



THE IHS PRIMARY CARE PROVIDER

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



December 2009

Volume 34 Number 12

Weight Gain in Pregnancy; Revised Guidelines Issued as Obesity Rates Soar

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

From the Institute of Medicine (IOM) on May 28, 2009:

It has been nearly two decades since guidelines for how much weight a woman should gain during pregnancy were issued by the Institute of Medicine. In that time, more research has been conducted on the effects of weight gain in pregnancy on the health of both mother and baby. There have also been dramatic changes in the population of women having babies. American women are now a more diverse group; they are having more twin and triplet pregnancies, and they tend to be older when they become pregnant. Women today are also heavier; a greater percentage of them are entering pregnancy overweight or obese, and many are gaining too much weight during pregnancy. Many of these changes carry the added burden of chronic disease, which can put the mother and her baby's health at risk.

The new weight gain guidelines are based on revised body mass index (BMI) categories and now have a recommendation for obese women. To meet the recommendations of the report, women need to gain within the weight gain ranges for their BMI category. Achieving the recommended gain will require individualized attention and support from a woman's care providers as well as her family and community.

Previous recommendations for weight gain in pregnancy had focused on avoiding problems associated with low birth weight, and pregnant women were often urged by their health care providers to gain significant weight during pregnancy. Their family and friends also encouraged them to "eat for two" -- ignoring the fact that one of the two is quite small and requires relatively few calories.

Transitions to a sedentary lifestyle and reliance on convenience foods have led to an epidemic of obesity, which includes many women of reproductive age. In the US, women starting pregnancy at a healthy weight are now in the minority. This is a major health concern as obese women face increased risks with pregnancy, including increased rates of gestational

diabetes, gestational hypertension, and cesarean delivery. Overall health care utilization and costs are also increased. Infants of obese mothers have increased risks of macrosomia and complications of delivery and face an elevated risk for developing obesity and diabetes as they mature. Rates of congenital anomalies are also increased in infants of obese women. For example, a recently published British meta-analysis demonstrated increased risks of neural tube defects, such as anencephaly and spina bifida; cardiovascular anomalies; cleft lip and palate; and other congenital abnormalities, including anorectal atresia, limb reduction anomalies, and hydrocephaly.

Given these risks, the best option is for a woman to achieve a healthy weight prior to conception. Any pre-conceptual visit provides an opportunity to encourage healthy eating and exercise (along with folate supplementation, immunization updates, and screening for chronic diseases and genetic risks). For women with morbid obesity, it may be prudent to recommend that pregnancy be avoided or delayed.

Despite our (and our patients) best efforts though, many women will become pregnant while outside of the recommended BMI range of 18.5 - 24.9. Underweight women need careful nutritional counseling and support. Overweight and obese women can also benefit from nutrition counseling as

In this Issue...

- 337 Weight Gain in Pregnancy; Revised Guidelines Issued as Obesity Rates Soar
- 340 White Earth Home Health Agency and IHS White Earth Health Center Collaborate on H1N1
- 342 IHS Patient Education Protocols and Codes Helping Facilities Meet National Patient Safety Goals
- 346 IHS Child Health Notes
- 348 Meetings of Interest
- 350 Position Vacancies
- 354 2009 Year-End Index

well as exercise education and other strategies to minimize weight gain in pregnancy and encourage weight loss after delivery. At the initial prenatal visit, the pregnant woman's weight and height should be obtained and her body mass index (BMI) calculated. Many useful calculators and tables are available to help with this. Her weight gain goal should then be identified and discussed. The new IOM recommended targets are shown in Table 1.

Although these recommendations are more conservative overall than prior established goals, some studies have suggested that morbidly obese women may be able to safely avoid gaining any weight in pregnancy. Also, for women who have had bariatric surgery, experience is growing about safe management strategies for pregnancy, including attention to micronutrients and risks and warning signs of post-surgical complications.

daunting it can be to address lifestyle changes with our patients (and, indeed, for us as health care workers as well). Asking people to reconsider what and how much they eat and to add exercise to their daily routine can be difficult. Sharing tools that work and the motivation to try them can be time-consuming. Addressing community obstacles including lack of access to affordable, healthy food choices and safe places for exercise can be overwhelming. But this is the fundamental health challenge of our time and deserves our full attention. Please take some time to review the resources below and consider how to integrate them into your practice.

Table 1. New recommendations for total weight gain and rate of weight gain during pregnancy, by pre-pregnancy BMI

Pre-Pregnancy BMI	BMI	Total Weight Gain Range (lbs)	Rates of Weight Gain 2nd & 3rd Trimester (Mean Range in lbs/wk)
Normal weight	18.5–24.9	25–35	1 (0.8–1)
Underweight	<18.5	28–40	1 (1–1.3)
Overweight	25.0–29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	≥30.0	11–20	0.5 (0.4–0.6)

Interventions to improve weight-related outcomes for pregnant women are most successful when they are intensive and interdisciplinary. One clinical trial conducted by Asbee, et al randomized women to an intensive dietary and lifestyle program or routine prenatal care. The intensive management group gained almost seven pounds less than the routine care group (28.7+/-12.5 lb vs. 35.6+/-15.5 lb, P=.01) and had fewer cesarean deliveries for “failure to progress” (25.0% vs. 58.3% P=.02). Adherence to IOM guidelines was most often predicted by having a healthy pre-pregnancy body mass index.

Postpartum weight loss can be invaluable. For example, in a retrospective review of postpartum weight change in a cohort of 2,581 women with GDM, those who lost more than 10 pounds before their next pregnancy had a lower risk of cesarean delivery in the subsequent pregnancy than those who gained more than 10 pounds. The adjusted OR for women who lost weight was 0.55 (95% CI 0.28-1.10, 4.7% of women who lost weight); vs. 1.70 (95% confidence interval [CI] 1.16-2.49, 9.7% of women who gained weight). The increased caloric requirements of nursing mothers make breastfeeding an especially useful postpartum weight loss tool.

I hesitated initially to write about this topic as I know how

Resources

The full Institute of Medicine report is available at <http://www.iom.edu/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx>

The Utah Department of Health has a great site with a BMI calculator and other information at <http://www.babyyourbaby.org/duringpregnancy/weightgain.htm>.

The site also has individual weight charts for each of the BMI categories

http://www.babyyourbaby.org/pdfs/WeightCharts/normal_weight_chart_red.pdf

http://www.babyyourbaby.org/pdfs/WeightCharts/underweight_chart_blue.pdf

http://www.babyyourbaby.org/pdfs/WeightCharts/overweight_chart_green.pdf

http://www.babyyourbaby.org/pdfs/WeightCharts/obese_chart_purple.pdf

Resources for I/T/U Health Systems and Communities include the following:

Healthy Weight for Life: A Comprehensive Strategy Across the Lifespan of American Indians and Alaska Natives ; Indian Health Service, 2009.

http://www.ihs.gov/MedicalPrograms/MCH/M/documents/IHS_HealthyForLife.pdf

Community Resources to Prevent Obesity: Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. *MMWR* July 24, 2009 / 58(RR07);1-26.

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm?s_cid=rr5807a1_e.

A patient handout about “Women of Size and Pregnancy” from the *Journal of Midwifery and Women’s Health* is available at <http://download.journals.elsevierhealth.com/pdfs/journals/1526-9523/PIIS1526952308004984.pdf>

J Midwifery Womens Health. 2009;54(2):153-154.

Exercise in Pregnancy Resources:

The March of Dimes, Spotlight on Exercise

http://www.marchofdimes.com/pnhec/159_515.asp

The March of Dimes, Fitness for Two

http://www.marchofdimes.com/professionals/14332_1150.asp

The Centers for Disease Control; Exercise for Everyone, Guidelines for Pregnancy

<http://www.cdc.gov/physicalactivity/everyone/guidelines/pregnancy.html>

Breastfeeding Resources:

<http://www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm>

A Resource for Twin Pregnancies:

Goodnight W, Newman, R. Optimal nutrition for improved twin pregnancy outcome. *Obstet Gynecol*. 2009;114:1121-34. (A PubMed link for this article is not available yet.)

References

1. Committee to Reexamine IOM Pregnancy Weight Guidelines. Institute of Medicine; National Research Council. Executive summary: Weight gain during pregnancy: Reexamining the guidelines. In: Rasmussen KM and Yaktine AL, eds. *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC. National Academies Press; 2009: 1. <http://www.iom.edu/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx>.
2. Asbee SM, Jenkins TR, Butler JR, et al. Preventing excessive weight gain during pregnancy through dietary and lifestyle counseling: a randomized controlled trial. *Obstet Gynecol*. 2009 Feb;113(2 Pt 1):305-12. <http://www.ncbi.nlm.nih.gov/pubmed/19155899>.
3. Chu SY, Bachman DJ, Callaghan WM, et al. Association between obesity during pregnancy and increased use of health care. *N Engl J Med*. 2008 Apr 3;358(14):1444-53. <http://www.ncbi.nlm.nih.gov/pubmed/18385496>. *NEJM* Full Content: <http://content.nejm.org/cgi/content/full/358/14/1444>.
4. Crane JM, White J, Murphy P, et al. The effect of

gestational weight gain by body mass index on maternal and neonatal outcomes. *J Obstet Gynaecol Can*. 2009 Jan;31(1):28-35. <http://www.ncbi.nlm.nih.gov/pubmed/19208280>.

5. Joy S, Istwan N, Rhea D, et al. The impact of maternal obesity on the incidence of adverse pregnancy outcomes in high-risk term pregnancies. *Am J Perinatol*. 2009 May;26(5):345-9. Epub 2008 Dec 9. <http://www.ncbi.nlm.nih.gov/pubmed/19067282>.
6. Kiel DW, Dodson EA, Artal R, et al. Gestational weight gain and pregnancy outcomes in obese women: how much is enough? *Obstet Gynecol*. 2007 Oct;110(4):752-8. <http://www.ncbi.nlm.nih.gov/pubmed/17906005>.
7. Paramsothy P, Lin YS, Kernic MA, Foster-Schubert KE. Interpregnancy weight gain and cesarean delivery risk in women with a history of gestational diabetes. *Obstet Gynecol*. 2009 Apr;113(4):817-23. <http://www.ncbi.nlm.nih.gov/pubmed/19305325>.
8. Stothard KJ, Tennant PW, Bell R, Rankin J. Maternal overweight and obesity and the risk of congenital anomalies: a systematic review and meta-analysis. *JAMA*. 2009 Feb 11;301(6):636-50. *i*.

White Earth Home Health Agency and IHS White Earth Health Center Collaborate on H1N1

Mina Spall, RN, and LT Deanna Pepper, RN, White Earth Service Unit, White Earth, Minnesota

In March 2003 the White Earth Home Health Agency and the White Earth Indian Health Service (IHS) started collaborating on emergency management and pandemic influenza plans. This collaboration has led to a team effort working together on H1N1 Influenza. In September 2009 both agencies started working to update their existing pandemic flu plans. With H1N1 threatening, the discussions led to how to handle pandemic influenza and H1N1 when it arrived at the White Earth reservation. The goal was to continue to provide patient care to chronically ill and well patients within the clinic setting, while taking care of patients with influenza-like illness (ILI) symptoms.

The team looked at the White Earth Community Center as a site to provide alternative care to patients with ILI. A walk through of this site was done and plans developed to offer an ILI clinic, to help keep the sick people separated from the generally healthy population. This clinic would have nursing staff to triage and screen patients, providers to evaluate them, and pharmacy staff to provide home care medications; mental health services would be available to patients as well. However, it was determined that due to lack of provider staff at the IHS, the Tribal Mobile Clinic Unit would be a better option to open a mobile flu clinic. The Tribal Health Dept. has a mobile clinic unit that is set up to screen and examine patients.

This mobile clinic unit is primarily used by a podiatrist who goes to the different communities on the reservation to evaluate, examine, and treat patients.

The White Earth Home Health Agency offered to staff this mobile clinic with public health nurses (PHNs) to screen, triage, and offer home measures to patients with ILI symptoms. On October 13, 2009, the triage nurse at the White Earth IHS called for assistance due to a high volume of patients with ILI, and the White Earth Home Health Agency responded. The mobile clinic unit was brought into the parking lot at the White Earth IHS clinic and set up. Initially, the van was staffed by two PHNs who screened and assessed patients. Patients who called the triage nurse at the clinic were triaged and directed to the mobile clinic unit with scheduled appointment times that were determined by the PHN, depending on symptom severity.

The PHN staff greeted the patients, registered them, triaged and assessed them, and provided patient education. They also were given a standing order to perform rapid strep screenings in the mobile clinic unit with a lab person available

in the unit to run the tests. If the strep screen was negative, the patient was offered home care measures as well as self-care medications. Patients requesting self-care medications were screened by a decentralized pharmacist who dispensed and gave instruction about the appropriate use of antipyretics, cough suppressants, and nasal decongestants. He or she was located as close to the mobile clinic unit as possible, just inside the door of the clinic in a vacant office. If a patient had a positive strep screen, the nurse had a standing order from a physician to treat the patient with antibiotics. Parameters were set for vital signs and symptoms. If the patient fell outside of the parameters or was considered, through the triage and assessment process, to need further evaluation, the PHN sent the patient into clinic to be evaluated in the urgent care clinic.

PHN staff in the mobile clinic unit, pharmacy staff, laboratory staff, security, and the triage nurse in the clinic all had hand radios to communicate with each other throughout this process. The first week, PHN staff evaluated an average of 10 - 15 patients per day in the mobile clinic unit. During the second and third weeks, approximately 15 - 20 patients per day were seen and evaluated. Entering the fourth week, there was a drop in the number of patients with ILI, and the PHN staff were able to reduce their force in the mobile clinic unit to one nurse. By week five, the number of patients with ILI symptoms needing to be sent to the mobile clinic unit decreased due to the clinic's ability to handle more appointments with an added locum tenens provider, and so the mobile clinic unit went into standby status.

In mid-October the H1N1 vaccine was received, and direct patient care staff were vaccinated at both IHS and Tribal Health Programs. With the plan that was developed in September, 2009, the White Earth Home Health Agency, which is also the public health authority for the reservation, would begin mass vaccination in the communities. Because of the amount of vaccine received, initially only pregnant women and young children ages six months to four years old were vaccinated. The PHNs went into homes, daycare settings, and communities to provide these vaccinations. As more vaccine was received, they began to open up community clinics throughout the reservation to vaccinate households with children under six months of age and also children age 5 - 18 years of age who were chronically ill. At this point (late November, 2009) approximately 900 people have been vaccinated thus far.

Without this collaborative effort, this endeavor would not have taken place. Both agencies have worked very well together to provide education and care to the patients of the White Earth Indian Reservation.



NEW MEXICO GERIATRIC EDUCATION CENTER

"Is This Really Alzheimer's Disease?" Recognizing, Diagnosing & Treating Dementia

This interactive workshop is designed for providers to receive hands-on instruction and practice in the early diagnosis and treatment of dementia.

CEUs for Physicians, Nurses, and other professional healthcare providers.

Limited Space—Sign Up Early

Janice Knoefel, MD

New Mexico Veteran Healthcare System

John Adair, MD

UNM School of Medicine

Shelley Leiphart, Psy.D.

New Mexico Veteran Healthcare System

Details:

**Friday, February 19
9:00 am—3:00 pm
Domenici Center, Room 3010
UNM Health Sciences Center
Lunch will be Provided**

Contact Information:

NM Geriatric Education Center
1001 Medical Arts Ave., NE
Room 244
Albuquerque NM 87102-2708
Phone: 505.272.4934

Registration Materials:

<http://hsc.unm.edu/som/fcm/gec>

The UNM New Mexico Geriatric Education Center (NMGEC) offers geriatric training with an emphasis on the delivery of health care to American Indian Elders. The NMGEC objectives are to enhance interdisciplinary geriatric continuing education with a distance learning component for health care professionals, faculty, fellows, residents, and students with an emphasis on American Indian Elders. This workshop is made possible by a grant from HRSA Bureau of Health Professions Grant No. D31HP08820

IHS Patient Education Protocols and Codes Helping Facilities Meet National Patient Safety Goals

CDR Michael Toedt, MD, FAAFP; CDR Michael Toedt, MD, FAAFP, Executive Director of Clinical Services, Cherokee Indian Hospital, Cherokee, North Carolina; Dominique M. Toedt, MD, Staff Physician (Hospitalist), Cherokee Indian Hospital; Sonya J. Vann, RN, BSN, Performance Improvement, Cherokee Nation W. W. Hastings Hospital, Tahlequah, Oklahoma; and Shirley Teter, MA, Office of Information Technology, Tucson, Arizona

Most care providers in IHS know about the many benefits of the IHS Patient Education Protocols and Codes, but did you know they also help meet National Patient Safety Goals? The IHS Patient Education Protocols and Codes can be used whenever providing health/patient education, whether to an individual, group, or community. Using the codes provides a uniform method of documentation of peer-approved education protocols. The codes provide for documentation of the following elements: 1) topic of the education (the disease state, illness, or condition), 2) subtopic of what the education is about, 3) readiness to learn, 4) patient's level of understanding, 5) time spend providing the education, and 6) identification of who provided the education. Additionally, the codes enable documentation of any behavior goals or additional comments. The protocols and codes are regularly reviewed and updated by IHS subject matter experts. In addition to providing standardized protocols, the codes allow for simplified documentation and computerized tracking and reporting of patient education activities. They provide a standardized means for documenting a facility's compliance with accreditation requirements, including the National Patient Safety Goals (NPSG).

Most facilities in the Indian health system have chosen to be accredited by a deeming authority recognized by Centers for Medicare and Medicaid (CMS). Recognized accrediting organizations include the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAHC), and DNV Healthcare, Inc., among others. Use of the IHS Patient Education Protocols and Codes provides a standardized means for documenting compliance with standards of care (and accreditation requirements). The National Patient Safety Goals have become a critical method by which the Joint Commission promotes and enforces major changes in patient safety in thousands of participating health care organizations in the US and around the world. Regardless of the accreditation

organization a facility has chosen, most facilities aim to comply with the National Patient Safety Goals.

The Joint Commission's National Patient Safety Goals encourage patients to ask questions about proper risk assessment and risk reduction, and include requirements for patient education for the following topics: 1) anticoagulation therapy; 2) hand hygiene and other means of prevention of spread of multi-drug resistant organisms, prevention of infection from central venous catheter insertion, and surgical site infection prevention; 3) fall reduction program; 4) reporting methods for care/safety concerns; 5) suicide hotline education; and 6) education about how a patient may initiate a rapid response to a deteriorating patient condition. All of these are covered by the standardized, peer-reviewed IHS Patient Education Protocols and Codes (see Table 1).

References

1. IHS National Patient Education Initiative, accessed 6/16/09 at <http://www.ihs.gov/NonMedicalPrograms/HealthEd/index.cfm?module=initiative&option=all&newquery=1>.
2. The Joint Commission National Patient Safety Goals accessed 6/16/09 at <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>

Table 1. IHS Patient Education Codes that address accreditation requirements for patient education documentation for National Patient Safety Goals (NPSG)

Education requirement	2010 IHS Patient Education Code	National Patient Safety Goal (2009 numbering)
anticoagulation therapy	Anticoagulation (ACC)	NPSG.03.05.01
hand hygiene (respiratory hygiene, other hygiene)	Subtopic Hygiene (HY)	NPSG.07.01.01
multi-drug resistant organisms	Multi-drug Resistant Organisms (MDRO) – Home Management (HM), Hygiene (HY), Isolation (ISO), Prevention (P), Procedures (PRO), Wound Care (WC)	NPSG.07.03.01
teach patients about infection prevention from central venous catheter insertion	Central Venous Catheter (CVC)-Complications (C), Procedures (PRO)	NPSG.07.04.01
surgical site infection prevention	Surgical Procedures and Endoscopy (SPE)-Prevention (PRE), Procedures (PRO), Wound Care (WC)	NPSG.07.05.01
fall reduction program	FALL-Literature (L) , Safety (S), Screening (SCR)	NPSG.09.02.01
teach patients how to report care/safety concerns	Medical Safety (MSAF)- Information (I) , Prevention (P)	NPSG.13.01.01
suicide hotline education	Depressive Disorders (DEP)-Hotline Information (HELP)	NPSG.15.01.01
rapid response team education	Admission (ADM)-Rapid Response Team (RRT)	NPSG.16.01.01
Universal Protocol	Surgical Procedures and Endoscopy (SPE) – Procedures (PRO), all PRO subtopics	UP.01.01.01

The IHS Patient Education Protocols and Codes can be a useful tool to help facilities in their efforts to meet the patient and family education requirements of the National Patient Safety Goals. However, the reader is cautioned to read the National Patient Safety Goals in detail to become familiar with other requirements beyond patient and family education (i.e., staff teaching and implementation of best-practices, policies, and procedures). The IHS Patient Education Protocols and Codes provide a useful, standardized means for documenting patient and family education, and their use is encouraged.



**Children are precious
...so are their teeth**
February is Children's Dental Health Month

NATIVE AMERICAN PROFESSIONAL PARENT RESOURCES, INC.
DENTAL SUPPORT CENTER



Electronic Subscription Available

You can subscribe to *The Provider* electronically. Any reader can now request that he or she be notified by e-mail when the latest issue of *The Provider* is available on the Internet. To start your electronic subscription, simply go to *The Provider* website (<http://www.ihs.gov/Provider>). Click on the “subscribe” link; note that the e-mail address from which you are sending this is the e-mail address to which the electronic notifications will be sent. Do not type anything in the subject or message boxes; simply click on “send.” You will receive an e-mail from LISTSERV.IHS.GOV; open this message and follow the instruction to click on the link indicated. You will receive a second e-mail from LISTSERV.IHS.GOV confirming you are subscribed to *The Provider* listserv.

If you also want to discontinue your hard copy subscription of the newsletter, please contact us by e-mail at the.provider@ihs.gov. Your name will be flagged telling us not to send a hard copy to you. Since the same list is used to send other vital information to you, you will not be dropped from our mailing list. You may reactivate your hard copy subscription at any time.

Proposed Changes in *The IHS Provider*

As most of our readers know, we are still having problems with the timely distribution of paper copies of *The Provider*. The transition to the UFMS has proved more difficult than anticipated, and we realize that these problems may persist for the coming year. We are proposing the following changes.

We will continue to publish monthly issues with all articles, meetings, announcements, position vacancies and so on, but we will distribute these electronically, using the *Provider* listserv to let those subscribed to that service know when issues are published to the website. This will assure that all who are interested can receive all of this information in a timely manner. Currently, about 15% of our readership has subscribed to the listserv (see the instructions above about how to do this) and the list has been growing at an annual rate of about 20 percent per year.

We will publish and mail paper issues on a quarterly basis, and these will contain only the *articles* for the past three issues.

This will assure that those without Internet access will still be able to see all of the clinical information, although these paper

issues will not include the time-sensitive information described above.

A significant proportion of the cost of publishing *The Provider* is the postage needed to distribute the 6000 copies that go out monthly, and so, by mailing only quarterly issues, we will be able to save the agency money, as well.

We are interested to hear feedback from readers to know if this idea poses any hardships, or if there are suggestions about how to revise this plan to better meet the needs of our readers. We anticipate making the switchover in January, so please send us your ideas now, so that we have time to consider them and incorporate them into our plans. Send these by e-mail to john.saari@ihs.gov.

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

“Truth is beauty and beauty truth, and that is all ye need to know on earth.”

Keats

Articles of Interest

Identification of children at very low risk of clinically important brain injuries after head trauma: a prospective cohort study. *Lancet*. Volume 374, Issue 9696, Pages 1160 – 1170.

This study tells us not who needs a head CT scan after trauma but who safely can forgo cranial imaging. The authors pooled results from multiple sites and developed rules for children < 2 years of age and those from 2 - 18 years of age that would safely exclude the possibility of clinically important traumatic brain injury. The prediction rule for children < 2 years (normal mental status, no scalp hematoma except frontal, no loss of consciousness or loss of consciousness for less than 5 seconds, non-severe injury mechanism, no palpable skull fracture, and acting normally according to the parents) was 100% specific and sensitive. The prediction rule for children 2 - 18 years (normal mental status, no loss of consciousness, no vomiting, non-severe injury mechanism, no signs of basilar skull fracture, and no severe headache) was 99.5% specific and 97% sensitive. Applying these rules, about 25% of children < 2 years old and 20% of children 2 - 18 years old could safely have been discharged from the Emergency Department without CT scans of the head.

Editorial Comment

This study helps us to decide which children are at such low risk for clinically important traumatic brain injury that they may forgo cranial imaging. This is important for all children as it avoids unneeded radiation. It is especially important for many Indian Health Service sites that are geographically remote. The decision to obtain a CT scan often involves transport that can be expensive and occasionally dangerous given weather conditions. These rules will allow us to safely decrease the number of patients transported for imaging.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

H1N1 novel influenza in American Indian and Alaska Native people. Information from the 1918 flu pandemic suggests that mortality rates were four times higher among American Indians (AI) than reported for US cities, while in Alaska, numerous Alaska Native (AN) communities were decimated and never repopulated. AI/AN people have experienced higher mortality for “pneumonia and influenza”; for AI/AN infants, the pneumonia and influenza mortality rate is four times higher than the US infant population.

What data are available for AI/AN in the current H1N1 novel flu pandemic? In Arizona, where AI/AN people comprise 4.9% of the state’s population, 19% of H1N1 hospitalizations and 17% of deaths have been in AI/AN people. Other indigenous populations have also experienced higher morbidity. Indigenous Australians were ten times more likely than non-indigenous Australians to be hospitalized for pandemic H1N1 in 2009. Aboriginal Canadians accounted for 25.6% of ICU admissions but represent only 3.8% of the Canadian population.

IHS is conducting influenza-like illness (ILI) surveillance using RPMS data transmitted to the IHS Influenza Awareness System (IIAS). The major outcome measure is the percentage of all IHS visits that are for ILI. Weekly summary reports can be found at www.ihs.gov/h1n1. As of November 7, the ILI % in IHS had peaked at 6% in the week ending October 17, 2009. As of November 8, 36,318 doses of H1N1 vaccine had been administered to patients at IHS, tribal and urban Indian facilities.

What is the response to evidence of increased morbidity in AI/AN people? Some states and local health jurisdictions have allocated a higher proportion of H1N1 vaccine to AI/AN populations. For example, Arizona allocates 10% of H1N1 vaccine to AI people, who comprise 4.9% of the population.

What can you do?

- Follow the local epidemiology of H1N1 illness/hospitalization in your region and state. Check with your facility to see if they are participating in the IHS surveillance so that you can get weekly reports on flu activity at your facility and Area.
- Ensure high risk patients with suspected H1N1 receive antiviral treatment as outlined in the CDC recommendations. Updated guidance for clinicians

can be found at <http://www.cdc.gov/h1n1flu/clinicians/>.

- Monitor vaccine coverage among the target groups and advocate with your state for H1N1 vaccine for your population.
- If your facility is not uploading ILI information to the IAS, consult with your information technology department and local leadership to consider taking part.

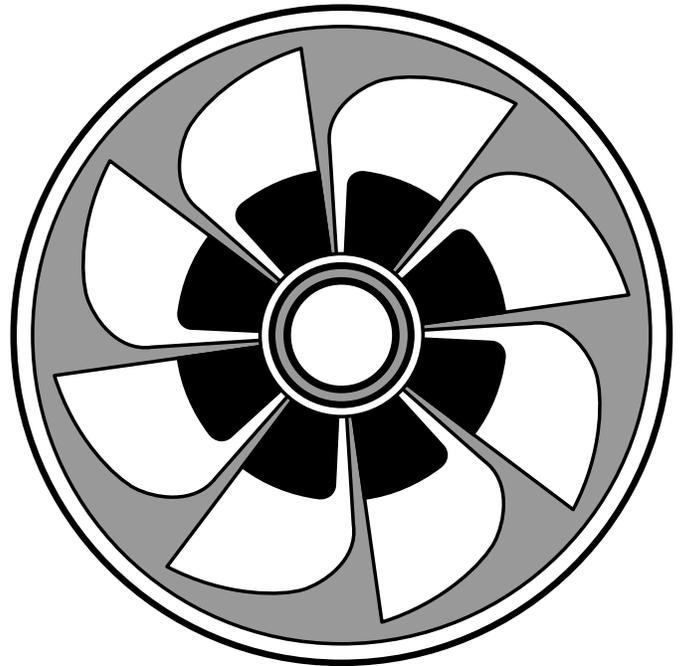
Recent literature on American Indian/Alaska Native Health Michael L. Bartholomew, MD

Nez Henderson P, Kanekar S, Wen Y, et al. Patterns of cigarette smoking initiation in two culturally distinct American Indian tribes. *Am J Public Health*. 2009 Nov;99(11):2020-5. http://www.ncbi.nlm.nih.gov/pubmed/19820215?itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum&ordinalpos=3

Despite declines in overall smoking rates in the past few decades in the general US population, the rates in American Indians and Alaska Natives (AI/AN) continue to remain elevated. Previous surveys on smoking behaviors have shown that AI/AN adults, 18 years and older, have the highest smoking rate (36.4%) of any major racial/ethnic group in the US.¹ Among youth, AI/ANs tend to have a higher smoking prevalence.² Non-smoking AI/AN youth are more likely to experiment with smoking than other racial/ethnic group.² Additionally, smoking rates among AI/AN populations tend to vary by region.³ The authors of this study analyzed data from the Education and Research Toward Health (EARTH) Study to better determine the patterns of smoking initiation among American Indians, aged 18 - 95 years who initiated smoking by 18 years of age, in two tribes located in the southwest and Northern Plains. There were 4,757 participants in the study, of which 2/3 were from the Northern Plains and 1/3 from the southwest. The cumulative incidence of smoking initiation by 18 years of age was higher in the Northern Plains (47%) than in the southwestern (27%) participants. The data were further analyzed by six birth cohorts (1930s and before, 1940-1949, 1950-1959, 1960-1969, 1970-1979, 1980-1988). Northern Plains men and women and southwest women showed an increase in the percentage of smoking initiation by age 18 in the younger birth cohorts. The Northern Plains participants and the southwest women in the younger birth cohorts were more likely to initiate smoking earlier than their older birth cohorts. The authors postulated several possibilities for these regional and age/gender differences including cultural, social, environmental, and biological factors. More research is needed to understand the association of these factors and smoking initiation in AI/AN youth so that appropriate and improved smoking prevention interventions can be developed.

References

1. Tobacco use among adults -- United States, 2007. *MMWR*. November 14, 2008;57(45): 1221-1226. Racial/ethnic differences among youths in cigarette smoking and susceptibility to start smoking -- United States, 2002 -- 2004. *MMWR*. December 1, 2006;55 (47); 1275-1277.
2. Statement of W. Craig Vanderwagen, MD, Director, Clinical and Preventive Services Office of Public Health, Indian Health Service before the Senate Indian Affairs Committee. February 12, 1998.



MEETINGS OF INTEREST

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>.

Midwinter Conference on Women's and Children's Health January 29 - 31, 2010; Telluride, Colorado

This is the 25th annual midwinter continuing education conference at Telluride. It will provide an update on clinical areas of interest to physicians, nurses, and advanced practice clinicians caring for women and children in Indian country. Speakers include experts currently and formerly with IHS. Topics will include pediatric respiratory illness, early and late preterm labor from both the obstetric and neonatal perspective, diabetes in pregnancy, childhood autism, antenatal testing, postpartum depression, and keeping childbirth normal. The formal CME/CEU program will be preceded by a non-CME Implanon training for the first 21 who sign up. The meeting is designed with ample time for networking and recreation. For more information, contact Alan G. Waxman, MD, at awaxman@salud.unm.edu.

The 2010 Meeting of the National Councils for Indian Health March 21 - 26, 2010; Phoenix, Arizona

The National Councils (Clinical Directors, Chief Executive Officers, Chief Medical Officers, Oral Health, Pharmacy, and Nurse Consultants) for Indian health will hold their 2010 annual meeting March 21 - 26, 2010 in Phoenix, Arizona. Engage in thought-provoking and innovative discussions about current Indian Health Service/tribal/urban program issues; Identify practical strategies to address these health care issues; Cultivate practical leadership skills to enhance health care delivery and services; Share ideas through networking and collaboration; and receive accredited continuing education. Indian health program Chief Executive Officers, clinico-administrators, and interested health care providers are invited to attend. The meeting will be held at the Hyatt Regency Phoenix, 122 North Second Street, Phoenix, Arizona 85004. Please make your hotel room reservations by March 1, 2010 by calling 1-(800) 233-1234 or (602) 252-1234. Be sure to ask for the "Indian Health Service" group rate. On-line registration and the conference agenda will be available late December at the Clinical Support Center web page at <http://www.csc.ihs.gov>. The IHS Clinical Support Center is the

accredited sponsor for this meeting. For more information, contact Gigi Holmes or CDR Ed Stein at (602) 364-7777; or e-mail gigi.holmes@ihs.gov.

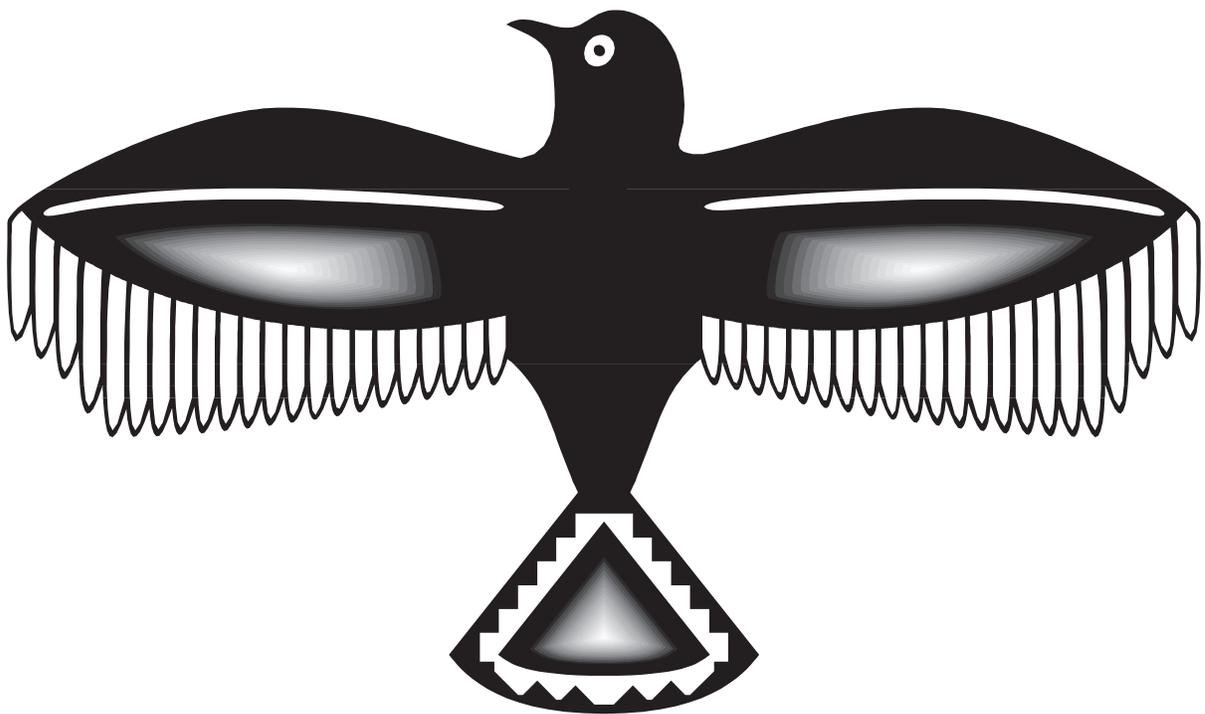
Advances in Indian Health April 27 - 30, 2010; Albuquerque, New Mexico

The Advances in Indian Health Conference, April 27 - 30, 2010 will be held at the Sheraton Uptown in Albuquerque, New Mexico. "Advances" is IHS's primary care clinical conference and attracts over 350 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 the EHR. With low tuition and a government rate 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 2010 on the UNM Office of CME website: http://hsc.unm.edu/som/cme/2010_Conferences.shtml. For more information, contact the course director, Ann Bullock, MD, at ann.bullock@ihs.gov.

The 14th Annual Elders Issue

The May 2009 issue of *THE IHS PROVIDER*, to be published on the occasion of National Older Americans Month, will be the fourteenth 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.



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.

Registered Nurse

Yavapai-Apache Nation; Camp Verde, Arizona

The Yavapai-Apache Nation has an immediate opening for a clinic nurse. This nursing opportunity is for a registered nurse at the Yavapai-Apache Health Center, in Camp Verde, Arizona. The position is in a tribally run facility, with an IHS provider, and IHS public health nurse. The clinic is an outpatient facility, built in 1998, with family medicine, dental, optometry, and behavioral health services. We work closely with Phoenix Indian Medical Center and local specialists. We expect to have telemedicine capabilities in the near future. The clinic fully utilizes the IHS Electronic Health Record. We work regular hours, and have 15 paid holidays. Full benefits are included.

The facility is located in the beautiful Verde Valley, home to the Yavapai-Apache Nation. The Yavapai-Apache Nation has about 2300 enrolled tribal members. We are located 90 miles north of Phoenix. The Verde Valley offers many outdoor activities such as hiking, canoeing, and fishing; other mountain and desert activities are just a short drive away. The applicant should be an outgoing, energetic, team player who is compassionate and focused on patient care.

For more information and an application, contact the Yavapai-Apache Nation, Human Resources, at (928) 567-1062. (12/09)

Family Practice Physician

Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("Basket-maker") Apache community with a population of 3,500. Our clinic has an opening for a board certified/eligible family practice physician

for purely outpatient care with a 40 hour work-week. Our site qualifies for IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. Our staff currently consists of a family practice physician, an internist, a pediatrician, a part-time FP physician (who focuses on prenatal care), three family practice mid-levels, an optometrist, and two dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with profits from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility with free personal training, a modern supermarket, a Best Western Hotel and Casino, and more. We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass.

We welcome you to visit our facility in person; to take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to <http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx>. Please call Dr. Cecilia Chao at (575) 759-3291 or 759-7230; or e-mail cecilia.chao@ihs.gov if you have any questions. (11/09)

Family Physician

SouthEast Alaska Regional Health Consortium Clinic; Juneau, Alaska

The SEARHC (SouthEast Alaska Regional Health Consortium) Clinic in Juneau, Alaska has an excellent opportunity for a family physician with obstetrics skills to join a medical staff at a unique clinic and hospital setting. Have the best of both worlds in a practice where we share hospitalist duties and staff an outpatient clinic, with excellent quality of life. We have the opportunity to practice full spectrum family medicine. Juneau is a National Health Service Corp Loan Repayment Site. Southeast Alaska has amazing winter and summer recreational activities. Enjoy Alaska's capital with access to theater, concerts, and annual musical festivals. Join a well rounded, collegial medical staff, with generous benefits. For information, contact Dr. Cate Buley, telephone (907) 364-4485; e-mail cbuley@searhc.org; or go to www.searhc.org. Job Requirements are a board certified family physician who has completed an accredited family medicine residency. (11/09)

Mid-Level Provider

Aleutian Pribilof Islands Association, Inc.

Provide health care services to whole generations of families. We are recruiting for a mid-level provider based in beautiful and interesting St. Paul Island or Unalaska, Alaska.

Duties include primary care, walk-in, urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Minimum experience: 2 - 3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Alaska Native Tribal health Consortium. Positions available immediately. Work 37.5 hours per week.

Qualifications/required knowledge and skills include the following: graduate of an accredited ANP, FNP, or PA-C program; requires a registration/license to practice in the State of Alaska; credentialing process to practice required; knowledge of related accreditation and certification requirements; three to five years experience (two years of supervision preferred) or an equivalent combination of education and/or experience; ability to perform medical examinations using standard medical procedures; knowledge of patient care charging to include "superbill" coding, patient histories, clinical operations and procedures, primary care principles and practices; ability to observe, assess, and record symptoms, reactions, and patient progress; ability to react calmly and effectively in emergency situations; up-to-date CPR and ACLS certifications; knowledge of drugs and their indications, contraindications, dosing, side effects, at proper administrations; knowledge of emerging trends in technologies, techniques, issues, and approaches in area of expertise; ability to clearly communicate medical information to professional practitioners and the general public; ability to educate patients and/or families as to the nature of disease and to provide instruction on proper care and treatment; ability to maintain quality, safety, and/or infection control standards; ability to self-manage assigned patient caseload, including organizing, prioritizing, and scheduling appointments, services, and work assignments; ability to make administrative and procedural decisions; computer literate; ability to give oral and written reports; willingness and means to travel on rotation throughout the Aleutian Pribilof Islands Region; valid Alaska driver's license; willing to take training and attend workshops and meetings periodically to enhance job performance and knowledge.

Salary DOE, includes benefits. Contractual commitment. Job description available upon request. Open until filled. Submit resumes with at least three professional references to Aleutian Pribilof Islands Association, Inc., Attn: Human Resources Director, 1131 E. International Airport Road, Anchorage, Alaska 99518; e-mail nancyb@apiai.org; telephone (907) 276-2700; fax (907) 279-4351. Native preference will be given to qualified applicant pursuant to P.L. 93-638. (11/09)

**Family Practice Physician/Medical Director
Carl T. Curtis Health Education Center
Omaha Tribe of Nebraska, Macy, Nebraska**

The Omaha Tribe of Nebraska is seeking a full-time, permanent physician medical director for the Carl T. Curtis Health Education Center. The CTCHEC is a comprehensive, tribal community-based ambulatory family medicine facility. Services include primary care, dental, behavioral health, substance abuse treatment, and diabetes. The physician medical director functions as the supervisor of the outpatient clinic, ambulance service, and a 25-bed long term care facility.

A 12-chair hemodialysis unit operates within the facility with a contracted nephrologist as medical director. Specialty consultants with regular clinics operating include podiatry, optometry, psychiatry, audiology, endocrinology, physical therapy, and occupational therapy.

The people of the Omaha Tribe are the descendents of the original first Nebraskans. Their ancestral home is their current home and lies among beautiful timber filled rolling hills following the Missouri River. Abundant wildlife with hunting and fishing available is a bonus benefit for the outdoors person. Driving times to nearby cities are 40 minutes to Sioux City, Iowa and 70 minutes to Omaha, Nebraska.

The physician that we are looking for in this position will appreciate a comprehensive, patient and family-first philosophy of practice. Our physician medical director will be interested in the broad, rural, "frontier" medical experiences. He/she will have daily access to behavioral health professionals, certified diabetes educators, and an energetic, multi-disciplinary team of colleagues anxiously awaiting his or her arrival. Hopefully, you are looking for us if you are a compassionate highly skilled physician. You practice medicine according to adopted evidence-based standards and are an exceptional listener and diagnostician. The Carl T. Curtis Health Education Center and the staff members are seeking a physician leader who is interested in excellence with experience in managing resources. If you are our physician medical director, a competitive salary; a full health, vision, and dental benefits package; student loan repayment; four weeks of paid vacation plus 20 paid holidays per year; and a retirement plan await you. Please help us find you by contacting Jessica Valentino, Administration by e-mail at Jessica.valentino@ihs.gov or Kelly Bean, Medical Staff, at Kelly.bean@ihs.gov. (10/09)

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

The Warm Springs Health and Wellness Center will have an opening for a board certified/eligible family physician starting April 1, 2010. 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, of which one is retiring 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 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. (10/09)

**Family/Pediatric Nurse Practitioner for School Health Program
Nurse Practitioner for San Simon Health Center
Sells Service Unit; Sells, Arizona**

The Sells Service Unit (SSU) in southern Arizona is recruiting for a family/pediatric nurse practitioner for our school health program. The SSU is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells, Arizona and three health centers: San Xavier Health Center, located in Tucson, the Santa Rosa Health Center, located in Santa Rosa, and the San Simon Health Center located in San Simon, Arizona, with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self management education.

Sixty miles east of the Sells Hospital by paved highway lies Tucson, Arizona's second largest metropolitan area, and home to nearly 750,000. Tucson, or "The Old Pueblo," is one of the oldest continuously inhabited sites in North America, steeped in a rich heritage of Indian and Spanish influence. It affords all of southern Arizona's limitless entertainment, recreation, shopping, and cultural opportunities. The area is a favored tourist and retirement center, boasting sunbelt attributes and low humidity, with effortless access to Old Mexico, pine forests, snow sports, and endless sightseeing opportunities . . . all within a setting of natural splendor.

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. Commuter van pool from Tucson is available for a monthly fee. For more

information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at Peter.Ziegler@ihs.gov. (9/09)

**Family Practice Physician
SouthEast Alaska Regional Health Consortium; Juneau,
Alaska**

The SEARHC (SouthEast Alaska Regional Health Consortium) Clinic in Juneau, Alaska has an excellent opportunity for a family physician with obstetrics skills to join a medical staff in a unique clinic and hospital setting. Have the best of both worlds in a practice where we share hospitalist duties and staff an outpatient clinic with excellent quality of life. We have the opportunity to practice full spectrum family medicine. Southeast Alaska has amazing winter and summer recreational activities. Enjoy Alaska's capital with access to theater, concerts, and annual musical festivals. Join a well rounded, collegial medical staff with generous benefits. For information contact Dr. Cate Buley, (907) 364-4485; cbuley@searhc.org or www.searhc.org. (9/09)

**Family Medicine, Internal Medicine, Emergency Medicine
Physicians
Sells Service Unit; Sells, Arizona**

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible family medicine, internal medicine, and emergency medicine physicians to join our experienced medical staff. The Sells Service Unit is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells, Arizona and three health centers: San Xavier Health Center, located in Tucson, the Santa Rosa Health Center, located in Santa Rosa, and the San Simon Health Center located in San Simon, with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self-management education.

Sixty miles east of the Sells Hospital by paved highway lies Tucson, Arizona's second largest metropolitan area, and home to nearly 750,000. Tucson, or "The Old Pueblo," is one of the oldest continuously inhabited sites in North America, steeped in a rich heritage of Indian and Spanish influence. It affords all of southern Arizona's limitless entertainment, recreation, shopping, and cultural opportunities. The area is a favored tourist and retirement center, boasting sunbelt attributes and low humidity, with effortless access to Old Mexico, pine forests, snow sports, and endless sightseeing opportunities . . . all within a setting of natural splendor.

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. Commuter

van pool from Tucson is available for a monthly fee. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at Peter.Ziegler@ihs.gov. (9/09)

**Internal Medicine Hospitalists
Physicians Assistants/Nurse Practitioners
Pine Ridge Service Unit; Pine Ridge, South Dakota**

The Pine Ridge Service Unit is seeking enthusiastic health care practitioners to come work with their current staff on the Pine Ridge Indian Reservation. The Pine Ridge Service Unit consists of a hospital located in Pine Ridge and two independently-staffed satellite clinics in Kyle and Wanblee, South Dakota.

The hospital is a multidisciplinary facility that includes inpatient, outpatient, urgent care, emergency, dental, behavioral health, pharmacy, ob/gyn, surgery, optometry, podiatry, pharmacy, and physical therapy services. The facility is currently seeking to strengthen the services and staff to ensure quality care for our population of 45,000 beneficiaries.

Pine Ridge is located just south of both the Black Hills and Badlands of South Dakota so the outdoor activity possibilities are unlimited. There are two colleges within fifty miles, and Rapid City, with its variety of cultural opportunities, is within ninety miles.

If you are interested in a challenging position with the opportunity to have a positive effect on developing and building health care services, please contact Jan C. Colton, DMD, PhD, Acting Clinical Director, Pine Ridge PHS Hospital, 1201 E. Highway 18, Pine Ridge, South Dakota, 57770; telephone (605) 867-3019. (9/09)



2009 YEAR-END INDEX

Major Subjects and Titles, Volume 34, January through December 2009

A

Alcohol Abuse (See "Behavioral Health")

B

Behavioral Health

- Agency Health Initiatives Spring 2009 Behavioral Health Update Jun
- Implementing Suicide Intervention Training in Rural Alaska Jul
- Naltraxone for Alcohol Dependence Nov

C

Cardiovascular Disease

- Stroke and American Indians: Information from the Strong Heart Study Oct

Cancer

- CHR's Speak Out About Cancer: Invitation to Listen, Call to Action Mar

Continuing Education

- The Birdfeeder (A Continuing Education Parable) Nov
- Measuring Gaps in Knowledge, Competence, and Performance Nov

D

Dental

- Dental X-Ray Imaging: Reducing Patient Radiation Exposure Nov
- Pioneers of Indian Health: Dr. Toyo Shimizu Mar

E

EHR (See Informatics)

G

Genetic Diseases

- Sickle Cell Disease and Native Americans Nov

Geriatrics

- Brief Update on the Fort Defiance Home-Based Care and Geriatric Program May
- Cherokee Nation Elder Services: A Case Study May
- Grandparent Caregivers May
- IHS Elder Care Initiative Grants May
- Looking Up From Our Work May
- Planning for Elder Services in Southeast Alaska May
- Taking Care of Our Communities: Overview of Long Term Care May

H

Health Systems Issues

- Blameless Reporting and Why It's Important to Health Care Apr
- Innovations in Planned Care and iCare Jun
- IHS Chronic Care Initiative: Innovations in Planned Care Apr
- Is iCare Right for You? Jun

HIV/AIDS

- Expanded HIV Testing in Two Service Units July – December 2007 Feb

I

Indian Health Service

- IHS Chronic Care Initiative: Innovations in Planned Care Apr
- Innovations in Planned Care and iCare Jun

• Pioneers of Indian Health: Dr. Toyo Shimizu	Mar
<i>Informatics</i>	
• Intercepting the Safety Pitfalls of the EHR	Sep
• Native Health Database: One Stop for Native Health Information	Jan
<i>Infectious Diseases</i>	
• Expanded HIV Testing in Two Service Units July – December 2007	Feb
• Financing Adult Vaccines	Jun
• H1N1 Influenza: Pregnancy Multiplies the Risk of Severe Disease	Oct
• STD Resources on the Internet	Feb
• White Earth Home Health Agency and IHS Health Center Collaborate on H1N1	Dec
<i>Injury Prevention</i>	
• Implementing Suicide Intervention Training in Rural Alaska	Jul
• Increasing Occupant Restraint Use Among Ho-Chunk Nation Members	Jul
• Taking Back Our Communities: Gang Prevention Strategies	Jul
• The Value of Injury Prevention Partnerships in Indian Country	Jul
 M	
<i>Medicolegal Issues</i>	
• Blameless Reporting and Why It's Important to Health Care	Apr
 O	
<i>Obesity</i>	
• Bariatric Surgery: Who is a Candidate and Where to Refer	Nov
• Weight Gain in Pregnancy: Revised Guidelines Issued as Obesity Rates Soar	Dec
<i>Obstetrics</i>	
• Weight Gain in Pregnancy: Revised Guidelines Issued as Obesity Rates Soar	Dec
 P	
<i>Patient Education</i>	
• IHS Patient Education Protocols and Codes Helping Meet NPSG	Dec
<i>Pediatrics</i>	
• Cooperative School and Community Based Intervention to Promote Diabetes Awareness and Prevention Behaviors Among Youth	Oct
• Story Is Medicine at the Pawnee Service Unit in Oklahoma	Jan
<i>Pharmacy</i>	
• Financing Adult Vaccines	Jun
<i>Prevention (See Also "Injury Prevention")</i>	
• Cooperative School and Community Based Intervention to Promote Diabetes Awareness and Prevention Behaviors Among Youth	Oct
• Dental X-Ray Imaging: Reducing Patient Radiation Exposure	Nov
• Expanded HIV Testing in Two Service Units July – December 2007	Feb
• Financing Adult Vaccines	Jun
• HP/DP Initiative: Showcasing Promising Strategies	Jun
• Resources to Help Your Patients Quit Smoking	Apr
• Story Is Medicine at the Pawnee Service Unit in Oklahoma	Jan
 S	
<i>Sexually Transmitted Diseases</i>	
• Expanded HIV Testing in Two Service Units July – December 2007	Feb
<i>Substance Abuse (See "Behavioral health")</i>	
 T	
<i>Tobacco</i>	
• Commercial Tobacco Prevalence, Perception, and Opinion	Sep
• Resources to Help Your Patients Quit Smoking	Apr

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

PRESORTED STANDARD
POSTAGE AND FEES PAID
U.S. DEPT. OF HEALTH & HUMAN
SERVICES
PHOENIX, AZ
PERMIT NO. 5691

CHANGE SERVICE REQUESTED

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE \$300



Change of Address or Request for New Subscription Form

Name _____ Job Title _____

Address _____

City/State/Zip _____

Worksite: IHS Tribal Urban Indian Other

Service Unit (if applicable) _____ Last Four Digits of SSN _____

Check one: New Subscription Change of address

If change of address, please include old address, below, or attach address label.

Old Address _____



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@ihs.gov. Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page (<http://www.ihs.gov/Provider>).

- Wesley J. Picciotti, MPADirector, CSC
- John F. Saari, MDEditor
- Cheryl BegayProduction Assistant
- Theodora R. Bradley, RN, MPHDirector, OCE
- Lisa Palucci, MSN, RNNursing Consultant
- Erma J. Casuse, CDADental Assisting Training Coordinator
- Edward J. Stein, PharmDPharmacy Consultant

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

Circulation: The PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

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.