THE IHS PRIMARY CARE PROVIDER

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

April 2000 **Volume 25, Number 4**

The Future of Indian Health through Legislation: Reauthorization of the Indian Health Care Improvement Act

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The foundation of the Federal government's responsibility for meeting the health needs of American Indians and Alaska Natives is found in two major pieces of legislation: The Snyder Act of 1921 and the Indian Health Care Improvement Act, Public Law 94-437, of 1976.

The Snyder Act authorized regular appropriations of funds for "the relief of distress and conservation of health" of American Indians and Alaska Natives. This act helped to ensure the continuation of improvements in health status that had been made over the previous 75 years, after the Army first treated the Indians for smallpox. The Indian Health Care Improvement Act, like the Snyder Act, was enacted to provide additional guidance and authority for the programs of the Federal government that deliver health services to the Indian population. The PL 94-437 legislation was passed to address long-standing deficiencies in Indian health care related to the number of health professionals serving Indian communities. It also was enacted to address the health needs of Indian people living in urban areas, and to increase access of all Indian people to other government programs that could benefit their health. The Act also focused attention on the need for health facility construction, replacement, and maintenance.

Public Law 94-437 has been reauthorized four times, and is scheduled to expire September 30, at the end of fiscal year 2000. Revising the language of the Act in the last year of the millennium presents an opportunity to remove barriers, increase flexibility for tribal and urban Indian health programs, and to lay the groundwork for eliminating health disparities between the Indian population and the rest of America's citizens.

A Changing World

In the years since the original Act was passed, the world has changed in many ways. One significant change is that the voice of "Indian country" has grown stronger. The expiration of the Indian Health Care Improvement Act provides an opportunity for Indian people to be heard through the legislative process.

In June 1999, the Indian Health Service convened a National Reauthorization Steering Committee composed of representatives from tribes and national Indian organizations to offer recommendations to the Indian Health Service for the reauthorization of the Act. The Committee drafted a legislative proposal that is based on the consensus of recommendations from four regional and numerous local meetings conducted from late 1998 through mid 1999.

In October 1999, the committee finished its work. The final product of the committee was a draft bill entitled, "Proposed Indian Health Care Amendments of 2000." This bill was submitted to the President, the Secretary of Health and Human Services (HHS), to my office, and to each of the authorizing committees in the House and Senate. This is an important and historic document: it is the first time that a Federal agency consulted with tribes and urban Indian program leadership in the initial development of a legislative proposal. It is important that everyone working within the Indian health system become familiar with the issues associated with

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reauthorization and the proposals within the new reauthorization language.

The proposed measure strongly endorses the expectation of Indian people for meaningful inclusion and consultation regarding Indian health activities and the President's commitment to involve tribal governments and Indian people in the decisions that affect them. It emphasizes the President's initiative to eliminate health disparities between America's population groups. The proposal states (new language indicated in italic): "A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians *regardless of where they live* to be raised to the highest possible level *that is no less than that of the general population* and to *provide* for the maximum participation of *Indian tribes, tribal organizations*, *and urban Indian organizations* in the planning, *delivery*, and management of those services." The themes of inclusion and consultation are a continuation of the policy that the President initiated in 1994 and later reaffirmed in a 1998 Executive Order to all Federal departments.

The disparity of health status for American Indians and Alaska Natives has many underlying causes. There are also disparities in access to health services, disparities in political presence, and disparities in opportunities, especially in the areas of education and economic development. There is widespread agreement that the health status of a population improves when there is also economic growth and prosperity. The health of an individual is determined more by where they are on the socioeconomic ladder than any other factor. While the Indian Health Care Improvement Act can authorize only those activities that can offer health benefits for Indian people, it does establish flexibility for entering into partnerships in arenas that can have positive health outcomes.

Disparity of Resources

In the past few years, we have seen unprecedented support by the current administration and the Congress for budget increases for the Indian Health Service. Unfortunately, the unmet health care needs of Indian people remain very large. A recent study by a joint workgroup of tribal, urban Indian, and Indian Health Service leaders examined the gap in health funding for Indian people. The study asked a simple question: What would it cost to assure a mainstream health care benefits package, similar to most employer-sponsored health insurance plans, to Indian people?

The study used actuarial techniques to estimate this cost. By using fiscal terms and concepts that decision makers are familiar with and use every day, the funding of Indian programs can be compared in measurable terms to funding of programs available to other citizens.

It is one thing to cite the statistic that the per capita spending on health for the general population is $3,600 and for Indian people it is $1,650 – that alone supports claims of health disparity. It is another thing to explain what $3,600 provides that $1,650 does not. That is what the Level-of-Need Funding Workgroup study helps define. To provide this benchmark package to only those American Indian and Alaska Natives currently using the Indian Health Service and tribal and urban Indian services would cost approximately $4 billion. The study found that to provide comparable health services to all the Indian population would require approximately $7.5 billion. Information and reports of the Level-of-Need Funding Workgroup are available on the IHS website at *http://www.ihs.gov/Nonmedicalprograms/LNF/*.

In addition, the tribes and Indian health organizations developed a needs-based budget that was presented to HHS as part of the department's overall budget development process. The needs-based budget request for the Indian Health Service estimated that $15 billion is necessary to provide the comprehensive health services that the Federal government intended when it entered into treaties with Indian nations. More than half of this amount would be consumed by one-time costs to modernize and expand the aged and inadequate infrastructure (hospitals, ambulatory clinics, etc.) of the Indian health system. The balance of approximately $7 billion would be needed annually to assure health care services to 1.5 million Indian people and to expand community-oriented programs targeting underlying conditions that contribute to the health disparity of Indians. It is difficult to see how the health disparity for Indians can be eliminated without increasing resources.

Collections and third-party reimbursements are increasingly significant as a source of funding for Indian health programs. In the proposed legislation, the tribes recommend eliminating barriers that currently prevent the Indian Health Service, tribal governments and organizations, and urban Indian health programs from accessing reimbursement from other Federal programs for which their patients are eligible, e.g., Medicaid, Medicare, and the Children's Health Insurance Program (CHIP).

Some specific goals include increasing the ability of the Indian health system to garner reimbursement from other federally funded health care programs, not allowing tribal members to be automatically assigned by a state to a non-Indian managed care health plan, and, when services are provided by an Indian health program, assuring that the full cost will be made available instead of a lesser percentage. The reauthorization language also provides an option for tribes to purchase Federal health and life insurance coverage for their employees.

The proposed legislation also recommends another funding source derived from the authority to combine resources from diverse government programs to focus on a particular health issue. Additional new authorities would allow for the easy transfer of land between Federal agencies for the construction or expansion of health facilities, a revolving loan fund, loan guarantees, and a grant program for loan repayment for construction projects.

The proposed measure also authorizes an Indian Health Service and Tribal Joint Venture Program to provide an avenue for creative and innovative financing by tribes for the construction of health facilities in exchange for a commitment from the Indian Health Service to provide equipment and staffing of the facility. The bill also provides for "other funding," so that the door is open for alternative financing options not usually available to a federal entity like the Indian Health Service.

Obtaining financial resources is an annual activity. Does it

need to remain so? The Indian Health Service budget is a discretionary program funded through the Department of the Interior appropriation process. In the deliberations and public forums conducted by the tribal National Steering Committee, the issue of whether Indian health programs should be an entitlement program instead of a discretionary program was raised – but not resolved. However, the bill does establish a National Bi-Partisan Commission on Indian Health Care Entitlement to explore this issue and its ramifications. The findings would be provided in a report to the tribes and to the Congress.

I foresee three possible outcomes: the Indian Health Service will remain a discretionary program; it will become an entitlement program; or there will be a combination of the two concepts. It is possible that findings may support an entitlement health benefits package that would become part of the recurring base of the Indian Health Service budget, with a discretionary portion of the budget to address the comprehensive, facilities, and public health aspects of the Indian health program.

Disparity Of Access

Delivering health services in Indian country is challenging when there is such a wide disparity in the number of health care workers there compared to the rest of the United States. In Indian country there are 79 percent fewer nurses, 60 percent fewer dentists and 45 percent fewer physicians.

This barrier to access to health care workers can be lowered, not eliminated, by the proposed bill's language addressing scholarships, loans, loan repayment programs, and licensing requirements.

The proposal for loans and scholarships would allow for tribal matching of funds from any tribal source and remove the present restriction that it not include other sources of Federal funds. This revision would allow an Indian Health Service region, with tribal consultation, to set priorities for the professions needed in a local region. In addition, it would direct that the payback time requirements for the scholarship or loan assistance would be performed within the region that provided the assistance.

As for the disparity in the number of health workers in Indian country, the proposed bill language establishes that the licensing requirements for the Indian Health Service would extend to tribal and urban Indian health programs. This means that the individual providing services must have a state license to provide health services but licensure does not need to be in the state where the services are being provided in the tribal, urban, or Indian Health Service facility.

The new bill proposal also addresses issues of access to health programs and the delivery of services. Targeted health activities, such as mammography screening, have been expanded to focus attention on all cancers. The bill also reflects the changes in the health challenges that have occurred since 1976, by expanding the focus on tuberculosis prevention and treatment of all "communicable and infectious diseases," such as AIDS and sexually transmitted diseases.

Especially significant is the authorization for epidemiology centers to be established in each of the 12 Indian Health Service Areas. The Comprehensive School Health Education Programs and the Indian Youth Program have been changed so that funding can be provided to tribal or urban programs throughout the United States for establishing programs in the schools Indian children attend and not just in schools that are run by the Bureau of Indian Affairs.

In the area of diabetes, new language provides authority for the continued funding of the 333 new programs and diabetes projects established as a result of the Balanced Budget Act of 1997, and directs that a national strategy to address diabetes be established.

The single major revision of the proposed bill is Title VII, "Behavioral Health" – a recognition by Indian leadership that many, if not the majority, of our health status issues and problems can be addressed by focusing on helping to promote positive behaviors throughout a community. If we treat the patient and not the family or community, or if we do not think about the consequences of not treating all of the components of that individual's social and health environment, we have made only a temporary health change for that individual. We can intervene and make a difference for some, but many of our patients return to the abusive environment, a community or family in need of positive role models or programs, or an environment of despair due to a lack of access to meaningful opportunities. The new language also integrates alcohol and substance abuse provisions with mental health and social services authorities.

The proposed bill also authorizes at least one youth treatment center for each of the Indian Health Service Areas and two in California (one northern and one southern). The proposal authorizes at least one inpatient psychiatric treatment facility in each of the IHS Areas.

Disparity Of Political Presence

While the voice of Indian country is being heard and listened to as never before, there remains a disparity in political presence. An example of progress in this arena is the recent policy decision by the Secretary of HHS to waive the cost-sharing requirement for parents of American Indian and Alaska Native children to participate in the Children's Health Insurance Program, "CHIP." This decision, which removed an economic barrier, represents the kinds of policy decisions and discussions that are occurring more and more frequently in the department and elsewhere as a result of Indian presence in the decision making process. It is a change from others saying, "Why should we do that?" to "How can we help? How can we assist? How should we do it?"

The increases in the Indian health budget are also the result of greater political presence through more direct tribal and urban program support of, and involvement and participation in the political process. Indian leadership has established open and continuous communication lines regarding Indian issues with members of Congress and with all parts of the administration.

For the past few years, Indian leadership and Indian advocates in Congress have sought to increase the political presence of Indian health in the Federal government by elevating the position of Director of Indian Health Service to Assistant Secretary. The tribes have indicated their strong desire that, should the current elevation bills not receive congressional action, the Indian Health Care Improvement Act

proposal include such a provision.

It is critical to the health of Indian people that a political presence be promoted and maintained. If Indian people do not have a presence on the political stage, their issues will not be addressed, even though they have a legal, moral, and humanitarian basis.

If we do not speak for ourselves, who will ask the question, "How can we?" Without our presence, the questions will revert back to, "Why should we?" We must guard against the "out of sight, out of mind" tendency that can develop when the competing voices for limited resources, time, and attention are louder than ours.

Changes In Health Status and Treatment

In the early 1800s, as the U.S. government continued the nation's expansion westward, the health threat to Army soldiers posed by Indian people ill with the diseases brought by the Army and settlers drew attention, and Army physicians took steps to curb smallpox and other contagious diseases. Even as the federal policies to help improve the health status of Indian people slowly took hold in the mid-1800s, other actions throughout the end of the century and into the next contrasted with those policies. In an effort to assimilate Indian people into the dominant society, many Indian children died while attending Indian boarding schools, because they were physically unable to defend themselves against illness and disease as a result of an impoverished way of life, isolation, and discrimination. The poor condition of their bodies, to be sure, was not helped by the forced exclusion of their tribal heritage, culture, and language from their daily life at their school. There were other attempts at assimilation and termination of treaty rights and tribal recognition, with equally tragic results for many families and generations.

As a people, we have survived. At one time our families were 10 million strong, eventually dwindling to less than a million. Today we are 2 million.

As a nation, we have a long way to go. We cannot change the past. However, we have the opportunity to change the future. The proposed reauthorization language will take us further along the road of honoring treaties and eliminating health disparities between the original people of this land and the rest of the population.

Editor's Note: This article was condensed from the article "IHS Works In Significantly Changed World," published in U.S. Medicine, February 2000. A complete copy of the article is available from the IHS website at http://www.ihs.gov *under the "Director's Statements" section of the "Press and Publications" home page.* □

Speaking With One Voice: Reauthorization of the Indian Health Care Improvement Act, PL 94-437

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Dr. Trujillo's article in this month's IHS Provider, "The Future of Indian Health through Legislation: Reauthorization of the Indian Health Care Improvement Act," discusses the many challenges faced by Indian health programs in light of the disparities in health status, resources, and access to health services. The article also touches upon the disparity of political presence related to Indian health issues. Indian tribes and urban programs have attained a greater political standing by working to maintain relationships with congressional members and staff and with all segments of the administration. However, it is important that everyone working in a tribal or urban program get involved and participate in the next steps of the legislative process necessary to enact the proposed amendments to the Indian Health Care Improvement Act (IHCIA).

The IHS supported a process of national consultation that examined the existing Indian Health Care Improvement Act and sought consensus on potential changes to the law. Dr. Trujillo felt strongly that every Indian health program, regardless of size or location, needed to be involved in this consultation process, as the existing law and any proposed changes would affect every tribal or urban program. The theme of this consultation was "Speaking With One Voice," and was chosen to reflect the consensus approach and the participation of the Indian Health Service, tribes, and urban programs (I/T/U) as partners in the process. This was a time consuming and complex undertaking. The product of the consultation, "Proposed IHCIA Amendments of 2000," was a 183 page draft bill (dated 10/6/99) submitted to various congressional committees, to Dr. Trujillo, and to the administration.

We are presently in the second session of the 106th Congress. The House Committee on Resources has introduced HR 3397, "The Indian Health Care Improvement Act Amendments of 2000," which is almost identical to the tribal

draft legislative proposal. The Senate Committee on Indian Affairs has not yet introduced its reauthorization bill, but plans to do so after the Congressional Budget Office has completed scoring the House bill for its anticipated cost. The committee anticipates the scoring of the proposed bill and its introduction by late April. While the Senate Committee on Indian Affairs held a hearing on the tribal draft on March 8th, the House Committee on Resources has yet to schedule hearings on the bill. The House committee anticipates a possible field hearing in late spring or early summer. As this is a Presidential and congressional election year, this session will be short, with a priority for completion of the annual appropriation bills. Hence, it will be difficult to accomplish passage of a reauthorization bill during the current session. It is important to note that while the above mentioned committees are the primary committees with jurisdiction for the reauthorization bill, this authority is shared with the Senate Finance Committee and the House Committees on Commerce and Ways and Means. This jurisdictional structure also makes it difficult to move legislation in an expeditious manner.

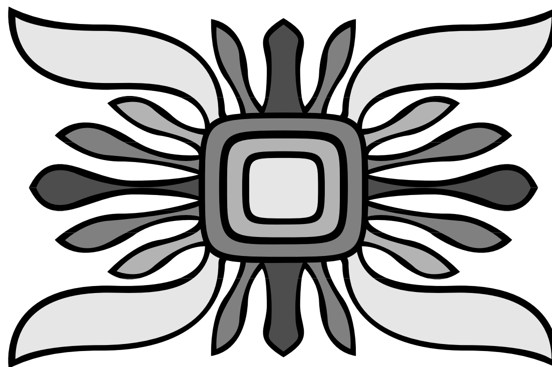
As noted above, while the Senate has not introduced a reauthorization bill, the Senate Committee on Indian Affairs held a hearing on March 8, 2000 to discuss the consultation process and the tribal draft bill previously mentioned. Witnesses testifying at this hearing included Dr. Trujillo, Director, Indian Health Service; Rachel Joseph, co-chair of the National Steering Committee; Richard Narcia, Lieutenant Governor of the Gila River Indian Community; Sally Smith, chair of the National Indian Health Board, and National Steering Committee member; Tex Hall, Chairman, Three Affiliated Tribes, and National Steering Committee member; and Kay Culbertson, President of the National Council of Urban Indian Health. To obtain a copy of the testimony of the witnesses, please contact Michael Mahsetky at (301) 443-7261 or Kitty Rogers at (602) 364-7777.

There is much work that can be done to help the legislative process to move forward with the proposed amendments to the Indian Health Care Improvement Act. Anyone working in an I/T/U setting can become actively involved in several areas. Two early steps in the consultation process were the selection of IHS representatives from each of the twelve IHS Areas and the formation of a National Steering Committee composed of elected tribal leaders and urban Indian health providers (see attached list). These individuals would be excellent contacts for additional information about Area-specific or national issues associated with the consultation process.

Begin by becoming knowledgeable about the proposed amendments to the IHCIA. Read the tribal draft bill (available on the IHS home page). You can also request a copy of the tribal draft bill from the IHS Clinical Support Center. This document includes a comment column that explains the proposed changes in language that is easy to understand. Get a copy of the House bill HR 3397 and become familiar with its contents and layout (the language is identical to the tribal draft bill).

As Federal employees you have the right to write to or otherwise contact your congressional representatives to express your support or share your views on the reauthorization of the Indian Health Care Improvement Act, as well as to show support for congressional hearings on this important legislation. These types of communication must be conducted on your own personal time and at your own expense for postage or telephone calls, to avoid violation of the antilobbying provisions in the Hatch Act.

It will be through working together and "speaking with one voice" that the I/T/U will see the proposed changes to the existing Indian Health Care Improvement Act become a reality. The tribal draft proposal is the voice of Indian country and its expression of support for a reauthorization bill that they believe will reduce the health disparities and assure a healthier future for American Indians and Alaska Natives. □



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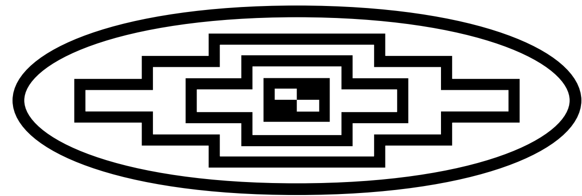

Nutrition Intervention in a Cardiovascular Risk Reduction Clinic

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Coronary artery disease (CAD) is one of the leading causes of death in American Indians over the age 45.[1] Intervention to reduce the risks of CAD by preventing or delaying further cardiac occurrences is the goal of the Native American Cardiovascular Risk Reduction Program (CVRRP) at the Santa Fe Indian Hospital. The CVRRP approach utilizes a multidisciplinary team, which includes a registered dietitian. Dietary intervention is an important component in the management and/or treatment of these high risk individuals. The American Heart Association (AHA) and the National Cholesterol Education Program (NCEP) recognize medical nutrition therapy as essential for the treatment of hyperlipidemia.[2] The two diets recommended for use in this situation are the so called “Step 1” and “Step 2” diets.

Estimating an individual's usual dietary nutrient intake is difficult. Yet assessment of dietary data is critical when investigating the relationship between diet and disease. Various methods for collecting food intake data are available. However, no single best method or “gold standard” exists. The need for an easy and accurate assessment tool to measure dietary fat intake in our patients was necessary. Moreover, including traditional foods in this assessment tool was also essential.

A number of Indian health and private sector cardiovascular programs were consulted about the assessment tools they used to measure dietary fat intake. Several reliable methods were suggested, but they all required using computer software and were therefore problematic for field use. The MEDFICTS, an assessment tool used to assess adherence to Step 1 and 2 diets, was recommended.

The MEDFICTS was adapted from a questionnaire called MEDICS, developed to assist physicians in gathering information about a patient’s dietary intake of fat and cholesterol.[2] It is a validated tool that lists food categories that comprise the major contributors to fat and cholesterol intake. This assessment tool uses a scoring system to assess adherence to Step 1 and 2 diets, but the scores do not equate to the number of fat grams consumed. Therefore, our clinic adapted the tool by expanding the categories to include regional and traditional foods and by listing the number of fat grams per standard

FAT INTAKE ASSESSMENT

Patient Name/ID: ______________________ Date: ______________

CATAGORY	A	B	C	D	E
MEAT	Portion size	Fat grams per portion	Amt. pt. eats	# times per wk	Weekly total (Multiply B*C*D)
Bacon, broiled/pan fried	1 med slice	3			
Brisket	1 oz	9			
Chicken, breast with skin, fried/baked	3.5 oz	9/8			
Chicken breast, w/out skin, fried/baked	3 oz	4/3			
Corned beef, canned, cured	1 oz	5			
Fish sticks, 4" x 2" x ½ "	1 stick	4			
Ground beef, baked or broiled	1 oz	6			
Ham, cured, regular	1 oz	3			
Hot dog, beef, 2 oz, regular/low fat	1 wiener	16/8			
Lamb, loin chop, broiled	3.5 oz	23			
Lunch meats					
Bologna, beef, 1 oz, regular/low fat	1 slice	8/4			
Ham, 1 oz, regular/lean	1 slice	3/1			
Meat loaf	1 oz	3			
Pork, center loin, broiled	1 oz	6			
Ribs, beef, whole, roasted or broiled	1 oz	9			
Roasted beef, chuck blade	1 oz	9			
Sausage					
Beef	1 oz	8			
Pork	1 link	4			
Steak, T-bone	1 oz	7			
				Total:	
EGGS	Portion size	Fat grams per portion	Amt. pt. eats	# times per wk	Weekly total (Multiply B*C*D)
Boiled	1 large egg	5			
Fried	1 large egg	7			
Poached	1 large egg	5			
Scrambled with milk	1 large egg	7			
White, from large egg	1	0			
Yolk, from large egg	1	5			
				Total:	
FRIED FOODS AND HIGH FAT SNACKS	Portion size	Fat grams per portion	Amt. pt eats	# times per wk	Weekly total (Multiply B*C*D)
Candy *(Hershey's milk chocolate bar)*	1.65 oz	15			
Chips *(potato, corn, cheese puffs)*	1 oz	10			
Crackers *(Club, Ritz, Cheddar, etc.)*	1 oz	7			
French Fries, fast food, small/med/large	1 order	12/17/22			
Fried Potatoes, homemade					
Nuts, mixed, dry roasted	1 oz	15			
Onion Rings, fast food	8-9 rings	16			
Pinon nuts	1 oz	17			
Popcorn, microwave, butter or original	3 ½ cup	11			
Snack mix, Chex	2/3 c (1 oz)	5			
Sunflower seeds, dry roasted	1 oz	15			
				Total:	

CATEGORY:	A	B	C	D	E
DAIRY	Portion size	Fat grams per portion	Amt. pt eats	# times per wk	Weekly total (Multiply B*C*D)
Cheese					
American, processed	1 oz	9			
Blue	1 oz	8			
Cheddar, Colby, Monterey	1 oz	9			
Cottage, low fat, 1% / 2%	1 cup	2/4			
Mozzarella	1 oz	6			
Mozzarella, part skim	1 oz	5			
Coffee Creamer					
Cream, 25% fat	1 Tbsp	4			
Half & half or flavored	1 Tbsp	2			
Non-dairy, liquid or powdered	1 Tbsp	1			
Ice Cream					
Premium (Haagen Daz)	½ cup	14			
Regular	½ cup	7			
Milk					
Evaporated, canned, whole	½ cup	7			
Low fat, 1% / 2%	1 cup	3/5			
Whole, 3/3%	1 cup	8			
Whole, dry	¼ cup	9			
Milk Shake					
Chocolate	10 oz	11			
Vanilla	10 oz	9			
Yogurt					
Low fat/Whole	8 oz	4/7			
				Total:	
BUTTER, SPREADS, AND DRESSINGS	Portion size	Fat grams per portion	Amt. pt eats	# times per wk	Weekly total (Multiply B*C*D)
Cream Cheese	1 oz (2 T)	10			
Butter	1 Tbsp	12			
Margarine					
Corn or safflower, tub or stick	1 Tbsp	11			
Shedd's Spread, Country Crock	1 Tbsp	7			
Mayonnaise/Miracle Whip	1 Tbsp	11/7			
Oil, corn or vegetable	1 Tbsp	14			
Peanut Butter	1 Tbsp	8			
Salad Dressing					
Italian/Reduced Cal	1 Tbsp	7/3			
Ranch/Reduced Cal	1 Tbsp	9/5			
Thousand Island/Reduced Cal	1 Tbsp	6/2			
Vinegar and Oil	1 Tbsp	8			
Sour Cream	1 Tbsp	3			
				Total:	
HIGH FAT BREAD PRODUCTS	Portion size	Fat grams per portion	Amt. pt eats	# times per wk	Weekly total (Multiply B*C*D)
Biscuits, KFC, 2 oz	1 biscuit	10			
Cornbread, made w/ whole milk, 1 piece	2½" x 1½"	5			
Croissant, plain	2 oz	12			
Fry bread, 5" diameter	1 piece	10			
Indian bread, white	1 slice	3			
Pancake, homemade, 4 " diameter	1 pancake	4			
Tortilla, flour, 9 ½" diameter	1 tortilla	4			
				Total:	

CATEGORY:	A	B	C	D	E
BAKED GOODS AND DESSERTS	Portion size	Fat grams per portion	Amt. pt eats	# times per wk	Weekly total (Multiply B*C*D)
Cake, from mix	1/12 of cake	11			
Cookies, Oreo, oat raisin, or choc chip	2-3 cookies	7			
Doughnut, cake, glazed	1 (1.5 oz)	10			
Doughnut, yeast, filled with cream	1 (3 oz)	21			
Muffin, from mix, or homemade	1 (2 oz)	6			
Pie, homemade					
Fruit	1/8 of 9" pie	19			
Cream	1/8 of 9" pie	21			
Pop tart	1 pastry	5			
Sweet roll, cinnamon	1 (2.5 oz)	15			
				Total:	
ENTREES	Portion size	Fat grams per portion	Amt. pt. eats	# times per wk	Weekly total (Multiply B*C*D)
Beans, pinto, prepared with lard	1 cup	4			
Burrito (approx. ½ cup filling)					
Bean and cheese	1 item	15			
Eggs (2), bacon, cheese	1 item	33			
Egg, bacon, fried potato, cheese	1 item	37			
Egg, fried potato, cheese	1 item	31			
Eggs (2), sausage, cheese	1 item	35			
Chile, canned	1 cup	23			
Enchilada (with 3 fried corn tortillas)					
Beef (3 oz) and cheese (3 oz)	1 item	61			
Cheese (3 oz)	1 item	43			
Chicken (3 oz) and cheese (3 oz)	1 item	49			
Fast Food					
Hamburger Helper/Tuna Helper	1 cup	13/15			
Lasagna, 7.5 oz serving (1 c)	1 cup	16			
Macaroni and cheese, from mix, Kraft	1 cup	17			
Oriental Food					
Beef pepper steak	11.5 oz	13			
Chicken chow mein	1 cup	13			
Egg roll, beef/pork, 2.25 oz	1 roll	6			
Kung pao pork	1 cup	33			
Pizza, cheese, deep dish	3.8 oz slice	11			
Posole, prepared with pork	1 cup	3			
Pot Pie, beef or chicken	7 oz	19			
Ramen Noodles, beef or chicken	1 packet	11			
Soup, canned, condensed					
Cream of chicken (w/ milk/water)	1 cup	12/7			
Cream of mushroom (milk/water)	1 cup	14/9			
Tomato (milk/water)	1 cup	6/2			
Stew, beef with vegetable	1 cup	14			
Tamale	2.5 oz	10			
				Total:	

Sources: Nutritionist IV Diet Analysis Software
Pennington, Jean A. T., Bowes and Church's *Food Values of Portions Commonly Used*, 17th ed., 1998
Wolfe, Wendy S., et al., Use and Nutrient Composition of Traditional Navajo Foods. *Ecology of Food and Nutrition*, Vol. 17, pp. 323-344,1985

COMBINED WEEKLY TOTAL: ____________

portion for all items. Local recipes were gathered and analyzed using Nutritionist IV and various other methods. By determining weekly menus and portion amounts consumed at each meal, one is able to assess weekly dietary fat intake. Total grams of fat taken in are evaluated to determine the percentage of calories consumed as fat, and this is compared to NCEP guidelines.[2]

This fat intake assessment, as modified from MEDFICTS, is used during the initial patient visit with the CVRRP dietitian, to determine a dietary baseline and to plan interventions; it is used again during the course of dietary interventions to measure change. The assessment takes about 20 minutes. Food models are used to illustrate portion sizes for patients.

This fat intake assessment tool is now in use with other patients outside of the CVRRP, and can be easily modified to include any new food product. The method assures a more accurate representation of dietary fat consumption in our population, and aids in personalizing an effective dietary treatment plan.

References

1. *Trends in Indian Health. U.S. Department of Health and Human Services. Indian Health Service:1997*
2. *Kris-Etherton P, Burns JH, Eissenstat B. Cardiovascular Nutrition: Strategies and tools for disease management and prevention. American Dietetic Association; 1998* □

LETTER TO THE EDITOR □

Obtaining an MPH by Distance Education

Editor:

I would like to let readers of The IHS Provider know that they can now receive education in the field of public health and/or a master of public health (MPH) degree without leaving the service unit at which they serve.

The mission of the Indian Health Service is to provide health care services and improve the overall public health of the American Indians and Alaska Natives. The skills to practice quality public health medicine are not universally available at all IHS, urban, and tribal health care sites.

Public health skills include the following:

- The ability to assess disease outbreaks.
- The ability to assess potential causality of disease processes.
- The ability to intelligently review health statistics and literature.
- The ability to structure a research plan to appropriately answer public health questions.
- The ability to develop and enhance interactions effectively in cross-cultural settings.
- Skills in policy development, program planning, legislation, and ethics.
- Enhanced communication skills allowing organization and facilitation of community collaboration.
- Budget and personnel management skills.

Public health skills are taught in master of public health programs. Until recently access to such course work has been limited by geography and distance, precluding most IHS providers from participating unless they left their service unit; one solution is identification of distance learning opportunities.

The University of South Florida, College of Public Health, (USF-COPH) was the first accredited school of public health to offer a 100% Internet-based or satellite-based MPH program (except for the last two-week course, which must be accomplished on campus in Tampa, Florida). In an effort to both improve patient care and promote professional staff retention, the Ft. Peck Service Unit in Poplar, Montana allowed interested providers to participate in this program during the last two semesters. The courses are made available through a cooperative agreement between USF-COPH, and Ft. Peck Community Tribal College.

Currently, the courses are available only within the state of Florida, at three CDC sites in the continental USA, at Ft. Peck, Montana, and at two sites in the countries of Belize and Venezuela. However, access to the program could easily be extended to other IHS, tribal, or urban program sites if similar cooperative agreements could be established with USF-COPH. Access to and participation in public health educational opportunities affords Indian health care providers in all professions the abilities to improve the care and services they are able to offer their patients.

For more information, contact Kimberlee Blevins, MPH, at the Office of Distance Learning, University of South Florida, College of Public Health; e-mail *kblevins@hsc.usf.edu;* telephone (813) 974-6666; or Roman Hendrickson, MD, at FPSU, Poplar, Montana; e-mail *rhendrickson@bilb2.billings.his.gov;* telephone (406) 768-3451.

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Improving Your Claims Process Electronically

Art Gonzales, Contract Project Officer, Computer/Health Systems Specialist, IHS Headquarters West, Albuquerque, New Mexico

The Indian Health Service (IHS) has an urgent need, from a fiscal standpoint, to implement an electronic data interchange to support revenue generation efforts for health care services across the country. As sites develop an increasing reliance on third part collections, any process to improve these processes will benefit local sites. Attempts to streamline the eligibility, billing, and claims processes will improve local revenue generation, and, ultimately, patient care. The information technology support center (ITSC) has recognized this need for the last few years. As a response to this need, the IHS can now use ENVOY electronic commerce products, available through the ENVOY-VA contract to assist in these efforts.

ENVOY products to support the following transactions are included in the contract:

- Eligibility Verification
- Electronic Remittance Advice Services
- Claim Generation, including UB92 Electronic Claim Generation, HCFA 1500 Print Image Generation, and NCPDP Real-Time Pharmacy Claims

There are currently 14 Task Orders from various sites, and several more have expressed interest in ENVOY products. The Gallup Indian Medical Center is the test site for integrating all the services and products that ENVOY offers under the contract.

Eligibility Verification

ENVOY's VeriQuest product is an integrated eligibility verification tool. It automatically captures eligibility data and verifies it without manual intervention, then either prints confirmation or uploads the information to the patient registration and financial systems.

VeriQuest is interfaced to each hospital's patient registration system to generate eligibility verification requests, triggered when each patient is keyed into the registration system. The system will automatically generate the request and print responses. Depending upon the eligibility database being queried, responses may be immediate or, due to processing capabilities of the payer's system, may be returned at a later time.

Remittance Advice Services

ENVOY's Diversified System Software (DSS) handles remittance information, supplemental billing, and conflict checking. DSS will allow IHS hospitals to receive electronic remittances and post them to the RPMS system. If desired, the system can then automatically generate secondary billing and check for 72 hour conflict for Medicare claims. ENVOY and the IHS Division of Information Resources are also exploring the Internet and its potential to facilitate the transaction process.

Claims

ENVOY provides several standard claims reports, including the following:

- Daily Reports: including Submitter Summary, Provider Statistics, Provider Summary, and Acceptance Report by Provider
- Monthly Reports: Submitter Summary and Provider Summary
- Claim Status Exception Reports: Daily Management Summary, Unprocessed Claims, Zero Payment, Claims Settlement, Request for Additional Information, and Claim Status Check

Because ENVOY does not have complete connectivity to all Medicare, Medicaid, and Blue Cross Blue Shield plans for both UB92s and HCFA 1500s, the Division of Information Resources also offers claims connectivity through its business partner, ECS. IHS, tribal and urban program sites may opt to use the ECS system rather than ENVOY should their connectivity needs warrant a claims capture system and connectivity to ECS payers.

Software Training and Support

ENVOY is responsible for maintaining the software's performance, operability, and integration with RPMS systems. ENVOY staff will provide customer support, Help Desk services, and training on both the VeriQuest and DSS products.

Need More Information?

To get more information about this project, please contact Art Gonzales at telephone (505) 248-4192; or e-mail *arthur.gonzales@mail.ihs.gov.* □

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The Provider is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; Fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov*. Previous issues of The Provider (beginning with the February 1994 issue) can be found at the CSC home page, *www.csc.ihs.gov*.

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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 and nursing 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.

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