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The Oral Health Status of American Indian/Alaska Native Preschool Children: A Crisis in Indian Country

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This is the first of three articles on the results of the 1999 Indian Health Service (IHS) oral health survey of dental patients. This article is focused on the oral health of preschool-age children. The second article will focus on school-age children, and the third article on adults and elders.

Introduction

The 1999 Oral Health Survey is a third look by the Indian Health Service (IHS) at the oral health status and treatment needs of American Indian and Alaska Native (AI/AN) dental patients served by the IHS, urban, and tribal dental clinics. The 1999 survey was designed to estimate the oral health status of dental patients at both the national and Area levels. Representing all of the 12 Areas, over 150 dentists serving in tribal, urban, and/or IHS dental clinics volunteered to participate in the survey. Approximately 36 percent of all tribal, urban, and IHS dental clinics participated. The IHS collected data on 12,881 dental patients ranging in age from 2 to 96 years. Five age groups were targeted: 2-5 years, 6-14 years, 15-19 years, 35-44 years, and 55 years and older. The data presented in the report have been adjusted to the FY 1997 Indian Health Service three-year user

population, which were the most current population data available at the time of the report.

Young children start to erupt their teeth at about 6 months of age. The primary teeth, also known as baby teeth, continue to erupt until the child is about 3 years of age. Tooth decay in the primary teeth of children 5 years of age or younger is one of the major health problems in the United States – especially among low-income populations and some ethnic groups. Although the primary teeth are eventually replaced by permanent teeth, they play a very important role in a child's oral health and development. They save space in the mouth for the permanent teeth to erupt and if extracted prematurely can cause speech or orthodontic problems (the need for braces). In addition, dental decay can be very difficult to treat in young children and sometimes requires hospitalization and the use of general anesthesia.

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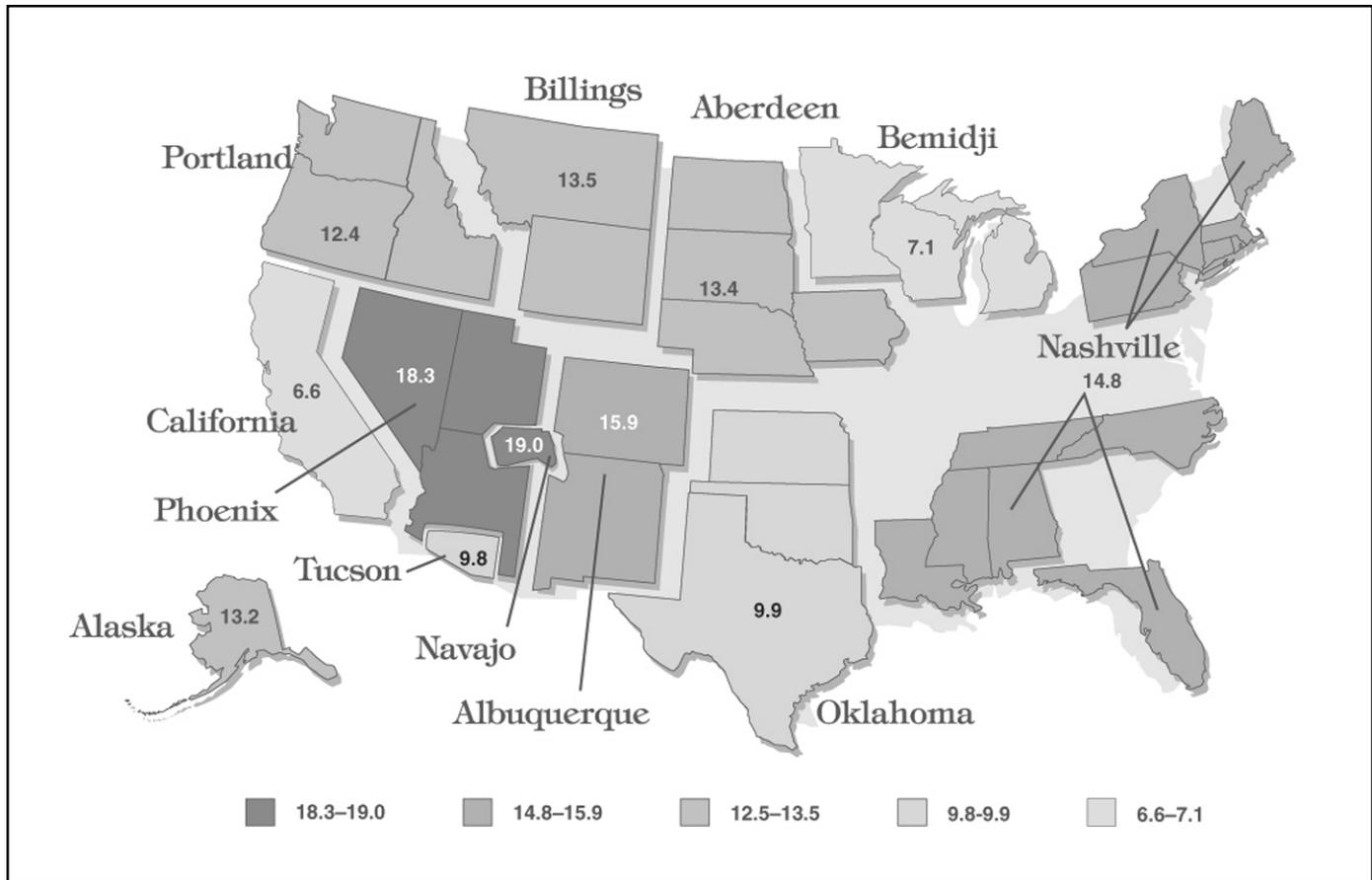
A total of 2,663 children between the ages of 2-5 years were examined during the 1999 Oral Health Survey. About 79 percent of these children had a history of dental decay (at least one tooth with a filling or untreated decay), and 68 percent had untreated decay at the time of the examination.

When stratified by Area, children in the California and Bemidji Areas had the lowest level of decay, while children in the Navajo and Phoenix Areas had the highest decay rates (see Figure 1).

with six or more teeth with decay is considered to have severe ECC. Using this definition, 60 percent of the children examined in the survey had severe ECC.

The upper anterior (front) teeth are among the first teeth to erupt and are often used by health professionals to identify children at higher risk of future decay. Of those children with a history of decay on their anterior teeth, 90 percent also had decay on their back (posterior) teeth. It should be noted, however, that 56 percent of the children with no decay on their anterior teeth

Figure 1. Mean dmfs* by Area for AI/AN Children Age 2-5 Years.



* dmfs = decayed, missing, and filled tooth surfaces, a measure of oral health in children

Early Childhood Caries

In the last 15 years, the IHS has implemented several programs designed to reduce a pattern of tooth decay known as Baby Bottle Tooth Decay (BBTD). This pattern of decay, usually seen in infants and toddlers, was thought to result from putting a child to bed with a baby bottle containing high sugar liquids such as juice, soda, or sugar water. Recent research, however, has shown that the disease process is much more complex, involving transmission of infectious bacteria, dietary habits, and oral hygiene. For this reason, the name of the condition has been expanded to Early Childhood Caries (ECC). Any child age 5 years or younger with decay on their upper front teeth or

had decay on their posterior teeth. These data suggest that children with anterior maxillary decay may be extremely susceptible to additional decay in the posterior teeth. Furthermore, sound anterior maxillary teeth are no guarantee of healthy, decay-free posterior teeth (see Table 1).

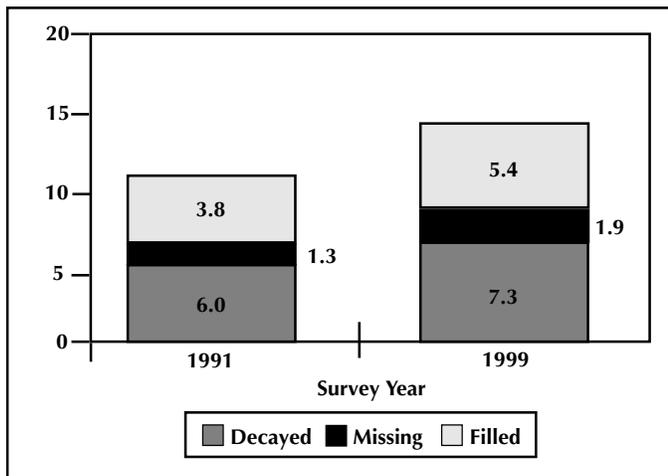
Table 1. Percent of Children with a History of Decay in Maxillary Incisor and Posterior Teeth.

Posterior Decay	Maxillary Incisor Decay	
	No	Yes
No	21%	5%
Yes	26%	48%
Mean dmfs	5.0	22.8

Trends Over Time

Based on the results of the 1991 and 1999 Oral Health Surveys, it appears that decay rates have increased in AI/AN preschool children (see Figure 2). Since 1991, there has been a

Figure 2. Mean Number of Decayed, Missing and Filled Surfaces in the Primary Teeth of Children 3-5 Years from Two IHS Surveys.



statistically significant increase in the number of decayed tooth surfaces ($p < 0.001$), missing tooth surfaces ($p < 0.001$), filled tooth surfaces ($p < 0.001$), and the total number of decayed, missing, and filled tooth surfaces (dmfs, $p < 0.001$). While there has been a slight increase in the prevalence of severe Early Childhood Caries (57% in 1991, compared to 60% in 1999) the difference is not statistically significant ($p = 0.07$). Anecdotal information from dental clinic staff also suggests an increase in caries rates among preschool children during the last 10 years.

Comparison to Healthy People 2010

Healthy People 2010 lists several national oral health objectives for preschool children. These include:

- Reduce the proportion of young children age 2-4 years with dental caries experience in their primary teeth to 11 percent.
- Reduce the proportion of young children age 2-4 years with untreated dental decay in their primary teeth to 9 percent.

If these goals are to be met in the American Indian/Alaska Native population, significant improvements in their oral health status must be accomplished in the next 10 years (Figure 3).

Comparison to National Data

The most current national data on oral health in preschool children are from the third National Health and Nutrition Examination Survey (NHANES III). NHANES III, conducted by the Centers for Disease Control and Prevention between 1988-1994, sampled the U.S. civilian non-institutionalized population.

The primary purpose of NHANES III was to collect information on the national prevalence of, trends in, and risk factors for selected diseases, including dental disease.

NHANES III examined 3,889 children between the ages of 2 and 5 years.¹ When compared to NHANES III, the AI/AN children examined by the IHS had significantly more dental decay (Figure 4). In fact, the percentage of children with untreated decay was more than three times higher in the AI/AN children compared to the NHANES III children (68% vs. 19%). The IHS Area with the lowest proportion of preschool children with untreated decay was Bemidji, and their proportion was still significantly higher than the national average (49% vs. 19%).

Conclusions

Very young AI/AN children experience tooth decay and do not have adequate access to preventive and restorative dental treatment. To make the problem worse, decay rates in this young-

Figure 3. American Indian and Alaska Native Children Ages 2-4 Years Compared to Healthy People 2010 Objectives.

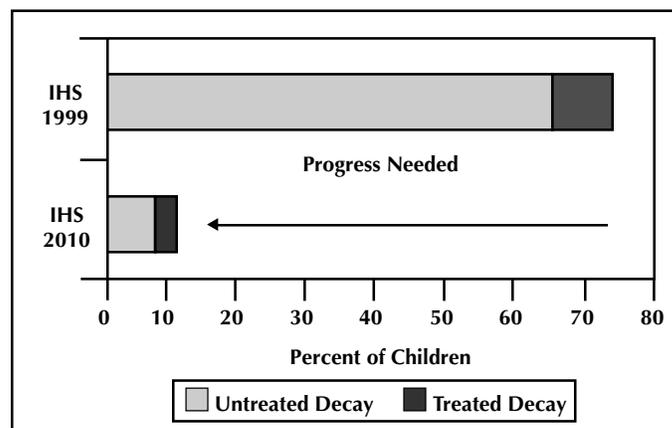
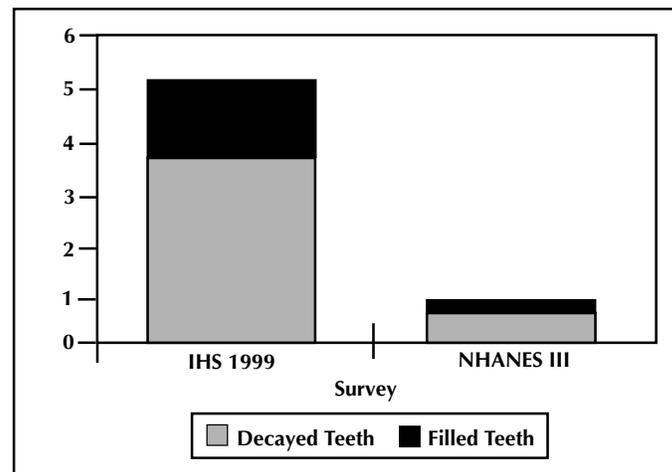


Figure 4. Mean Number of Decayed and Filled Primary Teeth (dtf) for Children Ages 2-5 Years, IHS 1999 Compared to NHANES III





est age group have increased significantly in the last nine years. Because tooth decay begins early and is severe among young Indian children, it affects their oral health for a lifetime. The following recommendations are provided in order to improve the oral health status and access to care for American Indian and Alaska Native preschool children.

Recommendations for Prevention Programs

- Encourage communities and tribal utilities to fluoridate their water supplies in order to reduce the rates of dental disease among AI/AN populations.
- Develop and target preventive interventions for children beginning at approximately 6 months of age including, but not limited to, use of fluoridated toothpaste and fluoride varnishes.
- Encourage the use of dental sealants in children ages 2 to 5 years, behavior permitting.

Recommendations for Access to Dental Care

- Encourage the first dental visit at age 1 year.
- Incorporate caries risk assessments into all preventive as well as restorative treatment plans.
- Increase the number of dental providers who are comprehensively trained and comfortable treating very young children.
- Increase the number of dental providers (dentists, dental hygienists, and dental assistants) who can provide preventive and restorative services.
- Increase enrollment of eligible families into publicly financed programs such as Medicaid and State Children's Health Insurance Program (SCHIP), and utilize third party reimbursement to contract for more dental providers.

Recommendations for Collaboration with and Education of Health Care Providers

- Encourage health care providers who see very young

children to assess the oral health of infants and toddlers, provide education to the parents or caregivers, and refer children in need to the dental clinic.

- Provide training to health care providers on appropriate dental screening techniques and referrals.
- Train health care providers to provide oral health educational messages and apply fluoride varnishes to high-risk children.
- Assure that medical care providers appropriately prescribe fluoride supplements.
- Work with nutritionists and WIC program staff to help educate families and individuals about the relationship between dental decay and dietary sugars.
- Collaborate with Head Start, Early Head Start, and day care programs to educate families and staff about the importance of oral health and primary prevention and access to care.

Recommendations for Education of Parents, Caregivers, and the Community

- Develop and implement education and intervention programs for mothers beginning with prenatal care, since the bacteria that cause tooth decay are usually transmitted from the mother to the child by about age 1 year.
- Educate community members, administrative and program staff, and tribal health boards and advocacy groups about the oral health of very young children.
- Teach parents and caregivers to brush their children's teeth daily.
- Encourage parents and caregivers to reduce their child's sugar consumption in bottles, tippy cups, foods, and beverages.
- Teach parents and caregivers to be aware of early signs of dental decay — white or brown spots — and to seek dental care.
- Educate community members, tribal health boards, and

other advocacy and policy groups about the prevention of dental disease in very young children.

Recommendations for Advocacy

- Share information with the U.S. Congress, foundations, and advocacy groups about the tremendous oral health disparities that exist between Indian people and the general U.S. population. Develop partnerships to address these health disparities.
- Educate tribal leaders about the oral health needs of Indian people and encourage their advocacy efforts with the Congress and other organizations and agencies.

Recommendations for Research

- Identify characteristics of AI/AN preschool children that contribute to the high prevalence of tooth decay, and test and evaluate programs to reduce the incidence and severity of tooth decay in this age group.

Reference

1. Vargas CM, Crall JJ, Schneider DA. Sociodemographic distribution of pediatric dental caries: NHANES III, 1988-1994. *J Am Dent Assoc.* 1998;129:1229-38.

HIPAA and the Indian Health Care System

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Abstract

The Health Insurance Portability and Accountability Act (HIPAA) is a reality. The specifics of the standardized transaction sets and privacy standards have been completed, and the formal regulations have been published, with other rules to follow. The regulations will impact health care in five major areas: standard transactions, standard code sets, uniform identifiers, security standards, and privacy standards. The required changes offer significant benefits through improved quality of claims, enhanced revenue collection, and reduced errors. To realize these benefits, health care programs must make a number of changes over the next two years.

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) will institute administrative reforms that will be phased in during the next two years. Of major importance in the HIPAA legislation is the issue of data and transaction standardization. Health care programs that electronically bill third parties for services provided to patients must comply with these measures or they will no longer be able to bill.¹

Important elements of HIPAA that require compliance²

The following are the elements of the HIPAA legislation that health care plans and providers should become familiar with:

- Establishes standard electronic transaction formulas.

- Requires standardized code sets within electronic transactions.
- Requires compliance with security measures to protect the confidentiality and integrity of health information.
- Prescribes provisions to protect patients' individual rights to privacy.
- Requires the use of unique identifiers (future).

What follows are brief explanations of the HIPAA Standards that drive these elements.

Transactions and Code Standards

Under the Transactions Standards, health plans must be able to reimburse providers, authorize services, certify referrals and coordinate benefits using a standard electronic format for each transaction. Providers should be able to check eligibility for coverage, verify claim status, request referrals or service authorizations, and receive electronic remittance to post receivables. Coding standards for reporting diagnoses and procedures are included in the transaction standards. The transaction and code standards were published August 16, 2000, and the compliance date is October 16, 2002.

Privacy Standards

The HIPAA Privacy Standards are intended to protect the privacy of all individually identifiable health information created or held by covered entities, regardless of whether it is or ever has been in electronic form. This includes paper records and oral communications.

Covered entities (health plans, providers, clearinghouses) must maintain documentation of their policies and procedures for complying with the standards, and must include a state-

ment of who has access to protected health information, how it is used within the covered entity, and when it would or would not be disclosed to other entities.

Providers must obtain a patient's consent for the disclosure or use of the patient's health information, even for treatment, payment, and health care operations purposes. Covered entities must make a reasonable effort not to use or disclose more than the minimum amount of information necessary to accomplish the intended purpose of the use or disclosure, except when the information is used for purposes of treatment. An individual has a right of access to his or her protected health information, to request amending or correcting it, and to receive an accounting of all disclosures. The privacy standards were published December 28, 2000 and the compliance date is April 14, 2003.

Security Standards

The HIPAA Security Standards must be applied by health plans, health care clearinghouses, and health care providers to all health information that is maintained or transmitted electronically. The standards are intended to protect both the system and the information it contains from unauthorized access and misuse. Each covered entity must assess its systems for potential risk and vulnerabilities to the health information it houses, and must develop, implement, and maintain appropriate security measures. The security requirements include:

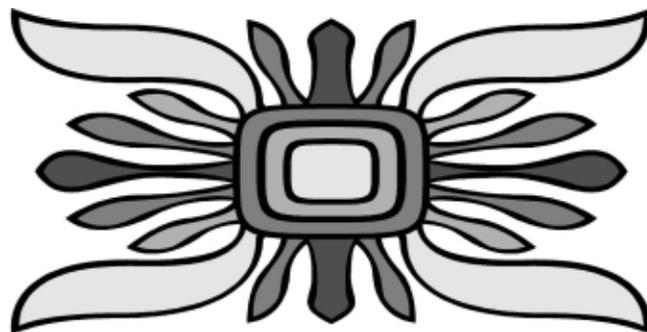
- Administrative procedures – security measures to protect data and manage the conduct of personnel in protecting data.

- Physical safeguards – protection of physical computer systems and related buildings from hazards and intrusion
- Technical security services – processes to protect, control, and monitor information access.
- Technical security mechanisms – processes to prevent unauthorized access to data transmitted over a communications network.

If an electronic signature is used for any transaction, the standards require that digital signature technology must be used. It is expected that the security standards will be published in fall 2001 and compliance will be required two years after that.

Identifiers Standards

The HIPAA National Identifiers Standards will define standard national identifiers for employers, health care providers, health plans, and individuals to be used in certain electronic transactions (as defined in the HIPAA Transactions Standards). Covered entities (health plans, providers, and clearinghouses) must accept and transmit the standard identifiers when required in a standard electronic transaction. The national employer identifier proposed by HHS is the Employer Identification Number (EIN) issued by the Internal Revenue Service. The national health care provider identifier proposed by HHS is the National Provider Identifier (NPI), which is currently being developed and tested by the Centers for Medicare and Medicaid Services (CMS; formerly HCFA, the Health Care Financing Administration). Standards for national health plan identifiers and individual identifiers have not yet been proposed by HHS.



Impact of HIPAA

HIPAA impacts all functions, processes, and systems that store, handle, or generate health information. The regulations will require that health care organizations rethink the manner in which they protect the security and privacy of patient information. HIPAA electronic transactions standards and security requirements will become key enablers of e-business in the health care industry. It is estimated that up to 80 percent of the impact of HIPAA standards will be in developing new policies and procedures, documentation, and training, while only 20 percent will involve technology such as hardware and software.¹

Compliance Costs vs. Benefits

While there will be significant costs associated with HIPAA, there are also significant benefits to be achieved through implementation of the HIPAA reforms. HIPAA is far more than just another series of government regulations to be satisfied. HIPAA will allow the health care industry to optimize the use of electronic commerce. The benefits of these technologies have not been fully utilized by the health care industry, mainly because of a lack of industry-wide standards. HIPAA resolves the standards issue and sets the stage for health care to move rapidly into e-health economy.³

To comply with the transaction standards, code sets, and identifiers requires upgrades to eligibility confirmation, coding, billing, and medical records applications presently in use. Meeting the new security standards will require a significant investment in policies, procedures, documentation, and training. The basic need for security has not changed. However, HIPAA requires health care organizations to invest extensively in security standards and technology in order to assure integrity of health information. The new privacy regulations will also impose a significant administrative burden on health care providers and payers. These regulations impose strict controls on what health care information can be released and to whom. Patients have new rights to limit access to their health care information. They also have rights to see their own records and challenge the accuracy of these records. This will require many changes in the procedures used in the handling of both electronic and paper records of personal health information.⁴

A proactive approach to HIPAA compliance can provide ample opportunity to plan and systematically introduce the changes required by HIPAA. The health care provider will benefit by the improvements in their business practices. Business-to-business transactions will be more uniform and much easier to manage. Faster confirmation of insurance verifications via electronic transactions will significantly reduce the costs associated with inaccurate insurance information. Electronic submission of standardization claims to all payers will result in accelerated payments, reduced claims adjudication, and increased revenue. The move to electronic transactions also reduces the need to send paper copies of patient information via fax or mailed photocopies to physicians or payers. The use of this technology



offers the potential for significant labor savings in medical records, clinical departments, and business offices.

Conclusion

HIPAA is a law that all health care providers who transmit or store any personal health information in electronic form in connection with a transaction are required to comply with. HIPAA standards are a challenge to the Indian health care system in that all health care programs are required to meet them. In order to bill third parties for health services, a program must be in compliance with HIPAA standards. There will be an adverse impact on the health care of programs that lose their ability for billing third parties for services provided.

The security standards provide a framework for enforcing privacy policies that protect confidentiality and data integrity, both of which are critical if a health care program is to maintain the confidence of the patients it serves. Misuse of personal health information is subject to civil penalties. Fines of up to \$25,000 will be imposed for multiple violations of a standard in the same year, while fines of up to \$250,000 and/or imprisonment for up to 10 years will be enforced for an employee knowingly misusing an individual's identifiable health information.⁵

The IHS is proactive in coordinating HIPAA information through a headquarters team that will provide the Areas and health care facilities with pertinent information concerning HIPAA, and to act as the focal point for sharing information about successful programs. An effort of this type will provide for a consistent

approach to becoming HIPAA compliant and should eliminate duplication of efforts by the Indian Health Service, tribal, and urban programs (I/T/U). The latest information on HIPAA and what the IHS is doing can be found at the IHS HIPAA website. This can be reached through the IHS website (www.ihs.gov) by clicking on the HIPAA icon at the bottom of the page.

Contacts for Headquarters and Area Personnel Working on HIPAA

Table 1 lists the Headquarters HIPAA team members, while Table 2 provides the contacts for each Area.

Table 1. National HIPAA Compliance Team Members

Name	Position	E-mail Address
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Godwin Odia	Quality Assurance	GODIA@HQE.IHS.GOV
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Richard Price	Regulatory & Legal Affairs	RPRICE@HQE.IHS.GOV
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References

1. Superior Consultant Holdings Corporation. What Every CFO Needs to Know. From Internet site superior@superiorconsultation.com.
2. Mitretek Systems. Health Insurance Portability and Accountability Act (HIPAA) of 1996 – Overview of the Law, Standards to be Developed, Steps to Become Compliant. Presented to IHS December 5, 2000.
3. Phoenix Health Systems. The Executive's Essential HIPAA. Audio-conference, March 27, 2001.
4. MIS Training Institute. HIPAA Security and Privacy Briefing: A Blueprint for Compliance. Briefing materials. February 19-21, 2001.
5. DHHS. Protecting the Privacy of Patients' Health Information — Summary of the Final Regulation, Fact Sheet. December 20, 2000, HHS Press Office.

Become an EPEC Trainer

EPEC is Education for Physicians on End-of-Life Care. The goal of the EPEC Project is to educate all U.S. physicians about the essential clinical competencies required to provide quality end-of-life care. At the heart of the Project is the EPEC Curriculum. It provides physicians and other members of the interdisciplinary team with basic knowledge and skills needed to appropriately care for dying patients.

EPEC is now offering a 2 1/2 day program specifically designed for physicians and other members of the health care team to become EPEC trainers. Approaches to teaching the full EPEC Curriculum will be demonstrated, and the issues in the

curriculum will be discussed so that you will be able to fulfill your obligation to implement EPEC in your organization or community. Each attendee will receive the two-volume Curriculum (Trainers Guide and Participant's Handbook).

The course will be held October 5 - 7, 2001 at the Chicago Marriott Downtown in Chicago, Illinois. The Cost of the conference is \$500. For more information call (877) 524-3732, or go to the EPEC website at www.epec.net. EPEC is supported by Northwestern University Medical School and the Robert Wood Johnson Foundation.

VA Fellowships for End-of-life Palliative Care

In keeping with the Department of Veterans Affairs' national leadership role in pain management initiatives for older Americans, the VA has created fellowships for end-of-life palliative care training in six academic locations across the country. Geared toward improving the care of veterans of advanced age and declining health, the fellowships are also intended to enhance the understanding and quality of palliative care on a national level.

According to Dr. Susan Block, Chief of Adult Psychosocial Oncology at the Dana-Farber Cancer Institute at Harvard Medical School and Brigham and Women's Hospital, "This program is one of the most important developments in the field of palliative care. The fellowships will train a cadre of expert clinicians who will serve as beacons for others interested in improving care at the end of life throughout the VA and the country."

Twenty-one healthcare sites applied to host the fellowships. The accepted locations are diverse, including Bronx, NY; Los Angeles, CA; Milwaukee, WI; Palo Alto, CA; Portland, OR; and San Antonio, TX. The designated sites will serve as starting points for what the VA hopes will be a national outreach effort in which information gathered in the fellowships is disseminated throughout the country in conferences, clinical demonstrations, and eventually, the residents' post-fellowship careers.

At a time when Americans are living longer than ever before, the VA has taken on a prominent role in relieving pain and suffering through bold initiatives that emphasize caring and communication in relationships between health care professionals, patients, and families. Dr. Stephanie Pincus, the VA's chief

officer for academic affiliations, stressed that "there comes a time when all the modern medicine in the world cannot cure illness. That's when treating the pain, communicating with compassion, and providing support and counseling become paramount. And that's what these fellowships are all about."

For more information about the program go to <http://www.va.gov/oa/fellowships>.





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