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An Intergenerational Family Community-Based Participatory Research Prevention Program: Hemish of Walatowa Family Circle Program

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Introduction

The Pueblo of Jemez, known traditionally as Walatowa, is a sovereign nation, 55 miles northwest of Albuquerque, where the University of New Mexico (UNM) is located. Walatowa is one of 19 New Mexico federally recognized tribes, with about 3,400 tribal members; about 58% live within tribal lands (*jemezpueblo.org*). Residents of Walatowa, known as the Hemish people, maintain a high degree of traditional practices and cultural knowledge, and are the only people to speak the Towa language; tribal estimates place language fluency at 80 - 85% (PoJ govt.). Towa is strictly an oral language, yet the preservation of Towa and the Hemish ways of life remain a tribal priority in all facets of life, not only for the sake of cultural preservation but also because the health and educational attainment of tribal members are believed to be affected by concerns of loss of language and culture. Like

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many other American Indian (AI) tribes, the Walatowa community faces challenges including alcohol and substance abuse threatening Hemish families and the tribe collectively, and putting children and youth at risk. The Walatowa community also has cultural and traditional strengths, which can be recognized as protective factors for prevention programs, including how elders pass on traditional wisdom within families (Duran and Duran, 1995; Belone et al, 2011; Goodkind et al, 2010; Mmari, Blum and Teufel-Shone, 2010).

This article reports on a partnership between the University of New Mexico and the Pueblo of Jemez to co-develop and implement an intergenerational prevention program (with children, parents and elders) based on cultural strengths and wisdom to promote family and child well-being. We report on our participatory research process, as well as the child health outcomes and lessons learned in our academic-tribal partnership that may be useful for other tribes.

History of Partnership

Since 1999, the Pueblo of Jemez and the UNM Center for Participatory Research (UNM-CPR) have partnered through a Community Based Participatory Research (CBPR) approach, involving community/cultural capacities, and culturally-centered interventions to improve health. In our first grant, the "Community Voices" research study, (CDC grant, 448 CCU 610818-04SIP24PR01, Protective Factors in Tribes), we utilized a CBPR approach to conduct key informant interviews and focus groups on community capacities and community member interpretations of their socio-cultural strengths; and identified the interconnectedness between the built, sociocultural, and natural environments with the value of maintaining cultural integrity (Wallerstein et al, 2003). The study identified multiple protective factors, such as the role of cultural practices and preservation, and participation in community and program events; as well as risk factors, such as the growing gap between elders and youth in terms of cultural transmission and language. This gap has interrupted cultural knowledge transfer, fostered family communication breakdown as parents struggle to raise their children, and contributed to alcohol and substance abuse.

Study participants also shared ideas about how best to intervene and strengthen shared community values, participation in and knowledge of cultural practices, and increase Towa language utilization. Recommendations led to the Pueblo of Jemez and UNM-CPR co-writing a second research grant to reduce identified child risk factors utilizing Hemish community and cultural strengths. This study, funded in 2005 by the Native American Research Centers for Health (NARCH III), aimed to co-create an inter-generational family program, incorporating a CBPR approach, and targeting 3rd through 5th grade children. The UNM team identified previous work from a tribal-academic partnership between the University of Nebraska and the Anishinabe people, a project known as *Bii-Zin-Da-De-Dah* in the Anishinabe language or *Listening to Each Other* in English. As a psycho/cultural/educational intervention to reduce alcohol and other drug abuse, *Bii-Zin-Da-De-Dah* showed that culturally-embedded prevention messages were retained and were more effective (Whitbeck, Hoyt, McMorris, et al., 2001; Whitbeck, Hoyt, Stubben, et al., 2001). We requested and received approval to adapt this intervention within the cultural values and ways of life of Jemez, which resulted in the creation of the Hemish of Walatowa Family Circle Project (FCP), developed specifically for Jemez children, families (parents, siblings), and elders.

Community-Based Participatory Research Approach

This over 10-year partnership between the Pueblo of Jemez and UNM-CPR is grounded in the principles of CBPR, including community ownership, capacity-building, and long-term commitment (Israel et al, 2005); and in the core values of service, respect, and responsibility, while striving towards an equitable and trusting relationship among partners. In the last decade and a half, CBPR has been increasingly recognized as an important research strategy to reduce health disparities (Minkler andWallerstein, 2008). Within tribes, participatory research is based in tribal sovereignty and being accountable to tribal demands for controlling research within their borders and with their members (Baldwin et al, 2009; Burhansstipanov et al, 2005; Christopher et al, 2008a; Fisher and Ball, 2005; Harala, 2005; LaVeaux and Christopher, 2009; Teufel-Shone et al, 2006; Thomas et al, 2009a; Wallerstein and Duran, 2010). "CBPR is not simply a community outreach strategy but represents a systematic effort to incorporate community participation and decision making, local theories of etiology and change, and community practices into the research effort" (Wallersten and Duran, 2006, p. 313). Community ownership was enhanced in Jemez when community members identified their own research interests from the Community Voices Project, and then requested UNM-CPR to collaborate in developing the intergenerational grant application.

Process of Developing the Intervention

The Family Circle Project was a four-year intervention study to co-develop and pilot the curriculum, working with a newly-reconstituted Jemez Advisory Council (AC), expanded from the Community Voices project. All members of the Advisory Council were from the Pueblo of Jemez, representing service providers, educators, parents, elders, and youth. Membership fluctuated, ranging in size and makeup over the course of the project years, and a core group has remained connected from 2005 to the present, despite funding ending in 2009. Presently, the core Advisory Council members are also identified as the Family Circle Project *Tribal Research Team (TRT)*.

Early in the first year, UNM re-confirmed all tribal approvals and received UNM Institutional Review Board approval, (HRRC#06113, April 20, 2006). The Advisory Council and UNM-CPR team then spent the first year, in an

Table 1. Hemish of Walatowa Family Circle Project curriculum components and structure

Curriculum Sessions	Curriculum Logo (*Designed by Robert Shendo*)	Session Format
1. Welcoming 2. Family Dinner 3. History 4. Way of Life 5. Vision 6. Community Challenges 7. Communication and Help Seeking 8. Recognizing Types of Anger 9. Managing Anger 10. Problem Solving 11. Being Different 12. Positive Relationships 13. Building Social Support 14. Making a Commitment		• Conducted by trained tribal facilitators, primarily in Towa • Family dinner • Greetings (Clan/Indian Names) • Sharing of Home Practice • Ice Breaker Activity • Activities: Separate adult & youth groups • Planning: Community Action Projects • Youth Journals • Wra

elaborate initial review process to identify what elements of the *Bii-Zin-Da-De-Dah* curriculum were evidence-based, to maintain, and what to integrate of cultural knowledge based in Jemez values, way of life, language, and history. In the second year, Advisory Council members, who received human research and protections trainings, conducted four focus groups with service providers, parents, elders, and youth, almost entirely in the Towa language, gaining skills towards becoming a Tribal Research Team. Focus group participants were asked to discuss strengths and challenges in their community, and what curriculum components they thought were important to include, especially, those which emphasized culture and prevention. Focus groups audio-recording transcriptions were meticulously translated from Towa to English and approved before outsider researcher exposure. After Advisory Council review, novel components were integrated, including traditional tribal greetings and introductions, traditional anger management concepts, traditional stories, and New Mexico Health Education Standards (*HealthEd@ped.state.nm.us/standards*). Additionally, we added a family community action project (CAP) that reflected the purpose of families giving back service to their community, even as they strengthened their own communication and child health. In the third and fourth year, two Hemish of Walatowa Family Circle Program pilots were conducted in Jemez. The curriculum, study sample, data collection, and analysis are presented below.

Hemish of Walatowa Family Circle Project Curriculum

In year three, the final 14-session (212 pages) Hemish of Walatowa Family Circle Project curriculum was produced for piloting with 3rd, 4th, and 5th grade children and their families, with artwork developed by a tribal elder and member of the Advisory Council (see Table 1. Curriculum). Other materials developed included 1) a videotaped introduction of tribal leaders talking about Jemez values and history produced by youth; 2) artwork of oral stories as told by Jemez elders; and 3) a facilitator's manual outlining each session. A pre/post test was also co-developed, one specifically for the parent/caregiver and the other for the child participant. Evaluation process instruments for the facilitators were also co-developed.

Intervention Sample

Recruitment of participants was open to all third, fourth and fifth grade children attending schools within the Pueblo of Jemez community and their families, who volunteered to participate. This decision respects a community view that all Walatowa children and families are at-risk, and the opportunity

Table 2. Hemish of Walatowa Family Circle Project program participant breakdown

Family Circle Program Participants	
Pilot Program 1 Launched: December 2007 Completed: - April 2008	**Pilot Program 2** Launched: March 2009 Completed: June 2009
11 Families Total: • Grandparents (3 female, 2 male) • Parents (11 female, 3 male) • Children (8 female, 6 male) *Overall Attendance:* • Average Percent of Families per Session = 76% • Average Number of Families per Session = 8 *Towa Language:* • 57% of the children stated that Towa was the language *they* most often spoke at home. • 93% of the children stated Towa is the language their *parents* often spoke at home.	*7 Families Total:* • Grandparents (2 female) • Parents (6 female, 1 male) • Children (4 female, 3 male) *Overall Attendance:* • Average Percent of Families per Session = 75% • Average Number of Families/Session = 6 *Towa Language:* • 28.5% of the children stated that Towa was the language *they* most often spoke at home. • 86% of the children stated Towa is the language their *parents* often spoke at home.

to benefit from a prevention program should not be based on criteria that are often a norm for outsider researchers. This approach to program exposure works for this highly connected community, and provided outsider researchers with learning about intervention research design and methods, particularly how to center the intervention within the community's worldview. Table 2 contains a breakdown of both pilots with selected participant demographics.

Data Methods and Collection

Each pilot was evaluated through a mixed methods quantitative and qualitative approach, including pre- and post-test surveys completed by children and adults; journals completed by the children; a mid-program evaluation focus group with the families; and self-administered facilitator logs that were completed after each session. The post-test also included a 360-degree evaluation method, where kids and parents were asked how they had changed, how their parent or child had changed, and how the family had changed (Hazucha et al, 1993; London and Wohlers, 1991; Walker and Smither, 1999). The pre-post instrument was drawn from approximately 20 different instruments that measured coping, mental health, historical trauma, cultural knowledge, alcohol/substance abuse, and community capacity, to name a few. Measurement scales around community capacity, leadership, youth, and elders, developed with Jemez during the Community Voices research project and then tested in two tribes, were also included in the pre/post survey (Oetzel et al, 2010). The AC then advised the UNM research team about which questions/items were irrelevant, not culturally appropriate, or

not beneficial to the community. Questions/statements were deleted and some new questions were added; as well, some of scales were adjusted to fit the community needs. With few exceptions, the questions were framed as ordinal Likert items with ranges of 4 to 7 responses or as binary questions with yes/no responses. After all the adaptations, the adult survey included approximately 400 questions and the child survey included around 200 questions.

The AC and facilitators conducted all of the pre/post-test data collection, (after receiving training by the UNM team on confidentiality and research ethics), which was highly important for translating the questions into Towa and for developing community capacity with regard to research. Having community members administer the surveys also created a comfortable environment for the participants. The pre-post was administered to 17 adults, 10 in the first year and 7 in the second. Twenty-one children took the pre-post, 14 in year one and 7 in year two. Each participant received a $20 gift card for completing each survey.

Analysis

All of the completed surveys were returned to the UNM research team for analysis, and we aggregated both pilots for reporting here. The surveys were scanned into TeleForm (Cardiff Software, Autonomy Corp.) and exported into Statistical Package for the Social Sciences (SPSS, IBM SPSS Statistics) program for statistical analysis. Likert scales were analyzed using a paired t-test. Cronbach's alpha was also calculated for each Likert scale at each pre- and post-test time. There are two competing challenges to analyzing the pre-post data. With a relatively small sample size, even with aggregating family data from both the two pilot implementations, detecting statistical significance can be difficult. In contrast to that, the very large number of questions almost ensures that potentially spurious significances will be identified. To address both these challenges, the following two-stage strategy was developed. The individual items were analyzed using either a sign test (for Likert items; Roberson et al, 1995) or McNemar's test (for binary items). If binary questions were in a list (e.g., stressful events within the past year), the positive responses were summed and analyzed using a paired t-test. Any tests with a p-value of 0.109 or less were selected for further analysis.

The selected items were then examined in the context of the scale they are part of and of the other items composing that scale. To establish plausibility for the statistical significance, we looked qualitatively at whether the other items and the scale were changing in the same manner or direction as the statistically significant item. Several scales that were particularly important as an assessment of outcomes were included regardless of statistical significance. These were the three scales related to parenting styles (Robinson et al, 1995), questions relating to language, and four scales related to community capacity in American Indian communities (Oetzel et al, 2010).

Program Participant Results

Children's Overall Results. We had both quantitative and qualitative results, though because of small sample size (from the pre/post-tests) and the richness of the qualitative data (from journals, mid-program evaluation focus group, the 360 degree post-test open-ended questions, as well as facilitator observations), we triangulated our few quantitative items with the wealth of quotes and personal reflections. Despite the small sample size, we had statistical significance for changes in children's responses between their pre- and post-tests; they indicated increased self-efficacy and coping skills (one's belief they can influence events in their lives), and reduced anxiety and depression symptoms. These positive changes can have a protective effect in the long term for chronic disease, violence, and substance abuse.

- Anxiety: The multi-dimensional anxiety scale, used in the survey, indicated children felt their anxiety was less upon completing the program (p-value = .02). One example item: *afraid other kids will make fun of me* (decreased, p-value = 0.06).
- Coping with Depression: The depression scale indicated children felt more capable of coping with depression symptoms upon completing the program (p-value =.02). One example item: *coping with loneliness* (increased, p-value = 0.06).

Parents' Overall Results. Although this program was intended as a prevention program for children, it also provided a family participation format; parents experienced the program alongside their children, with skill building exercises offered around communication, listening, and eating dinner together. Despite small sample size, parental data showed statistically significant changes related to language and culture.

- Towa Language: *Thinking in Towa* (p-value = 0.02). With the program predominantly facilitated in Towa, participants stated that their thinking in Towa had increased.
- Hemish History: *impact of tribal history on community* (p-value = 0.07). Post-test analysis showed that adult participants stated that Hemish history was more important upon completing this program.

Discussion/Lessons Learned

Several important lessons concerning ownership, sustainability, and adaptability emerged from the collaborative design and implementation of the Jemez Family Circle Program. These lessons provide key points for future partnerships and for collaborative intervention development with tribes.

Tribal ownership of the program was an intended outcome from the onset of the CBPR effort, where community partnering assured cultural and community input from the early research question development through FCP implementation. Partnering alone, however, may not ensure a

Figure 1. Each main hospital treating individuals from our two communities reports utilization data to its respective state's hospital data collection office.

Theme	Child Statements	Adult Statements
Coping & Control	*"I learned what you can do with your anger and how to control it."* *"I learned not to drink and to ask people for help and have parents to take care of you."*	*"How to talk about feelings, mostly anger and how we can control anger."* *"For me it feels like I can maintain myself by taking a break, stop and think about things that make me angry and learn to accept things that you can't change. Think positive to make things right."*
Positive Family Dynamics	*"It feels good to eat together as a family."* *"It felt good to be with my family."* *"What values are important to me are to listen to my parents. It makes me feel good."*	*"Eating together as a family. Preaching to our children the proper way of feeding the spirits and expressing how and what we learned for the day. Sharing problems, emotions, attention and how we can make our family proud of each other."* *"To listen to children. To address our children in a kind way. Take time for family time."*
Language & Culture	*"I felt proud about learning about the history of the Hemish of Walatowa people."* *"I learned that we should keep our language by talking more of Towa"* *"It felt very good because I finally learned about Hemish culture"*	*"I am grateful that I'm learning the Hemish way of life. I want for me and my family to learn as much as we can."* *"It's very interesting to know the background and history of our culture."* *"That our culture and tradition are important for our people of this community and they continue to participate in any cultural/traditional activities."*

sense of community ownership. Instead, it was important to have the combination of formal agreements such as a Memorandum of Understanding following the tribal approval processes, establishment a community Advisory Council (e.g., service providers, elders, leaders, parents, and youth) to provide guidance and wisdom, and ultimately recognition of tribal sovereignty regarding ownership of data and the project itself.

Sustainability has been positively reinforced by the ability to adapt the program to other timely issues. With the second pilot, the Pueblo of Jemez Department of Education took over the leadership and incorporated traditional Walatowa foods. The meals, which were catered by the Tribal Youth Empowerment program, exposed participants to forgotten recipes and reinforced traditional and cultural values, community norms, and tribal history. A direct outcome was a traditional foods and recipes booklet distributed to community members, which also strengthened organizational linkages

between Jemez Health and Human Services and the Department of Education. A second adaptation was the decision by the Summer Youth Program, within the Department of Health, to integrate the FCP curriculum into their traditional days for children age 7 - 15; teachers are also using units in their classrooms. The capacity for FCP to be adapted for priority community needs has resulted in continued tribal use, increased cultural-centeredness, and application in new settings.

Ultimately, sustainability is a challenge for any new intervention, with programs competing for resources. The decision to integrate elements of the curriculum into various venues has been positive, yet the need to consider sustainability remains. One illustration of this challenge is the publication of results. Tribal ownership of data has been respected and clearly outlined in this partnership; therefore publication of results has to be part of the tribal priorities that typically include informing leadership, program managers, and the tribal community at-large, rather than publishing to the external world. It is only now, two years after the grant ended, and with the deepening of ownership of the FCP within Jemez, that the Advisory Council is seeking to share the effectiveness of its approach. The willingness to publish also reflects a deepening partnership and trust between UNM-CPR, and the Jemez Advisory Council and Programs that we continue in a manner that supports mutual respect and co-learning.

Conclusion

Conclusions from this effort are two-fold, for the FCP itself and for the partnership. It has become clear that the FCP is a model for integrating Health and Education programs and can serve to strengthen other intra-tribal collaboration. It also is clear that interventions that have both an evidence base, as well as being centered within cultural traditions, elder knowledge, and Hemish of Walatowa values, can be followed for other prevention programming. Advisory Council members and facilitators have expressed how they gained many new skills and hope to continue utilizing these skills (i.e., program development, focus groups and interviews, program facilitation, as well as an array of evaluation and research skills). For the partnership, we have recognized the value of constantly revisiting our principles and our actions to assure that the next collaborative steps of grants or program development reflect Jemez priorities and interests. We hope the process outlined here can support other tribal-academic partnerships to do the same.

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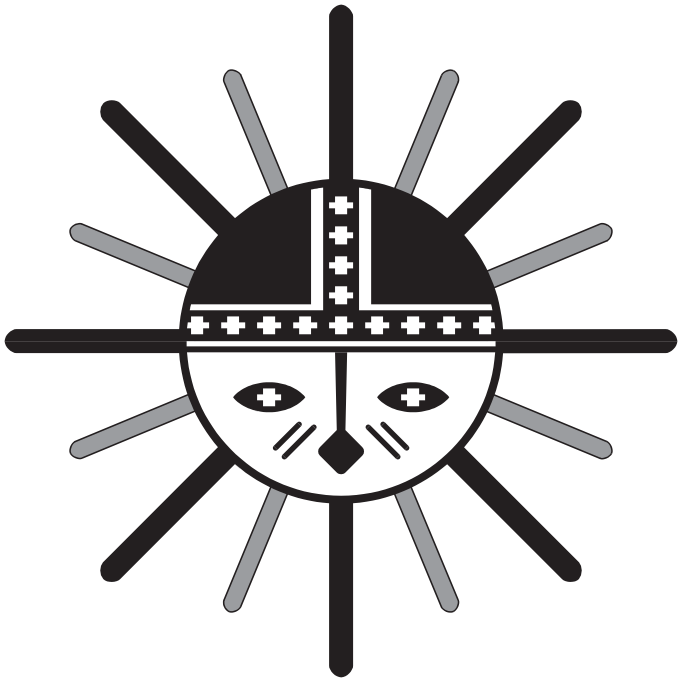

Utilization Management: Optimizing Resources

CDR Donna K. Strong, MSN, RN, CPHM, Utilization Review Coordinator, Northern Navajo Medical Center, Shiprock, New Mexico

Abstract

Utilization management, utilized by health care programs for over 20 years, helps provide and manage patient care through collection, assessment, and monitoring of data that pertain to patient services, care, and treatment.[1] Utilization management evaluates several different levels of patient care such as timeliness of services, length of stay, and readmission.

Health care programs depend on utilization management to ensure the patient receives appropriate services, at the appropriate time, and for the appropriate duration of time. Utilization management assists in determining appropriate medical services and treatment, and assists in eliminating unnecessary services. Utilization management evaluates the medical necessity of services and promotes cost effective use of services provided to the patient.

Patients benefit from utilization management through continual review and monitoring of patient care and services. Utilization management evaluates statistical trends such as length of stay and looks for areas of improvement to promote patient care through a safe and efficient manner.

What is Utilization Management?

Utilization management, also known as utilization review, is a process used to determine if the admitting diagnosis and treatment meet medical necessity for admission of the patient. This is determined through the collection, assessment, and monitoring of data that pertain to services and treatment provided. The Utilization Review Accreditation Commission (URAC) defines utilization management as "the evaluation of medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of applicable health benefits plan."[2] The review of care may be completed prior to or after the patient receives care, depending on the type of care received and the urgency of treatment, and is used to determine medical necessity of the care provided. The degree of care provided to the patient is based on criteria established by standards of care and practice guidelines. The criteria used to conduct a thorough review of medical necessity are precise, consistent, and limited to only the information needed to establish medical necessity.

Purpose of Utilization Management

According to the Department of Health and Human Services, the primary purpose of utilization management is to ensure that admissions and continued stays are appropriate, based on the hospitals admission and discharge rules and regulations, and that the patient's need for inpatient care and treatment meet medical necessity.[3] Hospitals rely on utilization management to ensure that patients receive appropriate services in a timely manner and for the appropriate duration of time to complete the necessary treatment required, therefore eliminating unnecessary services.[4] By keeping the utilization process on track through managing appropriate services and treatment required, utilization management assist the health care organization to run more efficient and economically. For example observation patients move through the system at a much faster rate than those patients who require a higher level of care. On-site utilization management keeps this process on track and ensures that patients receive necessary services required based on admitting diagnosis.

When is Utilization Management Required?

Utilization management begins when the patient is admitted to the hospital and continues to monitor services provided throughout the patients hospital admission. Utilization management evaluates the medical necessity of the admission and appropriateness of services provided, along with the need for ongoing care such as home health needs at the time of discharge. Once a provider determines the need for a particular service, the need must meet certain criteria and practice standard guidelines for approval.

The criteria used to evaluate medical necessity must be precise and consistent. The criteria used must describe the conditions or services to support the care level being requested. A review of documentation is conducted to compare the medical information to the medical necessity criteria for the admission. The review outcome is communicated to the admitting provider. Communication is completed in a timely manner in order to promote accurate and timely decision making.

Advantages of Utilization Management

Utilization review provides day-to-day feedback to the medical staff as it relates to level of care for the length of the treatment required. On-site utilization review assist with

keeping the patient moving through the system in a care-driven manner and at a faster rate than in the days prior to utilization management. The health care organization benefits from shorter inpatient hospital days and cost efficient treatment. Patients benefit from utilization management through continuous review and monitoring of patient care and services.

Conclusion

Health care reform has resulted in a growing interest in utilization management, making it an important factor in the US health care system as it reaches to all areas of health care operations. Utilization management plays an important role in authorizations for hospital admissions, treatments, and procedures to be paid by insurance companies, employers, and government.

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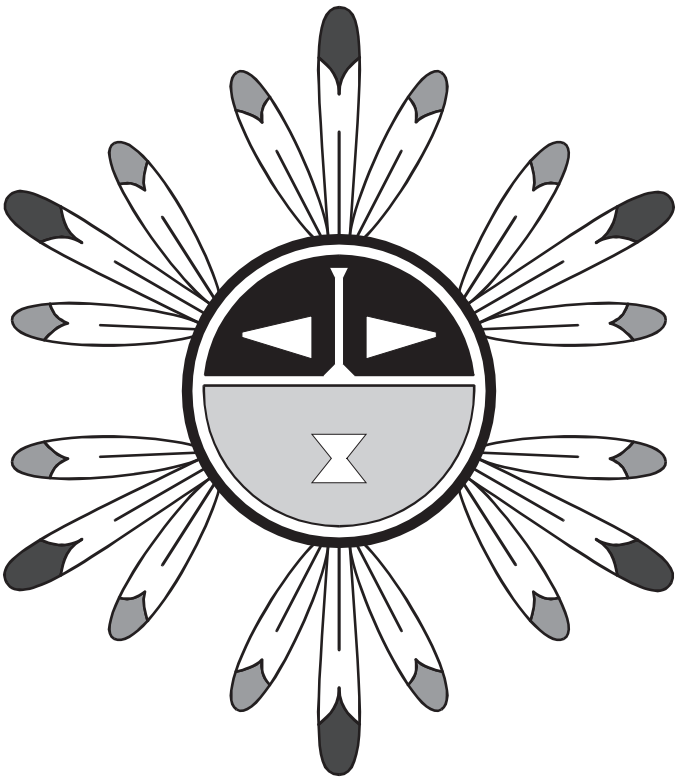

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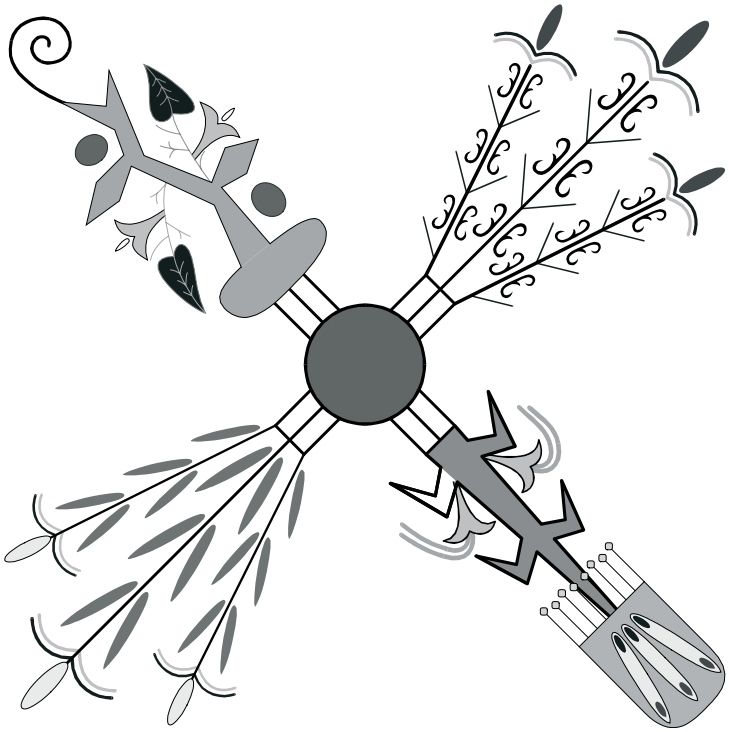

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"The first product of self-knowledge is humility."

Flannery O'Connor

Infectious Disease Updates
Rosalyn Singelton, MD, MPH

Healthy Homes: Indoor Air Quality and Respiratory Health

Background. American Indians/Alaska Natives experience high rates of respiratory infections and chronic respiratory conditions (Singleton R). Indoor environmental irritants (wood and tobacco smoke, dust, and combustion by-products) are known to exacerbate asthma and chronic respiratory disease. Studies in Navajo and Alaska AI/AN children have shown an association between lower respiratory infections and wood burning stoves (Robin L; Bulkow L). Evidence-based studies show that identifying and eliminating these environmental triggers may decrease respiratory symptoms in children with asthma (*http://www.epa.gov/asthma/triggers.html*) and can decrease respiratory infections in children (Wilkinson P).

Model projects. A woodstove change out study in the Nez Perce tribe led to a 52% reduction in small particulate matter (PM2.5) levels (Boulafentis J). In Nunavat, installation of heat recovery ventilators in homes reduced respiratory symptoms in Inuit children (Kovesi T). In Alaska, Alaska Native Tribal Health Consortium/Tribal Housing organizations/EPA/HUD are partnering in a study to evaluate the impact of home-based interventions (woodstove change out, installation of vents and range exhausts, and household education) on indoor air quality and respiratory symptoms in children.

Discussion. The burden of respiratory disease in AI/AN children may be reduced by innovative approaches to improving indoor air quality. A CDC Task Force concluded that the best evidence of impact is for home-based multi-component, multi-trigger interventions for children with asthma: interventions resulted in 21 fewer asthma symptom-days/year (Crocker DD).

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Recent literature on American Indian/Alaska Native Health
Jeff Powell, MD, MPH

TODAY Study Group, "A Clinical Trial to Maintain Glycemic Control in Youth with Type 2 Diabetes"; *New England Journal of Medicine*. Vol 366 No 24: 2247-2256

This month's submission focuses on the Treatment Options for Type 2 Diabetes in Adolescents and Youth (TODAY) study group's June, 2012 *NEJM* publication. The study is included here because AI/AN-serving providers squarely face the tough challenge of helping youth with type 2 diabetes. This study is notable as the largest, randomized, efficacy trial focused specifically on youth Type 2 Diabetes. In brief summary, the TODAY study tests the hypothesis that improved glycemic control (and insulin sensitivity) can be achieved using add-on treatment to traditional metformin monotherapy. The specific add-on treatments evaluated are 1) an oral insulin secretagogue, rosiglitazone, and 2) intensive lifestyle intervention.

This publication provides results for TODAY's primary research outcome: maintenance of diabetes "control" as defined by hemoglobin A_1c less than 8%. To clarify, 8% was

chosen as a cutpoint to identify *loss* of control. The analyses presented in the paper characterize the length of time (in months) until patients lose diabetes control (A_1c exceeds 8% for 3 months), or have destabilizing events like DKA, episodes of severe symptomatic hyperglycemia, or fail to get off insulin after another incidental illness.

The TODAY study follows 699 youth (10 - 17) with clinical and laboratory confirmed Type 2 Diabetes. The youth were enrolled via multiple referral centers across the national TODAY consortium, supported by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). This model of a research consortium was needed due to the small numbers of eligible youth at any one location. The study over-selected for minorities, in particular Non-Hispanic Black (32.5% of the cohort) and Hispanic (39.7%) youth. The enrollment process identified 1211 potentially eligible patients. Of these, 284 were excluded immediately, and 927 entered a "run-in phase." During this run-in, patients must have demonstrated compliance with appointments, with standard diabetes education, with medication use, and achievement of glucose control on metformin alone. This phase lasted 2 - 6 months. Of these 927 patients, 699 patients were randomized to the three treatment groups (122 patients did not meet eligibility criteria, and 106 either declined or had another reason for dis-enrollment). The three patient groups thus included 232 youth with T2 DM assigned to receive metformin alone, 233 receiving metformin plus rosiglitazone, and 234 receiving metformin and lifestyle intervention.

Figures 2 and 3 in the paper reveal the primary outcomes of this study (revealing the loss of DM control over an average duration of 3.86 years). The group receiving metformin alone "lost control" the quickest, with nearly 52% (a majority) reaching this endpoint. The metformin plus lifestyle intervention group was intermediate (and did not have a statistically significant difference with either group), with 47% of patients "losing DM control." The combination pharmacotherapy group (with metformin and rosiglitazone), fared the best: just 38.6% of these patients met the study endpoint. This paper presents summaries of sub-group analyses as well (Figure 3). The significance of analyses by sex and race are not yet clear. Boys did not demonstrate as much benefit from the combination therapy. Non-Hispanic Black youth showed a very high rate of failure with metformin alone (66%), with roughly equal improvements in the two other groups (the lifestyle intervention and rosiglitazone add-on therapies improved outcomes equally). Hispanic youth revealed no statistically significant differences between the three randomized treatment groups.

The results in this paper also include an analysis of change in BMI. These findings reveal the combination rosiglitazone-metformin group to have modest weight gain (0.86% increase in percent overweight at 24 months of treatment). The metformin + lifestyle intervention and metformin + rosiglitazone groups revealed modest weight loss (-5.02% and -4.42% respectively). Interestingly, neither BMI at baseline nor BMI over time was a predictor of treatment failure.

Summary/Conclusions. This study focuses on the ever-important care we provide youth with Type 2 Diabetes. One take home message is that our patients are very likely to require "add-on" therapy early in their type 2 diabetes course. Metformin alone did not "cut it" for the majority of study patients. The particulars of what type of add-on therapy cannot be determined by this study.

The presented results may raise more questions than they provide answers, particularly due to the restricted use status of rosiglitazone (please consult your regional endocrinologist). Luckily, future publications are likely to address some of the pending questions. The TODAY study included a broad array of physiologic and psychosocial data collection, with further analyses surely pending.

As a final note, I would like to comment that this study does not "prove" that lifestyle intervention programs for T2DM youth do not work. It simply did not show a benefit, overall, for this study. Yet this study does show that Black participant outcomes improved roughly equally between the add-on therapies of rosiglitazone versus lifestyle intervention (Figure 3C). This was not true for Hispanic youth and Non-Hispanic Whites. Again, this raises more questions.

Pursuing these questions with further research and new models of care is important. Surely, we can improve the outcomes from what was achievable in this study. The best we can do, in the very well implemented TODAY study, was that nearly 40% of patients lost diabetes control. The rising numbers of youth with this potentially life-altering and limiting illness implore us to keep trying new approaches, until we find interventions that truly "work."

Incorporating a Pharmacist Clinician into an Indian Health Service Pharmacy-Managed Anticoagulation Clinic: A Model for Role Expansion

Ryan McCallum, PharmD, PhC, BCPS, Staff Pharmacist, Gallup Indian Medical Center, Gallup, New Mexico

Recently the Surgeon General of the United States endorsed expanding clinical pharmacy practice as described by over four decades of positive outcomes in the report titled *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice*.[1,2] According to the Surgeon General, ". . . expanded pharmacy practice models improve patient and health system outcomes and optimize primary care access and delivery."

Consistent with this recommendation, in 1998, the Gallup Indian Medical Center (GIMC) created the pharmacy-managed anticoagulation clinic in Gallup, New Mexico, which independently manages patients' anticoagulation care. Service delivery occurs in accord with a collaborative practice agreement (CPA) between the pharmacists and physicians, which outlines the privileges and responsibilities of the anticoagulation pharmacist and consists of limited medication prescriptive authority as well as laboratory ordering and interpretation.

The established follow-up patient visit includes these elements: 1) the international normalized ratio (INR) is measured with point of care (POC) testing; 2) a patient interview is conducted, ascertaining warfarin side-effects, signs or symptoms of thrombus or thromboembolism occurrence, lifestyle factors that affect INR including dietary vitamin K intake, medication changes, and disease state changes; and 3) appropriate medications are prescribed and dispensed to the patient along with instructions for use.

In 2011, the clinic providers managed approximately 2000 patient visits. That same year, the GIMC pharmacy-managed anticoagulation clinic expanded the role of pharmacists further by adding a New Mexico pharmacist clinician (PhC). Below is a description the training required for pharmacists who aspire to become a PhC, the patient-visit responsibilities of the role at this site, and the service delivery and fiscal advantages of adding such a professional to the staff.

A PhC license is conferred by the New Mexico Board of Pharmacy to pharmacists who have completed the following: 1) state pharmacy license reciprocation to New Mexico; 2) an approved, 60-hour physical assessment course; and 3) a 300-patient/150-hour physician-supervised internship honing physical assessment and diagnostic skills. Benefits for earning a PhC license include medication prescriptive authority and recognition by third party payers, including New Mexico Medicaid and some private insurers.

The PhC anticoagulation patient visit follows the general procedure described above, but adds physical assessment to enhance patient care and conform to the Center for Medicaid and Medicare Services (CMS) billing structure. Expanded physical exam is comprised of vital sign collection (blood pressure, pulse, and respirations); a cardiovascular exam, including cardiac auscultation and palpation for pedal edema; pulmonary auscultation; a neurological exam; and any other pertinent physical exam components.

From November 1, 2011 to May 30, 2012 the anticoagulation PhC billed New Mexico Medicaid and private insurances $18,500 for 400 patient visits. Furthermore, the PhC collected $13,000 for GIMC from New Mexico Medicaid and private insurance companies during the same time period. Based on this collection rate and the 2011 workload, the full-time GIMC anticoagulation PhC could collect around $65,000 annually. Clinical interventions secondary to enhanced physical assessment techniques were made and documented as well. For example, a vital sign abnormality was appreciated and, to potentially prevent a dangerous outcome, wafarin was discontinued. Also, an abnormal musculoskeletal exam and neurologic exam resulted in lower extremity and brain imaging, respectively.

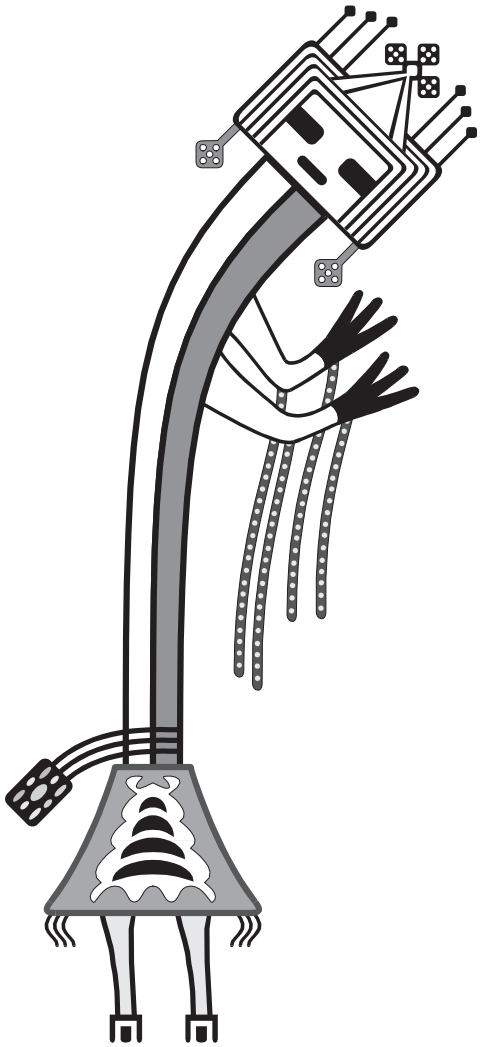
Integrating a PhC into a pharmacist-managed anticoagulation clinic has resulted in positive patient and fiscal outcomes, consistent with the Surgeon General's report. Consequently, pharmacists within GIMC and surrounding Area IHS facilities are currently pursuing PhC licensure.

References

1. Giberson S, Yoder S, Lee MP. *Improving Patient and*

Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.

2. *U.S. Surgeon General Endorsement letter for: Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist.* U.S. Public Health Service. December 14, 2011.



Google: Three Valuable Tips and a Useful Option

Diane Cooper MSLS, AHIP, NIH Library Services for IHS, Rockville, Maryland

Google will retrieve any web site on any topic you enter into the search box, the good and the bad together. The burden of deciding if the information in a site is reliable rests on your judgment. There are ways to search Google to retrieve more credible information and eliminate the less credible sites. In addition, you can decrease the thousands and thousands of results you retrieve to a more manageable list. Here are three basic tips to help you search Google more effectively.

Another option is to limit your search to only scholarly materials. To do this, select Google Scholar. Google Scholar is a subset of Google that weeds out general Web pages and brings you links to a range of scholarly materials. These include published articles, theses, technical reports, conference abstracts, and book citations from academic publishers, professional societies, universities, and repositories – the kind of resources you would expect from searching professional databases such as PubMed, Web of Science, and Scopus. Here are three tips for searching Google Scholar more effectively.

For help with searching Google or Google Scholar, feel free to contact me, Diane Cooper, Biomedical Librarian and Informationist for IHS/NIH Library, at *diane.cooper@nih.gov*.

GOOGLE BASIC	EXAMPLE	RETRIEVES/COMMENTS
Quotation Marks	"insulin like growth factor 2"	Retrieves only websites with the exact phrase
Site	**site.gov** diabetes **site.org** diabetes **site.edu** diabetes	Only retrieves websites on diabetes within 1) government sites [gov]; 2) organization sites [org]; and 3) education sites [edu]
Filetype	**filetype:ppt** thyroiditis **filetype:pdf** thyroiditis	Narrows your search to Powerpoints (ppt) or Adobe Acrobat (pdf) files

GOOGLE SCHOLAR	EXAMPLE	RETRIEVES/COMMENTS
Author	gardner parathyroid glands	If you know who wrote the paper you are looking for, you can add their last name to your search terms
Date Restrict	thyroiditis [click on Since 2012; English]	To limit your search to specific time, select "Since 2012" or "Since 2011" or "Since 2008" or "Custom Range" located under Any Time on the left side of the results
By Title	"A streamlined strategy for the biochemical investigation of adrenal incidentalomas"	Use quotation marks around the title of an article you are trying to find.

MEETINGS OF INTEREST

Advancements in Diabetes Seminars
Monthly; WebEx

Join us monthly for a series of one-hour WebEx seminars for health care program professionals who work with patients who have diabetes or are at risk for diabetes. Presented by experts in the field, these seminars will discuss what's new, update your knowledge and skills, and describe practical tools you can use to improve the care for people with diabetes. No registration is necessary. The accredited sponsors are the IHS Clinical Support Center and IHS Nutrition and Dietetics Training Program.

For information on upcoming seminars and/or previous seminars, including the recordings and handouts, click on this link and see Diabetes Seminar Resources: *http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars*

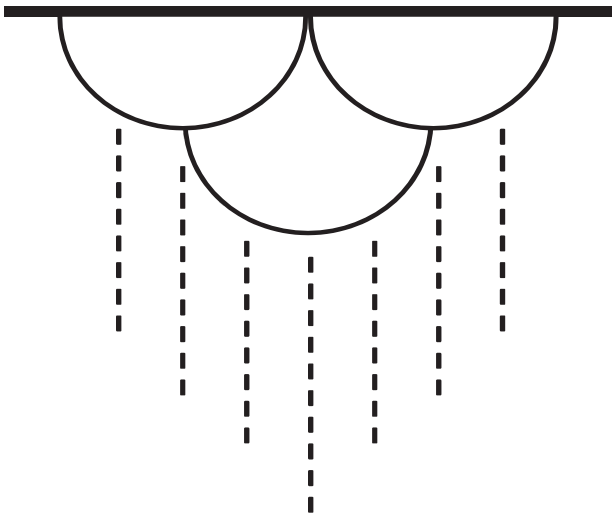
Available EHR Courses

EHR is the Indian Health Service's Electronic Health Record software that is based on the Resource and Patient Management System (RPMS) clinical information system. For more information about any of these courses described below, please visit the EHR website at *http://www.ihs.gov/CIO/EHR/index.cfm?module=rpms_ehr_training*. To see registration information for any of these courses, go to *http://www.ihs.gov/Cio/RPMS/index.cfm?module=Training&option=index*.

2012 Health Disparities Summit
October 31 – November 3, 2012; National Harbor, Maryland

The US Department of Health and Human Services (HHS), under the leadership of the Office of the Assistant Secretary for Health, the National Institute on Minority Health and Health Disparities (NIMHD) at the National Institutes of Health (NIH), and the HHS Office of Minority Health (OMH), invites you to the 2012 Science of Eliminating Health Disparities Summit (also called the *2012 Health Disparities Summit*.) The summit will be held on Wednesday, October 31 through Saturday, November 3, 212 at the Gaylord National Resort and Convention Center in National Harbor, Maryland.

The 2012 Science of Eliminating Health Disparities Summit is an HHS-wide endeavor involving a broad spectrum of the federal government that seeks to advance activities to eliminate health disparities. The agenda will build on the momentum of the 2008 Summit and the increased interest of federal agencies to demonstrate their commitment toward improving the health of all Americans. The 2012 Health Disparities Summit represents an ongoing focus on emerging science and its intersection with practice and policy, while maintaining momentum on current national and international trends in addressing the social determinants of health. For more information, go to *http://www.nimhd.nih.gov/summit_site/*.



POSITION VACANCIES

Editor's note: As a service to our readers, The IHS Provider *will publish notices of clinical positions available. Indian health program employers should send brief announcements as attachments by e-mail to* john.saari@ihs.gov. *Please include an e-mail address in the item so that there is a contact for the announcement. If there is more than one position, please combine them into one announcement per location. Submissions will be run for four months and then will be dropped, without notification,, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service ($100 for four months). The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Primary Care Physician
Zuni Comprehensive Community Health Center;
Zuni, New Mexico

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has openings for full-time primary care physicians starting in fall 2012. This is a family medicine model hospital and clinic providing the full range of primary care, including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics, with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 17 physicians, two NPs, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

Zuni Pueblo is one of the oldest continuously inhabited American Indian villages in the US, estimated to be at least 800 - 900 years old. It is located in the northwestern region of New Mexico, along the Arizona border. It is high desert, ranging from 6000 - 7000 feet in elevation, and is surrounded by beautiful sandstone mesas and canyons with scattered sage, juniper, and pinon pine trees. Many of our medical staff have been with us for several years, reflecting the high job and lifestyle satisfaction we enjoy in this community.

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page) or by e-mail at *john.bettler@ihs.gov*. CVs can be faxed to (505) 782-7405, attn. John Bettler. (7/12)

Medical Director
American Indian Health and Family Services of
Southeastern Michigan, Inc. (AIHFS); Detroit, Michigan

AIHFS is looking for a qualified candidate for the medical director position at our health center in Detroit, Michigan. A summary of the position is as follows: general professional guidance of primary care staff; collaborates with fellow physicians and executive director on administrative operations of the medical, dental, and behavioral health services; responsibilities for management of all aspects of the program including accreditation, infection prevention and control, patient safety risk management, and emergency preparedness. This position will report to the executive director. We are seeking someone with completion of an accredited medical school, internship, and completion of the certification examination by the medical board of examiners; a permanent current full and unrestricted license to practice medicine or osteopathy in Michigan; board certified or eligible in family practice. If board eligible, must be AAFP or AOA certified within six months from the date of hire. Current medication dispensing license (DEA). Experience and training must have been progressive and responsible, demonstrating good knowledge of current principles, practices, methods, and techniques in the field of medicine. Medical experience in an outpatient family medical clinic including pediatrics, obstetrical/gynecological, medical care, and non-emergency care. Possess current and valid Michigan driver's license with no DUI/DWI or reckless driving convictions in the last five years, having no more than two at-fault accidents in the last three years, and maintain a valid driver license during employment. Must pass a criminal background check with a Class I Fingerprint Clearance Card within the initial ninety days of employment. Must have updated immunization record. Must have a tuberculosis test upon employment and employee health profile updated on an annual basis. Must obtain/maintain CPR certification and a valid card during employment. Please send a cover letter with resume and references to AIHFS, PO Box 810, Dearborn, Michigan 48121, Attn: Jackie Allison, Administrative Assistant. You can also fax to (313) 846-0150. (7/11)

Certified Diabetes Educator
Salt River Pima-Maricopa Indian Community;
Scottsdale, Arizona

Under general supervision from the Health and Human Services Department (HHS) Health Service Division, Diabetes Services Program Manager, provides diabetes preventive care, screening, clinical care, case management, and education to all children, adults, elders, and families within the Salt River Pima-Maricopa Indian Community. This job class is treated as FLSA Exempt.

To apply for this position or to view the full job description, please visit our website at *http://www.srpmic-*

nsn.gov/employment/ then select Employment Opportunities. For additional information, contact Keolani Tynan, HR Recruitment Specialist, Salt River Pima-Maricopa Indian Community at (480) 362-7935. (7/12)

Family Practice Physician
Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful, 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("basket-maker") Apache community with a population of 4,000. Our clinic has an opening for a board certified/eligible family practice physician for purely outpatient care with a 40 hour work week. We also have vacancies for a pharmacist and a nurse. Our site qualifies for NHSC, IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. We have adopted the IPC model with care teams. Our staff currently consists of four family practice physicians, an internist, an optometrist, and three dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with profits from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility, a modern supermarket, a Best Western Hotel and Casino, and more.

We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass. We welcome you to visit our facility in person. To take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to *http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx*. Please call Dr. Cecilia Chao at (575) 759-3291 or (575) 759-7230; or e-mail *cecilia.chao@ihs.gov* if you have any questions. (6/12)

Family Practice Physician (1)
Physician Assistant or Family Nurse Practitioner (2)
United Indian Health Services, Inc. (UIHS),
Howonquet Clinic; Smith River, California
and
Family Practice Physician (1)
UIHS, Potawot Health Village; Arcata, California

UIHS is a premier health care organization located in beautiful northern California along the Pacific coast near the majestic redwoods. The organization is a unique nonprofit made up of a consortium of nine tribes, with a mission "To work together with our clients and community to achieve wellness through health services that reflect the traditional values of our American Indian Community." UIHS provides wraparound services that include medical, dental, behavioral health, and community services. Our focus is to empower our clients to become active participants in their care. If you value outdoor adventures such as backpacking, kayaking, biking, fishing, and surfing, and you envision yourself providing services to an underserved but deserving community in a caring and holistic manner, come join our team. Please visit our website at *www.uihs.org* or contact Trudy Adams for more information at (707) 825-4036 or email *trudy.adams@crihb.net*. (5/12)

Central Scheduler
Medical Clinic Manager
Human Resources Director
Psychiatrist
Physician (Internal Medicine or Family Practice)
Consolidated Tribal Health Project, Inc.;
Calpella, California

Consolidated Tribal Health Project, Inc. is a 501(c)(3) non-profit, ambulatory health clinic that has served rural Mendocino County since 1984. CTHP is governed by a board comprised of delegates from a consortium of nine area tribes, eight of which are federally recognized, and one that is not. Eight of the tribes are Pomo and one is Cahto. The campus is situated on a five-acre parcel owned by the corporation; it is not on tribal land.

CTHP has a Title V Compact, which gives the clinic self governance over our Indian Health Service funding allocation. An application for any of these positions is located at *www.cthp.org*. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (5/12)

Hospitalist
Gallup Indian Medical Center; Gallup, New Mexico

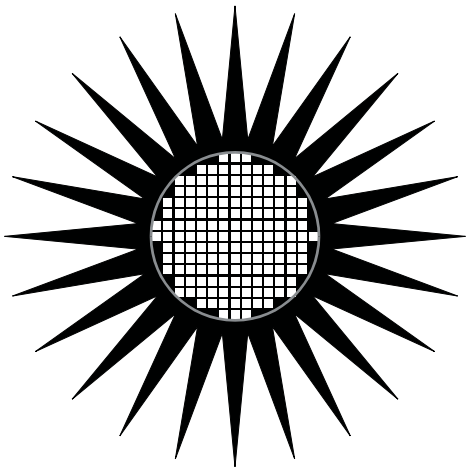
Gallup Indian Medical Center (GIMC) is currently seeking energetic and collegial internists for our new hospitalist program. The hospitalists care for all adult inpatients previously taken care of by family medicine and internal medicine physicians, and provide consultation services. We have seven FTEs for hospitalists, and while we are still growing, we enjoy further inpatient staffing support from internal medicine and family medicine.

GIMC is a 99-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Clinical specialties at GIMC include internal medicine, family medicine, critical care, cardiology, neurology, orthopedics, ENT, radiology, OB/GYN, general surgery, ophthalmology, pathology, pediatrics, emergency medicine, and anesthesiology. The hospitalists' daily census is approximately 25 - 30. There is a six bed ICU. Our patient population includes Navajos, Zunis, and others living nearby, as well referrals from smaller clinics and hospitals.

Gallup has a diverse community and is very livable,

offering a thriving art scene, excellent outdoor activities (biking, hiking, rock climbing, cross-country skiing), safe neighborhoods, diverse restaurants, national chains and local shops, and multiple public and parochial school options. The medical community is highly collegial, is committed to continuing education, has an on-going collaboration with Brigham and Women's Hospital, and has a high retention rate.

For more information, contact Eileen Barrett, MD, at (505) 722-1577 or e-mail *eileen.barrett@ihs.gov*. Or please consider faxing your CV to (505) 726-8557. (4/12)



Help us Save Money

The federal government is always exploring ways to reduce costs. One recent initiative is an effort to reduce printing expenses. As our readers know, last year we made a transition from an every month print version of *The Provider* to a quarterly print version, thus saving both printing and mailing costs. About 5000 readers still have paper subscriptions.

Although we made this change in the printing schedule, we continued to post the monthly edition of our journal to the CSC website. Currently, about 900 individuals are subscribers to the listserv that notifies them when each monthly issue is posted, and lists the contents of that issue. It is unknown how many readers simply access the website on a periodic basis without relying on the listserv for reminders that the monthly issue is available. It is also unknown how many individuals subscribe to both the print version and the listserv.

As one contribution to the effort to minimize costs, we would suggest to our readers the following: 1) if you have a paper subscription and are no longer using it, or if you know of someone who has left your facility but is still receiving the paper edition, please contact *Cheryl.Begay@ihs.gov* in our office to let her know that these subscriptions can be stopped; 2) if you have both a paper subscription and access to the on-line version, and it makes little difference to you which version you use, you may want to consider stopping the paper version and use the one on-line; and 3) if you are using the on-line version and are not on the listserv, you may want to join (go to *http://www.ihs.gov/provider/index.cfm?module=listserv*), as this provides us with more accurate data about readership.

Our goal is to reach as many readers in Indian Country as possible, using the format that is most useful to each individual. Beyond that, we would like to do whatever we can to reduce our expenses.

Please let us know if you have any questions or suggestions.

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THE IHS PRIMARY CARE PROVIDER
A journal for health professionals working with American Indians and Alaska Natives

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Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.

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

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