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Well Elder's Clinic: A Model for Indian Country

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"Look upon the faces of our elders with humility. They do not have to lecture or teach to impart the energy of the creator to those who seek it." — Crosslin Smith, Traditional Healer, National Indian Council on Aging (NICOA) 2000

Introduction

The challenge of integrating preventive and early disease identification strategies into the routine care of elders caused us to implement a multidisciplinary clinic for "well elders" at the Fort Peck Service Unit, which began in February 2000.

As better clinical information emerges and advances in diagnosis and treatment occur related to geriatric care, primary care providers are called upon to offer increased amounts of preventive services, early disease identification, screening, and health education to our elders. In the conventional and customary episodic care model, preventive services sometimes suffer in all age groups, and sometimes only acute and previously diagnosed chronic problems may be addressed. Primary care providers from varying backgrounds may have significant differences in their emphasis on, belief in, or understanding of the need for preventive services for elders. Inconsistent geriatric skills among providers may also act as a variable when trying to assure consistent geriatric care.

Our Well Elders Clinic was modeled loosely on the successful Well Child Clinic in place at our Indian Health Service facility in Fort Peck, Montana. The process that evolved sought to target common geriatric problems or syndromes and those health conditions for which evidence-based guidelines have been generated. Where possible we incorporated existing, commonly employed, validated geriatric screening instruments. Utilizing a designated "Well Elders Nurse," appointments with a physician and other health disciplines are coordinated. Standardized Patient Care Component (PCC) overprints are utilized to document the results of the physician encounter.

The Process

The Elders Clinic nurse calls each elder in advance to discuss what the clinic will offer them and schedules them accordingly. This may include assisting them to arrange transportation if necessary. Well Elders Clinics are scheduled in our Poplar, Montana facility on Thursday mornings, and on Wednesday mornings in our Wolf Point Clinic. This scheduling allows the clinics to be scheduled simultaneously with our Well Child Clinics. At these times, multiple disciplines are available to participate, including Dental, Optometry, Audiology, Podiatry, Exercise Physiology, Dietary, Laboratory, and Public Health Nursing. Scheduling of appointments with the other disciplines is coordinated with the elders, but may not necessarily occur on the same day, depending on appointment availability and the desires of the elder. Most elders seem to prefer not to spend more than two to three hours at the clinic at any one time.

The clinic is open to all elder patients, but priority is given to those over 65 and those age 55 and over with significant chronic disease. The clinic's goal is to offer all elders at least one evaluation every year.

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Patients are scheduled every 45 minutes, with a total of 5 openings per clinic, per provider. This schedule should allow the service unit to offer an annual evaluation to all individuals over age 60. Currently only one provider, who is board certified in Geriatrics, offers the preponderance of care to the patients in the Well Elders Clinic. Patient choice of provider is, however, honored when possible.

A standardized overprinted "Geriatric PCC" is utilized for documentation (see Figure 1). A "Functional Assessment PCC" (see Figure 2), and a "Mental Status PCC" (Figure 3), are also completed by the provider during the patient encounter.

Laboratory tests performed on each patient include a complete blood count, chemistry profile, urinalysis, thyroid stimulating hormone level, lipid profile, vitamin B-12 level, and prostate specific antigen (PSA) in men. Laboratory studies are not performed if they have been done in the preceding 12 months, unless some other indications to do them exist. A resting 12-lead EKG (electrocardiogram) is also done unless one has been performed in the preceeding 12 months

The findings of the evaluation are discussed with the patient, or with family if the elder so prefers. Changes in medications or therapies are reviewed, and appropriate follow up is scheduled. Referrals are made based on indications for mammography (up to age 70), bone densitometry, diabetes team, cardiac rehabilitation, physical therapy, and other providers.

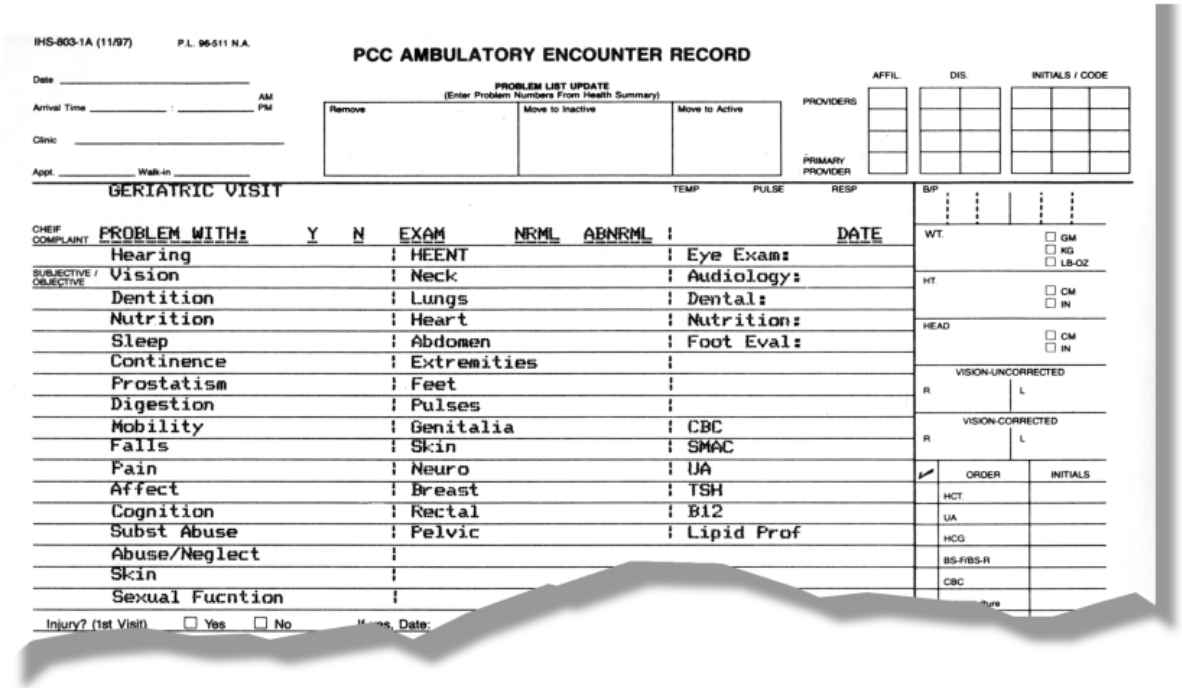
Preliminary Impressions

After the first six months of offering our Well Elders Clinic, we have seen slightly more than 50 patients. The most difficult problem encountered has been to convince the elders of the benefits that this clinic has to offer them. More than 65% of those elders contacted have refused the offer of an appointment. Many elders have for their entire life been exposed only to episodic care, with the exception of the females who have received Papanicolaou smears and breast exams. The concept of a preventive visit is a new and untested issue for the elders of our service unit. Yet, of those elders who did schedule a visit, the average length of time since they had last seen a provider was only 40 days (range 6 to 3144 days).

Despite the fact that generally our elders have been seen frequently by providers (averaging more than 10 encounters per year), and that in the recent past, a substantial number of new diagnoses had been added and/or changes in medications or therapy had been made, over 70% of the patients evaluated through the clinic had a new diagnosis of a chronic problem or condition added. Likewise more than 70% of patients seen through the clinic have had their medications modified. The most common new diagnoses made, in order of frequency, were the following: balance disorders including parkinsonism, benign prostatic hypertrophy, urinary incontinence, affective disorders, osteoporosis, hearing or visual complaints, dementia, and dental problems.

System issues identified thus far include the following: a need for funding for a dedicated clinic coordinator and case manager, an enhanced database other than the RPMS (Resource and Patient Management System) now in use, a significant need for expanded funding for and availability of dentures for the elderly, and a need for expanded, barrier-free housing and assisted living facilities for elders in our community.

Although our numbers are small and our data are not statistically significant, there are some important lessons that can be gleaned from our preliminary experiences. We are anxious to hear from any other sites in Indian Country that have implemented similar approaches.



IHS-803-1A (11/97) P.L. 96-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date _____

Arrival Time _____ : _____ AM PM

Clinic _____

Appt. _____ Walk-in _____

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)

Remove	Move to Inactive	Move to Active

	AFFIL.	DIS.	INITIALS / CODE
PROVIDERS			
PRIMARY PROVIDER			

GERIATRIC VISIT

TEMP PULSE RESP B/P

CHEIF COMPLAINT	PROBLEM WITH:	Y	N	EXAM	NRML	ABNRML		DATE
	Hearing			HEENT			Eye Exam:	
SUBJECTIVE / OBJECTIVE	Vision			Neck			Audiology:	
	Dentition			Lungs			Dental:	
	Nutrition			Heart			Nutrition:	
	Sleep			Abdomen			Foot Eval:	
	Continence			Extremities				
	Prostatism			Feet				
	Digestion			Pulses				
	Mobility			Genitalia			CBC	
	Falls			Skin			SMAC	
	Pain			Neuro			UA	
	Affect			Breast			TSH	
	Cognition			Rectal			B12	
	Subst Abuse			Pelvic			Lipid Prof	
	Abuse/Neglect							
	Skin							
	Sexual Fucntion							

WT. ☐ GM ☐ KG ☐ LB-OZ

HT. ☐ CM ☐ IN

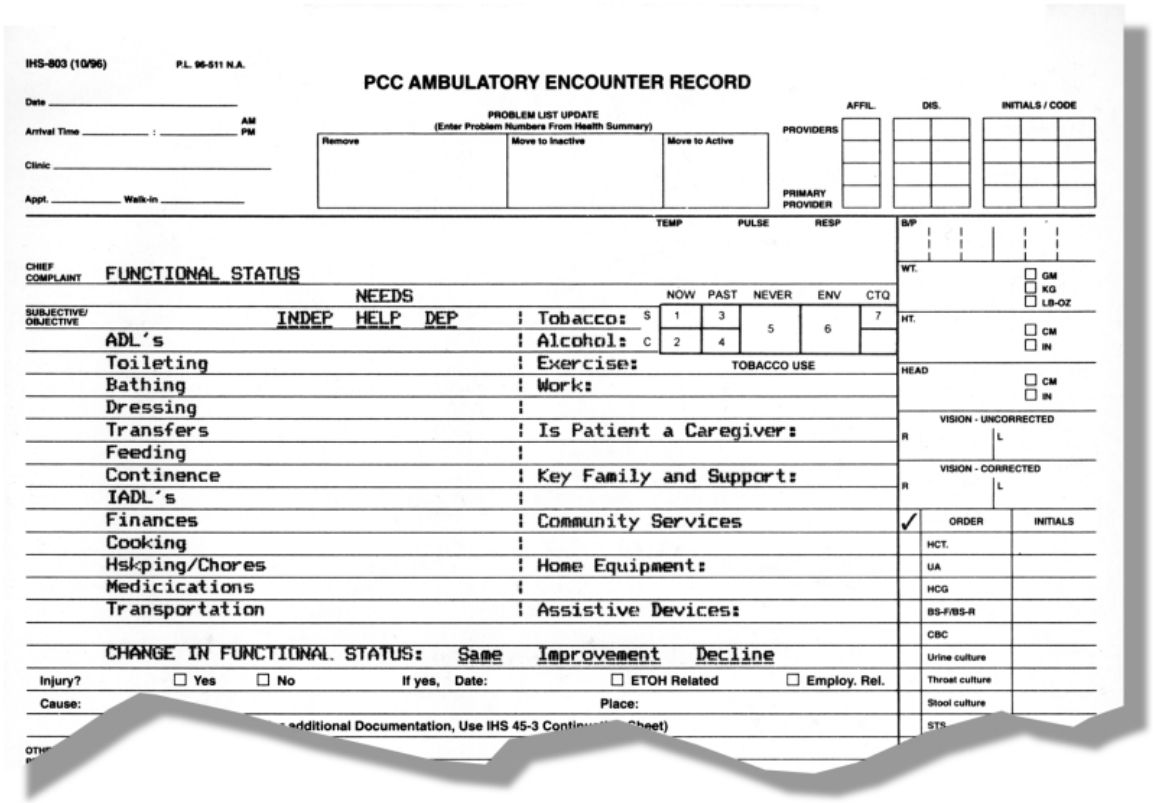
HEAD ☐ CM ☐ IN

VISION-UNCORRECTED R L

VISION-CORRECTED R L

✓	ORDER	INITIALS
	HCT	
	UA	
	HCG	
	BS-F/BS-R	
	CBC	

Injury? (1st Visit) ☐ Yes ☐ No If yes, Date:



IHS-803 (10/96) P.L. 96-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date _____
Arrival Time _____ : _____ AM PM
Clinic _____
Appt. _____ Walk-in _____

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)

Remove	Move to Inactive	Move to Active

AFFIL. DIS. INITIALS / CODE
PROVIDERS
PRIMARY PROVIDER

TEMP PULSE RESP B/P

CHIEF COMPLAINT: FUNCTIONAL STATUS

SUBJECTIVE/ OBJECTIVE

NEEDS

	INDEP	HELP	DEP
ADL's			
Toileting			
Bathing			
Dressing			
Transfers			
Feeding			
Continence			
IADL's			
Finances			
Cooking			
Hsk̶ping/Chores			
Medications			
Transportation			

Tobacco: S
Alcohol: C
Exercise:
Work:

NOW	PAST	NEVER	ENV	CTQ
1	3	5	6	7
2	4			

TOBACCO USE

Is Patient a Caregiver:

Key Family and Support:

Community Services

Home Equipment:

Assistive Devices:

CHANGE IN FUNCTIONAL STATUS: Same Improvement Decline

Injury? ☐ Yes ☐ No If yes, Date: ☐ ETOH Related ☐ Employ. Rel.

Cause: Place:

additional Documentation, Use IHS 45-3 Continu... Sheet)

WT. ☐ GM ☐ KG ☐ LB-OZ

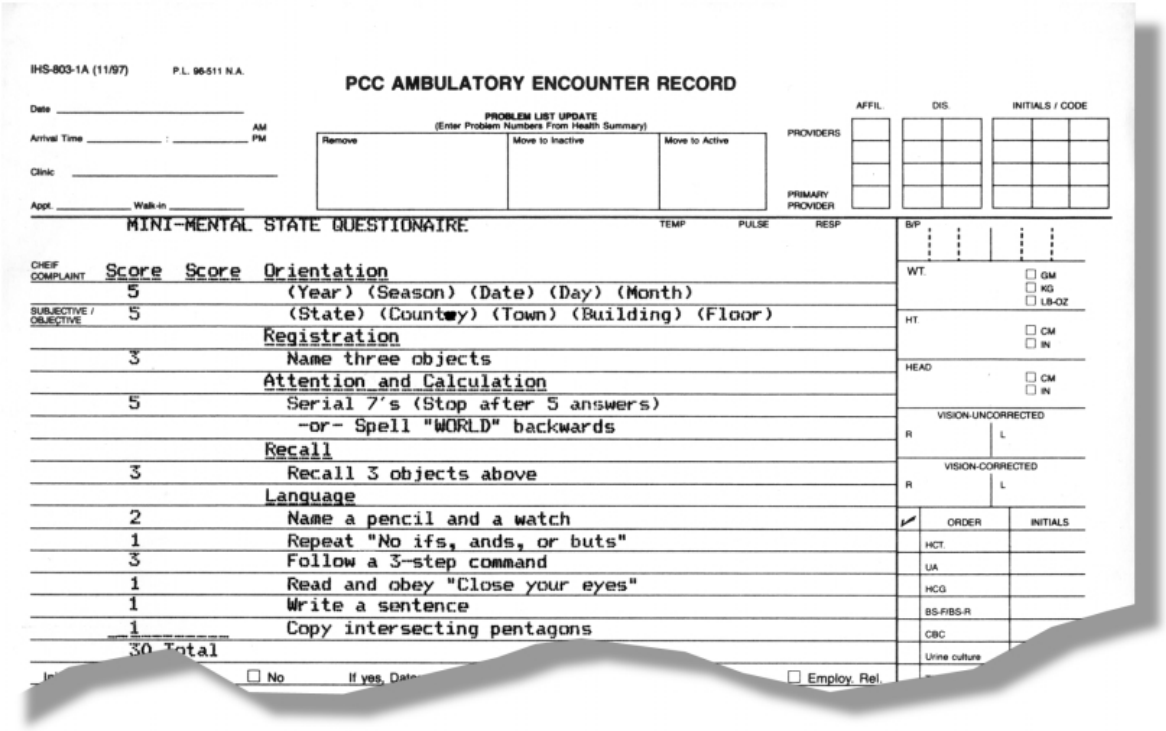
HT. ☐ CM ☐ IN

HEAD ☐ CM ☐ IN

VISION - UNCORRECTED R L

VISION - CORRECTED R L

✓	ORDER	INITIALS
	HCT.	
	UA	
	HCG	
	BS-F/BS-R	
	CBC	
	Urine culture	
	Throat culture	
	Stool culture	
	STS	



IHS-803-1A (11/97) P.L. 96-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date _____
Arrival Time _____ : _____ AM PM
Clinic _____
Appt. _____ Walk-in _____

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)

Remove	Move to Inactive	Move to Active

AFFIL. DIS. INITIALS / CODE
PROVIDERS
PRIMARY PROVIDER

MINI-MENTAL STATE QUESTIONAIRE

TEMP PULSE RESP B/P

CHIEF COMPLAINT / SUBJECTIVE / OBJECTIVE

Score	Score	
		Orientation
5		(Year) (Season) (Date) (Day) (Month)
5		(State) (Country) (Town) (Building) (Floor)
		Registration
3		Name three objects
		Attention and Calculation
5		Serial 7's (Stop after 5 answers)
		-or- Spell "WORLD" backwards
		Recall
3		Recall 3 objects above
		Language
2		Name a pencil and a watch
1		Repeat "No ifs, ands, or buts"
3		Follow a 3-step command
1		Read and obey "Close your eyes"
1		Write a sentence
1		Copy intersecting pentagons
30 Total		

☐ No If yes, Date: ☐ Employ. Rel.

WT. ☐ GM ☐ KG ☐ LB-OZ

HT. ☐ CM ☐ IN

HEAD ☐ CM ☐ IN

VISION-UNCORRECTED R L

VISION-CORRECTED R L

✓	ORDER	INITIALS
	HCT.	
	UA	
	HCG	
	BS-F/BS-R	
	CBC	
	Urine culture	

Comprehensive Geriatric Assessment in the Real World — the World of Indian Health

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Zuni, New Mexico

Over the last two decades, comprehensive geriatric assessment (CGA) has become an accepted component of quality geriatric services.[1] What is comprehensive geriatric assessment? It is a multidisciplinary process by which an elder is evaluated in a variety of ways, with the aim being to identify health and functional problems or risks, and then developing, implementing, and monitoring a plan to address those problems or risks. The overall effort is aimed at improving quality of life and function for the elder.

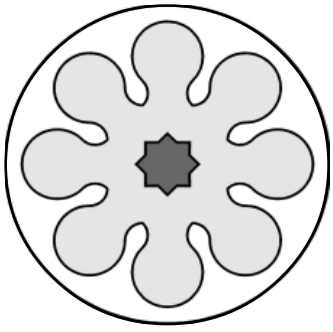
A great many models have been described, and a number of those models have been studied, with different studies showing positive outcomes for the process in improving quality of life, improving or slowing the decline of function, decreasing inappropriate prescribing, or enhancing diagnostic accuracy.[2] Campion has also described the positive effect of this process on the local health care system itself, in terms of improved overall geriatric care.[3]

An IHS workgroup in the early 1990s recognized CGA as an important step in developing a competent system of geriatric care in the Indian health care system.[4] But translating new models of health care delivery described in the literature to the unique settings in which we practice is not easy. What we can create in our particular setting often does not look like what we have read about. Even translating from one Indian health care site to another can be difficult. We have differing resources, differing cultures, and differing geographies.

In this issue of THE PROVIDER ("Well Elder's Clinic: A Model for Indian Country"; THE IHS PROVIDER, Volume 26, Number 1, pages 1-3, January 2001), Dr. Hendrickson describes one model of CGA, in its early stages, in Fort Peck, Montana. Other models of CGA are in place or in development in Southern Colorado Ute, Yakima, Santa Fe, Zuni, and elsewhere. Each of these models translates the process differently. Can these efforts be a guide to others in making this translation?

The IHS Elder Care Initiative is collaborating with the New Mexico Geriatric Education Center (NMGEC) to develop a manual of comprehensive geriatric assessment in Indian Country. We will take advantage of the work of Dr. Hendrickson and others who have developed a variety of models for CGA in Indian health care settings. The manual will describe these programs and provide the tools and processes they use. We plan to have the manual completed by June 2001, and intend to use it in the special half day session at the New Mexico Geriatric Education Center (NMGEC) Summer Geriatric Institute devoted to developing comprehensive geriatric assessment in Indian health care settings.

In everyday clinical practice, we work hard to translate between languages and cultures to provide quality health care. With comprehensive geriatric assessment we must extend that process to translate an innovative model of care to Indian health care settings in order to bring state-of-the-art care to American Indian and Alaska Native elders.



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Recent Updates in the Health Maintenance Reminders Section of the PCC Health Summary

Stanley P. Griffith, MD, Medical Informaticist, Information Technology Support Center, IHS, Albuquerque, New Mexico; William B. Mason and Lori Butcher, Cimarron Medical Informatics, Tucson, Arizona

Several changes have recently been completed in the Health Maintenance Reminders section of the Patient Care Component (PCC) Health Summary, changes that we hope will make these reminders significantly more useful to you. In particular, those reminders have been updated so that their default settings are consistent with the most recent recommendations of the U.S. Preventive Services Task Force (USPSTF) and, secondly, those defaults can now be modified in useful ways at each individual PCC site so that you can locally define what they should be. In this article we will review those changes in more detail so that you will be aware and can use this tool as effectively as possible.

Updated Standards

The first major change in the reminders is that the defaults have been updated. For those parameters specifically addressed by the USPSTF, the defaults are consistent with their latest recommendations (version 2.0). In instances where the PCC had an existing health reminder that the USPSTF does not currently recommend for routine use, that reminder is turned off in the default distribution but is still available to you if locally you wish to turn it on. For those reminders not specifically addressed by the USPSTF, we followed the recommendations of other appropriate groups (e.g., the Advisory Committee on Immunization Practices for immunizations) or consulted with an IHS Chief Clinical Consultants (CCC) (e.g., William Green, MD, Pediatrics CCC, on some of the childhood reminders) to determine a widely accepted and appropriate standard. But whether or not you agree with each and every one of these default standards, the second major change, the ability to customize these reminders locally, will allow you to readily modify any of these defaults to your preferences.

Local Customization

The second major change in the Health Reminders section is that the PCC will allow you to customize existing reminders to fit your locally determined standards. First, you can turn on a reminder that has been turned off in the default distribution merely by changing a site parameter as described below. Similarly, one that has been turned on can be turned off. For example, while a Pap reminder is turned on in the default distribution, the reminder for a pelvic exam has been turned off. If your site would still like this reminder to be displayed in your Health Reminders sections, you can accomplish this by turning the default on as described below.

Secondly, any of the existing reminders can be modified locally within the parameters of age-range, frequency, and sex. For example, in the default package, the mammography reminder is set to look for an annual mammogram in females between the ages of 50 and 69, inclusively. If your site would prefer that it look for an annual mammogram between 40 and 49 and then every other year between 50 and 74, you can do so by modifying the age-range and frequency parameters as described below.

Diabetes-Specific Reminders

Another change in this new version is that all of the diabetes-specific reminders for patients with diabetes have been removed from the general Health Reminders section, but retained in the special Diabetes Supplement to the Health Summary. The diabetes screening reminder (screening patients who are not known to have diabetes to see if they do) has been left in the general Health Reminders section, although it is turned off in the default distribution. This change removes unnecessary duplication, decreasing the size of the printed health summary.

Default Reminders

A summary of the reminders, their default logic, and whether or not they are turned on or off in the default distribution are shown in Table 1.

Setting Your Site Parameters

With this upgrade to the Health Summary there is a new set of options called "Health Maintenance Reminders" that is available under the Health Summary Maintenance menu.

Table 1. Health Reminders in the new version

Reminder Name	Default	Criteria
Blood Pressure	On	Every 2 years starting at age 3. If over age 21, increase to: 1) Annually if last diastolic BP between 85 and 89 inclusive; 2) Next visit if last systolic BP >139, diastolic BP >89. Cancel reminder if hypertension on the problem list.
Breast Exam	Off	This prompt will be turned off in the default package (Although turned off, default prompt is: Every year for females starting at age 20.)
Cholesterol	On	Every 5 years in men between 35-64, inclusive, females between 45-64, inclusive.
Colorectal CA Screen - Fecal Occult Blood	On	Every year starting at age 50. Cancel reminder if problem list diagnosis of colorectal cancer.
Colorectal CA Screen - Sigmoidoscopy	Off	This prompt will be turned off in the default package. (Although turned off, default prompt is: Sigmoidoscopy every 5 years starting at 50.) Turn off if sigmoidoscopy, BE, or colonoscopy within last 5 years.
Diabetes Screening	Off	This prompt will be turned off in the default package. (Although turned off, default prompt is: Every three years starting at age 18, unless a blood sugar has been recorded within the past three years; cancel prompt if diabetes is on the problem list.)
Hct/Hgb	On	At 12 months (unless done between age 9-12 months). At age 4 (unless done between ages 3-4).
Head Circumference	On	At or after birth, 2 mo., 4 mo., 6 mo., 12 mo., 18 mo., 2yrs. Cancel prompt after age 3. For example, if patient is 5 mo., check to make sure a HC was done at or after 4 mo.
Hearing Inquiry	On	Starting at age 65, every 2 years.
Hearing Test	On	At age 4 (unless done between ages 3-4).
Height	On	At or after birth, 2 mo., 4 mo., 6 mo., 12 mo., 18 mo. Then at or after age 2, 3, etc. annually to age 18. Once at or after age 18 up to 65. Annually starting again at 65.
Immunizations	On	Per the RPMS Immunization Package.
Influenza	On	Beginning on September 1 and ending on April 1: 1) every year starting at age 65, and 2) every year at any other age if patient has had a visit for any of the ICD codes in the "Surveillance Pneumoccocal Risk" taxonomy.
Mammogram	On	Every year in females between ages 50 and 69, inclusive. No need to cancel if breast cancer is on the problem list.
Pap Smear	On	Every 3 years in all females starting at 18 if no history of hysterectomy. If Hx of hysterectomy, display date of last Pap and under "Due date" display this text: "Patient has had hysterectomy. Pap may be needed based on clinical assessment."
Pelvic Exam	Off	This prompt will be turned off in the default package.
Physical Exam	Off	This prompt will be turned off in the default package. (Although turned off, default prompt is: every year starting at age 18.)
Pneumovax	On	Once 1) starting at age 65; or 2) if Problem List Dx in the "Surveillance Pneumoccocal Risk" taxonomy. Repeat once, 5 years after first, if Problem List Dx in the "High Pneumoccocal Risk" taxonomy or anyone over 65 who had first dose before 65.

Table 1. Health Reminders in the new version (continued)

Pneumovax Revaccination (Alaska)	Off	Once 1) starting at age 55; or 2) if Problem List Dx in the "Surveillance Pneumoccocal Risk" taxonomy. Repeat once, 5 years after first, in all patients.
Rectal	Off	This prompt will be turned off in the default package. (Although turned off, default prompt is: every year starting at age 40.)
Screening for Problem Alcohol Use	On	Every year starting at 13.
Screening for Tobacco Use	On	Every year starting at 13.
Strabismus/Amblyopia Screen	On	At age 3 (unless done in previous year).
Td-Adult	On	Every 10 years starting at age 12.
Tonometry	Off	This prompt will be turned off in the default package. (Although turned off, default prompt is: every 3 years starting at age 40, then every year starting at age 60.)
Tuberculosis	On	PPD at age 4 (unless done between age 3-4) and again at age 11 (unless done between 9-11). Cancel reminder if any tuberculosis diagnosis (other than tuberculosis contact) on Problem List.
Urinalysis	Off	None. Do not prompt for urinalysis in the default package.
Visual Acuity Exam	On	Starting at age 65, every 2 years.
Weight	On	At or after birth, 2 mo, 4 mo, 6 mo, 12 mo, 18 mo, 2yr; annually after that.

The menu is displayed below:

```
************************************
**          IHS Health Summary      **
** Health Maintenance Reminder Menu **
************************************
             Version 2.0

 OD   Display One Health Maintenance
      Reminder Description
 AI   Activate/Inactivate a Health
      Maintenance Reminder
 BH   Browse Health Summary
 HS   Generate Health Summary
 LS   Add/Modify Locally Defined HM
      Reminder Criteria
 PR   Print Health Maintenance Item
      Protocols
```

At the local level the site may opt to activate or inactivate individual reminders. This is done using the "AI" option above. The user first selects the reminder and then edits the active/inactive flag appropriately. If the flag is set to active and the reminder is defined as a part of a particular type of Health Summary, it will be displayed on that summary. If the flag is set to inactive, it will not.

The second aspect of a reminder that can be modified locally is its parameters for age-range, frequency, and sex. This is done using the "LS" option. The user first selects the reminder and then specifies the gender, minimum and maximum ages, and frequency for that reminder. Multiple frequencies can be individually specified for various combinations of sex and age-ranges. These locally defined criteria are then the criteria used to generate the reminders in the Health Reminders section of the Health Summary and the default criteria are ignored.

An addendum to the PCC Health Summary user manual will accompany the patch to the software and will describe in detail how to use these options. We anticipate that document will be available in February 2001 from the Information Technology Support Center's (ITSC) web pages within the IHS Internet web site.

Patch Needed

This new version of the Health Maintenance Reminders section of the PCC Health Summary can be added to you local PCC system by installing the following patch:

PCC Health Summary (APCH) Version 2.0 patch 5

This patch will be available in February 2001 and can be obtained through your local site manager or Area Office Information Systems support personnel.

Further Help

In this article we have summarized the changes in the new

version of the Health Maintenance Reminders section of the PCC Health Summary and described how you can use them. If you have additional questions or need help, please contact Cimarron Medical Informatics, preferably by sending an e-mail copied to all four of the following addresses: *garyl@newnorth.net*, *DRuss4440@aol.com*, *sbowman@pacifier.com*, and *butcherla@aol.com*. Because of frequent travel commitments, one of those individuals will likely be able to respond more promptly if you contact them by e-mail. If it is more convenient for you to try to reach Cimarron by telephone, you should, in turn, try Gary Lawless at (715) 358-3763, Dorothy Russell at (520) 743-3275, Steve Bowman at (360) 571-5362, and Lori Butcher at (520) 577-2146. Finally, if your question remains unresolved, please do not hesitate to contact the ITSC help desk at (505) 248-4371 or (888) 830-7280.

Navajo Area IHS Wears New Hat in Video Arena

Gayle Williamson, Media Specialist, Four Directions Health Communications, Health Promotions, Northern Navajo, Medical Center, Shiprock, New Mexico

It's been one year since Norman Patrick Brown's video, *Łįį Biyiin*, premiered to a special Native American audience at Sundance Film Festival. A video about diabetes prevention is not the usual fare at such a prestigious gathering of film makers, critics, and film lovers. But, *Łįį Biyiin*, or "Horse Song," is not the usual film fare, and the fact that the Indian Health Service funded this video is even more remarkable. . . and commendable.

Horse Song is about Jack White, a rural, traditional Navajo man, whose puzzling health, both physical and emotional, has been a source of concern and irritation for the entire family. Jack is obstinate in his refusal to go to the Indian hospital where "all they ever do is ask you personal questions and stick things in you." But soon Jack's condition worsens. Finding out he has diabetes, Jack begins his difficult journey back to health and harmony, including denial, frustration, learning, acceptance, and rediscovering the man he used to be and the family he loves.

The title, *Łįį Biyiin*, says a lot about Brown's lifelong commitment to making films and videos that are purely Navajo. It was shot in Cove, Arizona on the Navajo Reservation, all the actors are Navajo, and it is in the Navajo language with English subtitles. Collaborating with many health professionals at Northern Navajo Medical Center and other diabetes programs serving the Navajo Nation, Brown was able to deliver important information about diabetes while entertaining and evoking the kind of emotions that can lead to healthy lifestyle changes.

This 60 minute video was produced by Four Directions Health Communications, which is the media facility at Northern Navajo Medical Center in Shiprock, New Mexico. It is available, along with a group discussion guide, and at no charge, to any group or individual concerned about the health of their community. For more information, call Four Directions at (505) 368-6499.

Because it is uniquely Native American, and because it has English subtitles, Four Directions believes all tribes would benefit from the story of *Horse Song*.

Magnets in the Emergency Room Revisited

Editor:

I'd like to add my voice to that of pharmacist Cynthia Carter in support of keeping magnets in the ER ("Do you Have a Magnet in Your Emergency Room?" *The IHS Provider*, Volume 25, Number 11, Page 174, November 2000). In addition to removing some superficial ocular foreign bodies, they can be valuable retrieving ferrous metallic objects from soft tissues elsewhere.

In the ER (OK, "urgent care department") at Lame Deer in Montana, we kept a powerful cylindrical magnet handy. The end fits neatly into the socket of a steel cap, which tapers into a narrow but blunt probe. This probe can be inserted along the track left by a steel air rifle "BB" until it contacts the BB with a palpable click. By wiggling the magnet while massaging the BB, it is possible to extract the small projectile without resorting to a scalpel. I have also used the magnet, sometimes in concert with soft tissue X-rays, to localize sewing needles imbedded in heels. While in these cases a scalpel is sometimes necessary, I can go to the precise site where a hemostat can complete the job — with no fishing expeditions, and minimal tissue trauma.

Our clinic burned to the ground in 1996, and I haven't seen one of those intense little stainless steel magnets since. Does anyone know of a medical or technical supplier who could put us back in business? It would be an interesting (magnetic) field . . ..

Jon Hauxwell, MD
Medical Officer
Area Office
Billings, Montana

Training for Cancer Support Group Leaders is Available

The IHS Epidemiology Program continues to sponsor training for American Indian and Alaska Native people interested in starting cancer support groups in their own communities. The 4½ day training format includes lecture/discussion, group simulation, and education materials. The ideal support group leader is a cancer survivor, a family member, or a close friend who has shared the cancer experience.

The next training is scheduled for April 23-27, 2001 in Albuquerque, New Mexico. Our program will provide reimbursement for travel, tuition, and expenses for a limited number of people. For more information, please contact Roberta Paisano by phone at (505) 248-4132; or e-mail *roberta.paisano@mail.ihs.gov*.