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Depression in American Indians and Alaska Natives: A Review of Indian Health Policy and Services

The following is the second of three papers that were written during each author's participation in the Kaiser Family Foundation's Native American Health Policy Fellowship last year.

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Depression and other mental health disorders disproportionately affect American Indians and Alaska Natives, and there is a great need for services and resources to reduce disparities in this area. While there are a number of programs and policies that address these issues, more efforts are needed. This paper will review the problem of depression in American Indians and Alaska Natives and the policies that address mental health conditions in Indian communities.

Depression

Depression is one of the most prevalent and debilitating mental health conditions. When a person is clinically depressed, his or her ability to function, both mentally and physically, is affected, and this may last for weeks, months, or even years. Symptoms of depression include a persistent sad mood; loss of interest or pleasure in activities that were once enjoyed; significant change in appetite or body weight; difficulty sleeping or oversleeping; physical slowing or agitation; loss of energy; feelings of worthlessness or inappropriate guilt; difficulty thinking or concentrating; and recurrent thoughts of death or suicide.¹ There is a high degree of variation among people with depression in terms of symptoms, the course of the illness, and response to treatment, indicating that depression may have a number of complex and interacting causes. Psychosocial and environmental stressors are known risk factors for depression.¹

Depression, the second-leading cause of disease burden in the United States, is a chronic illness that affects 19 million people.² Research indicates that people diagnosed with depression have medical costs twice those of healthy individuals and that they visit hospital emergency rooms with a significantly greater frequency; depression is the cause of \$30 - \$50 billion of lost productivity annually.³ Seven of the top 10 drugs covered by managed care programs in many states are medications for depressive disorders.² Despite the efficacy of treatment, it is estimated that two thirds of individuals suffering from depression are not getting the help they need.¹

Some say that depression ignores race, ethnicity, educa-

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tion level, and socioeconomic status. Women experience depression at roughly twice the rate of men.¹ More than 2 million older Americans suffer from some form of depression.⁴ It has been reported that 70 to 90 percent of late-life depression is undiagnosed because of the older individual's depressive symptoms being attributed to other medical problems.⁴ A number of epidemiologic studies have reported that up to 2.5 percent of children and up to 8.3 percent of adolescents in the U.S. suffer from depression.⁵ Experts say that underlying some of the simmering rage among teens is undiagnosed depression.⁶ Studies strongly suggest that depression is more prevalent among adults with diabetes than among the general population.⁷

According to the Surgeon General's Report on Mental Health 1999, the U.S. mental health care system is not well equipped to meet the needs of racial and ethnic minority populations. Depression has often been misdiagnosed in communities of color because of cultural barriers such as language, trust and values in the relationship between doctor and patient, and reliance on the support of family and the religious community rather than mental health professionals during periods of emotional distress.⁸ According to a supplemental report to

the Surgeon General's Report on Mental Health entitled "Mental Health: Culture, Race and Ethnicity," racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity.²

Depression in American Indians and Alaska Natives

The history of American Indians and Alaska Natives (AI/AN) sets the stage for understanding their significant mental health needs.² Depression is a significant problem in many AI/AN communities.⁹ Treaties, legislation, and cultural upheaval play a considerable role in the problem of depression and the under-diagnosis of depression in American Indians today. Because AI/ANs comprise such a small percentage of the U.S. population, in general, national research studies do not include sufficiently large samples of AI/AN to draw accurate conclusions regarding their need for mental health care.² However, studies with AI/AN participants point to a high incidence of comorbid mental health and substance abuse/addiction problems, including anxiety, depression, and suicide.¹⁰ Cultural diversity among the 561 Federally recognized tribes is great, and cultural differences exist in the expression and reporting of distress among AI/AN²; this also may affect research findings.

Limited data suggest that the prevalence of psychiatric illness is high among elderly Indians, especially in the primary care and urban settings.¹¹ Compared with other women, the health and mental health status of American Indian women is generally worse.¹² American Indian women are at risk for many factors associated with depression, including poverty, lack of education, and larger numbers of children.¹² Many do not discriminate bodily from psychic distress and may express emotional distress in somatic terms or bodily symptoms. In a study by Shore and Stone, 1973, women from a Pacific Northwest tribe experienced a higher prevalence rate of duodenal ulcers, related to the pressure experienced from being part of a matrilineal culture and the stresses of acculturation. Acculturation and bicultural demands often place Indian women in a position of having to fulfill multiple and perhaps conflicting social roles.¹³

American Indian adolescents have been reported to exhibit high levels of depression, suicide, substance abuse, and quitting school.¹⁴ In addition, 31.6% of American Indian families live below the poverty level compared with a national rate of 13.1%.¹⁵ American Indian children growing up under these stressful circumstances are at high risk for behavioral and emotional problems.¹¹ Studies indicate that only 16.1% to 29% of youth meeting criteria for a current alcohol, drug, or mental disorder receive care for that disorder.¹¹ The age-adjusted suicide rate for AI/AN is 19.3 per 100,000 compared to 11.2 per 100,000 for U.S. all races in 1995.¹⁵ The age-adjusted alcoholism death rate for AI/AN is over 7 times the U.S. all races rate for 1995.¹⁵ All of these factors suggest AI/AN have high rates of depression or are at risk for devel-



oping mental illness.

The high burden of chronic disease among AI/AN also increases the risk of depression and other mental disorders. The prevalence rate for diabetes in American Indians is 2.8 times the overall U.S. rate, and evidence indicates that patients with diabetes are three times more likely to have a co-existing diagnosis of depression. Thus, the argument holds that American Indians, who already have a high prevalence of diabetes, are at increased risk for major depression.¹⁶

Addressing the Problem of Depression

Depression is the most treatable of all mental illnesses. About 60 to 80 percent of depressed people can be treated successfully.⁸ The single, explicit recommendation of the 1999 Surgeon General's Report on Mental Health is to "seek help if you have a mental health problem or think you have symptoms of a mental disorder." However, depression frequently occurs coincident with a variety of other physical illnesses, including heart disease, stroke, cancer, or diabetes, and is often unrecognized and untreated.¹

The most commonly used treatments for depression are antidepressant medication, psychotherapy, or a combination of the two. The two most common types of antidepressants are selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCA).¹ Advanced medications have major advantages over older therapies in decreasing absenteeism and increasing work performance.¹⁷ Thus, the high cost of these medications proves to be cost-effective. Most primary care patients with depression prefer counseling to medication.¹⁹

Alternative approaches to mental health care that emphasize the interrelationship between mind, body, and spirit can also play an important role in recovery and healing.¹⁹ Medical studies have confirmed that spirituality can have a profound effect on mental states, and that high levels of hope and optimism are key factors in fighting depression.²⁰ There is new public interest in herbal remedies for various medical conditions, including depression. St. John's Wort, an herbal remedy promoted as having antidepressant effects, is currently under study in its first large scale, controlled study funded by the National Institute for Mental Health. Studies have shown that light, moderate, and vigorous intensity exercise can reduce symptoms of depression.²¹ According to the Dietary Guidelines for Americans, 2000, regular physical activity promotes psychological well-being and self-esteem, and reduces feelings of depression. In a recent Roper Starch Worldwide survey, 94 percent of people said they exercise to improve their emotional well-being, and 87 percent said they do so to reduce stress.²² In addition to reducing symptoms of depression, aerobic forms of exercises have been suggested as one approach to reduce the costly effects of excessive or chronic stress.²⁴

Strategies for treating depression that are culturally appropriate and relevant for Indian communities are suggested to be effective. For example, a study in Seattle, Washington



revealed that two-thirds of the urban Indian patients sampled employed traditional healing practices regularly and felt that such practices significantly improved their health status.²⁴

Addressing the Problem of Depression in American Indians and Alaska Natives

The U.S. Census Bureau estimates that 4.1 million AI/AN lived in the United States in 2000. Access, availability, and utilization of healthcare are critical in addressing the problem of depression in AI/AN. However, only 1 in 5 American Indians reports access to Indian Health Service care.²⁵

From 1980 to 1995, over 2000 journal articles and book chapters were published on the mental health of American Indians. The most frequent service-related topics were the need for culturally sensitive assessment and care (76%), the importance of family and community to the treatment process (59%), the limitations of delivery systems and lack of local input into planning (47%), and the role of traditional healing (32%).¹¹ There is clearly a need for more comprehensive mental health services for AI/AN.

Legislation to authorize comprehensive mental health services for tribes has been enacted and amended several times, but Congress has consistently failed to appropriate funds for such initiatives.²⁵ A number of policies and programs have been implemented to deal with mental health disorders in Indian communities. Below, a number of such policies and programs have been reviewed to determine whether

they yield the most effective strategies to address mental health conditions in AI/AN, including comprehensive, culturally appropriate, and accessible care.

Mental Health Policies for American Indians and Alaska Natives

Indian Health Service. In 1955, the U.S. Government established the Indian Health Service (IHS) within what is now the Department of Health and Human Services. The goal of the IHS is to provide health care for AI/AN; however access is limited to approximately 20% of AI/AN due to the fact that clinics are located only on or near Indian reservations.²⁵ Only about 36% of AI/AN live on reservations or in other tribally defined areas; 64% live in other urban or rural areas.²⁵ The IHS has many health programs, including the Behavioral Health Program, which includes mental health, alcoholism, and substance abuse services. The vision of the IHS Behavioral Health Program is “so that the unique balance, resiliency, and strength of our AI/AN cultures are supported and enriched, we at the IHS Behavioral Health Program strive to eliminate the disease of alcoholism and other drug dependencies and the associated pain it brings to individuals of all ages, families, villages, communities, and tribes.” Eligible patients access the Behavioral Health Program through its direct health care system at IHS hospitals, clinics, and health programs on or near reservations. Mental Health services range from psychotherapy (counseling) and medications, as prescribed by health care providers, to traditional healing practices, alcoholism programs, and prevention activities.

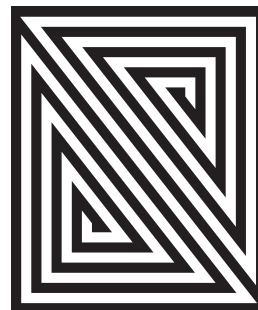
P.L. 106-260, the Tribal Self-Governance Amendments of 2000, amends the Indian Self-Determination and Educational Assistance Act to provide for tribal management of Indian health programs. Substance abuse and mental health are two programs that can be recommended for inclusion into the contracts or compacts between tribes and the Indian Health Service. While this act provides for an important shift of authority for health programs from the government to the tribes, the effectiveness of all programs is hampered by the significant lack of resources for Indian health. In testimony to the Senate Committee on Indian Affairs in 2000, Sally Smith, Chair of the National Indian Health Board, stated “Federal appropriations for Indian health have been shrinking relative to inflation, making it more difficult to provide health care to AI/AN.”

Indian Health Care Improvement Act. The Indian Health Care Improvement Act is the primary legislation that authorizes Congress to appropriate funding for Indian health services. This act was first passed in 1976 as Public Law 94-437 and has been reauthorized three times since. In the 107th Congress both the House²⁶ and Senate²⁷ have introduced amendments to the expired bill for its reauthorization. Title VII of the IHCA, Behavioral Health Programs, provides for the development of a comprehensive behavioral health prevention and treatment program that emphasizes collaboration between alcohol and

substance abuse, social services, and mental health programs. The draft legislation for the reauthorization of this act was developed through an extensive tribal consultation process. During this process, the National Indian Health Board stated its support for integrating programs, which are nurturing, fulfilling, accountable, and responsible in their ability to offer significant insight and opportunity for wellness and balance in our tribal communities.²⁷ The Indian Health Care Improvement Amendments section 701 (a)(5) ensures that Indians, as citizens of the United States and of the states in which they reside, have the same access to behavioral health services to which all citizens have access.²⁷

Rural Mental Health Accessibility Act of 2001. Additional pending legislation that may improve the mental health of American Indians includes the Rural Mental Health Accessibility Act of 2001, which authorizes monies to establish interdisciplinary programs in which mental health providers and primary care providers are trained side by side; establishes demonstration projects to provide mental health services via tele-health; and provides monies to conduct targeted public education campaigns with the goal of reducing the stigma and misinformation surrounding mental health.

Substance Abuse and Mental Health Services Administration. SAMHSA was established by Congress under Public Law 102-321 in 1992 to strengthen the Nation’s capacity to provide prevention, diagnosis, and treatment services for substance abuse and mental illness. An example of a recently funded initiative is the grant opportunities specifically for tribes and tribal communities, but these are very competitive and not every tribe or tribal community has the opportunity or resources for acquiring these grants.



Department of Justice. There is a great need to coordinate resources provided by different Federal agencies. One attempt to coordinate among Federal agencies involved the Mental Health and Community Safety Initiative for American Indian/Alaskan Native Children, Youth and Families. Launched in FY 2000 with the Department of Justice (DOJ), the Department of Health and Human Services (DHHS), and the Department of Interior, this initiative was designed to provide tribes with assistance in developing innovative strategies that focus on mental health issues. The Violence Against Women Act, passed in 1994, also specifies authorization for tribes to access services. The American Indian and Alaskan Native Affairs Desk has been established in the Department of Justice to enhance access to information by Federally recognized tribes regarding funding opportunities, training and technical assistance, and other relevant information. Previously the Department of Justice's primary involvement in Indian country was to investigate and prosecute crimes. Since 1994 the department seeks to empower tribes to combat crime at the local level by enhancing programs designed to better their own justice system, thereby reducing the environmental stressors that are known to be risk factors for depression among Indian women.

National Institutes of Health. The National Institutes of Health (NIH) is one of eight agencies in the Public Health Service of the Department of Health and Human Services, and is comprised of 27 separate Institutes and Centers including the National Institute of Mental Health (NIMH). The primary focus of NIH is research, and Congress has determined that medical research is a priority and plans to double the NIH budget within five years. However, the number of research studies on AI/AN health issues currently funded by NIH is low, despite significant and persistent disparities in their health status.¹ NIH has developed a strategic research plan to reduce and ultimately eliminate health disparities, which can be found at <http://heathdisparities.nih.gov/working/institutes.html>. One area of focus of the National Institute of Mental Health includes addressing suicide and depression among AI/AN. The NIMH web site will provide information for tribal leaders and tribal health directors on future Requests For Application (RFA).

Tribal Consultation. The Presidential Executive Order on Tribal Consultation and Memorandum initiated in 1994 states, "All executive departments and agencies shall consult with Indian tribes and respect tribal sovereignty as they develop policy on issues that impact Indian communities."²⁸ While the DHHS has a policy on tribal consultation, the Indian Health Service is the only agency that has implemented a comprehensive process for consultation. As agencies consider improvements in behavioral and mental health services, it is imperative that they consult in a meaningful way with AI/AN tribes to ensure that their policies and programs meet the sig-

nificant mental health needs in Indian communities.

Conclusions

AI/AN have less access to and availability of health care services, and thus have a greater disability burden from unmet mental health needs. Programs and policies are in place to address the problem; however, the resources are not. Congress, tribal leaders, agencies, and health care workers can effectively reduce the burden of disease caused by depression among AI/AN by addressing the following:

Data Collection: To determine the resources needed for adequate access to mental health service, improvements in the collection of data are critical in the assessment of problems and the impact of depression and other mental health disorders in AI/AN communities. More data are needed to help define the mental health needs of

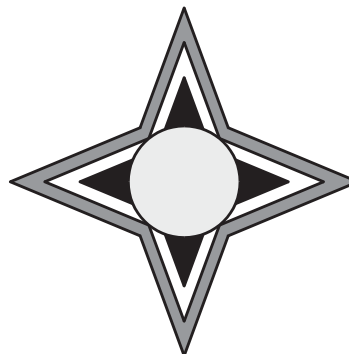
AI/AN, and to inform policy makers.²⁹ This includes measuring the impact of treatment methods used, such as pharmacologic agents, behavioral therapy, as well as alternative or complementary practices, including traditional healing practices and spirituality.

- *Education of Providers:* Culture counts, and cultural competency increases the likelihood of proper diagnosis and treatment.
- *Increase public awareness:* Specifically targeting AI/AN, thereby decreasing the stigma associated with depression.
- *Research:* Increase the numbers of AI/AN subjects and Indian communities involved in research on mental health issues, by offering projects through tribal colleges and over-sampling of AI/AN in large scale studies to ensure inclusion.
- *Prevention and Mental Health Promotion:* Prevention programs with proven effectiveness such as culturally and spiritually strong programs, and programs with a physical fitness component can help bring AI/AN people closer to a state of wellness.
- *Consultation:* Coordination and collaboration across agencies and with tribes is necessary in order to make positive impacts on eliminating health disparities.
- *Authorization of IHCA:* Increase the availability of, access to, and utilization of mental health services through authorization of the expired Indian Health Care Improvement Act.
- *Appropriate resources:* Allocation of adequate resources will improve the overall health of AI/AN.

As stated above, the problem of depression among AI/AN is real. There is much to be done, and there are many ways to be part of the solutions.

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PALLIATIVE CARE PEARLS □

The following article is the first in an ongoing series in support of the development of a unified approach to palliative care services for American Indians and Alaska Natives. The information will consist of brief, concise facts and information for providers of palliative care.

Dyspnea at the End of Life

Look for simple things first, then consider opioids as the drugs of choice

Judith A. Kitzes, MD, MPH, Soros Foundation, Project on Death In America Faculty Scholar, University of New Mexico Health Science Center, School of Medicine, Albuquerque, New Mexico

Assessment

Dyspnea may be present during the syndrome of imminent death, or it may occur earlier in the disease trajectory. Look for simple or common problems first: fluid overload, acute anxiety, severe pain, constipation, or urinary retention. Pulse oximetry, blood gases, electrocardiogram, or chest x-ray are not indicated if death is imminent.

General Treatment Measures

Try positioning (sitting up), use of an electric fan or open window, and relaxation techniques; decrease or discontinue intravenous fluids.

Treatment with Opioids

These are the drugs of choice, even in patients with chronic obstructive pulmonary disease. For an opioid naive patient, begin with low dose oral (10-15mg) or parental (2-5mg) morphine; if on chronic opioids, use 50% over the baseline regimen. If acute and severe, use 2-5mg morphine intravenously every 5-10 minutes until relief is obtained. Relief is what the patient perceives, and is not measured by oximetry or respirations/minute.

Treatment with Oxygen

This is not always helpful and is not always the first option. You may use a therapeutic trial; nasal cannulae are preferred over mask. There is little reason to go beyond 4-6 L/min.

Treatment with Other Drugs

These might include antitussives for cough, anticholinergics for secretions (e.g., a scopolamine patch), bronchodilators, and anxiolytics (e.g., lorazepam) for anxiety.

Family/team Discussions

Evidence is lacking that the use of opioids significantly hastens death in the presence of terminal dyspnea; a discussion

and ongoing dialogue including the family and the entire health care team is essential to avoid confusion about symptom relief versus fears of euthanasia or assisted suicide.

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Chronic Kidney Disease is a Public Health Issue

This article is the first in a series of 12 one-page articles about chronic kidney disease. This month's topic provides an overview of the series.

Andrew S. Narva, MD; and Theresa A. Kuracina, MS, RD, CDE, both from the Indian Health Service Kidney Disease Program, Albuquerque, New Mexico

American Indians experience high rates of chronic kidney disease (CKD), often resulting in end-stage renal disease (ESRD). At the end of 1999, 5361 people identified as AI/AN were being treated for ESRD, reflecting a prevalence rate 3.5 times greater than that of white Americans. The incidence rate for ESRD was 2.7 times the white rate and increased at 8% per year during the period 1992-1996. During the 10-year period from 1988-1997 the number of AI/AN with ESRD tripled.

The epidemic of diabetes mellitus among AI/AN, which began in the middle of the 20th century, appears to be driving the increase in ESRD. More than two-thirds (68%) of AI/AN who initiated treatment for ESRD in 1999 developed kidney failure as a result of diabetes, virtually all type 2, while only 25% of whites and 42% of blacks with ESRD were patients with diabetes. The incidence rate for ESRD due to type 2 diabetes among AI/AN during 1996-1999 (349/million) was three times the white rate (99/million), and was higher than any other disease-specific rate for any US race. Some communities of the southwest have extraordinarily high rates of kidney failure. In Zuni Pueblo, a community of 10,000 in western New Mexico, the prevalence of ESRD is 17,400 per million population. This is 4.5-, 5.7-, and 21.3-fold higher than that for African Americans, American Indians, and European Americans, respectively.

The purpose of this series of articles to be published in *The Provider* is to help clinicians improve the care we provide to patients with chronic kidney disease by describing new standards of care developed by the National Kidney Foundation, the Renal Physicians Association, and other kidney-related professional groups. These guidelines cover evaluation, classification, and treatment of persons with CKD, as well as preparation for renal replacement therapy (dialysis and transplantation).

The guidelines are similar to information published in *The Provider* over the past fifteen years but comprise a more comprehensive approach. These guidelines are evidence-based, reviewed by multiple disciplines, and available for general review prior to final publication. These guidelines are not

intended as standards or mandates. Rather, they should be used to "make informed decisions for each individual patient." However, it is likely that these guidelines will become the "gold standard" for the care of patients with chronic kidney disease.

This series will focus primarily on chronic kidney disease guidelines developed by the National Kidney Foundation through the Kidney Disease Outcome Quality Initiative (K/DOQI) and published in *The American Journal of Kidney Disease*; they can also be found at www.kidney.org/professionals/doqi/guidelineindex.cfm. In the coming months, we will summarize guidelines for:

- Evaluation, classification and monitoring of patients with CKD
- Evaluation and treatment of hypertension in CKD
- Evaluation and treatment of anemia in CKD
- Assessment of nutritional status and intervention
- Bone disease and disorders of calcium and phosphorus in CKD
- Lipid management in CKD
- Reducing cardiovascular disease in patients with CKD
- Assessment of functioning and well being in patients with CKD
- Preparation for kidney replacement therapy (modalities)
- Vascular access
- Performance measures for IHS

Why it matters

CKD is progressive and irreversible. Thus, the most effective interventions are those that identify patients as early as possible in the course of the disease and permit the institution of effective preventive measures. The patient care standards to be described in this series have the potential to significantly decrease the burden of CKD in the US population and among AI/AN. The public health model under which we operate and the high risk population we serve make the Indian health system an ideal model for implementation of these guidelines.

Personal Digital Assistants in the Indian Health Service

Scott Hamstra, MD, Whiteriver, Arizona; Chris Lamer, PharmD, CDE, Cherokee, North Carolina; and Carol Miller, BSN, MBA, McLean, Virginia; all with the Information Technology Support Center, Tucson, Arizona.

History and Background

John Sculley, the former Chairman of Apple Computer, coined the phrase “Personal Digital Assistant” (PDAs) with the release of the Apple Newton on July 22, 1993. The Newton was a small portable computer that was rich in features, including Internet connectivity, a phone book, a calendar, and an organizer. The Newton was heavy, had poor handwriting recognition, and was too expensive to be practical for its time.

In March 1995, Palm Computing launched the Palm Pilot. This PDA had fewer features and carried a much lower price tag. The Palm Pilot sold faster than the VCR, color TV, the cell phone, and even the personal computer. Since then, PDAs have become an integrated necessity in the information technology armamentarium.

With lower prices and the increased availability of clinical and non-clinical applications, the use of PDAs within the Indian Health Service (IHS) has been rapidly expanding. Providers and para-professionals have purchased their own PDAs and have been taking advantage of a wide variety of clinical and non-clinical applications. In response to this growing demand, the IHS Information Technology Support Center (ITSC) has initiated a PDA pilot test project in twelve Area sites. This will be the first in a series of articles to orient the novice to the use of PDAs and to provide additional knowledge to the expert user. In this first article, we will describe differences between some of the popular PDAs available to assist in selecting the most appropriate PDA for your intended usage.

Choosing a PDA

Your choice of a PDA will be based upon your primary use for the device, personal preference, and recommendations made by your IT or computer operations department. We will describe a few of the important considerations that should be considered when purchasing a PDA, including the following: 1) operating system, 2) hardware, 3) memory, 4) expansion capabilities, 5) battery life, 6) displays, 7) wireless capabilities such as e-mail and web-surfing, and 8) cost.

Operating System

Although many operating systems (OS) exist for PDA devices, two popular systems are utilized by a majority of PDA manufacturers. These systems are the Palm OS and the Windows CE OS. Differences between the two operating systems have been described in terms of their designed uses; the palm OS is designed to be utilized as an adjunct to the personal computer while the Windows CE OS has been designed to function as an independent computer.

With these differences come benefits and disadvantages. While offering greater functionality and the ability to run more than one program simultaneously, the Windows CE OS is less dependable and more prone to “crashes.” The palm OS is a very stable system but lacks some of the increased functionality of the Windows CE OS. Differences in software availability exist between the two OS choices, although software has been developed for both systems to provide similar functionality. As a rule, software written for the Palm OS is compatible with all Palm OS PDAs; for example, a program can be transferred from a Handspring Visor to a Palm m515 or a TRGpro without problem. Software based on one operating system (for example, Windows CE or Palm) is not usually compatible with the other.

Symbian (previously called EPOC OS) is another OS that has been utilized on PDAs (especially in Europe). Although no longer publicly marketed on PDAs, the Symbian OS can be found on new “smart” cell phones that offer advanced capabilities and graphical features.

Hardware

Nearly all PDAs share some way of interacting with a desktop computer. Generally, this is accomplished through the use of a PDA cradle, which is hooked up to your computer through either a serial or a USB port. This allows PDAs to perform a “hot sync” (an exchange of information) with the computer it is connected to. Not all cradles are designed the same, and different types or manufacturers of PDAs may require a different type of cradle. This is very important when several users may be sharing one computer. The type of PDA the several users each purchase may create a situation where they exceed the number of available ports on the computer, and it may not be possible to connect all cradles at once. If separate computers are utilized, the type of PDA used is less critical.

Memory

Memory is an extremely important issue -- too much is never enough. Every program that is installed on a PDA takes up space, which is called memory. Older PDAs used to be equipped with 2 megabytes (mb) of memory. Today many Palm OS PDAs come with 8 mb standard, and some are equipped with 16 mb (notably the Palm m515, Visor Pro, Treo communicators, and most Sony devices). PDAs that utilize the Windows CE OS require greater memory to operate. Most Windows CE PDAs are equipped with a standard 32 mb of memory although some PDAs such as the Jornada can be purchased with up to 64 mb of memory.

Although memory is a critical feature, it is also important to know that many PDAs can accept memory upgrades. Palms can utilize multimedia or SD cards; Sony utilizes the Memory Stick; many Windows CE devices can accept SD expansion cards; Handspring Visors and Treo Communicators may have expansion slots that can accept memory expansion modules; and the Treo can also accept SD cards.

Expansion

Many accessories, ranging from memory cards, to digital cameras, to miniature keyboards are available for PDAs. Many of the Palm Computing PDAs can be equipped with Multimedia or SD memory (storage) cards, as well as miniature keyboards that can be attached directly to the PDA. Sony PDAs can utilize Memory Sticks for memory and storage; nearly all of the Windows CE based PDAs accept memory expansion cards. Some Windows CE devices such as the Jornada and Compaq come with a built-in microphone and speakers. Handspring has taken an approach to broaden the utility of its organizers; Visors have an expansion slot that has been designed to accept a number of add on modules including: 1) modem and phone, 2) memory, 3) bar code scanners, 4) presentation utilities, 5) games, 6) digital cameras, 7) remote control devices, 8) voice recorders, 9) health and wellness manuals such as the Physician's Desk Reference, and even 10) a mini-massager. The Treo Communicator has been reported to retain this capability while providing the ability to utilize memory cards as well.

Battery Life

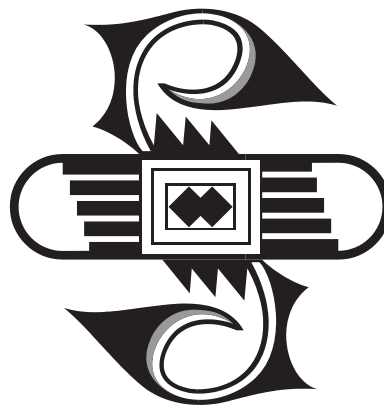
Battery life may affect your choice of a PDA. Most PDAs are utilizing rechargeable batteries that are stored within the device and recharge when you place the PDA on its cradle. Others require AA (some Blackberry devices) or AAA (Palm m105, m125, and older Handspring PDAs) batteries. If you have access your PDA cradle and an electrical outlet often (at least weekly), you may prefer to have a rechargeable battery. If you are frequently "out in the field" for prolonged periods of time and do not have access to a power outlet or your PDA cradle, you may prefer having the ability to stock up on batteries for your PDA. Some Windows CE devices, Sony PDAs,

and Blackberry devices are equipped with rechargeable lithium batteries that may also be replaced.

Factors influencing battery life include color displays (use more battery life than monochrome displays), operating systems (Windows CE tends to run batteries down more quickly due to the ability to run multiple programs at once, thus using more energy), and the use of the backlight (allows you to see your PDA in the dark) -- the longer you use your backlight, the faster your energy goes down.

Displays

Originally developed in monochrome (greenish background and black letters/numbers), PDAs have recently provided the user with the choice of a color display as well. Many of the higher-end PDAs such as the Palm m515, m130, Visor Prism, Visor Treo, Treo Communicators, Sony PDAs, and Windows CE OS devices provide color displays. The need for color is dependent upon the intended use of the device. If you want to store pictures or work with graphics, a color display may be essential in your choice of PDA. On the other hand, if you plan to use your PDA only as a database for words and numbers, or only plan on reading from your PDA, color may not be a factor in you selection. As stated above, at the present time color displays tend to drain battery life more quickly than the traditional monochrome displays.



Connectivity

Most PDAs have access to the Internet (e-mail, web pages, etc.) through one methodology or another. Palms have wireless capability when additional hardware is purchased, with the exception of the Palm i705, which has built-in connectivity through Palm.net services; the Handspring Visor can be fitted with the Visor Phone or a modem module and wireless services can be purchased through Cingular, Voice Stream, or Sprint; the Handspring Communicator comes equipped with a built in integrated cell phone; the Blackberry provides full time e-mail services and is currently one of the most secure wireless connections available through a government-specific Secure Multipurpose Internet Mail Extensions protocol upgrade; the Sony platform does not come equipped with wireless connectivity built in, although a modem attachment can be purchased; and the Windows CE platform provides many devices that come equipped with wireless capabilities such as the Jornada (with additional hardware), the Toshiba 2032, Audiovox Thera, and T-mobile Pocket PC edition.

Cost

In the end, one of the major determinants in your selection of a PDA may be the cost of the device. Early PDAs such as Apple's Newton ran as much as \$1,000 ten years ago. Fortunately, prices have dropped significantly as PDAs have been redesigned over the past years. A Palm OS-based PDA will run anywhere between \$100 to as much as \$500. With wireless capabilities, prices can be even higher. Windows CE-based devices are slightly higher priced, running about \$400 to \$800. Again, wireless connectivity is additional, and generally consists of a yearly or monthly payment.

As of this time, there are no cost savings with a government purchase contract for any of the PDAs. Prices for PDAs are very competitive; manufacturers are selling them at their lowest cost already and are unwilling to go lower. The Blackberry device is the only exception to this rule. The Blackberry can be purchased at a government rate in combination with a subscription for unlimited e-mail messaging for under \$1000. Other cost considerations should be made for warranties and extended warranties. Since PDAs are small and very transportable, there is a high potential to drop or accidentally damage the PDA. The screen is exceptionally vulnerable to falls and foreign objects, and one may spend the same amount of money replacing the PDA screen as one spent on the PDA device itself. A warranty will protect the PDA in these situations and may be worth the additional expense.

Summary

In summary, the choice of a PDA should be based upon your intended use for the device, personal preferences, and compatibility with other systems that are already in place. Be sure to check the recommendations made by your IT or computer operations department before making a purchase on your

own to ensure compatibility and adherence to local policy and procedures. Many websites are available that can provide further information on selecting a PDA such as the following:

<http://www.pdabuyersguide.com/index.htm>
<http://www.pdajd.com/vertical/tutorials/buyesrguide1.xml>
<http://www.pdamd.com/vertical/tutorials/buyersguide.xml>
<http://www.zdnet.com/special/filters/sc/pda/>
<http://www.pdabuzz.com/Features/BuyersGuide/>

Future Articles

Future articles will discuss the following subjects:

- the role of PDAs within the Indian Health Service
- results of the recent PDA usage survey
- clinical and non-clinical software
- the future role that PDAs may have within the Indian Health Service.



Send Us Your Notices About Your Meetings

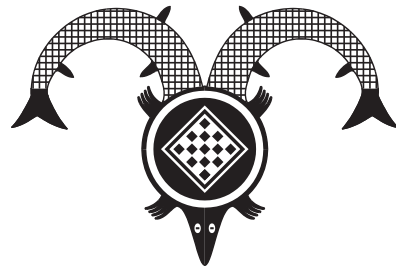
We continue to receive feedback from our readers asking *The Provider* to publish more announcements of continuing education activities in the *Meetings of Interest* section, and to publish them sooner. Those working in remote areas say that they need more information about what meetings are occurring, and they need it as early as possible so that they can make appropriate plans. In these days of shrinking resources, these meetings are often the most cost-efficient ways available to obtain high quality, relevant continuing professional education.

Keep in mind that it takes about three weeks from the time we deliver the finished copy to the printer until it reaches those in the field. All notices that we have available at the time we go to the printer are included, even if they are last minute submissions, so sometimes they appear within three weeks after they are received by us. However, if submissions come in just after the latest issue went to the printer, it can take up to seven weeks to get notices into the next issue that will come out.

We encourage all meeting planners who would want to invite a wide audience to attend their meetings to think about publishing notice about their activity in *The Provider*. Announcements can be placed early in the planning stages, even if all of the details aren't known, and the notice can be updated each month as more information becomes available.

There is no prescribed format for these notices; they should offer as much detail as is known about the target audience, goals, dates, location, featured faculty and topics, CE sponsorship and credit, location, costs, and contacts to register or obtain more information. Items can be submitted as paper copies through the mail, although it is faster and easier to use them if they come to us as an e-mail attachment.

Many of our readers prefer to attend meetings offered in Indian Country, so let's be sure that they know about as many opportunities as possible, with plenty of time to plan.



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.

Staff Physicians, Multiple Specialties Phoenix Area Indian Health Service

Challenging professional opportunity in a setting of rewarding, cross-cultural health care. Seeking BC/BE family practice, obstetrics and gynecology, internal medicine, general surgery, and emergency medicine physicians. Position available in urban and rural settings. Our physicians are eligible to apply for the IHS Loan Repayment Program. Please send resume and/or inquiries to Kim R. Smith by fax at (602) 364-5358; or e-mail kim.smith@mail.ihs.gov. Equal Opportunity Employer.

Chief of Medicine General Internists Phoenix Indian Medical Center; Phoenix, Arizona

Challenging professional opportunity in a rewarding cross-cultural health care setting. Recruiting a Chief of Medicine: Board Certified, five years of experience, prefer several years of IHS experience. Also recruiting for two full time general internists immediately, one with an interest in HIV/AIDS, and a third general internist position in summer, 2003. The practice utilizes a hospitalist internal medicine model and includes a busy primary care medicine clinic. The internal medicine department has a staff of eleven internists, including endocrinology, pulmonology, and other sub specialists. Please contact 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. Equal Opportunity Employer.

Licensed Clinical Social Worker LVN/RN/PHN Primary Care Physician Dental Director Greenville Rancheria; Greenville, California

The Greenville Rancheria is seeking a full-time, California licensed clinical social worker with experience in

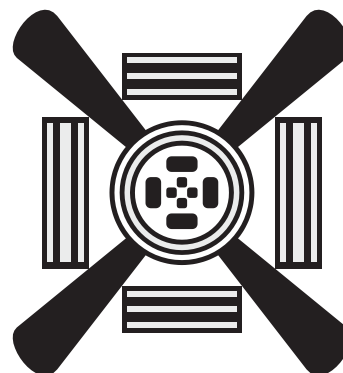
mental health and substance abuse counseling, to serve in Plumas and Tehama Counties. We are also seeking a full-time LVN/RN/PHN. Excellent comprehensive benefits package.

For the full-time primary care physician position, we prefer a physician who is board certified in family medicine or internal medicine. This is an active primary care community clinic (8 am - 5 pm, Monday - Friday with no after hours call/pager). There is a great working environment and friendly staff to assist you in giving the highest quality of care to both Indian and non-Indian patients. Excellent and competitive salary compensation (DOE) and a comprehensive benefits package (vision, medical, and dental). Relocation fees available.

We also have an immediate opening for a full-time California licensed dentist. Job responsibilities include comprehensive clinical chairside dentistry with professional work in prevention, diagnosis, and the treatment of diseases. Competitive pay and benefits package.

Interested in the Greenville Rancheria? It only gets better. The Greenville clinic is located in northeastern California, where the Sierra Nevada and Cascade mountain ranges meet. Set in Plumas County, which boasts more than 100 lakes and 1,000 miles of rivers and streams, with over a million acres of national forest. A beautiful place to water ski, snow ski, hike, hunt and fish, mountain bike, and play golf. With only eight people per square mile, and no stoplights, this rural, four seasons mountain retreat offers beauty, solitude, affordable living, and clean air. The location is absolutely beautiful!

To learn more about the Greenville Rancheria, we encourage you to visit our website. Interested applicants should forward a resume and letter of interest to Stephen D. Jones, Human Resource Department, Greenville Rancheria, P.O. Box



279, Greenville, California 95947; phone (530) 284-7990; fax (530) 284-6612; e-mail sjones.hr@greenvilleraancheria.com; or visit our website at www.greenvilleraancheria.com. Indian Preference, Title 25, USC 472 & 473.

Family Physician

Northern Navajo Medical Center; Shiprock, New Mexico

The Department of Family Medicine has an opening for a full time family physician who is interested in practicing the full spectrum of family medicine in an interesting, challenging, and rewarding work environment. Northern Navajo Medical Center is a 60-bed hospital in the Four Corners Region, surrounded by the most beautiful countryside in the United States. Shiprock is only a short drive from Telluride, Colorado or Taos, New Mexico for great skiing. Durango, Colorado and Moab, Utah offer internationally recognized mountain biking opportunities. Arches and Canyonlands National Parks, Canyon De Chelly, Monument Valley, and the Rocky Mountains are areas close by to enjoy local hiking, camping, kayaking, ice climbing, and fishing.



We are a group of 12 family physicians serving a busy outpatient panel of families and providing adult and pediatric inpatient, ICU, and obstetrics care. Call is one weekend out of five, cross-covering two weekdays per month. The Northern Navajo Medical Center has an excellent support staff including obstetricians, general surgeons, orthopedic surgeons, a podiatrist, ENT, and neurology, as well as midwives, pediatricians, internists, and psychiatrists.

Salary and benefits are competitive, housing is available, and loan repayment is available. Farmington, New Mexico and Cortez, Colorado are within 30 minutes drive if you are interested in commuting to work. If interested, please call Dr. Mary Porvaznik at (505) 368-7053; or e-mail mary.porvaznik@shiprock.ihs.gov.

Full-time Dentist, Full-time Hygienist (at Chico, California)

Full-time Dentist, Part-time Dentist (at Willows, California)

Northern Valley Indian Health, Inc.

Come join our dental team! Northern Valley Indian Health, Inc. is seeking a full-time dentist for the Chico and Willows clinics and a full-time hygienist for the Chico clinic. NVIH offers a competitive salary, comprehensive benefits package, and an opportunity for IHS loan repayment.

NVIH also has a part-time dentist position open in the Willows clinic. This part-time position will be staffed a minimum of two days per week. This is perfect for the semi-retired practitioner or someone employed part-time elsewhere.

The Northern Valley Indian Health, Inc. Willows Clinic is located between Redding and Sacramento, right off Interstate 5. Our Chico Clinic is just 35 miles east of the Willows site. For more information, contact Katie Leeman at NVIH, 845 W. East, Chico, California 95926; telephone (530) 896-9412; fax (530) 896-9406.

Family Practice Physician

Chapa-De Indian Health Program; Auburn, California

Chapa-De Indian Health Program is seeking a full-time BC/BE family practice physician to join our medical staff. Chapa-De is a comprehensive community care system located in beautiful northern California. We provide medical, dental, behavioral health, optometry, and pharmacy services for patients in a four county service area. Join our staff of four family practice physicians and a pediatrician. Provide inpatient care at a nearby 100-bed hospital. Enjoy a competitive salary, excellent benefits, and an opportunity for IHS loan repayment. Must have a California license. For more information, please contact Darla Clark, Clinical Administrator, at (530) 887-2800; or by e-mail at dccdihp@yahoo.com. CVs can be faxed to (530) 887-2849.

Family Physician

SouthEast Alaska Regional Health Consortium; Juneau, Alaska

We are seeking a BC/BE family physician to join a dynamic group practice in beautiful southeastern Alaska. Unlimited recreational opportunities, excellent school, music, and theater opportunities. Live and work in an area of unsurpassed natural beauty. State of the art Native health care facility; admit to private hospital. Call 1:6; obstetrics required. Competitive compensation package. For further details contact Dr. Doug Smith, Medical Director, at (907) 463-4057; or e-mail doug.smith@searhc.org.

Supervisory Clinical Nurse, GS610-11

Chinle Comprehensive Health Care Facility; Chinle, Arizona

The Chinle Comprehensive Health Care Facility, a 60-bed IHS hospital located approximately three hours east of Flagstaff, is seeking an experienced manager for ambulatory care unit. The unit provides care in three areas: adult, pediatrics, and maternal/child. Specialty clinics occur on a rotational basis. Must have a current unrestricted license. Previous experience managing professional and nonprofessional staff is a plus. The ideal candidate will enjoy collaborating with other disciplines and developing staff. Housing is available. Travel and relocation expenses paid.

Please send CV and/or inquiries to Lori Smith at (928) 674-7020; e-mail lorraine.smith@chinle.ihs.gov; or P.O. Drawer PH, Chinle, Arizona 86503.

Dietitian

Chinle Comprehensive Health Care Facility; Chinle, Arizona

Dietitian needed to work in the hospital and clinics of the Chinle Service Unit. The incumbent will possess a degree in dietetics, food, nutrition, food service management, institutional management, or related science. Candidates must have demonstrated in their work experience and training that they possess, or have the potential to develop the qualities of successful supervision. The candidate assists the Supervisory Dietitian with the planning, coordination, administration, and evaluation of individuals and families in nutritional principles, dietary plans, food selection, and economics; plans, calculates, and evaluates modified diets; determines what type of nutritional products to stock; and monitors inventory. Plans, advises, and participates in the development, execution, and evaluation of nutrition education programs; provides training to dietary employees, medical, nursing, and other hospital/clinic staff. She/he assists in establishing, evaluating, and reporting quality assurance data and acts as Supervisory Dietitian in the absences of the Supervisory Dietician. Performs other duties as assigned.

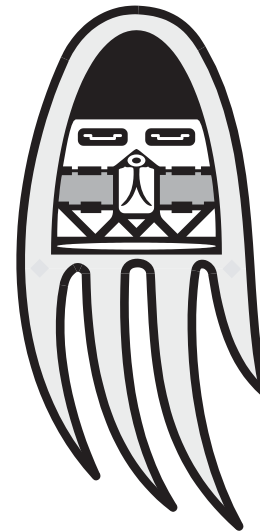
Travel and relocation expenses paid for eligible employees. The ideal candidate should enjoy living in a rural setting. Please send CV and/or inquiries to Lori Smith at (928) 674-7020; e-mail lorrain.smith@chinle.ihs.gov; or P.O. Drawer PH, Chinle, Arizona 86503.

Clinical Child Psychiatrist

Chinle Comprehensive Health Care Facility; Chinle, Arizona

The Chinle Comprehensive Health Care Facility, a 60-bed IHS hospital located approximately three hours east of Flagstaff, is seeking a clinical child psychiatrist. Applicant should enjoy working with children and enjoy living in a rural setting. Housing available. Travel and relocation expenses paid.

Please send CV and/or inquiries to Lori Smith at (928) 674-7020; e-mail lorraine.smith@chinle.ihs.gov; or P.O. Drawer PH, Chinle, AZ 86503.



Advanced Practice Nurses Annual Business Meeting Report

*Judith Whitecrane, CNM, Phoenix Indian Medical Center;
and APN representative to the National Council of Nurses,
Phoenix, Arizona*

The annual business meeting for advanced practice nurses (APNs) in Indian health was held June 3-4, 2002 in conjunction with the PA/APN Continuing Education Conference in Scottsdale, Arizona. About forty APNs from IHS, tribal, and urban programs attended this meeting. They included family nurse practitioners, adult nurse practitioners, certified nurse midwives, women's health care nurse practitioners, pediatric nurse practitioners, and mental health nurse practitioners.

The agenda included discussion of current issues affecting APNs, reports from the IHS Areas represented by attendees, and a special visit from the Acting Principal Nurse Consultant of the IHS, Celissa Stephens RN, MSN.

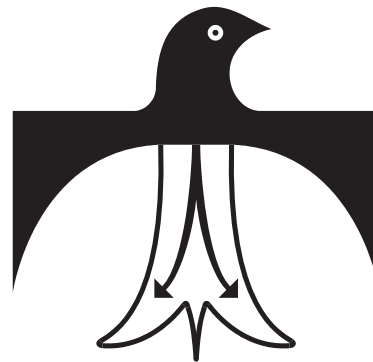
The following resolutions were determined to be of great importance to attendees and were submitted by the group to the IHS National Council of Nurses (NCON) for their support:

1. *Salary increase initiative:* Continue to support the salary increase initiative for IHS Civil Service nurses, including a yearly review of salaries to keep pace with the private sector. (Since this meeting, this initiative has been approved and is awaiting implementation.)
2. *Position Descriptions and Classification Standards:* Revise the outdated (1977) classification standards and position descriptions for APNs that describe the beginnings of the APN profession. (A fall meeting has been planned by NCON to begin this process.)
3. *Bonuses:* Encourage CEOs to provide retention on recruitment bonuses
4. *Hard to fill vacancies:* Consider APNs in hard to fill physician vacancies, especially mental health nurse practitioners. Patients need the care and APNs can deliver it.
5. *Continuing education:* Advocate for equitable continuing professional education funding for APNs comparable to physicians in Indian health.
6. *Loan repayment:* Advocate for continuing loan repayment for all APNs. Additionally, there are APNs working in supervisory and staff nursing

positions who have been unable to get loan repayment because they do not work in the area of their degree. For instance, a nurse-midwife who works as a supervisor of a remote obstetrics unit is not eligible for loan repayment because he or she is not working as a nurse-midwife.

7. *Position Paper:* Write a position paper for *The Provider* to inform readers of the workload, current practice, and potential additional contributions of APNs to Indian health. Workload data are needed for this (several NCON members have already sent workload data reports from their Areas).

The funding support for this annual meeting received from Headquarters Nursing is gratefully acknowledged.



NCME VIDEOTAPES AVAILABLE □

Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004.

These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These CME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in The IHS Provider on a regular basis.

NCME #801

Asthma in Children (60 minutes) Asthma in childhood is on the "top 10" list of reasons for ambulatory visits to primary care physicians every year. It is particularly problematic among urban populations and families of low socioeconomic status. Childhood asthma poses unique diagnostic and management challenges for pediatricians, family physicians, and all clinicians who deal with young patients.

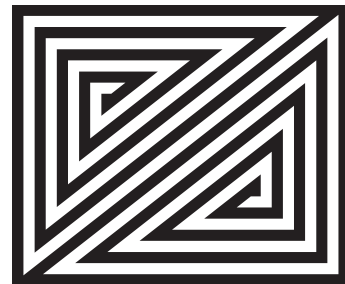
It has often been said, however, that the pediatric patient is not just a small adult. Beverly J. Sheares, MD of the Children's Hospital of New York-Presbyterian and the Pediatric Pulmonary Division of Columbia University College of Physicians and Surgeons, explains just what the critical differences are between adult and pediatric patients with asthma. In addition, she outlines her "fast-track" approach to recognizing this chronic respiratory disease and controlling both its symptoms and the underlying inflammation that defines the disease process.

To maximize the practical value of this educational program, Dr. Sheares, who includes the improvement of the health education skills of physicians and the self-regulation skills of families of children with asthma among her professional interests, explains how to get the most from the patient interview and the history when making the diagnosis, how to avoid common pitfalls in the physical examination, and why the chest X-ray is both important and potentially misleading. She then outlines the pros and cons of the important classes of asthma medications in the context of childhood asthma and describes how she enlists the child and the family in a partnership to ensure long-term control of asthma.

NCME #802

Treatment Adherence: How to Improve Patient Compliance (60 minutes) Statistics on patient adherence/compliance show that people don't always follow the doctor's orders. The National Council for Patient Education and Information estimates that about one half of prescriptions written in the United States are not taken properly. Nonadherence negatively impacts the elderly, patients with psychiatric disor-

ders, and HIV-infected patients, as well as patients with chronic diseases such as hypertension, diabetes, or asthma. Dr. Atkins presents strategies to improve adherence, which will in turn increase patients' chances of benefitting from recommended treatments. This program will help physicians and their office personnel develop a better understanding of patient behavior.



MEETINGS OF INTEREST □

Fourth Annual Diabetes Management: Type 2 Update October 4-5, 2002; Mt. Pleasant, Michigan

The Fourth Annual Diabetes Management: Type 2 Update will be sponsored by the Nimkee Memorial Wellness Center and The Saginaw Chippewa Indian Tribe of Michigan. The conference will be held October 4th and 5th at the Soaring Eagle Resort and Conference Center.

Our goal is to bring the latest in diabetes information to all health care providers. This includes physicians, pharmacists, nurse practitioners, physician assistants, nurses, diabetic educators, dietitians, health educators, pharmacy or dental technicians, and anyone interested in learning more about diabetes. Pending approval, CMEs and CEUs will be available.

A variety of aspects concerning diabetes will be offered including updates in nephrology, medications, cardiology, and holistic health. We will also have the latest on nutrition, neurology, and immunizations. The keynote speaker will be Dr. Richard Rubin from the Joslin Institute.

The registration fee is unchanged from last year at \$150 for physicians, \$110 for nurses and allied health, and \$60 for students or retired personnel. This will cover the cost of the sessions as well as credits and meals. If you bring a guest, \$40 will cover meals only. Dinner Friday as well as breakfast and lunch Saturday will be provided by Soaring Eagle.

This beautiful four star resort has an elegant conference center with excellent amenities. It is connected to the Soaring Eagle Casino, with all of its entertainment available. The resort has an indoor pool and wonderful spa. Childcare is available next to the center at Kids Quest during the afternoon and evening hours. First class rooms are available for Friday and Saturday at a special rate of \$71.00 per night.

For a brochure or more information, please call (800) 225-8172, extension 54674; e-mail bskutt@sagchip.org; or go to our website at www.sagchip.org.

Indigenous Healing Traditions of the Americas: Paths to a New Medicine November 14 - 17, 2002; Washington, DC

This conference will be convened in Washington, DC from November 14-17, 2002 to explore the uniqueness, wealth, and complexity of the healing traditions indigenous to the Americas, with emphasis on their potential for delivering culturally sensitive and effective health care. The conference objectives are as follows: to raise awareness of, and respect for the traditional healing systems of the Americas; to review cur-

rent successes in integrating indigenous medical traditions into Western health care delivery systems; to enhance knowledge of traditional healing systems among Western health care providers; and to provide the opportunity for better understanding through direct interactions with traditional healers.

This conference is organized by Pro-Cultura, Inc.; it is sponsored by the Continuum Center for Health and Healing, Beth Israel Medical Center; with the participation of the Association of American Indian Physicians; the Center for American Indian Research and Education, University of Minnesota; the Indian Health Service; the National Aboriginal Health Organization (Canada); the National Center for Complementary and Alternative Medicine, National Institutes of Health; the National Museum of the American Indian, Smithsonian Institution; the Native American Research and Training Center, University of Arizona; the Pan- American Health Organization/World Health Organization; and others.

The meeting will be held at the Hyatt Regency, Capitol Hill, Washington, DC. For registration, program, CME, or other additional information, visit www.procultura.org; e-mail mail@procultura.org; telephone (866) 547-3309; or fax (317) 328-1475.

Acute Coronary Syndrome Symposium November 15, 2002; Santa Fe, New Mexico November 16, 2002; Santa Fe, New Mexico (for PHNs and CHRs) November 16, 2002; Albuquerque, New Mexico

The Native American Cardiology Program is pleased announce the continuation of its latest Cardiovascular Continuing Medical Education Seminar Series with the Acute Coronary Syndrome Symposium. The full-day provider conference for physicians, physician assistants, nurse practitioners, nurses, pharmacists, along with interested others will include seminars on topics from clinical identification, to ECG interpretation, case studies, the use of cutting edge medical interventions, as well as effective CVD prevention activities from an Indian health perspective. The full-day nursing conference (November 16) will also focus on cardiovascular disease pathophysiology, clinical presentations, and evaluation, as well as the prevention of CVD.

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.



NTHRC FELLOWSHIPS

The Northwest Portland Area Indian Health Board is looking for American Indian and Alaska Native pre- and post-doctoral students who are interested in a fellowship position at Oregon Health and Sciences University or the University of Washington.

What Experience Will an NTHRC Fellowship Offer?

That's up to you. NTHRC has a short list of requirements for its fellows, but a long list of innovative and flexible tools that you can use to tailor your fellowship experience.

The Requirements

Each fellow will spend two years at one of the two premier medical research institutions of the Pacific Northwest:

Oregon Health & Sciences University in Portland, Oregon or the University of Washington in Seattle, Washington. Although you will choose one school as your "home base," you will attend frequent seminars and workshops at the other school. These seminars will help foster your research skills. At your home base, you will work with your mentor on a project in biomedical, clinical, behavioral, or population-based research.

For more information, contact Luella Azule, Project Coordinator, Northwest Tribal Research Center, Northwest Portland Area Indian Health Board, 527 SW Hall St., Suite 300, Portland, Oregon 97201; telephone (503) 228-4185.

NMGEC “Virtual” Geriatric Institute

The New Mexico Geriatric Education Center (NMGEC) is excited to announce their first “Virtual” Geriatric Institute videotaped from the actual Summer Geriatric Institute just held in June. From your office or home computer, and at your convenience, you can get the geriatric information you need to provide quality care for elders.

Topics include “Frail Elders,” “Fall Prevention,” “Incontinence,” Osteoarthritis,” “Osteoporosis,” “Sensory Deficits,” and “Oral Health.” Log on and check it out; the “Virtual” Geriatric Institute is accessible on our website at <http://hsc.unm.edu/som/fcm/gec>.

The tuition is \$40 per topic or \$100 for all. Tuition waivers are available for IHS/tribal providers, so please check with us about this. The course offers continuing medical education (CME) credit as well as continuing education credit for social workers (pending), nurses, and allied health providers.

If you have questions about this new offering from the NMGEC, please contact us by telephone at (505) 277-0911; or e-mail dfranklin@salud.unm.edu.



Change of Address or Request for New Subscription Form

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