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## A Reading Literacy Survey at the Phoenix Indian Medical Center

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### Introduction

Patient information literature is a commonly used and accepted method of supplementing verbal instructions and information provided during clinic and hospital visits. The material is generally intended to help patients and caregivers understand the management of disease states and recommended or necessary care. Unfortunately, these printed materials are often written at reading levels higher than the individual patient's level of literacy.

Healthcare providers at Phoenix Indian Medical Center (PIMC) had expressed concerns regarding patients' abilities to read educational materials given to them at the pharmacy and specialty clinics throughout the hospital. Research has determined that a person's level of literacy contributes to an overall understanding of disease states (both acute and chronic) and necessary care. Past studies have shown that poor reading skills can be associated with poor health.

Unfortunately, many healthcare providers are unable to identify patients with limited reading abilities. A provider may mistakenly think a patient's noncompliance with their regimen is due to a lack of motivation or having a different value system, when in reality the patient is illiterate. Inadequate reading skills often create a barrier to receiving good medical treatment. In an effort to improve patient education, the Patient and Family Education Committee at PIMC conducted a study to assess patient population literacy levels.

### Methods

This study was conducted at Phoenix Indian Medical Center. This 140-bed facility is operated by the United States Public Health Service, and provides a variety of both inpatient and outpatient services. These include many specialty clinics that meet the needs of the American Indian and Alaska Native community. The Phoenix Area Indian Health Service, which includes PIMC, provides healthcare for approximately 140,000 American Indian and Alaska Native (AI/AN) people in Arizona, California, Nevada, and Utah. PIMC provides medical service to members of twenty tribes located throughout Arizona.<sup>6</sup> The actual patient population seen at this facility is difficult to determine. The hospital consistently exceeds one hundred thousand patient visits each year. It should be noted that many patients are seen repeatedly throughout the year as part of their routine health care.

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From September 2000 through March 2001, 217 patients were asked to take part in a survey. The Phoenix Area Indian Health Service (PAIHS) Institutional Review Board (IRB) reviewed the proposal and deemed this project to be exempt from IRB review, allowing data collection to proceed. No written consent was obtained. The surveyors were instructed to obtain verbal consent prior to administration of the survey.

Patients were approached in a nonrandomized fashion at the various specialty clinics and wards in the hospital. Surveyors conducted the study in the following locations and departments: Surgery Ward; Medical Ward; Dental Clinic; Ear, Nose, and Throat Clinic; Emergency Department; Eye Clinic; Neurology Clinic; Obstetrics Clinic; Primary Care Medicine Clinic; Pediatric Clinic; Physical Therapy Department; Rheumatology Clinic; Surgery Clinic; and Women’s Clinic. Each department or clinic was contacted regarding participation and assisted in setting up a semi-private area for the patient interviews. Researchers conducted the interviews on days when an interview area was available.

As anticipated, this arrangement lent itself more towards convenience sampling (i.e., talking with patients who happened to have appointments or were being seen as a “walk-in” patient on the particular day scheduled). Patients were asked to participate after they had checked in for their appointment and were screened by the triage nurse. The survey was administered while the patient was waiting to see a health care practitioner or was otherwise unoccupied. Researchers attempted to collect equal amounts of data from each site visited, and to minimize bias in the selection of patients who were asked to participate.

The Patient and Family Education Committee determined *a priori* that not all patients seen at PIMC speak English, and decided to allow caregivers or family members (those responsible for translating materials to patients) to act as proxy for the patient. Originally, this study was going to allow patients, and parents of patients who were under the age of 18 to participate without written parental consent. Although the IRB did not initially require parental consent, the University of Arizona mandated that parental consent be obtained. Due to the nature of this survey, parental consent would not have been obtainable in all cases. As a result, patients under the age of 18 were excluded from this study. The only other group of patients excluded were those in the Intensive Care Unit (ICU). Prior to beginning the study, it was decided that surveying ICU patients would be an imposition, and that patients released from the ICU were often sent to “step-down” units prior to hospital discharge; these other areas of the hospital were surveyed; therefore we were able to sample some of these patients.

For patients who did not want to participate, researchers asked each of them if he/she would provide some general information. If the patient consented he/she was asked their birth date, whether or not English was the primary language spoken at home, and the last grade of school

they had completed. If the patient provided a reason for not wishing to participate, this information was noted on the survey.

The project was conducted as two separate inquiries. A nonexperimental, descriptive approach was used for this research. The first portion of this project was to determine the patient population’s average reading abilities. The Rapid Estimate of Adult Literacy in Medicine (REALM) test was used. According to the test’s authors, “The REALM is a reading recognition test that measures a patient’s ability to pronounce words in ascending order of difficulty. It is unique among reading recognition tests because all test words are commonly used lay medical terms, making REALM particularly useful for estimating literacy skill in medical settings.”<sup>7</sup> It is also considered to be a useful instrument in identifying patients who are likely to read at low levels (below the ninth grade level).<sup>7</sup>

The REALM test consists of a one page (single-sided) list of basic medical terms (See Figure 1). The words are listed in

**Figure 1. Rapid Estimate of Adult Literacy in Medicine (REALM) test**

<b>RAPID ESTIMATE OF ADULT LITERACY IN MEDICINE (REALM)®</b>														
Terry Davis, PhD • Michael Crouch, MD • Sandy Long, PhD														
Patient Name/		Reading Level _____												
Subject # _____	Date of Birth _____	Grade Completed _____												
Date _____	Clinic _____	Examiner _____												
List 1	List 2	List 3												
fat _____	fatigue _____	allergic _____												
flu _____	pelvic _____	menstrual _____												
pill _____	jaundice _____	testicle _____												
dose _____	infection _____	colitis _____												
eye _____	exercise _____	emergency _____												
stress _____	behavior _____	medication _____												
smear _____	prescription _____	occupation _____												
nerves _____	notify _____	sexually _____												
germs _____	gallbladder _____	alcoholism _____												
meals _____	calories _____	irritation _____												
disease _____	depression _____	constipation _____												
cancer _____	miscarraige _____	gonorrhoea _____												
caffeine _____	pregnancy _____	inflammatory _____												
attack _____	arthritis _____	diabetes _____												
kidney _____	nutrition _____	hepatitis _____												
hormones _____	menopause _____	antibiotics _____												
herpes _____	appendix _____	diagnosis _____												
seizure _____	abnormal _____	potassium _____												
bowel _____	syphilis _____	anemia _____												
asthma _____	hemorrhoids _____	obesity _____												
rectal _____	nausea _____	osteoporosis _____												
incest _____	directed _____	impetigo _____												
<table border="1" style="margin-left: auto; margin-right: 0;"> <thead> <tr> <th colspan="2" style="text-align: center;">SCORE</th> </tr> </thead> <tbody> <tr> <td>List 1</td> <td>_____</td> </tr> <tr> <td>List 2</td> <td>_____</td> </tr> <tr> <td>List 3</td> <td>_____</td> </tr> <tr> <td>Raw</td> <td>_____</td> </tr> <tr> <td>Score</td> <td>_____</td> </tr> </tbody> </table>			SCORE		List 1	_____	List 2	_____	List 3	_____	Raw	_____	Score	_____
SCORE														
List 1	_____													
List 2	_____													
List 3	_____													
Raw	_____													
Score	_____													

ascending order of difficulty. The patient is given a copy of the words (printed in large font) and asked to read as many words aloud as possible. At the recommendation of the IRB, the surveyor's instructions for administering the test were altered. The recommendation specifically indicated that the surveyor should enter the term "blank" for a response if the patient was silent for more than five seconds. The IRB felt that most AI/AN would be offended by this approach. Instead, the surveyor instructed patients, before they began, that if they were unable to pronounce a word or did not know the word to simply skip that word and move on to the next word. The surveyor graded the patient on a separate form, and later determined the patient's score (See Figure 2).

For short pieces, test the entire selection. For longer pieces, test at least three randomly selected samples of 100 words each. Do not use introductory paragraphs as part of the sample. Start each sample with the beginning of a paragraph.

Determine the average sentence length (SL) by counting the number of words in the sample and dividing by the number of sentences. Count as a sentence each independent unit of thought that is grammatically independent, i.e., if its end is punctuated by a period, question mark, exclamation point, semicolon

**Figure 2. Rapid Estimate of Adult Literacy in Medicine (REALM) administration and scoring**

<ol style="list-style-type: none"> <li>1. Give the patient a laminated copy of the REALM and score answers on an unlaminated copy that is attached to a clipboard. Hold the clipboard at an angle so that the patient is not distracted by your scoring procedure. Say: <i>"I want to hear you read as many words as you can from this list. Begin with the first word on List 1 and read aloud. When you come to a word you cannot read, do the best you can or say "blank" and go on to the next word."</i></li> <li>2. If the patient takes more than five seconds on a word, say "blank" and point to the next word, if necessary, to move the patient along. If the patient begins to miss every word, have him/her produce only known words.</li> <li>3. Count as an error any word not attempted or mispronounced. Score by marking a plus after each correct word, a check after each mispronounced word, and a minus after words not attempted. Count as correct any self-corrected word.</li> <li>4. Count the number of correct words for each list and record the numbers in the "SCORE" box. Total the numbers and match the total score with its grade equivalent below.</li> </ol>		
Raw Score	Grade Equivalent	Implications for Patient Education
0 - 18	3rd Grade & Below	Will not be able to read most low literacy materials; will need repeated oral instructions, materials composed primarily of illustrations, or audio or video tapes.
19 - 44	4th to 6th Grade	Will need low literacy materials; may not be able to read prescription labels.
45 - 60	7th to 8th Grade	Will struggle with most patient education materials; will not be offended by low literacy materials.
61 - 66	High School	Will be able to read most patient education materials

The REALM test has been used since the early 1990s. Studies assessing the test's validity correlate the REALM test results closely with other reading tests. The REALM test correlation to the Slosson Oral Reading Test – Revised (SORT-R) was determined to be 0.96 (P<0.0001).<sup>7</sup> The REALM test also correlates well with the recognition portion of the Peabody Individual Achievement Test – Revised (PIAT-R) with a correlation factor of 0.97 (P<0.0001).<sup>7</sup> The REALM study was chosen due to the ease of administration and length of time necessary to administer the survey. The test requires minimal training to administer, and most patients were able to complete the REALM test in just a few minutes.

The second portion of the study determined the reading levels at which common patient handouts were written. The Flesch method was used to evaluate a total of 37 handouts. The Flesch Method consists of four steps. The February 1980 issue of the American Journal of Hospital Pharmacy<sup>9</sup> published the following instructions:

or colon. In dialogue, count speech tags (e.g., "he said") as part of the quoted sentence.

Determine the word length (WL) by counting all the syllables in the sample as if reading the words aloud. Divide the syllables by the number of words in the sample and multiply by 100.

These indices are then applied to the formula to compute the reading ease (RE):

$$RE = 206.835 - 1.105(SL) - 0.846(WL)$$

A score of 100 means that an item is very easy to read, and a score of zero means the item is unreadable. See Table 1 for the interpretation of the reading ease scores. The Flesch method has been used for over 45 years, and it is considered to be a valid instrument for testing materials' readability levels when written at or above the fifth-grade level. It was chosen because it "predicts levels of reading difficulty without the need for validation

by samples of readers.”<sup>99</sup> The surveyor asked the medical staff at each survey site to point out commonly used pamphlets in their department. The handouts were then evaluated using the Flesch method.

## Results

A total of 217 patients (151 women and 66 men) were asked to take the REALM test. Twenty-three declined to participate after the survey was explained. The non-participants represented 10.59% (23/217) of the total population. Since participation in this survey was voluntary, patients were not obligated to provide any information. However, some did provide the demographic information and others did offer reasons for not wanting to participate. Of the 23 non-participants, 5 stated they had completed high school (or greater), 5 completed the 11<sup>th</sup> grade, one completed 9<sup>th</sup> grade, and the other 12 did not provide this information.

The surveyor recorded the non-participant’s reason for not wishing to take the survey if one was provided. One patient had forgotten her reading glasses and was unable to clearly read the print. Another was awaiting the arrival of another family member and did not have the time. Others did not feel well enough to participate. No patients in the inpatient services (Surgical, Medical, or Obstetrics Wards) were awakened to take the survey. One patient stated that, due to a mental handicap, he found reading very difficult and did not want to participate. The minimum age for participation in this survey was 18 years of age, and four patients who did not meet this criterion were approached. Once it was established that the patient was not 18 years of age, the encounter was discontinued. One patient from each of the following departments was excluded: Obstetrics Clinic, Primary Care Medicine Clinic, Emergency Department, and the Surgical Ward. The remaining 190 surveys were available for statistical analysis.

The majority [71.05% (135/190)] of the patients surveyed were women. This was not done intentionally; however, certain hospital services are provided specifically for women’s health. The Obstetrics Unit and Women’s Clinic would be expected to yield predominantly female samples. We also encountered a largely female sample when the survey was conducted at the Pediatrics Clinic, as female adults accompanied most of the children seen at this clinic.

The highest score attainable on the REALM test is 66. The highest score recorded was 66 (N = 32) and the lowest score was 9 (N = 1). As part of the survey patients were asked to give the last grade of school attended. In all, 127 of the patients surveyed had completed a high school education (including two patients who had general equivalency diplomas, or GEDs) or higher (college level and beyond). This figure represents 66.8% (127/190) of the completed surveys.

The average raw score on the REALM test was 59.2. This is equivalent to an average reading level of 7<sup>th</sup> to 8<sup>th</sup> grade abili-

ties. Davis et al., the creators of the REALM study, describe this population as those who “will struggle with most patient education materials; will not be offended by low literacy materials.”<sup>98</sup> Table 1 explains the grouping of the raw scores and their corresponding grade equivalent, and illustrates the frequencies recorded for each group.

Thirty-seven patient handouts were analyzed to determine their readability level. The Flesch method used to evaluate the literature generated a “Reading Ease” score that was matched to both a grade level equivalent and a description of style (See Table 2). The description of styles ranges from very easy to very difficult. There are a total of seven categories that were used to describe the patient handouts. Table 3 shows the breakdown of the numbers in each category.

**Table 1. Results of REALM assessments**

Raw Score	Grade Equivalent	Total Number	Percentage of Total
61 – 66	High School	121	63.68%
45 – 60	7 <sup>th</sup> to 8 <sup>th</sup> Grade	57	30.00%
19 – 44	4 <sup>th</sup> to 6 <sup>th</sup> Grade	10	5.26%
00 – 18	3 <sup>rd</sup> Grade and Below	2	1.05%

**Table 2. Flesch Reading Ease score**

Reading Ease	Grade	Description of Style	Syllables per 100 Words	Average Sentence Length
90 - 100	5	Very Easy	123	8
80 - 90	6	Easy	131	11
70 - 80	7	Fairly Easy	139	14
60 - 70	8 - 9	Standard	147	17
50 - 60	10 - 12	Fairly Difficult	155	21
30 - 50	College	Difficult	167	25
0 - 30	Coll. Grad.	Very Difficult	192	29

**Table 3. Flesch assessment of patient handouts**

Description of Style	Grade Level	Number of Handouts	Percent of Total
Very Difficult	College Graduate	0	0.0%
Difficult	College	5	13.5%
Fairly Difficult	10-12	9	24.3%
Standard	8-9	13	35.1%
Fairly Easy	7	7	18.9%
Easy	6	3	8.1%
Very Easy	5	0	0.0%

The intentions of this study did not include directly testing the patient's reading abilities with perception and understanding of the written materials examined. One of the reasons for choosing the Flesch method was that this instrument did not require patient validation, meaning that the investigators could determine the approximate readability level without having to ask patients to read the material. Table 4 lists the handouts that were analyzed and the reading level that was subsequently assigned to them. None of the handouts fell into the categories of "very difficult" or "very easy." Five handouts were written at a reading level appropriate for people who have some college level education. These were "Actos" (manufacturer's patient information), "A Patient's Guide to Treatment of Thyroid Disease with Levothyroxine," "Baby Shots" (a parent's guide to childhood immunizations), "Fitness Injury Prevention," and "Sertraline Hydrochloride." Greater than fifty-nine percent of the material was written at levels that should be understandable with a ninth grade education or less.

### Discussion

The survey results seem to be similar to populations seen throughout the United States. Generally speaking, a medical practitioner cannot judge a patient's level of literacy based on the last grade of school completed. This appears to be true with the patient population at PIMC. The average grade completed in the group surveyed was 12.23 years. However, the average patient could only read at the 7<sup>th</sup> - 8<sup>th</sup> grade level. Practitioners should never assume a patient can read at levels equivalent to their years in school.

Due to the nature of this research project, there were several limitations to the usefulness of the study. The most obvious problem involves those patients who declined to participate. There is no possible method to determine whether patients were declining because they were unable to read. Since

**Table 4. Analysis of Handouts at the Phoenix Indian Medical Center**

Handout Title	Average Sentence Length	Average Word Length	Reading Ease Score	Grade Level	Description
Actos	17.789	172.485	42.857	College	Difficult
All About Prevacid	15.091	155.120	60.286	8-9 <sup>th</sup>	Standard
A Patient's Guide to Cyclosporine Therapy	13.160	155.015	62.335	8-9 <sup>th</sup>	Standard
A Patient's Guide to Ear Infections	15.400	149.870	64.414	8-9 <sup>th</sup>	Standard
A Patient's Guide to Metered-Dose Inhalers	13.815	148.794	66.933	8-9 <sup>th</sup>	Standard
A Patient's Guide to the Treatment of Thyroid Disease with Levothyroxine	10.724	175.241	47.696	College	Difficult
Baby Shots	10.871	177.745	45.429	College	Difficult
Be Stroke Smart	14.869	159.064	57.175	10-12 <sup>th</sup>	Fairly Difficult
Breast Self-Examination	14.727	137.654	75.432	7 <sup>th</sup>	Fairly Easy
Chicken Pox Vaccine	15.650	160.703	54.995	10-12 <sup>th</sup>	Fairly Difficult
Diabetes Mellitus	13.885	142.105	72.521	7 <sup>th</sup>	Fairly Easy
Diphtheria, Tetanus, and Pertussis Vaccines	9.912	173.294	50.341	10-12 <sup>th</sup>	Fairly Difficult
Domestic Violence Resource Booklet	8.189	169.637	55.01	10-12 <sup>th</sup>	Fairly Difficult
Fitness Injury Prevention	18.500	167.567	46.295	College	Difficult
Hepatitis C	11.481	160.323	59.549	10-12 <sup>th</sup>	Fairly Difficult
How To Start A Walking Program	11.065	136.735	79.926	7 <sup>th</sup>	Fairly Easy
How To Take Birth Control Pills	16.095	146.449	66.603	8-9 <sup>th</sup>	Standard
How To Use Eye Drops	11.95	131.38	83.559	6 <sup>th</sup>	Easy
How To Use Eye Ointments and Gels	12.789	125.926	87.321	6 <sup>th</sup>	Easy
Living With Rheumatoid Arthritis	10.424	151.744	67.88	8-9 <sup>th</sup>	Standard
Making Choices About Contraception	12.333	151.652	66.019	8-9 <sup>th</sup>	Standard
Neck Owner's Manual	18.389	142.296	67.788	8-9 <sup>th</sup>	Standard
Nitroglycerin Sublingual Tablets	12.000	157.143	61.712	8-9 <sup>th</sup>	Standard
Patient Information Handout Acne	12.045	141.321	75.051	7 <sup>th</sup>	Fairly Easy
Peptic Ulcer Disease	14.176	151.037	64.669	8-9 <sup>th</sup>	Standard
PIMC Emergency Department Discharge Instructions	13.160	167.781	51.535	10-12 <sup>th</sup>	Fairly Difficult
Prenatal Warning Signs and Instructions	9.935	161.364	60.236	8-9 <sup>th</sup>	Standard
Scabies- Patient Information	14.130	144.615	70.149	7 <sup>th</sup>	Fairly Easy
Sensible Shoes	16.095	144.970	67.854	8-9 <sup>th</sup>	Standard
Sertraline Hydrochloride	15.190	168.652	48.737	College	Difficult
Tips For Success With Antibiotic Therapy	9.833	160.169	61.352	8-9 <sup>th</sup>	Standard
Tuberculosis	12.308	132.813	81.982	6 <sup>th</sup>	Easy
Understanding an Abnormal Pap Smear	15.409	157.227	58.181	10-12 <sup>th</sup>	Fairly Difficult
Valley Fever "Cocci"	15.629	131.280	79.909	7 <sup>th</sup>	Fairly Easy
VRE	10.409	143.231	75.096	7 <sup>th</sup>	Fairly Easy
Your Child and Antibiotics	12.800	158.750	59.540	10-12 <sup>th</sup>	Fairly Difficult
Your Treatment With Agenerase	13.750	161.515	56.237	10-12 <sup>th</sup>	Fairly Difficult

study participation was voluntary, it seemed unrealistic for the surveyor to follow-up with questions to determine the true reason for not wanting to be tested.

The REALM test is considered to be a valid instrument for estimating a patient's ability to read. However, a patient who is able to recognize and pronounce the words may not entirely understand written passages containing the same words. The REALM was designed to give a healthcare practitioner a quick and easy tool to determine if a patient may have problems understanding written materials. Another drawback to the REALM is that it has not been established as a valid indicator for patients whose primary language is not English. Twenty-eight of the patients asked to participate in this survey indicated that English was not the primary language spoken in their homes. Of these, 14 scored in the High School reading levels, 9 were in the 7 - 8<sup>th</sup> grade reading levels, 2 patients scored in the 4 - 6<sup>th</sup> grade level, and 3 were non-participants. This project did not intend to analyze differences between English speaking patients and those who do not use English as their primary language. Therefore, it would be outside the scope of this project to speculate whether or not these patient populations are truly different.

The Flesch method used for evaluating written patient information also has limitations. Written passages accompanied by illustrations cannot be scored differently with this method. Understanding of the written information may be greatly enhanced when it is accompanied by visual aids (especially ones that demonstrate techniques). There are several other factors

that can contribute to an item's "readability." Details such as the print size and the font used may influence how well a person is able to read the material.

Many patient information pamphlets do cover complicated topics. Sometimes using a difficult word is unavoidable. In these cases, it may be appropriate to phonetically spell out a word. For example, the pamphlet entitled "Baby Shots – A Healthy Dose of Love" provides information for parents following their child's immunization. By simply including the names of common vaccinations, the material scored in the "Fairly Difficult" category. Words like "diphtheria" or "haemophilus" were used to explain the different vaccines, and contributed to the Flesch score. It may help the patient understand these terms if a phonetic spelling appears with the words. If a patient sees "diphtheria," he or she may not visually recognize the term even though they would verbally understand it if it were used in conversation. It may increase patients' understanding if this word was followed by "(dip-thir-ee-a)."<sup>11</sup>

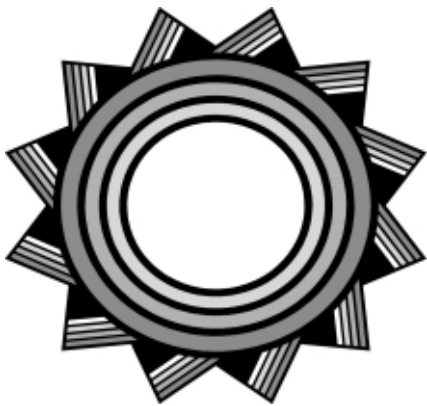
It is difficult for most health care professionals to imagine what life is like for a person with limited reading abilities. Many things that are taken for granted become barriers to understanding and completing everyday tasks. In terms of providing adequate health care, there is no systematic way to evaluate every patient's reading abilities. The REALM test is a valid instrument that is easy to use, and is accepted by most patients. A health care provider can use this test to quickly estimate a patient's reading abilities.

### Acknowledgments

We express our sincere thanks to Jane Johnson, PharmD candidate, surveyor, and Violet Geza, PharmD candidate, surveyor. Copies of the REALM may be obtained by contacting Dr. T. Davis, Department of Internal Medicine, LSUMC-S, P.O. Box 33932, Shreveport, Louisiana 71130-3932. □

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# The Kaiser Family Foundation Native American Health Policy Fellowship Program

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The Henry J. Kaiser Family Foundation (the Kaiser Foundation) has awarded fellowships for the past three years to outstanding American Indian and Alaska Native individuals who have made their career in health and welfare related fields and are interested in health policy. The Foundation has a strong commitment to American Indian and Alaska Native leadership development as a part of its overall activities as a non-profit, independent, national health care philanthropic organization dedicated to providing information and analysis on health issues to policymakers, the media, and the general public.

For several years, Kaiser has offered useful publications on issues related to Indian health policy, such as health insurance and access to care issues, Medicaid managed care, reauthorization of the Indian Health Care Improvement Act, and sources of financing and health spending for American Indians and Alaska Natives. Kaiser continues its commitment to American Indian and Alaska Native health by announcing the upcoming fourth year of the Native American Health Policy Fellowship Program. This article describes the fellowship program and contains application information. American Indians and Alaska Natives with at least three years of experience in Indian health are eligible to apply.

## Description

The purpose of the Henry J. Kaiser Native American Health Policy Fellowship Program is to give American Indians and Alaska Native health and welfare leaders an opportunity to learn more about national health and welfare policy issues that affect American Indian and Alaska Natives and gain a better understanding of the national policy-making process. Fellows work full-time for one year in Washington, DC, in a Congressional or Executive Branch office to gain first-hand knowledge of policy issues and how government works. Past fellows have worked with the Minority and Majority staff on the Senate Indian Affairs Committee, the House Commerce Committee, the White House Office on the President's Initiative for One America, the Democratic Policy Committee, Department of Health and Human Services, and in a Senator's office. In addition, fellows

participate in seminars on health and welfare policy issues and have the opportunity to meet with top administrators of agencies responsible for health and welfare programs, elected representatives, Congressional staff, and experts from policy research groups. The fellows also develop their research and analytic skills by writing a short policy paper on a topic related to American Indian and Alaska Native health care or welfare policy.

Eligibility requirements for this fellowship program include the following:

- Membership in an American Indian or Alaska Native tribe.
- At least three years of work experience in an Indian health program (Indian Health Service, tribal, or urban program; I/T/U) or other relevant setting (college, university, non-governmental, or public sector organizations can qualify).

A strong candidate would have a commitment to pursue a career in American Indian and Alaska Native health and welfare issues, with demonstrated leadership potential in their prior work and applications. Past fellows have included: Melissa McNeil, Executive Officer, Office of the Principal Chief for the Cherokee Nation; Beverly Russell, Women's Wellness/Special Projects Coordinator for The American Indian Community House, Inc; and Roberta Kinzhuma, Program Director, Oneida Nation Elderly Services. The current fellows are:

- Josie Atcitty (Navajo), Management Analyst for the Northern Navajo Medical Center, Shiprock, New Mexico. During her fellowship year she is working on Indian affairs for United States Senator Pete V. Domenici of New Mexico.
- Stacey L. Ecoffey, MSW (Oglala Sioux), Health and Human Services Committee Coordinator for the Oglala Sioux Tribe, Pine Ridge, South Dakota. During her fellowship she is working with the Senior Advisor for Tribal Affairs, Intergovernmental Affairs, Office of the Secretary at the Department of Health and Human Services.
- Barbara Finkbonner (Lummi), Director, Lummi Tribal Health Center, Bellingham, Washington. During her fellowship she is working with the minority staff on the House Commerce Committee.

The fellowship provides an annual stipend of \$40,000, a housing stipend, and certain travel expenses. The fellowship

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program runs from January to December. Fellows must make a commitment to work the entire year in Washington, DC, and usually take a leave of absence from their current job. Stipends are paid through the fellow's current employer or another sponsoring organization during the fellowship.

### Application Process

Applications for the 2002 Native American Health Policy Fellowship Program are available and are due August 15, 2001. Applications requests should be directed to:

Priya Helweg, Program Manager  
Native American Health Policy Fellowship Program  
The Henry J. Kaiser Family Foundation  
1450 G Street, NW, Suite 250  
Washington, DC 20005  
Tel: (202) 347-5270  
Fax: (202) 347-5274  
E-mail: [phelweg@kff.org](mailto:phelweg@kff.org)

Complete application forms are also available on the Kaiser Family Foundation website at [www.kff.org](http://www.kff.org).

Completed applications will include an application form, an "agreement to sponsor" form for the employer or sponsoring organization, two professional reference forms, a resumé, and a writing sample. Applications are reviewed by a national selection committee that includes several experts in Indian health policy. Up to eight applicants will be interviewed in Washington, DC, in October, and up to four fellows will be selected by November, 2001.

The Henry J. Kaiser Native American Health Policy Fellowship provides an outstanding opportunity for American Indians and Alaska Natives working in Indian health programs to learn more about how health policy is made and how Indian health policy issues are dealt with in Washington, DC. At a time when the Indian health system is changing rapidly, when tribes are assuming management of their own health programs, and when significant under-funding exists, it is critical for more American Indians and Alaska Natives to understand how Federal health policy is developed and how it affects Indian communities. The individuals who complete this fellowship have the potential to be leaders in the future of Indian health policy and to positively impact the future health of American Indian and Alaska Native people. □

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## Film About American Indian Veterans' Views About Health Care Available

In summer 2000, a film about American Indian Veterans and their views of health care delivery evolved in Tucson, Arizona. The film, entitled "Respect: A Vision to Better Serve Our American Indian Veterans," profiles nine American Indian Veterans who are primarily from the Western United States. Each Veteran is offered the opportunity to comment on common themes such as cultural taboos, financial hardships faced by those living on reservations, and stereotyping of American Indian patients.

One of the producers of the film is a registered nurse who has spent ten years working exclusively with American Indian Veterans and their families at the Southern Arizona VA Health Care System in Tucson. She is a member of the Veterans Health Administration's EEO American Indian Advisory Council, which provided funding for this film.

The film, which is approximately 30 minutes in length, is available to anyone who would like to become an advocate for American Indian people. Whether you are an administrator or a health care provider who works with American Indian patients

within the Veterans Affairs system or in the Indian Health Service, you may find this film useful as an educational tool in caring for your patients.

To receive your copy at no cost, please send your address to:

Yvonne Garcia, RN  
Southern Arizona VA Health Care System  
3601 S. Sixth Ave.  
Tucson, Arizona 85723 □





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# Notes from the Elder Care Initiative

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*Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Zuni, New Mexico*

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## Subscribe to the Eldercare Listserv

The number of individuals who have expressed an interest in keeping in touch on elder issues continues to grow. We have set up an e-mail listserv so that we can share information, resources, and ideas. The listserv is by far the least expensive and fastest way to keep in touch and we will generally be using it rather than sending out mailings. If you don't have access to e-mail, please mail or fax me a note that you want to stay on the reduced mailing list so that I can keep you "in the loop."

To subscribe to the listserv send e-mail to [listserv@hqt.ihs.gov](mailto:listserv@hqt.ihs.gov) with the following message in **plain** text in the **body (not the subject line!)** of the e-mail:

**subscribe eldercare yourfirstname  
yourlastname**

After you've subscribed, you can communicate with other participants in the listserv group. Address your e-mail to [eldercare@hqt.ihs.gov](mailto:eldercare@hqt.ihs.gov).

## PCC Comprehensive Elder Exam

As most of you know by now, the PCC (Patient Care Component) Comprehensive Elder Exam form is finally available as form IHS-865. This PCC walks the provider through a state-of-the-art annual geriatric assessment and can be used to collect data on the functional status of the older patient. The functional status information can be printed on the Health Summary and can be used to generate reports for your clinic or community. For details about how to order and use this new PCC form, look at the Elder Care Initiative website at [www.ihs.gov/medicalprograms/eldercare](http://www.ihs.gov/medicalprograms/eldercare) and click on "What's New."

## Guide to Comprehensive Geriatric Assessment in Indian Country

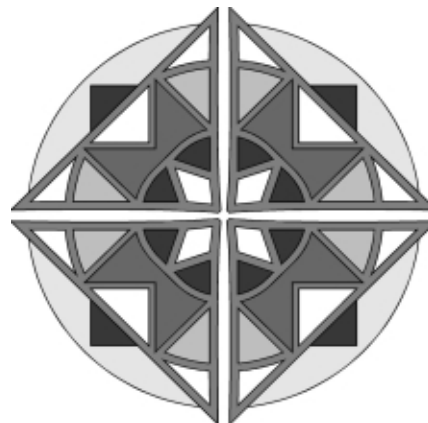
In collaboration with the New Mexico Geriatric Education Center, we have developed the "Guide to Comprehensive Geriatric Assessment in Indian Country." This handbook addresses geriatric assessment as it really happens in the Indian health care system and describes tools and approaches currently in use at various sites. We hope that it will be a great help to those developing geriatric clinics and assessment programs for their communities. Contact Dr. Bruce Finke (by e-mail,

mail, or fax) to obtain a copy (one copy per site please). We will need to do another printing, so these Guides will be mailed out in August.

## AoA Native American Caregiver Support Program

All Title VI (Senior Center and Meals on Wheels) programs will have received a letter describing the new Administration on Aging Native American Caregiver Support Program. As the letter states, "The purpose of this program is to help families caring for an older relative with a chronic illness or disability. The program will assist Tribes in providing multi-faceted systems of support services for family caregivers and for grandparents or older individuals who are relative caregivers."

Congress has appropriated \$5 million for this program for FY 2001. Eligible applicants to apply for both the formula and demonstration grants are current Title VI, Parts A and B grantees. There may be an opportunity for collaboration between clinics and hospitals and Senior Centers in developing these grant proposals. For more information, go to <http://www.aoa.dhhs.gov/t4/fy2001/nacsp-letter.html>.



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## RWJ Foundation Announces Community Partnerships for Older Adults Grants

Community Partnerships for Older Adults is a new, \$28-million initiative of the Robert Wood Johnson Foundation. This national program is designed to promote local efforts to improve the systems delivering long term care and supportive services to vulnerable older adults and their caregivers.

Over the next eight years, working groups in communities across the nation will receive grant funding to develop and implement strategies to:

- Mobilize and strengthen community resources to meet the growing need for long term care and supportive services.
- Increase communication and coordination among providers, and between providers and consumers.
- Promote a better quality of life for vulnerable older adults and their caregivers.

Find the Call for Proposals describing the program and information about how to apply at <http://www.muskie.usm.maine.edu/communitypartnerships/>

Please sign up on the listserv, stay in touch, and let me know how the Elder Care Initiative can help you provide quality care for the elders we serve. □

Bruce Finke, MD  
IHS Elder Care Initiative  
Box 467  
Zuni, New Mexico 87327  
E-mail: [bfinke@abq.ihs.gov](mailto:bfinke@abq.ihs.gov)  
Phone: (505) 782-7357  
Fax: (505) 782-7405  
Website: [www.ihs.gov/eldercare](http://www.ihs.gov/eldercare)

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## 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 Assistant, Nurse Practitioner, or Physician Yukon Kuskokwim Health Corporation; Bethel, Alaska

The Yukon Kuskokwim Health Corporation is looking for a full time physician assistant, nurse practitioner, or physician eligible for licensure in the state of Alaska to join our Village Operations Team as Director of Education. Responsibilities include the operations of Health Aide training, including basic training, advanced training, and EMS training, and ensuring its coordination with other components of the Health Aide Program. Located in the culturally rich Yukon-Kuskokwim Delta of Southeast Alaska, we support a staff of 190 Community Health Aides. Two years of clinical experience and two years in an educational setting are required. Experience with Health Aide training and distance education desirable. Grant writing, public relations, effective communication (oral and written), working knowledge of computers (Macintosh and Microsoft Office suite), and experience as an EMT or paramedic preferred. If interested, please submit a resume and cover letter to Yukon Kuskokwim Health Corporation, Attention: Dana L. Hall, Box 528, Bethel, AK 99559-0528; telephone (907) 543-6131; fax (907) 543-6143; e-mail [dana\\_hall@ykhc.org](mailto:dana_hall@ykhc.org).

### Physician Assistant, Nurse Practitioner, or Physician Yukon Kuskokwim Health Corporation; Bethel, Alaska

The Yukon Kuskokwim Health Corporation is looking for a full time registered nurse, nurse practitioner, or physician assistant eligible for licensure in the State of Alaska to join our Village Operations Team as Advanced Training Coordinator. Responsibilities include coordinating the activities of the Advanced Training Program and the delivery of the Well Child (EPSDT) Program as done by Advanced Trained Community Health Aides/

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Practitioners in Village Clinics. Located in the culturally rich Yukon-Kuskokwim Delta of Southeast Alaska, we support a staff of 190 Community Health Aides and 48 clinics. Two years of health care experience, one-year supervisory experience, and a positive work history is required. Grant writing, budget management, public relations, effective communication (oral and written), and working knowledge of computers (RPMS and Microsoft Office suite) preferred. Ability to perform special skills (e.g., immunizations, pap smears, well child screening, etc.) is preferred. Willingness to travel to village clinics a must. If interested, please submit a resume and cover letter to Yukon Kuskokwim Health Corporation, Attention: Dana L. Hall, Box 528, Bethel, AK 99559-0528; telephone (907) 543-6131; fax (907) 543-6143; e-mail [dana\\_hall@ykhc.org](mailto:dana_hall@ykhc.org)

### **Registered Nurse Yukon Kuskokwim Health Corporation; Bethel, Alaska**

The Yukon Kuskokwim Health Corporation is looking for a full time registered nurse eligible for licensure in the State of Alaska to join our Community Health and Wellness team as Diabetes Education RN. Responsibilities include planning, organizing, and coordinating diabetes related health promotion activities, maintaining the diabetes registry, providing care management, and building sustainable systems through Health Aide training and community mini-grants. Located in the culturally rich Yukon-Kuskokwim Delta of Southeast Alaska, we support a staff of 190 Community Health Aides and 48 clinics. Completion of a program of education in nursing from an accredited school of nursing, two years of health care experience in a cross-cultural setting, data management skills, and strong oral/written communication skills required. Certified Diabetes Educator (CDE), case management skills, diabetes registry experience, and data base management skills preferred. Willingness to travel to village in small planes a must. If interested please submit a resume and cover letter to Yukon Kuskokwim Health Corpora-

tion, Attention: Amber Norgaard, Box 528, Bethel, AK 99559-0528; telephone (907) 543-6131; fax (907) 543-6143; e-mail [amber\\_norgaard@ykhc.org](mailto:amber_norgaard@ykhc.org).

### **Physician Southern Indian Health Council; Alpine, California**

Seeking board certified family practice physician with interests in pediatrics, women's health, and addiction medicine to provide primary care at an outpatient rural clinic in east San Diego county serving American Indians and the general public. Medical directorship responsibility at a nearby youth residential treatment facility. Excellent benefits. Shared call coverage. No hospital work. Loan repayment possibilities. Send CV to Robert Sablove, MD, Medical Director, Southern Indian Health Council, P.O. Box 2128, Alpine, California 91903-2128; fax (619)445-0579; e-mail [rsablove@sihc.org](mailto:rsablove@sihc.org).

### **Certified Registered Nurse Anesthetist or Anesthesiologist Claremore, Oklahoma**

The Claremore PHS Indian Hospital is seeking a certified registered nurse anesthetist or an anesthesiologist. This is a full-time position in a three member department covering two operating rooms. Night call is taken from your home and does not involve trauma or a labor epidural service. Anesthetics are provided for a wide range of both inpatient and outpatient services including general surgery, OB/gyn, dentistry, and podiatry.

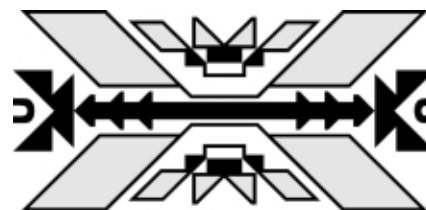
Claremore is a rapidly growing community near a major metropolitan area (Tulsa) with convenient access to scenic recreational and cultural opportunities. A warm climate and a relaxed practice with congenial staff make this an attractive salaried position.

Send CV to Paul Mobley, DO, Clinical Director, Claremore PHS Indian Hospital, 101 South Moore, Claremore, Oklahoma 74017-509; telephone (918) 342-6433; fax (918) 342-6517.

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## Correction

In the March issue of THE PROVIDER, there was a brief item entitled "University of Minnesota School of Nursing Announces Internet-based Masters Degree Program" (THE IHS PROVIDER, Volume 26, Number 3, March 2001, page 39). Since the publication of this piece, a more specific e-mail address has been established to contact the program. For more information please visit [www.nursing.umn.edu/telign.html](http://www.nursing.umn.edu/telign.html) or contact Trina Lone Hill at (888) 240-8636; e-mail [loneh001@umn.edu](mailto:loneh001@umn.edu). □



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## MEETINGS OF INTEREST □

### IHS Patient Education Conference

July 23-27, 2001; Cherokee, North Carolina

This conference is for all health care providers, including Medical Records, Quality Assurance, and Business Office staffs. The goals of this meeting are:

- Improved documentation of the patient education that is being provided by all providers;
- Improved documentation and coding of the patient education provided in order to better meet JCAHO standards;
- To assist facilities to increase reimbursement for patient education.

Presentations during the 3-day meeting will include empowerment of clients with chronic diseases, diabetes, or substance abuse disorders (and the subsequent documentation and coding of the patient education given); hands-on practice of documentation and coding; and presentations on meeting the JCAHO Patient and Family Education Standards, such as those for cultural and religious practices. For more information, contact any of the following IHS staff via e-mail or telephone: Becky Grizzle, Zuni; Linda Lucke, Blackfeet; Joann Holland, Lawton; Willadine Hughes, Whiteriver; Wanda Lambert, Cherokee; Margaret Bolte, Yakama; Mary Ann Cook, Red Lake; or Mary Wachacha, Nashville, telephone (615) 467-1533.

### The Winds Of Change, Faces Of Change, Challenges In Public Health Nursing

August 20-24, 2001; Albuquerque, New Mexico

This Indian Health Service public health nursing specialty training conference will be held at the Sheraton Uptown Hotel in Albuquerque, NM. It is sponsored by the Albuquerque Area Indian Health Service and the Navajo Area Indian Health Service Office of Public Health Nursing. The Indian Health Service Clinical Support Center will be the accredited sponsor of this meeting.

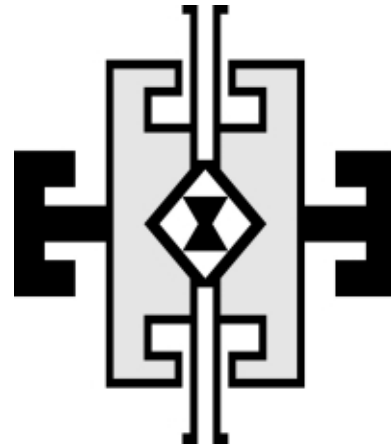
Public health nurses from all Indian Health Service and tribal programs are invited to participate. The curriculum will focus on the "scope of work" within public health nursing, with an overview of the fundamentals of public and community health. Topics include immunization and infectious disease updates, domestic violence, renal disease, childhood obesity, fundamentals of public health practice, and improving community health care through home visitation.

For registration information please contact Jim Sutton, PHN, Jicarilla Service Unit, P. O. Box 187, Dulce, New Mexico 87528; telephone (505) 759-3291, ext. 245; fax (505) 759-9292; or e-mail [jsutton@albmail.albuquerque.ihs.gov](mailto:jsutton@albmail.albuquerque.ihs.gov). The agenda will be available by late May 2001.

### Third Annual American Indian Elders Conference

August 22-24, 2001; Oklahoma City, Oklahoma

The Oklahoma Elder Care Planning Team announces the Third Annual American Indian Elders Conference entitled "Many



Faces of American Indian Elders," to be presented in Oklahoma City, Oklahoma. Two goals of this conference are to emphasize healthcare for American Indian Elders and increase the attendance of participants. The target audience includes consumers (elders) and health care providers (nurses, physicians, midlevel providers, social workers, community health workers, etc.).

The meeting will cover a variety of topics such as nutrition, diabetes, pain management, cancer, dementia, exercise/Tai Chi Chuan, end-of-life care, and much more. Partners planning this conference include the Lawton Indian Hospital, Wewoka Indian Health Center, Oklahoma City Area IHS, Southwest Oklahoma Area Health Education Center, American Cancer Society, Association of American Indian Physicians, State Department of Health, Chickasaw Nation, Cherokee Nation, Cheyenne and Arapaho Tribes and the Seminole Nation.

The meeting will be held at the Clarion Meridian Hotel and Convention Center, 737 South Meridian in Oklahoma City. Mark your calendars early! Brochures will be available in June. For more information, contact Mary Jac Rauh, Cameron University at SwOKAHEC (580) 581-2284, e-mail [maryjaacr@cameron.edu](mailto:maryjaacr@cameron.edu); or Carolyn Whitecloud at (405) 951-3716, or toll-free (888) 843-2591, ext. 3716.

### Should Government Cover Traditional Indian Medicine?

September 7-8, 2001; Scottsdale, Arizona

The University of Arizona College of Medicine and the Indian Health Service Clinical Support Center (the accredited spon-

sor) will sponsor a conference exploring the question, "Should Government Cover Traditional Indian Medicine?" in Scottsdale, Arizona, in September, 2001. Risks, benefits, and obstacles to governmental third party healers will be discussed by experts in governmental health care delivery and policy, American Indian and Alaska Native leaders and healers, and those who have first-hand experience with projects merging traditional healing with the biomedical health care system. The target audience includes heads of agencies responsible for delivery of or payment or policy for health care delivery to American Indians and Alaska Natives; and traditional healers. The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this continuing education activity for up to 13¾ hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. The Indian Health Service Clinical Support Center is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation, and designates this activity for 16.5 contact hours for nurses. For more information, contact Carol Goldtooth-Begay at the University of Arizona College of Medicine at (520) 318-7180, e-mail [mbegay@attglobal.net](mailto:mbegay@attglobal.net); or Dr. Kris Olson at [krisog2@aol.com](mailto:krisog2@aol.com). Registration is limited to 500 attendees.

### **Working Together for Diabetes Prevention: Exploring the Benefits and Challenges of Participatory Research** **September 12-14, 2001; Gallup, New Mexico**

On September 12-14, 2001 the National Diabetes Prevention Center Southwest will be sponsoring its third annual conference in Gallup, New Mexico.

The participatory approach to prevention research requires that researchers and communities collaborate as mutual partners throughout the research process — including planning, implementation, evaluation, dissemination of results, and deriving the resulting benefits. Anyone interested in networking and sharing experiences in diabetes prevention and participatory research should attend this conference. This may include physicians, nurses, pharmacists, nutritionists, health educators, community health representatives, tribal officials, community leaders, and students.

A series of pre-conference workshops will be offered on the morning of September 12<sup>th</sup>. These interactive workshops are designed to provide an opportunity for conference participants and invited consultants to come together and discuss the benefits and challenges of designing, implementing, and disseminating their community-based prevention research projects. If you have specific questions you would like addressed in the areas of 1) project design, 2) project implementation, 3) evaluation, or 4) sharing your results, these workshops can be tailored to better meet your needs. Send a brief description of your research project and specific questions to: National Diabetes Prevention Center Southwest, 214 E. Nizhoni Blvd., Gallup, NM

87301, Attn: LaVern Mraz; e-mail [Lmraz@salud.unm.edu](mailto:Lmraz@salud.unm.edu); telephone (888) 590-NDPC or (505) 863-0166.

For more information on the conference and the Call for Abstracts, please visit the NDPC website "What's New" at <http://hsc.unm.edu/ndpc>, or contact Laura Kesselman at (505) 266-0552; e-mail [kessjones@aol.com](mailto:kessjones@aol.com).

### **UCLA Intensive Course in Geriatric Medicine and Board Review** **September 12-15, 2001; Marina Del Rey, California**

This is an excellent comprehensive geriatrics review with faculty who are national leaders in the field. For more information about the conference contact the UCLA Multicampus Program in Geriatric Medicine and Gerontology, attn: Catarina de Carvalho. Telephone (310) 312-0531; fax (310) 312-0546; e-mail [cprata@ucla.edu](mailto:cprata@ucla.edu).

In past years UCLA has offered Indian health care providers a tuition discount. We will need to provide UCLA with the names of Indian health care providers who plan to attend. If you plan to attend this conference, please contact Bruce Finke, MD, IHS Elder Care Initiative, P. O. Box 467, Zuni, NM 87327; fax (505) 782-7405; e-mail [bfinke@albmail.albuquerque.ih.gov](mailto:bfinke@albmail.albuquerque.ih.gov).

### **Geriatric Medicine for the Family Physician** **September 13-16, 2001; Monterey, California**

This American Academy of Family Practice course is designed as a comprehensive update in geriatric medicine. For more information contact the AAFP at (800) 944-0000 or by going to their website at [www.aafp.org](http://www.aafp.org).

### **Third Annual Diabetes Management Conference: Type 2 Update** **September 14-15, 2001; Mt. Pleasant, Michigan**

Diabetes is an ever spreading problem in Native Americans and the U.S. in general. This conference is aimed at improving all health care providers' knowledge of current diabetes treatment, therefore improving quality of care and outcomes for clients. Physicians and nurses are invited, as well as allied health providers (such as pharmacists, physician assistants, nurse practitioners, diabetes and health educators, and pharmacy and dental technicians) and anyone else interested in learning more about diabetes.

Nimkee Memorial Wellness Center and the Saginaw Chippewa Indian Tribe are pleased to present this annual update. This conference will be held in mid-Michigan at the Soaring Eagle Casino and Resort. Registration will cover the costs of all presentations and materials, meals (dinner Friday, continental breakfast and lunch on Saturday), exhibits, and continuing education credits. Lodging is available at the four star Soaring Eagle Resort at a reduced rate for the conference. For a brochure or more information, please call (800) 225-8172, ext. 54683 or email [ssowmick@sagchip.org](mailto:ssowmick@sagchip.org).

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## Palliative Care and End of Life Clinical Training September 28 - October 2, 2001; Albuquerque, New Mexico

This is a five-day, intensive, practical, clinical conference on palliative care, pain management, and end-of-life care. The experience will support physicians and nurses for national certification in hospice and palliative medicine boards. Headquarters funding will support one clinical team (either tribal or IHS) from each IHS Area, such as a physician, a nurse, and a pharmacist or behavioral health provider (a total of three). The goal is to develop a provider team in each Area with palliative care and end-of-life care training as a resource for that Area. Those to participate will be chosen by the Area Chief Medical Officers by August 2001. Using Area funds to support travel and per diem, Areas may nominate additional teams to participate; however, the number of participants is limited. The IHS Clinical Support Center is the accredited sponsor.

The meeting will be held in Albuquerque, New Mexico. The training will be conducted by Dr. Robert Twycross, Director of the World Health Organization Collaborating Centre on Palliative Care and the Oxford International Centre for Palliative Care. For more information, contact Judith Kitzes, MD, MPH at (505) 248-4500; e-mail [judith.kitzes@mail.ihs.gov](mailto:judith.kitzes@mail.ihs.gov).

## Renal Disease in Racial and Ethnic Minority Groups October 19-20, 2001; Santa Fe, New Mexico

A meeting on Renal Disease in Racial and Ethnic Minority Groups will take place, under the auspices of the American Society of Nephrology and the International Society of Nephrology, at the Eldorado Hotel, Santa Fe, NM on October 19-20, 2001. The meeting will address the following topics in plenary session: 1) The current status of renal disease in minority groups around the world; 2) Pathophysiology and etiology of renal disease in these groups: genetic and environmental considerations; 3) Screening for renal disease in areas of high prevalence: methods of disease registration and prevention strategies; 4) Dialysis and renal transplantation; 5) Health economics, social considerations, role of governments and national and international funding agencies; and 6) Consensus statement development regarding future direction

For more information please contact Andrew S. Narva, MD, FACP, Indian Health Service Kidney Disease Program, 801 Vassar Drive, NE, Albuquerque, NM 87106; e-mail [anarva@albmail.albuquerque.ihs.gov](mailto:anarva@albmail.albuquerque.ihs.gov).

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## 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 #772

**Sleep Disorders: Assessment and Management in Primary Care (60 minutes)** Sleep-related complaints are common from patients in the primary care setting. Sleep apnea, insomnia and excessive daytime somnolence have a combined prevalence rate of 20% to 50%. Moreover, sleep-related symptoms are often features of many psychiatric syndromes. Dr. Basrthlen and Dr. Broch present an overview of sleep disorder with a particular emphasis on two common ones: sleep apnea and insomnia. In addition, they offer practical advice on when to refer patients to a sleep-wake disorders center as well as what patients can expect when being evaluated by a sleep specialist.

### NCME #773

**Erectile Dysfunction (ED) in Primary Care: Broaching the Subject, Treating the Problem (60 minutes)** Erectile dysfunction (ED) is a widespread problem that affects an estimated 30 million American men and their partners. In addition to diminishing quality-of-life, ED can be a marker for more serious conditions in men such as cardiovascular disease. In this program, three specialists in sexual function explore the anatomy and physiology of male sexuality and describe the causes of and latest treatment options for ED. The subtle but effective ways that physicians may help patients acknowledge sexual dysfunction are demonstrated. Guest commentary from 1998 Nobel Laureate in Medicine, Dr. Louis Ignarro, provides additional perspective on nitric oxide, the neurotransmitter for penile erection.

### NCME #774

**HIV/AIDS Update; Includes Report on the XIII International AIDS Conference, Durban, South Africa, July 9-14, 2000 (60 minutes)** The 13<sup>th</sup> International AIDS Conference was the first world AIDS conference to be held in a developing country, bringing delegates from around the world to the epicenter of the pandemic. Against this backdrop, several

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important clinical trial results were presented covering areas of intense interest to clinicians in the United States. In this video report, three specialists who attended the Durban conference discuss the global impact of HIV/AIDS, strategies for preventing mother-to-child transmission, controversies in antiretroviral therapy, complications of long-term therapy, treating opportunistic infections, the potential of structure treatment interruption (STI), and more...

#### NCME #775

**Community Acquired Pneumonia** (60 minutes) Pneumonia, once known as the “old man’s friend” for its effectiveness in easing the aged and infirmed into the life beyond, is still the most deadly infectious disease in the United States. Community-acquired pneumonia (CAP) is the cause of death in over 80,000 people a year in the United States – with an annual attributable cost of over \$8 billion dollars. In this program, Dr. Pomerantz provides an update on pneumonia – the causative pathogens, the risk factors for developing it, and the associated therapies.

#### NCME #777

**GI Bleeding: Dx Cancer?** (50 minutes) The patient presents with persistent GI bleeding and you rule out peptic ulcer, diverticulosis, and other common causes. Does the patient have cancer of the lower GI tract? Using a case study approach, Dr. James Patrick O’Leary discusses the differential diagnosis of colorectal cancer and effective management protocols. Special

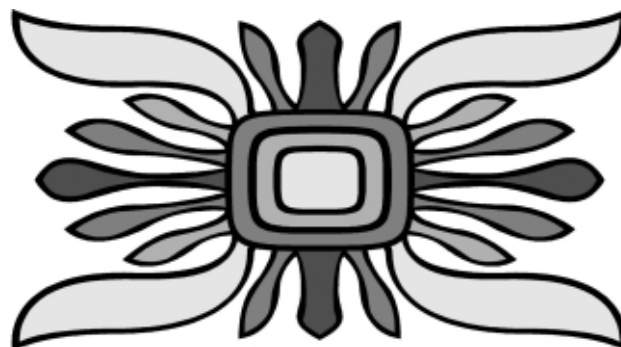
attention is given to identification of risk factors and proper screening, including the use of genetic tests in some patients with hereditary nonpolyposis colorectal cancer (HNPCC).

#### NCME #778

**New Immunosuppressive Strategies in Renal Transplantation** (60 minutes) This program introduces practical issues related to a new class of non-nephrotoxic immunosuppressive agents - the TOR inhibitors, exemplified by sirolimus. Doctor Hricik describes ongoing trials using sirolimus *de novo* with or without a calcineurin inhibitor. In addition, he addresses the promise of sirolimus as a non-nephrotoxic agent that may finally facilitate the safe withdrawal of steroids without an undue risk of rejection.

#### NCME #783

**Advances in the Treatment of Parkinson’s Disease** (60 minutes) Parkinson’s disease (PD) is a cruel twist of nature. Patients with PD often struggle with periods of dyskinesia – uncontrollable erratic movements – and akinesia - a frightening state of near total paralysis. Although the origins of PD in the brain are now known, a cure has yet to be discovered. Nevertheless, treatment advances in PD have alleviated the relentless debilitation experienced by many patients. This video program, presented by four experts in movement disorders, offers a concise update that includes practical information to help improve the quality-of-life for your patients.





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