

THE IHS PRIMARY CARE PROVIDER

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



July 2000

Volume 25, Number 7

The Use of the RPMS System and a Diabetes Audit in a Diabetes Clinic and Pharmacy Program

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Introduction

Diabetes affects approximately 15.7 million people in the United States (5.9% of the general population) and is expected to increase in prevalence with the recent adoption of the new diagnostic criteria.¹ Native Americans and some other minorities are at greater risk for developing diabetes. Epidemic in proportion, the prevalence of type 2 diabetes among American Indians and Alaska Natives in the United States is 12.2% for those over 19 years of age, and is rising.²

The direct and indirect costs of diabetes in the United States for 1997 have been estimated to be \$98 billion. This includes \$44.1 billion in direct medical and treatment costs and \$54 billion for indirect costs due to disability and mortality.³

The major complications of diabetes include kidney failure, blindness, amputations, and heart disease. Ten to twenty-one percent of all people with diabetes develop kidney disease. The rate of end-stage renal disease among Native Americans with diabetes is six times higher than that for all people with diabetes. The risk of a leg amputation is 15 to 40 times greater for a person (regardless of race or ethnicity) with diabetes. The rate of amputations among Native Americans is three to four times higher than in the general population.²

The Diabetes Control and Complications Trial (DCCT) has shown that tight control of type 1 diabetes, as defined by having a Hb_{A1c} less than 7%, can reduce the risk of developing retinopathy, nephropathy, and neuropathy by 76%, 54%, and 60%, respectively.⁴ Even with moderate control of diabetes, as defined by having a Hb_{A1c} of 8% or less, the reduction of complications is significant. Once the Hb_{A1c} reaches greater than 8%, the rate of complications escalates. Although these results were demon-

strated in patients with type 1 diabetes, it was felt that the results would be similar in patients with type 2 diabetes, since the complications are virtually the same in both types of diabetes.

Such a long-term study of patients with type 2 diabetes has been completed. The United Kingdom Prospective Diabetes Study (UKPDS) has shown that the Hb_{A1c} of the intensive therapy group (mean 7%) when compared to the conventional therapy group (mean 7.9%) was associated with a reduction in the risk of microvascular complications such as progression of retinopathy and microalbuminuria. Similarly, intensive blood pressure control (mean, 144/82 mm Hg) resulted in a 44% reduction of risk of fatal stroke and a 37% reduction in microvascular disease as compared to the conventionally managed group (mean, 154/87 mm Hg).

The UKPDS study has shown that any sustained reduction of Hb_{A1c} will benefit the patient with diabetes. The DCCT also

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showed the effectiveness of a team approach in the management of diabetes. The Diabetes Strategic Planning Committee at the Santa Fe Indian Hospital (SFIH) incorporated this approach in delivering diabetes care beginning in 1998.

The SFIH diabetes clinic and pharmacy program rely heavily upon the consistent use of the RPMS (Resource and Patient Management System) package and PCC (Patient Care Component) coding to track annual exams, blood pressure readings, laboratory values, and patient education for those who receive care at the facility. The RPMS-based IHS Diabetes Audit program tracks parameters that reflect the minimal standards of care for patients with diabetes. This program can be used at any IHS facility that uses the RPMS package.

The goal of our project described in this article was to use the Diabetes Audit and the RPMS Health Summary to show improved diabetes control in the Diabetes Clinic and the Pharmacy based management program. The process also served as a performance improvement tool for patient care.

The Study

A database of approximately 156 patients was established by reviewing and updating the Health Summaries of patients as they came through the Diabetes Clinic during 1998. From this database, 64 patients were studied and compared to 64 patients who received their diabetes care through the conventional clinic setting. A pharmacist was following an additional 16 patients who were referred to pharmacy from the clinic. Pharmacy interventions and follow-up visits were done from January 1998 through October 1998. This review covered the period January 1997 through December 1998. The data are shown in Table 1.

Discussion

Although there are encouraging trends, it would be premature to assert that a pharmacy managed program had a positive effect on control of Hb_{A1c} or blood pressure, although the groundwork has been done. Similarly, it is also too early to conclude that there is any improvement in Hb_{A1c} or blood pressure as a result of the SFIH Diabetes Clinic. Blood glucose control is slightly improved in patients that come through the Diabetes Clinic, but these data have many confounders, such as the fact that more complicated patients are referred to the Diabetes Clinic or pharmacist for more intensive management.

The use of the RPMS package to create a Health Summary specific for the Diabetes Clinic makes visits more efficient and may explain the improved performance in the following areas: total height/weight measurements, blood pressure measurement, and pneumovax and tetanus immunization administration. Paradoxically, there were actually poorer results with flu vaccine administration through the Diabetes Clinic.

Proper PCC coding was stressed through the Diabetes Clinic. The outpatient nurses staffing it were given inservice training, for example, on coding patient education and on how to update the immunization records. The health summary became an accurate reminder of annual examinations and immunizations. The improvement in compliance with foot exams, eye exams and education was the result of proper coding by the providers, nursing, and pharmacy.

Table 1. Audit Results (all data reported as percent)

	Jan. 1997 Control	Jan. 1998 Control	Jan. 1998 DM Clinic	Jan. 1998 Pharmacy
Age/sex:				
Female	50	50	45	38
Age 15-44	20	20	25	13
Age 45-64	56	52	55	63
Age > 65	17	28	20	25
On ACE Inhibitor:	15	19	25	25
Weight:				
Overweight (BMI>27.2)	48	45	52	63
Obese	28	30	27	19
No BMI (no height recorded)	31	30	8	6
Performed on at least 75% of visits:				
Weight	48	56	89	81
Blood Pressure	48	58	89	88
Blood Sugar(BS)	8	31	55	56
Exams performed annually:				
Foot	2	13	48	50
Eye	11	27	47	50
Education:				
Any diet	5	16	33	38
Exercise	2	11	45	50
Any Education	9	33	78	75
Immunizations up to date:				
Flu	N/A	38	19	6
Pneumovax	48	53	78	81
Td	67	69	81	94
Yearly Testing:				
Urine Analysis	19	58	81	88
Serum Creatinine	64	75	94	94
Cholesterol	66	75	95	94
Triglycerides	9	23	45	31
BS Control as measured by Hg_{A1c}:				
Acceptable (< 7.5%)	16	33	39	38
Fair (7.6- 10.0)	20	25	36	38
Poor (10.1 - 12.0)	13	11	19	19
Very Poor (> 12.0)	3	2	3	0
Undocumented	48	30	3	5
BP Control:				
Normotensive	17	23	22	6
Controlled HTN	20	13	33	31
Uncontrolled HTN	20	28	22	31
Severe HTN	6	8	9	13
Undocumented	43	28	14	19

The clinic also had a longer time slot (30 minutes, as compared to 15) and patients arrived early for laboratory testing. This provided an opportunity for education by pharmacy or nursing, or dietary consults by our nutritionist. Pharmacy and nursing were responsible for ordering the annual and other laboratory tests. The laboratory greatly assisted the clinic by making the results available to the providers during the patient's visit. An improvement in yearly testing of urine, cholesterol, triglycerides, and Hb_{A1c} may be partially explained by these improved procedures.

The physicians at Santa Fe Indian Hospital agreed to start annual microalbumin and triglyceride screening. Previously, triglycerides had not been part of the routine chemistry panel. Triglycerides were part of the lipid panel (a test sent out to the reference laboratory).

The results are biased in that an intensive chart review and updating of the health summary for immunizations and annual exams was performed on all the patients coming through the Diabetic Clinic and not on the control groups. Nevertheless, laboratory results and blood pressures, heights, and weights are unbiased for all patients regardless of where they received their care.

Conclusions

These results show the positive effects of a team approach, consistent PCC coding, and a more intensive clinic setting in the

management of patients with diabetes mellitus. It is too early to expect an improvement in the Hb_{A1c} values or blood pressure control. The clinic will continue to operate, and it will offer the ability to track the current trends. Using the Diabetes Audit has been a useful performance improvement tool for patient care at Santa Fe Indian Hospital.

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Maintaining Appropriately Trained Staff

A National Council of Nursing Position Paper

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The Issue

It is the responsibility of Indian Health Service/Tribal/Urban programs (I/T/Us) to assure and improve the quality of care provided to our beneficiaries through the availability of appropriately and adequately trained staff.

Background

The responsibility of administration to maintain appropriately and adequately trained staff is well recognized, and mandated by accrediting organizations such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC). Opportunities for training, education, and development have consistently been cited as positively impacting recruitment and retention of health care professionals and other health care workers. However, many issues impact negatively on the ability of I/T/Us to provide education and training to employees, including decreased funding; remote locations; small numbers of staff; lack of available technology, such as satellite television; and lack of motivation of individuals or groups of employees. In addition, historically, there has been disparity in the distribution of funding for training.

The Indian Health National Council of Nursing (NCON) recognizes that the responsibility for maintaining appropriately and adequately trained staff must be shared by I/T/Us at all levels of administration and practice. A collaborative, cohesive effort will be required to continue to provide training and educational opportunities to our employees in the future.

Discussion

There are several dimensions to assuring the availability of appropriately and adequately trained staff: preemployment, entry level education; orientation; on-the-job training; continuing education; and long term training.

Preemployment, Entry Level Education. Preemployment and entry level education qualifications are best dealt with through the development of comprehensive position descriptions; qualifications; knowledge, skills and abilities requirements; and, when appropriate, selective placement factors. Personnel Office benchmarks for many positions are severely outdated and do not reflect current practice. This often leads to General

Schedule(GS) ratings (and thus salary) lower than needed to recruit qualified candidates.

Orientation. Lack of adequate orientation is often cited as a source of dissatisfaction among Indian health care employees. Too often the pressures of short staffing lead to a “sink or swim,” “learn as you go” orientation. This is especially disconcerting to new graduates (who often come from widely varying basic education experiences) and new Indian Health Service or tribal employees, unfamiliar with the intricacies of Federal and tribal policies. In addition to increasing the stress level of new employees, the quality and safety of patient care may be impacted (e.g., fire procedures are unknown; the process of obtaining contract health care is a maze; documenting on a Patient Care Component (PCC) form and maintenance of the Health Summary are mysteries). The special cultural aspects of providing care and services to American Indians and Alaska Natives (AI/AN) are also often overlooked. This especially affects employees unaccustomed to dealing with cultures other than their own.

There may also be disparity between Areas, service units/facilities, departments, or even individuals in the quality and quantity of orientation received. The nursing department may have an excellent orientation program, but when the nurse educator or supervisor is on leave, no orientation occurs and it is not picked up on his or her return. Physicians may get full orientation at one facility; brief orientation at another; and none at a third facility. One Area Office may bring all new employees in for an orientation program, another may leave orientation up to individual service units/facilities. Preceptor and mentoring programs, where a new employee is paired with a more experienced employee, have proven successful in many settings.

JCAHO requires that health care organizations verify the competency of employees to perform their duties. In the private sector, competency assessment may be part of the preemployment screening process. The Federal government, however, must defer competency assessment until after the individual is hired. A new employee who met basic educational and training requirements may prove unable to perform basic competencies required by their position. Competency assessment, and subsequent training/education to bring an employee up to an acceptable level of competency, are time-consuming and may be costly, especially for departments already short-staffed and underfunded.

On-the-Job Training/Inservice Education. As with orientation, the quality and quantity of on-the-job training and inservices may vary widely. A hospital nursing department may have a full time nurse educator. The sole lab tech at a facility may report to

a lab full of equipment and no one around to show how to use it. Inservices may be provided on the day shift, missing employees who work full time evening or night shifts, or requiring them to stay over (and awake) or come in on their days off. Although many equipment companies routinely provide inservice on new equipment for staff, often they do not make the effort to reach remote locations.

Continuing Education. Continuing education may be provided “in-house” or out. Many of the same issues apply as for on-the-job training and inservices. In addition, because of the remoteness of many I/T/U facilities, the cost of bringing in qualified trainers and/or sending staff away to training also becomes a factor. In addition to travel costs, coverage and impact on patient care activities must also be considered. It is very difficult for an individual in a one person department, at any facility, to take time off. Although opportunities for continuing education via the Internet and satellite are increasing, many sites do not have access to the technology required to take advantage of these alternatives.

Traditionally, continuing education funding has been guaranteed to some health care providers on an individual basis; other health care categories may receive funding as a group; but many health care employees receive no special funding for education and training. Individuals often fail to utilize funding when it is available. Usually it is ancillary and support staff who miss out on training opportunities due to lack of funding, even when training could positively impact on the facility, e.g., coders who could improve third party billing and collections with increased training. When overall funding for a facility or Area is decreased, it is frequently education programs which suffer.

Professional employees often hold licenses (usually a condition of employment) from states that require the completion of continuing education to maintain licensure. Employees may also achieve specialty certification which requires ongoing continuing education. Although there is no obligation for the employer to provide continuing education in these circumstances, it is to the benefit of all I/T/U facilities to encourage retention of these employees by providing opportunities to obtain the required continuing education credit, by providing, at a minimum, administrative support, if financial support is not available. The Indian Health Clinical Support Center (CSC), by serving as the accredited sponsor of activities and awarding continuing education credits or continuing education units (CEUs) for health professional categories, is an excellent resource for helping professionals meet continuing education licensure requirements at the local level.

Long Term Training. Occasionally, an employee seeks long term training to improve skills or job marketability. This training usually consists of baccalaureate or masters level education, but may include lower level education or certification, e.g., a nursing assistant who wishes to become a licensed practical nurse. Many times the desired education would be beneficial to the facility, e.g., a nurse wants to obtain a nurse practitioner license and the facility needs cost effective primary care providers. When the education would benefit the Indian Health Service it is

logical to provide some support to the employee. There are some programs available, such as the 437 scholarships and the nursing Section 118 (formerly NECI) program. These programs are highly competitive and have been severely impacted by recent budget cuts and tribes compacting or contracting and taking their shares of these budgets. Employees at isolated rural facilities are at a disadvantage in regards to access to colleges and universities when compared to employees in more urban areas. The growth of distance learning opportunities, e.g., via satellite, videoconferencing, or the Internet, is improving access, but these technologies are not always available to I/T/U employees.

Recommendations

Preemployment, Entry Level Education

- Professional categories should work with the Indian Health Service and/or the Office of Personnel Management on a national level to upgrade basic personnel qualification benchmarks, many of which are over 20 years old, to assure appropriate rating of positions.
- Professional categories should develop standardized selective placement factors for critical positions, when appropriate.
- The Indian Health Service should encourage tribal and urban programs to implement basic minimum education and training requirements for positions to assure acquisition of adequately trained employees.

Orientation

- The Indian Health Service should develop a standard orientation program for export to all Areas and facilities. The program could be a self learning module, using video, computer, overhead, and/or slide formats, and should cover the basics of the Indian Health Service at a national level, e.g., headquarters organization, history, the legislative process, and other pertinent information.
- Similar orientations should be developed at the Area and tribal levels.
- Individual facilities should develop a standardized orientation program that is offered on a regular basis or which can be self administered.
- Each professional category should develop standardized, basic entry competencies, i.e., minimum knowledge, skills, or abilities needed to perform the duties of the job, for positions within their respective categories. All new employees should have their ability to meet these basic competencies objectively measured and documented at entrance on duty.
- Areas should consider development of regional “competency centers,” perhaps in concert with local community colleges or universities. Centers would provide entrance competency testing for a variety of employee categories, and remedial training if needed.

On-the-Job Training/Inservices

- Formal training plans and contracts should be developed and implemented to assist new employees who fail to meet basic entry level competencies to attain the required knowledge, skills, and/or abilities.
- All contracts for new equipment should include a requirement for staff training by the vendor.
- Professional categories should develop and maintain lists of basic resources, including individuals, as well as policy and procedure or technical manuals. When ever possible, manuals should be available “on-line,” or, at a minimum, on computer disk, to facilitate revision, access, and standardization.
- The Indian Health Services should facilitate acquisition and maintenance of computer hardware and software to enable computerization and export of manuals, computer assisted learning, Internet access, and other technological support.
- I/T/Us should facilitate use of local, in-house “experts” to provide inservice training between service units/facilities, assisting with travel between facilities, coverage, etc.
- The Indian Health Service should facilitate and nurture networking among members of professional categories, even if only at the Area level. This could be done through electronic mail groups, teleconferencing, newsletters, meetings, or other methods.

Continuing Education

- I/T/Us should pursue sponsorship of all professional training and education through the Clinical Support Center to assure the highest quality of education and so that continuing education credits can be awarded.
- The Indian Health Service should assess the current distribution of continuing education and training funds and develop a more equitable distribution plan that meets the needs of I/T/Us.
- I/T/Us should designate at least one individual at each facility to assess training and education needs; coordinate education programs, within and between facilities; and monitor use of education funds.
- I/T/Us should assess facility education needs and develop a prioritized education plan on an annual basis. Requests for continuing education should be evaluated based on the needs of the facility.
- I/T/Us should consider economies of scale when planning training programs, including the efficiency of bringing in speakers, opening programs to other I/T/U employees or facilities, sharing speakers, etc., as compared to sending individual employees to outside programs.
- The Indian Health Service should develop partnerships with colleges and universities to provide continuing education programs specifically tailored

to I/T/U needs or to utilize local school satellite and teleconferencing facilities.

- The Indian Health Service should commit to assuring Internet and electronic mail access at all I/T/U facilities to all employees.
- The Indian Health Service should develop, maintain, and distribute lists of resources for providing continuing education opportunities, such as formal programs, individual speakers, and self learning modules.
- The Indian Health Service should facilitate and support national meetings of employees in selected professional categories, perhaps rotating between categories from year to year.
- The Indian Health Service should encourage individual specialty certification by providing cash or other incentives for acquiring and maintaining national certification related to an individual’s position and profession.
- The Indian Health Service should encourage and facilitate attendance at professional conferences/conventions and membership and participation in professional associations.

Long Term Training

- I/T/Us should facilitate employees seeking advanced degrees through alternative means, e.g., distance training.
- The Indian Health Service should seek continued congressional support for programs such as 437 Scholarships and grants to schools providing scholarships and support to American Indian/Alaska Native students.

Summary

The National Council of Nursing believes that the challenges of maintaining an appropriately and adequately trained staff can be met through a proactive, collaborative approach at all levels of Indian health care. □

If you have comments or questions about this paper, please contact the author at (406) 247-7121, or contact Patricia Smith, RN, Nurse Consultant, Albuquerque Area IHS and Chair, National Council of Nursing, at (505) 248-4533.

The Effect of Patient Information on the Quality of Pharmacists' Drug Use Review Decisions

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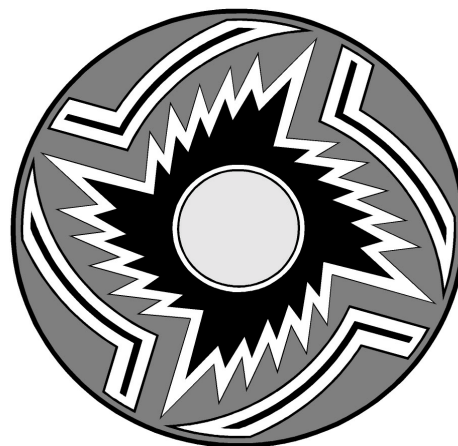
The ready access to patient information historically enjoyed by Indian Health Service (IHS) pharmacists is virtually unprecedented in pharmacy practice. In comparison, most pharmacists – especially those in the community setting – routinely practice in a virtual informational vacuum. Having practiced in the IHS myself (Gallup Indian Medical Center, 1980-82), I have long been a strong believer in the importance of patient information for optimizing clinical decision making. It seems axiomatic that one cannot make good decisions with poor information, much less with *no* information. I have always considered the IHS to be a model for what could be – and should be – the standard of practice in pharmacy.

To date, however, there has been little empirical research that demonstrates the effect of patient information on the quality of pharmacists' clinical decision making. This dearth of empirical data represents a significant threat to the future of pharmaceutical care in general, and, potentially, to the future of information access for IHS pharmacists in particular. Increasing pressures to streamline care and reduce costs, coupled with rising concerns about the confidentiality of patient information, could easily result in policies that would restrict information available to health care providers to a "need to know" basis. In such a scenario, providers who have not clearly demonstrated a need to know, and an ability to use, patient information to improve the safety and effectiveness of care will not have access to that information.

The study by Warholak-Juarez, et al, ("The Effect of Patient Information on the Quality of Pharmacists' Drug Use Review Decisions," *The IHS Provider*, Volume 24, Number 11, November 1999, pages 175-176) represents an important step toward establishing empirical support for pharmacists' access to patient information. It is, however, just the first step in a journey that should have begun many years ago. The managers of health care are increasingly requiring hard evidence to support practice systems. Justifications like, "this is the way we have always done it," are no longer acceptable. One hopes that this study will stimulate additional research in this important area. But time is of the essence, for the forces of information restriction are already in motion.

As they did with patient counseling, it is appropriate that IHS pharmacists take a leadership role in demonstrating and validating their system of practice to the managers and policy makers in health care. In so doing, IHS can help to ensure that pharmacy continues its evolution toward a true clinical health care profession, and that pharmacists in all practice settings have access to the information they need to provide pharmaceutical care to the patients they serve. □

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The Annual Conference for Advanced Practice Nurses and Physician Assistants

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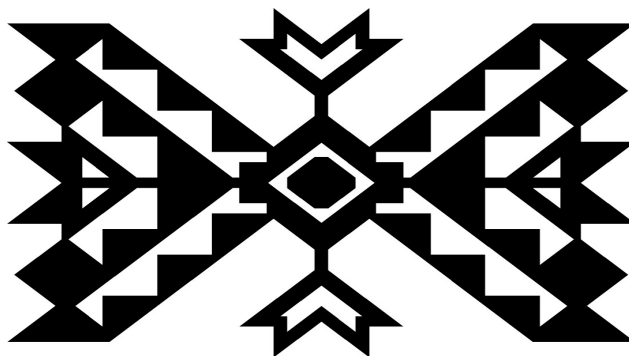
During the week of June 12-16, 2000, approximately 150 advanced practice nurses (APNs) and physician assistants (PAs) from nationwide Indian Health Service (IHS) and tribal health care facilities met in Scottsdale, Arizona for their annual continuing education conference. The attendees included nurse practitioners, physician assistants, certified nurse midwives, and pharmacists. These clinicians provide a significant amount of primary and specialty care throughout the Indian health system, often as the sole provider in remote, rural clinics. They also fulfill a wide diversity of other roles in Indian health facilities, such as health care administration, research, mental health, and program management.

During the first one and one-half days, an APN business meeting was held to hear updates about and discuss various administrative issues. In addition to networking and sharing resources, the business agenda included expert speakers on medical-legal issues, policy-making, grant writing, and specialty roles for APNs. CDR Sandra Dodge, FNP, Women's Health/Public Health Nurse Consultant, from the IHS Nursing Headquarters in Rockville, Maryland, presented the goals and current projects of the new Headquarters nursing staff.

During the balance of the week, four concurrent continuing

education sessions were held throughout each day, offering intensive seminars and workshops on diverse clinical topics, with an emphasis on primary care for American Indians and Alaska Natives. Health promotion, diagnosis and treatment updates, and prevention of infections were emphasized, as well as various social and mental health issues. An initial plenary session attended by all covered adolescent sexual health, a wellness approach to elder patients, and the objectives of GPRA (the Government Performance and Results Act) and the role of the Indian health provider. Nationally acclaimed experts in their health fields, the speakers provided interactive forums to address some of the unique aspects of Indian health care in urban and rural areas.

In addition to offering an exemplary agenda of continuing education topics, this annual IHS conference has been consistently well-organized and conducted with high professional standards. The IHS Clinical Support Center in Phoenix, the accredited sponsor, its staff, and guest speakers provided a cost-efficient (free attendance for IHS health care providers and only \$200 for non-IHS attendees), outstanding opportunity for both networking and education. Clinical support and funding were also received from IHS Nursing Headquarters. This IHS conference for non-physician primary care providers is traditionally held in June every year in Scottsdale. For information about next year's conference, please contact the IHS Clinical Support Center at (602) 364-7777.

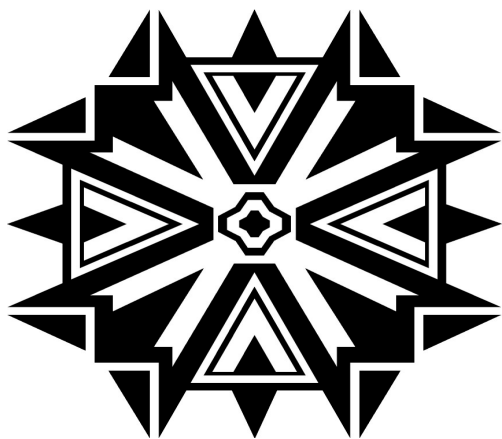


PCC Orphan Visits — Everyone Needs a Home

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In the late 1980s, many Indian Health Service (IHS) providers realized that an electronic summary of their patients' medical record would be essential to providing appropriate medical care. Overflowing charts and illegibility, as well as lost or misplaced results, contributed to this impression. Providers believed that an electronic medical record would greatly increase their ability to review the clinical data during the patient's visit. The Resource and Patient Management System (RPMS) Health Summary was born from this concept. The foundation of the Health Summary is the Patient Care Component (PCC), an electronic repository of data resulting from inpatient, outpatient, and field visits. The current Health Summary is a "snapshot" of the patient's medical record, pulling clinical data from PCC for display either on a computer screen or as a printed report.

The PCC has evolved into a key element for other functions in the IHS beyond the Health Summary. For example, PCC data are critical for billing, and also are necessary to collect and integrate epidemiologic data for reporting requirements. Patient visits are counted from PCC data and these counts are used for resource allocation purposes.



PCC Data are "Visit"-Focused

The demographic and clinical data collected and stored in the PCC are centered around the "patient visit." There are many components to a patient visit, such as an examination, a pharmacy order, and/or a laboratory test request.

Data enter the PCC in two ways, either manually and electronically. PCC data entry clerks manually enter data into the PCC from an encounter form that is completed by the provider during each patient visit. Multiple elements of data are entered; two key pieces are the purpose of visit (POV; that is, the diagnosis), and the primary provider for that visit.

In addition to manual data entry, many of the RPMS packages, such as Laboratory or Pharmacy, have a "link," enabling data to pass directly to the PCC electronically. The electronic data passed from these packages do not contain the POV and primary provider information.

If associated visits, such as to the laboratory or the pharmacy, occur on the same day as a patient visit to, say, the physician, the "electronic" data automatically merge with the "manual" data to create a "complete PCC visit." However, when visits to laboratory or pharmacy occur on a date other than the physician patient visit, an "orphan visit" is created – a visit created electronically that is missing the POV and primary provider.

Since visit data from the PCC are used for many purposes, including billing, resource analysis and allocation for limited IHS funds, and data reporting, it is important that all visits be merged into a complete visit. Orphan visits are not billable through the Third Party Billing Package nor are they exportable to the Data Center for Medicare or Medicaid billing or visit counting.

Avoiding Orphan Laboratory Visits

The Laboratory Package is one of the RPMS packages that automatically passes data to the PCC. In order for these "laboratory visits" to be completed and billable, they must be merged with the original patient visit. If the laboratory visit and actual patient visit are on the same date, these visits will automatically merge and become one complete visit.

In those cases when the laboratory visit occurs on a date other than the patient visit (e.g., the provider saw the patient on one day and requested a laboratory test to be done on a subsequent day before the next visit), an "orphan laboratory visit" is created, because of the difference in the dates of service. As mentioned, these orphan laboratory visits currently are not billable.

How can these orphan laboratory visits be avoided? Each site should consider implementing *both* of the following solutions:

- 1) *Require that the patient deliver to the laboratory a copy of the PCC encounter form that includes the order for the test(s) they are obtaining.* Each time a provider orders a laboratory test for a future time (e.g., “Come back in the morning for a fasting Lipid Panel”), a PCC encounter form would be completed by the provider. This form must contain the date, the test(s) ordered, the POV, and primary provider. The patient should take this encounter form to the laboratory. The laboratory staff should collect this encounter form when the patient arrives for the test and forward it to the PCC department. The PCC clerks will then have the POV and primary provider to complete the visit that was created by the laboratory visit.

- 2) *Each PCC department should use the “Orphan Laboratory Utility.”* This utility can either be run manually or automatically through Taskmanager and will attempt to merge orphan laboratory visits with the actual patient visit. Instructions for using this utility are in the PCC Data Entry manual, supervisor’s section. Additional computer programming to enhance this utility is in progress and should be released shortly. This option should be used in conjunction with the PCC error report to troubleshoot “real” orphan visits that need to be investigated.

In the longer term, the problem of the orphan laboratory visit should be solved by passing the POV and primary provider data electronically to the PCC along with the laboratory data to create a complete PCC visit, independent of any manual data entry by the PCC clerks. This addition to the Laboratory Package is currently being discussed. □

MEETINGS OF INTEREST □

Improving the Quality of Health Care for American Indians and Alaska Natives

August 3-8, 2000; Tucson, Arizona

The 29th Annual Meeting of the American Association of Indian Physicians (AAIP) will offer a number of activities including the ever popular Women’s Retreat, Medical Student Program, Gourd Dance/Pow Wow, and Plenary Sessions focusing on the annual meeting theme: “Improving the Quality of Health Care for American Indians and Alaska Natives.” We also will offer a high quality CME program that will include subspecialty updates for primary care physicians. This year’s annual meeting will be held at the Westin La Paloma Hotel located at 3800 East Sunrise Drive, Tucson, Arizona. This invitation is extended to all Indian and non-Indian physicians, physician assistants, medical students, nurses, tribal leaders, Indian organizations and other individuals interested in Indian health. For more information please contact AAIP at (405) 946-7072; e-mail aaip@ionet.net; or see our banner on our website at www.aaip.com.

The Pharmacy Practice Training Program (PPTP): A Certificate Program in Patient-Oriented Practice

August 7-10, 2000; Phoenix, Arizona

The goal of this four-day training program for pharmacists employed by the Indian Health Service or Indian health programs is to improve the participant’s ability to deliver direct patient care. This program encompasses the management of patient care functions in the areas of consultation, communication, interviewing techniques, laboratory test interpretation, conflict resolution, physical assessment, and disease state management. These techniques are taught utilizing case studies, which include role-playing and discussion. For additional information, contact the

IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004; phone (602) 364-7777; or e-mail: edward.stein@mail.ihs.gov.

Innovations in Elder Care: A Participatory Conference

August 19-22, 2000; Duluth, Minnesota

Planned to run concurrently with the National Indian Council on Aging (NICOA) 2000 conference, this meeting is intended to bring together those from throughout the Indian health care system who provide care to elders to share experiences in the development and implementation of programs to enhance care of elders. For more information, contact the National Indian Council on Aging, 10501 Montgomery Blvd., NE, Suite 210, Albuquerque, New Mexico 87111; telephone (505) 292-2001; fax (505) 292-1922; e-mail evagdpe@nicoa.org.

Clinical Pharmacy Nephrology CE Program

August 21 -25, 2000; Albuquerque, New Mexico

The overall objective of this course is to train pharmacists to act as consultants and pharmacotherapy managers of patients with progressive renal disease and end-stage renal disease, including those on dialysis or who have undergone transplantation.

The curriculum will include a review in renal anatomy and physiology, and the pathophysiology of chronic renal failure (CRF); diagnosis and intervention opportunities in CRF; diabetic nephropathy; and end-stage renal disease (ESRD) diagnosis and treatment options, including hemodialysis, peritoneal dialysis, and renal transplantation. Other topics to be covered include interpretation of laboratory data; anemia

management, pain control, blood pressure control, and bone disease in ESRD; infectious disease issues; nutritional issues; cultural considerations; and reimbursement issues. The course will utilize lectures, case reviews and case studies. Actual dialysis patients will explain what they want you to know about dialysis. Participants will be expected to complete reading assignments prior to participation, complete a written pre- and post-test, and create a personal action plan for utilizing their newly acquired knowledge at their home work site.

The meeting will be held at the Hawthorne Inn and Suites, telephone (505) 242-1555 or (877) 242-1142. For more information and/or to request registration information, please contact one of the following members of the IHS Nephrology Workgroup: Kim Zietlow, e-mail Kim.Zietlow@mail.IHS.gov; telephone (520) 338-4911; Vicky Chavez, e-mail vchavez@albmail.albuquerque.ihs.gov; telephone (505) 988-9821; Cindy Smith, e-mail csmith@gimc.ihs.gov; telephone (505) 722-1185; or Paul Melstrom, e-mail Akmelly@aol.com; telephone (907) 729-2112.

Type 2 Diabetes in American Indian Youth: An Emerging Epidemic **August 28-31, 2000; Gallup, New Mexico**

This conference will bring together researchers, health care professionals, tribal officials, and community leaders to address the growing problem of type 2 diabetes in American Indian and Alaska Native youth. The agenda will address the epidemiology of the problem, current research about the disease, diagnostic criteria, standards of care, and primary and secondary prevention programs. Included in the conference will be technical assistance sessions offered by the National Diabetes Prevention Center, which will provide experts who will answer questions and assist diabetes program personnel in the development of intervention, dissemination, and evaluation strategies for their communities. The conference is sponsored by the National Diabetes Prevention Center, the Centers for Disease Control and Prevention, the Pueblo of Zuni, Diné College, the Navajo Nation, the Gallup Indian Medical Center, Zuni-Ramah PHS, the University of New Mexico Prevention Research Center, and the IHS Clinical Support Center (the accredited sponsor).

The conference will be held at the Best Western Inn and Suites Hotel, 3009 W. Highway 66, Gallup, New Mexico 87301. For more information, contact Pandora Hughes, Native American Research and Training Center, Tucson, Arizona 85719; telephone (520) 621-5560; e-mail ahughes@ahsc.arizona.edu.

Caring for our Children: EMS Issues and Minority Health **September 14-17, 2000; Tucson, Arizona**

The face of the intermountain west is changing. Long rich in its American Indian and western heritage, new ethnic and racial immigration and migration are adding to the complexity of health care delivery in the region. Issues of access,

communication, and religious and cultural beliefs are having an impact on emergency medical services (EMS) systems. The Intermountain Regional EMS for Children Coordinating Council, Inc. (IRECC) is committed to ensuring that all children have access to the broad range of programs associated with EMSC. Please plan to join representatives from culturally diverse populations along with other health care professionals to discuss challenges that have hampered effective EMSC inclusiveness in the past, and potential strategies for overcoming those challenges.

The conference will be held at the Sheraton Tucson Hotel and Suites, 5151 East Grant Road, Tucson, Arizona. The special meeting room rate is \$54.00 plus tax for one or two people. Reservations may be made directly by calling (800) 257-7275 or (520) 323-6262. The deadline for the special meeting room rate is August 18, 2000.

For conference registration information, please contact the Department of Extended Studies, Montana State University, P. O. Box 172200, Bozeman, MT 59717-2200; phone (406) 994-6683; or e-mail mjarvis@montana.edu.

Earth, Wind, Fire, and Water **September 23-26, 2000; Onamia, Minnesota**

This 3^o day continuing education conference is sponsored by the National Alaska Native American Indian Nurses Association. The purpose is to help nurses integrate cultural concepts and values into their practices and it is open to any nurse who works with American Indians or Alaska Natives or is interested in Native American health care. Because of the proximity of this year's meeting place to Canada, nurses working with Canadian Natives are also invited to participate. There will be numerous presentations and workshops to choose from. There is a registration fee. For more information, call toll free at (888) 566-8773.

Second Annual Cancer Training for Physicians, Nurses, Nurse Practitioners, Pharmacists, and Other Clinicians **October 4, 2000; Seattle, Washington**

Leading experts will present their views on current issues for several cancer sites, new technology, and other topics specified in an upcoming survey of clinicians. The first Annual Cancer Training covered the areas of breast, prostate, cervix, colorectal, and lung cancers. Behavioral aspects of smoking, and palliation and pain management were also covered. This training is interactive between the presenters and participants. The IHS Clinical Support Center is the accredited sponsor. There is no course registration fee for member tribes or clinicians serving the American Indian/Alaska Native population. Pre-registration is required. Please contact Gary Brown, Regional Training Specialist, Northwest Tribal Cancer Control Project, Northwest Portland Area Indian Health Board, 527 SW Hall, Suite 300 Portland, Oregon 97201; phone (503) 228-4185 ext. 27 for more information. Current NTCCP activities can also be accessed at <http://www.npaihb.org/cancer/ntccp.html>.

Health Information on the Net: the Good, the Bad and the Deadly
October 4-5, 2000; Bethesda, Maryland

This is the Fifth Annual Conference of the Friends of the National Library of Medicine. The meeting will focus on the “empowered” health information consumer and the implications for health care providers. For more information, go to www.fnlm.org.

AMIA 2000 Annual Symposium
November 4-8, 2000; Los Angeles, California

Sponsored by the American Medical Informatics Association, the theme of the meeting is “converging information, technology, and health care.” For more information, go to www.amia.org.

AMSUS 107th Annual Meeting
November 5-10, 2000; Las Vegas, Nevada

This is the annual meeting of the Association of Military Surgeons United States, and the theme of this year’s event is

“Information Management – One Key to Healthcare Success.” For more information, go to www.amsus.org/meetings.

American Indian Kidney Conference
July 11-13, 2001; Oklahoma City, Oklahoma

The National Kidney Foundation of Oklahoma and the Oklahoma American Indian Kidney Council will sponsor this second annual conference to be held at the Clarion Meridian Hotel and Convention Center in July 2001. Information on prevention of hypertension, diabetes, and kidney disease and coping with kidney disease will be provided over the three days. The target audience included patients and their families, community health providers, medical professionals, and tribal leaders. Continuing education will be available for healthcare providers. For more information, contact Jo Ann Holland, RD, CDE, at the Lawton Indian Hospital, Lawton, Oklahoma; phone (580) 353-0350, extension 560.

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 #766
The Provocative Patient: Personality Disorders in the Primary Care Setting (60 minutes)

Most physicians will encounter patients with personality disorders. While some behaviors are more evident than others, prompt recognition followed by tempered interaction are critical to management that maximizes patient care and minimizes disruptions to your practice. In this video, four simulations of doctor-patient interactions provide a springboard for practical advice on how to recognize the antisocial, borderline, histrionic, and narcissistic personality.

NCME #768
Communication: A Positive Approach to Risk Management (60 minutes)

Lack of communication can lead to error, patient dissatisfaction, disputes, non-compliance, and litigation. This program

presents a positive approach to risk management using mini-case histories that illustrate the creation of trust and mutual respect through an open exchange of information. Guidelines are presented to assist formulating and implementing a risk management approach based on methodologies that underscore effective communication, minimizing the likelihood of litigation and enhancing the quality of patient care.

NCME #769
Diabetes: Managing a 21st Century Lifestyle Disease (60 minutes)

Diabetes mellitus affects nearly 6% of the U.S. population, making it one of the most common medical problems seen by physicians. Each year, diabetes costs the nation nearly \$100 billion in treatment and disability. Preventing complications, such as kidney failure, cardiovascular disease, blindness, and nerve damage, is an important component of regular care. Equally critical to successful treatment is effective patient self-management and education. Often, this means a coordinated and collaborative healthcare effort. Dr. Bernstein reviews the rising prevalence and pathophysiology of diabetes, including the disturbing rise in Type 2 diabetes among children. In addition, he discusses how associated syndromes, such as insulin resistance, are joining diabetes as major lifestyle diseases of the 21st century.

“Improving the Quality of Health Care For American Indians & Alaska Natives”

Tucson, Arizona



August 3-8, 2000

Association of American Indian Physicians 29th Annual Meeting and National Health Conference

Accredited Sponsor:

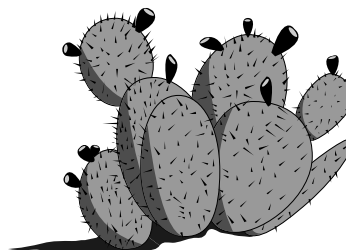
This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the University of Oklahoma Health Sciences Center College of Medicine and the Association of American Indian Physicians.

The University of Oklahoma College of Medicine is accredited by the ACCME to provide continuing medical education for physicians and designates this activity for hours in category 1 credit towards the AMA Physician's Recognition Award.

The Association of American Indian Physicians extends special invitation to everyone to attend and participate in this National Health conference to learn more about improving the quality of health care for American Indian and Alaska Natives. Indian and non-Indian physicians, physician assistants, nurses, residents, medical students, tribal leaders, healthcare administrators, and Indian community members are urged to attend. The Association of Native American Medical Students (ANAMS) will also meet at this time.

HOTEL INFORMATION

North of Tucson in the lush high Sonora Desert, nestled in the foothills of the Santa Catalina Mountains, The Westin La Paloma offers luxurious guest rooms, myriad recreational activities and the superb service expected at a AAA Four Diamond Award-winning resort. Golf enthusiasts can test their skills on the 27-hole Jack Nicklaus Signature course. Enjoy tennis or volleyball, hike the foothills, then cool off at one of the three swimming pools or on Arizona's longest resort water slide. And don't miss the impressive mountain views from the Westin's four restaurants.



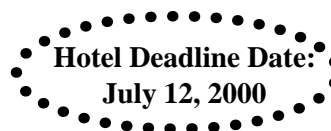
Please note there is a daily \$9.00 USD resort fee and 7.5 % sales tax not included.

**The Westin La Paloma
3800 East Sunrise Drive
Tucson, AZ 85718
520-742-6000**

The special conference rates are:

Guest Rooms

Single/Double: \$58.00



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.

Internal Medicine and Family Practice Physicians, Dentists, Podiatrist, Periodontist, Pediatrician, Registered Nurses Riverside/San Bernardino County Indian Health, Inc., Banning, California

The Riverside/San Bernardino County Indian Health, Inc. clinics are looking for doctors and dentists to work in southern California. Many of our facilities have state of the art equipment and buildings. Riverside/San Bernardino County Indian Health serves 32,000 Native Americans and their family members. The corporation clinics are designated federally qualified health centers and are JCAHO accredited; they are also approved as IHS loan repayment sites. The clinics are situated between San Bernardino, Palm Springs, and San Diego, 1½ hours or less from ocean, mountains, and deserts. Salaries and benefits are very competitive. A minimum of three years experience in clinical practice is preferred. To obtain an application or to send your CV, please contact Mike Absher, Human Resources Director, 11555½ Potrero Road, Banning, California 92220; or phone (909) 849-4761, extension 238.

Registered Nurse Duck Valley Indian Reservation, Owyhee, Nevada

The Owyhee Community Health Facility has an opening for an RN generalist in our small, rural facility. The 15 bed hospital provides acute care (although no obstetrical or surgical services are provided), ambulatory care, and emergency room services. Strong assessment, communication, and prioritization skills are needed. Experience the challenges and rewards of rural health care!

Enjoy, too, the relaxation of rural living on the beautiful Duck Valley Indian Reservation located in scenic northern Nevada. Four season outdoor activities – fishing, hiking, hunting, and skiing – are at your back door.

The salary range is \$20 to \$25 per hour, depending on experience. Relocation assistance is provided. Economical on-site housing is available. Three weeks paid vacation are offered the first year, and there are 12 paid holidays per year. There are no state income taxes in Nevada.

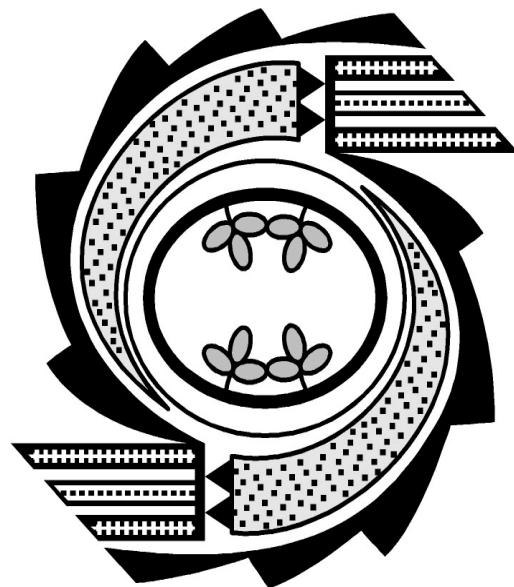
For more information, contact Dawn Kyser, RN, DON at

telephone (775) 757-2415. For an application, contact the Shoshone-Paiute Tribal Personnel Office at (775) 757-3211; fax (775) 757-2219, or write to P. O. Box 130, Owyhee, Nevada, 89832.

Obstetrical Nurses Chinle Comprehensive Care Facility, Chinle, Arizona

The Chinle Comprehensive Care Facility has four openings for clinical nurses on the Obstetrical Care Unit. Our facility is a 60 bed hospital centrally located on the Navajo Reservation. The labor and delivery area consists of four beds, including a triage room; postpartum has 12 beds, and there is a two bed antenatal testing area. Our nursery is a Level 1 unit with a capacity of 14 cribs.

Competitive salary and career benefits as a Federal employee are offered. For more information, contact Linda K. Begaye, RN, Acting OB Manager at (520) 674-7333.



NATIVE AMERICAN MEDICAL LITERATURE □

The following is an updated MEDLINE search on Native American medical literature. This computer search is published regularly as a service to our readers, so that you can be aware of what is being published about the health and health care of American Indians and Alaska Natives.

The Clinical Support Center cannot furnish the articles listed in this section of THE PROVIDER. For those of you who may wish to obtain a copy of a specific article, this can be facilitated by giving the librarian nearest you the unique identifying number (UI number), found at the end of each cited article.

If your facility lacks a library or librarian, try calling your nearest university library, the nearest state medical association, or the National Library of Medicine (1-800-272-47887) to obtain information on how to access journal literature within your region. Bear in mind that most local library networks function on the basis of reciprocity and, if you do not have a library at your facility, you may be charged for services provided.

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THE IHS PRIMARY CARE PROVIDER



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Circulation: THE PROVIDER (ISSN 1063-4398) is distributed to more than 6000 health care providers working for the IHS and tribal health programs, to medical and nursing schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

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

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

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