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The Oral Health of Adults and Elders

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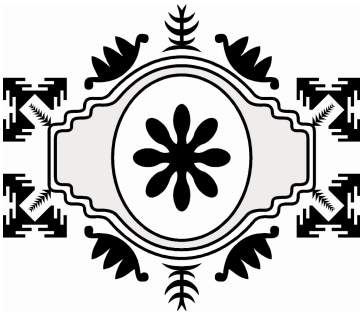
Introduction

The oral health of adult (age 35-44 years) and elder (age 55+ years) American Indians and Alaskan Natives (AI/AN) becomes more complicated than younger age groups. Whereas dental caries predominates the oral disease in children and adolescents, periodontal disease (gum disease) combines with caries in adults and elders to increase the threat of dental problems and tooth loss.

Periodontal disease is an infection of the supporting tissues of the teeth, i.e., the gingiva (gums) and the underlying alveolar bone. However, while caries is also an infection, the bacteria that cause each of these oral infections are very different.



The methods that are used for determining the presence and severity of periodontal disease include measuring the level of epithelial or connective tissue attachment on the teeth, and an indirect method of attachment loss determination called probing pocket depths. The IHS has adopted an index for measuring probing pocket depth, called the Community Periodontal Index of Treatment Needs (CPITN). Attachment loss and CPITN were used to measure periodontal disease for Adults and Elders in the oral health survey presented in this paper.

During the adult and elder age periods for AI/AN, two other important factors appear that help to magnify the detrimental effects of periodontal disease. These include type 2 diabetes and the long-term effects of tobacco use.

Adults

A total of 2,021 adults were examined during the 1999 survey. On average, the adults examined had lost four teeth

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due to oral infection or trauma, while two percent of this age group had lost all of their teeth. Sixty-eight percent of all adults with natural teeth had untreated caries. There were significant regional differences in the prevalence of dental caries or decay within IHS. Adults in the Alaska and Portland Areas had the lowest rates of untreated decay, while the Oklahoma and Navajo Areas had the highest (see Figure 1).

Periodontal disease was common among the adults. Gingivitis (bleeding gums) was found in 96 percent of those examined. Early periodontal disease (CPITN=3, pocket depths of 3.5 to 5.4mm) was found in 36 percent of adults, while 23 percent experienced advanced periodontal disease (CPITN=4, pocket depths of 5.5mm and deeper). The prevalence of this condition again varied from Area to Area (see Figure 2).

Approximately 11 percent of adults examined reported having diabetes. For those adults with natural teeth, 30 percent of diabetics were found to have advanced periodontal disease compared to 22 percent of adults without diabetes. This means that adults with diabetes are 38 percent more likely to have advanced periodontal disease compared to those adults without diabetes (prevalence ratio=1.38 95% CI=1.26-1.51).

In addition, diabetic patients with controlled blood sugar had less advanced periodontal disease (18%) compared to diabetic patients with poorly controlled blood sugar (31%).

Tobacco use was also measured in this survey. Thirty-eight percent of adults examined reported using tobacco on a regular basis. Among the tobacco users, 87 percent were smokers while 16 percent reported using smokeless tobacco. Advanced periodontal disease was found in 29 percent of the adult tobacco users compared with 20 percent for the non-tobacco users. This means that adult tobacco users are 46 percent more likely to have advanced periodontal disease compared to those that do not regularly use tobacco (prevalence ratio=1.46, 95% CI=1.36-1.55).

When periodontal disease occurs, the teeth roots are often exposed due to gingival recession. The exposure of teeth roots increases the likelihood of root caries. Of those adults examined, 15 percent were found to have root caries.

Elders

A total of 2,066 individuals age 55 years or older were examined in this oral health survey. The period of transition from adult to elder is a time of tremendous decline in oral health for AI/AN. Tooth loss, which increases dramatically with age for elders, was found to be a major health problem. The average number of remaining teeth for individuals at age 55 was 17 teeth, while by age 70, the average number of teeth remaining had fallen to only 11. While only 2 percent of adults were found to be completely

Figure 1. Percent of DMFS (decayed, missing, or filled surfaces) by IHS Area

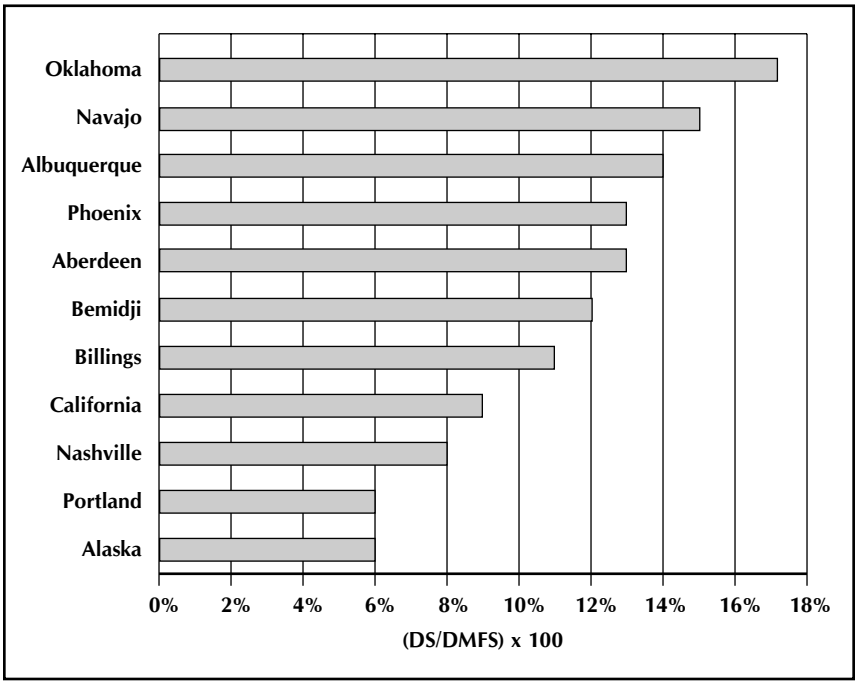
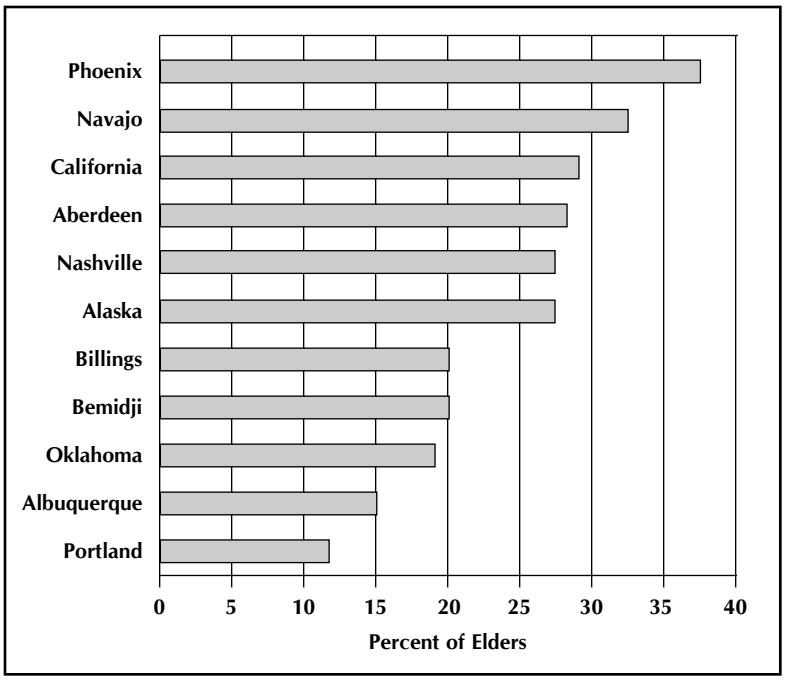


Figure 2. Prevelance of advanced periodontal disease by IHS Area



edentulous (no natural teeth remaining), 21 percent of elders had lost all of their natural teeth and 23 percent had lost all of their upper teeth. Among the elders with no natural remaining teeth, 20 percent were found to have no dentures (false teeth).

Among those elders with natural teeth remaining, 61 percent had untreated decay and 33 percent had root caries.

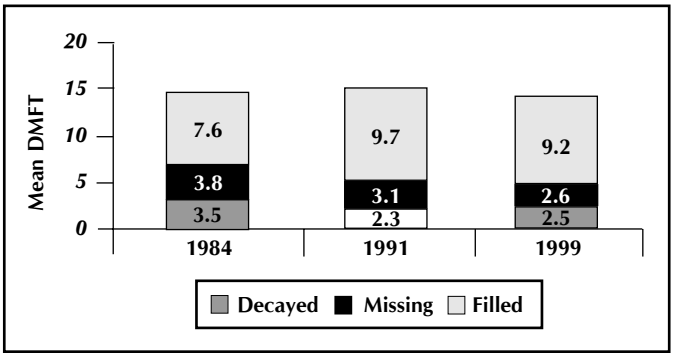
Due to the prevalence of tooth loss, the number of elders who were eligible for periodontal disease assessment had been reduced to approximately 1,500. Tooth loss and periodontal disease are strongly associated. Certain teeth (multi-rooted teeth) are more susceptible to the presence and severity of periodontal disease. As periodontal infection causes the loss of some teeth in the mouth, the individual's relative periodontal disease status actually improves. That is, as the unhealthy teeth are lost, the remaining dentition is relatively healthier. This paradoxical relationship between tooth loss and periodontal disease also affects decay rates. Obviously, as increasingly fewer teeth are present, fewer teeth are available to experience periodontal disease and caries. Therefore, for elders, the caries and periodontal disease measures tend to underestimate the effects of these infections unless tooth loss is considered.

Of those elders with natural teeth, 98 percent were found to have gingivitis (bleeding gums). Early periodontal disease (CPITN=3, pocket depths=3.5-5.4mm) was found in 34 percent of this age group, while advanced periodontal disease (CPITN=4, pocket depths=5.5+mm) was found in 27 percent. Diabetes and tobacco use have the greatest effect on elders of any age group. The longer the duration of diabetes and tobacco exposure, the more these factors contribute to the severity of periodontal disease and its related tooth loss. Elders with teeth and diabetes were found to have advanced periodontal disease at a prevalence rate of 31 percent, compared to 25 percent for the non-diabetic elder with teeth. Tobacco users with teeth were found to have advanced periodontal disease at a prevalence rate of 42 percent, compared to 24 percent for the non-tobacco user with teeth. Again, these statistics are seriously confounded by tooth loss.

Trends Over Time

Two previous IHS oral health surveys, conducted in 1984 and 1991, have provided comparison data to examine oral health changes over time. Between 1984 and 1991 the number of decayed and missing teeth in adults declined while the number of filled teeth increased. Between 1991 and the current survey, there was a slight decrease in the overall decay rate among adults (DMFT=15.07 vs. 14.40, p=0.001). See Figure 3. Among elders, there was a significant increase in the number of filled teeth from 1991 to 1999 (5.48 vs. 6.56, p<0.001). This increase in filled teeth may be associated with the increase of elders with 20 or more teeth (mean of 28 teeth in 1984 vs. mean of 33 teeth in 1999).

Figure 3. Mean number of decayed, missing and filled teeth in adults 35-44 years from three IHS patient surveys



There were several significant changes in periodontal disease status assessment methods utilized in the three surveys. However, for adults and elders, the periodontal disease status appears to have changed very little since 1991. While the number of teeth lost on average has been reduced for elders as mentioned above, there has been no change in the number of remaining teeth in dentate adults between 1991 and 1999 (24.2 and 24.4 respectively).

Comparison to Healthy People 2010

The National Oral Health Objectives for the Year 2010 (Healthy People 2010) outline several oral health status objectives for adults and elders:

- Reduce the proportion of adults with untreated decay to 15 percent.
- Increase to at least 42 percent the proportion of people aged 35+ years who have never lost a permanent tooth due to dental caries or periodontal disease.
- Reduce the prevalence of gingivitis among adults aged 35+ to no more than 41 percent.
- Reduce advanced periodontal disease to a prevalence of no more than 14 percent among people aged 35+ years.
- Reduce tobacco use by adults 18 years and older to 12 percent for cigarette smoking and 0.4 percent for smokeless tobacco.

Adult (35+ years of age) AI/AN were found to have an average 97 percent prevalence of gingivitis, compared to the Year 2010 objective of 42 percent. Advanced periodontitis was found to occur at a rate of 23 percent, compared to the Year 2010 objective of 14 percent. Pertaining to the caries objectives, there was an untreated decay rate of 68 percent for AI/AN, compared to the Year 2010 objective of 15 percent for those of age 35+ years. Seventy-eight percent of 35+ aged individuals had lost at least one tooth compared to the Year 2010 objective of 42 percent. The prevalence of smoking (33%) and smokeless tobacco use (6%) are both higher than the Year 2010 objectives. See Figure 4.

Comparison to National Data

The most current national data on oral health in adults are from NHANES III[1], which examined approximately 1,415 adults between the ages of 35-44 years. When compared to adults in NHANES III, the AI/AN adults examined by IHS had more tooth surfaces with untreated decay but fewer missing surfaces and a similar number of filled surfaces. In terms of tooth loss, the AI/AN adults had the same number of teeth present as the NHANES III adults (24.4 vs. 24.3). See Figure 5. While the AI/AN adults had significantly more periodontal disease (pockets > 6 mm), the prevalence of root caries was less than that found in NHANES III. The IHS Area with the lowest proportion of adults with advanced periodontal disease (pockets > 6mm) was Alaska, and their proportion was still three times higher than the national average (9% vs. 3%).

Conclusions

The oral health needs of AI/AN adults and elders remain untreated to a large extent. While dental caries continues to be an oral health problem for adults and elders, the cumulative effects of age, diabetes, and smoking allow periodontal disease to become the major oral health problem. Gingivitis, or inflammation of the gums, the first sign of periodontal disease, is ubiquitous among adults and elders. Untreated periodontal disease ultimately leads to the loss of many teeth for elders. The lack of natural teeth and general unavailability of adequate dental prosthetic services results in reduced chewing abilities among elders and adds to nutritional problems. As a result of the findings of this survey, several important recommendations can be offered to improve the oral health of adults and elders.

Recommendations for Prevention Programs

- Dental staffs should be encouraged to collaborate with existing IHS and tribal health groups regarding diabetes prevention and treatment.
- Dental clinics should routinely educate dental patients regarding the hazards of tobacco use and encourage tobacco users to quit.
- Utilize existing treatment protocols for the treatment

Figure 4. American Indian and Alaska Native adults age 35-44, compared to Healthy People 2010

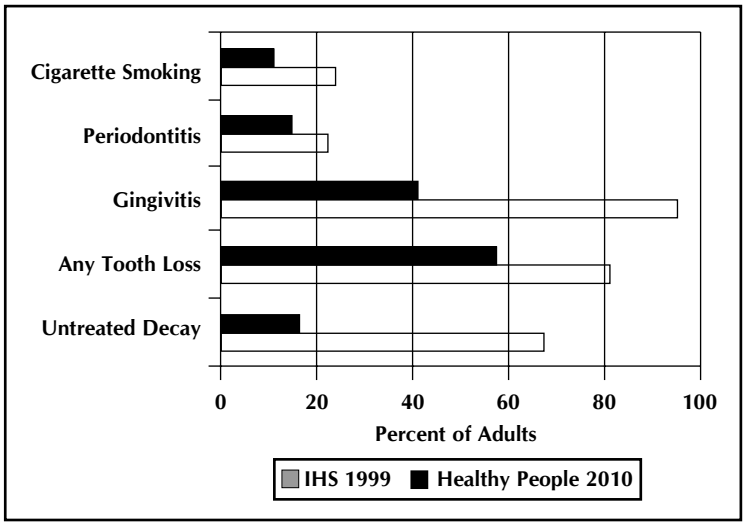
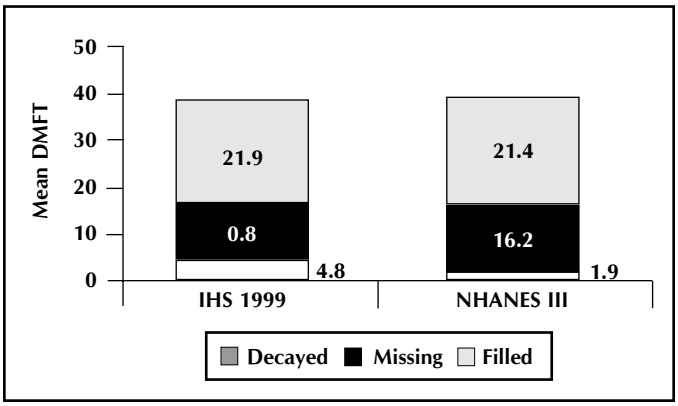


Figure 5. Mean number of decayed, missing and filled tooth surfaces for dentate adults 35-44 years IHS 1999 compared to NHANES III



and prevention of periodontal disease among diabetic patients.

- Encourage widespread use of oral hygiene aides such as fluoride rinses and anti-microbial dentifrices and rinses.

Recommendations for Access to Dental Care

- Refocus clinical efforts to encourage the resources and time needed for treating the complicated oral health needs of adults and elders. This especially includes emphasis on providing dentures for people with no natural teeth.
- Encourage, at a minimum, annual visits to the dental clinic for patients with diabetes.
- Allow easy access to dental care for adults and elders who are at high risk for oral disease, e.g., diabetics, smokers, debilitated individuals.
- Encourage the use of dental care extenders in order to allow the greatest utilization of existing resources.

Recommendations for Research

- Continue to explore collaborative efforts in the prevention and treatment of periodontal disease in diabetic patients.
- Encourage the collaboration of research in the areas of positive health behavior changes for adults and elders.

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Screening for Domestic Violence in IHS Hospitals and Clinics: Why Bother?

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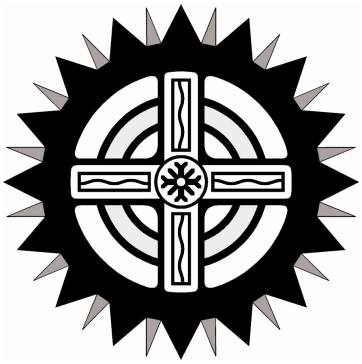
Domestic violence meets the criteria for diseases for which it is suitable to screen in the clinical setting.[1] In this article, domestic violence, then, will be referred to as a "disease" in order to demonstrate this point. The following criteria should be fulfilled before screening is instituted. The disease should have high prevalence and should pose serious consequences in the population to be screened. The natural history of the disease should be understood, and treatment must be available. The screening test should be sensitive and specific for the disease, and reliable in different settings. The test must be safe, acceptable to the patient, and have low cost. This review will show how each of these criteria is fulfilled in relation to domestic violence in Indian country.

Screening for domestic violence is also recommended by professional organizations.[2-6] Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)[7] and Government Performance and Improvement and Results Act (GPRA)[8] require screening, whether or not these recommendations or requirements are grounded in the above criteria.

Screening in IHS facilities for domestic violence is more likely to occur where policies and procedures are in place.[9] Administrative interventions increase compliance with domestic violence protocols. Screening for domestic violence improves after staff education and formal quality assurance feedback.[10]

The immediate argument against recommendation that we screen for domestic violence might be that this problem is very different from other "diseases" for which health care providers routinely screen because the patient is neither



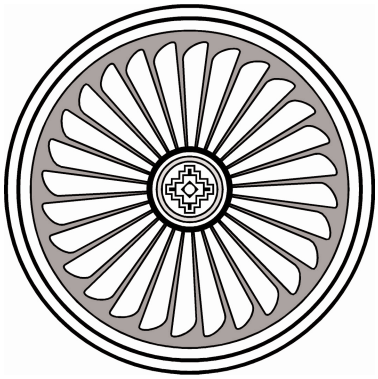
responsible for domestic violence, nor in control of it. The "diseased" person is the perpetrator.

Administrators need to clarify any mandatory reporting requirements that may exist in the state or reservation where we practice. Mandatory reporting of domestic violence by medical providers is extremely controversial. These issues are nicely summarized in a 1995 *JAMA* article.[11]

Studies in the general US population show that 95% of violence among intimates is perpetrated against women by a partner or former partner.[12] Men may be victims of domestic violence, and it can occur in homosexual relationships, but it is not as prevalent in these situations. This is why most screening guidelines recommend that women be screened.

Several studies are now available showing that domestic violence is at least as prevalent in Indian communities as in the general population. A computerized survey[13] of pregnant women in 1989-90 at the United States Public Health Service (USPHS) Albuquerque Indian Hospital revealed that 16% of women reported domestic violence within the year prior to their first prenatal visit. The National Family Violence Resurvey[14] found that Native American populations had higher rates of domestic violence than whites regardless of the degree of violence. A survey[15] of Navajo women seeking routine well woman care at an IHS facility showed that 13.5% of women reported physical abuse in the past year, and 41.9% reported physical abuse from a male partner at least once in their lives.

The San Carlos Apache Tribe requested a study[16] of domestic violence on that reservation, which showed that 75% of women reported "any" or "severe" violence in their current relationship. Although the studies in Native American women are limited by small sample size, the weight of evidence suggests that the prevalence of domestic violence among all women is high, including Native American women.



In the natural history of domestic violence, a cycle develops consisting of tension-building, explosion, followed by a "honeymoon period." Over time the cycle becomes shorter in duration and the violence becomes more severe. The cycle may last months or years at the beginning of a relationship, and may gradually shorten to days in duration. In addition, the relative amount of time in each phase of the cycle shifts to shorter tension-building time, shorter or absent honeymoon periods, and longer and more violent explosive episodes, possibly days or weeks in duration.

Domestic violence has serious consequences.[17] A review of female homicides in New Mexico found a disproportionately higher rate among Native American women (4.9 per 100,000 compared with 1.7 per 100,000 for Hispanics, and 1.8 per 100,000 for non-Hispanic whites). The same study revealed that domestic violence was the cause of death in 46% of Native American cases. Domestic violence is estimated[18] to have cost $1.8 billion per year to the health care system nationally in 1993. Women who were victims of domestic violence cost one health plan 92% more than a random sample of general female enrollees.[19]

The sequelae of domestic violence[20] include the following: domestic violence victims are more often also victims of nonconsensual sex; they have a less favorable impression of their physical and mental health status; have higher levels of smoking and chronic pain syndromes (headache, joint, chest, back, abdomen and pelvis); and they suffer more often from depression, generalized anxiety, substance abuse, spontaneous abortions and low birth weight babies, and post-traumatic stress disorder. The more severe the abuse, the more symptoms are present.[21]

The weakest link in the argument to screen for domestic violence in the clinical setting has to do with the availability of treatment, but evidence is starting to accumulate that shows that clinical interventions improve outcomes. The treatment[22] of an identified victim of domestic violence includes validation, counseling regarding the probability of escalating violence, information about local resources, and referral as appropriate and desirable to the patient. Safety planning should be directed to the victim's needs. The point is to help her be safer, not necessarily to leave the abusive relationship immediately.

At least three studies show that clinical intervention results in better outcomes. Victims of domestic violence benefit from appropriate office intervention and referral. Prenatal patients identified by screening adopt violence avoidance techniques after a 10-minute office safety planning intervention.[23] Participation in community-based domes-

tic violence advocacy programs clearly decreases the risk of violence: women randomly assigned to a community-based advocacy intervention experienced half the risk of violence of women who did not receive these services.[24] The decline over two decades in the rate at which women murder their intimate male partners in self-defense is partly due to the increased availability in domestic violence services, such as hotlines and shelters.[25]

Perpetrator/offender programs are not yet a reliable way to improve the woman's safety. This "treatment" cannot be recommended routinely to improve the victim's safety. Marriage counseling is contraindicated while there is a credible threat of violence. Addressing domestic violence in this manner often increases the level of violence.

There is at least one screening tool that fulfills criteria for a screening test. A suitable test must be sensitive (it finds what you want it to find), specific (it does not find what you are not interested in), and reliable (it has similar results in different settings). A screening test is often compared to a "gold standard" for identification of the condition you are interested in. For family violence screens, this gold standard is the Conflict Tactics Scale (CTS)[26] or its revision (CTS2).[27]

Examples of three domestic violence screening tools for which such comparisons are available include the following:

1. HITS[28] (91% sensitive): How often has your partner physically **hurt** you? How often has your partner **insulted** you? How often has your partner **threatened** you with harm? How often has your partner **screamed** at you?
2. Do you feel safe in your current relationship? Is there a partner from a previous relationship who is making you feel unsafe now? Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?[29]
3. The March of Dimes DV Screen[30] was reviewed in THE PROVIDER.[31] (>90% sensitive and specific, reliability recently shown in different settings.[32]): "Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone? Within the past year, has anyone forced you to have sexual activities? If you are pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?"

Several studies show that domestic violence screening is acceptable to patients. Most patients[33] favor routine inquiry by physicians about physical abuse (78%) and sexual abuse (68%), and believe physicians could help with problems related to physical abuse (80%) and sexual abuse (79%). Seventy-two percent of veterans and veterans' wives[34] believe physicians should routinely inquire about domestic violence. A large majority of women (89%) and men (93%) surveyed on the San Carlos Apache reservation[14] "would ... like to see doctors and nurses screening for domestic violence at the clinics" and felt the medical setting was a safe environment in which to discuss these issues.

The costs of screening for domestic violence usually involve provider discomfort around this issue and the time it takes to deal with a positive screen. Providers' discomfort with screening has been likened to "opening Pandora's box."[35] Medical providers are more comfortable asking about cigarettes, alcohol, sexual orientation, and drug use than about domestic violence.[36] This discomfort is easily remedied with further training and experience in screening.

While screening takes very little time, a positive screen does take more than the usual brief office encounter. When medical providers encounter a patient with a new, potentially fatal problem, we take the time to evaluate it. Domestic violence is no different than other potentially fatal medical conditions and requires a similar amount of time as, for example, a patient with chest pain or newly diagnosed diabetes.

Public health principles of disease screening support routine domestic violence screening in IHS hospitals and clinics.

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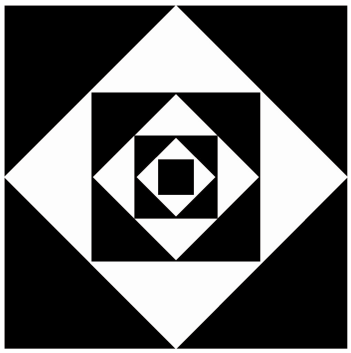

IHS National Clinical Pharmacy Specialist Credentialling

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This article gives a brief history of the recognition of pharmacists as primary care providers in the Indian Health Service (IHS) and examines the current processes for granting a national credential.

Pharmacists as Primary Providers

From 1976 to 1980 the IHS trained fifty-eight selected pharmacists as Pharmacist Practitioners (PPs) to assist with providing care at short-staffed sites throughout the agency. These PPs were utilized in many facilities in the IHS as non-physician primary care providers, offering acute and chronic disease management services. As the workload of pharmacy departments grew and the availability of other cadres of primary care providers improved, most of the PPs were eventually drawn back into the pharmacy to provide traditional pharmacy services, often gravitating towards administrative roles to facilitate their promotions in the system. Less than a handful of PPs still practice in the IHS today.

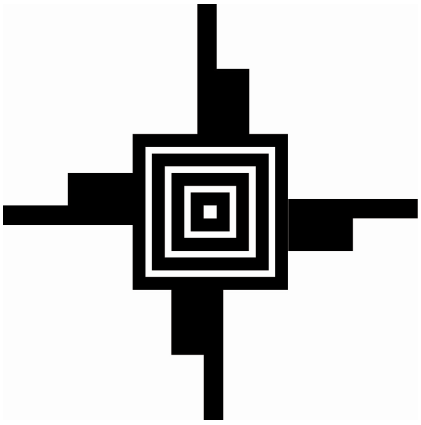
In the mid 90s, two IHS PPs, CAPT Laura Carver (Ret.) and CAPT David Kuhl, worked with the State of New Mexico Board of Pharmacy to develop an advanced practice license with the designation of pharmacist clinician (PhC). New Mexico legislation has recognized PhCs, along with physician assistants and nurse practitioners, as mid-level providers with prescriptive authority. As a licensed NM mid-level provider, the PhC can apply to become a Medicaid provider, eligible for Medicaid reimbursement. NM is the only state in the US that has both the RPh and PhC license designations.

Twenty years after the PP program began, IHS Director RADM Michael Trujillo, MD, recognized the role of pharmacists as primary care providers in a memo dated October 18, 1996. He outlined how specially trained pharmacists known as Clinical Pharmacy Specialists (CPSs) were to be credentialled by the local medical staff of each IHS facility. The medical staff was directed to determine the scope of practice for the CPS, including prescriptive authority, as well as other clinical duties to be performed. This memo allowed for pharmacists with an advanced degree and/or specialized clinical training to provide direct patient care under the supervision of the medical staff.

National Clinical Pharmacy Specialist Credential

In 1998, the IHS Pharmacy Branch, under the direction of Acting Chief Pharmacy Officer CAPT Michael Hope, formed a working group tasked with developing and implementing a national credential for CPSs. It was felt that IHS national recognition of pharmacists utilizing standardized criteria would help assure more uniform competency and quality of patient care. A nationally recognized credential would help to achieve recognition by the Center for Medicare and Medicaid Services (CMS) of pharmacists as primary care providers. A national credential would, upon transfer of the CPS from one station to another, confer a level of credibility that would facilitate acquiring privileges at the new station. The national credential would apply points towards promotion criteria for Commissioned Officers.

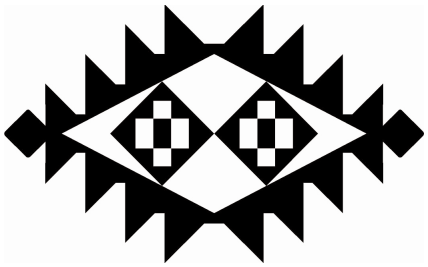
Two categories of CPS with prescriptive authority were delineated, with specific requirements for each. The National



Clinical Pharmacy Specialist (NCPS) category would apply to pharmacists involved in specific medication management programs (anticoagulation, tobacco cessation, asthma, pain management, diabetes, hypertension, or dyslipidemia). The NCPS-PP (NCPS - Pharmacist Practitioner) category would be specific for pharmacists who have a scope of practice that includes diagnosis as well as prescriptive authority (PPs, PhCs, or PAs). By 1999, bylaws for a national pharmacy credential committee had been completed, and the first committee members, lead by CAPT Michael Seybold, had been selected. Since that time the committee has developed criteria for NCPS and NCPS-PP categories. The committee meets twice a year to evaluate applications for NCPS and NCPS-PP.

A list of the current committee members, bylaws, minutes, protocol guidelines, scope of practice requirements for NCPS and NCPS-PP, as well as application forms can be found on the IHS Pharmacy Intranet site. The address is: *http://home.IHS.gov/MedicalPrgms/Pharmacy/News/credential/credmain.asp*

We want to encourage all IHS and tribal pharmacists to apply for NCPS credentials after they have practiced for at least one year as a locally recognized CPS. Remember, NCPS credentials will apply towards promotion credit. If you have any questions, please contact any of the committee members listed at the Pharmacy Intranet site.



MEETINGS OF INTEREST

14th Annual Southwest Regional Behavioral Health Conference
March 11-14, 2002; Albuquerque, NM

The 14th Annual Southwest Regional Behavioral Health Conference (SWRBHC), entitled "Complex Issues, Multiple Solutions," sponsored by the New Mexico Department of Health, Behavioral Health Services Division, will be held March 11-14, 2002 at the Sheraton Old Town Hotel in Albuquerque, NM.

The conference offers general sessions and 32 workshops on educational and clinical approaches to prevention and treatment in both mental health and substance abuse. Presentations will include: Natay's Reality Check, the Navajo rapper's inspiring story of his life as a former gang member, and the native traditions that turned his life around; David Powell on Integrating Spirituality into Therapy; Clayton Small discussing All My Relations, about strategies for mobilizing Native American/Alaskan Native communities; Michael Johnson on Slipping Through the Cracks: Young Adults and Criminal Behavior, on ways to understand and work with resistant young adults ages 18 - 24; H. Westley Clark (invited) on Treating Co-Occurring Disorders. Other workshops include Colin Ross on Trauma and Comorbidity; Charles Figley on Compassion Fatigue; Carlton Erickson on The Neurobiology of Drug Dependence; Jerry Shulman on Relapse Prevention; a panel of experts on Overdose Prevention; ethics for prevention specialists; ethics for treatment professionals; clinical supervision; disaster mental health intervention models; and much more. Twenty-two CEUs are approved for counselors (NBCC Provider #5462); additional applications for credits for alcohol & drug abuse counselors, alcohol and drug abuse prevention professionals, emergency medical technicians, mental health counselors, nurses, physicians, psychologists, and social workers are pending. The $295 Early Bird Special Rate covers all sessions, materials, opening reception, continental breakfasts, breaks and lunches.

For more information please contact Marian Greher or Theo Johnson at telephone (505) 856- 1717; fax (505) 856-1490; e-mail *swrsac2@att.net*; or visit the website at *www.health.state.nm.us.*

Diabetes Prevention Conference and Expo
April 4-5, 2002; Gallup New Mexico

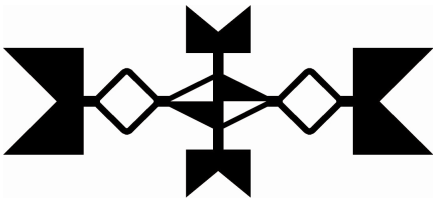
This meeting is sponsored by the Southwest Diabetes

The Cochrane Library Now Available

The Indian Health Service Office of Public Health (OPH) and Information Technology Support Center (ITSC) are pleased to announce that The Cochrane Library, a key source for evidence-based medicine, is now available on line to the Indian Health Service, tribal, and urban program (I/T/U) clinical community. The link to Cochrane can be found at the IHS Clinical Information Resources website, under the "Answers to Clinical Questions" folder, at *http://www.ihs.gov/MedicalPrograms/cir/*

Users will NOT need a password when they are accessing Cochrane from the IHS wide area network (WAN). From home or from an I/T/U site outside the IHS WAN, users will need a password to access The Cochrane Library. Requests for passwords should be submitted on line from The Cochrane Library introduction page on the web site.

We hope you will find this resource useful, and that you will volunteer to assist us in evaluating Cochrane and another service, Up To Date. For more information, contact Linza S.Bethea at telephone (520) 670-4872.

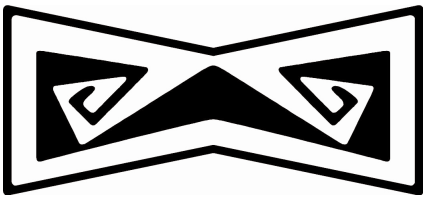


NCME VIDEOTAPES AVAILABLE

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 #788

The Aging Eye and Timely Intervention: Part I *(50 minutes)*

As a person ages, his or her eyes undergo changes. Some of these changes, such as dryness and itching, are usually merely nuisances, but others can cause vision loss if not treated promptly. Age-related eye problems must be diagnosed and treated as early as possible in order to preserve vision. Dr. Cynthia MacKay, Associate Clinical Professor of Ophthalmology at Columbia University College of Physicians and Surgeons in New York City, discusses major age-related eye problems such as glaucoma, macular degeneration, and retinal tears and detachments, combining an exploration of the pathophysiology of the aging eye with practical tips on diagnosis and management.

NCME #789

The Aging Eye and Timely Intervention: Part II *(50 minutes)*

With time, the human eye undergoes changes – some sufficiently serious to consider surgical intervention. Dr. Cynthia MacKay, Associate Clinical Professor of Ophthalmology at Columbia University College of

Physicians and Surgeons in New York City, discusses major eye-related problems such as cataracts, the relationship of blood glucose control and diabetic retinopathy, and laser "corrective" eye surgery. She discusses the development of cataracts, the ophthalmologic workup required for diagnosis, treatment criteria based on case-by-case timing, prevention strategies, and demonstrates surgical procedures. It is crucial, she explains, for physicians to convince patients with diabetes that managing their blood glucose control strongly affects the development of diabetic retinopathy. She describes the high risks and possible benefits of "corrective" laser surgery for older patients.

NCME #790
Update on Multiple Sclerosis: Diagnosis, Treatment, and Management, Part I *(50 minutes)*

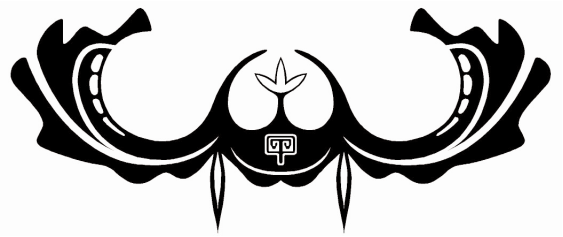
It strikes people in the prime of their lives. It comes and then, for most, vanishes, leaving noticeable and lasting deficits – impairments in movement, cognition, bodily functions, and senses. It is accompanied by an omnipresent and debilitating fatigue. And it is, for now, incurable.

Multiple sclerosis afflicts more than 350,000 Americans – less than one quarter of one percent of the population. Not long ago, the medical profession's attitude to patients with MS was "diagnosis and adios." But much has changed, and now much can be done for those whose disease is caught early.

Update on Multiple Sclerosis: Diagnosis, Treatment and Management is the first program in a two-part series jointly sponsored by the National Multiple Sclerosis Society and the Network for Continuing Medical Education. These programs, featuring some of the nation's preeminent experts on the disease, will provide practical information on how to care for patients with MS.

NCME #791
Contemporary Management of the Syncopal Patient *(50 minutes)*

Syncope – simple fainting – is the transient loss of consciousness with rapid and spontaneous return to normal. It can be benign, requiring little or no work-up, but it can also be a warning of life-threatening illness. Because patients rarely present during the syncopal episode, however, the physician typically enters the picture after the fact, when the patient is fully recovered. Was it a seizure? Is it just a vasovagal event? Does the patient have heart disease? Is hospitalization necessary? Three experts on syncope – an emergency physician, a general internist, and a cardiologist – share their perspectives on risk stratification, what constitutes the necessary and sufficient work-up, and selection of accurate but cost-effective diagnostic tests. Because cardiac causes of syncope are potentially the most serious, an extended discussion of electrophysiologic testing, tilt-table testing, and catheter ablation of serious arrhythmias is included.



PHS Physician Mentoring Program

The Physician Professional Advisory Committee (PPAC) to the Surgeon General has initiated a voluntary mentoring program for Public Health Service physicians. Initially this program will be limited to Commissioned Officers but the goal is to expand it to Civil Service PHS physicians in the future. The goal of the program is to promote professional growth and career development. Recently commissioned junior physicians ("protégés") with a grade of 0-3 or 0-4 and a call to active duty within the last 2-4 years can be matched with more senior physicians ("mentors") by agency, geographic area, or discipline. The mentors will have over five years experience in the PHS and will be at the grade of 0-5 or above. A description of the program and a mentor or protégé application is available at *www2.IHS.gov/ppac/Mentoring_Intro_page.htm*. Information and applications can also be obtained from CAPT Dean Effler, 401 Buster Rd., Toppenish, Washington 98948; telephone (509) 865-2102, ext. 224; or by e-mail at *usphsmentor@prodigy.net.*

The 6th Annual Elders Issue

The May 2002 issue of The IHS Provider, to be published on the occasion of National Older Americans Month, will be the sixth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

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THE IHS PRIMARY CARE PROVIDER

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

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

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