THE IHS PRIMARY CARE PROVIDER

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

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The New American Heart Association 2005 Guidelines for CPR and ECC

James M. Galloway, MD, FACP, FACC, Director, Native American Cardiology Program and Senior Cardiologist, Indian Health Service, Flagstaff, Arizona

High-quality CPR with fewer interruptions is the goal of the latest modifications in the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care. Survival from out-of-hospital cardiac arrest (i.e., the heart suddenly stops pumping blood) remains unacceptably low, averaging about 6 percent overall in the United States. We know that the performance of immediate bystander CPR can double or triple a cardiac arrest victim's chances of survival – and we know that survival rates can be more than 50 percent for victims when immediate and effective CPR is combined with prompt use of an automated external defibrillator. However, according to the AHA, the most common reason for an individual to die from cardiac arrest is that no one near by knew how to perform CPR – or, if they knew, they didn't perform it. This was, in part, because CPR training and performance were too complicated. Therefore, the new guidelines were developed to simplify CPR and make it easier to remember.

Experts at the University of Arizona and elsewhere have recommended performing chest compressions alone (without rescue breathing) but, since many cardiac arrest victims will benefit from rescue breaths as well, the new guidelines still recommend including that part of CPR for all victims. People who have drowned or whose hearts have stopped for reasons related to breathing problems are examples of those who clearly need rescue breaths, as well as chest compressions.

Streamlining CPR for the layperson who witnesses someone suffering a cardiac arrest has significant increased potential to save lives. Some steps from the prior CPR protocol were eliminated. For instance, if one encounters a person who cannot be awakened and is not breathing, he or she should assume that the person is in cardiac arrest. They should give two breaths and move right into giving chest compressions without wasting any time evaluating the victim.

The other major change for bystanders is to increase to 30 the number of chest compressions given before pausing to give two rescue breaths. This change applies to victims of all ages (except newborn infants) and is even recommended for healthcare professionals who might be working on their own before additional help arrives. When chest compressions are interrupted, blood flow stops. Limiting interruptions to chest compressions will result in greater survival. We also know that

In this Issue…

in any given series of chest compressions, earlier compressions are less effective than later ones. Therefore, fewer interruptions increase the percentage of effective chest compressions. Allowing the chest to fully recoil or return to its normal position between compressions also results in better refilling of blood in the heart, which allows more blood to be pumped to the rest of the body during the next compression.

This emphasis on providing CPR with fewer interruptions is also reflected in the changes to the new guidelines for using a defibrillator. For example, rescuers are advised to use only one shock before resuming CPR, rather than three, as previously recommended. Those who do not convert with the first shock will have a better chance of responding to another shock if they first receive some CPR. This also reduces the length of time that the victim is left with no blood flow to the heart, brain, and other vital organs.

Reference

Circulation, Volume 112, Issue 24 Supplement; December 13, 2005. This special supplement to *Circulation* is freely available at *http://circ.ahajournals.org/content/vol112/24_suppl/.*

Conference to Focus on Reducing Health Disparities in American Indians and Alaska Natives

Diabetes is a significant health problem in American Indians and Alaska Natives and will be the topic of the conference "Reducing Health Disparities in American Indian and Alaska Natives by Preventing Diabetes Throughout the Life Cycle," to be held on August 21 - 24, 2006 at the Cox Business Services Convention Center in Oklahoma City.

The conference is designed to provide a forum for sharing and exchanging information about ongoing prediabetes and diabetes prevention efforts. It will focus on community empowerment and involvement in diabetes prevention throughout the life cycle: infancy, youth, adult, and elder.

The conference will cover health disparities in diabetes and its complications in American Indians; how changes in existing communities can support wellness activities; tribal perspectives and the role of tribes in diabetes prevention; health professionals' roles in promoting/implementing prevention strategies; recruitment and retention of participants in diabetes prevention activities; and the introduction of new prevention strategies. It also will provide community members an opportunity to share successes and challenges. The event is co-sponsored by the Native American EXPORT Center from the College of Public Health at the University of Oklahoma Health Sciences Center, and the Oklahoma City Area Indian Health Service (IHS).

The accredited sponsor of the conference for continuing education is the IHS Clinical Support Center. The Clinical Support Center (CSC) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The CSC designates this activity for up to 12.5 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spends in the educational activity. This Category 1 credit is also accepted by the American Academy of Physician Assistants and the American College of Nurse-Midwives. The Indian Health Service CSC is a provider of continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation. This activity has been awarded 15 contact hours for nurses.

For more information about exhibits or registrations, or to submit an abstract online, visit ***export.ouhsc.edu***. If you are unable to access online registration, call toll-free (888) 231-4671 for a hard copy registration form. The deadline for early bird registration is June 15 and regular registration begins June 16.

To make hotel reservations, contact the following participating hotels: Renaissance Oklahoma City, the host hotel, at (405) 228-8000; Courtyard Marriott at (405) 232-2290; and Sheraton Oklahoma City at (405) 235-2780. Located in the heart of downtown Oklahoma City, the Cox Business Services Convention Center is surrounded by the Bricktown area and all three participating hotels.

Save the Date: April 24-26, 2006

18th Annual IHS Research Conference

"Discovering Pathways to Better Health for American Indians and Alaska Natives"

This three-day research conference will enhance our ability to ensure benefits of research to Native communities and peoples. The conference will also examine in depth the impact of aging and mental health research activity in American Indian and Alaska Native (AI/AN) communities. While this 18th Annual Indian Health Service (IHS) Research Conference will focus on aging and mental health, it will touch on all aspects of AI/AN health.

Who Should Attend

Stakeholders in American Indian/Alaska Native research activities including consumers, researchers, clinicians, health administrators and providers, educators, and community and tribal government leaders across the nation.

Conference Location

The IHS Research Conference will be held at the Albuquerque Convention Center, 401 2nd Street NW, Albuquerque, NM 87102.

Lodging

The host hotel will be the DoubleTree Hotel Albuquerque, 201 Marquette NW, Albuquerque, NM 85253, Phone: (505) 247-3344, Fax: (505) 247-7025. The DoubleTree Hotel is conveniently connected to the Albuquerque Convention Center via an indoor concourse.

Make your hotel room reservations by **March 24, 2006** by calling (505) 247-3344. Be sure to ask for the "Indian Health Service Research Conference" group rate. The hotel room rate is $66.00 single/$86 double per room, per night, plus tax. Check-in is 3:00 pm and check-out is 12:00 pm. Reservation requests received after the cut-off date will be accepted on a space available basis at the hotel's prevailing rates.

Call for Abstracts

Individuals who want to present their research should prepare an abstract and e-mail it (in Word format) to Leslie L. Randall, RN, MPH by **March 10, 2006** (see Call For Abstracts) at: lhr6@cdc.gov or lrandall@npaihb.org. Phone: 503.416.3298 (office) 503.697.7397 (home) or 503.621.8996 (cell)

Contact Information

For more information, contact Ellen Ortiz, Program Assistant, 5300 Homestead Rd., NE, Albuquerque, NM 87110, Phone: 505 248-4435 or E-mail: Ellen.Ortiz@ihs.gov.
On-line registration is available at the IHS Clinical Support Center website at http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/index.cfm.

Accreditation

The IHS Clinical Support Center is the accredited sponsor of this meeting. The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education, the American Nurses Credentialing Center's Commission on Accreditation, and the Accreditation Council for Pharmacy Education.

18th Annual IHS Research Conference
"Discovering Pathways to Better Health for American Indians and Alaska Natives"
Call for Abstracts

The 18th Annual IHS National Research Conference, "Discovering Pathways to Better Health for American Indians and Alaska Natives," is being held at the Albuquerque Convention Center. The host hotel is the Doubletree Hotel Albuquerque, 201 Marquette NW, Albuquerque, NM 85253, Phone: (505) 247-3344, Fax: (505) 247-7025. This conference will enhance our ability to ensure benefits of the research to Native communities and peoples. The conference will also examine in depth the impact of aging and mental health research activity in American Indian and Alaska Native (AI/AN) communities. While this 18th Annual Indian Health Service (IHS) Research Conference will focus on aging and mental health, it will touch on all aspects of AIAN health. Abstracts on all topics are welcome, as long as they concern research by, for, or about American Indians, Alaska Natives, First Nations and/or Inuit peoples. Submit your oral or poster presentation for the following categories **by March 10, 2006**:

Access to Care, Adolescent Health, Aging, AIDS, Alcohol and Substance Abuse, Alternative Healing Practices, Asthma, Cancer, Cardiovascular Disease, Other Chronic Illness, Continuity of Care/Medical Home Models, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Immunizations, Infectious Disease (e.g. RSV, Pneumococcal Disease, etc), Injury Prevention, Maternal and Child Health, Mental Health, Nutrition, Obesity, Oral Health, Telemedicine, Traditional Medicine, Urban Health and Women's Health.

Abstracts meeting one of the following criteria will be given special consideration:

- Submissions by AI/AN, First Nations, or Inuit students.
- Research that measures the effectiveness of innovative health care intervention, or that involves exemplary partnerships between researchers and tribes
- Research issues common to native populations in both Canada and the US.

PLEASE note: This **DOES NOT** replace your registration which will be handled by the IHS Clinical Support Center online and will be available late January. Visit the IHS Clinical Support Center website at http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/index.cfm to register

This conference is being co-sponsored and organized by the Native Research Network.

Instructions for Preparing Abstracts:

1. You should share your research results with the tribe(s) involved in the research for tribal review and approval before presenting the results at this meeting.
2. All abstracts accepted for either oral presentation or poster presentation will be reproduced in an abstract book for distribution. Therefore, all abstracts must be sent via email as attached documents formatted in **WORD**. Please follow the directions carefully on the following page.
3. Use the sample abstract form on the following page, as a guide for size as you prepare your abstract. All copies must fit within the frame.
4. The abstract content should be structured as follows:
   - Title [bolded]
   - Authors [First name, Middle Initial, Last name] Note: Do not include degrees after the authors' names. Place an asterisk before the name of the presenting author.
   - Single space after the Title and Authors.
   - Single-space the text of the abstract with one continuous paragraph using Times New Roman 12 CPI.
   - The text should be no more than 250 words. Do not include figures, tables, equations, mathematical signs or symbols, or references.
   - Organize the text in the following manner and bold the Purpose, Methods, Results, and Conclusions
     – A brief Purpose statement or Background of the study
     – A statement of the Methods used (including number of subjects and other pertinent data)
     – A summary of the Results presented in sufficient detail to support the conclusion and
     – A statement of the Conclusion. (It is not appropriate to state, "The results will be discussed.")
   - Single space after the text of the abstract.
   - Add "For further information:" in bold, followed by the primary author's full name, official title, organization, address, telephone number, fax number, and e-mail address.
5. Please check the desired form of presentation: oral, poster, or either one.
6. Please fill out the biographical sketch and email in word to the addresses below.
7. **Abstracts must be received by close of business March 10, 2006**.
8. We will notify authors of the acceptance or rejection of their paper no later than **March 24, 2006**.
9. All abstracts should be emailed to: lrandall@npaihb.org or lhr6@cdc.gov
   Leslie Randall, RN, MPH
   Phone: 503/416-3298 (office)
   503-697-7397 (home) or
   503-621-8996 (cell)
10. Questions and technical assistance requests should be directed to either Ms. Randall via e-mail, or phone.
11. Please fax the attached speaker forms to Leslie Randall at 503-228-8182.

Indian Health Service
18th Annual Research Conference

ABSTRACT TEMPLATE AND BIOGRAPHICAL DATA FORM

Using "avoidable hospitalization" indicators to access adequacy of Primary care: the Indian Health Service (IHS) 1980-1990. Blessing Yazzie, Eudora Jones, *Thomas L. Whitehorse.

Background: Major needs in assessing care included: using existing data; and assessing primary care. We used "avoidable hospitalization" indicators to assess how well IHS primary care prevented avoidable hospitalizations. **Methods:** The avoidable hospitalization indicators were: TB, pertussis, cervical cancer, rheumatic heart disease, and asthma, complications of hypertension, influenza and pneumococcal pneumonia in 65 + year olds, infant gastroenteritis and newborn disease due to isoimmunizations. The IHS inpatient database for years 1980-1990 provided the count of cases. The denominator was the IHS Service Population Derived from the census 1980-1990 of American Indian and Alaska Native residents. We calculated the The all US rates using the National Hospital Discharge Survey. **Results:** Hospitalization rates for most avoidable conditions decreased more than had all hospitalizations. However the rates of four conditions decreased less than all, and worsened relative to the change in the US; pneumococcal pneumonia for 65+ year olds, newborn hemolytic disease, hypoglycemia and asthma. **Conclusions:** IHS should investigate the epidemiology and the primary care of these conditions. Avoidable hospitalization indicators may detect changes in primary care or epidemiology rapidly and with good sensitivity.

For Further information: Blessing Yazzie, MD., PHD. Director, Tribal Health Program, 4300 Haxton Way, Tucson, AZ 85746-9352. 520-263-8500, 520-263-8516. Blessing@tribe.gov

Biographical Sketch (Please Type)

Primary Author/Presenter: _____
As you would like it in the Conference Program

Mailing Address: _____
_____
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City/State/Zip: _____
Phone Numbers: Work: _____ Fax: _____ E-mail: _____
Secondary Authors: *(Name, Title, Place of Employment)* _____
_____
_____
Submitted for: [ ] Oral Presentation [ ] Poster Presentation [ ] Either

If this Abstract is not accepted for oral presentation, would you consider a poster? [ ] Yes [ ] No

Indicate the Major content area of your abstract:

[ ] Nursing	[ ] Medicine	[ ] Environmental Health
[ ] Community Health	[ ] Nutrition	[ ] Behavioral/Mental Health
[ ] Dentistry	[ ] Epidemiology	[ ] Other_____

18th Annual IHS Research Conference

"Discovering Pathways to Better Health for American Indians and Alaska Natives"

REGISTRATION FORM

PLEASE PRINT:

Name: _____ Job Title: _____

Work Facility: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Work Fax #: _____

E-mail Address: _____

Employment Category:	☐ Tribal	☐ IHS	☐ Other Federal Agency
	☐ University	☐ Urban	☐ Other: _____
Professional Category:	☐ Physician	☐ Nurse	☐ Other:_____

I will be attending the IHS Research Conference on the following days:

- ☐ Sunday, April 23, 2006 – Pre-Conference
- ☐ Monday, April 24, 2006
- ☐ Tuesday, April 25, 2006
- ☐ Wednesday, April 26, 2006

I am interested in attending the following workshop offered Wednesday afternoon (please check one):

- ☐ Translating Research to Community Interventions
- ☐ Maneuvering the Research Maze
- ☐ IRB Toolkit
- ☐ Native Writes: Communication in the World of Science
- ☐ Grant Writing

Agenda-At-A-Glance

	Sunday, April 23	Monday, April 24	Tuesday, April 25	Wednesday, April 26
AM	Travel	Blessing and Welcome	Blessing and Welcome	Blessing and Welcome
		General Session	General Session	Abstracts Breakout
				Abstracts Breakout
Noon		Lunch/Poster Session*	Lunch/Poster Session*	Lunch on Own
PM	Registration	General Session	Discussion Sessions	Workshop Part 1
		Discussion Sessions	General Session	
	Pre-Conference	General Session	Activity Break	Workshop Part 2
	Reception	NRN Meeting	NARCH Past & Future	*(a continuation of Part 1)*

*Optional box lunches may be purchased by credit card in advance at $15 each. For more details, see form attached.

Please fax this completed registration form to Gigi Holmes at (602) 364-7788 no later than **April 7, 2006**. On-line registration is also available at http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/index.cfm.

Nursing and Allied Health Information Sources

Diane Cooper, Indian Health Service Biomedical Librarian/Informationist, National Institutes of Health Library, Bethesda, Maryland

Nursing and allied health professionals: you have a virtual giant book containing thousands of articles from dozens of journals in your fields. English language publications for nursing and most allied health fields (see Figure 1) are indexed in the *Cumulative Index to Nursing Literature and Allied Health* (CINAHL). You can search the CINAHL database and find articles on all subjects within the universe of your specialty. The database covers the period 1983 to the present and is updated monthly.

Figure 1. Specialties covered in CINAHL

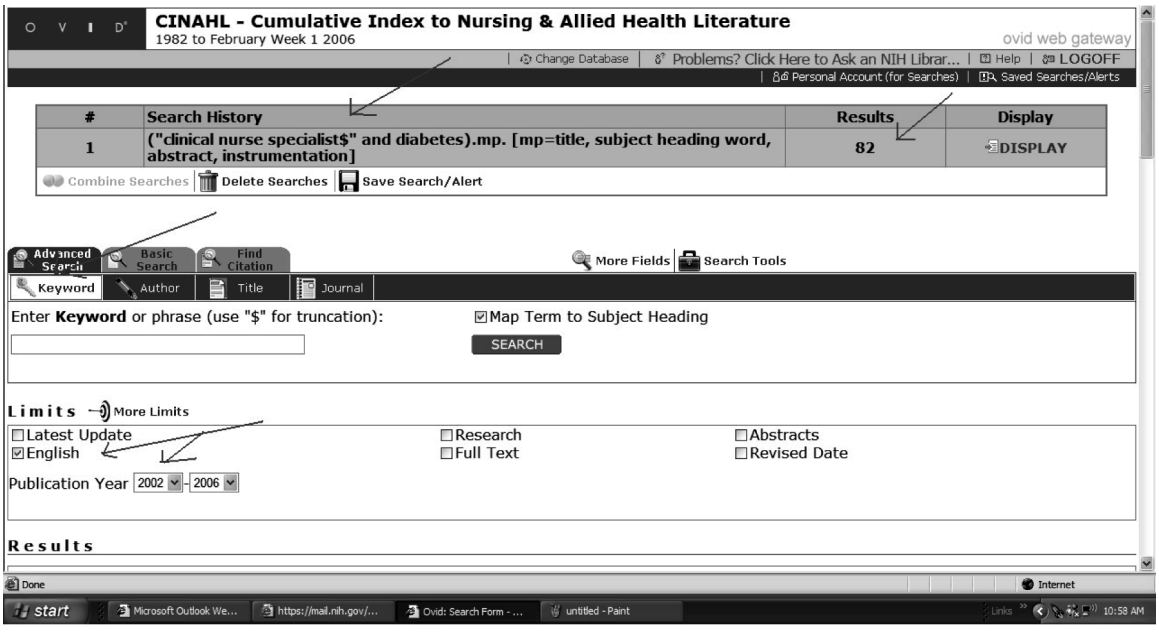
Nursing
Cardiopulmonary technology
Emergency service
Medical laboratory
Medical assistant
Medical records
Occupational therapy
Physical therapy
Physician assistant
Radiologic technology
Social services

If you have an information need, go to the CINAHL database in NIH's Health Services Research Library website. Go to *http://hsrl.nihlibrary.nih.gov* and move your cursor over the top menu to ***Research Tools***. Within the drop-down box, click on ***Databases***, and scroll down the page to the database **CINAHL**.

How to Do a Basic Search in CINAHL

1. Define your information need. For example: "I want to find articles on ways in which Clinical Nurse Specialists work with diabetes patients."
2. Identify the main concepts from your search statement. In this example the concepts are *clinical nurse specialists*; and *diabetes*.
3. Click on ***Keyword***.
4. Enter these concepts in the ***Search For*** box. Enter phrases, e.g., *clinical nurse specialists*, between quotation marks.
4. Use connectors (and, or) to narrow or broaden your search. In our example we would want to combine the two subjects together with the "and" connector. Also, you want to get the singular or plural form (truncation) of any words; to do that you use the $ sign. In our example, the search box would have: "clinical nurse specialist$" and diabetes. Note: when you type this in the search box and hit enter, the ***Results Box*** will show that the terms were searched in multiple places (*mp*). It will add the tag explaining what "mp" means, and will show there are 82 citations (see Figure 2).

Figure 2. Screenshot fo CINAHL page



5. The results may give you more citations than you want. You can limit your search by selecting in the ***Limit field*** **"***English language"* and a date range (for example, all articles from 2002 to 2006).
6. Click ***search*** and the results will appear below the search box. Or you can click on ***Display*** in the search box to go to a page listing the articles relevant to your search.
7. To print records, check the boxes to the left of each record you want to print. At the bottom of the page, under the ***Results Manager***, you can select to print only the records you selected, or you can print the entire search results. The printout format is defaulted to citation and abstract in OVID format, which is fine to start. Under ***Actions*** you can choose to display your results; preview a print version of your results; e-mail your results to someone else; or save them to a file to print out later.

Advanced Searches in CINAHL

An advanced search in **CINAHL** allows you to search different fields, such as author and title, at the same time.

Example 1: Awhile back, you read an article by R.L. Simpson on technology. Now, you want a copy.

1. On the **CINAHL** search screen, click on ***Advanced Search***.
2. Next, click on ***Author***, and in the first box enter "*Simpson RL.*" Use last name first and then initial(s) if known.
3. Click on ***Keyword***, and in the box enter *technology*.
4. Combine the author search with the keyword search by clicking on ***Combine Searches*** under the search boxes and see the results.

Example 2: You want information on diabetes in pregnancy from the *Journal of Diabetes Nursing.*

1. In the first search box, enter *diabetes* (use the keyword tab.)
2. In the next search box, enter *pregnancy* (use the keyword tab.)
3. In the third search box, enter "*Journal of Diabetes Nursing*" (in quotes, because it is a phrase, and use the journal tab)
4. Combine the entries by clicking on ***Combine Searches*** and use the default Boolean operator "and," which will combine each entry with "and."

If your search does not get you what you want, or if you have questions, comments, or suggestions, contact me at (301) 594-2449 or e-mail *cooperd@mail.nih.gov*.

Executive Leadership Development Program Announces 2006 Dates

VISION

The Executive Leadership Development Program is the preferred, premier leadership training program for Indian health care professionals.

PURPOSE

To educate current and future leaders to continually improve the health status of Indian people.

MISSION

The Executive Leadership Development Program will be the recognized leader in education and support services for Indian health care systems through collaboration, partnerships, and alliances.

Executive Leadership Development Program New Dates

ELDP collaborates with federal, tribal, and urban Indian health care systems to develop and increase leadership and management skills. In addition, participants develop new relationships and networks with other executives within the Indian health care systems.

SESSION DATES:

Session One – Aurora, CO
May 8 - 12, 2006

Session Two – Aurora, CO
June 19 - 23, 2006

Session Three – Aurora, CO
July 24 - 28, 2006

The IHS Clinical Support Center is the accredited sponsor.

Contact:
Indian Health Service Clinical Support Center
Executive Leadership Development Coordinator
Wes Picciotti or Gigi Holmes
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Two Renaissance Square, Suite 780
40 N. Central Avenue, Phoenix, Arizona 85004-4424
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Internet: *ELDP@mail.ihs.gov*
Website: *www.ihs.gov/nonmedicalprograms/eldp*

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 4, No. 1, January 2006) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Link between GDM and Type 2 DM can be broken.

Type 2 diabetes frequently results from progressive failure of pancreatic beta-cell function in the presence of chronic insulin resistance. We tested whether chronic amelioration of insulin resistance would preserve pancreatic beta-cell function and delay or prevent the onset of type 2 diabetes in high-risk Hispanic women.

Results: During a median follow-up of 30 months on blinded medication, average annual diabetes incidence rates in the 236 women who returned for at least one follow-up visit were 12.1 and 5.4% in women assigned to placebo and troglitazone, respectively ($P < 0.01$). Protection from diabetes in the troglitazone group

1. was closely related to the degree of reduction in endogenous insulin requirements 3 months after randomization,
2. persisted 8 months after study medications were stopped, and
3. was associated with preservation of beta-cell compensation for insulin resistance.

Conclusion: Treatment with troglitazone delayed or prevented the onset of type 2 diabetes in high-risk Hispanic women. The protective effect was associated with the preservation of pancreatic beta-cell function and appeared to be mediated by a reduction in the secretory demands placed on beta-cells by chronic insulin resistance.

Buchanan TA, et al. Preservation of pancreatic beta-cell function and prevention of type 2 diabetes by pharmacological treatment of insulin resistance in high-risk hispanic women. *Diabetes*. 2002 Sep;51(9):2796-803

OB/GYN CCC Editorial comment

This is the first randomized clinical trial to show prevention or delay in the onset of type 2 diabetes in former gestational diabetes mellitus (GDM) patients. Kim, et al showed that in GDM, the cumulative incidence of diabetes ranged to over 70% in studies that examined women six weeks postpartum to 28 years postpartum. Cumulative incidence of type 2 diabetes increased markedly in the first five years after delivery and appeared to plateau after ten years. An elevated fasting glucose level during pregnancy was the risk factor most commonly associated with future risk of type 2 diabetes. Targeting women with elevated fasting glucose levels during pregnancy may prove to have the greatest effect for the effort required. The above RCT by Buchanan, et al showed that the onset of type 2 DM could be delayed or prevented in women with a history of GDM.

There is evidence that a number of pharmacologic interventions may be of value in preventing the development of type 2 diabetes in patients with impaired glucose tolerance (or prediabetes). Drug therapy with metformin (a biguanide) or acarbose (an alpha-glucosidase inhibitor) has been shown to delay or prevent the progression of impaired glucose tolerance to type 2 diabetes. The thiazolidinedione troglitazone, which is no longer available, has also been shown to have a similar effect to other insulin sensitizers. Current expert opinion is that this is most likely a class effect, and is not specific to troglitazone only.

Troglitazone was removed from the market due to cases of hepatic failure. That is part of the reason for the required liver function test (LFT) monitoring with pioglitazone and rosiglitazone. Pioglitazone and rosiglitazone do not seem to cause hepatic failure as troglitazone did. Pioglitazone and rosiglitazone are considered similar to troglitazone and safe. It was initially recommended to monitor LFTs at baseline and every two months for the first year of therapy, periodically thereafter. The package insert has been relaxed and now recommends LFTs at baseline and periodically thereafter.

While the particular pharmacological treatment used by Buchanan, et al is no longer available to us, it appears that it was a drug class effect not limited to that particular agent. On the other hand, diet, exercise, and metformin are widely available.

From Your Colleagues
Carolyn Aoyama, HQE

Gestational Diabetes: ACOG/IHS Obstetrics, Neonatal and Gynecologic Care.

I want to make you aware of the Post Graduate Course on Obstetric, Neonatal and Gynecologic Care which will be offered this year, September 17 - 21 in Denver, Colorado. This course will include content on gestational diabetes, including how GDM affects the mother's health during her pregnancy, the

health of the fetus, and the neonate. Please consider attending this interesting course (*http://www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#Sep06*).

OB/GYN CCC Editorial comment

The ACOG/IHS Postgraduate Course represents a unique opportunity for Indian health staff who care for AI/AN women and children. There are no other major subject areas in which a major professional organization, like ACOG, has devoted so many resources to improving the care of Native people. The course is a thorough, 4½ day primer on all the relevant topics in the care of AI/AN women and neonates. It is a great resource for a staff member new to Indian health, or a seasoned staff member who wants a complete update. The course has been held since the 1980s, so most of the kinks have been worked out, as witnessed by its superlative ratings from past attendees. Each facility should consider sending at least one provider and one nurse to this year's course. Limited funding may be available; contact Carolyn Aoyama at *Carolyn.Aoyama@ihs.gov*.

Tom and Edith Welty, Flagstaff

Integrating prevention of mother-to-child HIV transmission (PMTCT) into routine antenatal care.

Here is an article published in *JAIDS* describing work done by our colleagues in Cameroon. We will be going to Cameroon again this month to help support the program there.

We trained 690 health workers in PMTCT and counseled 68,635 women, 91.9% of whom accepted HIV testing. Of 63,094 women tested, 8.7% were HIV-1-positive. Independent risk factors for infection included young age at first sexual intercourse, multiple sex partners, and positive syphilis serology ($P < 0.001$ for each). We counseled 98.7% of positive and negative mothers on a posttest basis. Of 5550 HIV-positive mothers, we counseled 5433 (97.9%) on single-dose NVP prophylaxis. Consistent training and programmatic support contributed to rapid upscaling and high uptake and counseling rates.

Welty TK, Bulterys M, Welty ER, et al. Integrating prevention of mother-to-child HIV transmission into routine antenatal care: the key to program expansion in Cameroon.

OB/GYN CCC Editorial comment

Edie and Tom retired from IHS after 26 years (23 with IHS and 3 with CDC) in 1997. They began to work as volunteers with the Cameroon Baptist Convention Health Board in 1998 and go there about six weeks a year to support their program. They wrote a grant to Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) in 2000, which was one of eight programs funded, and EGPAF has renewed it annually since then. The AIDS Program is quite comprehensive (summary available upon request).

"It is very gratifying for us to see how much they have accomplished with minimal resources. Everyone has been affected by HIV and is motivated to do as much as possible to prevent and treat it," say the Weltys.

Obstetrics

Bed Rest for pregnancy related hypertension should not be recommended.

Conclusions: Few randomized trials have evaluated rest for women with hypertension during pregnancy, and important information on side-effects and cost implication is missing from available trials. Although one small trial suggests that some bed rest may be associated with reduced risk of severe hypertension and preterm birth, these findings need to be confirmed in larger trials. At present, there is insufficient evidence to provide clear guidance for clinical practice. Therefore, bed rest should not be recommended routinely for hypertension in pregnancy, especially since more women appear to prefer unrestricted activity, if the choice were given.

Meher S, Abalos E, Carroli G. Bed rest with or without hospitalisation for hypertension during pregnancy. *The Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD003514.pub2. DOI: 10.1002/14651858.CD003514.pub2

Gynecology

Prior function and relationship, more than hormones, affect sexual function in midlife.

Conclusion: Prior function and relationship factors are more important than hormonal determinants of sexual function of women in midlife.

Dennerstein L, Lehert P, Burger H. The relative effects of hormones and relationship factors on sexual function of women through the natural menopausal transition. *Fertil Steril*. 2005 Jul;84(1):174-80.

Child Health

Adolescents: low-dose oral contraceptive relieved dysmenorrhea-associated pain.

Results: The mean Moos Menstrual Distress Questionnaire pain score was lower (less pain) in the OC group than the placebo group (3.1, standard deviation 3.2 compared with 5.8, standard deviation 4.5, $P = .004$, 95% confidence interval for the difference between means 0.88-4.53). By cycle 3, OC users rated their worst pain as less (mean pain rating 3.7 compared with 5.4, $P = .02$) and used fewer pain medications than placebo users (mean pain pills used 1.3 compared with 3.7, $P = .05$). By cycle 3, OC users reported fewer days of any pain, fewer days of severe pain, and fewer hours of pain on the worst pain day than placebo users; however, these differences did not reach statistical significance.

Conclusions: Among adolescents, a low-dose oral contraceptive relieved dysmenorrhea-associated pain more effectively than placebo. LEVEL OF EVIDENCE: I.

Davis AR, et al. Oral contraceptives for dysmenorrhea in adolescent girls: a randomized trial. *Obstet Gynecol*. 2005 Jul;106(1):97-104.

Features

ACOG

Vaginal birth not associated with incontinence later in life.

Contrary to the belief held by some, vaginal birth does not appear to be associated with incontinence later in life, a new study has found. The study, published in the December issue of *Obstetrics & Gynecology*, found that incontinence was more strongly related with family history.

Research finds 40% of pregnancy-related deaths potentially preventable.

The overall maternal mortality rate in the US is not as low as it could be, according to a review of pregnancy-related deaths published in the December issue of *Obstetrics & Gynecology*. The review found that 40% of all pregnancy-related deaths in North Carolina from 1995 - 1999 were potentially preventable. Worldwide, complications of pregnancy are a major source of mortality among women. Although the US saw a 99% reduction in maternal death during the 20th century, 29 developed nations still have lower maternal mortality rates.

Breastfeeding

Duration of lactation and incidence of type 2 diabetes (special editorial comments by Suzan Murphy, new CCCC columnist).

The following are comments on the December CCC Corner breastfeeding posting, "New studies shows a 15% reduction for the risk of diabetes for every year of lactation."

There are growing numbers of papers about the benefits of lactation for both the mom and baby. For our families where type 2 diabetes is a common, chronic threat and reality, a new tool — like breastfeeding — is a welcome addition to the diabetes prevention/care "tool kit." Studies in AI/AN and Native Canadian communities have linked breastfeeding with less risk of type 2 diabetes (Pettitt et al, 1997; Young et al, 2002) for offspring. Now studies support an even more profound maternal benefit for reducing diabetes risk (Stuebe AM et al, 2005). Breastfeeding could be the "immunization" that means less diabetes for future generations. Although there will be likely be more research about the mechanism for how this works, there are several possibilities, including enhanced maternal insulin sensitivity (Kjos SL et al, 1993; Tigas et al, 2002).

The CDC report, *Maternal Morbidity in American Indian and Alaska Native Women, 2002-2004*, by Bacak SJ et al, states the prevalence of gestational diabetes is 7.8%, an alarming number that hints at the spiraling increases ahead for our communities. The presence of diabetes during pregnancy dramatically increases the risk of diabetes for the offspring and the mother. Breastfeeding could reduce risk for both. Providing families/communities/tribal agencies with information about these benefits and ways to support the practice of breastfeeding will allow more families to breastfeed.

For ideas about ways to support breastfeeding, please watch for the new IHS MCH breastfeeding page. If a video/DVD would help, call 1-877-868-9473 for a 12 minute professionally done video, "Close to the Heart, Breastfeeding Our Children, Honoring Our Values." It is free and can be duplicated. Posters are also available at this number. For free written materials, consider ordering "The Easy Guide to Breastfeeding for American Indians and Alaska Native Families" (url below). Scroll down to pregnancy, it is the last item in the category. If you need more than the maximum 100 copies, use the comment section to explain the need. Thanks to IHS Head Start, there is a generous supply.

Featured Website

David Gahn, IHS Women's Health Website Coordinator

Vaginal Birth after Cesarean, a new Perinatology Corner Module worth 2 credits.

This is a new edition of our previous module of the same name. The main changes include a new risk factor grading system, plus how to apply that information to clinical practice. *http://www.ihs.gov/MedicalPrograms/MCH/M/VB01.cfm*.

Medical Mystery Tour

CC: I feel really cold and my side hurts, plus I am shaking all over. Let us recap from last month. A 21 year old G2P1001 presented complaining of nausea, vomiting, shaking chills, and contractions every two minutes. The patient was 37 3/7 weeks EGA by a 32 week ultrasound. Her prenatal history was not significant, but then again she had only three total prenatal visits. Her initial urinalysis showed WBC 10 - 30 hpf, positive leukocyte esterase, bacteria 1+, 3+ ketones, 1 - 5 epithethial cells/hpf, trace protein, nitrite negative, and negative casts.

The patient was subsequently transferred to a tertiary care facility approximately 500 miles away by air ambulance. Upon arrival the patient was afebrile, but had shaking chills. The patient had developed exquisite right flank pain. The physical examination was otherwise essentially unchanged. The cervix was 1 cm dilated, thick, and – 3 station

The referring facility subsequently reported the preliminary positive blood culture as gram negative rods. The patient's gentamicin was changed to 100 mg q 8 hours IV and the vancomycin was stopped. The suspected diagnosis was urosepsis. Five hours after admission the patient's white blood cell count increased to 26,100 cells/microL and the patient continued to have right flank and right lower quadrant pain. The right flank pain now required intermittent intravenous morphine.

The general surgery team concurred that the patient had pyelonephritis with a suspected perinephric abscess. They suggested adding vancomycin back to the regimen because of the preliminary positive blood culture at the referring facility had suggested gram positive cocci in clusters and was still unidentified. There was a significant prevalence of methicillin resistant *Staphylococcus aureus* infection in the patient's home region. The general surgery service agreed with obtaining a renal ultrasound in the morning.

Question

Is there anything else would you like to do now for this patient diagnosed with urosepsis at 37 weeks EGA?

The rest of the story . . ..

The general surgery service signed off the case after the renal ultrasound was reported as normal. Two days later the patient continued to have right flank and lower quadrant pain with a WBC of 22.9 K. The General Surgery Service was reconsulted and their suggested RUQ and RLQ ultrasounds were both negative, although there was a term fetus in the pelvis.

In the meantime, the blood culture was reported pan-sensitive *E. coli*. In view of the continued symptoms, the general surgery team suggested primary cesarean delivery and exploratory laparotomy/appendectomy (whether it was inflamed or not) versus vaginal delivery and computerized tomography after delivery. After discussion of the risks and benefits, a misoprostol cervical ripening was begun. The previous antibiotics were discontinued and the patient was started on ampicillin sulbactam 3 g q 6 IV. After the misoprostol 50 ug was placed vaginally, a prior blood culture returned with a second organism, a slender, elongated Gram negative rods, consistent with *Bacteroides fragilis*.

If there wasn't enough complicating the last few days of this patient's pregnancy, her midwife noted an unusual presenting structure. This was later confirmed to be a face presentation in right mentum transverse. In a rare stroke of good luck that week, the patient subsequently rotated her fetus to mentum anterior and delivered a normal infant in a double set up delivery suite later that evening.

Post partum, the patient's WBC decreased to 9.8K, but she continued with the same right sided pain. Computerized tomogram with contrast revealed a phlegmon surrounding a dilated appendix and appendicolith. Approximately 12 hours postpartum, the patient underwent an exploratory laparotomy. The general surgery team discovered a hardened retrocecal appendix which was completely avulsed at the base. The avulsion occurred either with the gentle attempts to visualize the appendix, or having already separated from the cecum. There was also a large appendicolith inferior to this. There was spillage of purulent material, but no bowel contents. An attempt was made to find where the base of the appendix came off the cecum. Two possible areas were treated with a 1-0 endoloops. The surgical incision was left open initially, but received a loose closure on postoperative day 2. The patient subsequently had an unremarkable postpartum course and was discharged on post partum day 3. The patient called back two weeks later and thanked the night shift L/D staff members for their care.

OB/GYN CCC Editorial comment

In retrospect, the initial urinalysis with 10 - 30 WBC/hpf was somewhat misleading, but consistent with an inflammatory process adjacent to the ureter and bladder. Microscopic hematuria and pyuria are found in up to one-third of patients with acute appendicitis. Patients with pyelonephritis will often continue to spike temperatures while they otherwise improve, although this patient's fever curve became increasing atypical for pyelonephritis. Lastly, although the lab result returned after the clinical decision was made to begin cervical ripening and post partum CT scan, the second positive blood culture with a different organism suggested a polymicrobial septic process.

Escherichia coli is the major causative pathogen in both uncomplicated upper and lower urinary tract infection, being present in approximately 70 to 95 percent of cases. *Staphylococcus saprophyticus* is found in 5 to 20 percent of cases of cystitis, or even higher in some studies. It can also cause pyelonephritis. Occasionally other Enterobacteriaceae such as *Proteus mirabilis* and Klebsiella species or enterococci are isolated from the urine of patients with acute pyelonephritis.

A renal abscess is an uncommon infection of the urinary tract. It can develop by one of two general mechanisms: hematogenous spread, which usually results in a cortical abscess; or ascending infection from the bladder, which primarily involves the medulla in most cases. In this patient's case the renal ultrasound was negative.

Appendicitis in Pregnancy

Acute appendicitis is the most common general surgical problem encountered during pregnancy, occurring equally in all trimesters. Estimates of its incidence have ranged from 0.1 to 0.06 percent of deliveries. The clinical features depend upon the stage of pregnancy, which may make diagnosis more difficult than in nonpregnant women. Because the location of the appendix migrates upward with the enlarging uterus, the location of pain or tenderness is variable. Other physiologic changes that occur during pregnancy may also cause confusion. For example, the normal white blood cell count ranges from 6,000 to 16,000 cell/mm^3 in the first and second trimesters, and may rise to 20,000 to 30,000 cells/mm^3 in labor. Another difficulty arises in the reluctance to expose pregnant women to radiation needed for diagnostic imaging.

These problems were underscored by the variable conclusions reached in a number of series of appendicitis in pregnancy. As an example, in three series with a total of 181 patients with suspected appendicitis, the pattern of presenting complaints, laboratory, and physical examination were unhelpful for establishing the diagnosis. In contrast, a third report comparing clinical features in 28 pregnant women with appendicitis to matched nonpregnant controls found no significant differences in clinical presentation.

Ultrasonography is safe and (as in nonpregnant women) may be helpful for diagnosis. In a series of 45 patients, for example, the sensitivity, specificity, and accuracy were estimated to be 100, 96, and 98 percent, respectively. The gravid uterus prevented adequate sonographic examination of the appendix in only three women, each of whom was near term.

Considering the above studies, and clinical experience, the

diagnosis of appendicitis should be considered in pregnant women complaining of new abdominal pain. The decision to proceed to laparotomy should be based upon the clinical and sonographic features and clinical judgment. The greatest risk is delayed intervention, which increases the risk of perforation. In two retrospective reviews, perforation occurred in 14 to 43 percent of patients. All of these patients had symptoms for longer than 24 hours. In another series that included 333 patients, fetal loss was much more frequent in patients in whom the appendix had perforated (36 versus 1.5 percent, respectively). Given the diagnostic difficulties and significant risk of fetal mortality with perforation, a higher negative laparotomy rate (20 to 35 percent) compared to nonpregnant women has generally been considered to be acceptable.

Maternal morbidity following appendectomy is low except in patients in whom the appendix has perforated. In contrast, pregnancy related complications are frequent, particularly when surgery was performed in the first or second trimester. This was illustrated in a series of 56 women who underwent appendectomy in various trimesters. Spontaneous abortion was observed in 4 of 12 patients (33 percent) who underwent appendectomy in the first trimester while 4 of 28 (14 percent) patients operated on in the second trimester delivered prematurely. No pregnancy complications were observed in women who underwent appendectomy in the third trimester.

Although an appendectomy is usually performed through a transverse incision over the point of maximal tenderness, a midline vertical incision is preferred by some surgeons since it permits adequate exposure of the abdomen for diagnosis and treatment of surgical conditions that mimic appendicitis. It also can be used for a cesarean delivery, if subsequently required for the usual obstetric indications. Dehiscence during vaginal delivery should not be a concern when the fascia has been appropriately reapproximated.

There have been several reports on the use of laparoscopic appendectomy in pregnancy suggesting that such procedures can be performed successfully during all trimesters and with few complications. However, considerable skill is required to perform such procedures in the presence of an enlarged uterus. Although promising, further studies are needed to better document the safety and efficiency of this approach. The long-term prognosis for women who underwent appendectomy is good. Such women do not appear to be at increased risk for infertility or other complications.

Midwives' Corner, Marsha Tahquechi, CNM
Shoulder Dystocia.

Shoulder dystocia, although a relatively rare complication of vaginal birth (0.6 - 1.4%), is one of the most dire of obstetric emergencies. Associated with certain risk factors, shoulder dystocia is largely unpredictable in its occurrence and preventability. Shoulder dystocia is described as either the impaction of the anterior shoulder behind the symphysis pubis, or the impaction of the posterior shoulder behind the sacral promontory. Resulting neonatal morbidities such as permanent brachial plexus injuries and /or mental impairment are one of the leading causes of malpractice litigation. This month's Midwives' Corner reviews shoulder dystocia from a variety of perspectives:

In a recent personal communication with Susan DeJoy, Director of the Midwifery Service at Baystate Medical Center in Springfield Mass, we discussed the history and the origin of the HELPS shoulder dystocia simulator training program. We (Dept Ob/GYN at Baystate Medical Center) developed and implemented a shoulder dystocia simulation training program in spring 2002, entitled HELPS ("call for Help, cut Episiotomy if needed, Legs back, Posterior arm, Suprapubic pressure"). Modeled after other simulations commonly used in health care for rare emergencies (CPR, NNR, ALSO), the training included both theory/didactic and skills practice portions. Emphasis was placed on teamwork, skills development, understanding other team members' roles, patient communication skills and risk reduction. All birth attendants — physicians, midwives, residents, and nurses — were required to attend, and the OB/Gyn Department Chair added certification in HELPS training to requirements for credentialing.

The training program was 1 - 2 hours in length: a short (<30min) overview of essential skills and maneuvers for each member of the team, who was in charge during an event, who needed to respond when help was called for (more on this later). Then the majority of time was spent practicing shoulder dystocia management with "Noelle," a manikin specially designed to teach birth skills. Participants were divided up into teams — provider, nurse, resident — and had to go through a predetermined set of steps to manage the problem, just like what you do in CPR certification. Everyone was then checked out and received a certificate of completion. If you are a credentialed provider here, that certificate needed to be submitted to the medical staff office for recredentialing. Once you have initial certification, you get recertified every two years by watching the CDROM and completing a posttest. A certificate is printed at the end of the posttest which, again, must go to medical staff office for re-credentialing. The office has verification of SD training as another checkbox on their forms, along with license verification, etc.

We discovered several systems issues as we implemented the training. First, when/how to call for help to get the right people to come to the right place. We had an existing "code white" stat page to gather a team in the OR to do a stat section, so we piggy-backed onto that: calling a code white to an LDRP room instead of the OR now means shoulder dystocia, and the code white team's beepers go off and the code white is announced overhead ("Code White, Room 1809"). The team that arrives is the charge nurse, the pod coordinator (another RN on the unit), the OR tech, the house attending, the anesthesia attending and the 3rd and 4th year residents. We also discovered that it was important that the L&D secretaries

knew what this was all about, as they could get lab slips ready for cord gases, etc, call NICU team down, get baby bands ready in case of fast transfer to NICU, etc.

How to do suprapubic pressure correctly. Many providers did not know that the FIRST thing you do is move the baby's shoulders to the oblique diameter; that going after the posterior shoulder was less traumatic than Wood's maneuver; and that episiotomy was not essential.

"Breaking the bed." CNMs generally do not break beds for delivery, but the doctors always break the bed and are somewhat incapacitated when they find the bed not broken. We also had to come to consensus on this. Talking this out really helped. The doctors now understand they might find the bed intact, and if that is a problem, they just say "Break the bed," and it will happen fast. Teaching alternative maneuvers to Wood's maneuver also helped.

The midwives understand that when you call for emergency help, you facilitate what your consultant needs without hesitation or discussion. Having the code white team arrive helps all of this, as there are enough people to do what ever is needed quickly.

OB/GYN CCC Editorial comment

If shoulder dystocia is a concern, some clinicians have empirically advocated immediately proceeding to delivery of the fetal shoulders to maintain the forward momentum of the fetus (see "CCC deliver through" maneuver for shoulder dystocia prevention below). Others support a short delay in delivery of the shoulders, arguing that the endogenous rotational mechanics of the second stage may spontaneously alleviate the obstruction.

The 'CCC deliver through' maneuver for shoulder dystocia prevention is a maneuver to completely avoid shoulder dsystocia by continuing the expulsive momentum and delivering the presenting part on through to the visualization of the anterior shoulder without stopping for suctioning the oropharynx, fetal mouth, or nares, and/or to reduce a nuchal cord. If you have any suspicion that the patient may be at risk for shoulder dystocia, then consider the following:

Pre-"CCC Deliver Through" maneuver. First, try to gauge the expulsion of the head for the initial peak of a contraction, e.g., not at the end of third Valsalva maneuver in a 60-90 second contraction in an exhausted parturient. If a regional anesthetic has been utilized, then also make sure that the anesthetic is at a nadir on motor function.

And now "CCC Deliver Through" maneuver. As soon as the head presents itself in the cardinal movements from extension, restitution, and onto external rotation, the provider should continue that momentum with gentle posterior traction toward the rectum on the fetal parietal bones until you clearly see delivery of the fetal anterior shoulder emerging from beneath the symphysis. Alternately one hand can be over the face and the other hand on the occiput to continue the momentum. At this time ask the mother to pant while you suction the infant as needed, or reduce any obstructing elements of the umbilical cord. Then ask the patient to continue to bear down gently and deliver the posterior shoulder and body.

Please note, this is unlike what some classic obstetrics texts recommend for the normal course of delivery of the fetal head. The main difference is that you do not halt the momentum after restitution or external rotation to suction the oropharynx. Also you do not halt the momentum to reduce a nuchal cord unless it is critically tight. Both suctioning and movement of the cord can be completed after delivery of the anterior shoulder.

After delivery of the anterior shoulder, then continue as you would normally, e.g., ask the mother to pant while you suction the oropharynx or manipulate the cord, then direct the fetal body anteriorly until the posterior shoulder passes the perineum to accomplish complete delivery. Please protect the perineum as you complete the delivery process after delivery of the anterior shoulder.

Once the head is out of the vagina, the head restitutes and the neck untwists. After a few moments, external rotation takes place as the shoulders move from the oblique to the anteroposterior diameter of the pelvis. One possible advantage is, if the "CCC Deliver Though" maneuver is done quickly enough, the accoucheur may deliver the anterior shoulder before the shoulders reach the full anteroposterior diameter of the pelvis that they achieve when external rotation occurs.

One caveat. While this maneuver seems to work 100% of the time in our less than random sample, we should be skeptical of anything that seems to work so well. A random sample of ~10 providers on L/D had heard of it, and many did it when they suspected shoulder dystocia was an imminent risk. In fact, it was so common that no one had a name for it — it was an unnamed automatic reflex. In addition, it seems to be used more commonly as the incidence of heavy parturients increases.

Would the 'CCC Deliver Through' maneuver increase perineal trauma? My experience with many, many deliveries the old way includes a few hundred 2nd degree lacerations (?10%) with the rare 3rd - 4th degree laceration during delivery of the head or the posterior shoulder. Yet, lacerations occurring during the delivery of the anterior shoulder, *per se*, would be very rare — for a ratio of ~ 0 - 1/1000+. As the "CCC Deliver Through" maneuver simply suggests that once the head is delivered, just do not stop to suction the oropharynx or reduce the cord until you have the anterior shoulder out, and then do everything else the same, the impact on perineal lacerations is probably closer to nil.

A better argument against this maneuver is that it is unstudied; e.g., perhaps just by the fact that one could perform the "CCC Deliver Through" maneuver at all meant that the shoulder dystocia was not going to occur anyway, or that the development of the true shoulder dystocia geometry would not allow one to deliver through to the anterior shoulder,

regardless. On the other hand, it may be more like the insurance business: if you have an expensive flood policy, then you'll never even see a heavy drizzle.

Navajo News; Jean Howe, Chinle

Depo-Provera in a lower dose: limited data to assess 104mg SQ vs. 150mg IM.

After the recent dramatic shifts in available information about the contraceptive patch, it is with some trepidation that I again address a hormonal contraceptive topic. But similar shifting sands of popularity and concern affect Depo-Provera and warrant ongoing attention.

Depo-Provera (depot medroxyprogesterone acetate or DMPA given 150 mg IM every 12 weeks) was first approved for use in the United States by the FDA in 1992. This approval came after many years of widespread international use, and DMPA quickly became popular in the U.S. as well. One issue that has limited its popularity is the weight gain often associated with DMPA use. The product information states that from an average initial body weight of 136 pounds, women gained an average of 5.4 pounds with one year of use, 8.1 pounds with two years of use, 13.8 pounds with four years of use, and 16.5 pounds with six years of use. A study done at Shiprock by Espey, et al, compared 172 women who used DMPA for one or two years with 134 women who used a non-progestin-based method or no method. The women using DMPA gained an average of six pounds more than the comparison group with one year of use and 11 pounds more with two years of use, thus suggesting that the weight gain issues may be even more significant with DMPA for Navajo women. DMPA use may thus indirectly increase the risk of diabetes and other health problems associated with obesity.

A more recent concern about DMPA is that the bone loss associated with long-term use may not completely resolve after DMPA is discontinued. These concerns have resulted in the addition of a "black box" warning recommending that use be limited to two years unless other forms of birth control are inadequate. Strategies to address these concerns are outlined in the January 2005 CCC Corner. The two year restriction remains controversial. In June 2005, the World Health Organization issued a statement on Hormonal Contraception and Bone Health recommending that:

- There should be no restriction on the use of DMPA, including no restriction on duration of use, among women aged 18 to 45 who are otherwise eligible to use the method.
- Among adolescents (menarche to <18) and women over 45, the advantages of using DMPA generally outweigh the theoretical safety concerns regarding fracture risk. Since data are insufficient to determine if this is the case with long-term use among these age groups, the overall risks and benefits for continuing use of the method should be reconsidered over time with the individual user.

Despite concerns about weight gain and bone health, DMPA remains a preferred contraceptive for many Navajo women. Thus, any improvement in the side effect profile would be important. In December 2004, the FDA approved marketing of a lower dose formulation of DMPA, under the name "depo-subQ provera 104" (DMPA-SC). It contains 30.7% less medroxyprogesterone acetate and is administered subcutaneously into the anterior thigh or abdominal wall. The product information describes three clinical trials where the weight gain averaged 3.5 pounds in the first year of use. A smaller comparison trial showed similar weight gain to DMPA-IM (7.5 vs. 7.6 pounds). The "black box" warning about bone loss is identical although this issue does not seem to have been studied yet in DMPA-SC. The subcutaneous formulation is believed to provide slower absorption with a lower early peak in dose and a lower total dose delivered; whether this will be shown to result in a lower side effect profile is not yet known. The SC and IM formulations are different and cannot be used interchangeably. One of the most interesting features of DMPA-SC is that patient self-administration may be possible; this would be a potential benefit to the many patients who find it difficult to keep clinic appointments every 12 weeks. In March 2005, DMPA-SC was approved by the FDA for the treatment of endometriosis pain.

Alas, a lower dose does not mean a lower cost. Local pricing inquiries revealed the following:

Depo-Provera 150mg IM prefilled syringe: $32.34
Depo-Provera 104mg SQ prefilled syringe: $48.85

This compares to an average cost locally of $4 to $29 for 12 weeks of OCPs, $66 for 12 weeks of Ortho-Evra patches, $262 for a Mirena IUD, or $40 for a Paraguard IUD. Whether the 50% increase in price for a 31% decrease in dose is a worthwhile investment will depend on additional studies of weight gain, bone density, and other issues. It may be especially valued by some women who are willing to self-administer DMPA-SC and find it burdensome to come to clinic every 12 weeks.

Jain J, Dutton C, Nicosia A, Wajszczuk C, Bode FR, Mishell DR. Pharmacokinetics, ovulation suppression and return to ovulation following a lower dose subcutaneous formulation of Depo-Provera. *Contraception*. 2004. 70:11-18.

Jain J, Jakimiuk AJ, Bode FR, Ross D, and Kaunitz AM. Contraceptive efficacy and safety of DMPA-S. *Contraception.* 2004 70:269-275.

Lakha F, Henderson C, Glasier A. The acceptability of self-administration of subcutaneous Depo-Provera. *Contraception*. 2005. 72:14-18.

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

"There are two tragedies in life. One is to lose your heart's desire. The other is to gain it."

George Bernard Shaw

Articles of Interest

A head-to-head comparison: "clean-void" bag versus catheter urinalysis in the diagnosis of urinary tract infection in young children. *J Pediatr*. 2005 Oct;147(4):451-6. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Select+from+History&db=pubmed&query_key=2*

- A comparison of the validity of the urinalysis of clean voided bag specimens versus catheter obtained specimens in non–toilet trained children < 3 years of age
- Surprisingly, the bag specimens were more sensitive than catheterized specimens (85% versus 71%)
- Sensitivity was lower for both bag and catheter specimens in children < 90 days old (69% and 46%)
- Specificity was consistently lower for bag specimens than catheter samples (62% versus 97%)
- The authors conclude that for low risk children a bag specimen could be used as a screening test to determine which infants need to undergo catheterization for culture

Choice of urine collection methods for the diagnosis of urinary tract infection in young, febrile infants. *Arch Pediatr Adolesc Med*. 2005 Oct;159(10):915-22. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

- This is a report from the *Pediatric Research in Office Settings* Febrile Infant Study
- A survey of the workup of 3066 infants < 90 days with a temperature > 38 C who presented to pediatric offices. Care was at the discretion of each provider
- Only 54% of infants had a urinalysis done at all
- Bag specimens were as sensitive as catheterized specimens but less specific
- Infection rates were similar in bag specimens (8.5%) versus catheterized specimens (10.8%)
- False positive cultures for bag urine cultures were reduced by defining many culture results as "ambiguous" (7%). Ambiguous cultures were defined as having > 1 organism, non pathogenic bacteria, or colony counts <1,000/cc
- The authors conclude that bag specimens are suitable for urine culture if practitioners do not treat ambiguous results as true UTI

Editorial Comment

These articles are full of angst about transurethral catheterization. In both studies the authors regard urinary catheterization as very traumatic to patients and their parents. The authors also state that catheterization is technically difficult and unavailable in many offices, which I found surprising. In this era of infant HIB and Pneumococcal vaccines, UTIs are the most common serious bacterial infections in children. We should try and diagnose them correctly.

The first step is to obtain urine when indicated. It was surprising that only 50% of febrile infants < 90 days had urine obtained when presenting to an office setting. Even a bag specimen would be better than nothing, recognizing that the urinalysis has a much lower sensitivity in infants < 90 days. The second problem is that a bag specimen that is falsely positive in this young age group may lead to hospitalization. The needless hospitalization will not be sorted out until 48 hours later with a negative culture or an "ambiguous" culture that is defined as negative.

It seems reasonable to obtain catheterized specimens on all children < 90 days in which a high degree of specificity is required to avoid unnecessary hospitalization. For children > 1 year of age, without a previous UTI, a bag specimen might be an acceptable screening tool. Between 90 days and 1 year of age, I would favor catheterization, but each practitioner will need to make their own determination based on the risk/benefit to the patient and their clinic's skill at catheterization. More important than the method of urine collection is the acknowledgement that a urine sample must be obtained in young children who are highly febrile and have no identifiable source for their fever.

Infectious Disease Updates; Rosalyn Singleton, MD, MPH
Making sense of the 2006 Immunization Schedule

The 2006 Immunization Schedule is now available at *http://www.cdc.gov/mmwr/pdf/wk/mm5451-Immunization.pdf*. True to form, the new schedule looks to be even more complex than 2005. While our eyes are crossing over the many columns and colored bars, how do we decide on the essentials?

Here's a schedule that reflects some IHS priorities – they may differ slightly for you.

Birth	Birth dose of hep B is a great safety net to prevent vertical transmission
2 months	DTaP, IPV, HepB, Hib, PCV7. We give the 3 P's: Pediarix™, Pedvax®, Prevnar®
4 months	DTaP, IPV, Hib, PCV7. We give the 3 P's; extra dose of Hep B is ok
6 months	DTaP, IPV, HepB, PCV7. We give the 2 P's: Pediarix™ and Prevnar®
12 months	Hib, MMR, Var, PCV7 (now there's MMR-V)
15 months	DTaP, HepA; both can be given as early as 12 months, but that's a lot of shots
24 months	(or any visit at least 6 months after the first Hep A) - Hep A 2
4-6 years	DTaP, IPV, MMR
11-12 years	Tdap, Menactra™ (depending on supply)

Other issues:

1. Because of high risk of early Hib disease, PedvaxHIB is the preferred product for Hib vaccination in Native Americans. It is the only Hib vaccine that produces protective titers after the first dose. In Alaska, a change to Hibtiter in 1996 resulted in increased Hib cases in partially vaccinated children.
2. Recommend booster doses of Hib and PCV7 at 12 months since titers fall rapidly after primary series and breakthrough cases have occurred.
3. Influenza at any visit for 6-23 month olds – 2nd dose the first year.
4. Tdap was just licensed for adults as well as adolescents and can be given as early as 2 years after a Td vaccine in the event of an outbreak.

Recent literature on American Indian/Alaskan Native Health; Doug Esposito, MD

Beyond Red Lake — the persistent crisis in American Indian health care. *N Engl J Med*. 2005;353:1881-3. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16267317&query_hl=1&itool=pubmed_docsum*

The author, who is an American Indian physician, describes many of the disparities in socioeconomic and health status and access to services faced by AI/AN populations living on reservations, in very personal terms. This is a short article restating what all of us working in Indian health already know. Nevertheless, it's worth reading, as is the commentary by David Grossman, MD, cited below, which focuses more on the plight of the urban off-reservation Indian.

Measuring disparity among American Indians and Alaska Natives; who's counting whom? *Med Care.* 2003;41(5):579-81. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12719680&query_hl=65&itool=pubmed_DocSum*

American Indians and suicide: a neglected area of research. *Trauma Violence Abuse*. 2006 Jan;7(1):19-33. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16332979&query_hl=1&itool=pubmed_DocSum*

The authors review the available literature, embellished with information from personal communications with experts and leaders in the field, to paint a picture of the current status of suicide in AI/AN communities. Although the term "suicide" appears in the title, this paper is actually more of a review of the overall state of knowledge and service (or, more correctly, under service) of mental and behavioral health issues in general for the specified population. This is a well done paper, and a valuable resource for anyone interested in planning suicide studies or interventions among AI/AN populations, or for anyone just interested in understanding the scope of the mental and behavioral health issues and needs of Native Americans.

Follow-up

In follow-up to my review of the subject of Pediatric Oral Health Therapists for American Indian/Alaska Native children in October (*http://www.ihs.gov/MedicalPrograms/MCH/C/documents/ICHN1005.doc*), I would like to point out a few commentaries that appeared in the December 2005 issue of the *American Journal of Public Health*.

Improving the oral health of Alaska natives. *Am J Public Health.* 2005;95(11):1880. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16195503&query_hl=46&itool=pubmed_docsum*

APHA presidents support dental therapists. *Am J Public Health.* 2005;95(11):1880-1. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16195502&query_hl=48&itool=pubmed_docsum*

Sekiguchi et al respond. *Am J Public Health.* 2005;95(11):1881. *http://www.ajph.org/cgi/search?sortspec=relevance&author1=sekiguchi&fulltext=&pubdate_year=&volume=&firstpage*

Announcements from the AAP Indian Health Special Interest Group
Sunnah Kim, MS

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, tribal or urban facility that you'd like for us to publicize (i.e. AAP website or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to *indianhealth@aap.org* or complete the on-line *locum tenens* form at *http://www.aap.org/nach/locumtenens.htm*.

INDIAN HEALTH SERVICE
Alcoholism and Substance Abuse Program
As part of the Clinical and Public Health Leadership Series
And the IHS Clinical Support Center (the accredited sponsor) Announce the

2006 Clinical Update on Substance Abuse and Dependency

(formerly the Primary Care Provider Training on Chemical Dependency)

Phoenix, Arizona	Bangor, Maine
May 9 - 11, 2006	June 20 - 22, 2006
(30 Training Slots)	(30 Training Slots)

PRE-REGISTRATION

- Complete the pre-registration form and fax to **Cheryl Begay at (602) 364-7788 by March 31, 2006.** If you are selected to attend the training, you will be notified by April 7 for the May session and by May 8 for the June session. Participants are expected to attend all three days of the training session. You may choose to register on-line at: *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.
- Travel and training expenses are paid by the Division of Behavioral Health and are coordinated by the Clinical Support Center in Phoenix, Arizona. You will be notified by the Clinical Support Center regarding your travel arrangements.
- If selected, employees of P.L. 93-638 compacted or contracted tribal facilities that have taken tribal shares from the ASAPB and/or the CSC will be charged a fee of $350 to attend the training session and will be expected to provide for their own travel and *per diem* expenses.

ACCREDITATION

The Indian Health Service (IHS) Clinical Support Center (CSC) is accredited by the Association Council for Continuing Medical Education to sponsor continuing medical education for physicians. The CSC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

CONTACTS

Wilbur Woodis, Division of Behavioral Health, IHS Headquarters, Rockville, Maryland
telephone (301) 443-6581; fax (301) 443-7623; e-mail *wwoodis@hqe.ihs.gov*
Anthony Dekker, DO (Course Information), Phoenix Indian Medical Center, Phoenix, Arizona
telephone (602) 263-1200; e-mail *anthony.dekker@ihs.gov*
Cheryl Begay (Registration and Travel Arrangements), Clinical Support Center, Phoenix, Arizona
telephone (602) 364-7777; fax (602) 364-7788; e-mail *cheryl.begay@ihs.gov*

OBOT COURSE

The Office Based Opioid Treatment (OBOT) Course will be offered following the above course on May 12, 2006 in Phoenix, Arizona and on June 23, 2006 in Bangor, Maine. The faculty features the top clinicians and researchers in the field. This new treatment modality reduces the regulatory burden on physicians who choose to practice opioid addiction therapy. It is open to all physicians and nurses, including federal, state, and military.

2006 Clinical Update on Substance Abuse and Dependency
Pre-Registration

☐ **May 9-11, 2006 – Phoenix, Arizona (Pre-Registration Due March 31, 2006)**
Wingate Inn Phoenix, 2520 North Central Avenue, Phoenix, AZ, 85004; (602) 716-9900

☐ **June 20-22, 2006 – Bangor, Maine (Pre-Registration Due May 1, 2006)**
Location TBD

PLEASE PRINT:

Name: _____ Job Title: _____

Work Facility: _____ Work Telephone: _____

Work Address: _____ Work Fax No.: _____

City/State/Zip: _____ E-mail Address: _____

Employment Category: ☐ Civil Service ☐ Commissioned Corps ☐ Direct IHS
☐ *Contracting Tribe ☐ *Compacting Tribe ☐ Urban Program
☐ Other: _____

Professional Category: ☐Physician ☐PA ☐Nurse ☐Pharmacist ☐Other:_____

Check Preference for Treatment Experience: ☐ Male ☐ Female

Check here if you plan to attend Friday's **OBOT** Course: ☐ Yes

Why do you want to attend the CUSAD training? In 150 words or less, write a brief summary and include the following information:

1. What clinical area are you currently working in?
2. How will you utilize the training in your current position?
3. Have you had previous chemical dependency training and what type(s)?

Supervisor's Name (print): _____ Supervisor's Approval: _____
Signature

If selected, participants are expected to attend all three days of the training session.

Note:** There is a $350 tuition fee for those employees of P.L. 93-638 contracted or compacted tribal facility that have taken tribal shares of the ASAPB and/or the CSC. Please make checks payable to ***IHS Clinical Support Center.

Fax by the deadline date to: Cheryl Begay, IHS Clinical Support Center, Fax (602) 364-7788.
Or register on-line at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/.*

SAVE THIS DATE!

May 22-26, 2006

The Indian Health Service Clinical Support Center
Announces
The 2006 PA/APN Continuing Education Seminar

For Physician Assistants and Advanced Practice Nurses

Chaparral Suites Hotel
5001 North Scottsdale Road, Scottsdale, Arizona 85250
(480) 949-1414

Designed for physician assistants, nurse practitioners, nurse midwives, and pharmacist practitioners working for Indian health programs, this CE seminar provides an opportunity to network with peers/colleagues on issues of common concern, update knowledge of current health trends and issues, enhance skills to improve patient care, and receive accredited continuing education.

CURRICULUM
The advanced practice nurses' business meeting will be held Monday, May 22 through the morning of Tuesday, May 23. The continuing education seminar will begin at 1:00 pm on Tuesday, May 23 and continue through 12:00 noon on Friday, May 26. The agenda will include plenary and concurrent workshop sessions on a variety of clinical topics. The complete agenda with registration forms will be available in late February.

ACCREDITED SPONSOR
The IHS Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Continuing education credits for PAs and CNMs will be requested from the AAPA and the ACNM.

LODGING
Please make your room reservation early by calling the toll-free reservations number, **1-800-528-1456,** or call the Chaparral Suites Hotel at (480) 949-1414. Mention you are a participant of the "IHS-Annual Physician Assistant and Advanced Practice Nurse Conference" to secure the special group rate of $95.00 + tax (single/double) per night. ***The deadline for making room reservations is April 21, 2006***. Any reservation request received after this date will be accepted on a space available basis only. Please be advised that you will need to guarantee your reservation with a credit card or personal check for the first night of lodging.

The hotel provides transportation to/from the airport. When you arrive at the airport, go to the baggage claim area and locate the telephone board that lists various hotels.

NOTE: A registration fee of $300 will apply for those employed by compacting tribes that have taken their share of CSC funds and for those working in the private sector.

WATCH YOUR MAIL FOR REGISTRATION INFORMATION!
IHS Clinical Support Center, 40 N. Central Ave, Suite 780, Phoenix, AZ 85004 (602) 364-7777

The 11th Annual Elders Issue

The May 2006 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the eleventh annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

MEETINGS OF INTEREST ☐

EHR: Overview, Implementation, and Lessons Learned
Cherokee, North Carolina and Warm Springs, Oregon

Please check the following website for dates, and to register: *http://www.ihs.gov/Cio/RPMS/index.cfm?module=training&option=Index*. This class is ideal for sites that are getting ready for the electronic health record and want to see it in the clinical practice setting. Clinical staff will demonstrate a patient visit from start to finish. There will be presentations from nursing, physician, pharmacy, lab, diabetes program/case mgt, and coding staff. Participants will then break into small groups and visit with specific departments, including pharmacy, physician, nursing, medical records, computer support, dental, coding and billing.

Experience the EHR first hand. Practice entering lab, pharmacy, and nursing orders, and progress notes in the EHR training lab. Discuss preparations, process issues, and lessons learned; understand metrics that are used to measure EHR.

As a result of having attended this activity, participants will be able to:

- Gain insight about utilizing the Indian Health Service Electronic Health Record in the ambulatory practice setting
- Describe preparations, roles and responsibilities, policies and procedures that are essential for EHR implementation and success
- Practice using the electronic health record to document a simulated patient visit
- Identify metrics that can be used to measure the impact of the electronic health record
- Describe potential risk management issues

Behavioral Health Conference on Suicide Prevention and Intervention
March 28 - 30, 2006; Bloomington, Minnesota

Presented by the Bemidji Area Indian Health Service and the IHS Clinical Support Center (the accredited sponsor), this meeting will be held at the Marriott Hotel in Bloomington, Minnesota. Topics include community approach to suicide prevention; ER provider assessment; acute treatment of suicide attempts and drug ingestions; ER provider treatment of methamphetamine toxicity and other illegal drugs of abuse seen in suicide attempts; overview of research on the impact of methamphetamine on the brain and severe depression leading to suicide risk; physician assessment and management of chronic suicide attempters; question, persuade, refer (QPR): a basic suicide intervention tool for community members; community and school-based prevention and intervention models; group treatment for patients with trauma histories, mental illness, and multiple suicide attempts; critical incident stress (CISM): what it is and how it helps individuals and communities deal with extreme stress; and teen violence, community concerns, and gang prevention/intervention. The IHS Clinical Support Center is the accredited sponsor. The CSC is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. The CSC designates this activity for up to 16 hours of Category 1 credit toward the AMA Physician Recognition Award.

Room reservations can be made by calling the Marriott Hotel and requesting the "Indian Health Service" block of rooms. Contact the Minneapolis Marriott Hotel, 2020 American Blvd., East Bloomington, Minnesota 55425; telephone (952) 854-7441. The room reservation deadline is March 13, 2006. Room rates are $113.00/night for single or double occupancy.

For more information contact James Brown at telephone (218) 444-0485; e-mail *james.brown@ihs.gov*.

Second Annual Alaska Palliative Care Symposium
April 3 – 5, 2006; Anchorage, Alaska

The 2nd annual Alaska palliative care symposium is scheduled for April 3 - 5, 2006 at the Captain Cook Hotel in Anchorage, Alaska. The symposium features nationally respected palliative care speakers and the opportunity for health care providers to come together to share palliative care knowledge and resources. It is designed for physicians, midlevel practitioners, nurses, pharmacists, social workers, and other health care providers interested in palliative care.

The 2006 symposium includes plenary speakers Susan D. Block, MD and J. Andrew Billings, MD who are co-directors of the Harvard Medical School Center for Palliative Care. Ross Hays, MD, Professor in the Departments of Rehabilitation Medicine and Pediatrics at the University of Washington School of Medicine and Director of the Palliative Care Consulting Service at the Children's Hospital and Medical Center in Seattle, Washington will be the plenary speaker for a half-day session on April 5 on Pediatric Palliative Care. The program will feature both basic and advanced palliative care topics. Attendees will once again receive a tool kit which includes many books and other materials that allow them to easily consult palliative care resources when they return home.

Participants in the symposium include the Alaska Native Tribal Health Consortium, the Alaska Federal Health Care Partnership, the Alaska Pain Network, Alaska Regional Hospital, Cancer Information Service—A program of the National Cancer Institute, Community Cancer Coordination Advocates, Hospice of Anchorage, the Indian Health Service, the Intercultural Cancer Council, Providence Alaska Medical Center, and the University of Alaska Anchorage. This is funded in part by the National Cancer Institute, grant #1R25 CA104120-01.

For more information, go to *www.palliativeak.org*, or contact Karen Mitchell at telephone (907) 729-4491; e-mail *kmmitchell@anthc.org*.

IHS Basic and Refresher Colposcopy Training
April 5 – 7, 2006; Albuquerque, New Mexico

The Indian Health Service and Centers for Disease Control and Prevention are pleased to announce colposcopy training for IHS, tribal, and urban program providers. A basic colposcopy course and a simultaneous refresher course will be given April 5 - 7 in Albuquerque, New Mexico. The two courses will be taught by a faculty of nationally recognized experts both in cervical cancer screening and in colposcopy education. Lecture and small group formats will be featured. Tuition will be waived and travel and per diem covered for IHS participants and those tribal providers whose tribes did not take their shares from the IHS Division of Epidemiology and Disease Prevention. Others are invited to participate at a nominal cost.

The basic course is intended for women's health care providers wanting to increase access to colposcopy for their patients with abnormal Pap tests. The course will provide the necessary training to begin an IHS-approved preceptorship that will ultimately lead to privileges to perform colposcopy in IHS, tribal, and urban settings.

The refresher course will offer a review and update for colposcopists in practice and those currently participating in a preceptorship. It will be especially useful to those whose practice doesn't include a large number of high-grade lesions. Small group sessions will focus on more difficult diagnoses and management issues. The ASCCP Colposcopy Mentorship Program Exam will be given at the conclusion of the course.

For more information or to register, please contact Roberta Paisano at telephone (505) 248-4132 or e-mail *roberta.paisano@ihs.gov*.

Culturally Based Substance Abuse Treatments for American Indians/Alaska Natives and Latinos
April 17 - 19, 2006; Tucson, Arizona

Studies have suggested that cultural interventions play a significant role in the recovery process for American Indians, Alaska Natives, and Latinos. The purpose of this conference is to provide a forum for mental health clinicians, substance abuse/dependence counselors, researchers, policy makers, and community leaders to discuss and review cultural interventions used as promising or best practices in the treatment of substance abuse in American Indians, Alaska Natives, and Latinos.

The conference will provide participants the opportunity to discuss the problem of addiction in a cultural context, including the role of historical trauma as a factor in alcohol abuse and as a basis for using cultural interventions in the treatment of alcohol abuse/polysubstance abuse. Information will be presented on the use of different cultural interventions by American Indian/Alaska Native counselors and Latino counselors in the treatment of substance abuse in their respective populations. Selected policy implications (e.g., reimbursement issues) of using culturally based interventions in substance abuse treatment will also be discussed. The meeting will be held at the Tucson Omni National Golf Resort and Spa.

For further information please contact Pandora Hughes by telephone at (520) 621-5075, or e-mail *ahughes@AHSC.arizona.edu*. For more information about conference registration, or to review the conference agenda, go to *http://www.publichealth.arizona.edu/CHE/Research/*.

18th Annual IHS Research Conference
April 24 - 26, 2006; Albuquerque, New Mexico

The 18th Annual Indian Health Service (IHS) Research Conference, entitled "*Discovering Pathways to Better Health for American Indians and Alaska Natives,"* will bring together many stakeholders in American Indian/Alaska Native research activities including clinicians, health administrators, educators, consumers, researchers, and community and tribal government leaders across the nation. This three-day conference will enhance our ability to ensure benefits of research to Native communities and peoples. The conference will also examine in depth the impact of aging and mental health research activity in American Indian and Alaska Native (AI/AN) communities. While this 18th Annual IHS Research Conference will focus on aging and mental health, it will also touch on all aspects of AI/AN health.

The conference will be held at the Albuquerque Convention Center, 401 2nd Street NW, Albuquerque, New Mexico 87102. The host hotel will be the DoubleTree Hotel Albuquerque, 201 Marquette NW, Albuquerque, New Mexico 85253; telephone (505) 247-3344; fax (505) 247-7025. The DoubleTree Hotel is conveniently connected to the Albuquerque Convention Center via an indoor concourse. The hotel room rate is $66.00 single/$86 double per room, per night, plus tax. Be sure to mention the "IHS Research Conference" to receive this rate. Deadline for making room reservations is **March 24, 2006**.

The conference is sponsored by the Indian Health Service, the Native Research Network, and the IHS Clinical Support Center (the accredited sponsor). Individuals who wish to present their research should prepare an abstract and e-mail it (in Word format) to Leslie L. Randall, RN, MPH by March 10, 2006 (see Call For Abstracts in this issue) at *lhr6@cdc.gov* or *lrandall@npaihb.org*. She may be reached by telephone at (503) 416-3298.

For more information about the conference, contact Ellen Ortiz, Program Assistant, 5300 Homestead Rd., NE, Albuquerque, New Mexico 87110; telephone (505) 248-4435; or e-mail *Ellen.Ortiz@ihs.gov.* On-line registration is available at the IHS Clinical Support Center website at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/index.cfm*.

6th Annual Advances in Indian Health
May 2 - 5, 2006; Albuquerque, New Mexico

The 6th Annual Advances in Indian Health Conference is offered for primary care physicians, nurses, and physician assistants who work with American Indian and Alaskan Native populations at Federal, tribal, and urban program sites.

Medical students and residents who are interested in serving these populations are also welcome.

Both new and experienced attendees will learn about advances in clinical care specifically relevant to Native American populations with an emphasis on southwestern tribes. Opportunities to learn from experienced career clinicians who are experts in native people's health will be emphasized. Indian Health Service Chief Clinical Consultants and disease control program directors will be available for consultation and program development.

The conference format has changed to include another full day of lectures and workshops. The brochure is posted on the UNM CME web site at *http://hsc.unm.edu/cme*. For additional information, please contact Kathy Breckenridge, University of New Mexico Office of Continuing Medical Education, at (505) 272-3942, or e-mail our the UNM CME Office to request at brochure at *CMEWeb@salud.unm.edu*.

Embracing Our Traditions, Values, and Teachings: Native Peoples of North America HIV/AIDS Conference
May 2 - 6, 2006; Anchorage, Alaska

The *Embracing Our Traditions, Values, and Teachings: Native Peoples of North America HIV/AIDS Conference* is the first national conference on HIV/AIDS and Native peoples that is planned by and for members of the target population. More than 800 researchers, clinicians, social service providers, advocates, government representatives, and Native people living with HIV/AIDS are expected to share in multiple sessions organized around six conference tracks: Research; Mental Health; Prevention; Special Populations and Stigma; Spiritual Issues and Leadership; and Treatment, Care, and Support. The William A. Egan Civic and Convention Center in Anchorage is the primary conference venue.

The impact of HIV and AIDS on Native communities may appear small when compared with that in some other populations. However, because the Native population in the United States numbers only about 2.6 million, rising infection rates can have a huge overall impact on this small population.

Deadlines for submitting abstracts and scholarship applications to *Embracing Our Traditions* have passed, but registration is open to all interested parties. Additional information is available at the conference website, *www.embracingourtraditions.org*, or by contacting the Conference Secretariat at (800) 749-9620 or by e-mail at *embracingourtraditions@s-3.com*.

2006 Indian Health Service Eye Care National Meeting
May 8 - 12, 2006; Fullerton, California

Urban, tribal and IHS staff are invited to attend the Indian Health Service Eye Care 2006 National Meeting to be held on the Fullerton, California campus of the Southern California College of Optometry. In addition to programmatic topics, 33.5 hours of accredited clinical continuing education will be presented by national eye care authorities, with topics tailored to the clinical challenges and presentations unique to populations we serve, including uveitis, herpetic eye disease, pediatric eye conditions, cranial nerve palsies, diabetic and other retinopathies, genetic considerations in eye care, etc. There is no CE fee for I/T/U staff.

For a detailed meeting outline and more information including registration directions, please contact Dr. Richard A. Hatch by e-mail at *richard.hatch@ihs.gov*; or telephone (505) 722-1332.

2006 Clinical Update on Substance Abuse and Dependency (Formerly known as the Primary Care Provider Training on Chemical Dependency)
May 9 - 11, 2006; Phoenix, Arizona
June 20 - 22, 2006; Bangor, Maine

This three-day intensive workshop includes both didactic and experiential training. The curriculum is updated annually with the most current clinical assessment and treatment information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 - 3 person teams from the same facility representing the various disciplines targeted). The IHS Clinical Support Center is the accredited sponsor.

The May 9 – 11 conference site is the Wingate Inn Phoenix, 2520 N. Central Ave, Phoenix, Arizona, 85004. Make your hotel room reservations by **April 17, 2006** by calling (602) 716-9900. Be sure to ask for the "Indian Health Service" group rate. Conference room rates are $109.00 per night plus tax (single). Check-in is 3 pm and check-out is 12 noon. Reservation requests received after the cut-off date will be at prevailing rates based on availability. The conference site for the June 20 – 22 offering in Bangor, Maine has not been announced yet.

For more information, please contact Cheryl Begay at the Clinical Support Center, telephone (602) 364-7777 or e-mail *cheryl.begay@ihs.gov*. To register online, go to *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.

Office Based Opioid Treatment Course
May 12, 2006; Phoenix, Arizona
June 23, 2006; Bangor, Maine

The IHS invites physicians and nurses to register for the upcoming Office Based Opioid Treatment (OBOT) Course to be held Friday, May 12, 2006 in Phoenix, Arizona and to be repeated June 23, 2006 in Bangor, Maine.

The course faculty features the top clinicians and researchers in the field. This new treatment modality reduces the regulatory burden on physicians who choose to practice opioid addiction therapy. It is open to all physicians and nurses, including federal, state, and military. The IHS Clinical Support Center is the accredited sponsor. For more information, contact Dr. Anthony Dekker at (602) 263-1200 or e-mail *anthony.dekker@ihs.gov*.

The IHS Physician Assistant and Advanced Practice Nurse Annual CE Seminar
May 22 - 26, 2006; Scottsdale, Arizona

Designed for physician assistants, nurse practitioners, nurse midwives, and pharmacist practitioners working for Indian health programs, this CE seminar will provide an opportunity to network with peers/colleagues on issues of common concern, update knowledge of current health trends and issues, develop new skills to improve patient care, and receive accredited continuing education. The program will offer approximately 20 hours of discipline-specific continuing education designed to meet the needs of those providing primary care to American Indians and Alaska Natives.

The seminar will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258; telephone (480) 949-1414. Please make your room reservation early by calling the toll free number, 1-800-528-1456. Mention you are a participant of the "IHS Annual Physician Assistant and Advanced Practice Nurse Seminar." The deadline for making room reservations is April 21, 2006.

A business meeting for all Advanced Practice Nurses will be held Monday, May 22 through the morning of Tuesday, May 23. The CE seminar will begin at 1:00 pm on Tuesday, May 23 and continue through noon on Friday, May 26. The agenda will include plenary and concurrent workshop sessions on a variety of clinical topics. The complete agenda and registration forms will be available by late February. A registration fee of $300 will apply for those employed by compacting tribes or those in the private sector.

For more information, contact CDR Dora Bradley or LT Lisa Palucci at the IHS Clinical Support Center, telephone (602) 364-7777 or e-mail *theodora.bradley@mail.ihs.gov*.

20th Annual National Council of Nurse Administrators (NCONA) 2006 Conference
June 5 - 9, 2006; Kansas City, Missouri

IHS, tribal, and urban program nurses are encouraged to attend the 20th Annual NCONA Meeting and Conference entitled "*Crossing the Threshold to an Enlightened Practice"* to be held at the Westin Crown Center, Kansas City, Missouri, One Pershing Road, Kansas City, Missouri 64108; telephone (816) 474-4400; fax (816) 391-4438. Please make your room reservations by May 5 by calling the toll free number (888) 627-8538 and ask for the "NCONA," or the "IHS" group rate. Single occupancy rate is $91.00 per night plus tax. Check-in is 3 pm and check-out is 12:00 noon.

The IHS Clinical Support Center is the accredited sponsor of this meeting. For more information about the conference, visit the NCONA website at *http://www.ihs.gov/MedicalPrograms/ncona*. On-line registration is available.

Summer Geriatric Institute
June 22 - 24, 2006; Albuquerque, New Mexico

The New Mexico Geriatric Education Center at the University of New Mexico Health Sciences Center announces the next Summer Geriatric Institute, June 22 - 24, 2006 at the Hilton Inn, University Blvd., Albuquerque, New Mexico. This year's institute will build on your geriatric skills and knowledge while joining with the IHS focus on "Health Promotion and Disease Prevention" but with an emphasis on the elders. Our theme is "Healthy Aging: Maintaining Harmony in Mind, Body and Spirit." CME/CEUs will be available.

The NMGEC will once again provide tuition waivers for tribal and IHS providers to attend the institute. Please contact us for a waiver application and/or Institute registration at (505) 272-4934; or e-mail Darlene Franklin at *dfranklin@salud.unm.edu*.

ACOG/IHS Denver Course: Obstetric, Neonatal and Gynecologic Care
September 17 - 21, 2006; Aurora, Colorado

This annual women's health update for nurses, advanced practice clinicians, and physicians provides a four-day schedule of lectures, workshops, hands-on sessions, and team building. The large interdisciplinary faculty collaborates to teach clinical and practical topics as they apply in Indian health settings. Many faculty members are your colleagues in IHS and tribal facilities; private sector faculty also bring a wide range of experience providing Indian health care.

Learn the latest evidence-based approaches to maternal and child health services, and share problems and solutions with your colleagues from across Indian country. The course can also serve as a good foundation for professionals who are new to women's health care or new to the Indian health system.

In addition to the basic course, you may sign up for the Neonatal Resuscitation Program, and come away with your certificate from this convenient pre-course program. The opportunity to fulfill continuing education requirements in a concentrated format is significant: with the optional NRP, we can document your participation in nine half-days of education.

Sign up early! You'll have first chance for support from your facility and coverage for your time in Denver. Getting these benefits lined up takes time, so don't delay and miss out! In addition, early registration holds your place, and puts you in line for possible availability of scholarship funds.

Watch your mail for the course brochure and registration form. To download the 2006 brochure immediately, click on *www.ihs.gov/MedicalPrograms/MCH/F/ACOG01.cfm* or *www.ihs.gov/MedicalPrograms/MCH/F/documents/ACOG_06brochR1_1.pdf*. For more information, contact Yvonne Malloy by e-mail at *ymalloy@acog.org*.

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 on an organizational letterhead to: Editor, The IHS Provider, The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, 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. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

BC/BE General Internist
Tuba City Regional Health Care Corporation; Tuba City, Arizona

Tuba City Regional Health Care Corporation (TCRHCC) will have an opening for a BC/BE general internist in summer, 2006. This internist will be joining an eight member internal medicine department and must have strong inpatient and outpatient medicine skills. The provider must also have very good critical care skills, including line placement and ventilator management. Call averages out to one in nine, doing a week of hospitalist medicine every 4 - 5 weeks. We highly value interpersonal working skills and clinical quality. TCRHCC is a full service hospital with a medical staff of over 60 physicians and a full range of specialty care. We are located in Northern Arizona, 70 miles north of Flagstaff, with close proximity to the Grand Canyon and numerous national parks, forests, and scenic areas. We serve primarily the Navajo, Hopi, and San Juan Paiute peoples. Since we are a P.L. 93-638 facility, physicians can be hired either as Commissioned Officers or direct corporate hires of TCRHCC.

For more information, please contact Joe Magee MD, Chief of Internal Medicine, TCRHCC at (928) 283-2406, or by e-mail at *jmageel@tcimc.ihs.gov*.

Family Practice or Internal Medicine Physician/Medical Director
Dentist/Dental Director
Seldovia Village Tribe Health Center (SVTHC); Homer, Alaska

SVT Health Center is recruiting a full-time family practice/primary care/internal medicine physician and a dentist to join our health care team to provide leadership for the interdisciplinary medical/dental teams and provide quality patient care within the community health center model of care. The ideal candidate is an outgoing, hard worker and team player who is compassionate and focused on patient care. The clinician will be working with Medicaid, underinsured, and sliding-fee patients. Computer literacy is a must. SVTHC offers a competitive salary and generous benefits package.

The health center is located in south central Alaska on beautiful Kachemak Bay. There are many outdoor activities including clam digging, fishing, hiking, kayaking, camping, and boating. The community is a quick four-hour drive from Anchorage.

Applicants can send a resume to SVT Health Center, 880 East Road, Homer, Alaska 99603; fax (907) 226-2230; or e-mail *dbreedin@sut.org*. If you have questions, contact Dotty at (907) 226-2228, ext. 106.

Pharmacist Supervisor
Sault Tribe of Chippewa Indians; Manistique, Michigan

The Sault Tribe of Chippewa Indians is currently recruiting for various health care positions. Our tribal health division is the largest governmental program within the tribe and has a staff of 270, with a budget of over $24 million. We currently maintain ten health centers and clinics in the Upper Peninsula of Michigan.

We are currently searching for an exceptional team member who holds a Bachelor of Science Degree in Pharmacy or a Doctor of Pharmacy and be a licensed registered pharmacist in Michigan. This individual will have supervisory experience and possess the initiative and enthusiasm to take on the challenges of a new health facility in Manistique, Michigan. Check us out on the web at *www.saulttribe.com*, or call 1-866-635-7032 for a detailed job description.

Clinical Program Consultant (Medical Information)
Phoenix Area Indian Health Service

The Phoenix Area Indian Health Service has one immediate opening for a Clinical Program Consultant (Medical Information; GS-0601-13). This position serves as the Phoenix Area-wide Electronic Health Record Program Consultant. Program responsibilities include implementation, training, and on-going support of multi-service clinical software applications used in the hospital and clinical setting in a three-state area. The multi-service applications include, but are not limited to the Indian Health Service Electronic Health Records, Patient Care Component (PCC), and other related software applications that automate the capture of clinical encounter information and its subsequent retrieval. This position will manage customization of site parameters, and addresses integration issues with other software packages. This position requires that the incumbent has clinical experience in a health profession and must have the licensure, registration, or certification that is required for that health profession.

For more information, please contact Cathy Ayatta, Office of Human Resources, Phoenix Area Indian Health Service, at (602) 364-5219.

Physician
Redbird Smith Health Center; Sallisaw, Oklahoma

The Redbird Smith Health Center is currently seeking a full-time family medicine physician. This 22,900 sq. foot facility is one of six rural ambulatory clinics operated by the Cherokee Nation. Other services offered at this facility include dental, radiology, public health nursing, an in-depth diabetes program, pharmacy, and laboratory. Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, no weekends, no call, and relocation expenses are available.

If interested in this exciting opportunity, please submit a completed Cherokee Nation application, along with copies of degrees and/or certificates, to Cherokee Nation Health Administration Office, Attn: Kathy Kilpatrick or Angie Cone, P.O. Box 948, Tahlequah, Oklahoma 74465; telephone (918) 453-5000; fax (918) 458-6174; or e-mail *kathy-kilpatrick@cherokee.org* or *angie-cone@cherokee.org.* We would also like to extend an invitation to come and visit our clinic – we feel confident you'll love our charming southern hospitality.

For more detailed information regarding job listings, log onto our website at *www.cherokee.org*. Applicants with Indian preference must submit a copy of their Certificate Degree of Indian Blood (CDIB) along with their application. All applicants will be required to pass a pre-employment drug screen and complete a background check.

Dentist
Cherokee Nation Health Services; Northeastern Oklahoma

We are currently seeking dentists at our Jay, Sallisaw, and Stilwell rural ambulatory clinics. Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, and relocation expenses. Applicants should be self-starters who are compassionate about their patients. If interested in this exciting opportunity, please submit a completed Cherokee Nation Application, along with copies of degrees and/or certificates, to Cherokee Nation Health Administration Office, Attn: Kathy Kilpatrick or Angie Cone, P.O. Box 948, Tahlequah, Oklahoma 74465; telephone (918) 453-5000; fax (918) 458-6174; or e-mail mail *kathy-kilpatrick@cherokee.org* or *angie-cone@cherokee.org.*

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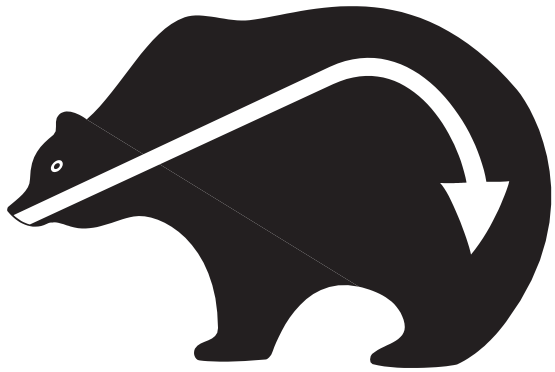
Internal Medicine, Family Practice and Emergency Medicine Physicians; Surgeons, Radiologist, and Dentists
Chinle Service Unit, Indian Health Service; Chinle, Arizona

Got Hózhó? That's the Navajo word for joy . . .. Here on the Navajo Reservation there's a great mix of challenging health care work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work *(naanish)* and enjoy the small collegial community that we live in. Our 60-bed acute care Indian Health Service hospital is located in Chinle, Arizona — the heart of the Navajo Reservation. We also have two health centers associated with the hospital. At work we see unique pathology, and practice evidence-based medicine. Our colleagues have trained at some of the top programs in the country, and we enjoy learning from each other in an atmosphere of interdepartmental collaboration. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients.

During our time off, many of us explore the beautiful southwest, bike on some of the finest slick rock, and ski the slopes of the Rocky Mountains. It's a great life — challenging and interesting work, while experiencing the peaceful culture of the Navajo people and the beautiful land of the Southwest.

We're looking to fill position in internal medicine, emergency medicine, family practice, med/peds, pediatrics, psychiatry, dentistry, optometry, surgery, radiology, anesthesiology, speech and language pathology, and nursing! We are also looking for the right candidate to fill a Supervisory Medical Officer (SMO) position at our brand new satellite clinic, the Pinon Health Center.

Learn more about where "*Naanish Baa Hózhó" (work is joyful).* Contact Heidi Arnholm, Medical Staff Recruiter, Chinle IHS Hospital, at telephone (928) 674-7607 or (928) 674-7609; e-mail *heidi.arnholm@ihs.gov*.



Family Practice Physician and Pediatrician
PHS Indian Health Clinics, Poplar and Wolf Point, Montana

Fort Peck Service Unit is looking for board eligible/board certified family practice and pediatrics physicians to join their medical staff. The medical staff is composed of five family practice, one internal medicine, and two pediatrics physicians, as well as a podiatrist and four FNPs. We are currently contracting for obstetrics services; however, we are open to providers doing OB.

The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. There are two clinic sites, one in Poplar and one in Wolf Point. These are ambulatory clinics; however our providers have privileges at the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. For example, the IHS and the private hospital have a cardiac rehab center. By cooperating with the IHS, the hospital has been able to get CT scan and a mammography unit. The clinics and the hospitals have complete laboratory, ultrasound, and radiology departments. Tribal Health has a dialysis unit attached to the Poplar clinic. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community to encourage a "Healthier Community." Customer service is our priority.

The IHS has excellent benefits for Civil Service and Commissioned Corps employees. We are a designated NHSC site. You can get more information about the community and the service unit by checking out *www.ftpeck.ihs.gov* and *www.wolfpoint.com*. Fort Peck Tribes can also be found at *www.fortpecktribes.org*, and the Fort Peck Community College at *www.fpcc.edu*. If you are interested in an exciting practice, please contact Dr. Mike Uphues at (406) 653-1641; or e-mail *Michael.uphues@ihs.gov*. Alternatively, you may contact Rose Neumiller at (406) 768-3491, (406) 653-1641, or home phone (406) 653-2743; e-mail *rose.neumiller@ihs.gov*. Finally, you may contact the Billings Area Physician Recruiter, Audrey Jones at (406) 247-7126; e-mail *Audrey.Jones@Ihs.gov*. We look forward to communicating with you.

Pediatrician and Family Practice, Internal Medicine, and Emergency Medicine Physicians
PHS Indian Hospital, Browning, Montana

The Blackfeet Service Unit is home to the Blackfeet Community Hospital, a 27-bed hospital, active outpatient clinic, and well-equipped emergency department. Inpatient care includes obstetrics and elective general surgery. We also offer community health nursing, an active diabetes program, optometry, laboratory, dental, and ENT services, along with behavioral and social services, and women's health. We are seeking candidates who are committed to improving the health of the local community and being part of a team approach to medicine. The hospital is located 13 miles from Glacier National Park. The area offers spectacular mountains and incredible outdoor activities year-round. We are a designated NHSC site. If you are interested in joining our medical team, contact Dr. Jonie Hines at *jonie.hines@ihs.gov;* telephone (406) 338-6365 or Audrey Jones at *Audrey.Jones@ihs.gov*; telephone (406) 247-7126.

Dentists
Cass Lake and Red Lake, Minnesota

Bemidji, the first city on the Mississippi River, is a historically charming, progressive, and beautiful city. The Bemidji Area offers the finest in shopping, high level education, medical care, technology, lodging, and government services. Minnesota has a fine education system, and this year it ranked first nationwide in ACT test scores. Bemidji itself is home to Bemidji State University and the Concordia Language Villages. With over 400 lakes in a 25 mile radius, outdoor activities abound throughout the year. Enjoy biking, hiking, skiing (both water and snow), hunting, fishing, and the Boundary Water Canoeing Area, which is just 100 miles to the north of Bemidji and is home to some of the best canoeing in the United States.

Cass Lake Hospital is located 15 minutes east of Bemidji. It is a new facility with a nine chair, hospital-based dental clinic with three full time dentists and a part time hygienist. They provide a wide range of services including surgical extractions, endodontics, fixed/removable prosthetics, and community health promotion/disease prevention programs.

For more information about Cass Lake, please contact Dr. Robert Mork, DDS, Chief Dental Officer, Cass Lake Hospital; telephone (218) 335-3200.

Red Lake Hospital located 35 minutes north of Bemidji. They do a lot of surgery, endodontics, and pedodontics. The Red Lake Tribe provides $25,000 for laboratory fees so they do more prosthodontics than most Indian health clinics.

General Duties: Provides clinical diagnosis, evaluation, studies, and treatment services of professionally acceptable quantity and quality in accordance with sound public health practice. Education and Information: Provides professional information and education services to patients, other citizens of the community(s) who reside within the scope of work area assigned and to other health service workers as appropriate. Licensure: Applicants must be currently licensed to practice in a state, the District of Columbia, or Puerto Rico. Both of these are possible loan repayment sites.

If you have any questions regarding the Bemidji Area or the Public Health Service, please call Dr. William Canada, DDS at (218) 679-3912, ext. 141; or e-mail *william.canada@ihs.gov*.

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THE IHS PRIMARY CARE PROVIDER

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

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov.* Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(www.ihs.gov/PublicInfo/Publications/HealthProvider.asp).*

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.

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

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