THE IHS PRIMARY CARE PROVIDER

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

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Annual Elders Issue

This May 2004 issue of *The IHS Provider*, published on the occasion of National Older Americans Month, is the ninth annual issue dedicated to our elders. We are greatful for the opportunity to honor our elders with a collection of articles devoted to their health and health care. Indian Health Service, tribal, and urban program professionals are encouraged to submit articles for the May 2005 issue on elders. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries can be addressed to the attention of the editor at the address on the back page of this issue.

Nana

Kathleen Marquart, PA-C, Portland, Oregon

This last week has been a hard one for our family. "Nana" is my mother, grandma to the grandchildren, and great grandmother to her five great-grandchildren. Her given name is Rosalina, but our family knows her as Nana. In Haida, this means grandmother, although she is Tlingit, from the Eagle Clan. Last week our Nana had pneumonia in both lungs, and was put in the hospital. The doctors were very guarded about her prognosis.

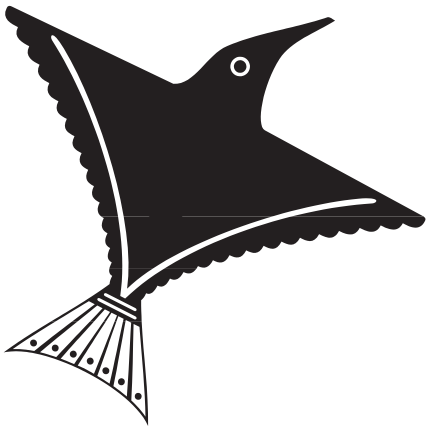
Nana is 86 years old. Sometimes, when you look at her she seems so fragile and little, not the woman who raised seven children, had eighteen grandchildren, and had a husband and partner for 69 years. Not the woman who picked up a big stick on the beach when I was young, entirely ready and determined to fight off a bear to protect her children, when my oldest brother had played a trick on her to make her believe there was one lurking in the brush.

We grew up in Wrangell, in the Southeastern part of Alaska. Wrangell is on an island, so getting there was either by boat or seaplane, and there were not many planes then. I remember once as a child I had a severe toothache. To get care, my Dad had to take me to the nearest dentist, nine hours away by his boat, and we were slowed by a strong southwest gale. Our father was Haida, a commercial fisherman, hunter, and trapper. He was often away from home for long periods, out to the fishing grounds. At times, he took his three young sons out with him. He was a teacher and a role model, and he taught them about fishing, weather, and how to work. My mother was always busy with her family. Her parents lived in a house about twenty five yards from us, so we kids were

In this Issue...

there daily asking for candy and favors (something not foreign to other grandparents today). Nana made a lot of our clothing. I remember two sets consisting of a coat, muff, and hat that she had made for both my sister and myself, out of a single aqua coat that had come from the Salvation Army. She made bread, donuts, and maple bars every week. A group of her friends would gather at our house to have coffee, tea, and hot, buttery buns. We were lucky to have her at home every day when we returned from school.

Our Nana was a very independent woman — strong when she had to be, but always loving with her children and her husband. She always told us that when Dad had to leave us to go fishing, we had to be strong and not cry. Even though we would miss him and be lonely for him, we weren't to let on about it when he left. She said that this could distract him when he needed to have all of his wits about him. Fishing and Mother Nature have claimed many people who were not watching.



She raised four daughters, who are all independent and strong willed. Our brothers most often were with Dad, and learned the ways of the sea and fishing. But, sometimes our entire family would all go out on the seining boat together. We would anchor in an isolated and beautiful bay. We would always have a row boat, and could go ashore to dig for clams, and gather gumboots (a mussel) from the rocks. We would have a fire on the beach and cook all the salmon, halibut, red snapper, and clams that we could eat. Then we would go back to the boat and watch the aurora borealis, nature's firework show, until we headed for home sleepy, full, tired, and with our family.

My Mom and Dad were always teasing us, like most Indian families do. We grew up with lots of laughter and joking. I remember one summer when Mom was pregnant with my youngest brother, her sixth child. She was up on a ladder, probably up about 35 or 40 feet, putting shutters on our upstairs windows. She thought nothing of it, saying that if she waited for Dad to do it, it might be years! From those windows, we could see out over the sea for miles. We would watch for our father's boat, and could spot it coming. All of us would be excited to have them back at home, safe and happy, and hopefully with a hold full of fish.

Nana was an only child. My father was raised by friends of his family because his mother had "consumption" (tuberculosis) when he was eighteen months old. She had been "sent south" to a sanatorium, where she died. He had four siblings, but never knew them, so he was like an only child. Both my parents wanted a large family, with my Dad wanting a dozen, but settling for seven. They raised us with an exceptional sense of loyalty to family, respect, and committed involvement. They gave us a strong value system and a work ethic, both of which have endured throughout our lives. They respected each other and their children. And, in return, we could not help but give them respect and love.

My folks decided they wanted to move to the "lower 48" some time after my youngest sister had to be transferred to Children's Hospital in Seattle for a health problem. This was an unusual decision for an Indian family from Wrangell at that time. When I was young and growing up there, Alaska was not even a state yet. But, my Mom and Dad decided they wanted their children to have more of a chance to have a different experience, and access to improved opportunities for education. So, we moved down on the *Anna Marie*, my Dad's seining boat. Everything we had was on that boat: all the children, our maternal grandfather, our dog Molly, all of the furniture that would fit into the hold, and all the plants that my Mom could take.

We crossed the Queen Charlotte Sound at an especially rough time (and it is always somewhat rough). Some got so sick on our small seine boat that it ended up that all my sisters and two of my brothers took a freighter down to British Columbia, and then a train on down to Seattle, Washington.

It was a great change in all of our lives, but at least we had each other to rely upon. We had many challenges facing this new world, about as foreign to us as you can imagine any place in the world might be for you. We had to learn how to be in both worlds. This is not unlike many other Indians who live in the dominant urban society, yet who come from traditions and culture that bear little resemblance to what they encounter later.

After Mother had finished raising her children, she started and maintained her own business. She had a store on a reservation where she sold Indian artwork, jewelry, and antiques. My father, for a time, sold marine and fishing-related supplies. And although he helped her as he could with her business, my father mostly continued to go to Alaska to fish (once it's in your blood, you know . . ..). She was an entrepreneur long before it was something many women were doing, certainly Tlingit women away from where they grew up. Moreover, she was a long lasting one at that. Nana lost her business after 26 years, to a fire that destroyed the shop, all the merchandise, everything. It was a hard time for both of them. My Dad had partially retired from fishing. Nana started to exhibit signs of Parkinson's disease. She was 75 years old. They had been married for 59 years.

When Nana started to have more health problems, there was never any discussion of having her anywhere else but in their home. Dad took care of her full time for the last three years of his life. All of our family would visit and give him a break, so he could go into his next project of getting his "new" old boat ready for his next trolling venture.

Hand trolling for salmon is what he had done when he first started going with Mom. (He had actually known her from when they were twelve years old. He had liked her then, but was too shy to let her know.) But, "the Ol' Man," as he had come to be known to all his crew members over the years, always had a new venture — a lifelong history of new ventures. They started as a child, and were destined to never end. The full time care Nana came to require slowed progress on his later ones, but they were there in the wings, waiting for breaks while one of us could watch her for a period so he could have a little more time to pull his latest boat together.

We lost our father in fall 2002. It was entirely unexpected. He went to sleep one night with his Nana, and was gone. It was a huge loss that left emptiness in all of our lives. Nana's Parkinson's disease had already progressed to a point of waxing and waning dementia. It was during the development of these difficult changes that he had become her sole caretaker, for all intents and purposes.

Now, at times, she thinks that Dad is out fishing and will be home soon. In some ways, this is good, because she does not always have to know that he is gone, and continuously have to suffer the pain that loss can bring after a lifetime like theirs together. But, there are many times that she is totally lucent, and knows that he is not with her, but is waiting for her to be with him when her time comes too.

We have as a family kept Nana in her home, in the surroundings most familiar to her. There, every day she is close to all of her family who love her and accept her, wherever she may be mentally. She knows that she is home, and that she is safe and loved, despite her confusion. We all take care of her. I have two sisters in Alaska who come down every two to three months, and brothers from Alaska and Hawaii who come to be with her when breaks from their fishing allow. Her main care providers are her oldest grandson and third oldest granddaughter, who live with her. As the oldest daughter, I take care of all of her finances and health care arrangements. Since I live in Portland, I'm fortunate to be able to get to Seattle more frequently than my bothers and sisters, so I get to spend a lot of time with her. Last summer, she fell and broke her upper arm. Since then, she needs even more constant assistance and care, including hands-on help for every movement from place to place in the house.

We as a family have no problem with this. We want to be there for Nana. She raised all of us, and both she and Dad gave each of us, and the grandchildren, and the great-grandchildren their values, including a strong sense of family. She still has laughter and humor. In fact, she still comes out with lines that both amaze us and give us pause to remember that she has had a very full life, one that has continued for almost 86 years. We see no great sacrifice in together making sure she is always taken care of where she is comfortable, in her own home. Rather, we have a joy that this is possible, and a pride in participating.

While Nana was in the hospital with pneumonia, it became clear how even many of her grandchildren's friends were worried and concerned about her. This is because when they visit at the house they get involved, too, in helping to take care of her. They have helped with wound care, feeding her, and watching when she was trying to get up without any assistance. Even her great-grandson who is only three years old will announce that "Nana is getting up!" to alert others that help is needed. They all interact with her, and she with them. Often they sit with her, hold her hand and watch TV, or just visit.

Nana has been discharged home from the hospital and the transfer care unit at the nursing home. Everyone in our family did not like her being there. We did not want her to think that we left her there. We all wanted her home, where we knew best how to take care of her, give her the traditional foods that she knows and likes to eat. The comments that came from my nephew and niece, observations from that experience and that setting, were that there were so many of the other elders that had no visitors, and were so lonely for human contact and recognition. It was hard on them to see that.

They wanted Nana home, where she belongs, and as soon as possible. Our mother is strong, and she is still with us. We could not be happier about that.

Kathleen Marquart, PA-C, is a very respected Indian health care practitioner, well known throughout Indian country. She shares this account with us of Nana, her mother, from a personal perspective rather than a clinical one.

American Indian and Alaska Native Long Term Care: Challenges and Opportunities

Bruce Finke, MD, Coordinator, IHS Elder Care Initiative, Northampton, Massachusetts

"Long-term care is a set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity."[1] American Indian and Alaska Native communities have always had systems of long term care (LTC) based on family and extended family relationships. These traditional systems are increasingly under stress from cultural and demographic changes, and are widely felt to be inadequate for the needs that exist. Across Indian country, tribal and urban programs are in various stages of developing LTC systems and services for elders and younger individuals with disability.

"Creating a system of long term care that keeps culture in it can be done, *but only with real intent and unflagging commitment.*"[2] The focus of planning and program development in LTC is at the tribal and community level. Only in this way will formal LTC systems or services be developed with an awareness of and sensitivity to traditional LTC systems. The types of services and the manner in which formal LTC services are implemented can have a profound effect on the cultural health of a community.

It is easier to build than to maintain formal systems for long term care. The ongoing costs of service delivery far outstrip the initial cost of facility or program development. It is clear that home and community-based services are the core around which a formal LTC system should be established. Facility-based care (especially nursing home) is more costly, more restrictive to personal freedom, and disruptive to the traditional LTC system we hope to support. Essential components of home and community-based LTC include acute and chronic medical care, adequate and accessible housing, activities of daily living support, transportation, elder day programs, and case management (including a robust social services capability).

Resources for formal LTC development come from disparate sources. The Administration on Aging (AoA) is the lead federal agency for aging. In the past, the focus of the AoA has been to develop social and nutritional services for the elderly, as well as provide information and assistance to elders in need of resources. The programs built with this effort have been termed the "Aging Network." In more recent years, AoA funding has provided for family caregiver support and efforts to "rebalance" the nation's long term care resources toward more home and community based care.

In Indian country, AoA funds tribal Title VI programs and the Family Caregiver Support Programs. Additional funding to Indian country comes from AoA through the State and Area Agencies on Aging. Medicaid (the federal-state partnership that provides health care to eligible low-income Americans) pays for the majority of LTC services in this country. While the institutional LTC benefit (reimbursing nursing home care) is fairly standard, support for home and community based services is quite uneven among the states. The Veterans Health Administration (VHA) provides LTC services to eligible veterans.

Resources for LTC system development come from many other federal agencies as well, in the form of loans and grants for facility construction, training, and transportation. Special note should be made of the involvement of the Administration for Native Americans (ANA) this past year in funding the development of reimbursable long term care services (in collaboration with an IHS grant program). The challenge at the local level is to take disparate funding streams and programs and construct an integrated, comprehensive system of care at the community level. Many tribes are doing just that.

Comprehensive long term care is not part of the package of health care services the IHS is funded to provide. At the same time, current IHS programs and services include many components of long term care. The degree to which IHS funding resources are used to support the care of frail elders living in the community depends on local priorities and capacity. It requires a decision by the local clinic, hospital, or service unit to devote time and resources to meeting the unmet needs of their elders. A great deal depends on the willingness of local leadership to make that decision. We must make a determined effort to integrate health care into the systems of long term care developing in Indian country if we are to avoid recreating the flawed, disconnected system that prevails outside of Indian country. Many tribal and IHS clinics and hospitals are doing just that.

"It is clear that urban Indians will have need for long term health care as they age. The ability to incorporate long term care services into urban Indian health programs is not defined."[3] A number of urban programs are actively exploring their role in providing LTC services to the growing urban elder population in an effort to define both the need and their capacity to meet that need.

Long term care for American Indian and Alaska Native elders is changing and evolving, and both the opportunities and challenges are great. Working as communities, we can build formal systems of long term care that respect and complement traditional patterns of care, integrate health care, and provide support that makes it possible for elders to continue to play a vital role in the lives of their families and communities.

References

1. Kane RA, Kane RL. Long-term Care: Principles, Programs, and Policies. New York, NY:Springer,1987.
2. Henderson JN. How do we understand and incorporate elders' teaching and tribal values in planning a long term care system? in *American Indian and Alaska Native Roundtable on Long Term Care: Final Report 2002*.
3. Foquera R. How do we address the long term care needs of urban Indian elders? ibid.

Grants for Services for the Elderly Awarded

In September 2003, the Indian Health Service awarded 20 grants for a total of 1 million dollars per year for three years to tribes, tribal consortia, and urban programs for the development of reimbursement-based or otherwise sustainable long term care services for the elderly. The Administration for Native Americans (ANA) joined the IHS in this grant program, providing funding for 6 of the 20 grants.

Successful applications included plans to develop personal care services for the elderly, respite care, elder day health, elder housing, and reimbursable case-management services. Tribes and Indian communities developed these projects to meet the long term care needs of their elders. They are designed to be self-supporting through reimbursement or other mechanisms within the three-year life of the grant. Sixty applications were received, for nearly 3 million dollars in requests. All of the grant awards were for between $30,000 and $50,000 per year for up to three years.

Viewed from the health care perspective, these grants are a critical investment in desperately needed services for American Indian and Alaska Native elderly. Viewed from the economic development perspective, they are a wise investment in the economies of these communities, providing seed money for economically viable ventures that will create jobs and opportunities in these communities.

Grants were awarded to the following tribes, tribal consortia, and urban programs:

Trenton Indian Service Unit
Pyramid Lake Paiute Tribe
Seattle Indian Health Board
Lac Du Flambeau Band of Lake Superior Chippewa
Indian Health Center of Santa Clara Valley
Citizen Potawatomi Nation
NW Washington Indian Health Board
Poarch Band of Creek Indians
Eastern Shoshone Tribe
Aleutian/Pribilof Islands Association, Inc.
Port Gamble S'Klallam Tribe
Native American Community Health Center, Inc.
Inter-Tribal Council of California, Inc.
Inter Tribal Council of Arizona, Inc.
Lummi Indian Business Council
Pokagon Band of Potawatomi Indians
Indian Health Council, Inc.
Ute Indian Tribe
Pueblo of Isleta
Kaw Nation of Oklahoma

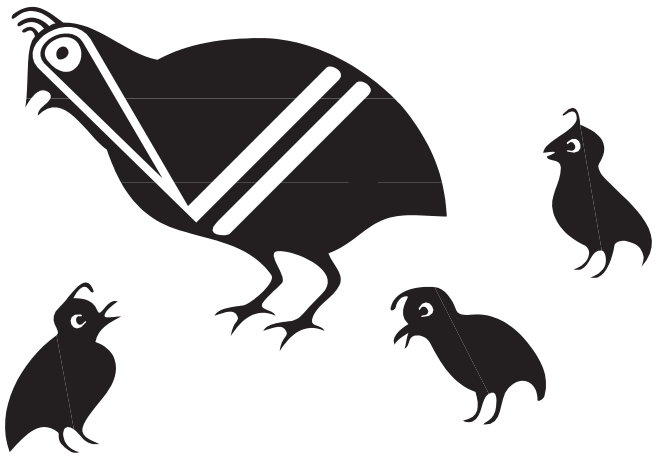
A New Website for Elders and Those Serving Them

A website has been established by the Administration on Aging (AoA), through its contractor Kauffman & Associates, Inc., to provide a broad array of federal and other relevant information and alerts to American Indian, Alaskan Native, and Native Hawaiian programs serving Native elders. It can be found at *www.olderindians.org*.

The information provided addresses services, research data, and policies important to the lives of elders and their families. The site provides quick links to funding opportunities, Title VI news, and relevant news, reports, and alerts from AoA and other agencies.

The "Spirit of Elders," a Title VI training and technical assistance newsletter, is included on the website. This newsletter provides current information on activities at the Administration on Aging, including Tribal Listening Sessions and training conferences. It also highlights successful programs in Indian country. The January 2004 issue highlighted the Muscogee Creek Elderly Nutrition Program, and in April 2004, the focus was on the Fort Belknap Community Transportation System.

The website also provides data and information from other departments and agencies that comprise the Federal Interagency Task Force on Older Indians. This Task Force makes recommendations to the Assistant Secretary for Aging on ways to improve interagency collaboration, enhance services, and identify problems or barriers that prevent or diminish collaboration. Currently, the membership of the Task Force and member agency profiles are on the website. Future additions will include Task Force reports and data from member agencies.



Know your Palliative Care Emergencies

The following article is another in an ongoing series in support of the development of a unified approach to palliative care services for American Indians and Alaska Natives. The series consists of brief, concise facts and information for providers of palliative care.

Judith A. Kitzes, MD, MPH, Soros Foundation, Project on Death In America Faculty Scholar, University of New Mexico Health Science Center, School of Medicine, Albuquerque, New Mexico

Quickly respond to relieve suffering in patients and families

Like in other acute emergencies, health care professionals need to respond quickly to palliative care emergencies by maintaining a high index of suspicion. Palliative care management options depend on whether prognosis is long or short, and focus on preserving function and quality of life.

Common

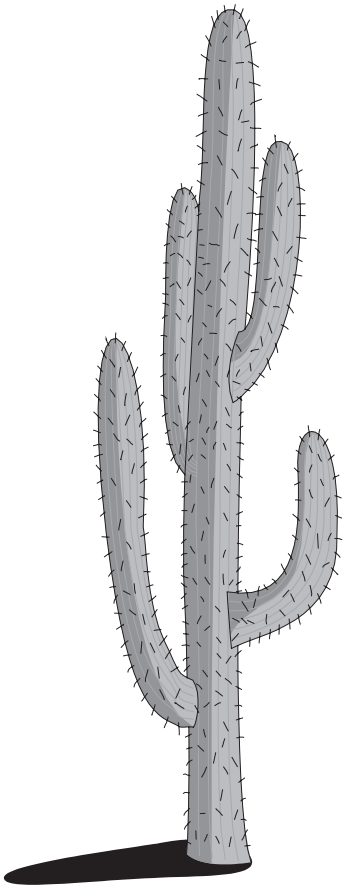
Refractory, Severe Pain: broad category of disease progression
Seizures: common with cerebral tumors, meningeal involvement; less with infection, drug toxicity/withdrawal, metabolic processes, intracerebral hemorrhages
Intractable Nausea/Vomiting: CNS disease, hepatic failure, renal failure, bowel obstruction, gastric disease, constipation, opioids, hypercalcemia, hyponatremia, chemotherapy, or radiation therapy
Delirium: hypercalcemia, dehydration; psychotropic drugs; lung, heart, kidney, or liver failure; imminent death

Oncological

Hypercalcemia: metastatic bone lesions, parathyroid hormone-like peptide
Spinal Cord Compression: 5% of patients; treatment can prevent paralysis and incontinence
Superior Vena Cava Syndrome: Primary and metastatic lung cancers, lymphomas
Urinary Obstruction: pelvic tumors (cervix, prostate)
Acute Bowel Obstruction: 3-15% of end-stage cancer (colorectal, ovarian, prostate, uterine, gastric, mesothelial), IBD, fecal impactions, opioid induced, severe constipation.
Cardiac Tampanade: Lung/mediastinum tumors (lung, breast, lymphomas, leukemias)
Massive Hemorrhage: head and neck tumors infiltrate large vessels

Management Reference

American Academy Of Hospice and Palliative Medicine, Pocket Guide to Hospice and Palliative Medicine, 2003; *www.aahpm.org*.



Notes from the Elder Care Initiative

Bruce Finke, MD, Coordinator, IHS Eldere Care Initiative, Northamptom, Massachusetts

Excellent Geriatric Training Opportunity Available

On September 29 - October 2, 2004, the 21st Annual UCLA Intensive Course in Geriatric Medicine and Board Review will be held in Marina del Rey, California. This is a very good, comprehensive review with faculty who are national leaders in geriatrics. This is the perfect course for a primary care clinician willing to serve as the local geriatrics consultant or interested in developing specialty services for elders. A discounted registration fee is offered to Indian health providers. To register, contact Catarina deCarvalho at *CdeCarvalho@mednet.ucla.edu*, or Bruce Finke at *bruce.finke@mail.ihs.gov*.

The evidence-based elder periodic exam was the topic for the February Primary Care Listserv Discussion. The full discussion is captured at *www.ihs.gov/MedicalPrograms/MCH/M/PCForum_docs/ExamElderDiscussion41004.doc*. The discussion summary is at *www.ihs.gov/MedicalPrograms/MCH/M/PCForum_docs/ElderSummary41004.doc*.

From the Literature

A large (15,000) cohort of men and women recruited from primary care practices as part of a cancer epidemiology study had heel ultrasound measurements performed with a mean follow-up of 1.9 years. Fractures were ascertained from admission data (missing less serious fractures and many vertebral fractures). Men and women in the lowest 10% of the cohort (as measured by broadband ultrasound attenuation, BUA) had over 4 times the risk of fracture over the study period as men and women in the highest 30% (RR 4.44, 95% CI 2.24 - 8.89). The lowest 10% BUA was roughly equivalent to 2.0 SD below the mean at age 45 in men and 1.5% below the mean at age 45 in women. Ultrasound prediction of fracture risk was independent of clinical risk factors and had the same power of prediction in older and younger persons and in men and women. Bone density as measured by heel ultrasound is a continuous variable. Every 1 SD decrease in BUA was associated with a doubling of the risk of fracture (RR 1.95, 95% CI 1.50B2.52).

This study adds to the evidence (Siris, et al) that ultrasound bone assessment is a reliable predictor of fracture risk. Ultrasound is an accessible modality for many Indian health facilities, but treatment trials have all been based on the more expensive and less accessible DEXA modality. It is also one of the few large studies to look at prospective bone health data and fracture risk in men. The authors point out that a population-based approach to bone health (through ensuring adequate calcium and vitamin D intake and regular physical activity) has the potential to increase bone density (as measured by heel ultrasound or DEXA) and thus reduce the rate of fracture.

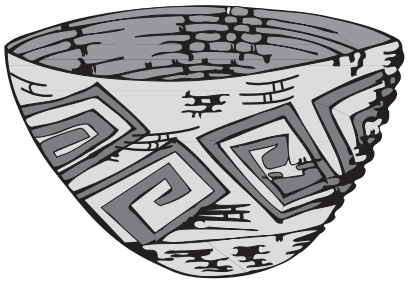
Kaws K-T et al. Prediction of total and hip fracture risk in men and women by quantitative ultrasound of the calcaneous: EPPIC-Norfolk prospective population study. *Lancet* 2004 Jan17; 363:197-202.

Siris ES, et al. Identification and fracture outcomes of undiagnosed low bone mineral density in postmenopausal women; results from the National Osteoporosis Risk Assessment. *JAMA* 2001. 286(22): 2815-2822.

Conferences and Training Opportunities

There are still scholarships available for the Geriatric Summer Institute in Albuquerque June 17 - 19 (The Elder In Crisis: Managing Geriatric Emergencies). Scholarships are available for Indian health professionals. There is a CHR track also. For information, contact Darlene Franklin by telephone at (505) 272-4934; e-mail *dfranlkin@salud.unm.edu*.

Prevention in Native Women, August 4 - 6, 2004 in Albuquerque, New Mexico, includes the topics of Preventive Care for Older Women and Osteoporosis. If you care for Native American women of any age, then you should attend if you are a physician, advanced practice nurse, physician assistant, or nurse. Information is available at *www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004*.



Basics of Automated Drug Ordering Systems

Stewart Jorgensen, RPh, Greater Leech Lake Service Unit, Cass Lake, Minnesota

The new trend in the management of ordering pharmaceuticals is automated systems. Software systems will keep track of your pharmacy medication inventory and order needed medications when the supply is below the minimum level set by the pharmacy. These systems will increase the inventory for each drug item ordered in and decrease the drug inventory for each item dispensed. The following brief description is based on our experience with the Viking Computer Services JITI system.[1]

Setup

There are two methods for setup for the automated ordering systems. Both methods benefit greatly from the use of scanners. Scanners can be a huge time saver, since rather than typing in names or NDC numbers, the drug's bar codes can be scanned in. Both methods will require you to set maximum and minimum levels for each individual drug, based on usage and storage space. Beware of where you set the levels, because the minimum and maximum are trigger points in the software and not exact levels.

For example, let's say drug X has a minimum level set at 350 tablets and a maximum level set at 1350 tablets, and drug X is purchased in bottles of 1000 tablets. Now, the system software is set up to trigger a reorder when the inventory for drug X is at or below 350 tablets, but the actual order is not generated until after you direct the system to compile the orders for the entire pharmacy, usually at the end of the day. If the inventory of drug X at the order time is 350 tablets, the system will order one bottle of 1000 tablets, but if the inventory is at 349 or below, the systems are set up to order two bottles of 1000 tablets. The software is set up to order enough tablets to meet or exceed the maximum, to the next whole order unit.

The first method for initiating the system is the "all at once" method, whereby the entire drug inventory is scanned in and minimums and maximums are established for all drugs at one time; this will usually require several people and several days to accomplish. The advantage is that you will have accomplished a one-time, total change in your drug ordering system.

The second method for run up is the "staged" method, whereby you divide the pharmacy in to sections and scan in each section one at a time. For example you may only scan in drugs from the eyes and ears section, drugs from your Scriptpro, or refrigeration items, adding sections until the entire inventory from the pharmacy is scanned in. This method allows the pharmacy staff to scan the drug items in over several days or weeks and gives the staff a chance to get familiar with the software and how it works at a slower pace. It keeps problems small and makes it easier to make any adjustments when needed.

Implementation

The software is programmed to create an order on the pharmacy's command (usually at the end of the day). This will prepare an order of all drugs that have reached their minimums and order enough to meet or exceed the maximum amounts. The order then can be viewed, and any adjustments to the order can be made before sending the order to the wholesaler.

The software for receipt of an order is similar. When the order is received, the contents are compared to the invoice from the wholesaler, and any adjustments for shortages, outages, and mispicks can be made. After the adjustments are made in the sent order, you convert the sent order to a received order and the inventory for each item on the order is increased.

Problems

- Drugs taken for night cabinets and after hours prepacks will not be subtracted from the automated inventory until dispensed and run through the computer system, but the drug will not be available from the physical pharmacy drug inventory.
- Staff must account for lost, spilled, and expired drugs.
- A change in a drug brand requires you to delete the old brand and add the new brand.
- All items must be run through the computer system to correctly adjust the inventory.
- Adjustments must be made for seasonal items, adjusting the reorder amounts and reorder point at different times of year.

Summary

An automated order system can be used to provide for more consistent inventory control with less daily monitoring by the pharmacy dispensing staff. It is especially useful in situations of low or TDY staffing, but a greater amount of planning is required in facilities supplying multiple stock locations, as might be found in hospitals or those supplying outlying clinics.

Reference

Viking Computer Services Just In Time Inventory (JITI) System Manual

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@tcimic.ihs.gov.

IHS Child Health Notes

Articles of Interest: Routine Tests in Bronchiolitis

Concurrent serious bacterial infections in 2396 infants and children hospitalized with respiratory syncytial virus lower respiratory tract infections. *Arch Pediatr Adolesc Med*. 2002 Apr;156(4):322-4. *www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&li st_uids=11929363&itool=iconabstrPMID: 11929363*

- Reviewed records over 7 respiratory seasons
- No positive CSF cultures
- 12 positive blood cultures but all were contaminants
- 1% had positive urine cultures

Concurrent serious bacterial infections in 912 infants and children hospitalized for treatment of respiratory syncytial virus lower respiratory tract infection. *The Pediatric Infectious Disease Journal*. Volume 23(3) March 2004 pp 267-269.

- Same author as in first study, but now 900 more patients with bronchiolitis from 2000-2002
- No positive CSF cultures, 3 positive blood cultures (0.4%) but 10% positive urine cultures
- No infants under 90 days with positive blood or CSF cultures

Diagnosis and testing in bronchiolitis: a systematic review. *Arch Pediatr Adolesc Med*. 2004 Feb;158(2):119-26. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstr act&list_uids=14757603&itool=iconabstr*.

- Rapid RSV testing is accurate but does not change treatment
- CXR cannot reliably distinguish between viral and bacterial disease
- CBC counts did not affect treatment or distinguish viral from bacterial disease

Editorial Comment

Never has so much testing been done to so many with so little benefit as in bronchiolitis. The first two articles confirm what many have suspected. If you have a clinical presentation of bronchiolitis with rhinorrhea and wheezing, your risk of having a serious bacterial illness is almost zero. The presence of fever, even in an infant less than 3 months old, does not mean CSF and blood cultures need to be obtained if the child looks well and has symptoms consistent with bronchiolitis. Interestingly, the studies had widely varying results for urinary tract infections, from 1% to 10%. Other studies reviewed have confirmed the low risk of meningitis or sepsis in bronchiolitis, and most have had positive urine cultures in the 1-5% range, which is probably consistent with asymptomatic bacteriuria rates in females.

Similarly, the third study shows that the frequent use or RSV tests, CBCs, and chest x-rays adds nothing to diagnosis or therapy in clinical bronchiolitis.

A reasonable approach is to recognize that the presence of wheezing in a young child in winter is most consistent with bronchiolitis. Routine sepsis work-up is not needed in a febrile infant with bronchiolitis less than 3 months unless they appear unusually ill. A chest x- ray is not needed unless there is a concern about atelectasis. A routine CBC is not needed. If any test should be done, it might be a urinalysis, recognizing that positive results may represent the background asymptomatic bactiuria rate in females. Rapid RSV testing is not needed unless it will stop you from giving unneeded antibiotics.

Recent literature on American Indian/Alaskan Native Health

Health service access, use, and insurance coverage among American Indians/Alaska Natives and Whites: what role does the Indian Health Service play? *Am J Public Health*. 2004 Jan;94(1):53-9. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstr act&list_uids=14713698&itool=iconabstr*.

- Federal funding does not cover all services needed for AI/AN, but AI/AN had better measures of preventive care and access to care than other impoverished populations

Delivering equitable care: comparing preventive services in Manitoba. *Am J Public Health*. 2003 Dec;93(12):2086-92. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstr act&list_uids=14652339&itool=iconabstr*.

- Compared services for which there were established programs (immunizations and mammography) against cervical cancer screening for which there is not an established program. Established programs showed excellent numbers across all socio-economic and ethnic groups. Programs that were not established had much less success in poorer groups and Native Americans. This study demonstrates that it is

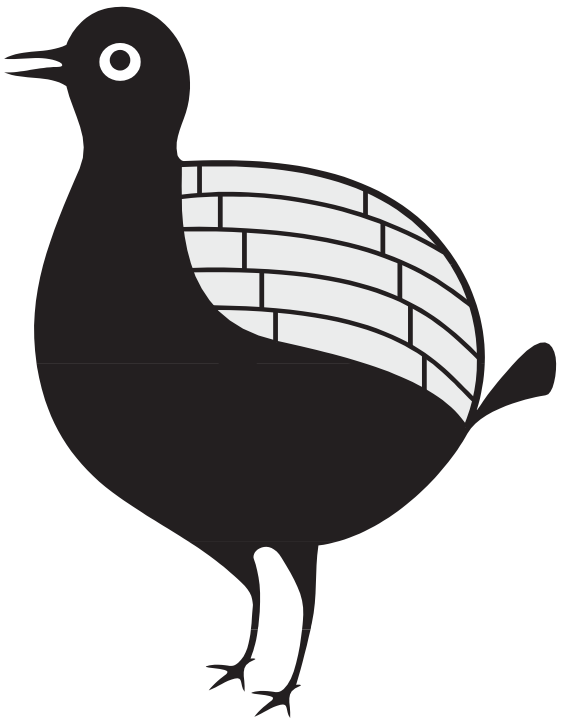
not enough to know that something is a standard – a program needs to be in place to insure the standard is met.

Rheumatic disease in Native American children: opportunities and challenges. *Curr Rheumatol Rep*. 2003 Dec;5(6):471-6. Review. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstr act&list_uids=14609493&itool=iconabstr*.

- Rheumatic diseases occur at 5 - 7 times the rate in Native Americans in the Midwest as compared to Caucasian populations. The authors' work with tribes in the northern Great Plains suggests that some of this increase may be familial and related to founder effects, something to keep an eye out for in all AI/AN. Is this increase in pediatric rheumatic illnesses seen in other tribal areas?

Meetings of Interest for Child Health

Biennial IHS Tribal and Urban (ITU) Meeting on Women's Health and Maternity Care, August 4 - 6, 2004 in Albuquerque, NM; go to *http://hsc.unm.educme*.



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 2, No. 4 , April 2004) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

News Flash

It's almost getting too late to sign up, but still available is the 2004 Biennial OB/GYN meeting: Prevention in Women's Health, August 4 - 6, 2004, in Albuquerque, New Mexico. Great continuing education, plus good networking for all providers of care for women/MCH. Contact Neil Murphy for questions at *nmurphy@anmc.org*, or go to *www.ihs.gov/Medical Programs/MCH/M/CN01.cfm#August2004*.

ACOG

Nausea and Vomiting of Pregnancy, ACOG Practice Bulletin No. 52. The following recommendations are based on good and consistent scientific evidence (Level A):

- Taking a multivitamin at the time of conception may decrease the severity of nausea and vomiting of pregnancy.
- Treatment of nausea and vomiting of pregnancy with vitamin B6 or vitamin B6 plus doxylamine is safe and effective and should be considered first-line pharmacotherapy.
- In patients with hyperemesis gravidarum who also have suppressed thyroid- stimulating hormone levels, treatment of hyperthyroidism should not be undertaken without evidence of intrinsic thyroid disease (including goiter and/or thyroid autoantibodies).

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Treatment of nausea and vomiting of pregnancy with ginger has shown beneficial effects and can be considered as a nonpharmacologic option.
- In refractory cases of nausea and vomiting of pregnancy, the following medications have been shown to be safe and efficacious in pregnancy: antihistamine H1 receptor blockers, phenothiazines, and benzamides.
- Early treatment of nausea and vomiting of pregnancy is recommended to prevent progression to hyperemesis gravidarum.
- Treatment of severe nausea and vomiting of pregnancy or hyperemesis gravidarum with methylprednisolone may be efficacious in refractory cases; however, the risk profile of methylprednisolone suggests it should be a treatment of last resort.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Intravenous hydration should be used for the patient who cannot tolerate oral liquids for a prolonged period or if clinical signs of dehydration are present. Correction of ketosis and vitamin deficiency should be strongly considered. Dextrose and vitamins, especially thiamine, should be included in the therapy when prolonged vomiting is present.
- Enteral or parenteral nutrition should be initiated for any patient who cannot maintain her weight because of vomiting.

Reference

Nausea and vomiting of pregnancy. ACOG Practice Bulletin No. 52. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2004;103:803-15.

From George Gilson, Anchorage

Thyroid Disorders in Pregnancy: a new Perinatology Corner learning module is available.

S. N. is a 27 year-old G5P3 at 10 weeks gestation who is complaining of severe nausea and vomiting. She is sent to you for consultation by an outlying facility. Physical examination is unremarkable. Liver functions, electrolytes, and thyroid functions are drawn and are reported as follows: TSH: 0.01 mIU/mL (nl: 0.46-4.68); Free T4: 2.01 ng/dL (nl: 0.78-2.19); ALT/AST: within normal limits; electrolyte panel: within normal limits, except K = 3.1 mEq/L.

Should you take any action? What would be most appropriate?

S. N. returns post partum. The patient returns to see you postpartum, referred for a tubal sterilization procedure. You repeat her thyroid functions and they return as follows: TSH: 5.18 mIU/mL (nl: 0.46-4.68); Free T4: 0.53 ng/dL (nl: 0.78-2.19). Should you take any action? What would be most appropriate?

Would you like the answers to these questions? A free CEU/CME module is available at *http://www.ihs.gov/MedicalPrograms/MCH/M/THYR01.cfm.*

From Janet Mehring, Anchorage

Teenage pregnancy prevention: what resources are available to manage and/or prevent teenage pregnancy in the Indian health system? Here are some examples from Alaska (*www.ihs.gov/MedicalPrograms/MCH/M/faqdnlds/AlaskaTeenPregnancy31404.doc*); Phoenix/Sells, and several other resources (*www.ihs.gov/MedicalPrograms/MCH/M/faqdnlds/OtherResTeenagePreg32704.doc*). Do you know of any other successful programs to decrease teenage pregnancy in Indian country? Contact Janet Mehring at *janetruth196@email.uophx.edu*, or Neil Murphy.

Hot Topics:

Obstetrics

Visual dipstick urinalysis at the 1+ (30 mg/dL) threshold not reliable. Conclusion: The accuracy of dipstick urinalysis with a 1+ threshold in the prediction of significant proteinuria is poor and therefore of limited usefulness to the clinician. Accuracy may be improved at higher thresholds (greater than 1+ proteinuria), but available data are sparse and of poor methodological quality. Therefore, it is not possible to make meaningful inferences about accuracy at higher urine dipstick thresholds. There is an urgent need for research in this area of common obstetric practice. Waugh JJ, Clark TJ, Divakaran TG, Khan KS, Kilby MD. Accuracy of urinalysis dipstick techniques in predicting significant proteinuria in pregnancy. *Obstet Gynecol.* 2004 Apr;103(4):769-77.*http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=15051572&dopt=Abstract*.

OB/GYN CCC Editorial Comment

The dipstick urine has no use in screening routine prenatal patients. On the other hand, once a patient has shown signs of pre-eclampsia, e.g., BP > 140/90, or symptoms, then urine testing should be performed.

Gynecology

Gynecology in Native Women: an IHS biennial meeting featuring internationally known faculty. The Biennial Women's Health meeting will be held August 4 - 6, 2004 in Albuquerque, New Mexico. The theme is "Prevention in Native Women," but it will include many others topics, as well. If your facility cares for Native women of any age, then you should attend if you are a physician, advanced practice nurse, physician assistant, or nurse. One of the featured speakers will be Lois Jovanovic, from the Samsum Diabetes Research Institute. Information is available at *www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004*.

OB/GYN CCC Editorial comment

This is arguably the best conference for those who care for Native American women. The target audience is clinical and opinion leaders from all facilities. Many are sending teams of physicians, midlevels, and nurses. There will be domestic violence and breastfeeding tracks. Many other topics will be covered including hormone replacement, diabetes in pregnancy, school-based care, elder care, incontinence, adolescent issues, and cardiovascular disease. CME/CEU available.

Frequently asked questions

Q. What is the clinical significance of endometrial cells found on Pap smears?

A. It is only significant in women over 40 years of age, and then an endometrial biopsy should be performed. *http://www.ihs.gov/MedicalPrograms/MCH/M/Faqdnlds/EndometrialCellPap31404.doc*.

Q. Can misoprostol be used in an outpatient setting? What is the cost-effectiveness for the use of cytotec or any other induction agents?

A. Misoprostol is more cost-effective than the comparable commercial agents. *http://www.ihs.gov/MedicalPrograms/MCH/M/faqdnlds/OutptMiso32704.doc*.

Q. Can we use Lispro in pregnancy?

A. Yes, we can use lispro in pregnancy. *http://www.ihs.gov/MedicalPrograms/MCH/M/faqdnlds/Lispro31304.doc*.

Evidence Based Periodic Exam in the Elderly Native Americans

Dr. Bruce Finke has presented a set of Guidelines for Preventive Care Services for the Elderly developed by an Indian health workgroup, which very closely follow the USPSTF guidelines for persons over 65 with some "expert opinion" recommendations added. See discussion at *www.ihs.gov/MedicalPrograms/MCH/M/PCForum_docs/ElderExamPrimer11604.doc*.See full text at *www.ihs.gov/MedicalPrograms/MCH/M/PCForum_docs/ExamElderlyDiscussion32004. doc*.

Osteoporosis summary from the above guidelines

1. Osteoporosis screening is clearly an "emerging issue" in the Indian health system, with clinicians and programs struggling with whether published guidelines should be applied to the AI/AN population and, if so, how?
2. Many of the discussants were uncomfortable with the lack of AI/AN-specific data on which to base decisions. While there are some limited data suggesting that self-identified Native American women may be at the same risk as Caucasian women, the heterogeneity of the AI/AN population makes generalizations difficult. As is often the case in AI/AN health, we are forced to make judgments about implementing guidelines not based in our specific practice settings. Two sites that

have initiated more comprehensive screening (one with DEXA, another with heel ultrasound) reported that they are seeing significant numbers of women with T-scores < -2.5.

3. Access to screening is problematic for many sites, with geographic barriers to DEXA scanning figuring prominently. Some discussants have had difficulty with the financial implications of a widespread screening effort. Others felt that the USPSTF recommendation for screening should set the standard of care.
4. There was a great deal of discussion about modalities of screening. DEXA represents the "gold standard" but presents access problems. Several sites are using heel ultrasound as a primary screening approach. They argued that the data for heel ultrasound, although limited, show ultrasound to be a good predictor of fracture rate and that a screening program based on heel ultrasound can improve access to treatment for those at highest risk. Others do not believe that the evidence supports the use of ultrasound. We were reminded that our goal is to prevent fractures, and that fracture rates are the real gold standard.
5. Diabetes is reported as a risk factor for osteoporosis. This, of course, has significant implications for our population.
6. Several sites reported routinely offering calcium carbonate and a multivitamin containing vitamin D to all older persons.
7. In many ways this robust and lively discussion gets to the heart of what we are trying to do in the Indian health system: provide high quality, evidence- based health care within the framework of a strong public health model.

Primary Care Discussion Forum: Adult Asthma

On August 1, 2004, thanks to Charles (Ty) Reidhead, from Whiteriver, Arizona, we will hold an Adult Asthma Discussion. Ty is the IHS Internal Medicine CCC.

The discussion forum provides an e-mail listserv-based discussion moderated by national leaders in a particular field. The discussion is captured and summarized online, here at *www.ihs.gov/MedicalPrograms/MCH/M/PCdiscForum.asp*. To subscribe, go the site below and click the word 'subscribe' in the first paragraph *www.ihs.gov/MedicalPrograms/MCH/M/MCHdiscuss.asp*

Other Contents, April 2004

Abstract of the Month

Singleton Vaginal Breech Delivery at Term: Still a Safe Option

From your colleagues

From Barbara Fine: 2004 National Women's Health Week celebration, May 9-15, 2004

From Bill Green: Indian Health - Special Interest Group Forum Now Available online

From Steve Holve: IHS Child Health Notes: New service from Pediatric CCC

From Ursula Knoki-Wilson: Keeping the sacred in child-birth practices

From Deborah Lessmeier: Patient at 4-6 weeks gestation with a varicella like rash?

From Judy Thierry: School based care; Distance Learning Certificate in MCH Epidemiology: Fellowships; Online Alcohol Screening; Funds for HIV and Prevention Services Into Reproductive Health and Community Settings; Do you live in a state with a primary seat belt law?

From Judy Ungerleider: Value of the total protein to creatinine ratio in pre-eclampsia?

Hot Topics:

Obstetrics

Safety of Vaginal Birth After Cesarean; Subdural hemorrhages not uncommon in full-term infants; Mediolateral episiotomy: worse pelvic floor function, incontinence, and prolapse; Vegetarian diet in pregnancy raises risk of false-positive Down syndrome screen; Use of ginger in early pregnancy will reduce their symptoms; Parental attitudes about a pregnancy predict birth weight in a low-income population; Predictors of Cesarean Delivery for the Second Twin in Vaginal Delivery of the First Twin; Can Biophysical Profiles in Labor Predict C-Section? Normal Control in Pregnant Women with Hypothyroidism; Benefits of Incomplete Courses of Antenatal Corticosteroids; Effects of Automobile Crashes Occurring During Pregnancy.

Gynecology

Single 1.5 mg levonorgestrel dose can substitute two 0.75 mg doses 12 h apart; Emergency Contraception Resources: Not-2-Late.com; Progestin only pills; Women often choose surgery after extended drug treatment of menorrhagia; 2 Randomized Trials on Menorrhagia Compare Medical Therapy With Hysterectomy; Managing Ovarian Cysts in Postmenopausal Women; High-Grade Squamous Intraepithelial Lesions: Abbreviating Post treatment Surveillance; 3 year screening is cost effective versus annual screening over 30 years; Effect of Oral Contraceptives on Functional Ovarian Cysts; Metabolic Abnormalities in Bulimia Nervosa; Can Women Self-Screen for Cervical Abnormalities? Diagnosing and Managing Endometriosis; Effects of Oral Contraceptive Use in Older Smokers; Extending the Interval between Pap Smears; Vaginal Delivery Affects Pelvic Organ Support

Child Health

Ending an Anti-tobacco Youth Campaign on Adolescent Susceptibility to Smoking; New Community Pediatrics Web Site Launched; FAS "Better Safe than Sorry"

Chronic Illness and Disease

Virtual colonoscopy sensitivity is low; Cigarette smoking, awareness of diabetes, binge drinking, drinking/driving and others; Smoking ban linked to drop in heart attacks; Type 2 diabetes linked to cognitive decline in women; Long- Term Sequelae of Breast Cancer Treatment; Exercise Testing as a Predictor of Mortality in Women; Asthma Surveillance and Epidemiology; Abortions do not raise breast cancer risk

Features

AFP: Cochrane For Clinicians: What Is the Best Collection Device for Screening Cervical Smears? Shoulder Dystocia Chapter updated

ACOG: ACOG supports universal care: Cover the Uninsured

AHRQ: Rural studies examine telecolposcopy for women with abnormal Pap smears

Breastfeeding: Breastfeeding Track at Biennial OB/GYN meeting in August 2004

Domestic Violence: Domestic Violence Track at Biennial OB/GYN meeting in August 2004; Take a Leadership Role in Combating Sexual Violence in US: Funding available

Elder Care News: Prevention in Native Women: IHS Biennial meeting in August 2004

Hormone Replacement Update: Nonhormonal alternatives for the treatment of hot flashes; Use of Ultra-Low-Dose Estrogen to Prevent Bone Loss; Transdermal Estrogen and Venous Thromboembolism; Breast Cancer Risk Related to Type of HRT

MCH Alert: Effectiveness of school-based suicide-prevention program evaluated

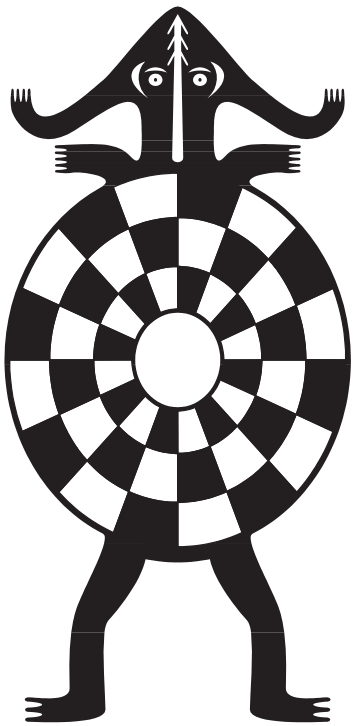
Medscape: Bisphosphonates in Osteoporosis: Emerging Science Endometriosis and Infertility Opioid Analgesia: Practical Treatment of the Patient with Chronic Pain:

Office of Women's Health, CDC: First rapid HIV test approved for use with oral fluid

Osteoporosis: Osteoporosis in American Indian/Alaska Native Women, 2004 Early Discontinuation of Osteoporosis Treatment

Patient Education: Eating Disorders; Anorexia Nervosa; Sports and Women Athletes: The Female Athlete Triad

What's new on the ITU MCH web pages: Thyroid Disorders in Pregnancy, New Perinatology Corner Module — Free CEU /CME



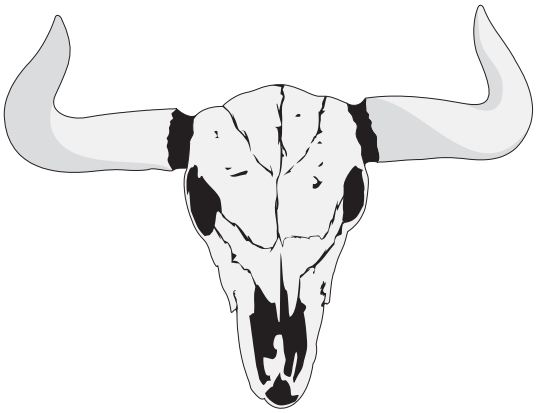
CSC Reaccredited by ANCC for Six Years

The Indian Health Service Clinical Support Center (CSC) is pleased to announce that it has received another six-year reaccreditation as a provider of continuing nursing education from the American Nurses Credentialing Center (ANCC). The accreditation site survey, held December 3, 2003 at CSC, included an opening conference and interviews with administrators, nurse planners, and support staff to review the written application and self-study report; a review of documents and records, policies and procedures, evaluation data, and meeting minutes; and a tour of the CSC's Office of Continuing Education (OCE). Telephone interviews were conducted with CE planners, participants, and selected faculty from the I/T/U settings. The survey appraisers worked closely with the OCE to amplify, clarify, and verify adherence to criteria through information presented in the written application materials and to identify strengths and any areas of concern. Following the visit, the appraiser team submitted a report to the ANCC Accreditation Program for its final accreditation decision. In April 2004, OCE was notified of ANCC's decision for reaccreditation for the period February 20, 2004 to February 28, 2010. The CSC has been accredited by ANCC since February 1992.

During the exit interview, the survey appraisers highly praised the organization's CE sponsorship manual available on the IHS website, noting that it was easily accessible and user-friendly as a guide in the development of quality continuing education programs. CSC was also commended for its system-wide process to meet the CE needs for Indian health providers across the country and they expressed the thought that it could be a model for other accredited providers. The OCE reviews and awards professional continuing education credits for more than 200 activities, programs, workshops, and conferences annually.

The Mission of the IHS Clinical Support Center is to serve Indian health program providers through education, communication, and special initiatives. The Mission of the OCE is to develop and support continuing education activities that meet the needs of Indian Health Service, tribal, and urban Indian health care providers (primarily, but not exclusively, nurses, physicians, physician assistants, and pharmacists) throughout the United States. CSC recognizes that continuing education for nurses is essential to the promotion and enhancement of health and the prevention of disease. The office is committed to providing nursing professionals the assurance that they receive quality continuing education activities as prescribed by ANCC's rigorous accreditation process.

CSC is also nationally accredited by the Accreditation Council for Continuing Medical Education through 2005, and the American Council of Pharmaceutical Education through 2006.



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THE IHS PRIMARY CARE PROVIDER

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

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

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.

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

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