THE IHS PRIMARY CARE PROVIDER

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

January 2004 **Volume 29 Number 1**

The IHS Behavioral Health System

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With the widespread deployment of the Behavioral Health System (BHS) v3.0 in January 2003 and the earlier release of MH/SS v2.0, behavioral health is at the forefront of the Indian Health Service (IHS) and the health care industry-wide movement toward the use of computer-based patient records. For several years, through the use of these applications, BH providers have been able to electronically document not only Purpose of Visit and Activity codes needed for billing and workload reports, but also encounter notes and treatment plans. This has given the BH programs the only fully capable electronic medical record in the Indian health system to date.

There are now over 120 IHS, tribal, and urban (I/T/U) sites using BHS v3.0 to electronically document the provision of mental health, alcohol and substance abuse, and social work services. An effort is presently underway to expand this capability to other medical programs, through the IHS Electronic Health Record. The November 2003 issue of *The IHS Primary Care Provider* included a general discussion of the benefits of an electronic health record and provided additional information on the IHS-EHR product and program.

The movement toward the use of an electronic health record (EHR) coincided with a decision by the previous IHS Director, based on consultation with tribal and urban leaders, to set aside funding from the FY 2001 Omnibus Appropriations Act for improved behavioral health data collection and analysis. Additionally, in order to provide more comprehensive services and improve client outcomes, many I/T/U mental health, alcohol/substance abuse, and social work programs are combining their activities into one integrated behavioral health (BH) service delivery model. This integration requires improved information technology to support the flow of information needed for comprehensive case management, while also maintaining client confidentiality and privacy. Providers, now often in larger and busier behavioral health departments, need a user-friendly software application that allows them to optimize their time with clients while still meeting important clinical documentation and reporting requirements. In this time of decreased funding and competing priorities, I/T/U health care facilities and programs are increasingly concerned with maximizing collections for BH services, just like for other clinical services.

In FY 2002, the IHS Information and Technology Support Center (ITSC) partnered with the Division of Behavioral Health (DBH) to develop a long-term, integrated BH application. A Behavioral Health Management Information System

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(BHMIS) workgroup, consisting of practicing I/T/U BH clinicians and program managers, was formed and tasked with defining the requirements of the long-term application, as well as those for the interim BH applications including BHS v3.0 and its corresponding graphical user interface version.

Current BH Applications

The ITSC demonstrated BHS v3.0 and a prototype of the Behavioral Health graphical user interface (BHGUI) application at several I/T/U meetings this year, including the National Councils for Indian Health meeting, the annual IHS Division of Behavioral Health (DBH) meeting, and two annual National Council of Urban Indian health meetings. In FY 2003, over 250 BH providers and support staff were trained on BHS v3.0. Eleven Areas participated in 16 two-day training events. Many of the new users of BHS v3.0 are providers at tribal and urban facilities. The application is in use at diverse locations, such as a youth alcohol and substance abuse residential treatment center in South Dakota, an IHS-direct mental health program in Chinle, Arizona, and an urban outpatient behavioral health program in Jamaica Plains, Massachusetts.

Functionality

BHS v3.0 and the BHGUI combine select functionality and data elements from the earlier behavioral health applications — MH/SS v2.0, the Navajo version of MH/SS, and CDMIS. With BHS v3.0, providers can document clinical care, record program activities, and generate a wide variety of reports. Individual, family and group services can be recorded, including SOAP progress notes and any patient and family education provided. Treatment plans and treatment reviews can also be recorded in detail. The CDMIS staging tool, a placement tool administered at different intervals in the continum of care in alcohol and substance abuse treatment, can also be recorded electronically. Non-direct client care activities such as community prevention and consultation services and clinical supervision can be recorded. The addition of a new suicide surveillance tool allows programs, Area Offices, and the DBH to record and track the occurrence of suicide attempts and completions, and provides important epidemiological information.

While the graphical user interface provides the user with a familiar Windows-style front end, the very robust "roll and scroll" BHS v3.0 remains the back-end to the BHGUI. GUIs are intended to be more intuitive and user-friendly than roll and scroll applications, and a user-centered design approach to their development can enhance their usability even more.

Usability and Design

Direct provider entry of clinical information is encouraged when using the BH applications. Direct provider entry improves the accuracy of clinical notes, reduces errors, and helps protect patient confidentiality. However, the BH applications will continue to permit the entry of clinical data by support staff. Most I/T/U behavioral health programs continue to use a hybrid system of computerized and paper-based patient records. Improved technology allowing the integration of original documents and correspondence (signed releases, discharge summaries, consultation reports from outside facilities, etc.) into the patient's computerized record will help to achieve a truly comprehensive electronic medical record (EMR).

Perhaps more than improved technology, improved usability and design will be the factors that make the provider give up the pen and chart for the keyboard and screen. With this in mind, the IHS has contracted with Human Factors International (HFI), recognized experts in the field of GUI usability and design. HFI and the ITSC conducted extensive end-user interviews and usability testing of preliminary BH user interface structures at four I/T/U behavioral health programs. In June 2003, HFI provided a final usability analysis of the prototype BHGUI, final BH style sheets, and GUI standards. It is hoped that the long-term behavioral health application, developed using GUI industry standards, user-centered design, and usability testing and analysis, will encourage more providers to make the transition to an EMR.

BHGUI and Patient Chart

The BHGUI resides within the existing IHS GUI application, Patient Chart. Patient Chart was released in December 2001, and a cache-compliant version, Patient Chart v1.3, was released in September 2003. Patient Chart facilitates access to a variety of RPMS data, direct manipulation of problem list information, entry of vital signs and measurements, viewing and graphing of measurements and labs, lab order entry, and Referred Care (RCIS) entry and look-up. The BH module, or "tab," will be accessible only to those providers who are given the appropriate security keys. The BH module contains all of the current functionality in BHS v3.0, including the ability to document patient encounters and treatment plans (see Figures 1 and 2 at the end of the article).

Graphical user interfaces are generally more intuitive and acceptable to those users familiar with Windows and Mac applications, and Patient Chart provides a readily accessible and user-friendly alternative to the existing RPMS behavioral health application. Many facilities currently using RPMS will already have the software and desktop requirements necessary to run Patient Chart.

Beta testing of the BHGUI began on September 26, 2003 at the following I/T/U sites:

- Chinle Comprehensive Health Care Center
- Warm Springs Health Center
- Phoenix Indian Medical Center
- Shingle Springs Tribal Health Center

Friendship House, an urban residential alcohol and substance abuse treatment center in San Francisco, will join the beta process at a later date. The second phase of beta will include testing of the new Group Entry functionality as well as modifi-

cations and enhancements that were made based on feedback received during the initial beta testing period. The BHGUI, Patient Chart v1.4, will be released in January 2004. A training and deployment plan for FY 2004 is being developed.

The Future

The BHMIS work group, comprised of I/T/U mental health, alcohol/substance abuse, and social work subject matter experts, met in Albuquerque in November to review the development of the BHGUI and to refocus attention on the development of the long-term application. New requirements include the VHA Text Integration Utility (TIU) for clinical documentation; computerized provider order entry (CPOE) for medication, lab, radiology and dietetic orders; clinical decision support (CDS) or clinical guidelines; and inclusion of the VHA Mental Health Assistant (MHA) application. MHA is an application that allows the provider to administer standard psychological and behavioral health tests with a text-based or graphical display of the results. Programming on the long-term application, Integrated Behavioral Health (IBH), will begin in February 2004.

The BHMIS workgroup also discussed the implications of including the IBH as a component of the IHS Electronic Health Record (EHR), currently in development. Those BH programs located at sites not implementing the EHR will be able to continue to use BHS v3.0 or the BHGUI in Patient Chart. Additional information and updates can be found on the Integrated Behavioral Health (IBH) web pages on the IHS Internet site at *http://www.ihs.gov/cio/bh*.

Figure 1. BH GUI; Regular Visit (fictitious data)

Figure 2. BH GUI; Treatment Plan (fictitious data)

Treatment Plan Add

Treatment Plan Documentation — Demo/Hospital Clinic

SMALL,AMY CECILIA F 04/15/1974 276269538 31585

Date Treatment Plan Established	12/22/2003	**Designated Provider**	MOORE,CATHERINE
Program	MENTAL HEALTH	Concurring Supervisor	ADAM,ADAM
Case Admit Date	12/22/2003	Concurring Date	12/22/2003
Resolve By Date	6 /22/2004	Status	ACTIVE
Next Review Date	1 /22/2004	Date Closed/Resolved	12/22/2003

Diagnosis/Problem | Plan Narrative | Plan Review

Axis I: Major Depressive Disorder, Recurrent, Moderate

Axis II: No Diagnosis

Axis III: Asthma

Axis IV: Major Psychosocial or Environmental Problems

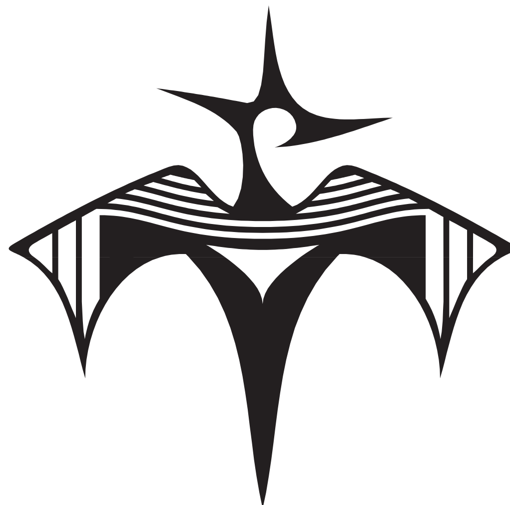
Code	Narrative
1	PRIMARY SUPPORT GROUP PROBLEMS

Add Delete

Axis V: (GAF) 65

Problem(s): sad and tearful every day; isolating from family and friends; missing work 1 - 3 x month because of depressed mood

Close Save Clear



Editor's Note: The following is excerpted from the monthly Notes from the Elder Care Initiative *that is published as an e-mail newsletter. Information about how to subscribe can be found below. We would appreciate your feedback about whether or not you will find a periodic digest of this publication printed in* The Provider *useful.*

Notes From The Elder Care Initiative

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Northampton, Massachusetts

What's New

Medicaid Home Care for Tribal Health Services: A Tool Kit for Developing New Programs

Under contract from the Indian Health Service Elder Care Initiative, the UCLA Center for Health Policy Research, American Indian/Alaska Native Research Program has developed and disseminated a series of state-specific guides to funding for home and community-based long-term care services for the elderly. These toolkits identify the state programs that support home and community-based long-term care services, detail eligibility requirements for elders, and outline the requirements for tribal programs as service providers under the various programs.

Information includes:

- Why provide Medicaid personal care services?
- What are personal care and other non-medical in-home services?
- Medicaid programs that provide in-home services
- How personal care and other in-home services are provided
- Tips for developing a plan for delivering Medicaid home care services

This concise and readable guide will be a valuable technical assistance tool for tribes developing long-term care services.

The toolkit is available on-line at the Indian Health Service Elder Care Initiative website at *http://www.ihs.gov/medicalprograms/eldercare* or the UCLA Center for Health Policy Research website at *http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=79*. Hard copies are available on request.

From the Literature

Anticoagulation In Nonvalvular Atrial Fibrillation

A number of studies have shown the benefit of anticoagulation in patients with atrial fibrillation (including older patients). Two new studies emphasize this and add to our understanding.

In the "real world" setting of a large HMO, Go, et al followed over 11,000 persons, mean age of 71, with nonvalvular atrial fibrillation and no contraindication to anticoagulation, for up to three years. Those on warfarin anticoagulation had a reduction in risk of stroke and thromboembolism of 64% and a reduction in all cause mortality of 31%. Intracranial bleeding was "uncommon" but increased in those on warfarin, while there was no increased risk of extracranial hemorrhage.

In the second study, in the same cohort of patients, Hylek, et al evaluated the outcome of anticoagulation based on intensity of treatment. There was a clear benefit for those patients with nonvalvular atrial fibrillation whose INR was above 2.0 compared to those with an INR of 1.5 - 1.9, with a reduction in both frequency and severity of stroke. There was no increased risk of intracranial bleeding in those with an INR of under 3.9.

Anticoagulation to an INR of 2.0 in those with nonvalvular atrial fibrillation and no contraindications reduces frequency and severity of stroke and saves lives.

References

1. Go AS, Hylek EM, Chang Y, Phillips KA, Henault LE, Capra AM, Jensvold NG, Selby JV, Singer DE. Anticoagulation therapy for stroke prevention in atrial fibrillation: how well do randomized trials translate into clinical practice? *JAMA*. 2003;290(20):2685-92.
2. Hylek EM, Go AS, Chang Y, Jensvold NG, Henault LE, Selby JV, Singer DE. Effect of intensity of oral anticoagulation on stroke severity and mortality in atrial fibrillation. *N Engl J Med. 2003;349(11):1019-26.*

How to Subscribe

To subscribe to the monthly e-mail newsletter, *Notes from the Elder Care Initiative*, subscribe to the *Eldercare* listserv by sending an e-mail to *listserv@listserv.ihs.gov*. In the body of the e-mail write the following: subscribe eldercare your first name your last name. More information is available at *http://www.ihs.gov/cio/listserver/index.cfm*.

PALLATIVE CARE PEARLS □

Death Pronouncement: Final Medical Act

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

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

Since the Civil War in the United States, physicians have been engaged in "death pronouncement." The phone will ring, and you will hear, "Please come and pronounce this patient."

Preparation

Review the circumstances of the death (expected, or sudden); presence of family; unusual family dynamics; age, diagnosis of patient; status of attending physician notification; appropriateness of an autopsy request or Organ Donor Network contact; preference for spiritual support.

In the Room with Family Present

Bring the nurse or chaplain in to help with introductions. Empathetic statements are appropriate, such as, "I'm sorry for your loss . . .," or "This must be very difficult for you . . .." Explain what you are there to do, and invite the family to stay as long as they want.

Pronouncement tasks

- Identify the patient: hospital ID tag.
- Note the general appearance of the body.
- Ascertain that the patient does not rouse to verbal or tactile stimuli.
- Check for absence of heart sounds, carotid pulse, spontaneous respirations, pupillary light reflex, and position of the pupils.

Medical Record Documentation

- Your name and name of person who called you to pronounce death.
- Physical examination.
- Date and time of death; time of your completed assessment.
- Status of family and attending physician notification.
- Status of autopsy request.
- Coroner notification if required.

Self Care

Allow yourself a few moments to be quiet and still in the presence of death. If needed, debrief with a colleague or friend.

References

1. Marshall SA, Ruedy J. On Call: Principles and protocols. Philadelphia, Saunders.
2. Marchand LR, Kushner KP. Death Pronouncement: survival tips for residents. *American Family Physician*. July 1998. *www.aafp.org/afp/980700ap/rsvoice.html*.
3. Magrane BP, Gilliland MGF, King D. Certification of Death by Family Physicians. *American Family Physician*, 1997;October:1433-8.
4. Weissman, D. Fast Fact and Concepts #04: Death Pronouncement. June, 2000. End-of-Life Physician Education Resource Center: www.eperc.mcw.edu.

Disclaimer

Palliative Care Pearls provides educational information. This information is not medical advice. Health care providers should exercise their own independent clinical judgment.

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 1, No. 11, December 2003) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Emergency Contraception: Pharmacy Access in Albuquerque, New Mexico

Espey E, Ogburn T, Howard D, Qualls C, Ogburn J. *Obstetrics and Gynecology* 2003;102(5):918 - 921

Objective: Emergency contraception could reduce the approximately 3 million unintended pregnancies that occur annually in the United States. Dedicated emergency contraception products may be particularly useful because instructions are easy to understand and simple to follow. However, they must be available within a few days to women who have had unprotected intercourse. The goal of this study was to investigate whether women presenting to pharmacies in a moderately sized metropolitan area with a prescription for Plan B or Preven could get it filled.

Methods: Two research assistants posed as women needing emergency contraception. They visited 89 pharmacies in Albuquerque, New Mexico, presenting a prescription for either Plan B or Preven. The assistants recorded the availability of the products in the pharmacies. When the product was not in stock, the research assistants asked pharmacy providers why the products were not carried. Fisher exact test was performed to compare categoric data.

Results: Plan B and Preven were in stock at only 19 visits (11%). Of the pharmacies that did not stock the products, 53% reported they could obtain Plan B or Preven within 24 hours. The most common reason cited by pharmacy providers for not stocking Plan B or Preven was the lack of prescriptions received for them (65%).

Conclusion: Plan B and Preven were not in stock at the majority of pharmacies in a moderately sized metropolitan area. Lack of availability at the pharmacy constitutes a major barrier to emergency contraception access.

OB/GYN CCC Editorial comment:

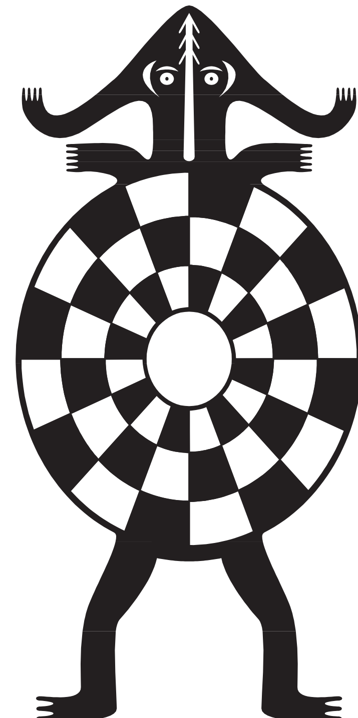
As stated in Chapter 13 of the IHS Manual, the Indian Health system is authorized to provide FDA approved contraceptive methods. The above article suggests that there are access issues in the greater Albuquerque area for the general population. On the other hand, emergency contraception methods are FDA approved and should be readily available to American Indian and Alaska Native patients, nation-wide.

Emergency contraception was a matter of lively discussion in the *Primary Care Discussion Forum* this month. If you want to join the Primary Care Discussion Forum, please contact Jason Crim at *jason.crim@mail.ihs.gov*.

By the way, Drs. Espey and Ogburn are former IHS OB/GYNs who worked at Gallup Indian Medical Center. Both are now on the faculty of the University of New Mexico. They are key contributors to best practices in women's health in Indian Health. Both are regular faculty at the ACOG/IHS OB/GYN Postgraduate Course. In addition, Dr. Ogburn is the ACOG/IHS Postgraduate Course Director.

Other contraception related articles by Drs. Espey and Ogburn include the following:

1. Espey E, Ogburn T, Espey D, Etsitty V. IUD-related knowledge, attitudes and practices among Navajo Area Indian Health Service providers. *Perspect Sex*



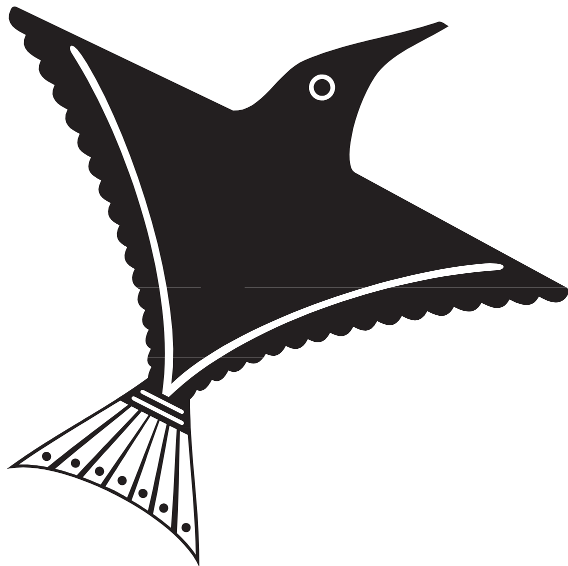
Reprod Health. 2003;35(4):169-73.
2. Espey E, Ogburn T. Perpetuating negative attitudes about the intrauterine device: textbooks lag behind the evidence. *Contraception*. 2002;65(6):389-95.
3. Espey E, Steinhart J, Ogburn T, Qualls C. Depo-provera associated with weight gain in Navajo women. *Contraception*. 2000;62(2):55-8.

From your colleagues:

Burt Attico, Phoenix

Emergency Contraception: Semantics is a part of "the game."

ACOG defines pregnancy as beginning at implantation. We also know from the sensitive pregnancy tests and IVF work, that a large percentage of fertilizations do not implant, that they dissolve, and/or spontaneously abort — either way, they terminate spontaneously. That is why 3-5 embryos are routinely inserted (it was 4-8 at one time previously), so that at least one embryo might potentially implant (and often doesn't). With Plan B, which is only progestin, part of its actions are:



- inhibit ovulation
- changing cervical permeability
- influencing tubal motility
- influence the endometrium

We really don't always know how it works in each case, except for Hatcher's theories on emergency contraception. This is a very controversial subject, with the latest word being that the expert committee voted recently to approve OTC sales of Plan B.

OB/GYN CCC Editorial comment:

Emergency contraception (EC) can prevent a significant number of unintended pregnancies. EC works by a variety of mechanisms. The mechanisms appear to occur in the order listed above, e.g., more common to least common: inhibit ovulation, changing cervical permeability, influencing tubal motility function, and influencing the endometrium. As the medical definition of pregnancy begins with implantation, EC is not an abortifacient.

Clinically, EC is most effective if used within the first 24 hours after unprotected coitus. It is marketed for use up to 72 hours after unprotected coitus, though its effectiveness declines rapidly with time.

By some non-medical definitions, if EC hasn't worked by one of the above three other mechanisms already, then EC could effect implantation. Those who believe that pregnancy begins with fertilization, and have mentioned the evidence that the other mechanisms are more frequent than changing the endometrial lining to the patient, may choose to refer a patient seeking EC to another provider. All providers should be able to present the patient a non-directive informed consent and a facile and timely treatment alternative.

The ethical question, however, is, no matter what your belief system, have you adequately counseled the patient about the four mechanisms, so that the patient can make a non-directed informed consent? We should leave it up to the values of the patient herself as to whether she wants to use EC based on the best information we can offer.

Any comments regarding EC are strictly those of the authors, and not necessarily those of the Indian health system, or the author of this newsletter. If you have any comments, please share them by joining the Primary Care Discussion Forum where this topic was recently discussed.

From Chuck North, Albuquerque

Dr. North raised an issue in the July OB/GYN CCC Corner. Here is an article that was just released on the same topic.

Chaperone Use by Family Physicians During the Collection of a Pap Smear

The use of chaperones during gynecologic examinations remains a controversial issue with no formal guidelines or legal mandates. The topic is poorly addressed by the medical literature and by our current medical education system. No consensus is found among state medical and osteopathic boards on the use of a chaperone. From the legal perspective, the recommendations are nearly unanimous in strongly supporting the use of chaperones. Many questions related to this issue are unanswered. Does chaperone use decrease malpractice claims? Does chaperone use have an impact on clinical efficiency, as the inverse relationship with the volume of Pap smears performed suggests?

What are the regional influences contributing to the geographic variation in reported use of a chaperone? We believe the question with highest priority is, What is the perspective of patients?

Reference

Rockwell P, Steyer T, Ruffin M. Chaperone use by family physicians during the collection of a Pap smear. *Annals of Family Medicine*. 2003;1:218-220.

OB/GYN CCC Editorial comment

After the 2002 Biennial OB/GYN Meeting, there should be no controversy in the Indian health system about the use of chaperones during examinations of the breasts or genitals. It is the standard of care. If your current staffing does not encourage this practice, then your staffing needs to modified accordingly. Please also see the ACOG benchmark statement below.

ACOG's Ethics in Gynecology: Sexual Misconduct in the Practice of Obstetrics and Gynecology: Ethical Considerations

"…The request by either a patient or a physician to have a chaperon present during a physical examination should be accommodated irrespective of the physician's gender . . .. Local practices and expectations differ with regard to the use of chaperons, but the presence of a third person in the examination room can confer benefits for both patient and physician, regardless of the gender of the chaperon . . .."

Clarification: Non clean catch urine sampling terminology

Dr. North wanted to add a clarification to comments in the October OB/GYN CCC Corner and November *IHS Primary Care Provider* about non-clean catch urine specimens obtained in pregnancy. The term "non-clean catch urine" sampling referred to a method of urine collection. A non-clean catch specimen is a urine sample that was not intended to be a clean catch specimen. It is a descriptive term, e.g., fasting versus non-fasting or random blood glucose testing. None of Dr. North's comments were meant to make any implications about the practices of the staff obtaining those types of specimen.

Other items that are available in the full text December 2003 Volume 1, No. 11 at
http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm

From your colleagues:

From Burt Attico and Katy Ciacco Palatianos: Possible methods of preventing cerebral palsy; Chorioamnionitis and Cerebral Palsy in Term and Near-Term Infants.
From Katy Ciacco Palatianos: To settle or not to settle?
From Sandra Dodge: 101 Way to ask someone if they are safe.
From Bruce Finke: The Elder Care Initiative Office Moves East.
From James Galloway and Terry Cullen: Diabetes and Cardiovascular Disease Review.
From Ursula Knoki-Wilson: 'Nurse Run Clinic' models.
From Kelly Moore: New Pediatric Chief Clinical Consultant: Steve Holve, MD.
From Oida Vincent: Are we required to obtain sensitivities on GBBS for PCN allergic patients? Eager for AI/AN applicants to Ph.D. program in the biomedical sciences.

Hot Topics:

Obstetrics: Diabetes mellitus complicating pregnancy; Thrombophilic disorders and fetal loss: a meta-analysis; Screening for Congenital Cardiovascular Malformations; Can Eating More DHA Increase Duration of Pregnancy? Immunity to CMV Reduces Risk of Congenital Infection; Postpartum Depression Linked to Later Violence in Children.
Gynecology: Primary and Secondary Syphilis —- United States, 2002; The 2001 Bethesda System Terminology; Depression in Older Women with Urinary Incontinence; Factors Affecting Accuracy of Mammography Screening; Multidose vs. Single-Dose Therapy in Ectopic Pregnancy; Weekly Therapy Is Effective in Prevention of Osteoporosis; Low-Dose Mifepristone Shrinks Uterine Fibroids; Low BMD Is Associated with Cognitive Decline in Women; Breast Cyst Aspiration.

Child Health: Prophylaxis for Infants of Mothers with Hepatitis B; Evaluation of Bone Mass in Young Female Athletes; Hearing Assessment in Infants and Children; High School Students in BIA Schools: Tobacco, Alcohol, and other Drug Use; Adolescent's level of linguistic acculturation and their well-being.

Features

AFP: POEMS HPV Triage for ASC-US Pap Results Makes Sense; False-Positive Mammograms Do Not Deter Women; Follow-up Mammography Is Low Yield; Oxybutynin or Tolterodine for Overactive Bladder? Iron in Nonanemic, Fatigued Women.

Annals of Family Medicine: Women's Experiences of Abnormal Cervical Cytology: Illness Representations, Care Processes, and Outcomes; Periodic Abstinence From Pap (PAP) Smear Study: Women's Perceptions of Pap Smear Screening; Factors Affecting the Detection Rate of Human Papillomavirus; Cervical Cancer Screening.

ACOG: ACOG Opinion Addresses Elective Cesarean Controversy; Use of progesterone to reduce preterm birth; Dystocia and Augmentation of Labor (ACOG Practice Bulletin).

Breastfeeding: Breastfeeding and Risk for Respiratory Disease in Infants.

Elder Care News: Influenza Vaccination; Anticoagulation with atrial fibrillation.

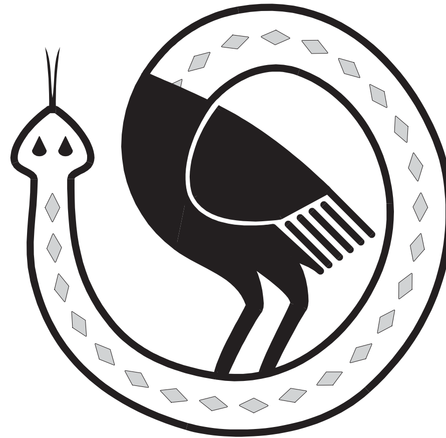
Hormone Replacement Update: Minimizing Menopausal Symptoms; Gabapentin Reduces Hot Flushes; Raloxifene Does Not Affect Sexual Functioning.

International Health: A guide for health professionals working with Aboriginal peoples.

MCH Alert: Postpartum counseling perceptions and practices; Cost estimates for Adolescent pregnancy and adolescent pregnancy prevention; Web site offers one-stop shopping for information about federal grants.

Office of Women's Health, CDC: Women's Health Newsletter, CDC Patient Education; Youth Violence Prevention Through Community-Level Change; Sociocultural and Community Risk and Protective Factors for Child Maltreatment and Youth Violence.

Primary Care Discussion Forum: Cervical Cancer Screening: New Guidelines and New Technologies; Emergency Contraception.



Editor's Note: The following information is brought to our attention by Jean Charles-Azure and Candace Jones from the Nutrition and Dietetics Program. They thought that given the high prevalence and health disparity associated with obesity and overweight among the AI/AN population, this resource was worth sharing widely with I/T/U staff

Case Studies in Disease Prevention and Health Promotion: Assessment and Management of Adult Obesity

Produced with support from the Robert Wood Johnson Foundation, and developed in collaboration with the U.S. Department of Health and Human Services, *Assessment and Management of Adult Obesity* consists of ten booklets that offer practical recommendations for addressing adult obesity in the primary care setting. The primer offers practical advice on:

- evaluating patients for current and potential health risks related to weight – beginning with a measure of the body mass index (BMI);
- understanding medication and surgical options;
- improving communication and counseling; and
- making office environments more accomodating to obese patients.

The booklets are in PDF format, and will require Adobe Reader to view. Clinical Tools and Patient Handouts, which appear throughout the booklets, are also available below, as well as a CME activity.

A Primer For Physicians
Booklet 1 - Introduction and Clinical Considerations
Booklet 2 - Evaluating Your Patients for Overweight or Obesity
Booklet 3 -Assessing Readiness and Making Treatment Decisions
Booklet 4 - Dietary Management
Booklet 5 - Physical Activity Management
Booklet 6 - Pharmacological Management
Booklet 7 - Surgical Management
Booklet 8 - Communication and Counseling Strategies
Booklet 9 - Setting Up the Office Environment
Booklet 10 - Resources for Physicians and Patients

Continuing Medical Education Activity and Program Evaluation Form

Clinical Tools
Assessment of Health Risks
Assessment of Patient Readiness
Treatment Options
The Office Environment

Patient Handouts
Weight Loss Management
Physical Activity and Exercise
Pharmacological and Surgical Management

This 10-booklet primer is also available in print or on CD-ROM and is free of charge from:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
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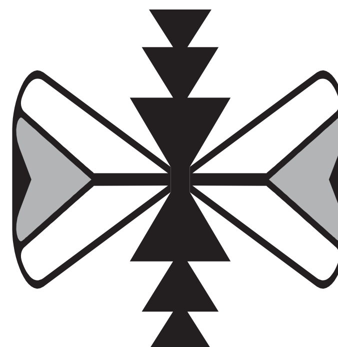
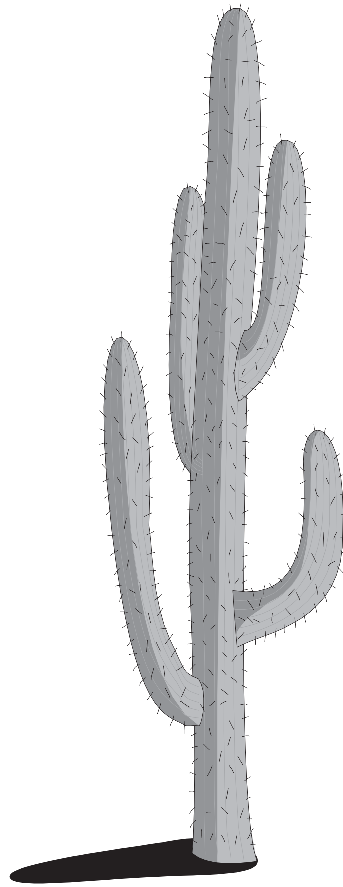


The 9th Annual Elders Issue

The May 2004 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the ninth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.



Executive Leadership Development Program Announces 2004 Dates

VISION

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

PURPOSE

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

MISSION

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

Executive Leadership Development Program New Dates

ELDP collaborates with federal, tribal and urban Indian health care systems to develop and increase leadership and management skills. In addition, participants develop new relationships and networks with other executives within the Indian health care systems.

SESSION DATES:

Session One – Aurora, CO
May 3-7, 2004

Session Two – Aurora, CO
June 21-25, 2004

Session Three – Aurora, CO
July 26-30, 2004

The IHS Clinical Support Center is an accredited sponsor.

Indian Health Service Clinical Support Center
Executive Leadership Development Coordinator
Indian Health Service, Clinical Support Center
Two Renaissance Square, Suite 780
40 N. Central Avenue, Phoenix, Arizona 85004-4424
Phone: (602) 364-7777 FAX: (602) 364-7788
Internet: *ELDP@mail.ihs.gov*
Website: *www.ihs.gov/nonmedicalprograms/eldp*

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 #820

The Management of Psoriasis Today *(60 minutes)* This video program opens with a discussion of the pathogenesis and triggers for psoriasis and the distinctive clinical features of the various types of psoriasis. Special attention is given to the treatment of patients with mild localized psoriasis in the primary care setting. Recommended follow-up for the patient with mild psoriasis is provided. Also addressed are conventional options to treat moderate-to-severe psoriasis in a specialized dermatologic clinic and the selective use of biologic agents that target the underlying pathogenesis of psoriasis, now viewed as the most prevalent t-cell-mediated disease of the skin. The program includes recommended websites from the American Academy of Dermatology and the National Psoriasis Foundation that provide updates on the clinical evaluation and care of patients with psoriasis.

NCME #821

HIV/AIDS: Update 2003 *(50 minutes)* Each year, researchers and clinicians from around the world gather at the International AIDS Society (IAS) meeting to share data from ongoing clinical trials and to report on their experience in treating patients with HIV/AIDS through a variety of regimens using multiple antiretroviral agents. Since the last meeting of this organization in Barcelona, a number of new drugs have been approved for use in the United States, a number of treatment guidelines have been updated, and a pivotal investigation regarding an HIV vaccine has been canceled. Dr. Grossman will review the information that was disseminated at this year's meeting of the IAS in Paris and will focus on some of the more challenging problems; adherence to recommended drug combinations, adverse effects, therapeutic failures, resistance, and long-term survival.

NCME #822

Prostate Problems: An Update for the Primary Care Practitioner *(50 minutes)* Each year, millions of men present to their physicians with nonspecific symptoms that might signal prostatitis, benign prostatic hyperplasia (BPH), or prostate cancer. With the aging of the US population, the rates of prostate disease are likely to rise even further. Dr. Romas outlines useful strategies for differentiating inflammatory and neoplastic diseases of the prostate, and discusses the medical and surgical options for treatment. Effective drug therapy for prostatitis and BPH now permits most cases to be managed in the primary care setting. For patients with prostate cancer, the role of the primary care practitioner centers mainly on screening and diagnosis; Dr. Romas summarizes the current practice guidelines for both, and discusses the dilemmas surrounding prostate-specific antigen (PSA) as a screening tool. These recommendations will help primary care physicians recognize prostate diseases in their earliest and most treatable stages, reduce their morbidity and mortality, and improve patients' quality of life.

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.*

Physician
Fort McDowell Yavapai Nation; Fountain Hills (Phoenix) Arizona

The Fort McDowell Yavapai Nation is currently seeking a full-time physician to provide medical care, including diagnosis and treatment, to patients of the Wassaja Memorial Health Center. Qualifications include the following: 1) high school diploma or GED certification and a medical (MD or DO) degree; 2) completion of an accredited Residency program in Family Practice or Internal Medicine; 3) board certification in Family Practice or Internal Medicine; 4) current unrestricted medical license to practice in the State of Arizona; 5) current unrestricted Federal Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate; 6) Advanced Cardiac Life Support (ACLS) certification; 7) a minimum of three (3) years experience as a practicing physician in a clinic or hospital environment; 8) experience with, and sensitivity to, health care in Native American communities and/or minority health issues; and 9) current Arizona driver's license and the ability to meet FMYN insurance standards. FMYN offers a salary range of $95,000 to $140,000 per annum (DOE). This position is open until filled.

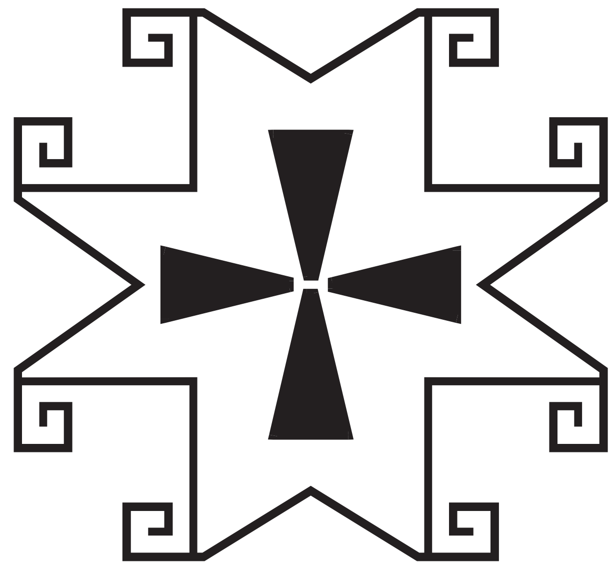
Submit resume to Fort McDowell Yavapai Nation, Human Resources Department, Attn: Kirby Sayles, PO Box 17779, Fountain Hills, Arizona 85269; telephone (480) 816-7118; fax (480) 816-9524; or e-mail *ksayles@ftmcdowell.org*.

Applicants claiming Indian Preference must submit a copy of their Certificate of Indian Blood with their resume. Applicants will be required to pass a pre-employment drug screen and complete a background check, which may include fingerprinting.

Physicians and other health care workers
Northwest Tribes; Washington, Oregon, and Idaho

The Northwest Tribal Recruitment Projects (NTRP) networks with 43 northwest tribes to recruit and place health care professionals into tribal health care facilities and programs. NTRP searches for health professionals who seek challenging and fulfilling positions in Native American communities. To this end, the NTRP works to make more health professionals aware of the rewarding opportunities available in Indian health care programs in the states of Oregon, Washington, and Idaho. These include positions with the tribes directly as well as with the Indian Health Service (IHS). We have numerous vacancies at any given time in the health and allied health fields. We can alert you to current positions in your profession quickly and provide you with tribal applications and vacancy announcements. We, in turn, alert the hiring authority and provide the clinics with advanced copies of your resume. Often, the hiring authority will call applicants before the applicant can officially apply. This process has significantly reduced time for all parties concerned.

NTRP also provides tribal profiles, answers to commonly asked questions, information regarding the Indian Health Service College Loan Repayment Program and other information



about the area served. We also offer an informative CD that explains the Indian Health Service, the Commissioned Corp, and tribal hire placements. To register with NTRP, please provide an updated resume (preferably in a Word document) with accurate contact information to Northwest Portland Area Indian Health Board, 527 SW Hall, Suite 300, Portland Oregon 97201; e-mail

your resume to *gsmall@npaihb.org*; or fax it to (503) 228-8182. For further information please contact NTRP toll free at (800) 338-8166.

McGrath Health Center Midlevel Provider
Tanana Chiefs Conference; McGrath, Alaska

Tanana Chiefs Conference is seeking a Midlevel Provider for the McGrath Health Center. Incumbent is responsible for providing high quality patient care and some quality assurance administrative support at the McGrath Health Center located in McGrath, Alaska. Minimum qualification include: Certified Family or Advanced Nurse Practitioner licensed to practice in Alaska or with the ability to obtain an Alaska license; certification in advanced emergency skills (PALS, ACLS) required; strong emergency skills and independent practice experience required;

experience working in Rural Alaska preferred; computer skills using MS Word and Excel; EMT I or EMT II certification preferred; strong verbal, written, interpersonal, organizational, and analytical skills; must maintain strict confidentiality. Contact Willow Bowen, HR Technician at (907) 452-8251 extension 3128; e-mail *willow.bowen@tananachiefs.org*; or visit the Tanana Chiefs Conference website at *www.tananachiefs.org*.

Medical Director/Family Practice Physician
Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc., (NACHCI) is recruiting for a Medical Director/Family Practice Physician to work in a growing primary health care clinic.

NACHCI is a non-profit, 501 (c) 3, Urban Indian Health Center located in central Phoenix and provides primary care services to eligible Native Americans residing in the Phoenix Metropolitan Area. The clinic is open Monday through Friday, 8:00AM to 5:00PM (we recently added an evening clinic once a week). No weekends or holidays.

The Medical Director/Family Practice Physician will be responsible for supervising a physician assistant, a family nurse practitioner, two medical assistants and a licensed practical nurse. In addition to seeing patients, the incumbent will be responsible for overseeing the activities of the medical clinic as well as ensuring compliance with accreditation standards. The incumbent is directly supervised by the Medical Services Director.

The ideal candidate has the following characteristics: board certified; 3-5 years experience as a medical director/physician; an Arizona license; knowledgeable about accreditation standards; and Spanish speaking a plus.

Salary is competitive and we offer good benefits, which include a 403 (b) plan, medical, dental, etc.

If you are interested in working in a positive, friendly environment where the staff is committed to providing the highest level of services to the patients we serve, then NACHCI is the place for you. Please contact David Tonemah, Medical Services Director, at (602) 279-5262, extension 256 for more information.

Family Practice Physician
Dzilth-Na-O-Dith-Hle Indian Health Service Health Center; Bloomfield, New Mexico

The Dzilth-Na-O-Dith-Hle Indian Health Service Health Center is seeking a board certified family practice physician for a full-time position.

The facility is currently a four-provider outpatient clinic that is primary care oriented, with outpatient, dental, optometry, pharmacy, mental health, lab, radiology and other services. Our referral facility is the Northern Navajo Medical Center in Shiprock, New Mexico, located approximately 70 miles away.

The Dzilth-Na-O-Dith-Hle Indian Health Service Health Center is located on the Navajo Reservation in the “Four corners” area of New Mexico, which borders Colorado, Arizona and Utah. This area is renown for its outdoor activities including hiking, biking, skiing, kayaking, fishing, and many others. We are located approximately 40 miles from Farmington, New Mexico, from where many of the staff commute. For more information on our area, go to *www.farmingtonnm.org*.

Commissioned Corps or Civil Service positions are available. Please contact Don Casebolt, MD, 6 RD 7586, Bloomfield, New Mexico 87413; telephone (505) 632-1801, extension 6728.

Staff Dentist
Pit River Health Service; Burney, California

The Pit River Burney Health Facility is seeking to fill a vacant full time staff dentist position. The incumbent will assist in the planning and implementation of the dental program goals, which include preventative education and corrective dental services to eligible persons within the scope of the Indian Health Service contract guidelines. Must be proficient in providing routine dental services including general restorative procedures, crowns and bridges, removable prosthetics, endodontics, and oral surgery. Assist with staff supervision and policy/procedure development, and provide in-service training to staff and community members. Ideal person should have a State of California Dental License, current DEA certificate, CPR and current certificate on radiographic safety and procedures. Minimum of one year professional or practical experience, internship, or residency training.

Pit River Health Service is located in the beautiful intermountain area: to see just a sample view of our area, go to the *www.bumeyfalls.com* webpage. It will give you a wonderful presentation on our area, and you will see why we enjoy living here. This site can give you all a lot of information that might be of interest.

Please submit your resume to Pat Lilya, Operations Manager, Pit River Health Service, 36977 Park Avenue, Burney, California 96013; telephone (530) 335-5090; fax (530) 335-5421.

Fiscal Officer
Pit River Health Service; Burney, California

The Pit River Health Service administrative offices are seeking to fill a full time fiscal officer position. He or she will be responsible for the financial stability and accountability of all program activities; to develop, implement, and maintain the fiscal policies and procedures; to maintain internal fiscal controls with professional accounting standards; to maintain accurate financial records; to ensure compliance with reporting requirements; to assist with the preparation and revision of budgets; to coordinate audits; to supervise, monitor, and evaluate the duties, responsibilities, and performance of the fiscal department staff, to include accounts payable, payroll, billing, data entry, and contract health service staff.

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RN/Clinic Manager
Pit River Health Service; Burney, California

This full time position is available for the health clinic. The staff person would provide for the assessment, planning, implementation, and evaluation of nursing care to patients; assist in development and maintenance of nursing care to patients; and assist in development and maintenance of standards of care. He or she will also provide direct nursing care as needed. The incumbent must have current licensure in California as an RN, with a minimum of five years experience, including two years ambulatory outpatient experience and one year supervisory experience.

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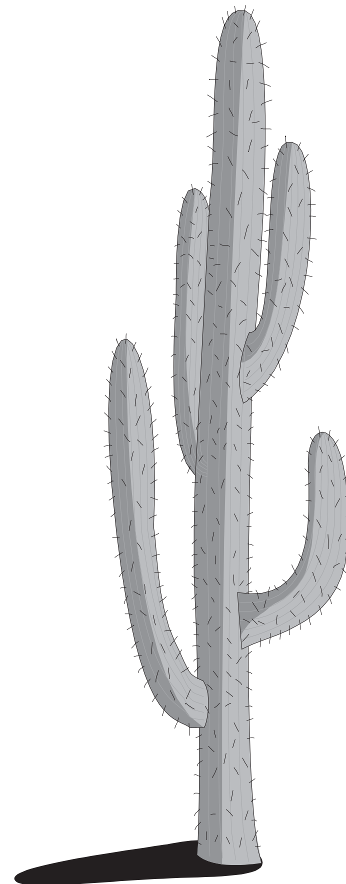

MEETINGS OF INTEREST ❑

The 2004 Meeting of the National Councils for Indian Health
February 23 - 26, 2004; San Diego, California

The National Councils (Clinical Directors, Chief Executive Officers, Chief Medical Officers, Oral Health, and Nurse Consultants) for Indian health will hold their 2004 annual meeting February 23-26, 2004 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. The focus this year will be "Proactive Partners in the Global Health Community." 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 (602) 364-7777, or e-mail *gigi.holmes@phx.ihs.gov*.

Fundamentals of HIV/AIDS Preceptorships
February 24 - 26, 2004; Phoenix, Arizona

These clinical preceptorships in HIV/AIDS are funded by an interagency agreement between the IHS the Pacific AIDS Education and Training Center. The IHS Clinical Support Center is the accredited sponsor for continuing education.

These preceptorships are offered to physicians and other health care providers (nurses, physician assistants, case managers, and pharmacists) working in American Indian and Alaska Native communities who have an interest in learning more about the fundamentals of counseling, testing, epidemiology, diagnosis, and management of HIV disease. A second element teaches participants how and where to access expert consultation on HIV care and treatment using the Internet and/or telephone consultation lines. A third component is the afternoon sessions when participants choose from a variety of opportunities to observe peer clinicians provide pre- and posttest counseling, or provide care at one of five local sites.

The program emphasizes skills building in counseling and testing, obtaining expert consultation through a variety of media, and in clinical experience at the Phoenix Indian Medical Center, the Carl T. Hayden Veteran's Administration Hospital, the Maricopa County Health Department STD clinic, Phoenix Children's Hospital, and the McDowell Health Care Center, a Ryan White funded clinic specializing in care of the person with HIV.

For more information, contact Erica Avery, Director, HIV Center of Excellence, Phoenix Indian Medical Center; telephone (602) 263-1541; or e-mail *erica.avery@pimc.ihs.gov*.

IHS Colposcopy Update and Review
March 5 - 7, 2004; Albuquerque, New Mexico

This course is a 2 1/2-day update and review for ob/gyn physicians, family physicians, and advanced practice clinicians who perform colposcopy in IHS, tribal, and urban program facilities. The faculty will be nationally recognized experts in lower genital tract disease. The program will emphasize new developments in cervical cancer screening and the management of abnormal Pap tests. Diagnosis and treatment of diseases of the vulva and vagina will also be covered. The format will include lectures and small group discussions and slide reviews. The ASCCP Colposcopy mentorship Exam will be offered (optional) to interested participants at the conclusion of the program.

For more information, contact Roberta Paisano, IHS National Epidemiology Program, 5300 Homestead Road, NE, Albuquerque, New Mexico 87110; telephone (505) 248-4132; e-mail *roberta.paisano@mail.ihs.gov*.

American Indian and Alaska Natives Health Care Provider Conference
March 6, 2004; Phoenix, Arizona

The Sun Health Research Institute invites all Indian Health Service providers, tribal health representatives, tribal/urban health organizations, and non-governmental health organizations you to attend the "Native American Healthcare Provider

Conference" to be held on March 6, 2004, at the Hyatt Regency Hotel in downtown Phoenix.

The conference will focus on reaching out to Native American communities and Indian Health Service providers, in an effort to provide education and information about dementia, Alzheimer's disease, and other age-related diseases.

Not much is known currently about dementia and Alzheimer's disease in the Native American population. We aim to increase awareness among health care providers so they may better understand Alzheimer's disease within the Native American population.

Continuing Medical Education (CME) credits will be offered to physicians (11.5 credit hours). This activity has been approved by Sun Health.

We are looking forward to working with all of you to make this conference a success. There will be no cost to participate. If you have any questions or comments please do not hesitate to contact Minnie Jim, Native American Outreach Coordinator, at telephone (623) 875- 6524; e-mail *Minnie.Jim@sun-health.org*.

Panel on Indian Health at 2004 American College of Physicians (ACP) Annual Session
April 22 - 24, 2004; New Orleans, Louisiana

For the first time, the ACP Annual Session will include a panel devoted to Indian health entitled "The Changing Health Status of American Indians and Alaska Natives." The Annual Session is intended for all physicians involved in the practice of internal medicine. This includes general internists, subspecialists in internal medicine, family physicians, general practitioners, and residents and fellows in internal medicine and its subspecialties. Medical students and allied health professionals will find many sessions of interest and will benefit from the scope and depth of the program. There will be an opportunity for physicians from Indian health (I/T/U) to meet during the annual session.

For more information, call (800) 523-1546, ext. 2600; or visit the website at *www.acponline.org*.

Sixth National Conference on Changing Patterns of Cancer in Native Communities
September 9 - 12, 2004; Phoenix, Arizona

Subtitled "Honoring Our Native Families from Prevention to Cure," this conference will focus on cancer epidemiology, control, and survival among Native populations. The goal is to evaluate progress in prevention of cancer in Native groups and in the early diagnosis, treatment, and survival of Native people diagnosed with cancer. The target audience for the conference will be community members, advocates, researchers, clinicians, and other health service providers working with Native populations: American Indians, Alaska Natives, American Samoans, and Native Hawaiians.

Featured topics will include Survivorship, Prevention, Early Detection and Screening, Cultural Sensitivity, Tobacco Issues, Traditional Diet, Men's Cancer Issues, Navigator System, Community Partnerships, and Understanding Cancer Statistics and Registries. Featured Speakers include Wilma Mankiller (Cherokee Nation); Dr. James Hampton (Medical Director, Troy and Dollie Smith Cancer Center); Charles Wiggins (Utah Cancer Registry); Linda Burhansstipanov (Native American Cancer Research; and Marc Heyison (Men Against Breast Cancer).

Hosted by Spirit of Eagles, the conference will be held at the Wild Horse Pass Resort and Spa. For more information, contact the conference planning committee at (877) 372-1617; e- *nativecircle@mayo.edu*; or visit the website at *www.mayo.edu/leadershipinitiative*.

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THE IHS PRIMARY CARE PROVIDER

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

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov*. Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(www.csc.ihs.gov)*.

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

Circulation: The Provider (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical 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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