seminar will be held at that time as well.

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, at telephone (252) 726-9202; e-mail *lauriej@ec.rr.com*. The COA's website includes the full agenda, online forms for abstract submission, online registration forms, travel information, and more. Click on the "professional conference" button on the home page.

Advances in Indian Health
May 1 - 3, 2002; Albuquerque, New Mexico

The 3rd Annual Advances in Indian Health Conference is offered for primary care physicians, nurses, and physician assistants who work with American Indian and Alaskan Native populations at Federal, tribal and 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 populations, with an emphasis on southwestern tribes. Opportunities to learn from experienced career clinicians who are experts in American Indian and Alaska Native health care will be emphasized. Indian Health Service Chief Clinical Consultants and disease control program directors will be available for consultation and program development.

The meeting will be held at the Sheraton Old Town Hotel, 800 Rio Grande Blvd. NW, Albuquerque, NM 87104; telephone (505) 883-6300; fax (505) 842-9863. The special conference room rate is $89.00 single or double occupancy, plus tax. The deadline for this rate is March 31, 2002.

A Registration Form is posted on the UNM CME web site at *http://hsc.unm.edu/cme*. The conference brochure will be available in February 2002. To be on our mailing list, please call the Office of Continuing Medical Education at (505) 272-3942. The brochure will also be available, in February, on the UNM CME website. For additional information please contact Kathy Breckenridge, University of New Mexico Office of Continuing Medical Education, at (505) 272-3942 or Julie Lucero, Albuquerque Indian Health Service at (505) 248-4016.

Acute Coronary Syndrome Symposium
May 17, 2002; Flagstaff, Arizona

The Native American Cardiology Program is pleased to announce the initiation of its latest Cardiovascular Continuing Medical Education Program with its offering of the Indian Health Service's Acute Coronary Syndrome Symposium, to be held at the Flagstaff Medical Center in beautiful Flagstaff, Arizona on Friday, May 17, 2002. The full-day conference will include seminars on topics from ECG interpretation to the use of the latest medical interventions in cardiology.

There is no charge for clinicians working in the Indian health system but we do request prior registration to hold your seat; please call (928) 214-3920.

Women's Wellness Journey -- A Lifetime Path
May 21-22, 2002; Green Bay, Wisconsin

This is a conference designed for women who are health care professionals or health care consumers, and who are interested in lifetime wellness. Hosted by the Bemidji Area Indian Health Service, this meeting will focus on spiritual, physical, emotional, and mental aspects of wellness in women of all ages. The two-day program is meant to be educational and fun. CEUs for some presentations may be available. It will be held at the Green Bay Radisson, Green Bay, Wisconsin. For further information, contact Jenny Jenkins at the Bemidji Area Office, telephone (218) 444-0488; e-mail *jennifer.jenkins@mail.ihs.gov.*

The IHS Physician Assistant and Advanced Practice Nurse Annual CE Seminar
June 3-7, 2002; Scottsdale, Arizona

Designed for physician assistants, nurse practitioners, nurse midwives, and pharmacist practitioners working for Indian health programs, this three-day CE seminar will provide an opportunity to network with peers/colleagues on issues of common concern, update knowledge of current health care trends and issues, develop new skills to improve patient care, and receive continuing education credit. The program 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. The seminar will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, AZ 85258; telephone (480) 949- 1414. The agenda will include plenary and concurrent workshop sessions on a variety of clinical topics. The complete agenda and registration forms will be available by mid-April. A business meeting for all Advanced Practice Nurses will be held Monday, June 3rd through the morning of Tuesday, June 4th. The Physician Assistants' business meeting will tentatively be held Thursday evening, June 6th. A registration fee of $250 will apply for those registrants employed by compacting tribes or those in the private sector. For more information, contact CDR Dora Bradley at the IHS Clinical Support Center, telephone (602) 364-7777; or email *theodora.bradley@mail.ihs.gov*.

Summer Geriatric Institute
June 13-15, 2002; Albuquerque, New Mexico

The New Mexico Geriatric Education Center (NMGEC) announces their annual Summer Geriatric Institute. This year's meeting will present a comprehensive interdisciplinary view of the challenges of physical disability in older adults. Topics will include Frailty, Falls/Injuries, Arthritis/Joint Pain, Urinary Problems, and Neurologic/Sensory Impairment. The focus of the NMGEC is on providing geriatric/gerontologic education to health care providers, especially those caring for the American Indian population.

Registration fees are as follows: MD/DO/PhD, $245; PharmD, $195; Nurses, and others, $175; Students are admitted for free but still need to register. There will be tuition waivers for those working with elders in IHS or tribal facilities; contact the NMGEC for an application. This activity is co- sponsored by the IHS Elder Care Initiative.

For more information, contact Darlene Franklin, Associate Director, New Mexico Geriatric Education Center, Department of Family and Community Medicine, University of New Mexico Health Sciences Center, 1836 Lomas Blvd. NE, 2nd Fl., Albuquerque, New Mexico 87131-6086; telephone (505) 277-0911; fax (505) 277-9897; e-mail *dfranklin@salud.unm.edu*; website *http://hsc.unm.edu/gec.*

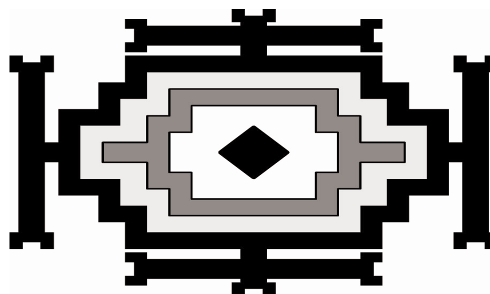
IHS National Council of Nurse Administrators (NCONA) Annual Meeting and Conference
June 10-14, 2002; Missoula, Montana

IHS nurse administrators are encouraged to attend the annual NCONA Meeting and Conference to be held at the Holiday Inn Missoula - Parkside, 200 S. Pattee Street, Missoula, Montana 59802; telephone (800) 399-0408 or (406) 721-8550; fax (406) 728-3472; Internet address *http://www.park- side.com*. The deadline to make your room reservations is May 9, 2002. The IHS Clinical Support Center is the accredited sponsor of this meeting. More information about the conference will follow.

The 3rd Annual American Indian Kidney Conference 2002
July 9 - 11, 2002; Oklahoma City, Oklahoma

The 3rd Annual American Indian Kidney Conference will be held July 9, 10, and 11 in Oklahoma City at the Clarion Meridan Hotel and Conference Center. This three-day conference will provide timely information on the prevention and treatment of kidney diseases for patients, para-professionals, and professionals.

For additional information, contact Jo Ann Holland at (580) 353-0350, ext. 560.



Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care

September 8 - 12, 2002

Denver

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, 801 Thompson Ave, Suite 300 Rockville, MD 20852 (phone: 301-443-1840; fax: 301-594-6213 or 6135).

POSTGRADUATE COURSE ON OBSTETRIC, NEONATAL, AND GYNECOLOGIC CARE

(Please type or print)

Name ______________________________ **❑ PA ❑ MD/DO ❑ NP** **❑ CNM ❑ RN ❑ Other ________**

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 8-12, 2002 . 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.

A NEW PROGRAM FOR CURRENT AND FUTURE INDIAN HEALTH CARE EXECUTIVES

VISION

The Executive Leadership Development Program is the preferred premier leadership-training program for Indian health care professionals..

PURPOSE

To educate current and future leaders to continually improve the health status of Indian people.

MISSION

The Executive Leadership Development Program will be the recognized leader in education and support services for Indian health care systems through collaboration, partnerships and alliances.

The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian health care executives whether they work in Federal, tribal, or urban settings.

Individuals who are program coordinators or managers of clinical, community, environmental, or engineering programs will find this beneficial. The interactive curriculum includes topics that will be integrated through the use of exercises, case studies, and team projects.

The Executive Leadership Development Program will be presented in three 4 ½ day sessions over 12 months. Each session builds on the previous session. Participants should anticipate an intense experience to develop and practice skills to be an effective leader. Independent time is used for reading assignments or working with fellow team members on business simulations, cases, and presentations. At the end of each session, participants will receive a certificate of accomplishment from the sponsoring academic institutions. After all three sessions have been completed, participants will receive a certificate of completion from the Indian Health Service.

NEW SESSION DATES:
University of Nebraska at Omaha

Session One – June 24-28, 2002

OPM Western Management Group
Session Two – March 25-29, 2002
Session Two – July 22-26, 2002

University of Illinois at Chicago
Session Three - September 8-13, 2002

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The IHS Clinical Support Center designates this continuing education activity for up to 28 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the education activity.

The Indian Health Service Clinical Support Center is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education. This activity has been awarded 26 contact hours (2.6 CEUs) under Universal Program Number 600-000-99-096-L04.

The Indian Health Service is accredited as a provider of continuing education in nursing by American Nurses Credentialing Center Commission on Accreditation, and designates this program for 36 contact hours for nurses.

Continuing Education Units for Chief Executive Officers, Administrative Officers and Dentists designates this program for 36 contact hours.

Elaine Alexander, RN,
Executive Leadership Development Coordinator
Indian Health Service, Clinical Support Center
Two Renaissance Square, Suite 780
40 N. Central Avenue, Phoenix, Arizona 85004-4424

Phone: (602) 364-7777 FAX: (602) 364-7788
Internet: *ELDP@phx.ihs.gov* Website: *www.ihs.gov*

POSITION VACANCIES □

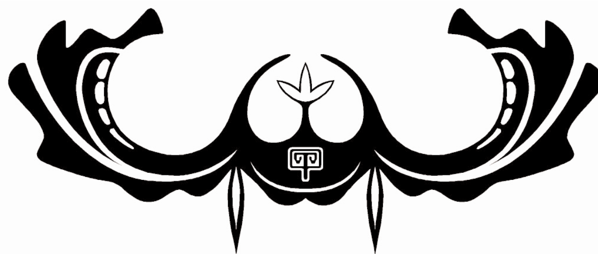
Editor's note: As a service to our readers, The IHS Provider *will publish notices of clinical positions available. Indian health program employers should send brief announcements on an organizational letterhead to: Editor,* The IHS Provider, *The IHS Clinical Support Center, Two Renaissance Square, 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.*

Cardiologist (non-invasive)
Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center, located in the Navajo Area IHS in western New Mexico, is recruiting a second non-invasive cardiologist to join the Internal Medicine group. GIMC is the largest hospital in the Navajo Area, with a wide referral area. The Internal Medicine group consists of eight internists. Included in the practice are echocardiography, treadmill stress echos, dobutamine stress echos, and pacemaker interrogation. Coronary artery disease and valvular heart disease are the predominant cardiac pathologies. Minimal call is associated with the position. Salary is competitive with IHS and New Mexico cardiology standards. For more information contact William Krzymowski, MD, FACP at telephone (505) 722-1342; or e-mail *wkrzymowski@gimc.ihs.com*.

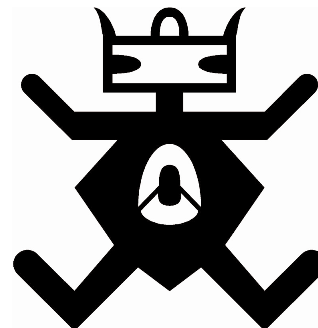
Pharmacist
Salt River Pima-Maricopa Indian Community; Scottsdale, Arizona

Position description: Will perform all pharmacy operations, including filling authorized prescriptions and providing education and counseling for patients of the Salt River Clinic. Duties will include the following: Prepares medications for patients from original prescriptions. Prepares and maintains prepackaged drugs. Under standing orders, determines need for medication refills on patients with chronic illnesses. Reviews all drug orders written in the patient's permanent medical record to assure the appropriateness of the prescribed therapy. Resolves all discrepancies with the prescribing provider prior to dispensing medication. Maintains strict records of medications dispensed. Provides education and counseling to patients which includes, but is not limited to, the proper use of medications, possible side effects, correct storage of medications, dosage schedule, and identification of potential barriers to compliance. Maintains inventory and tight controls of all pharmaceuticals in the pharmacy, particularly the controlled drugs such as narcotics and sedatives. Orders drugs as appropriate. Ensures proper and safe storage and care of all pharmaceuticals. Confers with the pharmacy staff at Phoenix Indian Medical Center and the Phoenix Area Office of the Indian Health Service. Coordinates with all SRP-MIC pharmacy staff to ensure coverage for the Salt River Clinic Pharmacy. Maintains pharmacy data and prepares reports as required. Maintains JCAHO (Joint Commission for



the Accreditation of Health Care Organizations) standards, professional licensure, and continuing education credits required for field. Performs other duties as assigned to maintain and enhance program and agency operation.

Requires a BS in Pharmacy and at least two years of experience as a full-time pharmacist. Must be licensed in the state of Arizona. Clinic experience preferred. Familiarity with the Indian Health Service system and formulary desired. Ability to meet SRPMIC insurance requirements required. Pay Rate $59,200 to $70,755 per year, commensurate with experience. Must pass a pre-employment drug test. Native American Preference Applies. Equal Opportunity Employer. Contact the SRP-MIC Human Resources Department, 10005 East Osborn Road, Scottsdale, Arizona 85256; telephone (480) 850-8096; Internet address *www.srpmicjob.com*.



Nurse Practitioner (Primary Care – Corrections)
Salt River Pima-Maricopa Indian Community; Scottsdale, Arizona

Job Description: Will provide preventive, diagnostics and therapeutic health care services to members of the Salt River Pima-Maricopa Indian Community. Works on-site at the SRP-MIC Detention Facility in coordination with the SRPMIC Health Department and Salt River Clinic. The position will require irregular work hours, including some evenings and weekends throughout a 40-hour work week. Duties will include: Obtains health history from each patient; takes vital signs, performs physical examinations and orders necessary laboratory tests, as needed. Physical exams may include: routine gynecological check ups, Pap smears, and cultures for laboratory examination. Interprets results of laboratory, x-ray and other tests; diagnoses and treats illnesses within parameters of professionally accepted standards for nurse practitioner, conferring with primary care physicians and specialists as needed. Adjusts treatment within established standing orders. Distinguishes between normal and abnormal findings to recognize various stages of serious physical, emotional, or mental problems. Refers difficult or complicated cases to physicians or other health care providers as appropriate. Writes prescriptions for medications within nurse practitioner's scope of practice. Instructs patients in the proper use of medications and possible side effects. Dispenses non-prescription medicines and other items as needed. Additional duties as required.

Skills/Requirements: A Bachelor's degree in Nursing and current registration as a professional nurse practitioner in the state of Arizona with content in family practice program of studies for nurse practitioner. Prefer Master's degree and two or more years of experience as registered professional nurse practitioner. Must maintain current certification and/or licensure appropriate to a nurse practitioner, including national certification (ANCC or AANP) and pursue a minimum of 10 CED hours annually. Must possess prescription privileges certificate from the state of Arizona, registered independent DEA number. Must have a valid Arizona driver's license and be able to meet SRPMIC insurance requirements. Pay Rate:$47,518 to $56,792 per year, commensurate with experience. Must pass a pre-employment drug test. Native American Preference Applies. Equal Opportunity Employer. Contact the SRP-MIC Human Resources Department, 10005 East Osborn Road, Scottsdale, Arizona 85256; telephone (480) 850-8096; Internet address *www.srpmicjob.com*.

Licensed Clinical Social Worker
Greenville Rancheria; Greenville, California

Qualified applicant must have experience in mental health and substance abuse counseling. LCSW required. Would be serving Native Americans and non-Indians residing in Plumas and Tehama Counties. Excellent benefits package. Pay D.O.E. Contact Stephen Jones at (530) 284-7990, ext. 226.

Dental Assistant/Registered Dental Assistant
Greenville Rancheria; Greenville, California

Looking for a friendly, knowledgeable, and professional individual with one to two years plus of experience in a dental clinic setting, an individual seeking to give nothing less than first class service and care to the patients of the Greenville Rancheria Dental Clinic. Excellent benefits package. Pay D.O.E.Contact Stephen Jones at (530) 284-7990, ext. 226.

Licensed Vocational Nurse
Greenville Rancheria; Greenville, California

Seeking a full-time nurse to provide clinical nursing, placing patients in rooms, taking vitals, providing immunizations, and taking chief complaints in a busy back office primary care setting. Clinic locations in Red Bluff and Greenville, California. Pay D.O.E. Contact Stephen Jones at (530) 284-7990, ext. 226.

Billing Supervisor
Greenville Rancheria; Greenville, California

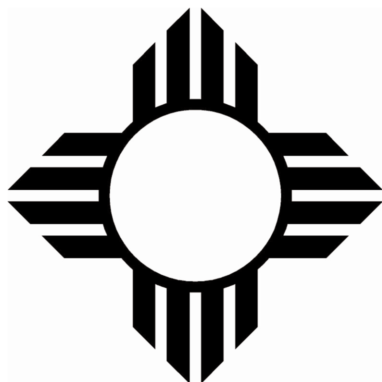
Seeking a full time Billing Supervisor to provide operational and technical support. Must have knowledge of Medicare, MediCal and commercial billing. Knowledge of FQHS is desirable. Excellent pay/benefits. Contact Stephen Jones at (530) 284-7990, ext, 226.

Data Entry Clerk/coder
Greenville Rancheria; Greenville, California

Seeking a dependable and detail-oriented full time Data Entry Clerk/Coder. Must be computer literate and have basic keyboarding skills. Experience with ICD-9 coding a must. Must have an understanding of medical terminology. Billing background desirable. Excellent benefits package and competitive salary. Contact Stephen Jones at (530) 284-7990 ext. 226.

Internal Medicine Physician
Phoenix Indian Medical Center; Phoenix, Arizona

With the expansion of our Intensive Care Unit to twelve beds, the Phoenix Indian Medical Center is looking for one additional internal medicine physician (BC/BE) to join its Internal Medicine Department. The practice utilizes a hospitalist IM model and includes a busy primary care medicine clinic. These additional positions would make a total of ten general internists in the department. Specialty medical consultants at present include full, part time, or contract pulmonary, cardiology, rheumatology, dermatology, allergy, nephrology, and gastroenterology physician services. If interested please send CV to Eric M. Ossowski, MD, Acting Chief, Internal Medicine Department, Phoenix Indian Medical Center, 4212 N. 16th Street, Phoenix, Arizona 85016-5319; fax (602) 263-1593; telephone (602) 263-1537; or e-mail *eric.ossowski@pimc.ihs.gov*.



Operating Room Internship
Gallup Indian Medical Center Gallup, New Mexico

The Gallup Indian Medical Center (GIMC), in beautiful Gallup, New Mexico – the Heart of Indian Country – is offering an Operating Room Internship. This is the professional opportunity of a lifetime. The purpose of this intensive four-week training opportunity is to fill vacant OR Clinical Nurse positions at Gallup Indian Medical Center. The course is AORN-sponsored for 81 Continuing Education credits, and is designed to prepare the RN with no OR experience to perform competently in the Operating Room. The course runs from June 10 through July 10, 2002. It requires that the attendee hire on with Gallup Indian Medical Center's Operating Room as a clinical nurse GS-610-09/10. If you have always wanted to work in the OR, but didn't know how to get the training, then this is the position for you! For more information and/or and application, contact Janet King, RN, OR Supervisory Clinical Nurse at telephone (505) 722-1232; or by e-mail at *janet.king@gimc.ihs.gov*.

Family Practice Physician
Taos, New Mexico

The Taos/Picuris Indian Health Center in Taos, New Mexico is recruiting for an experienced Family Practitioner. The applicant should have at least three years of experience, and will be the supervisor of a small medical staff consisting of three medical providers and one dentist. The Taos and Picuris tribes have requested to become their own service unit, separating from the Santa Fe Service Unit. If this is approved, this will become a Clinical Director position. Please call (505) 758-4224 for more information.

Nurses: Clinical Staff Nurse, Medical, Surgical, and Pediatric
Phoenix Indian Medical Center; Phoenix, Arizona

Interested in a career that is challenging and want to add a new dimension to your nursing practice? Then we would like you to join our team. The Phoenix Indian Medical Center (PIMC), a 127-bed community-based hospital, is seeking experienced registered nurses (grades 0-3/0-4/0-5) who are competent in all aspects of patient care and who want more for their career. PIMC provides a wide range of primary care and specialty care services. The nurses work 12-hour shifts -- days, nights, weekends, and holidays. As a Federal facility, we offer excellent employment benefits. Salary is based on education and years of experience. Visit Hospitalsoup.com for more information. Contact Jeannette M. Yazzie, RN, BSN,

Nursing Management and Program Analyst, Phoenix Indian Medical Center, 4212 N. 16th Street, Phoenix, Arizona 85016; telephone (602) 263-1582; fax (602) 263-1666; e-mail *jeannette.yazzie@pimc.ihs.gov*.

Clinical Staff Nurse, Float Pool
Phoenix Area Indian Health Service; Phoenix, Arizona

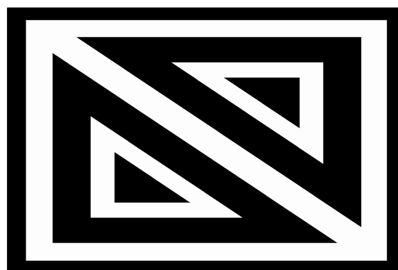
The Phoenix Indian Medical Center (PIMC), a 127-bed community based hospital, is seeking experienced registered nurses who are competent in all aspects of patient care and want more for their career. The float pool staffs are full time, permanent Indian Health Service employees, working 80 hours per two-week pay period. Nursing assignment is scheduled and based on the employees' experience and competency; therefore assignments are mainly to the Medical, Surgical, Pediatric, Ambulatory Care, and possibly ER units. Nurses' work 12-hour shifts -- days, nights, weekends and holidays. Visit *Hospitalsoup.com* for more information. Contact Jeannette M. Yazzie, RN, BSN, Nursing Management and Program Analyst, Phoenix Indian Medical Center, 4212 N. 16th Street, Phoenix, Arizona 85016; telephone (602) 263-1582; fax (602) 263-1666; e-mail *jeannette.yazzie@pimc.ihs.gov*.

Orthopaedic Surgeon
Tuba City Indian Medical Center, Tuba City, Arizona

We are looking for qualified and enthusiastic board eligible orthopaedic surgeons interested in working and living in northern Arizona. This position can be created to fit your timetable and lifestyle: Commissioned Corps officer, full-time/part-time employment, office non- surgical practice, contract employment, or locum tenens. Tuba City Indian Medical Center is a 72 bed acute care Level II trauma center located in northern Arizona at 5000 feet above sea level on the arid Kaibeto Plateau. There are a myriad activities available including bicycling, canyoning, rafting, rock climbing, and snow skiing among the numerous canyons and peaks. To name a few nearby attractions are the Grand Canyon, Bryce and Zion Canyons, the Colorado River and the San Francisco Mountains. You can work with an excellent medical staff, your children can play in safe neighborhoods, and your family will enjoy the great community spirit. Competitive salary with benefits, include moving allowance and loan repayment options, are offered. Interested? Direct your questions about this unusual and very rewarding job opportunity to Vivian K. Chang at (928) 283 2406, or send your CV to PO Box 600, Tuba City, Arizona 86045; or e-mail *vchang@tcimc.ihs.gov*.

The 6th Annual Elders Issue

The May 2002 issue of The IHS Provider, to be published on the occasion of National Older Americans Month, will be the sixth 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 and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue. □



Change of Address or Request for New Subscription Form

Name ______________________________ Job Title ______________________

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Check One: ☐ New Subscription ☐ Change of Address

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*.

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

Circulation: THE PROVIDER (ISSN 1063-4398) is distributed to more than 6000 health care providers working in 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 receiver 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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