THE IHS PRIMARY CARE PROVIDER

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

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# Inter-Tribal Pharmacy Network: A Vehicle to Manage Pharmacy Costs and Improve Patient Care

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Pharmacy Directors at tribal clinics in Wisconsin, under the direction of the Wisconsin Tribal Health Directors Association, undertook a coordinated effort to contain the escalating costs of pharmaceutical care. The Inter-Tribal Pharmacy Project, conducted as part of the Wisconsin Inter-Tribal Managed Care Demonstration Project (WIM Care), resulted in substantial savings and opened up opportunity beyond the original business-oriented objectives. Through this forum, pharmacists have the potential to expand their role in the pharmaceutical management of patients and improve the quality of patient care. The model and process may allow pharmacies and clinics in other regions to realize similar benefits.

**Background**

The eleven Wisconsin Native American tribes each operate their own tribal health centers under self-governance and in accordance with the Indian Self-Determination and Education Assistance Act, Public Law 93-638. The clinics provide health care for approximately 47,000 American Indian persons in the state. The Indian Health Service (IHS) does not directly operate health programs or hospitals in Wisconsin.

Under self-determination or self-governance, Wisconsin tribal health programs have, for the most part, grown apart from and operated independently from each other and from the IHS. Inter-tribal health-related collaboration generally focuses on matters of state and federal health policy, and is often facilitated through the Wisconsin Tribal Health Directors Association (an association of all health administrators from Wisconsin tribal clinics) or through the Great Lakes Inter-Tribal Council Indian Health Programs. The Great Lakes Inter-Tribal Council is a consortium of eleven Wisconsin and Michigan tribes that provides a wide range of technical assistance to the tribes, including extensive consultation for health programs.

Tribes in the upper Midwest, like tribes across the country, have experienced a decline in federal funding in relationship to the rapidly increasing local health care expenditures.

## In this Issue...

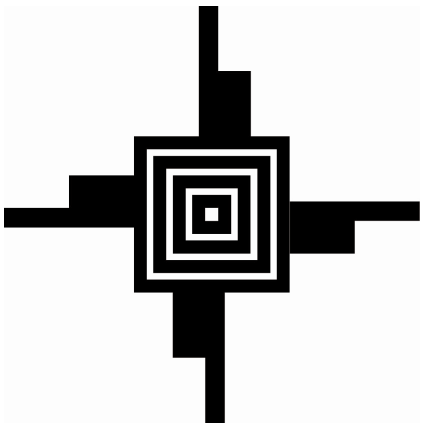
The expanded influence of managed care in both the public and private sectors has intensified the financial pressures. Facing these trends, Wisconsin tribal health leaders pursued collaborative ways to enhance their strategic position in the health care marketplace and strengthen their financial and management capacity.

### WIM Care: Model and Process

The Wisconsin Inter-Tribal Managed Care Demonstration Project (WIM Care) was initiated in 1996 as a partnership between the University of Wisconsin Medical School and the Great Lakes Inter-Tribal Council. WIM Care conducted extensive data analysis, and then implemented management and clinical strategies to improve quality of care, reduce costs, and increase revenues at tribal clinics. The project was initially supported by a three-year Robert Wood Johnson Foundation demonstration grant.

With WIM Care, the Wisconsin tribal leaders and health directors, and the Great Lakes Inter-Tribal Council undertook collaborative strategies that reflected changes in clinical, financial and management models and kept pace with trends in the wider health care industry. They invited the state's largest public academic institution, the University of Wisconsin, to become a partner with the tribes in this endeavor. Through this partnership, the tribes sought access to the same information and practice innovations as their colleagues in academia.

As part of WIM Care, ten participating tribal clinics completed an inter-tribal initiative to reduce their overall pharmacy costs. A network of tribal pharmacies negotiated joint contracts for discounted products and improved services from pharmaceutical vendors. The new contracts are saving the participating tribes approximately ten percent overall in their pharmacy budgets, with individual tribal pharmacies saving as much as 14 percent.



### The WIM Care Inter-Tribal Pharmacy Project: Methods and Activities

Most tribal clinics in Wisconsin operate in-house pharmacies and employ at least one pharmacist. As with the rest of the health care industry, tribal clinics devote a large percentage of their overall budgets to stocking their pharmacies.

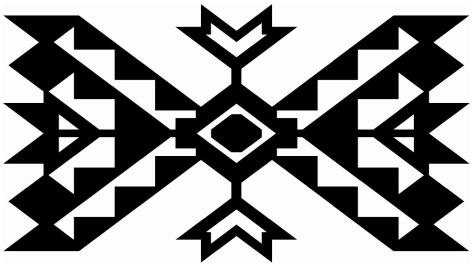
Tribal leaders shared a perception that pharmacy costs were high and rising too quickly. But in order for pharmacists to gain support for significant changes in current business practices, pharmacists would have to carefully document the problem. WIM Care staff analyzed data from the tribes' RPMS (Resource and Patient Management System) database (the RPMS is the primary data management system used at IHS and many tribal facilities), and surveyed the tribal pharmacies to determine their actual costs, buying patterns, providers' prescribing patterns, suppliers, and drug prices. These data validated some preconceptions. Data from the tribes' RPMS showed that Contract Health Service (CHS; funding for health care services for eligible, uninsured or underinsured tribal members who are referred outside of their tribal clinic for care) costs for pharmacy-related services alone had risen 24% from 1995 to 1997 for nine Wisconsin tribes.

The Inter-Tribal Pharmacy Project began with an organized network of tribal pharmacists from ten clinics. The group has undertaken several activities to reduce or contain pharmacy costs and to improve the pharmaceutical care of patients. These include forming a buying group, participating in available federal drug purchasing discount programs, considering an inter-tribal formulary, and seeking expanded participation by the tribal pharmacists and clinicians in patient education and pharmaceutical management of chronic conditions.

### Forming a Buying Group: the Process and Challenges

The surveys showed that tribal sites purchased from 80% to 90% of all pharmaceutical supplies from wholesalers -- intermediaries between drug manufacturers and buyers. Each tribal pharmacy had developed independent relationships with suppliers and drug manufacturers. A single tribal pharmacy spent anywhere from $140,000 to approximately $1.7 million on pharmaceuticals per year. Yet no single pharmacy had enough volume to leverage lower prices from their vendors and suppliers. As a group, however, they purchased several million dollars worth of pharmaceuticals per year. This, they reasoned, was enough volume to gain bargaining power.

Great differentials exist among tribal pharmacies in purchasing volume, internal staffing, and market leverage. Smaller tribes often stand to gain the most from inter-tribal endeavors. Larger clinics that already enjoy some degree of market leverage may be reluctant to compromise their autono-



my. Tribal clinics in Wisconsin had a history of working collaboratively, and were therefore familiar with this potential conflict. In order to move forward, the clinics sought solutions that would accommodate, rather than override, the potentially differential benefits available to individuals within a group endeavor.

A Request for Proposals was distributed to several pharmacy vendors. Pharmacists anticipated that it would be difficult to get all tribes to choose one single vendor. Health facilities are often reluctant to break with established relationships, particularly if the degree of financial gain is uncertain. Each pharmacy operation had to account for the cost it would incur for changing vendors, installing new computer equipment, and training staff in new ordering procedures.

The Request for Proposals was designed to alleviate these concerns. First, it asked pharmaceutical vendors to provide an overall price for the volume of the group as a whole. The vendors were invited to propose a scale of discount levels for different possible total volumes of drug purchases (from $0 to 1 million, $1 million to $ 2 million, etc). This ensured that if one tribe decided not to participate (thus lowering the overall volume of the group purchase), the other pharmacies could still receive a discount. The vendors were also to propose graduated discount levels based on each tribes' individual purchase volume. This allowed the tribes the option to use their purchasing leverage as a group and still attain tribe-specific discounts, which often works to the advantage of the larger purchasers within the group. (The trade-off is that small volume purchasers within the group receive lower discounts than if the group were to solicit one price as a whole.) The group would select which method of discount to adopt. Then each tribe would have a separate contract, each incorporating a template of provisions applicable to all group members. This approach would allow each tribe to chose its own payment and delivery method.

Ultimately, six pharmaceutical distributors responded with proposals, and some conducted on-site visits. Two vendors offered very similar discount packages. The tribes, as it turned out, were split in preference between these two potential vendors. They ultimately developed two contracts for the two subgroups that provided a degree of discount above the price tribes received as individual purchasers.

The tribal clinics' purchasing leverage as a network was undeniably diminished when they divided into two groups. Their overall savings was lower, and they sacrificed the ability to attain some ancillary services and products (such as free overnight services or upgraded computer software billing packages) that may have been offered to the whole group at no or low cost. Yet, this compromise allowed the process to move forward. As participants became more comfortable with considering alternative vendor relationships, the clinics were well positioned to further consolidate their purchasing in future negotiations.

Indeed, as it turned out, three tribes became dissatisfied with the quality of the services from their chosen vendor. These tribes switched services to the other vendor, bringing the total volume purchased up again significantly. This did, in the end, increase the level of discount available to all participants from that vendor. The expanded contract provided tribes additional incentives and discounts for optional services.

### Federal Pharmacy Discount Programs: Adding leverage

Three federal drug purchasing discount programs are available to American Indian tribal clinics: Federal Ceiling Price**,** the Federal Supply Schedule discount (available to federal agencies, including tribal clinics) and the Public Health Service 340B Pricing Program (available to Federally Qualified Health Centers). Many clinics, however, were either unaware of these programs or were not participating. In some cases, eligibility criteria are confusing or conflicting. Documentation of eligibility was perceived as complicated or onerous, as is the record-keeping required of participants. Yet, these programs offer exceptional opportunities to reduce the costs of purchasing product.

WIM Care researched the discount programs extensively, and pharmacists renewed efforts to pursue participation. The group had several written and verbal exchanges with representatives for each discount program and convened meetings with the programs' federal officials. Despite this concentrated effort, it was still difficult for some of the sites to access the discounts when they dealt directly with the manufacturers. In several cases, the drug manufacturer or supplier challenged the clinics' eligibility for these programs. As a group, however, the pharmacies were able to attain consistent information, and could negotiate more effectively.

Indeed, one criterion for choosing a pharmaceutical vendor was its ability to assist the tribal pharmacies to attain the federal discounts on products, beyond the supplier discount that applied only to drug acquisition and distribution costs. Ultimately, most participating tribes contracted with a vendor that had extensive experience and willingness to work with the federal discount programs. In many cases, the vendor has been able to procure even lower prices from manufacturers on behalf of the tribal sites.

### Future Opportunities

The tribal sites plan to continue to use the inter-tribal network to negotiate purchasing discounts. Beyond this immediate benefit, the clinics are well positioned to undertake more complex projects.

First, they have considered establishing an inter-tribal formulary and Pharmacy and Therapeutics (P&T) committee. By limiting the universe of drugs that the pharmacies carry and that the physicians prescribe, the tribal sites may improve the quality and consistency of drug therapy for patients. They may potentially reduce costs by replacing expensive drug therapies with equally effective and less expensive alternatives. It can be difficult, however, for a single pharmacist and medical director at a small tribal clinic to review new drugs and drug classes on a regular basis. This becomes more probable when a group of tribal clinics share the workload. Pharmacists at each participating clinic can then become expert in a certain class of drugs and, collaborating with his or her colleagues at other clinics, may effectively maintain and update a formulary. Formularies, however, are inevitably fraught with controversy and dissent within individual clinics, among managers and providers, as well as with patients. For these reasons, inter-tribal formulary development is a longer-range goal.

Pharmacists are also considering an effort to reduce the prices that Contract Health Service departments pay for patient prescriptions at non-tribal pharmacies. The pharmacists may undertake negotiations as a group, and some regional clusters of clinics may be positioned to conduct group purchasing with the contract pharmacies.

Finally, clinics are exploring methods to better integrate pharmacists into teams with clinical and public health staff, as part of an overall effort to improve the quality of patient care and education. Pharmacists hope to expand their role in helping patients with the pharmaceutical self-management of certain chronic health conditions, including asthma, diabetes, or heart disease. This effort requires concentrated team building within individual tribal sites. The pharmacists' network can support this by providing a forum to share experiences and information as these clinical professionals strengthen the role they play in the patient care team.

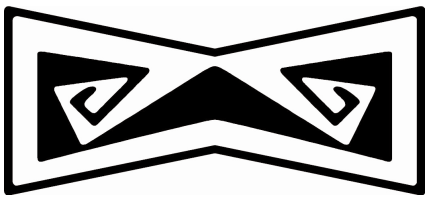
### Overall Assessment of Benefits

Through their network, tribal pharmacies have increased their leverage in the regional and national purchasing pool and have built a sound infrastructure for future inter-tribal collaboration. This network provides an opportunity for joint negotiation and contracting, group purchasing, formulary development and management, and the broader application of pharmacy practice in improving the quality of patient care.

*Achieve substantial savings*. By forming a network, ten participating tribal clinics were able to negotiate joint discounts with pharmaceutical suppliers and save as much as 14 percent in their drug purchasing costs. This is the clearest short-term benefit for the tribal clinics. While individual discount percentages vary according to volume, all tribal pharmacies benefit to some degree from their new contracts and savings. Even smaller pharmacies have realized significant savings, benefitting from the network's economies of scale.

*Gain leverage for future inter-tribal activities*. Tribal pharmacies are now positioned to continue to collaborate as a group. Their network has already gained wide recognition, and pharmaceutical vendors are aggressively seeking their business.

*Share expertise, resources, and workload*. Beyond business negotiations, the network also provides pharmacists a substantial corollary benefit: a venue for communication and information sharing. Through this network, pharmacists gained new information regarding the federal discounts available to tribes. They are also well positioned to form an inter-tribal P&T Committee and to establish and maintain an inter-tribal formulary. This particularly benefits the smaller tribes that otherwise lack the internal staff and resources to conduct these activities. Overall, tribal pharmacies are now better positioned to adopt industry wide practices to both reduce costs and improve the quality of patient pharmaceutical care.



# Diabetes Patient Education in the IHS

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The Rapid City Service Unit Diabetes Program recently completed a continuing professional education course for its health care providers on diabetes patient education. During this activity, we reviewed the Indian Health Service (IHS) Diabetes Program diabetes patient education curriculum. The "basic" and "complications" materials that make up this curriculum have been in use for more than a decade. At this time they are no longer endorsed by the national IHS Diabetes Program, are no longer being reprinted, and are not available through the IHS Diabetes Program at Headquarters West.

In the process of packaging and delivering our recent Rapid City Service Unit (RCSU) course on diabetes patient education, we've made several observations about the modules, and we wanted to share these with others who are delivering diabetes care in the Indian health system. Patient education is essential to delivering diabetes care. For numerous reasons, we also believe that several features of the IHS diabetes education modules should still be a part of the core content of diabetes patient education programs that are delivered at Indian Health Service, tribal, and urban (I/T/U) sites. Several changes are needed, however, to make them more useful and easily accessible.

We will begin by placing our observations in a list, and then we will elaborate on the items in our list in the paragraphs below.

1. The modular unit concept is still essential to any diabetes education program.
2. Materials that accompany the old modules can be updated and revised and still be extremely useful.
3. Any modules used and IHS RPMS (Resource and Patient Management System) PCC (Patient Care Component) education codes need to correspond.
4. Placing an updated version of the modules on the Internet on the IHS diabetes website should be considered.
5. A course to present diabetes patient education specific to Indian country should also be considered.

Our first observation is simply that some type of a modular system is absolutely necessary to deliver adequate diabetes education to patients. There is too much material to be presented in less than the better part of a day; more than a day can easily be spent to deliver it all well. This information covers discrete subjects that lend themselves to a modular approach. The various modules require specialized expertise and might best be presented by different professions represented on the staff.

Optimally, diabetes patient education should be done by a multidisciplinary team. In our clinic we have nurse educators, a nutritionist, fitness-technicians, psychologists, a podiatrist, Community Health Representative (CHR) case managers, and a variety of primary care medical providers seeing patients with diabetes. A modular system divides the material into "bite-sized" chunks that can be presented conveniently in a brief education session, and separates the content into areas that lend themselves to the expertise of the various team members.

It was exciting years ago for one of the authors (FN), as a rookie Diabetes Control Officer, to work with the IHS Diabetes Control Officers (DCO) team that assembled the original diabetes patient education course for the IHS. In the decade since that time, diabetes care has been revolutionized, and the modules have been in need of an update to reflect the current state of the art. Since they were written, we have learned more about how tightly blood pressure and blood sugar should be controlled in the patient with diabetes, and also much more about lipids. We found out that there is such a thing as microalbuminuria, that it should be monitored, and that it has treatment implications. We know more about diabetic limb salvage and the psychological aspects of diabetes.

Currently the national IHS Diabetes Program is working with a contractor to modify the Living with Diabetes curriculum available through the American Diabetes Association for use in the Indian health system. Our diabetes team at the Rapid City Indian Hospital sent representatives to the program developed by the State of South Dakota as part of their efforts to certify programs to be qualified to receive third party billing for diabetes education. The state provides many diabetes patient education materials free of charge. There are also numerous diabetes patient education materials available from pharmaceutical companies and other sources. Wherever diabetes education materials are obtained, it makes sense to fit them into a framework based on the new IHS diabetes patient education codes for the reasons that will be addressed below.

There are several reasons why each patient education

module needs to have a unique computer code. The patient education coding system developed by the headquarters diabetes team and the IHS patient education program is one of the most useful aspects of the old modules. For the benefit of an individual provider tracking the education that has been presented to a patient, for communication between staff members, as well as for auditing charts to compile a service unit report, it is extremely convenient to use a short code such as "DM-EX" and feel with confidence that it communicates, with some precision, the content of the 15-20 minute education session that has been given to the patient on the topic. Busy providers just don't have the time to take another 20 minutes to record what they've done. It is very useful to know that if the nurse educator records "DM-FTC," that she has done a complete foot exam and the associated diabetes education session, which includes coverage of a foot care self exam, footwear, and other foot care as in the agreed upon standard. These education codes are recognized by the RPMS software and function well within our system. Compatibility with information technology systems is another important ingredient of an optimal patient education system.

The old IHS modules are very specific in the content that they outline for the education session and the required amount of time to be spent on each session. This standardization of diabetes education coding is certainly one of the great attributes of the modules and one of the main reasons why the concept and design of the old curriculum should still form the centerpiece of a diabetes patient education program in the IHS. The national IHS Diabetes Program is working closely with the IHS Health Education Program to give us new patient education codes that will be an integral part of our systems.

Another strong point in favor of such a coding system is the fact that all of us are still struggling with the need to bill for our services. South Dakota has recently mandated that all third party payers cover diabetes patient education. Additionally, the IHS Diabetes Program has been working with CMS (Center for Medicare and Medicaid Services; formerly HCFA, or the Health Care Financing Agency) to become a deeming entity for diabetes patient education programs in Indian country. The hope is that soon diabetes patient education programs certified by the IHS Diabetes Program will then be eligible for reimbursement from CMS.

At the Rapid City Service Unit we bill diabetes education primarily on the basis of time. If our billing practices are ever called into question on an audit by a third party payer or Medicare, we are on firm footing if we are able to refer to something as specific the "DM-EX" section of the old curriculum and show the content of the exercise session and its explicit time allowance quoted as 15-20 minutes. In this era of tightening resources, we need to be able to provide some type of justification for billing for a 25-minute visit that may have had only brief documentation followed by the abbreviation "DM-EX."

Although there may not be one single curriculum to fit the entire IHS, we believe the curriculum should be highly uniform within any particular service unit or facility. We think one way accomplish this would be for specific materials to be designed in the form of small booklets for each of the modules that are ultimately assigned an RPMS (or other) code. These could take providers through the various sessions from beginning to end. Providers could go from page to page using these booklets as their outline for the session they are delivering and then give the booklet to the patient as the educational handout. We have done this with several of the modules and found it to be very satisfactory. We can be confident, then, that whichever member of the team presents the material, the content of the session has been what the team agrees is important in the coverage of the subject, and not some very highly individualized session that is really not at all what other members of the team would like to see presented.

There are some excellent printed patient materials that accompany the IHS diabetes education modules. We are quite confident that these could be redesigned to cover the topics in all of the modules in a very well defined manner. We're convinced that everyone, from CHRs to physicians, could be taught how to do diabetes education well using such a system. As they were previously outlined, the modules are very explicit and helpful, but they were too cumbersome to follow while the educational session was in progress. As a result, each session could end up being significantly different from another.

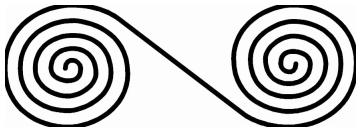
We also feel that it would be advantageous to have the updated versions of the old modules in electronic format on the IHS website. In this fashion, they could be downloaded by anyone and individualized to fit the particular setting in which they were going to be utilized. We suspect that if the IHS Diabetes Program were to serve as a clearinghouse for any innovations that people made to fit their service unit, these innovations could be used periodically to enhance the curriculum. We are continually impressed by the abilities of the people in the field in Indian country who are providing diabetes care and education, and we're constantly learning new ways to do a better job from them. Indeed we are learning things from all the different team members, each of whom has their own special talents and perspectives of the care of the patient with diabetes.

A course for health care providers on how to use the IHS modules has not existed, and we believe that it should be considered. This could be designed and offered on an IHS-wide, Area, or local level. Several features of the IHS system, such as the RPMS codes and many of the materials themselves, are quite unique. The old modules were somewhat self-explanatory, and we hope that the new system that the Diabetes Program's contractor provides will be, as well; however many times it falls to staff who have not had a great deal of experience in providing diabetes education to implement the use of a system like this. Such a course, if packaged and delivered periodically, could serve as a useful introduction to diabetes patient education at facilities where diabetes education pro-

grams are only beginning to be implemented, or as a useful update in facilities where staff turnover has resulted in a new group of individuals picking up the diabetes education program and moving it forward without the benefit of experienced staff to get them started.

Patient education is at the very core of diabetes therapy. We have to convince people with this disease to make many behavioral changes for something that may not affect them for 5, 10, 20, or more years. People need to be persuaded that it's worth it. In our clinic none of us can tell you how many times we've had patients tell us that "No one has ever explained this to me before so that I could understand." We can't practice medicine like that in the 21st century.

Diabetes care in particular requires a great deal of education. We have an excellent start. However, over the years, we have lacked many of the resources we have needed to present up-to-date diabetes education at many of the sites where we serve. With new updates, our somewhat outmoded diabetes patient education system can form the core of a truly fine tool for working with our patients to combat this devastating disease in the years ahead. Local customization will assure that the message is appropriate for the site where it will be delivered. Incorporation of some of the suggestions mentioned above might enhance those efforts.



# Correction

In the October issue, we ran an item about how to subscribe to the Advanced Practice Nurse Listserv. The e-mail address given was incorrect. The correct instructions are as follows:

**Subscribe to Advanced Practice Nursing Listserv**

An Advanced Practice Nursing (APN) listserv is now operational. It is available to IHS, tribal, and urban APNs. If you would like to subscribe, please send an e-mail message to *listserver@hqt.ihs.gov*. In the body of the message type: "subscribe apn Jane Doe" (inserting your name). No subject for the message is necessary. You will receive confirmation via e-mail that you have been successfully added to the list of subscribers.

For additional information contact Judy Whitecrane, CNM, at Phoenix Indian Medical Center; telephone (602) 263-1550; or e-mail *judy.whitecrane@mail.ihs.gov.*

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— *The Editors*

# Elder Care Training Opportunities Available from the VA

**Special Fellowships Program in Advanced Geriatrics (SFPAG)**

The goal of the SFPAG is to develop outstanding academic and/or health care systems physician leaders with vision and knowledge in geriatrics, who are committed to leading the discipline in the 21st century. To accomplish this goal, the VA is offering a national post- residency, two year advanced geriatric fellowship at seven VA Geriatric Research, Education, and Clinical Centers (GRECCS). This VA fellowship will provide outstanding geriatric medicine or geriatric psychiatry research training, interdisciplinary educational opportunities, and advanced clinical and program administration learning opportunities.

SFPAG sites are at the following locations:

- VA Greater Los Angeles Health Care System/UCLA
- VA Ann Arbor Health Care System/University of Michigan
- VAMC Durham, NC/Duke University
- Central Arkansas Veterans Health Care System/University of Arkansas
- VA Puget Sound Health Care System/University of Washington
- South Texas Veterans Health Care System/University of Texas
- VAMC St. Louis/Saint Louis University

For further information, contact Laural Opalinski, SFPAG Coordinator, at telephone (301) 268-4107; or go to *www.grecc-gla.org/sfpag*.

**Interprofessional Fellowships in Palliative Care**

The Department of Veterans Affairs is offering one-year fellowships in palliative care at six VA facilities. Each of the training sites will select up to four 1-year (or equivalent) fellows/trainees to begin between July and September 2002. At least one and no more than two of these fellows may be a physician at each of the sites. Each site will select one to three associated health (non-physician) fellows/trainees in professions involved in the practice of palliative care (e.g., nursing, social work, pharmacy, psychology, or chaplaincy). The training for associated health professions may be for a period of one year or less, depending upon the profession and the curriculum plan.

The purpose of this VA fellowship program is to develop leaders with the vision, knowledge, and commitment to lead palliative care into the 21st century, as well as to increase recruitment and retention of these professionals for the Veterans Health Administration. There is no obligation to work for the VA after completion of the program.

Sites for the fellowships are Palo Alto, California; Milwaukee, Wisconsin; Bronx, New York; Portland, Oregon; Los Angeles, California; San Antonio, Texas.

For further information, go to *http://www.va.gov/oaa/fellowships/palliative.asp.*

# Materials Available from the IHS Elder Care Initiative

The following materials are available from the IHS Elder Care Initiative, while supplies last.

1. Long Term Care Service Needs of American Indian Elders – The IHS Santa Fe Service Unit. Catherine Hennessey, Robert John, Lonnie Roy 1999. *A study done in collaboration with the CDC. While some parts are specific to the Santa Fe Service unit, other parts have application throughout Indian Country.*
2. American Indian and Alaska Native Elders: An Assessment of their Current Status and Provision of Services. Robert John, 1995. *Although getting old, much of this data is still valid, and it is still the only comprehensive collection available. IHS funded.*
3. The NICOA Report – Health and Long Term Care for Indian Elders. Robert John and Dave Baldridge, 1995.

## Change of Address or Request for New Subscription Form

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**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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