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Introduction to the July 2010 Special Issue on Injury Prevention

For American Indian and Alaska Native (AI/AN) people, the economic cost of unintentional injuries amounts to more than two billion dollars a year. The financial and emotional strain can be devastating for families and communities already overburdened by substantially higher rates of disease and lower life expectancies than the overall US population. That is why this special July issue of *The IHS Primary Care Provider* focuses on an important but often overlooked public health priority: preventing injuries and unnecessary deaths in AI/AN communities. The articles highlight how the Indian Health Service (IHS) and tribes are working together to prevent injuries and fatalities from suicides, motor vehicle crashes, and falls.

Although the AI/AN injury mortality rate has decreased by more than 50 percent since the 1970s, injuries remain the leading cause of death for individuals 1 - 44 years old. The following articles reveal innovative ways our partners are making our communities safer. For more information about what you can do to prevent injuries, contact the IHS Injury Prevention Program Manager, CAPT Nancy Bill, at (301) 443-0105; or visit the IHS Injury Prevention website at *http://www.injprev.ihs.gov*. Our future is defined by the lives we save. Together, we can protect lives and create healthier communities.

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Special Thanks to Dr. Lawrence Berger

Once again, we are grateful for the efforts of Lawrence Berger, MD, MPH, Clinical Assistant Professor of Pediatrics, University of New Mexico School of Medicine and Academic Director, IHS Injury Prevention Fellowship Program, Albuquerque, New Mexico, who has worked throughout the year to put together this, the fourth annual special issue of *The Provider* devoted to injury prevention.

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Suicide Prevention: The Role of the IHS Environmental Health Officer

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Background

Suicide is a serious public health problem in tribal communities nationwide. Between 1999 and 2006, suicide was the second leading cause of death for American Indians and Alaska Natives (AI/AN) ages 10 - 34 and the 8th leading cause of death overall, resulting in 2,746 deaths. The suicide rate for AI/AN ages 10 - 44 was 15.63 between 1999 and 2006, which is nearly 1.5 times higher than the rate for all US races. In terms of years of potential life lost (YPLL), suicide completions resulted in 88,657 YPLL between 1999 and 2006 among AI/AN.[1] The AI/AN suicide rate varies widely by state, as demonstrated in the map in Figure 1.

While these numbers are sobering, it is likely they are under-reported. Multiple studies have addressed the issue of racial misclassification of AI/AN on death certificates;[2,3] one study found suicide deaths were particularly underestimated among AI/AN living in Montana.[4]

A combination of individual, relational, community, and societal factors contribute to the risk of suicide. Risk factors for suicide include a previous attempt(s), history of alcohol and substance abuse, easy access to lethal means, loss, and local epidemics of suicide. A comprehensive list of suicide risk factors and protective factors can be found at the Centers for Disease Control and Prevention website.[5]

The stigma surrounding suicide has deep roots in many tribal communities. Stigma can prevent those who need mental health care from seeking it, increasing the risk for suicide.[6] Also, stigma can make prevention efforts difficult in communities where it exists. If a community is unwilling to discuss or acknowledge the issue of suicide, then there may be resistance to any prevention efforts proposed. Some communities have extreme protective custody laws, further complicating help-seeking and the timely provision of appropriate care. Stigma is also evidenced in the fact that homicide is often viewed as a larger problem than suicide, but between 1999 and 2006, there were 836 more deaths by suicide than homicide among AI/AN.[1] Multiple studies have documented the importance of stigma reduction as a part of a comprehensive suicide prevention program.[7-9] The lack of confidentiality that exists in some small communities can cause individuals to not seek treatment for behavioral health issues.

Compounding the problem is a lack of behavioral health providers in Indian Country. Many of the Indian Health Service (IHS), tribal, and urban mental health programs do not have enough staff to operate 24 hours a day and 7 days a week.[10] Out of 242 tribal health centers nationwide, ten percent (10%) noted no mental health services were provided at all.[11] A study released in 2000 indicated there was only one children's mental health provider for every 25,000 Indian children.[12] IHS does not have a current vacancy rate for behavioral health providers, but acknowledges that, anecdotally, there is a shortage.[13] These figures indicate a clear need for additional mental health providers in Indian Country.

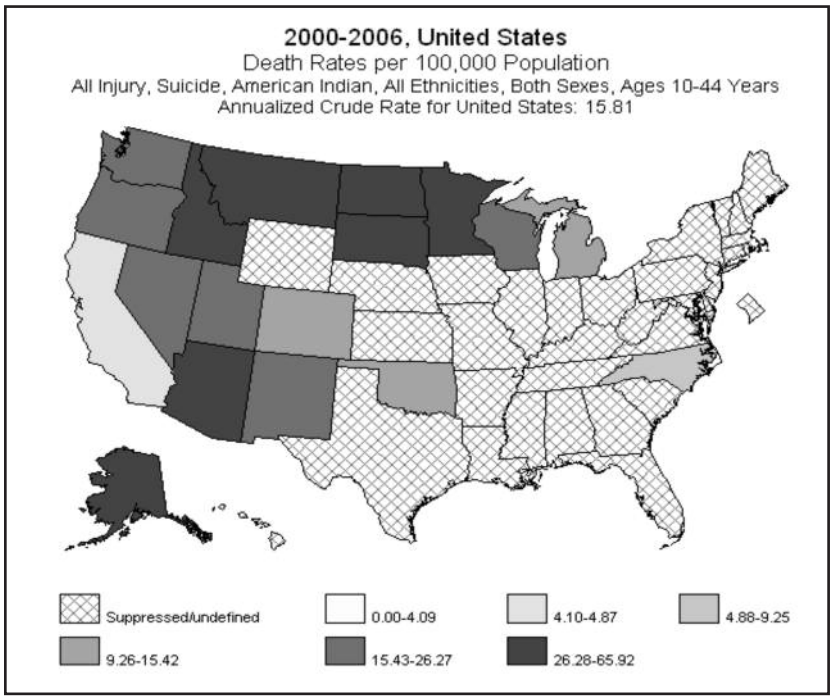
Because of this shortage it is likely the majority of behavioral health providers are only able to focus their efforts on treatment of behavioral health disorders, leaving little or no time to work on community-based prevention activities. Due to this shortage, providers may be reluctant to initiate or get involved with prevention activities.

IHS developed a Suicide Prevention work plan whose purpose is to develop, advocate for, and coordinate a comprehensive cultural-and community-based approach to reduce suicidal behaviors and suicides in AI/AN communities.[14] The work plan follows, in many aspects, the National Strategy for Suicide Prevention, which is a national initiative to reduce the impact of suicide and suicidal behaviors. The work plan outlines several objectives in the area of awareness, interventions, and methodology; and lists the following goals:

- Promote awareness that suicide is a public health problem that is preventable;
- Implement training for recognition of at-risk behavior and delivery of effective treatment;
- Develop and promote effective clinical and professional practices;
- Develop and implement community-based suicide prevention programs;
- Promote and support research on suicide and suicide prevention;
- Improve and expand surveillance systems; and
- Implement best practices.

This list clearly indicates the need for collaborative

Figure 1. Map of suicide rates by state, AI/AN, ages 10 - 44, 2000 - 2006



Reports for All Ages include those of unknown age.
* Rates based on 20 or fewer deaths may be unstable. States with these rates are cross-hatched in the map (see legend above). Such rates have an asterisk.

Produced by: Office of Statistics & Programming, National Center for Injury Prevention & Control, CDC. Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

partnerships between clinical and community/public health disciplines. IHS Environmental Health Officers (EHOs) should be active participants in this effort, as they are uniquely qualified through their education and experience in community-based injury prevention initiatives.

EHOs Role in Injury Prevention

EHOs working in injury prevention (IP) seems an oddity to many people in the field of environmental health. Yet, most EHOs in IHS are involved in IP at some point in their careers. This role dates back to the mid to late 1980s with the development of severe injury surveillance systems and injury prevention training sponsored by the IHS Office of Environmental Health and Engineering (OEHE) Division of Environmental Health Services (DEHS). The DEHS program is divided into three distinct components: general environmental health, institutional environmental health, and injury prevention. Even the mission of the IHS DEHS, to "reduce and eliminate environmentally related disease and injury" establishes injury prevention as an inherent responsibility of all IHS EHOs.

The IHS IP Program is embodied by four guiding principles: evidence-based community prevention strategies, reliable injury surveillance data, building tribal capacity, and fostering collaborative partnerships. Several public health models, including the Haddon Matrix (pre-event/event/post-event; host, agent/environment) and the CDC's National Center for Injury Prevention's "Public Health Approach" (surveillance, risk factor identification, implementation, and intervention evaluation) have influenced development of the guiding principles.[15] To ensure staff knowledge and competency, the IP Program at the Headquarters and Area levels have provided support for injury-specific training (i.e., three short courses, as well as a year-long Injury Prevention Fellowship), technical assistance and support from IHS injury experts (i.e., Area Injury Prevention Specialists and District IP Coordinators), and opportunities for project development and implementation. These extensive resources, along with the fact that EHOs work in the local community, prepare them to serve such injury prevention roles as injury prevention practitioners, technical experts, facilitators and/or supporters of community coalitions, project officers for IHS-awarded tribal injury prevention cooperative agreements, data collectors, and technical advisors for grant writing.

IHS EHOs have made considerable contributions to the field of unintentional injury prevention, including fire prevention, motor vehicle safety, drowning prevention, and pedestrian safety.[16-19] EHO work in intentional injury has not been as widespread, and there are only a few articles detailing such work. Examples include retrospective studies of severe assault injury, efforts to reduce bullying, suicide intervention training, and reducing access to firearms.[20-25] EHOs have the potential to contribute more extensively to the prevention of intentional injury, specifically suicide prevention.

EHOs Role in Suicide Prevention

The number of EHOs currently involved with suicide prevention is relatively small. Nevertheless, EHOs have already made important contributions to the field of suicide prevention in Indian Country (Table 1). Many of the key elements in designing interventions to prevent unintentional injuries also apply to intentional injuries: forming partnerships, providing technical assistance, identifying effective strategies and tailoring them to the needs of individual communities, and collecting data. Partnerships are essential in suicide prevention. EHOs have extensive experience in coalition building and forming partnerships. EHOs can provide technical assistance to tribes that are currently addressing suicide prevention or would like to become involved in suicide prevention. Technical assistance includes assistance with grant

Table 1. EHOs Contributions to Suicide Prevention

Training, coalition building, and partnerships	• EHOs partnered with the State of Nevada Office of Suicide Prevention to collaborate on suicide prevention activities such as awareness, gatekeeper training, and a phone text pilot program at a tribal school. • EHOs are involved in several tribally-based suicide prevention coalitions and task forces in Nevada, Utah, and Alaska. These coalitions have been successful in engaging the clinical staff and starting community dialogue about suicide. • Partnered with the University of Nevada Las Vegas to facilitate focus groups at a tribal School. The data collected was used to drive suicide prevention activities at the school.
Project design, implementation and evaluation	• Implementation of an Applied Suicide Intervention Skills Training program in northwest Alaska. • Assistance with development and submission of a tribal-based Garret Lee Smith Suicide Prevention proposal, which resulted in an award of $1.5M for suicide prevention for tribes in Nevada. • Providing technical assistance to tribes in Nevada who were awarded funding from the IHS Meth and Suicide Prevention Initiative (MSPI). • Implementing a safe firearm storage program in Alaska. • Assisted tribes who applied for funding for Phoenix Area Injury Prevention Demonstration Projects related to suicide prevention. Resulted in over $40,000 awarded to tribes to implement suicide prevention interventions.
Data collection and assessment	• Provided suicide data for tribes applying for Area Injury Prevention Demonstration Projects and a Garret Lee Smith Suicide Prevention Grant. • Working to improve suicide surveillance for a tribe in Utah.
Policy development	• Currently working with a tribe in Utah to repeal a tribal ordinance in which a suicide attempt is punishable by jail time or fines.

formulation, developing goals and objectives for suicide prevention projects, and advice on the choice and implementation of best-practice suicide prevention interventions. Within the IHS, EHOs have taken the lead in injury surveillance for many years. Surveillance data have been provided to tribes to guide injury prevention activities and support funding proposals. Suicide data should be included in routine injury surveillance, and EHOs can work with tribes to increase the quality of suicide data.

Intentional injuries occur in predictable patterns, just as unintentional injuries do. Public health models used in unintentional injury prevention can also be applied when designing interventions to prevent suicide. In fact, the National Strategy for Suicide Prevention advocates for a public health approach to suicide prevention, and the Suicide Prevention Resource Center (SPRC) (which provides support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions, and policies) has developed guidelines for using the public health approach specifically to address suicide.[26,27] This application of the public health approach is not radically different from what EHOs are currently using to address unintentional injuries. However, it is important to remember that suicide is the outcome of extremely complex circumstances. While most public health approach steps apply when designing an intervention, not all interventions are straightforward, as is the case when addressing unintentional injuries.[28]

Despite the numerous similarities between suicide prevention and unintentional injury prevention, there are a few differences. In suicide prevention, progress in implementing interventions is slower compared to unintentional injury prevention. In communities that have been impacted by suicide, emotions can sometimes impede prevention activities. Also, more consideration should be given to cultural and spiritual elements when addressing suicide prevention as compared to unintentional injury prevention.

Many EHOs are reluctant to become involved in suicide prevention. They may see suicide prevention as the exclusive purview of the behavioral health/mental health profession. They may share the fear and stigma surrounding suicide, and prefer to distance themselves from the issue, or accept the myth that talking about suicide promotes suicidal thoughts and

actions. Some feel that their lack of specific knowledge of suicide-related terminology, data sources, and best practices makes them unsuitable to participate in prevention efforts. Finally, even if they are interested in participating in prevention efforts, they make lack the support of supervisors who don't accept intentional injuries as a legitimate or high-priority subject for environmental health officers.

Some EHOs lack adequate training in behavioral health, but if suicide is viewed as a public health problem – and not solely a behavioral health one – EHOs are well equipped to work in the field of suicide prevention. EHOs can attend training to become better prepared to work in the field of suicide prevention. Gatekeeper training is an excellent avenue for EHOs to take their first steps into the field. The workshops convey information about suicide terminology, risk and protective factors, and suicide prevention best practices; and provide skills training to recognize, support, and refer individuals at risk of suicide. Well-established gatekeeper training programs include SafeTALK; Applied Suicide Intervention Skills Training (ASIST); and Question, Persuade, and Refer (QPR).[29-31] Suicide prevention content can also be incorporated into the IHS IP program's "short courses" on injury prevention, and is offered in the form of free, on-line workshops sponsored by the NCSPT and SPRC. These trainings not only help EHOs to become more comfortable with the issue of suicide, but also give them valuable knowledge when working with tribes on suicide prevention initiatives.

Suicide is a complex public health problem that will likely be unresponsive to one-dimensional prevention strategies.[28] Multifaceted approaches that encompass all three strategies of suicide prevention (universal, selective, and indicated) are preferred. Examples of best practices in suicide prevention can be found at the SPRC website and in an article published by the Journal of the American Medical Association titled: *"Suicide Prevention Strategies: A Systematic Review"*.[32,33] Table 2 lists suicide interventions broken down by strategy. Furthermore, since suicide is such a complex issue, the expertise of many professional and community members is needed to address suicide. While most collaborations are community-based, successful collaborations have also been school- and clinic-based. Table 3 lists potential collaborators in a suicide prevention coalition or task force.

Conclusion

Suicide is a serious public health problem that should not be ignored by public health professionals. EHOs working in IHS can have a role in suicide prevention, just as they do in the prevention of unintentional injuries. Currently, EHOs are already collecting injury data, bringing partners together, and providing technical assistance to tribes. EHOs have a foundation in public health knowledge through education and experience. For example, most EHOs have experience in injury prevention coalition building and maintaining existing coalitions by assisting in the development of goals and objectives. EHOs work in one of the few disciplines in IHS where the focus is on the prevention of disease and injury rather than treatment. In many rural communities EHOs serve as one of the primary public health practitioners, acting as public health experts for the tribes they serve. Many EHOs have advanced training in injury prevention, including the IHS

Table 2. Suicide Prevention Strategies

Universal Prevention Strategies: Reduce risk and enhance protective or mitigating factors	• Restrict access to lethal means: - Safe firearm storage - Safe medication storage • Public health messages/media campaigns • School-based interventions • Gatekeeper interventions • Screening
Selective Prevention Strategies: Address population specific characteristics that place individuals at a higher than average risk	• Population-specific approaches • American Indian Life Skills Development Curriculum • Managing depression
Indicated Prevention Strategies: Treat individuals with precursor signs and symptoms to prevent development of full-blown disorders	• Emergency room screening and follow-up • Contact with high-risk individuals through letters or phone calls • Brief psychological intervention

*Adapted from the Handbook of Injury and Violence Prevention, Haas, 2007

Table 3. Potential Members of a Suicide Prevention Coalition

Administrative	Health-Related	Community Members
• Tribal Council members • Tribal administrators • Tribal Health Board members • Grant writers	• Tribal/IHS mental health providers • IHS environmental health officers • Public health nurses • Clinic health directors • Community health representatives • Community health aides • Local and state agencies • Social workers • Tribal injury prevention practitioners	• School staff • Suicide survivors (personal or family member) • Tribal spiritual leaders • Clergy • Interested community members • Youth workers/youth leaders

IP short courses and the IHS IP Fellowship. This advanced training, combined with experience working in tribal communities and education, make EHOs very qualified to expand their role in injury prevention to include suicide prevention.

The mission of the IHS IP Program is to raise the health status of American Indians and Alaska Natives to the highest possible level by decreasing the incidence of severe injuries and death to the lowest possible level and increasing the ability of tribes to address their injury problems.[34] We know EHOs play a critical role in fulfilling this mission, and we are challenging EHOs to take up the charge issued by RADM John Babb at the 2008 Commissioned Officer Foundation Symposium: *"If not now, then when; if not here, then where; if not you, then who?"*

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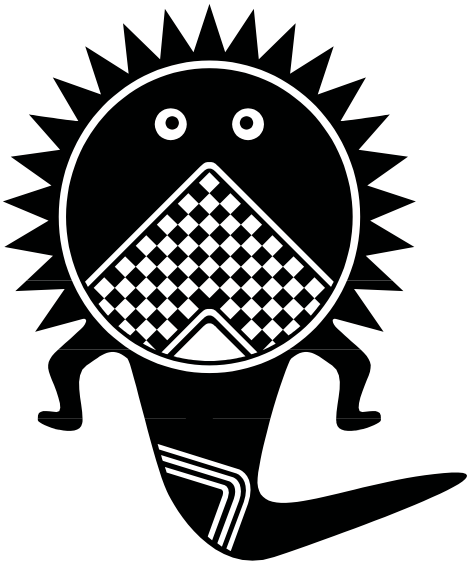

Tai Chi for Elder Falls Prevention

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Introduction

Every year, one in three adults over the age of 65 years has a fall. Of those who fall, 20% to 30% suffer moderate to severe injuries.[1] Among older adults living independently who suffer a fall-related hip fracture, a quarter will need to stay in a nursing home for at least a year and 20% will die within a year of their injury.[2] The fear of falling in itself can prevent older adults from enjoying daily activities or even venturing outside of their homes.[3,4]

To prevent fall injuries, the Centers for Disease Control and Prevention (CDC) recommends that older adults:[5]

- Exercise regularly
- Ask their doctor or pharmacist to review their medicines to reduce side effects and interactions
- Have their eyes checked by an eye doctor at least once a year
- Improve the lighting in their home and reduce home hazards that can lead to falls

According to the CDC, the most beneficial forms of exercise to reduce falls are "programs like tai chi that increase strength and improve balance."[1] Tai chi is among the most-studied exercise programs for older adults. In addition to improving balance,[6] there is evidence that tai chi can reduce systolic blood pressure and fear of falling,[7] enhance the quality of life and functional mobility among older adults with osteoarthritis,[8] and improve glucose control and the quality of life among individuals with diabetes.[9,10] A tai chi program of one-hour classes offered twice weekly in senior centers in Oregon reduced the frequency of falls by 55%.[5] Tai chi has been shown to be one of the most cost-effective interventions to reduce hip fractures.[11] Staff from the Mayo Clinic recommend tai chi as a means of stress reduction, as well as for its other health benefits:

> "Tai chi is sometimes described as "meditation in motion" because it promotes serenity through gentle movements -- connecting the mind and body . . .. Tai chi, also called tai chi chuan, is a noncompetitive, self-paced system of gentle physical exercise and stretching. To do tai chi, you perform a series of postures or movements in a slow, graceful manner . . .. Tai chi emphasizes technique over strength. In fact, because tai chi is low impact, it may be especially suitable if you're an older adult who otherwise may not exercise. You may also find tai chi appealing because it's inexpensive, requires no special equipment, and can be done indoors or out, either alone or in a group."[12]

Because of the many potential benefits of tai chi, we explored the feasibility of instituting a tai chi program for older adults in our service population. Would IHS and tribal agency directors be willing to promote the program? How difficult would it be to recruit and train instructors? Most importantly, would tai chi be embraced by elders, or rejected as too unusual or culturally inappropriate?

Formative Evaluation

To obtain input from community members and local health experts, we conducted interviews and focus groups, distributed a survey at community events, and solicited feedback at several community meetings. The focus groups were conducted with older adults who were living independently. Our moderator guide was patterned after that of Basia, et al.[13] We asked about current physical activities, barriers and motivators for exercise participation, preferences regarding optimal frequency and location of group classes, and interest in various possible exercise programs, including tai chi. In addition to describing tai chi and its health benefits, we demonstrated several tai chi movements.

The most important finding from the focus groups, interviews, and survey was that community members were very receptive to tai chi. Many felt it would be beneficial because of its slow, gentle movements; simplicity; and low cost. They liked the idea that tai chi could be performed at home as well as in groups; by frail individuals as well as more active adults. Several community members remarked on how tai chi's spiritual nature – its connection to the flow of inner, vital energies (chi) – resonated with traditional views of health and restoring balance among mind, body, and spirit.

Concern about falling was widespread, and people were enthusiastic about interventions to reduce fall injuries. Other insights from the community assessment were that the exercises should be made culturally relevant; homebound adults and those living remote, rural areas should have access to a tai chi program; and group classes could be held at community recreational centers and during the weekly elders meetings to improve participation.

Implementing the Tai Chi Program

We began by offering a weekly tai chi class at one of the senior centers. At first, we taught exercises that could be performed while sitting in chairs. This allowed for participation by adults who had mobility problems or who

found it difficult to combine upper and lower extremity movements. As participants gained confidence and stamina, standing exercises were introduced.

There were small numbers of participants initially. However, at the annual Diabetes Wellness Event we had to add a second tai chi presentation because of the substantial interest in the program. This was followed by a multi-day, train-the-trainers session resulting in 25 participants being certified as instructors in "Tai Chi for Diabetes." The new instructors are now providing instruction in the 18 tai chi moves recommended by Dr. Paul Lam "to prevent and improve the control of diabetes."[14] The Healthy Heart Project also has adopted the use of tai chi. Among the benefits anticipated for heart patients practicing tai chi's are reductions in blood pressure, relief of stress, and promotion of social interaction.

With multiple tai chi classes now being offered in several of our communities, we prepared a brochure to "market" tai chi. The brochure includes a brief description of tai chi and its health benefits, sample exercise, class times and locations, and contact information.

To make the program accessible to individuals outside of the scheduled classes, we developed a spiral-bound notebook of ten exercises entitled, "Tai Chi: Balance Your Wellness." Printed in color, each page describes one exercise (e.g., "brushing the horse's tail," "butterfly," "parting the waves") with a photograph of local community members performing it. We also produced a 10-minute DVD of our local participants performing several tai chi movements. The DVD will be used by our tai chi instructors and distributed to interested community members. Community health representatives have also received training in how to teach tai chi to homebound adults using the notebook and DVD, for example, to improve mobility after hospitalizations.

Conclusion

Tai Chi is becoming a valuable component of a comprehensive approach to elder falls prevention in our communities. As more community members participate and report their satisfaction and enjoyment of tai chi, interest in the classes continues to grow among both individuals and health programs. The next steps for our tai chi program are to recruit individuals from the community to become instructors; adopt objective measures, such as balance testing, to assess the impact of the tai chi program on participants health and well-being; and explore ways to sustain community interest and financial support for the program.

Tai chi is not for everyone. Some people will prefer a more vigorous workout, or will have medical reasons to avoid this form exercise (e.g., joint or spinal problems, severe osteoporosis[12]). However, we hope our very positive experience with tai chi at an American Indian nation will encourage other community-based falls-prevention and wellness programs to offer this ancient yet modern approach as an option for healing and improved well-being. Further information and a list of instructors by state, are available from the online Tai Chi Health Information Center.[15] Details about a CDC-funded program to disseminate tai chi as an evidence-based, community falls-prevention strategy are provided in the article, "Tai Chi: Moving for Better Balance."[16]

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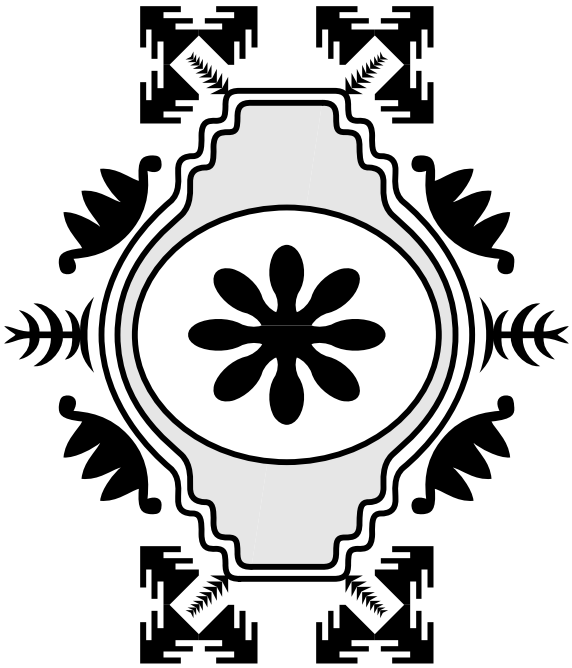

Sources of Needs Assessment Data That Can Be Used to Plan CE Activities

The new focus in planning continuing education activities is the identification of gaps in provider knowledge, competence, or performance that can be addressed with your activity. Ideally, these gaps should apply specifically to the American Indian and Alaska Native population and the providers who serve them. Where can you obtain data that help you identify these gaps? From time to time, we will publish items that either give you such data or show you where you can find them. When you are asked about the sources of your needs assessment data in your CE planning process, it will be easy enough to refer to these specific resources.

By many measures, injuries are one of the leading causes of morbidity and mortality in the population we serve. In fact, they are the leading cause of death in the younger portion of the AI/AN population – that subgroup with the greatest remaining number of years of life to live. Our observation is that, given the magnitude of the problem, injury prevention is underrepresented in the continuing professional education activities we sponsor. We encourage you to examine the available data for the IHS, your Area, your community, and your facility to see where you might try to target your CE efforts. Your injury prevention specialists will be most willing to help you research the data you will want to demonstrate the needs of your learners.

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Child Passenger Safety: A Comprehensive Program is a Sustainable Program

Amanda Parris, MPH, Environmental Health Officer, Indian Health Service, Keams Canyon Service Unit, Polacca, Arizona

Introduction

Motor vehicle crashes are a leading cause of injury and the number one cause of death for American Indian and Alaskan Native (AI/AN) children.[1] Correctly used, child passenger safety (CPS) devices (hereafter also called "car seats") can reduce the risk of death in a crash by 40 -70%.[2] However, car seat use rates in many AI/AN communities are much lower than the national rate, which is 87% for children from birth to age seven.[3]

Implementing a car seat education and distribution program is an effective strategy to increase restraint use. A car seat education and distribution program is defined as one that 1) combines education about proper use of car seats with distribution of car seats; 2) targets parents and caregivers experiencing financial hardship or who do not understand the importance of obtaining and using a car seat; and 3) provides car seats to parents and caregivers through terms of a loan, low-cost rental, or give away.[4] Many communities, tribal and non-tribal alike, have initiated car seat education and distribution programs, only to see them disappear when a grant ends or volunteers lose interest. I sought to identify barriers and key elements to sustaining a CPS program in order to provide recommendations to tribes wanting to maintain their CPS program over the long-term.

Methods

I performed a literature review on CPS programs to develop a key informant interview guide. I then conducted twelve phone interviews with CPS program managers working in tribal communities across the US to identify challenges, lessons learned, and keys to sustaining a CPS program. The number of years as CPS program manager ranged from one to twelve, with an average of five years.

I also conducted two focus groups with parents and caregivers to understand their preferences and needs in a CPS program. Participants ranged in age from 21 to 64 years, with 34 years as the average age. Participants were mothers (n = 9), fathers (n = 2) and grandmothers (n = 2). All participants cared for at least one child, eight years old or younger, with the majority caring for a child under eight years old (n = 12). All participants were tribal members residing on reservation lands.

Eight Key Elements to Sustainability

The literature review, key informant interviews, and the focus groups identified eight key elements to sustaining a CPS program: 1) advocacy; 2) child restraint law; 3) resources; 4) partnerships; 5) policy; 6) accessible services; 7) data and evaluation; and 8) program coordination. Fulfillment of the eight key elements amounted to implementing a comprehensive CPS program. Thus, a comprehensive CPS program was a sustainable program (Table 1).

Advocacy

"Advocacy" means having a vocal and noticeable presence to influence leadership to make CPS a priority, parents and caregivers to buy-into CPS, and decision-makers to effect policy change and allocate resources. Support from the tribal council is necessary to secure funding, pass child restraint laws, and promote enforcement of the laws. Some approaches to advocacy include making an annual report to council that includes compelling data on restraint use and injuries, CPS activities conducted in the community, and barriers to increasing car seat use; having articles published in the local paper; sending e-mail quizzes about CPS to tribal employees with prizes for correct answers; and meeting with decision-makers, such as the chief of police, tribal judge, council members, prosecutor, and agency directors to discuss CPS issues.

Child restraint law

Lack of a primary child restraint law, or lack of its enforcement due to understaffing or lack of commitment, is a serious barrier to sustaining a CPS program. Without a tribal law, community members often perceive that car seats are only needed when driving off-reservation. Primary laws (where a citation can be issued based solely on the non-use of a car seat) have been demonstrated to be more effective than secondary laws (where citations can only be issued secondary to some other violation).[2]

Ways to increase acceptance of a primary child restraint law include issuing a written warning prior to a citation; having clear policies regarding penalties; and offering alternatives to monetary fines, such as attendance at a child passenger safety class or waiving a fine upon presentation of a car seat. Fines collected for car seat violations can be used to purchase new car seats or other resources for the community's CPS program.

Resources

CPS programs need a continuing supply of approved car seats, storage facilities, and funds for marketing, staff training,

Table 1: Keys To Sustainability

Advocacy	A vocal and noticeable presence that influences leadership to prioritize child passenger safety (CPS), parents and caregivers to buy-into CPS, policy change, and resource allocation.
Child Restraint Law	Ensuring a primary child restraint law is in place and vigorously enforced with provisions for alternative penalties such as attendance of a CPS class.
Resources	Identifying and obtaining funding or support for resources such as child restraints, a storage facility, trainings/certifications, and staff/volunteers.
Partnerships	Developing and sustaining partnerships with federal, tribal, state, and local programs working with children, or in the area of health and safety, collaborating with partners to provide services.
Policy	Ensuring written policies and procedures for providing CPS services are in place to support conservation of resources, management of liability issues, and provision of appropriate and uniform services.
Accessible Services	Ensuring it is easy for community members to locate and obtain CPS services, linking community members to services.
Data and Evaluation	Documenting program activities, managing program records, evaluating and reporting program activities and their impact on restraint use.
Program Coordination	Having a coordinator, preferably an individual, tie all the key elements together and manage the program.

and salary support. Programs most likely to be sustainable are those that have multiple funding sources, several of which are summarized in Table 2. Funding sources include direct support from tribes, grants and cooperative agreements, budgets for medical and preventive services, donations, and state support.[5-7] Examples of state support would be an injury prevention program within the state's Department of Health; Transitional Assistance For Needy Families (TANF) car seat reimbursements; or a Medicaid-based car seat distribution program, an approach demonstrated to be comparable in cost effectiveness to federal vaccination programs with coverage likely for special seats only at this time.[7,8]

Programs can estimate the number of car seats needed for one year based on the number distributed in previous years, the number of births per year data, tribal enrollment data, and data from other agencies serving children, such as Head Start and the Women/Infants/Children (WIC) nutrition program.

While the majority of interviewed programs distribute car seats without charging any fees, others collect funds from parents and caregivers. Primary reasons for the latter approach are that funds can be used to purchase more car seats or used for other operating expenses. Also, parents may be more likely to consistently place their children in a car seat if there is some financial investment in the purchase. The downside of charging fees is that cost is a barrier for low-income families, and managing money and keeping accurate financial records is burdensome for program staff. Loaner programs, where car seats are loaned to parents for a period of time based on the type of restraint (e.g., one year for infant seats, several years for toddler seats and combination seats) are less frequently offered as an alternative to the sale or free distribution of restraints to eligible families. Reasons for the decline in popularity of loaner programs include more complicated record-keeping, an increased exposure to liability issues, the need to inspect and clean returned car seats, unusable returned car seats, and low restraint return rates.[9-12] Loaner programs still have a role, especially for children with special needs requiring expensive, custom-designed car seats, or for programs distributing infant-only restraints, where the loaner duration is short.

Liability issues can be best managed through written policies and procedures for parent education and completion of liability release forms. The Safe Kids network provides CPS technician training and recertification services.[13]

Table 2: Funding opportunities for child passenger safety programs.

Opportunity	Who Can Apply	Resources	Scope
BIA Child Passenger Safety Grant	Tribal programs	Car seats	Reimbursement grant; for purchase of car seats to be distributed through an event/program. Apply annually.
BIA Indian Highway Safety Grant	Tribal programs	Car seats; Storage; Staff Training; Marketing; Staff Salary (depends on project)	Reimbursement grant; priority areas have been impaired driving, occupant protection, traffic records.
Governor's Office of Highway Safety Grant	Taxable and non-profit organizations; state, county, local government programs	Car seats; Storage; Staff Training; Marketing; Staff Salary (overtime)	Reimbursement grant; priority areas have been speed, impaired driving, occupant protection, emergency medical services.
IHS Ride Safe Program	Region XI AIAN Head Start programs	Car seats; Storage (Possibly); Staff Training; Marketing	Pre-designed program; CPS education for students and parents; provides a car seat for each student; requires evaluation and follow-up; mandatory 1 week workshop. Apply annually.
IHS Tribal Injury Prevention Cooperative Agreement Program	Tribal programs	Car seats; Storage; Staff Training; Marketing; Staff Salary for fulltime program coordinator	Reimbursement grant (draw-down); prioritizes injury prevention, all injury types, through use of evidence-based strategies.
CDC Motor Vehicle Injury Prevention Grant	Tribal programs	Staff Training; Marketing; Staff Salary for a full-time program coordinator	Reimbursement grant (draw-down); prioritizes prevention of motor vehicle crash injuries through use of evidence-based strategies.

Partnerships

The National Safe Kids Program attributes the success of their education and distribution program to partnerships and networking. The program has distributed nearly 100,000 car seats to low-income, underserved, culturally-diverse families through state and local Safe Kids coalitions.[14] At the community level, obvious CPS partners include programs that work with children, health and safety agencies, and law enforcement. Partners can link parents and caregivers to CPS services, help staff CPS clinics, promote CPS events in the community, and provide in-kind resources (e.g., storage space, or meeting rooms). For example, Safe Kids-certified CPS technicians have been recruited from IHS health care centers, tribal health services, and BIA law enforcement. Police officers who receive CPS technician training become advocates for CPS in both the community and within the police department.

One tribal community had difficulty obtaining a supply of car seats and managing the provision of services when grant funding for the CPS program was discontinued. In response, the local community coalition partnered with a county injury prevention program to provide car seat education and distribution services during outpatient clinics at the IHS health care center. In addition to providing enhanced resources and skills, partnerships can alleviate one of the major barriers to sustainability, staff turnover and understaffing. Staff turnover results in a loss of knowledge and experience, and understaffing makes it difficult to implement a comprehensive program.

Policy

Written policies and procedures are necessary to provide appropriate, fair, and uniform services, conserve resources, and manage liability issues. CPS policies address to whom, when, where, and how car seats will be distributed. For example, establishing a policy where only one restraint is provided per child per stage of life helps sustain a limited supply of restraints, allowing the program to serve a greater number of children. Written policies also guide how program activities are documented and records are maintained, how observational surveys of car seat use are performed, and what parents and caregivers are told about using the car seats and returning restraints involved in a crash.[4,9,10]

Accessible Services

"Accessible" CPS services are ones well-known to community members and easy for the target population to locate and utilize. They include both education and distribution services. Children in need of services can be identified by networking with local institutions such as schools or maternal and child health programs. Additionally, promoting and managing a CPS services referral system can help connect community members to services. Advertising can be done at health facilities via personal contacts, bulletin boards, and through closed-circuit television, by distributing flyers door-to-door, through radio public service announcements, and by road-side billboards. Educational services can be delivered at drive-through car seat events, in classrooms, and through one-on-one training sessions.

Focus groups or community surveys provide insight into community preferences and barriers to receiving services. They can help answer questions such as:

- Is it better to have appointments, walk-ins, or both?
- What are the best hours, days of the week, and locations for services?
- How long should training sessions last?
- Who besides parents might benefit from CPS education?
- Where would be best to advertise CPS services, using what methods?
- How much would families be able to pay for a car seat?

Data and Evaluation

Data are essential to document and improve program performance; provide accountability to the tribal leadership and funding sources; measure the program's impact; identify community needs; and justify requests for additional resources. Basic program data track the car seat inventory (what seats come in and what seats go out) by type of seat and by funding source, the names of children receiving services, referrals, services provided, and proof of liability release. Statistics to document the importance of CPS and the impact of the CPS program include police-reported crashes with child injuries; ambulance run logs; and the number of emergency visits and hospitalizations involving children injured in motor vehicle crashes. The annual number of citations or warnings issued for non-use of car seats reflects the level of enforcement of existing child restraint laws. Program impact should also be evaluated by conducting formal observational surveys of restraint use in the community.

Program Coordination

Establishing, coordinating, and maintaining the key elements of a CPS program involve many activities, among them:

- Serving as the CPS contact person for questions and referrals
- Networking and coordinating with partners and potential partners
- Uncovering and responding to program funding opportunities
- Monitoring income and expenditures
- Documenting inventory and services provided
- Conducting observational restraint use surveys
- Managing, summarizing, and analyzing CPS program data

- Arranging CPS technician training sessions and recruiting candidates for training
- Writing reports and making presentations to tribal leadership and community members.

A community CPS program should therefore support an official, salaried CPS program coordinator position. This person could be a Tribal Injury Prevention Program coordinator, or a community "champion." The role might be its own position, or a job duty listed under a new or existing position. The position could be housed in an existing community program, tribal agency, or IHS facility.

Conclusion

Sustaining programs over time is a challenge for all community-based efforts.[15-17] Sustainability is vital not only to meet the ever-continuing needs for CPS services, but also to prevent the disappointment, mistrust, and pessimism that inevitably results when valuable programs disappear for want of planning, resources, leadership, or community support. As long as children are transported in motor vehicles, every community needs a comprehensive, sustainable CPS program.

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The IHS Falls Prevention Initiative

CAPT Nancy M. Bill, MPH, CHES, Injury Prevention Program Manager, Indian Health Service Rockville, Maryland; and Bruce Finke, MD, IHS Elder Health Consultant, IHS Nashville Area, Northampton, Massachusetts

Unintentional falls are a leading cause of mortality and morbidity for persons age 65 and older in the US. A 2003 CDC cost study estimated that direct medical costs due to fall injuries among adults ages 65 year and older in the US totaled $0.2 billion for fatal falls and $19 billion for nonfatal fall-related injuries (source: National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, June 10, 2008).

The IHS Injury Prevention (IP) program established unintentional fall prevention for adults 65 years and older as one of the two IP program priorities in 2008. Until recently, the IP program has worked solely in the arena of environmental home assessments in fall prevention. The IP staff focus was limited to receiving referrals from the public health nurse, community health representatives and others to conduct home assessments for fall risk hazards. The outreach to others in clinical settings was very limited. The IP program priority in unintentional fall prevention launched an important initiative to seek out key partners and evidence-based programs in fall prevention. One key partnership formed involved Dr. Bruce Finke who is the IHS Elder Health Consultant. This summary describes the preliminary work of a collaborative effort by IHS Elder Care and the IP programs to reduce fall-related injuries in the elderly.

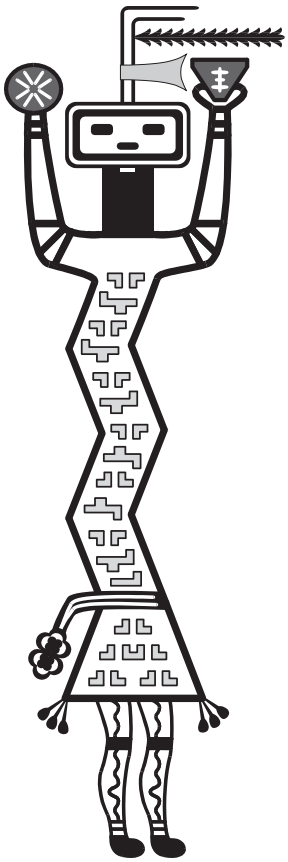
The effort began in October 2009 with the identified aim of developing a comprehensive approach to the prevention of fall-related injuries in the elderly living in the community. The initial plan was to identify the best available evidence for effective public health injury prevention, clinical, and community-based interventions for AI/AN communities. The CDC Injury Prevention and Healthy Aging programs have been instrumental in this effort, providing both expertise and funding.

Three workgroups have been working on developing the initial background materials. Through web-based meetings the workgroups have addressed these specific assignments:

1. *Data*. Research current fall-related data to gain insight into the nature and extent of fall-related injury
2. *Evidence*. Identify strong, evidence-based strategies to reduce fall injury in the elderly
3. *Inventory*. Collect and catalogue the current work occurring in American Indian/Alaska Native communities

On April 30, 2010, a meeting was convened by all the group leads and others to explore and further develop their initial findings. The workgroups are now finalizing their reports to be assembled into a document that will serve as the basis for widespread review and discussion by stakeholders and program staff throughout Indian Country. Out of that broad-based review and discussion will emerge recommendations for action.

The fall prevention initiative has changed the approach in the IHS IP, merging effective strategies and forming new collaboration with clinicians (pharmacy, physical therapy, nutritionist, etc.) toward a comprehensive approach to prevent fall-related injury in the elderly living in the community. This effort supports the IHS priorities articulated by Dr. Roubideaux as we seek to improve the quality of and access to both clinical care and preventive services in close partnership with tribal programs. Please contact Nancy Bill, IP Program Manager (*nancy.bill@ihs.gov*) or Dr. Bruce Finke, IHS Elder Health Consultant (*bruce.finke@ihs.gov*) for more information.



New Guidance on Birth Control: CDC Releases US version of WHO Medical Selection Criteria for Contraception

Jean E. Howe, MD, MPH, Chief Clinical Consultant in Obstetrics and Gynecology, and staff Obstetrician/Gynecologist, Northern Navajo Medical Center, Shiprock, New Mexico

The Centers for Disease Control and Prevention (CDC) has issued a modification of the World Health Organization (WHO) Medical Selection Criteria for Contraception for use in the US. This easy to use tool can help women and their health care providers consider the relative risks and benefits of various contraceptive methods for those affected by a wide array of medical conditions.

The original WHO guidance is now in its 4th edition. Modification for use in individual countries has been anticipated by the WHO and has now been undertaken by the CDC for use in the US. Over 60 characteristics and medical conditions are covered. In the majority of categories, the US and WHO guidance are consistent. WHO recommendations modified for US use include guidance for contraceptive use for women with venous thromboembolism, valvular heart disease, ovarian cancer, uterine fibroids, and for postpartum and breastfeeding women. Recommendations were also added for women with rheumatoid arthritis, a history of bariatric surgery, peripartum cardiomyopathy, endometrial hyperplasia, inflammatory bowel disease, and solid organ transplantation.

The Selection Criteria are based on assessment of the risks and benefits of use of a specific method by a woman with a specific medical condition. This pairing of method use and medical condition is then given a rating from 1 to 4 as follows:

1 A condition for which there is no restriction for the use of the contraceptive method.

2 A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.

3 A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.

4 A condition that represents an unacceptable health risk if the contraceptive method is used.

These ratings are summarized in a color-coded chart for easy reference and counseling. Rating categories 1 (dark green) and 2 (light green) fill the majority of the chart, while rating categories 3 (pink) and 4 (red) are easily identifiable.

Why Does This Matter?

Women in the US are at high risk for unintended pregnancy. A recent report of national estimates of contraceptive use and method choice based on the National Surveys of Family Growth from 1982, 1995, 2002, and 2006 - 08 highlights changing patterns of contraceptive use in the US. The 2006 - 08 interviews were conducted with over 7,000 women between the ages of 15 and 44. Findings included near universality of contraceptive use among women of reproductive age, with 99% of all women who had ever had intercourse with a male partner reporting the use of at least one contraceptive method in their lifetime. However this does not mean that contraceptive use is completely consistent or effective. One-half of all pregnancies in the US are unintended, and the average probability of an unintended pregnancy is 12% during a year of contraceptive use; this is unchanged since 1995. Most unintended pregnancies among contraceptive users are due to inconsistent or incorrect use, not failure of the method itself.

The following trends were noted:

- About 62% of the 61.9 million women aged 15 - 44 years were currently using contraception.
- The leading contraceptive method in the recent survey was the oral contraceptive pill, used by an estimated 10.7 million women aged 15 - 44 years. Female sterilization was used by 10.3 million women. These have been the leading methods since 1982.
- The most common pattern of contraceptive use is to use the condom at first intercourse, the pill to delay the first birth, and female sterilization when the desired family size is achieved. There are wide variations from this pattern.
- From 2002 to 2006 - 08, the percentage of women who had ever used emergency contraception increased from 4% to 10%. Use of the contraceptive patch rose from 1% to 10%. IUD use increased from 2% to 8% among contraceptors with one child and from 3% to 11% of contraceptors with two children.

- 7.3% of the population surveyed (corresponding to 4.5 million women 15 - 44 years old) were at risk for unintended pregnancy, as they reported having intercourse without contraception in the prior three months. The remaining unintended pregnancies occurred in the 38.2 million contraceptive users, primarily because of inconsistent or incorrect contraceptive use.

Efficacy rates are higher with longer acting methods, and women seeking contraception may benefit from ready access to these methods.

Highlighted Recommendations

One area that has been a cause of consternation for many is when to start postpartum contraception. The Medical Selection Criteria address this specifically for both breastfeeding and non-breastfeeding women. For breastfeeding women, estrogen-containing methods (the combined pill, the patch, and the ring) are assigned a "2" after one month postpartum (advantages outweigh risks); prior to one month postpartum they are considered a "3" (risks may outweigh advantages). Progesterone-based methods (progesterone only pills, Depo-Provera, Implanon) are a "2" (advantages outweigh risks) from delivery onward and become a "1" (no restriction) after one month. For women who are not breastfeeding, the progesterone-based methods are a "1" from delivery onward and the estrogen-containing methods are a "1" after 21 days. Estrogen-based methods are rated "3" for non-breastfeeding women for the first 21 days only.

IUD insertion within 10 minutes of delivery is a "1" (Copper IUD) or "2" (Mirena IUD). Both become a "2" from 10 minutes until 4 weeks postpartum; after 4 weeks, placement of either IUD is a "1." Understandably, IUD placement is not appropriate in the setting of puerperal sepsis and is assigned a "4" until the infection is resolved. IUD use is an option for women with a history of ectopic pregnancy (rating = "1") and for women with a past history of PID (rating = "1" with an interval pregnancy and "2" without an interval pregnancy).

Another area of discussion has been long-term Depo-Provera use. The majority of studies have shown that women lose bone mineral density while on Depo-Provera but regain bone mass after they discontinue the method. Depo-Provera use is unrestricted (rating = "1") between the ages 18 and 45. This rating becomes a "2" (benefits generally outweigh risks) for women under 18 or over 45; this is due to incomplete data about the effect of Depo-Provera on the development of adequate bone mass in adolescence and for consideration of facilitating restoration of bone mass prior to menopause. Thus, women who desire to use Depo-Provera and do not have other contraindications should be supported in their decision. Bone density testing is unnecessary and should not be performed.

What Can a Busy Clinician Do To Help Prevent Unintended Pregnancy?

Print out the color coded Summary Chart (the link is below) and review it for a quick refresher on the safety of most contraceptive methods for most women. Get laminated copies and distribute them throughout your clinic. Offer contraception to all reproductive age women at every visit. Break down barriers to contraception by minimizing delays in starting a method or obtaining refills. An IUD or Implanon can usually be placed the same day; pill, patch, and ring refills should permit dispensing of more than one month supply at a time whenever possible. Repeat Depo-Provera injections can often be managed as nurse visits with written protocols. Make condoms freely available throughout the facility. Emergency contraception should also be readily available.

Support from Indian Health Service National Pharmacy and Therapeutics Committee

On June 22 - 23, the IHS National Pharmacy and Therapeutics Committee (NPTC) met. One of the tasks of the NPTC is to develop and maintain the National Core Formulary (NCF). This is the master list of medications that all IHS facilities are required to stock. The NCF is designed to assure that patients receiving care at more than one facility can receive refills of their medications without disruption. It also seeks to honor best evidence-based practices and to minimize costs throughout the system.

At the June meeting, several medications commonly used in women's health were added to the National Core Formulary. Contraceptives added included low dose (20mcg) and medium dose (30 – 35 mcg) monophasic oral contraceptive pills (OCPs), triphasic OCPs, progesterone only pills, contraceptive patches (Ortho Evra), contraceptive vaginal rings (Nuvaring), injectable contraceptives (Depo-Provera), and emergency contraception (Plan B or Next Choice). The IHS NPTC also supports widespread availability of IUDs (Paraguard and Mirena) and contraceptive implants (Implanon) but did not add these to the formulary, as they do not require routine refills and are dependent on having a skilled clinician available for insertion and removal.

Other medications approved by the NPTC at this session include estrogen and progesterone replacement oral tablets, estrogen vaginal cream, alendronate, calcium, and vitamin D.

References

Centers for Disease Control and Prevention. US Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR* .2010;59(No. RR-04). *http://www.cdc.gov/mmwr/PDF/rr/rr5904.pdf*

Mosher WD, Jones J. Use of Contraception in the United States: 1982-2008. National Center for Health Statistics. *Vital Health Stat*. 23 (29). 2010.

http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf

World Health Organization. Medical Eligibility Criteria for Contraceptive Use, Fourth Edition, 2009. *http://whqlibdoc.who.int/publications/2009/9789241563888_eng.pdf*

Resources

The color coded Summary Chart (the key tool for discussing choices with patients and an essential reference for clinicians) is available as a word document from the CDC; follow the link below and scroll down to "Resources." *http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm*

The full document is available at: *http://www.cdc.gov/mmwr/PDF/rr/rr5904.pdf*

The entire July issue of the journal Contraception is devoted to this topic and includes systematic reviews informing many of the recommendations. *http://www.contraceptionjournal.org/*

Get continuing education credit from the CDC for reviewing the guidelines: *http://www2a.cdc.gov/ce/availableactivities.asp*

This is one article from the *Women's Health Notes*, an online newsletter for those working in women's health at IHS, tribal, and urban sites. The online newsletter is available for **subscription** through the IHS listserv: *http://www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=87&startrow=76*

Current and past issues, and many other resources, are available at the **IHS MCH Website**: *http://www.ihs.gov/MedicalPrograms/MCH/index.cfm?module=whn_home*

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Park Hill, OK 74451

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Pre-Conference Courses & Fee Schedule
Please enroll early! Limited Enrollment in all courses

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☐ **PEPP - 2 day course *** **Must attend both days for certification* **[ ] $75. Members [ ] $125. Non-Members**	**Nov. 1-2**
☐ **Emergency Medical Responder/First Responder Refresher 2 day course*** **Must attend both days for certification* **[ ] $40. Members [ ] $90. Non-Members**	**Nov. 1-2**
☐ **Preceptor Workshop—1 day course [ ]$40. Members [ ] $90. Non-Members**	**Nov. 2 ONLY**

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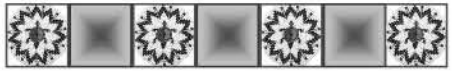

19th Annual NNAEMSA Educational Conference

Nov. 01—Nov. 05, 2010

Pre-conference:
November 01-02, 2010

Tropicana Las Vegas
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Las Vegas, NV
1-800-634-4000

Conference Information at
www.nnaemsa.com or call

Larry Richmond at 605-355-2435
Bill White at 520-371-2993
Linda Squirrel at 918-453-5024
Anthony Sequoyah at 828-736-0885
Celesta Johnson at 918-759-7944

Conference at a Glance

NNAEMSA is excited to be able to provide you with excellent instructors and up-to-date training at this year's conference. Here's a glance of what we have lined up for you.

"Check out the Pre-Conference"

First Responders/Emergency Medical Responders, We heard your requests and Mark Bighorse will provide a ***Refresher class*** for you!

Rescuers, FF, & Medical Responders, TEEX will present their updated course with the New curriculum "***Weapons of Mass Destruction" course.***

EMT's & Paramedics, get your Pediatric skills honed and receive recertification in the ***PEPP course*** presented by Larry Richmond.

EMS Instructors & Field Training Officers Preceptor Training, *Gina Riggs will* cover roles & responsibilities of the preceptor/FTO and much more, get all of the updated information for the new CoAEMSP national accreditation

Returning favorites for the Conference include:

Brian Bledsoe*, an internationally known speaker, instructor, author and paramedic recognized for his energetic, humorous and motivational style.*

John Todaro*, a phenomenal speaker who adds humor to his very motivational and informative presentations.*

Speakers from our own Tribal/IHS EMS and Hospitals will include: Larry Richmond, Jason Clark, Christopher Black, & Dr. Aaron Price & Brent Ford.

From Rural EMS & Training, ***Laurel Havens and Gina Riggs*** *will be returning this year with topics for the EMS Instructor, First Responders, EMT's and Paramedics.*

Hurry and get your Early Registration sent in & Make your Hotel Reservations Today. 1-800-634-4000 The Newly Renovated "Tropicana Las Vegas"

Conference Schedule

PRE-CONFERENCE

Monday, November 01	
Pre-Conference Registration	7:30 am - 8:00 am
First Responder/EMR Refresher	8:00 am - 5:00 pm
Weapons of Mass Destruction	8:00 am - 5:00 pm
PEPP	8:00 am - 5:00 pm
Tuesday, November 02	
Pre-Conference Registration	7:30 am - 8:00 am
First Responder/EMR Refresher	8:00 am - 5:00 pm
Weapons of Mass Destruction	8:00 am - 5:00 pm
PEPP	8:00 am - 5:00 pm
Preceptor Workshop	8:00 am - 5:00 pm

GENERAL CONFERENCE

Wednesday, November 03	
Registration	7:30 am - 8:15 am
Opening Ceremonies	8:30 am - 9:00 am
General Session	9:00 am - 10:00 am
General Session 2	10:30 am - 12:00 pm
Breakout Session	1:00 pm - 2:00 pm
Breakout Session	2:30 pm - 3:30 pm
Breakout Session	4:00 pm - 5:00 pm
Thursday, November 04	
General Session 1	8:30 am - 10:00 am
General Session 2	10:30 am - 12:00 am
Awards Luncheon	Noon - 2:00pm
Breakout Session	2:00 pm - 3:00 pm
Breakout Session	4:00 pm - 5:00 pm
Member Meeting	5:30 pm - 7:00 pm
Friday, November 05	
General Session	9:00 am - 10:30 am

For a complete listing of courses offered, please visit out **website at** ***www.nnaemsa.com***

Registration

Discounted fees are available if you pre-register by October 1st . Pre-registration is required for the pre-conference courses. You will receive confirmation of your acceptance into the pre-conference.

All cancellations must be made in writing & mailed to NNAEMSA, Attn: Linda Squirrel, Treasurer, PO Box 68 Park Hill, OK 74451. Cancellations prior to September 30th will receive a full refund. Cancellations received after September 30th, but before October 15th, will be charged a $50 handling fee. Cancellations on or after October 15th are non-refundable, but substitutions are permitted.

Your conference registration fee includes attendance to all conference presentations, conference notebook, conference t-shirt, raffle ticket and one ticket for the Awards Luncheon. Separate fees apply to the pre-conference. Additional luncheon tickets can be purchased for $30 per person.

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MEETINGS OF INTEREST

Advancements in Diabetes Seminars
Monthly; WebEx

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

Upcoming seminars include:

- August 19, 2010
  Advanced diabetes management Case Studies by Jo Ellen Habas, MD
- September 8, 2010
  Exercise and Cardiometabolic Risk Reduction in Diabetes and Prediabetes by Ralph La Forge

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

Available EHR Courses

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

The Pharmacy Practice Training Program: a program in patient-oriented practice (PPTP)
August 2 – 5 or August 23 - 26, 2010; Scottsdale, Arizona

The goal of this four-day training program for pharmacists employed by the Indian Health Service or Indian health programs is to improve the participant's ability to deliver direct patient care. This program encompasses the management of patient care functions in the areas of consultation, communication, interviewing techniques, laboratory test interpretation, conflict resolution, physical assessment, and disease state management. The course is made up of case studies that include role playing and discussion and provides 27 hours of pharmacy continuing education. It will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258. For more information, look for "Event Calendar" at *http://www.csc.ihs.gov/* or contact CDR Ed Stein at the IHS Clinical Support Center by e-mail at *ed.stein@ihs.gov*.

Advances in Indian Health
May 3 - 6, 2011; Albuquerque, New Mexico

The Advances in Indian Health Conference, May 3 - 6, 2011, will be held at the Sheraton Uptown in Albuquerque, New Mexico. "Advances" is IHS's primary care clinical conference and attracts over 600 clinicians from across the Indian health system. The conference covers many primary care topics with special emphasis on diabetes, mental health, substance abuse, women's health, geriatrics, pediatrics, and EHR. With low tuition and government rates available for the conference hotel, Advances is a low cost way for clinicians to receive up to 28 hours of CME/CE on issues of particular importance to Indian health patients and practices. The conference brochure will be available in early 2011 on the UNM Office of CME website, *http://hsc.unm.edu/som/cme/*. For more information, contact the course director, Ann Bullock, MD, at *annbull@nc-cherokee.com*.

POSITION VACANCIES

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

Clinical and Administrative Director
Lower Elwha Health Services Deptartment; Port Angeles, Washington

The Lower Elwha Health Services Department is committed to the highest standards of ethics and integrity. We treat our patients and one another with dignity, respect, courtesy, and consideration, creating a safe and professional work environment. We are accountable for the responsible use of our current resources and the careful planning of our future growth and development. We promote healthy leadership by recruiting, retaining, and empowering our staff who share those values.

We are seeking a board certified physician in family or internal medicine and who has a minimum of five years of experience, strong clinical skills, and evidence of practice leadership. An MPH, or MBA or equivalent business experience is preferred, and experience with budgeting and fiscal accountability will enhance your candidacy. This position will provide overall clinical and administrative direction for the overall operations of the health department. These responsibilities include policy development and implementation; program development; oversight of fiscal viability of the pertinent programs, including budget development and monitoring; and personnel service administration for the health department. The Health Director may also represent the Lower Elwha Klallam Tribe and participate with other directors, theChief Executive Officer, and the Business Council.

The position is full time, 40% clinical and 60% administrative, Monday through Friday; 8 – 5.

Bordered on the west by the Pacific Ocean, on the east by the Hood Canal, and on the north by the Strait of Juan de Fuca, the Olympic Peninsula is anchored by the majestic Olympic Mountains. No other place in America can match its diversity in terrain and weather in such a compact geographic area. This career and lifestyle opportunity offers an excellent balance between administrative responsibilities and clinical practice in an outpatient only setting.

For more information, please contact Linda Bush, Office Manager, Lower Elwha Health Clinic, 243511 Hwy 101 West, Port Angeles, Washington 98363; telephone (360) 452-6252. ext. 15; fax: (360) 452-6274; e-mail: *linda.bush@elwha.nsn.us*. (07/10)

Family Practice Physician
Yakama Indian Health Center; Toppenish, Washington

The Yakama Indian Health Center is recruiting for two positions in family practice, pediatrics, or internal medicine to join our staff of four physicians, three ARNP, and two PA-C. We are a modern facility with on-site pharmacy services, an open access appointment system, electronic health records, a moderately busy outpatient practice, and a user population of 10,000 members of the Confederated Tribes and Bands of the Yakama Nation.

Located 150 miles southeast of Seattle in the Yakima Valley, Toppenish has a lot to offer both the outdoor enthusiast and the urban sophisticate. Hunt, fish, or golf during the day, then attend a Broadway musical at the Capitol Theatre in Yakima. Skiing at White Pass or Crystal Mountain is only an hour away, and the Yakama Nation Museum and Cultural Heritage Center in downtown Toppenish stays open seven days a week.

Base salaries depend upon experience, and range from $155,000 to $177,000. Other benefits may include loan payback, retention or recruitment bonuses, and moving expenses. For more information, please call our Clinical Director, Rex Quaempts, or our Management Analyst, Pam Leslie at (509) 865-2102. This advertisement will stay open until both positions are filled. (7/10)

Family Practice Physician
Warm Springs Health and Wellness Center; Warm Springs, Oregon

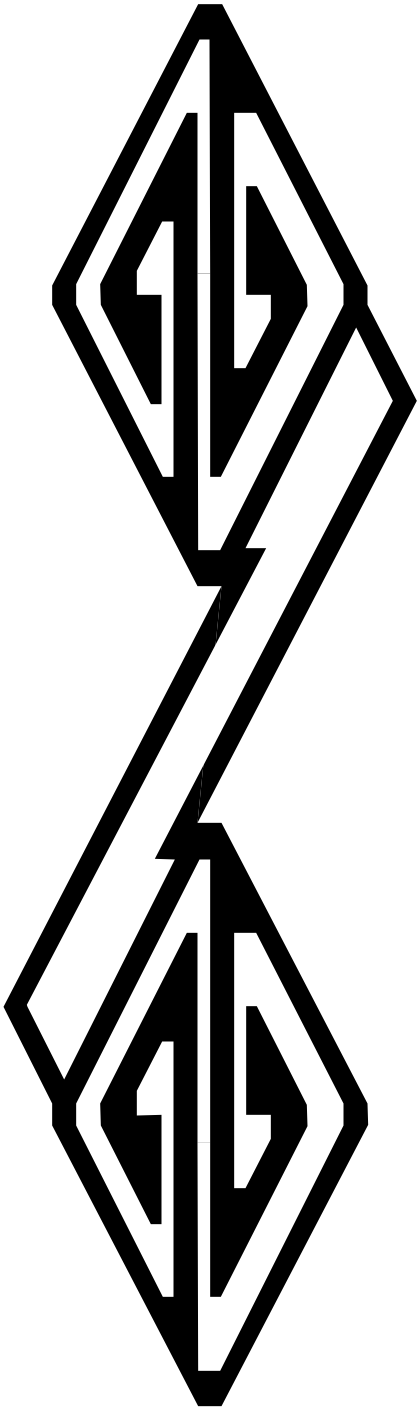
The Warm Springs Health and Wellness Center has an opening for a board certified/eligible family physician. Located in the high desert of central Oregon, we have a clinic that we are very proud of and a local community that has much to offer in recreational opportunities and livability. Our facility has been known for innovation and providing high quality care and has received numerous awards over the past ten years. We have positions for five family physicians, one of whom recently retired after 27 years of service. Our remaining four doctors have a combined 62 years of experience in Warm Springs. This makes us one of the most stable physician staffs in the IHS. Our clinic primarily serves the Confederate Tribes

of Warm Springs. We have a moderately busy outpatient practice, with our doctors seeing about 15 - 18 patients per day under an open access appointment system. We were a pilot site for the IHS Innovations in Planned Care (IPC) project and continue to make advances in how we provide care to our patients. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626. (4/10)

Family Physician
SouthEast Alaska Regional Health Consortium; Juneau, Alaska

The SEARHC Ethel Lund Medical Center in Juneau, Alaska is searching for a full-time family physician with obstetrics to join a great medical staff of 14 providers (ten physicians and four midlevels) at a unique clinic and hospital setting. Have the best of both worlds by joining our practice where we share hospitalist duties one week every 6 - 8 weeks, and spend our remaining time in an outpatient clinic with great staff and excellent quality of life. We have the opportunity to practice full spectrum family medicine.

Work in Southeast Alaska with access to amazing winter and summer recreational activities. Live in the state capital with access to theater, concerts, annual musical festivals and quick travel to other communities by ferry or plane. Consider joining a well rounded, collegial medical staff at a beautiful clinic with generous benefits. For more information, contact Dr. Cate Buley, Assistant Medical Director, Ethel Lund Medical Center, Juneau, Alaska; telephone (907) 364-4485; e-mail *cbuley@searhc.org*; or go to *www.searhc.org* to learn more. (4/10)



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

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