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The IHS Behavioral Health System

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With the widespread deployment of the Behavioral Health System (BHS) v3.0 in January 2003 and the earlier release of MH/SS v2.0, behavioral health is at the forefront of the Indian Health Service (IHS) and the health care industry-wide movement toward the use of computer-based patient records. For several years, through the use of these applications, BH providers have been able to electronically document not only Purpose of Visit and Activity codes needed for billing and workload reports, but also encounter notes and treatment plans. This has given the BH programs the only fully capable electronic medical record in the Indian health system to date.

There are now over 120 IHS, tribal, and urban (I/T/U) sites using BHS v3.0 to electronically document the provision of mental health, alcohol and substance abuse, and social work services. An effort is presently underway to expand this capability to other medical programs, through the IHS Electronic Health Record. The November 2003 issue of *The IHS Primary Care Provider* included a general discussion of the benefits of an electronic health record and provided additional information on the IHS-EHR product and program.

The movement toward the use of an electronic health record (EHR) coincided with a decision by the previous IHS Director, based on consultation with tribal and urban leaders, to set aside funding from the FY 2001 Omnibus Appropriations Act for improved behavioral health data collection and analysis. Additionally, in order to provide more comprehensive services and improve client outcomes, many I/T/U mental health, alcohol/substance abuse, and social work programs are combining their activities into one integrated behavioral health (BH) service delivery model. This integration requires improved information technology to support the flow of information needed for comprehensive case management, while also maintaining client confidentiality and privacy. Providers, now often in larger and busier behavioral health departments, need a user-friendly software application that allows them to optimize their time with clients while still meeting important clinical documentation and reporting requirements. In this time of decreased funding and competing priorities, I/T/U health care facilities and programs are increasingly concerned with maximizing collections for BH services, just like for other clinical services.

In FY 2002, the IHS Information and Technology Support Center (ITSC) partnered with the Division of Behavioral Health (DBH) to develop a long-term, integrated BH application. A Behavioral Health Management Information System

In this Issue...

(BHMIS) workgroup, consisting of practicing I/T/U BH clinicians and program managers, was formed and tasked with defining the requirements of the long-term application, as well as those for the interim BH applications including BHS v3.0 and its corresponding graphical user interface version.

Current BH Applications

The ITSC demonstrated BHS v3.0 and a prototype of the Behavioral Health graphical user interface (BHGUI) application at several I/T/U meetings this year, including the National Councils for Indian Health meeting, the annual IHS Division of Behavioral Health (DBH) meeting, and two annual National Council of Urban Indian health meetings. In FY 2003, over 250 BH providers and support staff were trained on BHS v3.0. Eleven Areas participated in 16 two-day training events. Many of the new users of BHS v3.0 are providers at tribal and urban facilities. The application is in use at diverse locations, such as a youth alcohol and substance abuse residential treatment center in South Dakota, an IHS-direct mental health program in Chinle, Arizona, and an urban outpatient behavioral health program in Jamaica Plains, Massachusetts.

Functionality

BHS v3.0 and the BHGUI combine select functionality and data elements from the earlier behavioral health applications — MH/SS v2.0, the Navajo version of MH/SS, and CDMIS. With BHS v3.0, providers can document clinical care, record program activities, and generate a wide variety of reports. Individual, family and group services can be recorded, including SOAP progress notes and any patient and family education provided. Treatment plans and treatment reviews can also be recorded in detail. The CDMIS staging tool, a placement tool administered at different intervals in the continum of care in alcohol and substance abuse treatment, can also be recorded electronically. Non-direct client care activities such as community prevention and consultation services and clinical supervision can be recorded. The addition of a new suicide surveillance tool allows programs, Area Offices, and the DBH to record and track the occurrence of suicide attempts and completions, and provides important epidemiological information.

While the graphical user interface provides the user with a familiar Windows-style front end, the very robust "roll and scroll" BHS v3.0 remains the back-end to the BHGUI. GUIs are intended to be more intuitive and user-friendly than roll and scroll applications, and a user-centered design approach to their development can enhance their usability even more.

Usability and Design

Direct provider entry of clinical information is encouraged when using the BH applications. Direct provider entry improves the accuracy of clinical notes, reduces errors, and helps protect patient confidentiality. However, the BH applications will continue to permit the entry of clinical data by support staff. Most I/T/U behavioral health programs continue to use a hybrid system of computerized and paper-based patient records. Improved technology allowing the integration of original documents and correspondence (signed releases, discharge summaries, consultation reports from outside facilities, etc.) into the patient's computerized record will help to achieve a truly comprehensive electronic medical record (EMR).

Perhaps more than improved technology, improved usability and design will be the factors that make the provider give up the pen and chart for the keyboard and screen. With this in mind, the IHS has contracted with Human Factors International (HFI), recognized experts in the field of GUI usability and design. HFI and the ITSC conducted extensive end-user interviews and usability testing of preliminary BH user interface structures at four I/T/U behavioral health programs. In June 2003, HFI provided a final usability analysis of the prototype BHGUI, final BH style sheets, and GUI standards. It is hoped that the long-term behavioral health application, developed using GUI industry standards, user-centered design, and usability testing and analysis, will encourage more providers to make the transition to an EMR.

BHGUI and Patient Chart

The BHGUI resides within the existing IHS GUI application, Patient Chart. Patient Chart was released in December 2001, and a cache-compliant version, Patient Chart v1.3, was released in September 2003. Patient Chart facilitates access to a variety of RPMS data, direct manipulation of problem list information, entry of vital signs and measurements, viewing and graphing of measurements and labs, lab order entry, and Referred Care (RCIS) entry and look-up. The BH module, or "tab," will be accessible only to those providers who are given the appropriate security keys. The BH module contains all of the current functionality in BHS v3.0, including the ability to document patient encounters and treatment plans (see Figures 1 and 2 at the end of the article).

Graphical user interfaces are generally more intuitive and acceptable to those users familiar with Windows and Mac applications, and Patient Chart provides a readily accessible and user-friendly alternative to the existing RPMS behavioral health application. Many facilities currently using RPMS will already have the software and desktop requirements necessary to run Patient Chart.

Beta testing of the BHGUI began on September 26, 2003 at the following I/T/U sites:

- Chinle Comprehensive Health Care Center
- Warm Springs Health Center
- Phoenix Indian Medical Center
- Shingle Springs Tribal Health Center

Friendship House, an urban residential alcohol and substance abuse treatment center in San Francisco, will join the beta process at a later date. The second phase of beta will include testing of the new Group Entry functionality as well as modifi-

cations and enhancements that were made based on feedback received during the initial beta testing period. The BHGUI, Patient Chart v1.4, will be released in January 2004. A training and deployment plan for FY 2004 is being developed.

The Future

The BHMIS work group, comprised of I/T/U mental health, alcohol/substance abuse, and social work subject matter experts, met in Albuquerque in November to review the development of the BHGUI and to refocus attention on the development of the long-term application. New requirements include the VHA Text Integration Utility (TIU) for clinical documentation; computerized provider order entry (CPOE) for medication, lab, radiology and dietetic orders; clinical decision support (CDS) or clinical guidelines; and inclusion of the VHA Mental Health Assistant (MHA) application. MHA is an application that allows the provider to administer standard psychological and behavioral health tests with a text-based or graphical display of the results. Programming on the long-term application, Integrated Behavioral Health (IBH), will begin in February 2004.

The BHMIS workgroup also discussed the implications of including the IBH as a component of the IHS Electronic Health Record (EHR), currently in development. Those BH programs located at sites not implementing the EHR will be able to continue to use BHS v3.0 or the BHGUI in Patient Chart. Additional information and updates can be found on the Integrated Behavioral Health (IBH) web pages on the IHS Internet site at *http://www.ihs.gov/cio/bh*.

Figure 1. BH GUI; Regular Visit (fictitious data)

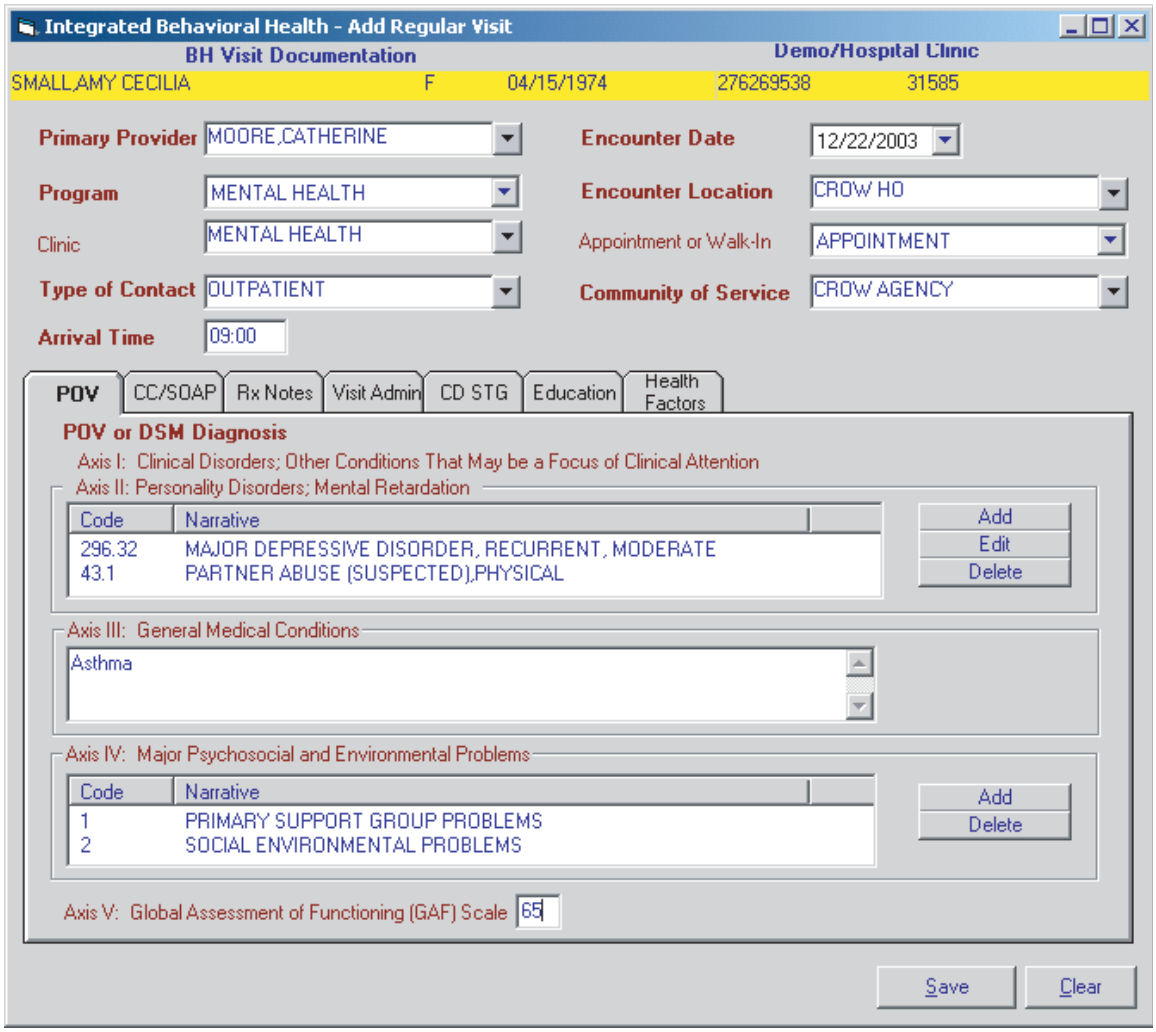
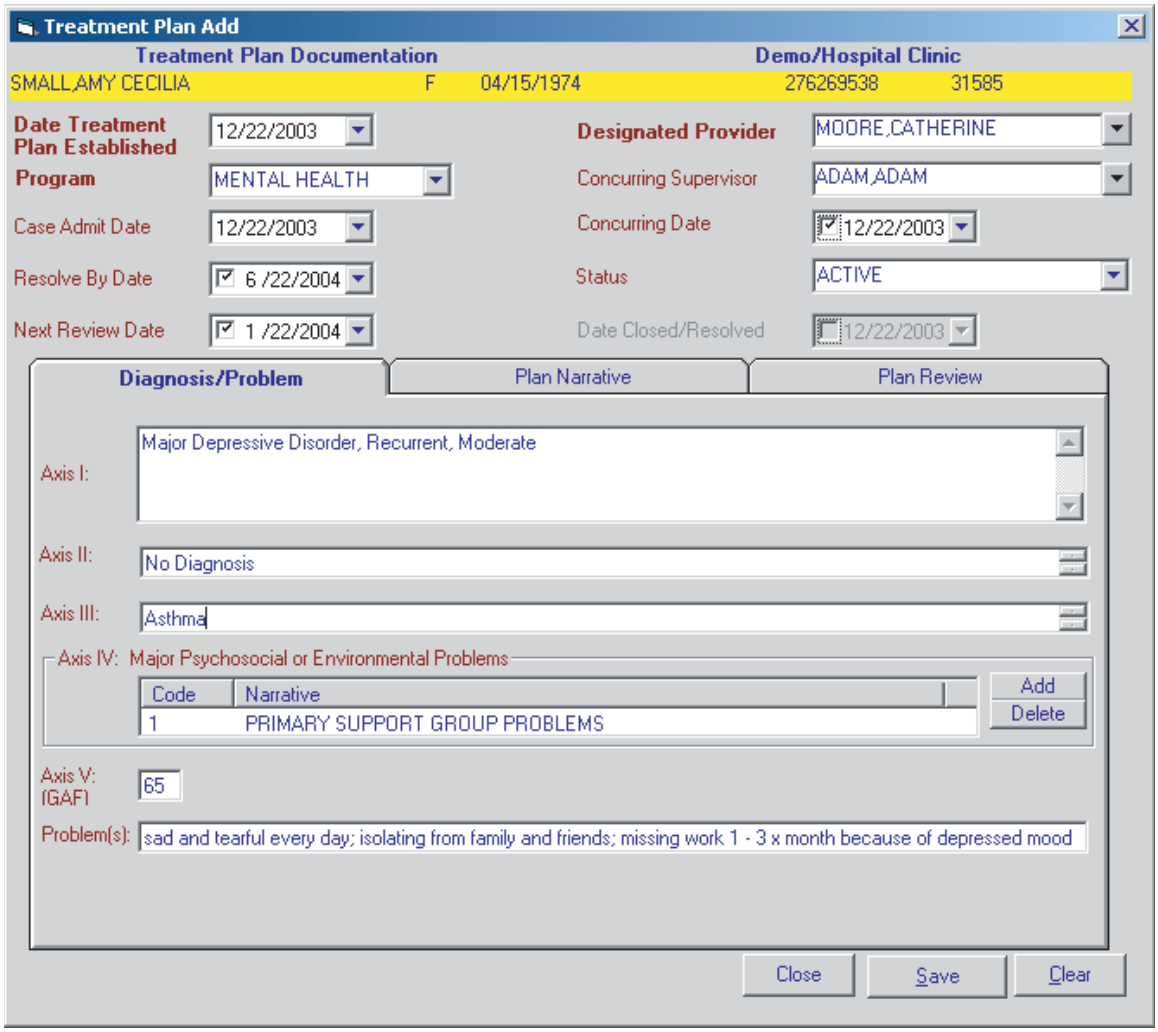


Figure 2. BH GUI; Treatment Plan (fictitious data)



Editor's Note: The following is excerpted from the monthly Notes from the Elder Care Initiative *that is published as an e-mail newsletter. Information about how to subscribe can be found below. We would appreciate your feedback about whether or not you will find a periodic digest of this publication printed in* The Provider *useful.*

Notes From The Elder Care Initiative

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Northampton, Massachusetts

What's New

Medicaid Home Care for Tribal Health Services: A Tool Kit for Developing New Programs

Under contract from the Indian Health Service Elder Care Initiative, the UCLA Center for Health Policy Research, American Indian/Alaska Native Research Program has developed and disseminated a series of state-specific guides to funding for home and community-based long-term care services for the elderly. These toolkits identify the state programs that support home and community-based long-term care services, detail eligibility requirements for elders, and outline the requirements for tribal programs as service providers under the various programs.

Information includes:

- Why provide Medicaid personal care services?
- What are personal care and other non-medical in-home services?
- Medicaid programs that provide in-home services
- How personal care and other in-home services are provided
- Tips for developing a plan for delivering Medicaid home care services

This concise and readable guide will be a valuable technical assistance tool for tribes developing long-term care services.

The toolkit is available on-line at the Indian Health Service Elder Care Initiative website at *http://www.ihs.gov/medicalprograms/eldercare* or the UCLA Center for Health Policy Research website at *http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=79*. Hard copies are available on request.

From the Literature

Anticoagulation In Nonvalvular Atrial Fibrillation

A number of studies have shown the benefit of anticoagulation in patients with atrial fibrillation (including older patients). Two new studies emphasize this and add to our understanding.

In the "real world" setting of a large HMO, Go, et al followed over 11,000 persons, mean age of 71, with nonvalvular atrial fibrillation and no contraindication to anticoagulation, for up to three years. Those on warfarin anticoagulation had a reduction in risk of stroke and thromboembolism of 64% and a reduction in all cause mortality of 31%. Intracranial bleeding was "uncommon" but increased in those on warfarin, while there was no increased risk of extracranial hemorrhage.

In the second study, in the same cohort of patients, Hylek, et al evaluated the outcome of anticoagulation based on intensity of treatment. There was a clear benefit for those patients with nonvalvular atrial fibrillation whose INR was above 2.0 compared to those with an INR of 1.5 - 1.9, with a reduction in both frequency and severity of stroke. There was no increased risk of intracranial bleeding in those with an INR of under 3.9.

Anticoagulation to an INR of 2.0 in those with nonvalvular atrial fibrillation and no contraindications reduces frequency and severity of stroke and saves lives.

References

1. Go AS, Hylek EM, Chang Y, Phillips KA, Henault LE, Capra AM, Jensvold NG, Selby JV, Singer DE. Anticoagulation therapy for stroke prevention in atrial fibrillation: how well do randomized trials translate into clinical practice? *JAMA*. 2003;290(20):2685-92.
2. Hylek EM, Go AS, Chang Y, Jensvold NG, Henault LE, Selby JV, Singer DE. Effect of intensity of oral anticoagulation on stroke severity and mortality in atrial fibrillation. *N Engl J Med. 2003;349(11):1019-26.*

How to Subscribe

To subscribe to the monthly e-mail newsletter, *Notes from the Elder Care Initiative*, subscribe to the *Eldercare* listserv by sending an e-mail to *listserv@listserv.ihs.gov*. In the body of the e-mail write the following: subscribe eldercare your first name your last name. More information is available at *http://www.ihs.gov/cio/listserver/index.cfm*.

Death Pronouncement: Final Medical Act

The following article is another in an ongoing series in support of the development of a unified approach to palliative care services for American Indians and Alaska Natives. The series consists of brief, concise facts and information for providers of palliative care

Judith A. Kitzes, MD, MPH, Soros Foundation, Project on Death In America Faculty Scholar, University of New Mexico Health Science Center, School of Medicine, Albuquerque, New Mexico

Since the Civil War in the United States, physicians have been engaged in "death pronouncement." The phone will ring, and you will hear, "Please come and pronounce this patient."

Preparation

Review the circumstances of the death (expected, or sudden); presence of family; unusual family dynamics; age, diagnosis of patient; status of attending physician notification; appropriateness of an autopsy request or Organ Donor Network contact; preference for spiritual support.

In the Room with Family Present

Bring the nurse or chaplain in to help with introductions. Empathetic statements are appropriate, such as, "I'm sorry for your loss . . .," or "This must be very difficult for you . . .." Explain what you are there to do, and invite the family to stay as long as they want.

Pronouncement tasks

- Identify the patient: hospital ID tag.
- Note the general appearance of the body.
- Ascertain that the patient does not rouse to verbal or tactile stimuli.
- Check for absence of heart sounds, carotid pulse, spontaneous respirations, pupillary light reflex, and position of the pupils.

Medical Record Documentation

- Your name and name of person who called you to pronounce death.
- Physical examination.
- Date and time of death; time of your completed assessment.
- Status of family and attending physician notification.
- Status of autopsy request.
- Coroner notification if required.

Self Care

Allow yourself a few moments to be quiet and still in the presence of death. If needed, debrief with a colleague or friend.

References

1. Marshall SA, Ruedy J. On Call: Principles and protocols. Philadelphia, Saunders.
2. Marchand LR, Kushner KP. Death Pronouncement: survival tips for residents. *American Family Physician*. July 1998. *www.aafp.org/afp/980700ap/rsvoice.html*.
3. Magrane BP, Gilliland MGF, King D. Certification of Death by Family Physicians. *American Family Physician*, 1997;October:1433-8.
4. Weissman, D. Fast Fact and Concepts #04: Death Pronouncement. June, 2000. End-of-Life Physician Education Resource Center: www.eperc.mcw.edu.

Disclaimer

Palliative Care Pearls provides educational information. This information is not medical advice. Health care providers should exercise their own independent clinical judgment.

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 1, No. 11, December 2003) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Emergency Contraception: Pharmacy Access in Albuquerque, New Mexico

Espey E, Ogburn T, Howard D, Qualls C, Ogburn J. *Obstetrics and Gynecology* 2003;102(5):918 - 921

Objective: Emergency contraception could reduce the approximately 3 million unintended pregnancies that occur annually in the United States. Dedicated emergency contraception products may be particularly useful because instructions are easy to understand and simple to follow. However, they must be available within a few days to women who have had unprotected intercourse. The goal of this study was to investigate whether women presenting to pharmacies in a moderately sized metropolitan area with a prescription for Plan B or Preven could get it filled.

Methods: Two research assistants posed as women needing emergency contraception. They visited 89 pharmacies in Albuquerque, New Mexico, presenting a prescription for either Plan B or Preven. The assistants recorded the availability of the products in the pharmacies. When the product was not in stock, the research assistants asked pharmacy providers why the products were not carried. Fisher exact test was performed to compare categoric data.

Results: Plan B and Preven were in stock at only 19 visits (11%). Of the pharmacies that did not stock the products, 53% reported they could obtain Plan B or Preven within 24 hours. The most common reason cited by pharmacy providers for not stocking Plan B or Preven was the lack of prescriptions received for them (65%).

Conclusion: Plan B and Preven were not in stock at the majority of pharmacies in a moderately sized metropolitan area. Lack of availability at the pharmacy constitutes a major barrier to emergency contraception access.

OB/GYN CCC Editorial comment:

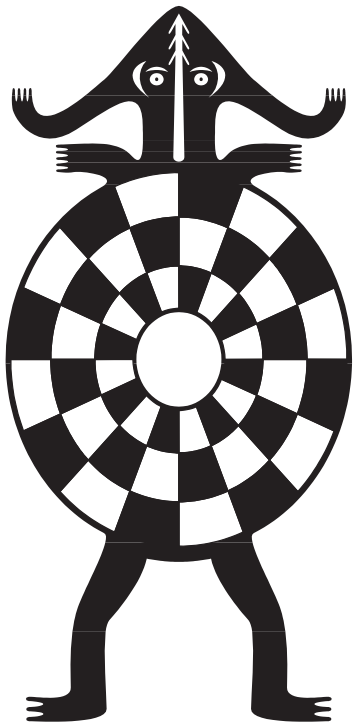
As stated in Chapter 13 of the IHS Manual, the Indian Health system is authorized to provide FDA approved contraceptive methods. The above article suggests that there are access issues in the greater Albuquerque area for the general population. On the other hand, emergency contraception methods are FDA approved and should be readily available to American Indian and Alaska Native patients, nation-wide.

Emergency contraception was a matter of lively discussion in the *Primary Care Discussion Forum* this month. If you want to join the Primary Care Discussion Forum, please contact Jason Crim at *jason.crim@mail.ihs.gov*.

By the way, Drs. Espey and Ogburn are former IHS OB/GYNs who worked at Gallup Indian Medical Center. Both are now on the faculty of the University of New Mexico. They are key contributors to best practices in women's health in Indian Health. Both are regular faculty at the ACOG/IHS OB/GYN Postgraduate Course. In addition, Dr. Ogburn is the ACOG/IHS Postgraduate Course Director.

Other contraception related articles by Drs. Espey and Ogburn include the following:

1. Espey E, Ogburn T, Espey D, Etsitty V. IUD-related knowledge, attitudes and practices among Navajo Area Indian Health Service providers. *Perspect Sex*



Reprod Health. 2003;35(4):169-73.
2. Espey E, Ogburn T. Perpetuating negative attitudes about the intrauterine device: textbooks lag behind the evidence. *Contraception*. 2002;65(6):389-95.
3. Espey E, Steinhart J, Ogburn T, Qualls C. Depo-provera associated with weight gain in Navajo women. *Contraception*. 2000;62(2):55-8.

From your colleagues:

Burt Attico, Phoenix

Emergency Contraception: Semantics is a part of "the game."

ACOG defines pregnancy as beginning at implantation. We also know from the sensitive pregnancy tests and IVF work, that a large percentage of fertilizations do not implant, that they dissolve, and/or spontaneously abort — either way, they terminate spontaneously. That is why 3-5 embryos are routinely inserted (it was 4-8 at one time previously), so that at least one embryo might potentially

implant (and often doesn't). With Plan B, which is only progestin, part of its actions are:

- inhibit ovulation
- changing cervical permeability
- influencing tubal motility
- influence the endometrium

We really don't always know how it works in each case, except for Hatcher's theories on emergency contraception. This is a very controversial subject, with the latest word being that the expert committee voted recently to approve OTC sales of Plan B.

OB/GYN CCC Editorial comment:

Emergency contraception (EC) can prevent a significant number of unintended pregnancies. EC works by a variety of mechanisms. The mechanisms appear to occur in the order listed above, e.g., more common to least common: inhibit ovulation, changing cervical permeability, influencing tubal motility function, and influencing the endometrium. As the medical definition of pregnancy begins with implantation, EC is not an abortifacient.

Clinically, EC is most effective if used within the first 24 hours after unprotected coitus. It is marketed for use up to 72 hours after unprotected coitus, though its effectiveness declines rapidly with time.

By some non-medical definitions, if EC hasn't worked by one of the above three other mechanisms already, then EC could effect implantation. Those who believe that pregnancy begins with fertilization, and have mentioned the evidence that the other mechanisms are more frequent than changing the endometrial lining to the patient, may choose to refer a patient seeking EC to another provider. All providers should be able to present the patient a non-directive informed consent and a facile and timely treatment alternative.

The ethical question, however, is, no matter what your belief system, have you adequately counseled the patient about the four mechanisms, so that the patient can make a non-directed informed consent? We should leave it up to the values of the patient herself as to whether she wants to use EC based on the best information we can offer.

Any comments regarding EC are strictly those of the authors, and not necessarily those of the Indian health system, or the author of this newsletter. If you have any comments, please share them by joining the Primary Care Discussion Forum where this topic was recently discussed.

From Chuck North, Albuquerque

Dr. North raised an issue in the July OB/GYN CCC Corner. Here is an article that was just released on the same topic.

Chaperone Use by Family Physicians During the Collection of a Pap Smear

The use of chaperones during gynecologic examinations remains a controversial issue with no formal guidelines or legal mandates. The topic is poorly addressed by the medical literature and by our current medical education system. No consensus is found among state medical and osteopathic boards on the use of a chaperone. From the legal perspective, the recommendations are nearly unanimous in strongly supporting the use of chaperones. Many questions related to this issue are unanswered. Does chaperone use decrease malpractice claims? Does chaperone use have an impact on clinical efficiency, as the inverse relationship with the volume of Pap smears performed suggests?

What are the regional influences contributing to the geographic variation in reported use of a chaperone? We believe the question with highest priority is, What is the perspective of patients?

Reference

Rockwell P, Steyer T, Ruffin M. Chaperone use by family physicians during the collection of a Pap smear. *Annals of Family Medicine*. 2003;1:218-220.

OB/GYN CCC Editorial comment

After the 2002 Biennial OB/GYN Meeting, there should be no controversy in the Indian health system about the use of chaperones during examinations of the breasts or genitals. It is the standard of care. If your current staffing does not encourage this practice, then your staffing needs to modified accordingly. Please also see the ACOG benchmark statement below.

ACOG's Ethics in Gynecology: Sexual Misconduct in the Practice of Obstetrics and Gynecology: Ethical Considerations

"…The request by either a patient or a physician to have a chaperon present during a physical examination should be accommodated irrespective of the physician's gender . . .. Local practices and expectations differ with regard to the use of chaperons, but the presence of a third person in the examination room can confer benefits for both patient and physician, regardless of the gender of the chaperon . . .."

Clarification: Non clean catch urine sampling terminology

Dr. North wanted to add a clarification to comments in the October OB/GYN CCC Corner and November *IHS Primary Care Provider* about non-clean catch urine specimens obtained in pregnancy. The term "non-clean catch urine" sampling referred to a method of urine collection. A non-clean catch specimen is a urine sample that was not intended to be a clean catch specimen. It is a descriptive term, e.g., fasting versus non-fasting or random blood glucose testing. None of Dr. North's comments were meant to make any implications about the practices of the staff obtaining those types of specimen.

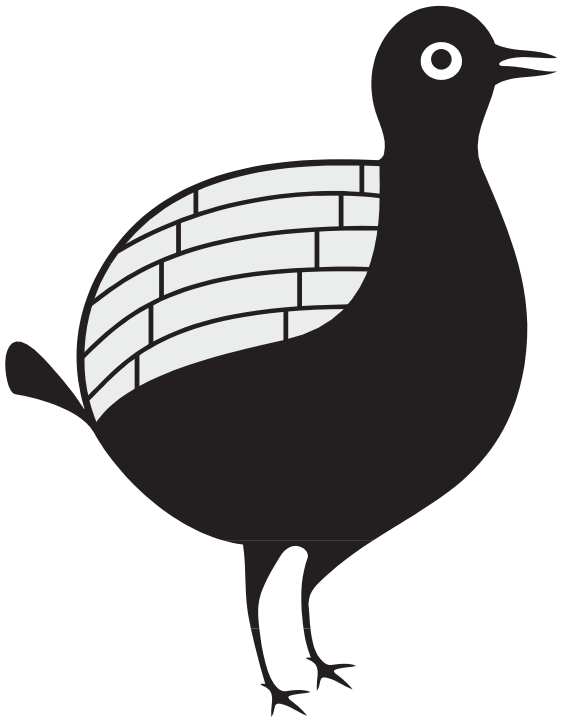
Other items that are available in the full text December 2003 Volume 1, No. 11 at
http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm

From your colleagues:

From Burt Attico and Katy Ciacco Palatianos: Possible methods of preventing cerebral palsy; Chorioamnionitis and Cerebral Palsy in Term and Near-Term Infants.
From Katy Ciacco Palatianos: To settle or not to settle?
From Sandra Dodge: 101 Way to ask someone if they are safe.
From Bruce Finke: The Elder Care Initiative Office Moves East.
From James Galloway and Terry Cullen: Diabetes and Cardiovascular Disease Review.
From Ursula Knoki-Wilson: 'Nurse Run Clinic' models.
From Kelly Moore: New Pediatric Chief Clinical Consultant: Steve Holve, MD.
From Oida Vincent: Are we required to obtain sensitivities on GBBS for PCN allergic patients? Eager for AI/AN applicants to Ph.D. program in the biomedical sciences.

Hot Topics:

Obstetrics: Diabetes mellitus complicating pregnancy; Thrombophilic disorders and fetal loss: a meta-analysis; Screening for Congenital Cardiovascular Malformations; Can Eating More DHA Increase Duration of Pregnancy? Immunity to CMV Reduces Risk of Congenital Infection; Postpartum Depression Linked to Later Violence in Children.
Gynecology: Primary and Secondary Syphilis —- United States, 2002; The 2001 Bethesda System Terminology; Depression in Older Women with Urinary Incontinence; Factors Affecting Accuracy of Mammography Screening; Multidose vs. Single-Dose Therapy in Ectopic Pregnancy; Weekly Therapy Is Effective in Prevention of Osteoporosis; Low-Dose Mifepristone Shrinks Uterine Fibroids; Low BMD Is Associated with Cognitive Decline in Women; Breast Cyst Aspiration.



Child Health: Prophylaxis for Infants of Mothers with Hepatitis B; Evaluation of Bone Mass in Young Female Athletes; Hearing Assessment in Infants and Children; High School Students in BIA Schools: Tobacco, Alcohol, and other Drug Use; Adolescent's level of linguistic acculturation and their well-being.

Features

AFP: POEMS HPV Triage for ASC-US Pap Results Makes Sense; False-Positive Mammograms Do Not Deter Women; Follow-up Mammography Is Low Yield; Oxybutynin or Tolterodine for Overactive Bladder? Iron in Nonanemic, Fatigued Women.

Annals of Family Medicine: Women's Experiences of Abnormal Cervical Cytology: Illness Representations, Care Processes, and Outcomes; Periodic Abstinence From Pap (PAP) Smear Study: Women's Perceptions of Pap Smear Screening; Factors Affecting the Detection Rate of Human Papillomavirus; Cervical Cancer Screening.

ACOG: ACOG Opinion Addresses Elective Cesarean Controversy; Use of progesterone to reduce preterm birth; Dystocia and Augmentation of Labor (ACOG Practice Bulletin).

Breastfeeding: Breastfeeding and Risk for Respiratory Disease in Infants.

Elder Care News: Influenza Vaccination; Anticoagulation with atrial fibrillation.

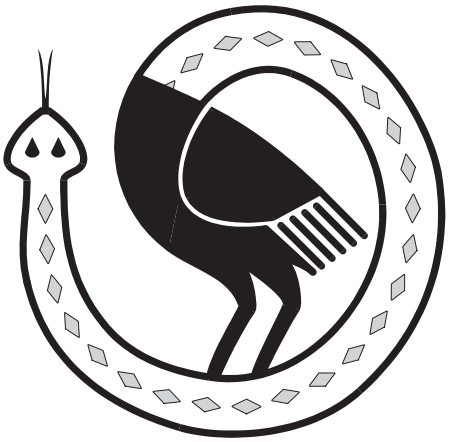
Hormone Replacement Update: Minimizing Menopausal Symptoms; Gabapentin Reduces Hot Flushes; Raloxifene Does Not Affect Sexual Functioning.

International Health: A guide for health professionals working with Aboriginal peoples.

MCH Alert: Postpartum counseling perceptions and practices; Cost estimates for Adolescent pregnancy and adolescent pregnancy prevention; Web site offers one-stop shopping for information about federal grants.

Office of Women's Health, CDC: Women's Health Newsletter, CDC Patient Education; Youth Violence Prevention Through Community-Level Change; Sociocultural and Community Risk and Protective Factors for Child Maltreatment and Youth Violence.

Primary Care Discussion Forum: Cervical Cancer Screening: New Guidelines and New Technologies; Emergency Contraception.



Editor's Note: The following information is brought to our attention by Jean Charles-Azure and Candace Jones from the Nutrition and Dietetics Program. They thought that given the high prevalence and health disparity associated with obesity and overweight among the AI/AN population, this resource was worth sharing widely with I/T/U staff

Case Studies in Disease Prevention and Health Promotion: Assessment and Management of Adult Obesity

Produced with support from the Robert Wood Johnson Foundation, and developed in collaboration with the U.S. Department of Health and Human Services, *Assessment and Management of Adult Obesity* consists of ten booklets that offer practical recommendations for addressing adult obesity in the primary care setting. The primer offers practical advice on:

- evaluating patients for current and potential health risks related to weight – beginning with a measure of the body mass index (BMI);
- understanding medication and surgical options;
- improving communication and counseling; and
- making office environments more accomodating to obese patients.

The booklets are in PDF format, and will require Adobe Reader to view. Clinical Tools and Patient Handouts, which appear throughout the booklets, are also available below, as well as a CME activity.

A Primer For Physicians
Booklet 1 - Introduction and Clinical Considerations
Booklet 2 - Evaluating Your Patients for Overweight or Obesity
Booklet 3 -Assessing Readiness and Making Treatment Decisions
Booklet 4 - Dietary Management
Booklet 5 - Physical Activity Management
Booklet 6 - Pharmacological Management
Booklet 7 - Surgical Management
Booklet 8 - Communication and Counseling Strategies
Booklet 9 - Setting Up the Office Environment
Booklet 10 - Resources for Physicians and Patients

Continuing Medical Education Activity and Program Evaluation Form

Clinical Tools
Assessment of Health Risks
Assessment of Patient Readiness
Treatment Options
The Office Environment

Patient Handouts
Weight Loss Management
Physical Activity and Exercise
Pharmacological and Surgical Management

This 10-booklet primer is also available in print or on CD-ROM and is free of charge from:

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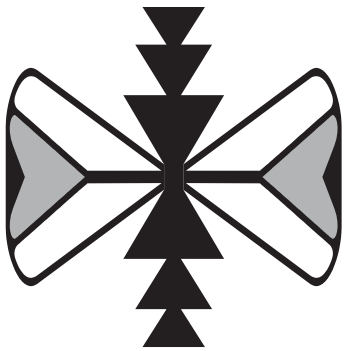
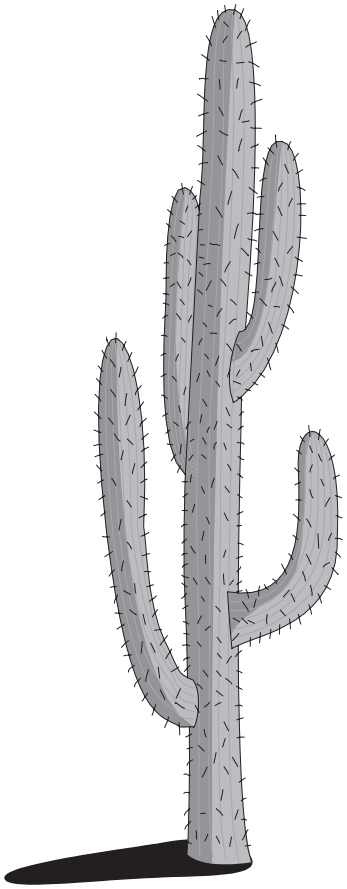


The 9th Annual Elders Issue

The May 2004 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the ninth 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

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

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Circulation: The PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

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

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

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