THE IHS PRIMARY CARE PROVIDER

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New RPMS Immunization Package Facilitates Immunization Tracking and Recall

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Later this year Headquarters West Division of Information Resources will release a complete rewrite of the Resource and Patient Management System (RPMS) Immunization software package. This new version, 7.0, replaces Version 6.8 of the MCH package. With the same release, Q-man will be updated so that the vaccine codes reflect the new immunization codes, and the Immunization section of the Health Summary will be reformatted.

Retained Features

The new package retains all of the features contained in Version 6.8, as follows:

1. ability to track immunizations and forecast immunization due dates
2. ability to add and edit immunizations and skin tests
3. ability to print lists of, and letters to, persons due for immunizations
4. ability to print Quarterly Immunization Report (age-appropriate immunization rates for children ages 3-27 months) and Vaccine Accountability Report (doses administered, by age)

New Features

In addition, the new Immunization Package contains several new or updated features that increase its usefulness for immunization tracking and recall.

IMM/Serve Forecasting Algorithm. One of the problems with the old immunization program was its inability to keep up with the rapidly changing immunization schedule. To overcome that shortcoming, we contracted with Medical Decisions Associates for a license to use their IMM/Serve forecasting software, which evaluates immunization histories and determines due dates. IMM/Serve is updated each time there is a change in vaccine recommendations and currently forecasts DTaP/Td, hepatitis B, polio, MMR, hepatitis A, varicella, Hib and pneumococcal conjugate vaccines (Table 1). IMM/Serve allows the user to choose among several vaccine scheduling options and to choose which vaccines will be forecast. The forecasting algorithm also includes universal forecasting of influenza and pneumococcal vaccines for persons 65 years of age and older, and the ability to build a registry of high risk individuals who need these vaccines. Other vaccines, (e.g., meningococcal, typhoid) and immune globulins (e.g., HBIG, RSV Monoclonal antibody) are available for data entry but are not forecast.

Expanded Data Entry Function. The new Immunization Package facilitates data entry at the time of vaccination, and captures all of the documentation required by the National Childhood Vaccine Injury Act, including date, age, facility, vaccine type and series number, lot number, date of Vaccine Information Statement, and vaccine provider.

Customized Due Letters. In the new package, a manager can easily customize Due Letters and Official Immunization

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Table 1. Vaccines forecast through the new immunization program as of November, 1999*

Vaccine	minimum age forecast	maximum age forecast
DTaP/Td	2 months	—
polio	2 months	18 years
Hib	2 months	59 months
hepatitis B	birth	18 years
varicella	12 months	18 years
MMR	12 months	18 years
hepatitis A	24 months	18 years
**conjugate pneumococcal	2 months	59 months
pneumococcal polysaccharide	65 years (55 in Alaska)	—
influenza	65 years	—

* RSV Monoclonal antibody (Synagis) is not forecast, but is available for data entry.
** Forecasting for conjugate pneumococcal vaccine should be inactivated by the program manager until this vaccine is available.

Reports, and maintain several letter formats including Due Letters, Well Baby Clinic reminders, and Official Immunization Records.

Due List and Due Letter Options. The new package offers more options in selecting due letters or lists for a patient group, including the ability to make a search template from Q-man (i.e., all adults over 65 who had a visit in the past year) and apply it to a list or batch of letters. The provider can search for a specific vaccine received or due, or for a specific lot number received.

Export Utility. The new package gives a manager the ability to download patient and immunization data from RPMS into a flat text file (ASCII or HL7). From this text file, the data can be imported to a software package like the CDC immunization auditing software, CASA, or to a State Immunization Registry.

Two Year Old Report. In addition to the Quarterly Immunization Report (Table 2), the new package contains a new Two-Year-Old Immunization Report (Table 3), which presents vaccine-specific (e.g., one MMR by age 2 years) and vaccine-combination (e.g., four DTaP, three polio, three Hib, three Hep B, one MMR) immunization rates for two-year-olds to chart progress toward National Health Objectives.

Table 2. Definitions of age-appropriate immunizations by age for the Quarterly Report

Age Range	Minimum requirement for age-appropriate immunizations
3-4 months	one DTaP, one polio, one Hib, one HepB
5-6 months	two DTaP, two polio, two Hib, two HepB
7-15 months	three DTaP, two polio, two Hib, two HepB
16-18 months	three DTaP, two polio, three Hib, two HepB, one MMR
19-23 months	four DTaP, three polio, three Hib, three HepB, one MMR
24-27 months	four DTaP, three polio, three Hib, three HepB, one MMR

Table 3. Immunization rates calculated for 24-35 month-olds in the Two-Year-Old Report

Calculation	Example
Vaccines completed by specific ages	DTaP#1 by 3, 5, 7, 12, 16, 19, 24, or 36 months
Vaccine series completed by specific ages	DTaP#1, polio#1, Hib#1, and HepB#1 by 3, 5, 7, 12, 16, 19, 24, or 36 months
National Objectives	DTaP#4, polio#3, Hib#3, MMR#1, by 24 or 36 months

Using The Immunization Package to Improve Immunization Rates

Evidence from published studies shows that recall messages to families of children overdue for immunizations and reminders in advance of appointments were the most cost-effective means of improving immunization rates.[1] Acomputerized registry is the backbone of a tracking and recall system.[2,3] The key components are an accurate count of children who are followed in your clinic, accurate immunization histories in the database, timely reminders sent to children due for immunizations, follow-up of children who miss immunizations, and regular determination of immunization rates with feedback to providers about the rates and ways to improve them.

Accurate count of children followed in clinic. Maintaining an accurate registry of children requires that all children within one's jurisdiction are registered in the RPMS and activated into the immunization registry. At Alaska Native Medical Center (ANMC), any child less than 2 years old who is registered in RPMS is activated into the immunization registry at the time of registration. In addition, someone needs to inactivate children who move or go to another provider. The new Immunization Package allows a manager to designate why a child was inactivated (when a death is entered into RPMS, the person is automatically inactivated).

Accurate immunization histories. Having accurate immunization histories involves a lot of work. It requires timely data entry for all immunizations given in clinic, as well as data entry of historical vaccines given elsewhere. After years of frustration with an inaccurate database, the ANMC pediatrics clinic began doing point-of-service data entry in 1996. Nurses and case manager also enter historical immunizations.

Timely reminders. If the immunization histories are accurate, then a manager or nurse can print accurate due letters for parents. In addition, reminder letters can be printed and sent to parents of children "past due" (over a month overdue) for immunizations.

Regular determination of immunization rates. Research shows that assessment of immunization rates and feedback to providers can improve immunization rates in a clinic practice. If the immunization histories are accurate, a manager can print age-appropriate immunization rates (Quarterly Report) and two-year-old immunization rates (Two-Year-Old Report) to apprise clinic staff of progress in meeting immunization goals. Reviewing these reports will help individual clinics determine where to concen-

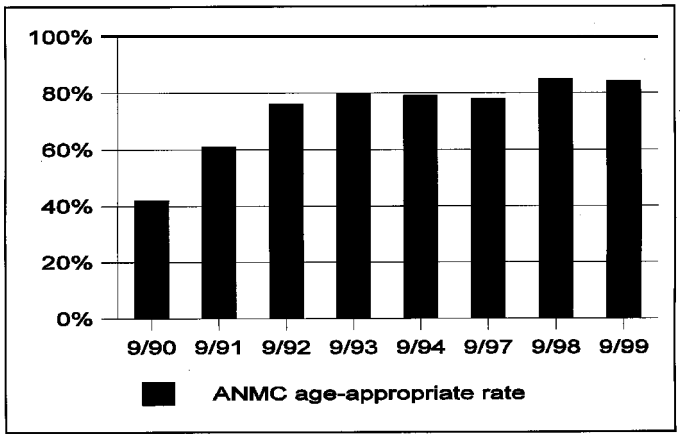
trate their efforts (e.g., if 3- to 4-month-olds have low immunization rates, a clinic will want to concentrate on getting infants in for their 2-month-old immunizations).

Case Report

In 1991 the immunization rate for Anchorage children followed at ANMC was unknown, and the RPMS Immunization Package was not being utilized. That year, the pediatrics clinic decided to place a high priority on achieving on-time immunizations. A programmer activated all Anchorage children less than two years old (n = ~2000) registered in the RPMS into the Immunization Registry. A case manager was assigned, who reviewed charts and inactivated about 350 patients who had moved or who were receiving care elsewhere. The case manager then conducted quarterly reviews of children 3 to 27 months of age who were overdue for immunizations and sent due letters or followed up with parents by phone. In 1996 nurses began point-of-service data entry, which allowed entry of lot numbers, contraindications, and adverse events, thus improving the quality and timeliness of immunization data entry. Currently, in 1999, the age-appropriate immunization rate for Anchorage children is 84-89% (Figure 1) despite the high turnover rate for clinic patients, and a large number of patients who utilize multiple facilities. Nurses enter all the required documentation items (vaccine, date, dose number, lot number, Vaccine Information Statement date, and provider) for each vaccine given in pediatrics clinic.

For more information, contact Rosalyn Singleton, MD, Arctic Investigations Program, Centers for Disease Control, 4055 Tudor Centre Drive, Anchorage, AK 99508; phone (907) 729-3418; fax (907) 729-3429; e-mail *ris2@cdc.gov*. □

Figure 1. Quarterly age-appropriate immunization rates from September 1990 to September 1999 in Anchorage children followed at Alaska Native Medical Center as printed from RPMS



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FOCUS ON ELDERS □

Prevention and the Periodic Health Examination for Elders

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

The periodic preventive health outpatient visit plays an important role in health promotion and disease prevention. The best examples of this in current use are the Well Child and the Well Women exams. These visits form the cornerstone of preventive services for children and women. The periodic preventive visit for older individuals also has a clear role to play in providing quality, age-specific care.

Just as the Well Child and Well Woman exams are designed to accomplish specific functions, so the elder preventive visit must be tailored to fit the specific needs of the elderly patient. The comprehensive elder exam can fulfill a number of functions, not all evident at first glance. These include:

- Screening for impairment of function
- Screening for disease and geriatric syndromes (e.g., falls, incontinence)
- Screening for abuse, neglect, and exploitation

- Ensuring access to available services
- Patient education and risk factor modification counseling
- Caregiver support
- Developing or updating the patient database
- Developing a sense of relationship and understanding with the patient and his/her family
- Data collection for public health interventions (through the RPMS system)

It is important to recognize that there is ample evidence that health promotion activities have a role in the prevention of disability and the maintenance of health and independence in old age.[1] In addition, there is evidence to support a number of screening activities in older individuals with the goal of prolonging and improving the quality of life. The U.S. Preventive Services Task Force has issued a set of recommended, evidence-based preventive services for age 65 and older[2], as reviewed in the January, 1999 *IHS Primary Care Provider* (Volume 24, Number 1, p 8).

The office-based comprehensive elder exam should serve as the periodic preventive visit for all older patients. In future articles we will review the key elements of this examination, discuss strategies for implementing it in a busy clinic, and examine patient selection ("How old is old?"). The periodic elder exam will be the cornerstone to preventive care for our elderly patients, ensuring that we and they are taking advantage of every available resource to help them maintain health and function. □

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1. Kaplan GA, Behavioral, Social, and Socioenvironmental Factors Adding Years to Life and Live to Years, in Public Health and Aging, ed. Hickey T, Speers MA, Prohaska TR; Johns Hopkins University Press, Baltimore, 1997
2. U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Baltimore: Williams & Wilkins, 1996

MEETINGS OF INTEREST □

Clinical Recognition and Management of Heart Disease – with a Special Session on Cardiovascular Disease in Indian Health
January 19-21, 2000; Tucson, Arizona

This course, sponsored by the American College of Physicians – American Society of Internal Medicine, is designed to update primary care providers, particularly family physicians, internists, and emergency medicine providers, on the triage of patients with chest pain, the management of myocardial infarction, the intermediate coronary syndrome, ischemic heart disease, hypertension, hyperlipidemia, atrial fibrillation, and ventricular arrhythmias. Interventions in the primary and secondary prevention of heart disease will be presented. Heart disease in women will be reviewed, and there will be multiple electives on topics such as physical examination of the heart utilizing teaching mannequins, and chest radiographs. Dr. Barbara Howard, principle investigator for the Strong Heart Study, and Dr. James Galloway of the Native American Cardiology Program will provide insights into diabetes and heart disease as well as other issues in Native Americans related to cardiovascular disease. For more information or a registration form, please contact ACP-ASIM at (800) 523-1546, ext 2600 and request information on course code G01.

Midwinter OB/Peds Conference
January 28-30, 2000; Telluride, Colorado

The Fifteenth Annual Midwinter OB/Peds Conference will be held in Telluride, Colorado, January 28-30, 2000. This conference will offer continuing education to providers interested in new developments in health care for women and children. Among the planned presentations will be "Pediatric Vulvovaginitis," "Noncontraceptive Benefits of Birth Control Pills," "Navajo Ceremonials and Rituals," and "New Medications for Management of the Menopause." The IHS Clinical Support Center is the accredited sponsor; the CSC is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. For more information contact Alan Waxman, MD at (505) 722-1000 or Diana Hu, MD at (520) 283-2501.

Annual NAIHS Internist Meeting
January 28-30, 2000; Telluride, Colorado

The Annual Navajo Area IHS Internists Meeting will be held in Telluride, Colorado, January 28-30, 2000. Featured topics will include resistant hypertension, Parkinson's disease, pacemakers, and anticoagulation, among others. For more information, contact Dr. Bruce Tempest at (505) 722-1000; e-mail *btempest@gimc.ihs.gov*.

The Next Millennium: The 2000 Meeting of the National Councils of the IHS
January 31-February-3, 2000; San Diego, California

The National Councils (Clinical Directors, Service Unit Directors, Chief Medical Officers, and Nurse Consultants) of the Indian Health Service will hold their 2000 annual meeting January 31-February 3, 2000 in San Diego, California. 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 Clinico- administrators

are invited to attend. The meeting site is the Bahia Resort Hotel, 998 W. Mission Beach Drive, San Diego, California. The Clinical Support Center (CSC) is the accredited sponsor for this meeting. Please contact Gigi Holmes at the Clinical Support Center at (602) 364-7777, or e-mail *gigi.holmes@phx.ihs.gov*.

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

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

The refresher course is targeted at IHS, tribal, or urban program colposcopists desiring a review and update of colposcopy and management of lower genital tract neoplasia. It is ideal for colposcopists still in their preceptorships and those practicing colposcopists who don't have the opportunity to see a large volume of high grade dysplasia or cancer in their practices. For more information or application materials, contact Roberta Paisano, IHS Cancer Prevention, 5300 Homestead Road, NE, Albuquerque, New Mexico 87110; phone (505) 248-4132; e-mail *roberta.paisano@mail.ihs.gov*.

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

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

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

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

This two and a half day conference will provide information on prevention of kidney disease and coping with kidney disease. The target audience is patients and families, community health providers, medical professionals, and tribal leaders. For more information, contact Jo Ann Holland, RD, CDE, Lawton IHS Hospital, Lawton, OK; phone (580) 353-0350, ext. 560. Please note that the dates for this meeting have changed and that those listed in the last issue of *The Provider* were incorrect.

Project Making Medicine
May 2000; Oklahoma City, Oklahoma

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

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

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

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

The initial application consists of 1) a letter of intent from the applicant that includes the commitment to provide specialized services to Native American children for at least two years following completion of training; 2) a letter of commitment from their immediate supervisor stating that the applicant will be allowed to participate in the training for the duration of the program and will be supported in the requirements as outlined above; 3) a letter of support from the tribe or IHS agency stating the applicant will be allowed to participate in the training for the duration of the project, that the agency supports the requirements

as outlined above, and the agency will sponsor a *Project Making Medicine* on-site visit; 4) a copy of the applicant's current license; and 5) a *curriculum vitae.*

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

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

POSITION VACANCY □

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

Director, Center of American Indian and Minority Health; University of Minnesota, Duluth, School of Medicine, Duluth, Minnesota

Teaching, Research, and Administrative Responsibilities. The director reports directly to the Dean, School of Medicine, UMD. The director is responsible for academic leadership for the Center of American Indian and Minority Health (CAIMH) and serves as principal investigator with ultimate responsibility for administration of programs, budgets, and personnel of federal grants housed in the CAIMH. The director is expected to develop and maintain effective outreach strategies linking the CAIMH with university, professional, and constituent communities which include tribal, local, state, and national organizations. The director serves on the executive staff of the school with special responsibility for minority affairs and is expected to provide ongoing leadership in school efforts to refine school policy affecting admissions, student affairs, and curriculum as well as articulation of new research and grant initiatives.

The successful candidate must have the ability to provide creative faculty leadership in the school, to maintain productive relationships, and to work effectively with a diverse administration, faculty, and staff among schools and colleges at UMD as well as multidisciplinary administrators, faculty, and staff in the Academic Health Center, Twin Cities Campus. The director must promote recognition, understanding, and respect for cultural and human diversity in the school and provide leadership in efforts for early identification, recruitment, admissions, retention, and mentorship of diversity students through academic course work, residency programs, and board examinations. As a faculty person, the director must be able to assume leadership in the development and revision of school curriculum according to diversity initiatives required by the Liaison Committee for Medical Education and to meet CAIMH responsibilities as a member of the School of Medicine admissions committee and other academic committees as assigned.

Qualifications. The essential qualifications are: 1) MD or DO degree; 2) be eligible for a faculty appointment and hold a current unrestricted license in good standing in some state or be eligible for a license; and, 3) possess a record of achievement in American Indian and minority health care. The desired qualifications are: 1) five years post-residency professional experience; and, 2) three years administrative experience including grants management. Candidates must possess a record of leadership in American Indian and minority health. Candidates must exhibit excellent communication skills. In addition to an appreciation for recruitment, teaching, research, and outreach, the successful candidate must be fully committed to school efforts in rural medicine and American Indian health care.

The starting date is negotiable since the application deadline will remain open until the position is filled. The school aspires, however, to a July 1, 2000 start date. The position of director for the CAIMH is a full-time, 12-month appointment with an initial appointment of three years, annually renewable thereafter. Faculty appointment and salary are negotiable and commensurate with experience and interests of the selected candidate.

Applications must include a letter expressing interest, experience, and strengths as they relate to the position; a current resume; a personal statement detailing the applicant's philosophy and accomplishments concerning diversity; and three letters of recommendation. The search committee will begin its review of completed applications on January 18, 2000, and will continue until the position is filled. The completed applications must be submitted to John Red Horse, PhD, Chair of the Search Committee, c/o Lori Isaacson, 10 University Dr., 113 Med, Duluth, MN 55812-2487; phone (218) 726-6287; e-mail *jredhors@d.umn.edu.*

The University of Minnesota is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation.

A NEW PROGRAM FOR CURRENT AND FUTURE INDIAN HEALTH CARE EXECUTIVES

VISION

To prepare confident and competent individuals and teams for executive work within Indian health care settings.

PURPOSE

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

MISSION

To ensure new competencies and fresh prespectives to the current and future leaders in Indian health care settings by developing partnerships with various tribes, universities, foundations, and private sector organizations.

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 4½ 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.

Session One A (or)
January 9-13, 2000
Tucson, Arizona with the University of Arizona

Session One B
March 26-30, 2000
Tucson, Arizona with the University of Arizona

Session Two
May 21-25, 2000
Montana, Minnesota or Wisconsin

Session Three
August 20-24, 2000
Washington or Oregon

The Indian Health Service (IHS) Clinical SupportCenter 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.

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YEAR-END INDEX

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THE IHS PRIMARY CARE PROVIDER

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

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

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

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