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Scratching the Surface: Evolving Domestic Violence Screening in One Service Unit

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Problem Definition

Women in the U.S. are more likely to be injured, raped, or killed by a current or ex-male partner than by all other types of assailants combined.[1] During the 1990s, it became increasingly clear that the medical community should be on the front line in the identification of and intervention in domestic violence (DV).[2] In 1991, the American College of Obstetricians and Gynecologists developed the first informational packet on domestic violence that was to be distributed by a national medical society.[3] The Joint Commission on Accreditation of Hospitals and Health Care Organizations (JCAHO)[4] has required hospitals to have protocols for the identification and treatment of abused women since 1992. By 1996, the American College of Emergency Physicians published guidelines for both emergency physicians as well as for Emergency Medical Service providers encouraging a formal response to domestic violence patients.[5]

Other medical professions, from primary care physicians to registered nurses, soon followed suit. Professional associations established formal guidelines and policies for their members to screen, treat, and refer patients for assistance related to domestic violence. However, education and training regarding domestic violence was generally lacking in medical education.[6] Education is essential: providers need to recognize warning signs as well as know how and what to ask. Education and training efforts presume that the single, most valuable contribution a medical provider can offer is to identify and acknowledge the abuse.[7] Within the past decade, however, it became clear that while education may initially raise awareness, without formalized policies to screen and refer for domestic violence, recognition and response to domestic violence would falter over time.[8] Protocols make the education substantive; content becomes *need to know* instead of just *nice to know.*

By the mid-1990s, the Family Violence Prevention Fund (FVPF) had created a model based on the premise that training, policy, and protocols are three equally important compo-

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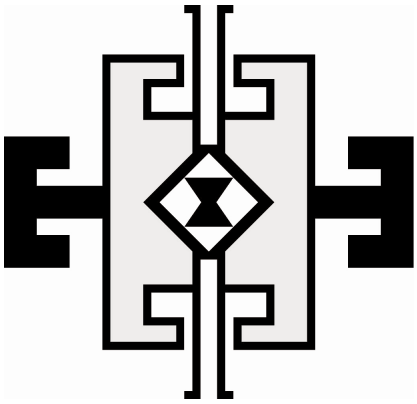
nents in establishing a long-term, sustainable program to address domestic violence in the medical setting.

Background: New Mexico

Domestic violence-related activities at the Indian Health Service (IHS) Hospital in Albuquerque (referred to as Albuquerque Indian Hospital, or AIH) occurred concurrent with many of the state and national DV activities. One team member (DC) became concerned about this issue working in the AIH Urgent Care Clinic and began researching this topic. Research in New Mexico indicates that Native American women are at significant risk for domestic violence. According to the U.S. Census, Native American women comprised 3.14% of Albuquerque's female population in 1990; however, Native American women made up 14.2% of the residents at a local Albuquerque domestic violence shelter in 1996.[9] A study conducted by the University of New Mexico's Department of Emergency Medicine found that New Mexico Native American women are at higher risk for domestic-violence related homicide than Hispanic and non-Hispanic white women.[10]

Evolution of AIH Domestic Violence Activities

Discussions with two nurses with similar concerns led to the formation of a DV team at AIH. Formal invitations were sent to each AIH department head with the hope that each department would send one representative to form a multidisciplinary team. Many of the individuals who initially expressed interest in belonging to the domestic violence team had a personal desire to know what to do and what to say when they encountered signs of violence and abuse.



The initial team consisted of a doctor, a social worker, two nurses, a health educator, an x-ray technician, a nurse administrator, and a security officer (five women and three men). They began monthly meetings in May 1997, and spent part of most meetings with a guest speaker from one of several advocacy groups in Albuquerque and the surrounding pueblos. Turnover in the team has lead to the loss of some members and the gain of others from other departments, e.g., pharmacy and lab, as well as a Masters in Public Health graduate student (CM). The core group, consisting of the original doctor, social worker and two nurses remains. They are Donald Clark, Kathy Manygoats, Marlene Lamebull, and Terry Williams .

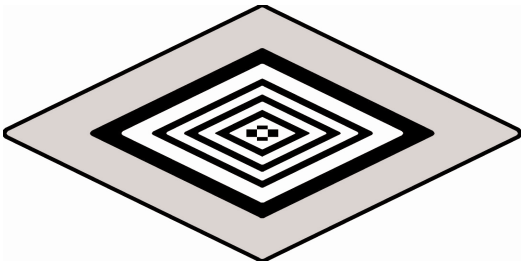
Members of the team wanted to institutionalize the service unit's (SU) response to DV, that is to make DV screening as natural as taking blood pressures and temperatures in triage. To that end the team chose three goals: to make AIH a safe place to talk about and obtain information regarding DV, to develop formal methods of identification and referral of DV, and to learn about available community resources. We restricted ourselves to the patients visiting the hospital and excluded those visiting the Albuquerque Service Unit's field clinics, recognizing that different methods may be required in rural settings.

The initial months were busy with several simultaneous activities. The team:

- Invited a guest member from a local DV advocacy group
- Struggled with the definition of domestic violence and whether and how to include other forms of family violence in our committee's efforts
- Developed a screening tool
- Wrote policies and procedures for DV screening and referral with an evaluation component
- Discussed the details (when and where) of screening.

At about the same time, New Mexico was chosen as one of ten states to introduce the Family Violence Prevention Fund's National Health Initiative. Two AIH staff members (DC and KM) joined the state task force and underwent training in this model in October 1997. The information obtained at this training included copies of hospital and emergency room policies and procedures and samples of screening instruments. These templates helped the team to finish the initial tasks much more quickly.

Two major decisions are critical in any domestic violence screening program. One is how to screen, i.e., verbally or with a written questionnaire, and the second is determining which women to screen. Although some literature suggests that verbally screening patients for violence is more effective than a written history form,[11] the AIH team selected the written tool, reasoning that a written screen would be more consistent to implement across the SU and would provide documentation for quality control evaluation. The other major decision was



whether to screen all women who come to the facility at each visit or to screen only at specific times and in certain clinical situations. These two approaches are known as universal and targeted screening, respectively.

Over 7,500 women 18 years of age and older made about 47,000 outpatient visits to AIH for their own concerns in 1996; these estimates do not include times that adult women brought children or elders to the clinics, nor does it include any visits to field clinics. Our initial plan was to screen adult women in targeted situations, specifically at visits for well woman care, contraception counseling, pregnancy, or any injury. But a Resource Patient Management System (RPMS) review of visits during 1996 showed that only half of the women visiting AIH in 1996 came for these reasons. This realization changed the focus of our screening efforts to universal screening.

As a result of this change we dropped our previous screening tool, which was lengthy and meant to be educational. Instead we adapted McFarland's three-question screen[12] because of its brevity and proven sensitivity and specificity. This screen was described in the October 1993 *IHS Provider*.[13] The three questions relate to physical abuse in pregnancy, physical violence in the past year, and a question regarding unwilling or forced sex in the past year. Specific guidelines for administering the tool include:

- The screen is not to be administered if it might increase a woman's danger. Therefore it is only administered if someone old enough to talk does not accompany the woman.
- Nursing staff administers the screen when the patient is placed in an exam room while waiting to see the medical provider. The nurse explains that the screen is voluntary, that it is part of her confidential medical record, and that the medical provider will follow up any positive responses to the screen.
- The nurse verbally administers the screen if reading or language barriers preclude an individual from responding to the written screen.
- If the screen had been administered at a recent prior visit, the nurse asks if there's been a change since the screen.
- The nurse notes on the Patient Care Component (PCC) if the screen was given, declined, declined because there is no change from recent screen, or if the screen was not given because the patient is not alone. The nurse initials these notations.
- The intervention for a positive response includes acknowledgment of the abuse and its probable continued escalation, discussion of a safety plan, and offering information regarding resources and advocacy within AIH and the local community. Referrals are made only at the patient's request.

The team's main concern was that the screening process would offend patients. We initiated a two month pilot period (January and February, 1998) using this screening tool in different primary care settings: Urgent Care, a well woman and prenatal practice, and in an internist's and a family doctor's primary care clinics. Four providers performed these screens, two male, two female; three physicians and one nurse practitioner. We were relieved that no patient expressed anger or offense, and that several expressed gratitude for the screen. The service unit formally adopted the DV screening policies and procedures on March 1, 1998.

Two problems became apparent almost immediately. The Albuquerque Area went through JCAHO accreditation in April 1998. During the second DV team meeting in June 1997, the administrative nurse coordinating the service unit's JCAHO recertification activities directed the team to develop policies and procedures as soon as possible in preparation for recertification. This pressure turned out to be both good and bad. It forced the team to focus on the policies and procedures; however, we neglected staff education due to time constraints, and did not keep other staff informed about our activities and proposals. The idea of DV screening was generally well received by the medical and nursing staffs, but universal screening was initially opposed as just one more thing to do, and as competition for other public health priorities such as alcohol abuse screening.

We did not appreciate the lifetime prevalence of DV among the friends and families (extended or immediate) of our staff, and the resulting discomfort experienced in asking about this particular problem. The team members quickly learned

how to refer staff to the Employee Assistance Program (EAP), if they desired; however, most of these discussions took place off the record between the two nurse team members and staff who expressed personal difficulty with this subject. Both the nurses were approachable and willing to conduct one-on-one training for those who wanted it. Over time, most staff members came to feel comfortable and competent in screening for domestic violence.

The medical staff's initial comments fell into two general categories. Universal screening was thought to be impractical because of competing public health priorities; it should be targeted at certain times or for certain types of visits. There was also a feeling that if the nurses do not administer the screen, then it just won't get done; routine aspects of a clinical visit should be addressed by nursing standards of care.

Concurrent with these AIH domestic violence-screening activities, AIH was one of a dozen sites in New Mexico competitively selected to participate in the FVPF model domestic violence program training. Five members of the AIH team attended a three-day training in June 1998. Each NM team was at a different stage of DV intervention, some just starting, others with well-developed policies and procedures. The teams applied the model to the unique concerns of each site's service population and each team's stage of development. This training helped the AIH team members to be on the same page and provided goals for further development of DV activities, such as the staff seminars.

As a result of the resistance encountered among service unit staff, and with information obtained in the statewide training, the team placed more emphasis on AIH staff education in service unit-wide and department-specific training activities. Seminars included information learned during the monthly committee meetings, and used several community advocates as speakers. These training activities included general information about DV and resources, including EAP. They provided a forum for staff to raise issues, such as the portability of temporary restraining orders on and off of reservations, and legal obligations to report DV for adult and teenage victims. Seminars were tailored to specific department's needs; for example, some seminars included role-playing exercises to decrease discomfort with this topic, while others addressed documentation of domestic violence in the medical record, the use of diagrams like the SF 531 body map (available through medical records), and Polaroid cameras for documentation.

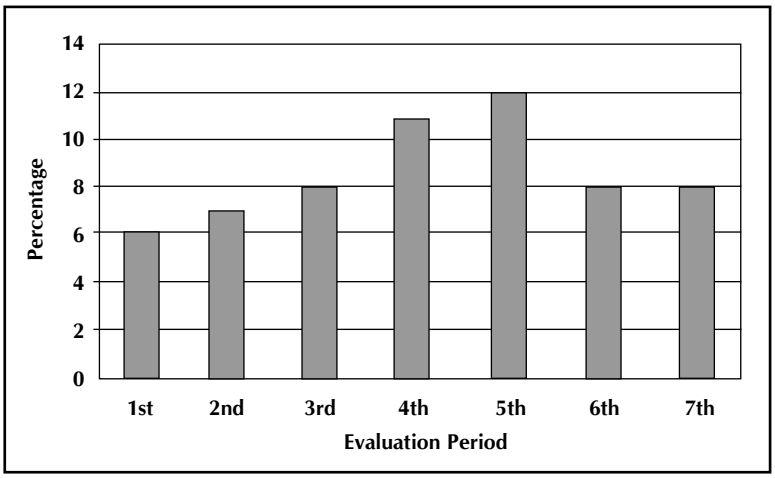
No informational packets for victims of DV available locally contained Native American-specific information. We developed a wallet-sized trifold with a brief safety plan, as well as phone numbers of DV agencies and resources, to distribute to patients and to place in exam rooms and bathrooms in the clinic.

We expected DV screening to catch on more quickly than it did. We thought that we could decrease discomfort around this issue with education and concrete recommendations regarding what to say and do when providers encounter a positive screen. We confidently believed that everyone would see the importance of this issue once they had identified a few victims of DV and capably handled the encounters. We thought a kind of virtuous circle of positive feedback would result once a critical mass of nurse and medical providers began to see the positive effects of their efforts.

In keeping with these preconceptions, the team developed a periodic quality assurance review to identify which nurses and physicians administered the domestic violence screen and to provide periodic reminders and information to the hospital management regarding the team's sustained activities. DV team members meet every six months for an intensive four hour review of medical charts, which reflects a random selection of 10% of charts of female patients ages 18 years and older from the AIH patient data base, resulting in a review of about 700 charts. Each member tabulates which physicians and nurses utilize the domestic violence screen. The results are compiled and reported at medical staff and nursing meetings.

The virtuous circle has yet to occur. Granted, more providers were screening patients for domestic violence. During the first six-month period, only 6% of visits by female patients 18 years and older were screened for domestic violence. By the fifth six-month review, the percentage of visits of adult female patients screened had increased to 12%. While the concept of positive feedback was not entirely abandoned, we hoped that we would reach a critical mass of providers when the implementation of the screen became a part of the nursing evaluation in June 2000, 2½ years from the time the screen was first pilot tested. Despite this, by the 6th and 7th evaluation periods, i.e. at the end of 3½ years, the percentage of visits screened for DV had dropped back to 8% (see Figure 1).

Figure 1. Percentage of visit screened for domestic violence



We believe other factors contributed to this decline in screening, including the fact that AIH has been going through downsizing since December 1995, with accelerating changes

since May 2000. This has impacted staff morale in many ways, but the main effect this has had on DV screening is in nursing personnel turnover. Since May 2000, the service unit has relied heavily on contract nurses who may not be familiar with our protocols. In addition, the number of nurses staffing Urgent Care is fewer, whether contract nurses or not. On busy days, there is barely enough time for nurses to call patients to rooms, let alone to spend a minute orienting the patient to the screening tool. Further changes in the AIH outpatient delivery system expected over the next one to two years may have even greater effects on DV screening. Lastly, it is doubtful whether domestic violence screening at AIH would survive if the DV Team lost its core members. No other staff members have expressed the commitment to carry on the Team's activities, despite the interest and participation in the Team's activities shown by many employees at Albuquerque Indian Hospital.

Two other DV-related activities have occurred at AIH. The DV team hosted a meeting of field clinic DV teams and community DV advocates in June 2001, which resulted in the sharing of information among the different programs, and members attending each other's meetings and workshops. This has already benefitted patients, since many DV victims from surrounding Native American communities seek care at AIH. Knowledge of local community resources helps staff advise these patients.

In addition, the Service Unit's Maternal Child Health (MCH) committee revised the Prenatal form in April 2000 to include DV screening at the first prenatal and 28 weeks visits. The revised form includes a reminder to screen for DV and alcohol/drugs. Screening in this fashion has proved remarkably successful. The percentage of prenatal patients screened for domestic violence at least once during pregnancy rose from 58% to 87%. The MCH committee chairman feels the success is due to the routine nature of the screening, and the fact that the reminder to screen is printed on the prenatal form.

Such routine inclusion of reminders on the PCC form may be possible with PCC+ with an option to include a printed reminder to screen for domestic violence on a service unit's visit form in the near future. PCC+ is undergoing final testing at this time before widespread implementation throughout the IHS.

AIH Accomplishments and Challenges

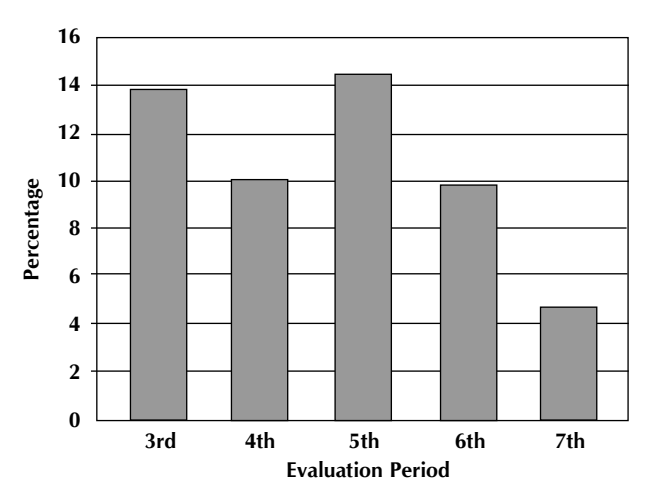
In the general sense, the AIH team's three broad goals have been accomplished. AIH is a safe environment for patients to ask about and be referred to resources for domestic violence. The team has also made significant inroads in establishing a system-wide approach throughout the outpatient clinics in addressing domestic violence. Policies and procedures for DV screening are in place, and an evaluation mechanism has been used consistently. Lastly, each member of the team has learned about issues and local resources to identify, treat, and refer patients with problems related to domestic violence. This information has been folded into the treatment and referral of patients, and shared with other staff.

In the more particular sense, AIH can document success in the following:

- Providing training on domestic violence for medical and nursing providers and raising awareness at departmental and staff meetings
- Making materials and resources available in waiting areas, exam rooms, and women's bathrooms

The overarching goal to institutionalize the identification and treatment or referral of victims of DV remains elusive. This is especially frustrating because all preliminary information indicates that screening is effective in identifying victims of domestic violence. At least 4% of the screens, usually more, come back positive. Figure 2 shows the percentage of positive responses to the domestic violence screens identified in the periodic evaluations.

Figure 2. Percentage of screens that were positive*



**Positive responses to screening were not tracked in evaluation periods 1 and 2. Data reflect all positive responses which may include some responses that arise from assaults by strangers*

Suggestions and Recommendations

As mentioned previously, policies without actions are meaningless. Most IHS facilities have policies for DV.[14] What might be missing is education about DV for staff, along with periodic review mechanisms to monitor the implementation of the policies.

The good news is that several model DV policies and procedures are available to choose from. You do not need to reinvent the wheel, but some thought should be given to what is feasible in your facility. A cookie-cutter DV policy cannot be applied to all hospitals and clinics.

If your facility is large enough to have a multidisciplinary team to coordinate DV efforts, this would be helpful. The perspectives of various departments guided our planning of the logistics of DV screening. Teamwork has other values, too. As individual team members come and go, the team itself can

retain institutional memory regarding what has been done, what has worked and not worked. A team is also good for moral support. A project of this nature is hard work, emotionally difficult, and often discouraging. Team members offer each other support in this emotionally charged issue. Throughout the process, the community advocate is an invaluable source of information to community resources.

Invite your hospital or clinic's administration to send a team member. If that is not possible, take time to keep the administration informed of the team's activities and obtain their support. One of our team members became the Albuquerque Service Unit Director. Her understanding of our activities has helped smooth the way at several steps. For example, our team was concerned that evening clinic staff would not come to morning training activities. The Service Unit Director instructed department heads to offer overtime for this event.

If your facility is a small clinic or health center, consider a larger service unit-wide team that includes representatives from the field clinics. Pooling resources, even if only clerical assistance, can go a long way toward lightening the workload. Field clinic staff can also develop or join teams that include other community agencies.

Talk and listen to your colleagues. Keep them apprised of the team's work and progress, and listen to feedback.

It is clear that screening for DV will have to change as the system changes. Flexibility and adaptation are critical as we continue to find how best to screen for domestic violence with the resources available and in whatever situations we work in.

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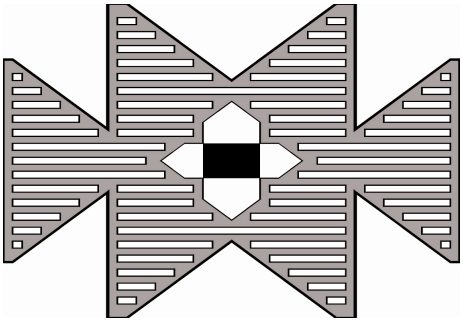

The Native American Cardiology Program: A Collaborative Approach to Subspecialty Cardiology Care

James M. Galloway, MD, FACP, FACC; Eric A. Brody, MD, FACC; Beth Malasky, MD, FACC; Neil Freund, DO, FACC; all from the Native American Cardiology Program, Tucson, Arizona

Cardiovascular disease has emerged as the most common cause of death for American Indians and is now the focus of a major initiative for prevention activities for tribes and urban programs, as well as for the Indian Health Service. Cardiovascular disease has also become a major cause of disability and hospitalization, as well as an indication for both inpatient and outpatient procedures, resulting in increasing expenditures of our limited Indian Health Service (IHS) and tribal Contract Health Service funds. As a result, a need for aggressive treatment and prevention activities has been recognized by the tribes as well as by the IHS.

Prior to the initiation of the Native American Cardiology Program (NACP), the only specialized cardiology care available for American Indian patients throughout much of the country, including the southwest, was from private cardiology groups, generally available at great distances from the patients' homes and reservation-based clinics. The care was not comprehensive and often consisted of a single visit, typically lacking continuity of care, cultural sensitivity, and a vision of coordinated prevention activities. Services obtained from multiple providers were poorly coordinated and lacked a systematic approach to the development of prevention activities; as well, there were few incentives to control medical costs.

Recognizing these needs, the NACP was started in 1993 at the University of Arizona as a collaboration between the Navajo, Phoenix, and Tucson Areas of the Indian Health Service. The program was developed to provide direct cardiovascular care to Native Americans on-site at reservation clinics, as well as to provide tertiary care for complex cardiovascular disease in Tucson. It has evolved to become a unique collaboration between the Indian Health Service, the University of Arizona, the University Medical Center, the Flagstaff Medical Center, the Southwestern Arizona Veterans Administration Healthcare System, as well as Native American tribes and communities. Many of the staff comprising the NACP are employed by our partner organizations and are subsequently assigned to the NACP under the direction of Dr. Galloway and staff.

The mission of the NACP is to promote cardiovascular health and wellness through state-of-the-art treatment, education, and prevention for Native American patients throughout the southwest. The NACP employs primary and secondary prevention measures in an effort to stem the rising epidemic of cardiovascular disease and diabetes now afflicting Native American communities. The research arm of our program focuses entirely upon tribally requested evaluations related to the epidemiology of cardiovascular disease among Native Americans, prevention strategies for decreasing cardiovascular disease and diabetes in Native Americans, as well as evaluations of the effectiveness of these strategies.

The NACP has realized significant benefits through its association with the Sarver Heart Center at the University of Arizona, including the availability of additional manpower support, programmatic support, recruitment potential, and the increased academic vigor derived from an academic center. The NACP has also achieved many similar benefits through its association with the the Southwestern Arizona Veterans Administration Healthcare System, enjoying the additional advantage of the cost savings realized from the utilization of another federal facility for subspecialty services performed by IHS physicians. The recent association and partnership with the Flagstaff Medical Center has expanded these benefits as well as the diagnostic and therapeutic interventions available to our patients through this program. Generous private donations have provided support for diagnostic and other equipment related to direct patient care as well.

The NACP now supports over 30 hospitals and clinics in Arizona, Nevada, New Mexico, and Utah. We hold clinics, including on-site echocardiography, in field hospitals on a regular basis. The program offers multiple services from a distance, including both telephone consultation and telemedicine services. The latter include distance cardiology clinics through real-time telemedicine, Doppler, two dimensional, and color tele-echocardiography, as well as dobutamine stress echocardiography provided at a distant field site, which we can oversee real-time from our offices in Tucson and Flagstaff.

The NACP actively supports primary care providers in the field through continuing education sessions held in conjunc-

tion with cardiologist visits, by teleconferences in the hospitals where this is available, and through the annual IHS cardiology conferences hosted by the NACP. Project staff serve as faculty at conferences throughout the country discussing cardiovascular disease and its risk factors and prevention in Native Americans. The NACP regularly hosts rural physician and mid-level provider training for IHS and tribal employees at the university, where participants can learn about stress testing, pacemakers, ICU management, cardiac evaluation and treatment, and echocardiography.

The NACP focuses on the provision of exemplary health promotion and disease prevention activities while providing high quality, culturally sensitive and appropriate cardiology services to our American Indian patients and their families. This includes the integration, when desired, of traditional healing services. The program orchestrates individual and regional cardiology prevention services and publishes guidelines, including primary, secondary, and tertiary prevention services, and registries. National IHS cardiovascular prevention guidelines on lipid management have recently been released and are available on the Internet at *http://www.ihs.gov/MedicalPrograms/Cardiology/LipidGuidelines.pdf*. Other guidelines are currently under development.

Continuity of care is a vital component of these services, and this is managed in Tucson and in Flagstaff as well as locally at reservation and urban facilities. Contract Health Service expenditures for cardiology care have been significantly reduced through assurance of the appropriate utilization of diagnostic studies, patient evaluation, and medication use. However, the major benefit has been a marked improvement in the quality of care provided to the Native American patients we serve.

The NACP maintains several Area registries, including a Pacer Registry for all Native American patients with pacemakers throughout Arizona. There are over 150 active patients in the Pacer Registry. Physicians at multiple sites in the field have been trained to evaluate and analyze pacemakers using facilities at the local and neighboring hospitals and clinics, and we assist in their oversight. The on-site pacer checks in Tucson and Flagstaff are provided through NACP medical staff and emphasize direct communication with the patients' primary care physicians on the reservations. The program also provides patient assistance with logistics and cultural issues.

Perspectives on Native American Cardiology

Despite the historical absence of significant levels of coronary artery disease in Native Americans,[1] cardiovascular disease is now the leading cause of death in Native American people. Recent data confirm the clinical impression of a dramatic increase in coronary artery disease recognized by many of us in the field caring for adults in Indian country, whether we are in the field of family practice, internal medicine, emergency medicine, or cardiology.[2] Indeed, data from the Strong Heart Study reveal that the incidence of cardiovascular disease among Native Americans is now almost twice that found in the general U.S. population.[3] In addition, other studies clearly indicate that this worrisome trend is significantly increasing,[4] placing higher priorities on aggressive acute management and prevention.[5]

Furthermore, few areas of clinical medicine are evolving as quickly as the clinical management of cardiovascular disease. This rapid change demands considerable effort in order to remain current with the emerging literature, guidelines, and recommendations being developed by a multitude of sources. Therefore, we at the Native American Cardiology Program feel that we may be able assist by offering succinct reviews of some pertinent cardiovascular issues on a periodic basis in THE IHS PROVIDER, covering such topics as primary and secondary prevention, diagnosis, acute and chronic therapy, as well as the epidemiology of cardiovascular disease in Native Americans.

In our first article, we present an introduction to the Native American Cardiology Program, a successful regional subspecialty program. This, then, is the first of a number of articles and reviews we at the Native American Cardiology Program, as your partners in Indian health, will offer for your review. We hope you will find this series helpful to you and the patients we mutually serve.

James M. Galloway, MD, FACP, FACC

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Patients at high cardiovascular risk due to valvular disease, severe coronary artery disease, or other cardiovascular disease, but who are not yet at the point of needing invasive intervention, are also maintained on high risk registries to assure they do not get lost to follow-up.

Anticoagulation levels of affected Native American patients are monitored by the NACP nursing staff. The nurses work directly with the medical and laboratory staff on the reservations, monitoring anticoagulation levels and initiating intervention activities, if necessary, through the public health nursing staff. We are proud that many facilities serving Native Americans have now developed their own anticoagulation clinics for the patients they serve.

Rural public health nursing (PHN) services following hospitalization are coordinated by the Native American Cardiology Program staff in concert with service unit or tribal staff. Upon discharge of our inpatients, the PHN staff is advised by our program of the patient's present status and is instructed about follow-up procedures to ensure they receive the appropriate medications and specialized treatments they need.

The staff of the Native American Cardiology Program is comprised of Dr. James Galloway; Dr. Eric Brody; Dr. Beth Malasky; Dr. Neil Freund; Dr. Robert McNamara; Laura Koepke, ANP-C; Betsy Painter, FNP; Terri Wilson, RN; Phyllis Sanderson; Carol Locust, PhD; Diane Steuart; Lin Lawson; Julie Bursell; and Juanita Ortegas.

Ms. Donna Shalala, then Secretary of the Department of Health and Human Services, awarded the Native American Cardiology Program and its staff the "Secretary of Health and Human Services Award for Distinguished Service" for its "innovative delivery of comprehensive cardiovascular care for Native American people through exceptional teamwork and collaboration with academic, federal, state, private and tribal institutions." Dr. Galloway and the NACP have been recognized by the Hopi Tribe for the "Outstanding Provision of Health Services" and by the Tucson VA Medical Center for "Distinguished service in the delivery of healthcare to Native people."

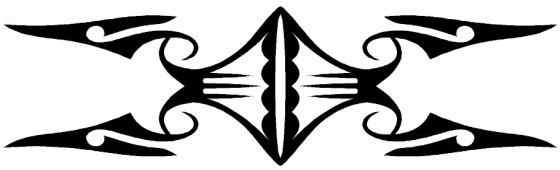
The program has also been honored by two Exemplary Group Performance Awards from the Phoenix Area of the Indian Health Service. Most recently, the Arizona Hospital and Healthcare Association awarded the prestigious Salsbury Award to Dr.Galloway in recognition of his dedication, leadership, and outstanding contributions to the health of the people of Arizona through his efforts with Native Americans.

The Native American Cardiology Program serves as an example of regional subspecialty care provided by the Indian Health Service and offers a model for the development of other focused, subspecialty services that could be shared between Indian Health Service Areas and tribal and urban programs, providing optimal services to a clinicians, hospitals, and clinics through coordinated and culturally sensitive Indian health care.

The Native American Cardiology Program is broadening its efforts to combat cardiovascular disease through a national initiative, with integration of its efforts with Indian communities and tribal prevention activities as well as the IHS Diabetes Program and other agencies such as the National Institutes of Health and the Centers for Disease Control and Prevention. Efforts to increase the awareness of the impact of cardiovascular disease in Native American communities, as well as the general medical community, are underway through publications and seminars.

Within Indian country, a series of intensive one-day seminars for clinicians focusing on the prevention, diagnosis, and treatment of acute coronary syndromes is being offered. The initial conference will be held in Flagstaff, Arizona on May 17, 2002. Another five conferences will be held in other parts of the country; the dates and locations will be publicized well in advance here in THE PROVIDER, as well as by direct notification of the nearby clinics and hospitals. We invite your participation in any of these conferences. All are presented at no charge to the participants.

We at the Native American Cardiology Program are available to you through our offices in Flagstaff at (928) 214-3920 or at the University of Arizona at (520) 694-7000.



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THE IHS PRIMARY CARE PROVIDER

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