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Indian Country: Get Yourself Talking, Get Yourself Tested! Presenting the 2010 GYTNOW Campaign



April is STD Awareness Month. This is a special issue of *The IHS Primary Care Provider* devoted to STD screening, prevention, and treatment, with an emphasis on screening in American Indian and Alaska Native youths.

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Of the approximately 19 million new sexually transmitted diseases (STDs) that occur every year in the US, almost half will be among people 15 to 24 years old, and many will go undiagnosed. Because STDs often have no symptoms, many who are infected don't know it. High rates of STDs can cause severe health consequences for women. If left untreated, 10 to 20 percent of chlamydia and gonorrhea infections can result in pelvic inflammatory disease (PID) – a condition that may result in long-term complications such as chronic pelvic pain, ectopic pregnancy, and infertility. Furthermore, untreated STDs are estimated to cause at least 24,000 women in America to become infertile each year. Lack of information and fear of talking about sex with partners and health care providers keep many people from getting tested and treated.

Although race and ethnicity are not, by themselves, risk factors for getting an STD, American Indian and Alaskan Native (AI/AN) people are disproportionately impacted by high rates of several STDs, including chlamydia, gonorrhea, primary and secondary syphilis, and HIV/AIDS. According to 2008 national STD surveillance data, AI/AN have chlamydia at rates 4.7 times higher than whites, and gonorrhea at rates 3.6 times higher than whites.¹ Moreover, AI/AN in 2005 ranked

third in rates of HIV/AIDS diagnosis, after blacks and Hispanics.²

In response to these high rates of STDs, the Centers for Disease Control and Prevention (CDC) and the Indian Health Services (IHS) are extending an ongoing partnership with MTV Networks, the Kaiser Family Foundation, and Planned Parenthood Foundation to help young people make responsible decisions about their sexual health. This partnership is committed to teaching youth how to talk about sex with their partners, parents, and health care providers, including where to go to get tested and treated for STDs.

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The Campaign

The GYT, or Get Yourself Tested, campaign was conceived to create a social movement around getting tested for STDs. The GYT campaign aims to remove the taboos surrounding STD testing through the involvement of music and celebrity talent, and special promotions hosted on MTV Networks. This year GYT will focus on “get yourself talking,” as well as “get yourself tested.” The goal of GYT’s expanded message is to encourage conversations among young people and between them and their sex partners, parents, and providers. The campaign will launch in April 2010, in conjunction with National STD Testing Month. The campaign will continue throughout the year, with new, quarterly, creative material updates and offerings.

The IHS National STD Program, in collaboration with the CDC and other partners, will support this year’s campaign through its efforts to expand and promote the initiative’s reach across Indian Country. The IHS will collaborate with tribal and urban Indian health programs (I/T/U) to disseminate campaign marketing materials, increase access to STD/HIV screening and treatment services, and encourage open discussions with youth regarding sexual risk taking behaviors and responsible decision making.

The Campaign/Initiative

This year’s national campaign will incorporate a number of new focuses including:

- An expanded focus on targeting messages to young people who may be uncomfortable or uncertain about asking providers for sexual health services or talking to their partners or friends about testing for STDs
- Online resources for both patients and providers to support and encourage conversations about sexual health
- Digital tool kits containing the art, promotional pieces, and other aspects of the campaign that can be customized, downloaded, and printed
- An extended effort to reach out to college campuses (including tribal colleges and universities [TCU])
- Online resources to help evaluate the effect of campaign activities on local programs
- Rebranding websites and messaging with the new campaign slogans and art work (see <http://www.gytnow.org>)

In addition to supporting the campaign’s broad initiatives, the IHS National STD Program, and its partners throughout Indian Country, will work to compliment and further extend the campaign’s reach to AI/AN communities. The IHS National STD Program will increase campaign awareness, promote screening and treatment services, empower community participation, and strengthen advocacy for AI/AN-specific STD/HIV prevention activities by:

- Partnering with I/T/U to promote and offer STD screening and treatment services, including HIV testing
- Reaching out to TCUs
- Promoting GTYNOW in AI/AN-focused media
- Developing an AI/AN-specific widget to locate clinics where STD tests can be performed. This widget is free for download at <http://www.cdcnpin.org/stdawareness>
- Promoting collaborative screening events with state and local health departments. If an I/T/U or tribal entity is interested in partnering with a state or local program to host a screening event, refer to the directory for contact information for those programs at <http://www.cdcnpin.org/stdawareness/directory.htm>

Testing for chlamydia and gonorrhea, two of the most common STDs affecting AI/AN communities, is easier than ever before, with many clinics now offering urine-based tests. Also, rapid HIV tests can provide results in approximately 20 minutes, simply by swabbing the inside of the mouth. Early diagnosis and treatment of STDs is critical to maintaining the health of many young AI/AN people. Fostering a sense of sexual responsibility and encouraging dialogue with partners and health care providers is a necessary first step toward addressing the wider issue of STDs among AI/AN.

The IHS STD Program is urging programs to “get yourself talking” about STDs with colleagues and community partners. IHS STD Program is also asking stakeholders to widely distribute materials encouraging participation in the GYT campaign during April and throughout the year.

The IHS STD Program welcomes and values the participation and support of I/T/U programs in the GYT campaign, and hopes that these campaign materials will generate local demand for screening of STDs, increase community awareness, and create momentum to help further STD/HIV prevention efforts among AI/AN.

For more information about the GYT campaign, visit www.GYTNOW.org. For more information about the IHS National STD Program, contact Scott Tulloch by e-mail at scott.tulloch@ihs.gov; telephone (505) 248-4344.

References

1. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2008*. Atlanta, GA: U.S. Department of Health and Human Services; November 2009.
2. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Rev ed. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2007, Atlanta, GA: U.S.

Sexual Risk Assessment and Risk Factors for Sexually Transmitted Diseases

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Sexually transmitted diseases (STDs) including chlamydia (CT) and gonorrhea (GC) are among the most common reportable infections nationwide. If left untreated, many STDs can result in serious health consequences including infertility, ectopic pregnancy, and chronic pelvic pain in women. STDs can also increase risk of HIV transmission and acquisition. Because many STDs do not have symptoms, *screening* for asymptomatic infection is a cornerstone of STD prevention. The following article and adjoining table describe screening recommendations for various populations, and additional considerations for identifying individuals at high risk for STDs. Please note that screening for cervical cancer (i.e., Pap testing) is not addressed in this document.

Performing a sexual risk assessment

A brief risk assessment can guide decisions about what screening tests for STDs are indicated for particular patients. The content of a brief risk assessment should cover the following areas, summarized as “**The 5 P’s**”:

Past STDs:	“Have you ever had an STD in the past?”
Partners:	“Have you had sex with men, women, or both?” “In the past six months, how many people have you had sex with?”
Practices: (sexual/needle sharing)	Do you have vaginal sex (penis in vagina)? ... anal sex (penis in anus/butt)? ... oral sex (penis in mouth or mouth on vagina/vulva)? “Have you ever used needles to inject/shoot drugs?”
Prevention:	“What do you do to prevent STDs and HIV?” “Tell me about your use of condoms with your recent partner.”
Pregnancy plans and prevention:	“How would it be for you if you were to get pregnant now?” “What are you doing to prevent pregnancy now?”

Risk factors by population

Adolescents and young women (age 25 and younger). Because of high levels of disease in this age group, sexual activity alone represents a significant risk for acquiring CT or GC. Annual screening for CT and GC is recommended for all sexually active women age 25 and younger.

Women over age 25. Screening for CT and GC in women over age 25 should be limited to women with risk factors including:

- Prior CT or GC infections, particularly in the past 24 months
- Multiple sex partners within the past year
- Suspicion that a recent partner may have had concurrent partners
- New sex partner in the past three months
- Exchanging sex for drugs or money within the past year
- Other factors identified locally, including prevalence of infection in the community

Men who have sex with men (MSM). Screening for STDs (CT, GC, syphilis, HIV) is recommended at least annually for all MSM. More frequent screening is recommended for MSM with the following risk factors.

- Multiple or anonymous partners
- Sex in conjunction with illicit drug use, including methamphetamine
- Sex partners who engage in these activities

Men who have sex with women (MSW). Routine screening is not recommended for men who have sex with women. Screening should be targeted to men in high-risk settings such as STD clinics, Job Corps, and corrections, as well as men with risk factors such as prior CT or GC infection (within past 24 months).

STD Screening Recommendations, 2010

The following recommendations are based on guidelines for STD screening from the Centers for Disease Control and Prevention, United States Preventive Services Task Force, Infectious Disease Society of America, Region IX Infertility Prevention Project, and the California STD Control Branch. In populations for whom no recommendations exist, screening should be based on risk factors, local epidemiology and

prevalence of specific STDs in the particular clinical setting. All individuals diagnosed with chlamydia or gonorrhea should be retested for repeat infection at 3 months after treatment; retesting can also be performed anytime the patient returns for care in the 3-12 months after treatment. Other factors to consider prior to screening are summarized in the footnotes below.

	Population	STD Screening Recommendations	Frequency	Comments
Women	Women 25 years of age and younger ¹⁻³	Chlamydia (CT) Gonorrhea (GC) Other STDs according to risk. HIV	Annually Annually At least once, then repeat annually only if high-risk	CT/GC: consider screening more frequently for those at increased risk
	Women over 25 years of age ¹⁻⁴	No routine screening for STDs HIV	Screen according to risk At least once prior to age 64, then repeat annually only if high-risk	Targeted CT/GC screening recommended for women with risk factors.
	Pregnant women ^{1, 5}	CT GC Syphilis HIV Hepatitis B Surface Antigen (HBsAg)	First trimester First trimester First trimester First trimester First trimester	Repeat screening for CT, GC, syphilis, HIV, HBsAg in third trimester if at increased risk. (Some clinicians in areas with elevated syphilis morbidity triple screen for syphilis.)
	HIV-positive women ^{6, 7} Heterosexual men ³	CT GC Syphilis Trichomoniasis HSV-2 Hepatitis B Surface Antigen (HBsAg) Hepatitis C	Annually Annually Annually First visit First visit First visit First visit Repeat screening every 3-6 months, as indicated by risk	CT: <ul style="list-style-type: none"> • urine/cervical • rectal (if exposed) GC: <ul style="list-style-type: none"> • urine/cervical • rectal and pharyngeal (if exposed)

	Population	STD Screening Recommendations	Frequency	Comments
Men		No routine screening for STDs. HIV	Screen according to risk. At least once prior to age 64, then annually only if high-risk	Targeted screening for CT in high risk settings (e.g. corrections) or if risk factors (e.g. CT in past 24 months)
	Men who have sex with men (MSM) ^{1,3,6}	CT GC Syphilis HIV Hepatitis B Surface Antigen (HBsAg)	Annually Annually Annually Annually At least once Repeat screening every 3-6 months, as indicated by risk	CT: <ul style="list-style-type: none"> urine/urethral rectal (if exposed) GC: <ul style="list-style-type: none"> urine/urethral rectal and pharyngeal (if exposed)
	HIV positive men ^{6, 7}	CT GC Syphilis HSV-2 Hepatitis B Surface Antigen (HBsAg) Hepatitis C	Annually Annually Annually First visit First visit First visit Repeat screening every 3-6 months, as indicated by risk	CT: <ul style="list-style-type: none"> urine/urethral rectal (if exposed) GC: <ul style="list-style-type: none"> urine/urethral rectal and pharyngeal (if exposed)

Notes and References

- Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines. MMWR 2006;55(No. RR-11).
- California Guidelines for Gonorrhea Screening and Diagnostic Testing among Women in Family Planning and Primary Care Settings. www.cdph.ca.gov/programs/std
- Screening for asymptomatic HSV-2 infection should be offered to select patients based on an assessment of their motivation to reduce their risk. Universal screening in the general population should not be offered. Screening should be offered to patients in partnerships or considering partnerships with HSV-2-infected individuals. Herpes education and prevention counseling should be provided to every patient tested or screened for HSV-2. Guidelines for the Use of Herpes Simplex Virus (HSV) Type 2 Serologies – Recommendations from the STD Controllers Association and the California Department of Public Health. www.cdph.ca.gov/programs/std
- Risk factors for CT or GC in women over 25: prior CT or GC infection, particularly in past 24 months; more than one sex partner in the past year; suspicion that a recent partner may have had concurrent partners; new sex partner in past 3 months; exchanging sex for drugs or money in the past year;

- African American women up to age 30, and other population factors identified locally, including community prevalence of infection.
- In pregnant women with a history of injection drug use or a history of blood transfusion or organ transplantation before 1992, screening for hepatitis C should be conducted. Universal screening for HSV-2 infection in pregnancy is not recommended; consider screening with HSV-2 type-specific serology for pregnant women without a history of herpes and a partner with HSV-2 infection. California Guidelines for STD Screening and Treatment in Pregnancy. www.cdph.ca.gov/programs/std
- Routine hepatitis B vaccination is recommended for MSM and past or current injection drug users. HBsAg testing should be performed at the same visit that the first vaccine dose is given; if testing is not feasible in the current setting, routine vaccination of these populations should continue. Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Infection. MMWR 2008; 57 (RR-8).
- Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2009 Update by the HIV Medicine Association of the Infectious Disease Society of America. *Clinical Infectious Diseases* 2009; 49, 651-681.

Harnessing Sexually Transmitted Disease (STD) Surveillance in Indian Country to Strengthen STD Clinical Services to At-Risk Populations

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Introduction

Sexually transmitted diseases (STDs) including chlamydia, gonorrhea, and syphilis continue to impose a significant health burden on American Indians and Alaska Native (AI/AN) people as compared to other race/ethnicity groups. In 2007, among all races and ethnicities, AI/AN had the second highest rates of chlamydia and gonorrhea, and the third highest rates of primary and secondary (P&S) syphilis. In 2007, reported case rates of chlamydia, gonorrhea, and primary and secondary syphilis among AI/AN were 2 to 5 times higher than comparable rates for whites. The publication of the Indian Health Surveillance Report on Sexually Transmitted Diseases (STD), 2007 is a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the IHS. The most recent report uses 2007 data, and is an update to an earlier report that used 2004 data. Findings from this report are intended to increase awareness regarding the burden of STDs in AI/AN populations, which may lead to improvements in STD testing and clinical care, and increases in funding and research activities related to STD prevention and control in these communities.¹

Key Points and National Trends in STDs among AI/AN

Chlamydia

- Chlamydia is the most common nationally notifiable disease in the US. Chlamydial infections disproportionately affect young women and are frequently asymptomatic. If untreated, chlamydial infections can result in serious complications, including pelvic inflammatory disease (PID), infertility, and ectopic pregnancy. Chlamydia can be transmitted from mother to child during delivery and can facilitate the transmission of HIV.
- In 2007, among all race/ethnicities, AI/AN had the second highest chlamydia rate (732.9 cases per

100,000 population), which was 4.5 times higher than the rate for whites (162.3 cases per 100,000 population). African-Americans had the highest chlamydia rate (1,398.7 cases per 100,000 population).

- In 2007, 17,871 of 1,108,374 chlamydial infections (1.6%) occurred among AI/AN. The AI/AN chlamydia rate increased by 7.2% during 2006 - 2007 (2006 rate: 790.1 cases per 100,000 population) (Figure 1).
- In 2007, the chlamydia rate among AI/AN women in the US (1,158.2 cases per 100,000 females) was nearly 4 times higher than the rate among AI/AN men (293.8 cases per 100,000 males), likely reflecting a greater number of women screened for this infection.
- Among AI/AN women, the highest age-specific rates of reported chlamydia in 2007 were among 20- to 24-year olds (4,626.3 per 100,000 females) and 15- to 19-year olds (4,360.4 per 100,000 females). These two age groups also represented the highest age-specific rates among all women in the US.
- Age-specific rates among AI/AN men, while substantially lower than the rates in AI/AN women, were highest among 20-to 24- year-olds (1,163.3 cases per 100,000 males). This age group also had the highest rates among all men in the US (932.9 cases per 100,000 males)

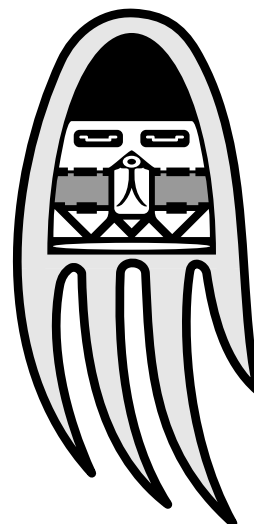
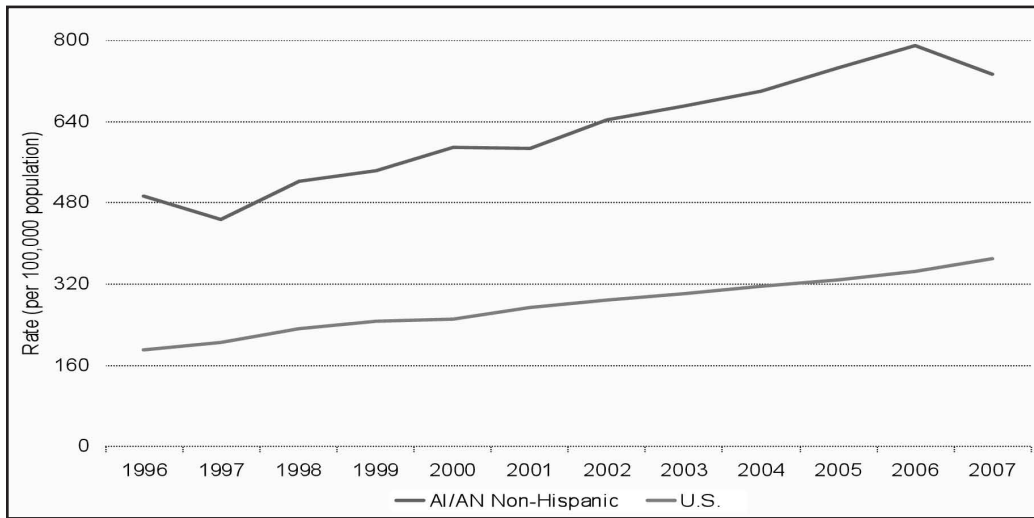


Figure 1. Total Chlamydia Rates, AI/AN Non-Hispanic and US 1996-2007



(278.2 cases per 100,000 males). This age group also had the highest rates among all men in the US (450.1 cases per 100,000 males).

Primary and Secondary Syphilis

• Syphilis, in its primary and secondary stages, is a highly infectious, but easily curable STD. If untreated, syphilis can lead to serious long-term complications including stroke, heart disease, and death. Syphilis can be transmitted from untreated mothers to their fetuses, potentially leading to stillbirths and congenital deformities. Syphilis has been shown to facilitate the

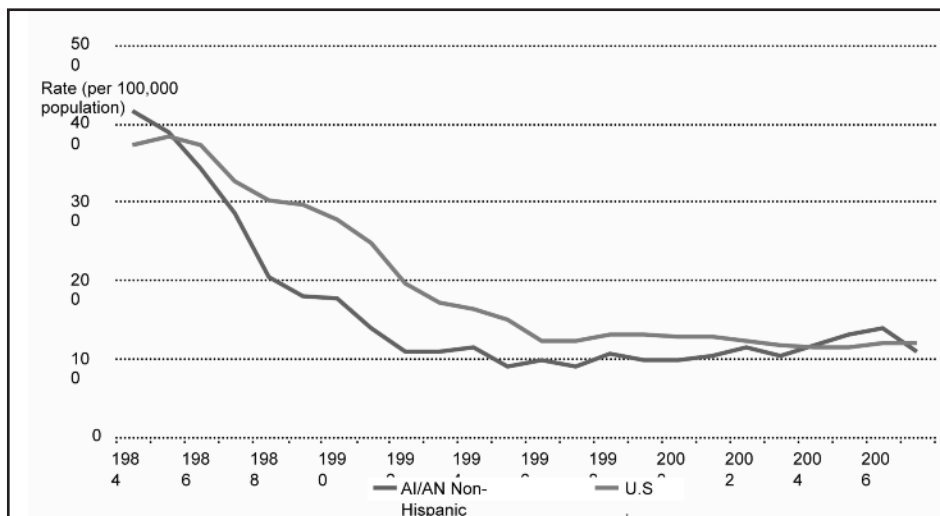
transmission of HIV two- to five-fold.

Gonorrhea

- Gonorrhea is the second most common nationally notifiable disease in the US; like chlamydia is a major cause of PID, infertility, and ectopic pregnancy. Gonococcal infections may be transmitted from mother to infant during delivery and can facilitate the transmission of HIV.
- In 2007, among all race/ethnicities, AI/AN had the second highest gonorrhea rate (107.1 cases per 100,000 population), which was 3.1 times higher than the rate for whites (34.7 cases per 100,000 population). African-Americans had the highest gonorrhea rates (662.9 cases per 100,000 population)
- In 2007, 2,657 of 355,991 gonococcal infections (0.7%) reported to CDC occurred among AI/AN. The AI/AN gonorrhea rate decreased by 21.8% during 2006 - 2007 (2006 rate: 136.9 cases per 100,000 population). Comparatively, the total US gonorrhea rates decreased by 0.7% during 2006-2007 (Figure 2).
- In 2007, the gonorrhea rate among AI/AN women in the US (143.4 cases per 100,000) females was 2.1 times higher than the rate among AI/AN men (69.5 cases per 100,000 males)
- Among AI/AN women, the highest age-specific rates of reported gonorrhea in 2007 were among 20- to 24-year olds (578.7 cases per 100,000 females) and 15- to 19- year olds (455.7 cases per 100,000 females). These two age groups also represented the highest age-specific rates among all women in the US.
- Age-specific gonorrhea rates among AI/AN men, while substantially lower than the rates in AI/AN women, were highest among 20- to 24- year olds

- In 2007, among all race/ethnicities, AI/AN had the third highest primary and secondary syphilis (P&S) rate (3.4 cases per 100,000 population), which was 1.7 times higher than the rate for whites (2.0 cases per 100,000 population). African-Americans had the highest P&S rate (14.0 cases per 100,000 population), followed by Hispanics (4.3 cases per 100,000 population)
- In 2007, 85 of 11,466 P&S infections (0.7%) reported to CDC occurred among AI/AN. The AI/AN P&S rate increased by 6.2% during 2006-2007 (2006 rate: 3.2 per 100,000 population) (Figure 3).
- In 2007, the male-to-female P&S rate ratio among AI/AN was 1.7, indicating a higher number of cases being diagnosed among men than women. In contrast, for the total US the male-to-female P&S rate ratio has risen steadily since 1996 from 1.2 to 6.0 in 2007 suggesting an increase in syphilis among men who have sex with men (MSM) during this time.
- In 2007, among AI/AN, age-specific P&S syphilis rates were highest among women aged 25 - 29 years (7.8 cases per 100,000 population) and among men aged 30 - 34 years (18.2 cases per 100,000) population. For the total US, the highest age-specific P&S rates were reported among women aged 20 - 24 years (3.5 cases per 100,000 population) and among men aged 35 - 39 years (14.9 cases per 100,000).

Figure 2. Total Gonorrhea Rates, AI/AN Non-Hispanic, US, 1996-2007



1.7 times higher than the rate for whites (2.0 cases per 100,000 population). African-Americans had the highest P&S rate (14.0 cases per 100,000 population),

followed by Hispanics (4.3 cases per 100,000 population)

- In 2007, 85 of 11,466 P&S infections (0.7%) reported to CDC occurred among AI/AN. The AI/AN P&S rate increased by 6.2% during 2006-2007 (2006 rate: 3.2 per 100,000 population) (Figure 3).

- In 2007, the male-to-female P&S rate ratio among AI/AN was 1.7, indicating a higher number of cases being diagnosed among men than women. In contrast, for the total

Summary of IHS Area STD Profiles²
Chlamydia

- The overall IHS chlamydia rate in 2007 was 760.1 cases per 100,000 population. This was 2.1 times higher than the corresponding US rate (Figure 4).

- Ten of 12 IHS Areas had higher 2007 chlamydia rates compared to the US rates
- Four IHS Areas (Aberdeen, Alaska, Tucson, and Billings) had chlamydia rates 3.1 to 5.8 times higher than the US rate. STD rates presented in the IHS STD profile section of the report include only STD cases which occurred among AI/AN residing in counties where IHS has responsibility.
- In 2007, all IHS Areas had female chlamydia rates that were between 2.7 and 5.8 times higher than male rates, likely reflecting greater numbers of women screened for this infection.³
- During 2006 - 2007 overall chlamydia rates in the US increased 7.5% (from 344.3 to 370.2), while overall IHS chlamydia rates decreased by 0.9%; IHS Areas with the greatest increases were Tucson (89.8%) and Albuquerque (43.8%); Nashville had the largest decrease (-38.0%).

Primary and Secondary Syphilis

- Syphilis, in its primary and secondary stages, is a highly infectious, but easily curable STD. If untreated, syphilis can lead to serious long-term complications including stroke, heart disease, and death. Syphilis can be transmitted from untreated mothers to their fetuses, potentially leading to stillbirths and congenital deformities. Syphilis has been shown to facilitate the transmission of HIV two-to five-fold.
- In 2007, among all race/ethnicities, AI/AN had the third highest primary and secondary syphilis (P&S) rate (3.4 cases per 100,000 population), which was

Figure 3. Total P&S Syphilis Rates, AI/AN Non-Hispanic, US, 1997-2007

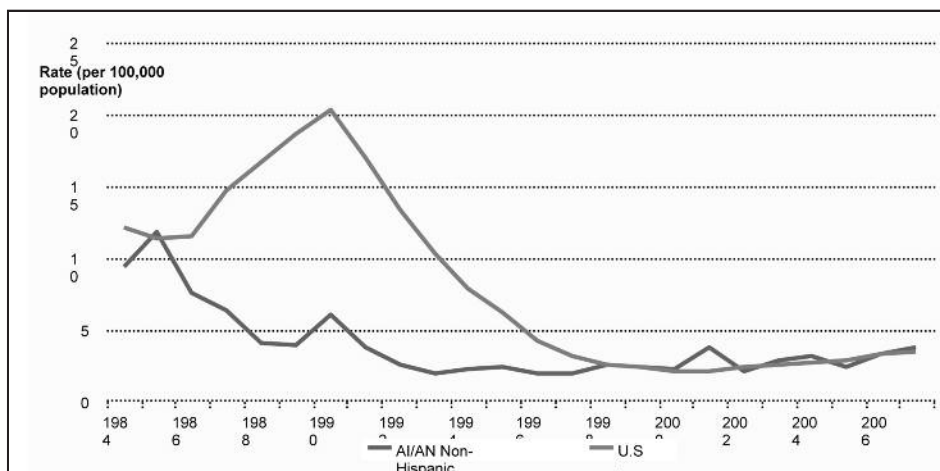
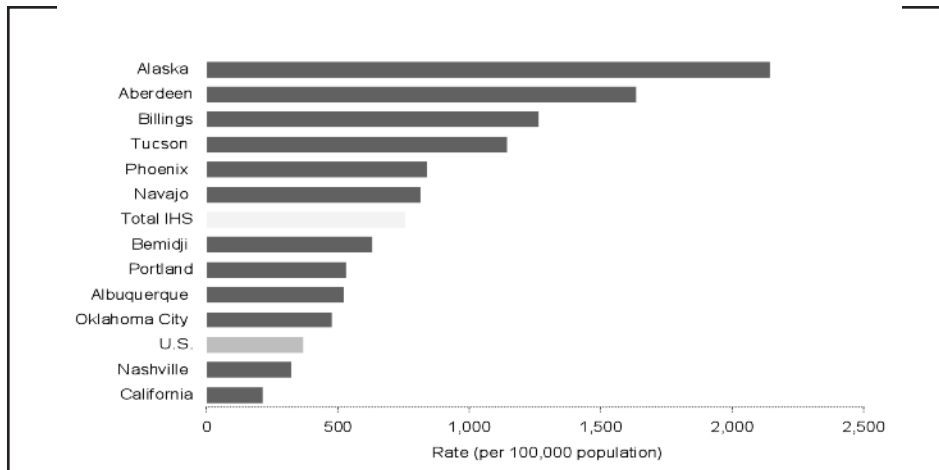


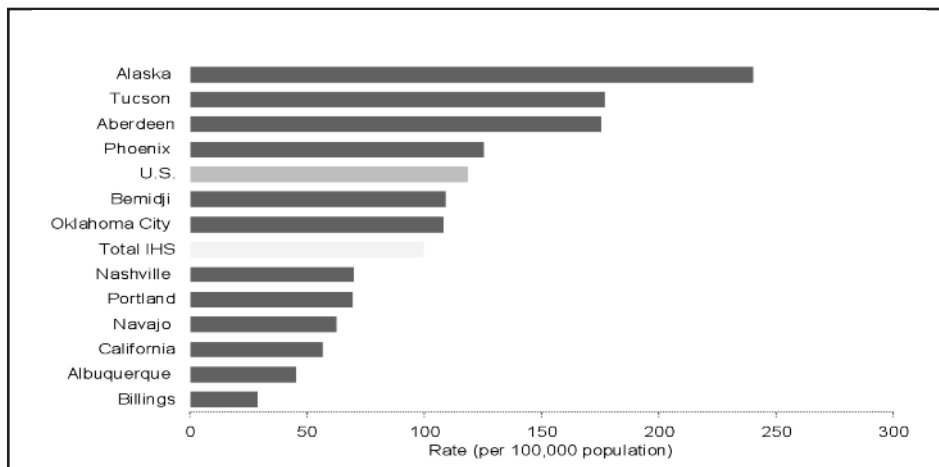
Figure 4. Chlamydia Rates by IHS Area, 2007



Gonorrhea

- In 2007, the overall IHS gonorrhea rate was lower than US rates (99.9 and 118.9 cases per 100,000 population respectively) (Figure 5).
- Four IHS Areas (Aberdeen, Alaska, Phoenix, Tucson) had 2007 gonorrhea rates higher than the US rate
- In 2007, the overall IHS female gonorrhea rate was 2.2 times the male gonorrhea rate; all 12 IHS Areas had higher female gonorrhea rates than male gonorrhea rates.
- During 2006 - 2007, overall gonorrhea rates in the US decreased 0.7% (from 119.7 to 118.9), while overall IHS gonorrhea rates decreased by 16.3%.
- IHS Areas with the greatest increases were Tucson (50.0%) and Albuquerque (19.9%); while five IHS Areas had decreases greater than 20% (Aberdeen, Billings, Nashville, Navajo and Phoenix)

Figure 5. Gonorrhea Rates by IHS Area, 2007



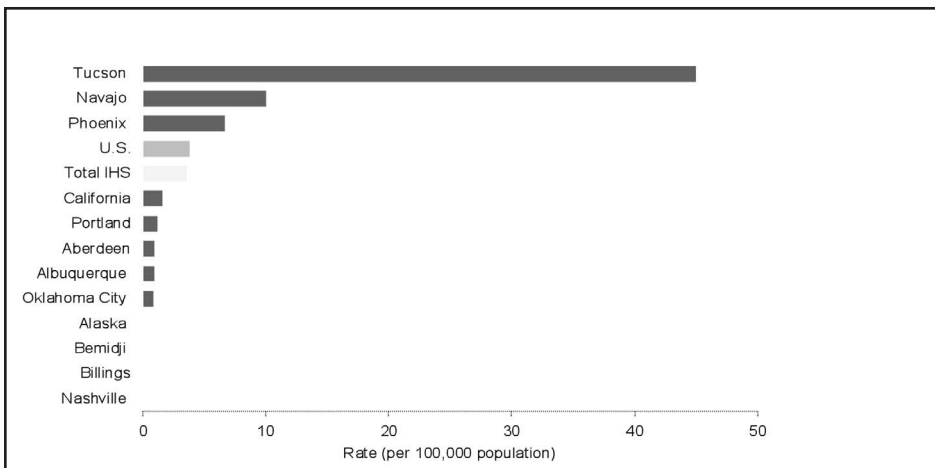
Primary and Secondary Syphilis

- In 2007, the overall IHS P&S rate was nearly the same as the US rate (3.6 vs. 3.8 cases per 100,000 population respectively) (Figure 6).
- Within IHS, 56 of the 63 (86%) P&S cases in 2007 occurred in four Areas in the southwest (Navajo [23 cases], Tucson [16 cases], Phoenix [14 cases] and Albuquerque [1 case]); four IHS Areas had no P&S cases in 2007 (Alaska, Bemidji, Billings, and Nashville).
- In 2007, the P&S male-female rate ratio for IHS overall was 1.0, which indicates a similar number of cases occurring among men and women. The US male-female ratio was 6.0
- During 2006 - 2007, overall P&S rates in the US and the overall IHS rates increased 9.5% from 3.3 to 3.6 cases per 100,000 population; among IHS areas the largest increase occurred in the Tucson (from 0.0 to 45.0 cases per 100,000) and the Phoenix (from 3.8 to 6.7 cases per 100,000; the Navajo had the largest decrease in cases (from 33 to 23).

efforts to improve access, quality, and delivery of STD testing and partner management, and to encourage safer sex practices, including condom use, among populations at risk within AI/AN communities.

Standard recommendations for STD/HIV testing, treatment, and partner management are available from the CDC STD Treatment Guidelines.² Items that can be standardized into a clinical care protocol have been summarized in Table 1. Many of these items can be customized for implementation within electronic health/medical records. Providers are encouraged to keep the treatment guidelines readily available for use in choosing appropriate STD treatment regimens, complying with nationally recommended screening practices, and for use in counseling patients regarding safer sex behaviors. These guidelines can be viewed and downloaded from the CDC website at <http://www.cdc.gov/std/treatment/>.

Figure 6. P&S Syphilis Rates by IHS Area, 2007



High STD Rates in AI/AN Communities: Opportunities to improve clinical services

High rates of STDs in AI/AN communities mainly affect youth. Adolescents are at higher risk for STDs due to biological predisposition, participation in unprotected intercourse, engagement in multiple sexual partnerships of limited duration, and obstacles in seeking health care. High STD rates in youth are an indicator of unprotected sexual practices that can also lead to unintended pregnancy and HIV infection. High STD rates can also be indicators of limited knowledge; unclear perception of risk; and lack of, inconsistent, or incorrect use of prevention methods, such as condoms. These challenges support the need for increased

Important Considerations in Addressing STDs in Your Facility and Community

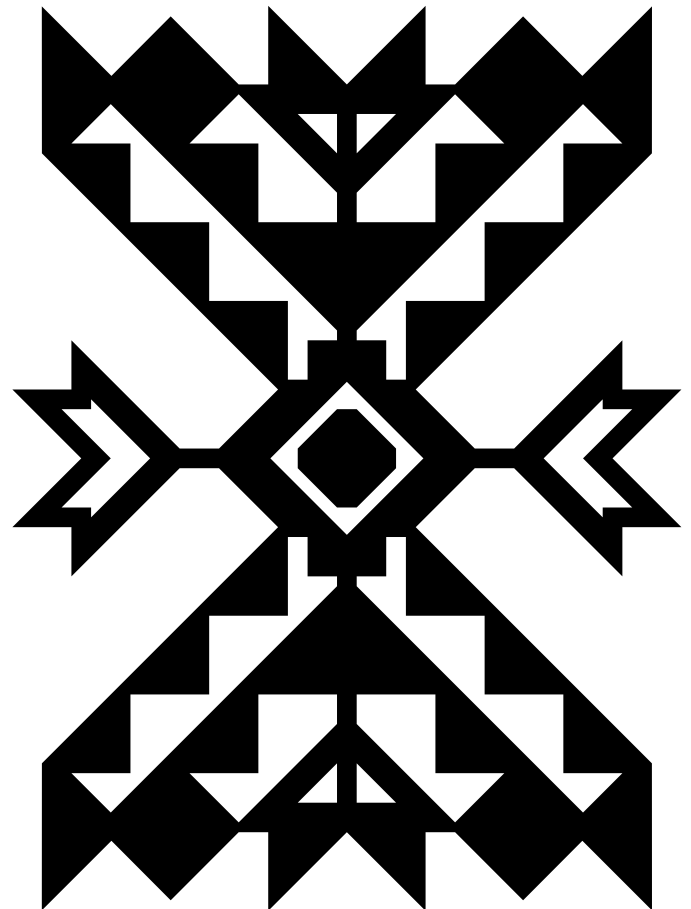
- **Screening.** Screening for STDs is a critical strategy to identify and treat STDs. A comprehensive overview of STD screening recommendations appear elsewhere in this issue in Dr. Ina Park's article, *STD Screening Recommendations, 2010*.
- **Presumptive Treatment.** Patients presenting with symptoms should be considered for chlamydia, gonorrhea, and/or syphilis treatment as appropriate for clinical signs. Providers should not wait for lab results before providing treatment.
- **Comprehensive testing for STDs and HIV.** Due to similar behavioral risk factors and the risk of STD/HIV co-transmission, persons diagnosed with a bacterial STD or HIV should receive testing for other STDs (e.g., HIV, chlamydia, gonorrhea, and syphilis).
- **Partner Services.**³ Partners of STD cases should be notified and treated presumptively for the contact infection at the time of testing.
- **Expedited Partner Therapy (EPT).*** EPT is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.
 - For chlamydia, provide prescription (with accompanying instructions) of azithromycin 1gm PO x 1 dose for patient to give to partner.
 - For gonorrhea, provide prescription of cefixime 400mg PO x 1 dose (with accompanying instructions) for patient to give to partner(s)
- **Public Health Reporting.** Chlamydia, gonorrhea, syphilis, and HIV are reportable diseases in every state. States have individual reporting forms and requirements. Providers should be familiar with these procedures.

*As allowed by state law. For more information on the legal status of EPT by state, visit <http://www.cdc.gov/std/EPT/legal>.

References

1. Centers for Disease Control and Prevention and Indian Health Service. Indian Health Surveillance Report—Sexually Transmitted Diseases 2007, Atlanta, GA: U.S. Department of Health and Human Services, September 2009.
2. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2006. *MMWR* 2006;55 (No RR-11):2-14.
3. Centers for Disease Control and Prevention (CDC). Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. *Morbidity Mortality Weekly Report*. 2008 Nov 7;57(RR-9):1-83.

For a copy of the IHS STD Surveillance Report, 2007 or for additional information on implementing STD prevention and control activities in Indian Country, contact: Scott Tulloch, Program Manager, IHS National STD Program, (505) 248-4344; e-mail scott.tulloch@ihs.gov.



Using Media Technologies to Reach Native Youth

Stephanie Craig-Rushing, MPH, Project Director, Project Red Talon, Northwest Portland Area Indian Health Board, Portland, Oregon



Interactive media technologies (like the Internet, cell phones, and computer games) are increasingly being used to address an array of public health topics, including nutrition, weight loss, physical activity, eating disorders, smoking cessation, alcoholism, stress management, diabetes self-management, asthma self-management, coping skills, and chronic pain. While early studies focused primarily on their feasibility and acceptability, more recent studies have begun to evaluate their ability to produce meaningful changes in knowledge, attitudes, perceptions, intentions, and behavior – many showing positive or promising results. To optimize their effectiveness, research supports the inclusion of several important features: 1) tailored, personalized, and individualized content; 2) content that fosters engagement with the material over multiple sessions; 3) interactivity and social support; and 4) multimedia integration.

Media technologies can be particularly useful for reaching tech-savvy youth on sensitive health topics, like sexual health. They can cost-effectively reach large numbers of youth in geographically dispersed locations, and can communicate sexual health messages in an educational, entertaining, and private way. (For a systematic review of 29 technology-based sexual health interventions, please contact Stephanie Craig Rushing at scraig@npaihb.org.)

Social media tools (like social networking sites, micro-blogging, and virtual worlds) are also increasingly being used to promote public health. Federal agencies, state health departments, and health advocacy groups now offer blogs, podcasts, RSS (Really Simple Syndication) news feeds, Twitter, and widgets, covering health topics from the seasonal flu to Food and Drug Administration (FDA) recalls. While a growing body of evidence supports their use, more thorough evaluations are needed to discover the breadth and limitations

of their effectiveness. Useful tips and tools for using social media to promote public health are available from the CDC at www.cdc.gov/SocialMedia/.

Media Technology Use in Indian Country

In 2009, Native Public Media surveyed 196 American Indian and Alaska Native (AI/AN) adults (20 - 75 years-old), from over 120 tribes living in 28 states, about their access to and use of media technology. Overall, technology use was quite common and diverse among AI/AN adults. Among those surveyed, 90% reported having a computer, 93% reported having a cell phone, 85% reported having an iPod, 85% reported having a digital camera, 52% reported having a video camera, and 44% reported having a webcam. Most respondents reported accessing computers at work (96%) and at home (91%), while schools and tribal/community centers were utilized by roughly one-third of respondents. The full report can be downloaded from www.nativepublicmedia.org.

In 2009, Project Red Talon surveyed over 400 AI/AN youth (13 - 21 years-old) living in Oregon, Washington, and Idaho to better understand how they use media technologies. In general, technology use was exceptionally common and diverse among survey respondents, mirroring patterns reported by teens in the general population. Seventy-five percent of northwestern AI/AN youth reported using the Internet, 78% reported using cell phones, and 36% reported playing video games on a daily or weekly basis. Thirty-five percent reported that they would feel most comfortable getting sexual health information from the Internet, and 44% reported having done so in the past. These findings are now being used by the Northwest Portland Area Indian Health Board to inform the selection and adaptation of culturally-appropriate interventions targeting AI/AN youth in the Pacific Northwest. Links to the survey and regional data are available online at http://www.npaihb.org/epicenter/project/media_technologies_supporting_health_education/.

A Few Ideas for Integrating Media Technologies Into Your Outreach and Care

1. *Use mobile mediums (cell phones, e-mail, text messaging) to notify clients about lab results or remind them about scheduled appointments.* The Cochrane Collaboration recently developed cell phone messaging protocols for preventive health care, communicating test results, sending reminders about scheduled appointments, and managing long-term conditions. (See Gurol-Urganci, de Jongh, Vodopivec-Jamsek, et al, 2009.) Several studies have demonstrated major cost savings, shorter wait times, and increased convenience and satisfaction, with better or similar efficacy compared with standard communication strategies.
2. *Sex Ed Internet Scavenger Hunt.* Have students

brainstorm their sexual health questions on anonymous index cards. Select appropriate questions, and then have the students search credible websites (like Planned Parenthood) to locate accurate answers.

3. *Host a Movie Night.* Watch and discuss some of the STD/HIV/Sexuality videos included in this guide. What elements were good? Bad? Funny? Accurate? Wrong? What did you learn? What questions remain?
4. *Hold a Video Contest.* Ask students to create and post their own YouTube videos that promote abstinence, safe sex, condom use, or STD testing. Host a red carpet showing.

Some Technology-Based Resources and Tools

Please note that media technologies change frequently, so some of these links may no longer be operative. Material in these sites may not be appropriate for all ages and audiences. A larger list of resources and tools is available at http://www.npaihb.org/epicenter/project/media_technologies_supporting_health_education/.

Resource/Tool	Description
AI/AN-Specific	
STD/HIV Testing Locator Widget for AI/AN http://www.cdcnpin.org/stdawareness/tools.htm	Place the widget on your website, and when a ZIP code is entered, it will return the nearest STD/HIV testing locations.
It's Your Life Video http://www.nnaapc.org/programs/sdaihc.htm	This film documents a Native teen's decision to take her first HIV test. Community voices, HIV statistics, and risk reduction messages are interwoven throughout her story.
No Place Like Home for Sex Education http://www.noplacelikehome.org/nativeamerican.php	Practical information and fact sheets for talking to AI/AN children about sex, starting at age 3, going through grade 12.
Adolescent-Specific	
Teen Talk Planned Parenthood http://www.plannedparenthood.org/teen-talk/	A comprehensive website that covers relationships, birth control, STDs, HIV, safer sex, pregnancy, and emergency contraception. Interactive features include 1) Q&A, videos, a location finder for clinics in your area, 2) The Check – Answer a few simple questions to see if you should get tested for STDs/HIV, and 3) My Method – Answer a few simple questions for help picking a birth control method that fits your life.
Think. Your Cause. Your Effect. (MTV) http://www.itsyoursexlife.org	MTV offers a free Guide to Safe Sex, the opportunity to call Dr. Drew, and up-to-date news reels, videos, vlogs (video blogs), and much more.
Drugs + HIV > learn the link http://hiv.drugabuse.gov	This site discusses the link between drugs, alcohol and HIV infection. Interactive features include: webisodes, videos, and a "Where R They Now?" chart that illustrates the HIV-drug connection for one group of friends.
Pos or Not Computer Game http://www.posornot.com	This interactive game is designed to challenge assumptions about HIV, by showing that you can't tell people's HIV-status by their gender, age, interests, or the way they look.

Sex Degrees of Separation http://calculators.lloydspharmacy.com/SexDegrees/	By answering a brief questionnaire, the calculator estimates the number of indirect (and direct) sexual partners that you've had, going back six degrees of separation.
DoSomething.org www.dosomething.org/ http://www.dosomething.org/whatsyourthing/HIV+and+Sexuality	Use the power of the Internet to do something good. The site includes a page dedicated specifically to HIV and sexuality issues.
Internet Sexuality Information Services (ISIS) http://www.isis-inc.org/	View winning entries from the Fresh Focus Sex-Ed Video Contest and the InBrief Underwear Design Contest.
MySpace and Facebook Applications	
Fact Check: HPV http://apps.facebook.com/factcheck/	Get the facts you need to protect yourself and others from Human Papillomavirus (HPV), a leading cause of cervical cancer and genital warts.
StayTeen http://www.myspace.com/stayteen	StayTeens provides teens with information on how to “stay teen” by offering accurate information about teen pregnancy, and peer advice on teen sexual health.
Videos for Teens and Young Adults	
Safe In The City http://www.youtube.com/user/SafeintheCityVideo	A 23-minute educational video addressing STDs/HIV, condom use, and sexual health. When shown in clinic waiting rooms, the video has been shown to reduce new STDs diagnoses.
Emergency Contraception http://www.youtube.com/watch?v=ks0WMzULJWM	This video includes how to use a condom properly, what to do if the condom breaks, how you can obtain emergency contraception, and how emergency contraception prevents pregnancy.
The Positive Project http://www.thepositiveproject.org	This site contains over 1,100 video interviews, offering first-person accounts of what it is like to live with HIV/AIDS. Their personal stories represent all ages, genders, cultures and backgrounds, including several AI/AN.
YouTube Channel Dedicated to Talking About HIV/AIDS http://www.youtube.com/Italkbecause	Join the conversation! Film and upload your own testimonial. Share why talking about HIV/AIDS is important to you.
Where is your Line http://whereisyourline.org	Told through a “sex-positive” lens, THE LINE is a 24 minute documentary about a young woman and her rapist. The filmmaker confronts her attacker, recording the conversation with a hidden camera. Sex workers, survivors and activists discuss justice, accountability, and today’s “rape culture.”

Sexual Health Text Messaging Services for Teens and Young Adults

Sexual Health Questions? Text 66746 and start your question with the keyword ASKST. Teens can use the text messaging service to answer questions about their body, birth control, STDs, relationships, sexual identity, or to help find a sexual health clinic, rape or abuse crisis center or hotline, or to help out a friend.

Looking for an STD/HIV Clinic? Text your zip code to KNOWIT (566948).

INDIAN HEALTH SERVICE, DIVISION OF BEHAVIORAL HEALTH



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Developing an Intervention for Youth – From Research to Action

Jessica Leston, MPH, STD Program Manager, Alaska Native Tribal Health Consortium, Anchorage, Alaska; and Cornelia Jessen, MA, Alaska Native Tribal Health Consortium, Anchorage

The disparity in sexually transmitted disease (STD) rates between Alaska Native and non-Native populations, particularly among young adults and females, is significant and concerning. Many factors may contribute to high rates of STD, including social and cultural factors, geography, and access to care. However, there are limited published data on effective approaches to addressing sexual health issues, and reducing STD/HIV transmission in Alaska Native and American Indian populations.

To better understand sexual health knowledge, beliefs, and attitudes, the Alaska Native Tribal Health Consortium's STD Program conducted a series of focus groups and in-depth interviews to guide the development of culturally appropriate, community driven, sexual health interventions. The focus group and interview protocol were approved by the Alaska Area Institutional Review Board and reviewed and approved by regional tribal health organizations that participated in the project.

A convenience sample of Alaska Native adolescents (n = 105; ages 15 - 24) from five rural communities in Alaska participated in 21 focus group sessions, with participants separated by sex and age. Themes were assessed with respect to knowledge and beliefs about STD, HIV/AIDS, and unplanned pregnancy, as well as perceptions of how adolescents prefer to learn about sexual health issues. Interview data (n = 39) were also gathered from elders, community leaders, religious leaders, parents, teachers, and health care workers to evaluate community attitudes regarding STD, HIV, unplanned pregnancy, and how the community preferred adolescents learn about sexual health issues.

Major findings of the focus groups were as follows:

- STD/HIV and unplanned pregnancy messages are viewed within a framework of disease prevention and health protection activities;
- sexual health messages should be delivered via the Internet and school;
- adolescents want to hear messages promoting STD/HIV testing and condom use;
- easier access to condoms is needed;
- there is a basic understanding of sexual health, but adolescents have a number of unanswered questions pertaining to STD/HIV;

- recognition that alcohol and drug use affect sexual behavior and risk taking; and
- issues of privacy and embarrassment affect health care seeking behaviors for sexual health issues.

The results of this focus group project provide an initial understanding of the knowledge, attitudes, and beliefs about STD, HIV/AIDS, and unplanned pregnancy among Alaska Native youth. Also, it is important to affirm that there was nothing said or implied in the community interviews with community members that contradicted the health communication or interventions the youth requested.

This qualitative research created a foundation to build a culturally appropriate and community-driven intervention, one that is delivered within the framework of health protection and promotion; is communicated via the Internet and in schools; promotes STD/HIV testing and condom use; makes access to condoms easier; addresses unanswered questions; helps alleviate concerns about privacy and embarrassment; and addresses alcohol and drug use and sexual risk taking.

With Alaska Native youth and the results of the focus groups and in-depth interviews in mind, an Internet-based sexual health intervention emerged. *Iknowmine.org* is intended to give teenagers and adolescents the tools necessary to make informed sexual health decisions. By accessing *iknowmine.org*, youth can

- order condoms;
- order chlamydia and gonorrhea home screening kits;
- ask sexual health questions to Anchorage-based providers;
- find specific information on STDs, HIV, unplanned pregnancy, and related issues;
- find HIV/STD testing and treatment locations throughout Alaska;
- request assistance in scheduling sexual health medical appointments;
- watch videos and read stories about STDs/HIV and unplanned pregnancy; and
- participate in educational polls, surveys, and a blog.

To offer chlamydia and chlamydia home screening on *iknowmine.org*, ANTHC is joining the Johns Hopkins University (JHU) project, "I Want the Kit" (www.iwantthekit.org), which provides self-collected specimen kits through the Internet or by calling a toll-free number. Upon request, testing kits are sent to individuals, who collect their own biological sample, and then return the specimen in a pre-paid mailer to the JHU lab. These results will be delivered

within existing state and regional protocols for reporting, surveillance, partnership tracing, and follow-up care systems. Self-collected specimens offers advantages over traditional testing methods, as patients can order a kit through the Internet, collect their own specimen in the privacy of their home, and return the specimen for testing and receive confidential results, as well as referral service to care in case of positive test results.

Iknowmine.org is part of a broader social marketing strategy that involves the use of social networking sites like MySpace®, Facebook®, and Twitter®; community health fair display tables; a traditional poster and flyer campaign; and give-away items such as condoms, stickers, and t-shirts. In the future *iknowmine.org* will use TV ads, bus signs, and a text

message campaign. The goal of the social marketing campaign is to engage the community and to encourage youth to think and learn more about sexual health issues.

One of the fundamental principles of public health practice is community participation, which asserts that success in achieving change is enhanced by the active participation of the intended audience in defining their own high-priority solutions. Our findings – driven by the youth themselves – have been critical in designing and implementing sexual health interventions and could promote greater community involvement and acceptance of a subject matter that is oftentimes difficult to address.



Helping Native Teens Make Healthy Decisions

Lori de Ravello MPH, Centers for Disease Control and Prevention, Division of STD Prevention/IHS National STD Program, Albuquerque, New Mexico; and Scott Tulloch, Centers for Disease Control and Prevention, Division of STD Prevention/IHS National STD Program, Albuquerque

All youth – including Native youth – face extreme pressures to fit in and belong. To make the best decisions, youth need factual and science-based information that is delivered in a way they can relate and, by people they can trust and feel comfortable talking with about the pressures of fitting in and belonging. To help fill this need, the Indian Health Service's (IHS) National STD Program collaborated with the National Coalition of STD Directors (Washington, DC), Mercer University School of Medicine (Macon, Georgia), and Northwest Portland Area Indian Health Board's Project Red Talon (Portland, Oregon) to develop Native Students Together Against Negative Decisions (STAND). Native STAND is a comprehensive curriculum for training peer educators to promote healthy decision making for Native youth.

The Native STAND curriculum was developed by a multi-disciplinary workgroup that included American Indian and Alaska Native (AI/AN) youth, an AI/AN elder, public health and youth development experts, and health curriculum developers. It is designed to meet the needs of today's AI/AN youth, by honoring tradition and culture while meeting AI/AN youth where they are today: walking between two different – but interconnected – worlds. While Native STAND acknowledges that AI/AN youth face many of the same challenges as mainstream youth, it embraces the power of traditional teachings and cultural strengths that AI/AN youth have within themselves and their communities.

Native STAND was adapted from Students Together Against Negative Decisions (STAND) – a peer educator curriculum developed for rural youth. The STAND curriculum has been evaluated and is theoretically based. The STAND curriculum uses the Transtheoretical Model (Stages of Change) and the Diffusion of Innovations Model (identifying and relying on popular opinion leaders to promote change). Its approach is comprehensive and skills-based, and includes STD, HIV, and teen pregnancy prevention, as well as providing students skill to prevent drug and alcohol use and reduce dating violence. These skill sessions focus on positive personal development, including team building, diversity, self-esteem, goals and values, decision making, negotiation and refusal skills, peer educator skills, and effective communication. The

students that participate are identified by their peers; the process ensures that nominees are representative of diverse social groups and cliques.

Native STAND is being piloted in four Bureau of Indian Education residential schools. Results from the pilot projects will be available in fall 2010. Several other entities (e.g., Oregon Health Sciences University and Planned Parenthood of Minnesota, South Dakota and North Dakota) have applied for and been granted funds to implement variations of Native STAND. Oregon Health Sciences University (OHSU) will collaborate with the Shoshone Bannock tribe in Idaho to implement Native STAND in an afterschool program. This particular program will incorporate videography. Planned Parenthood of Minnesota will implement Native STAND with young AI/AN women in Duluth and Bemidji.

If you would like more information about Native STAND, contact Dana Cropper-Williams, National Coalition of STD Directors, at dcropper@ncsddc.org; telephone (202) 842-4660.



Four National HIV/STD Related Measures: How is your Service Unit Doing?

Brigg Reilley, MPH, HIV Surveillance Coordinator, Indian Health Service; Albuquerque, New Mexico

While most providers are familiar with Government Performance and Results Act (GPRA) scores, there are many Other National Measures (ONMs) that service units can access to assess their clinical practices. Here are four HIV/STD-related measures that can be easily accessed.

Chlamydia Screening (ONM)

This measure checks the proportion of female active clinical patients age 16 - 25 screened for chlamydia once per year. *While national figures for Indian Health Service/Tribal/Urban Indian (I/T/U) facilities are not yet available, a recent pilot in one IHS Area showed a rate of 37% (range 0 - 53%).*

STD Screening (ONM)

This Clinical Reporting System (CRS) measure checks four key STDs: chlamydia, syphilis, gonorrhea, and HIV/AIDS. If a patient is positive for any one of these STDs (as determined by purpose of visit), the patient should be screened for the other three STDs within 60 days. *The I/T/U national rate for STD screening is 40% (range 0 - 67%).*

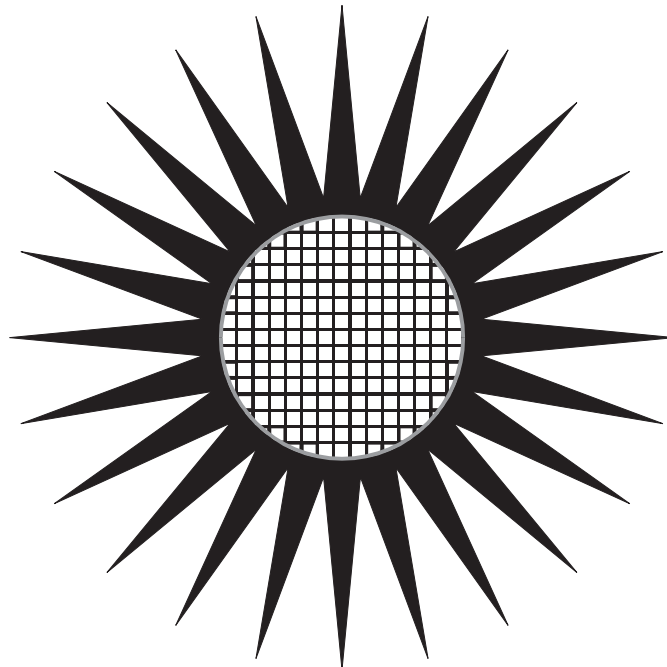
Prenatal HIV Screening (GPRA)

This measure assesses how well a service unit is doing complying with the recommendation that Active Clinical pregnant patients be screened for HIV. *The I/T/U national rate for Prenatal HIV Screening is 82% (range 0 - 100%).*

Adolescent and Adult HIV Screening (ONM)

This measure assesses how well a service unit is doing complying with the 2006 CDC guideline that all patients ages 13 - 64 should be screened for HIV at least once, regardless of risk factors, and re-tested based on clinical judgment. The CRS measure checks number of patients screened for HIV among the user population ages 13 - 64 with no prior HIV diagnosis. *The I/T/U national rate for HIV Screening is 7% (range 0 - 37%).*

If you would like additional information, or if you would like to request technical assistance to conduct a confidential HIV/STD screening audit at your facility, contact Brigg Reilley at Brigg.Reilley@ihs.gov.



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

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

In this issue, the brief item about the four national STD measures not only suggests a source of performance data that may provide a baseline on which to improve using your CE program, but even includes an offer to obtain a baseline screening audit. Taken all together, this collection of articles gives you a host of ideas about how you may be able to strengthen your STD prevention program; your CE program can play an important role.

Translating the Needs Assessment Process into Objectives for a Regularly Scheduled Hourly Series: How Do You Do This?

Today, we received a report on a session held recently as part of a regularly scheduled series at one of our facilities that has been doing this for awhile. On the “Documentation Form” under Needs Assessment, it said, “Our GPRA numbers are not at goal (below the 2010 goal of 33%) for colon cancer screening.” The objectives for this session followed the needs

assessment, and were as follows: 1) compare and contrast the different tools for colon cancer screening; 2) Compare the facility’s rates of colon cancer and our rates of colon cancer screening, and 3) discuss ways in which the facility can increase our rates of colon cancer screening, focusing on patients, families, and providers.



The 15th Annual Elders Issue

The May 2010 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the fifteenth 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.

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Stay Up-to-Date on STD Issues Impacting AI/AN

Join the IHS National STD Program’s STD Listserv

Send an e-mail to listserv@listserv.ihs.gov

In the body of the e-mail write “subscribe STD <your name here>”

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

“All that I know I learned after age thirty.”

George Clemenceau

Article of Interest

Effectiveness of the pentavalent rotavirus vaccine in preventing gastroenteritis in the United States. *Pediatrics*. 2010 Feb;125(2):e208-13. <http://pediatrics.aappublications.org/cgi/content/full/125/2/e208>

In this case-controlled study, investigators looked at the effectiveness of the pentavalent rotavirus vaccine (Rotateq®) for the prevention of rotavirus gastroenteritis (RGE) in children who received the complete series of three doses and those who only received one or two doses of the vaccine. A complete three-dose Rotateq® series provided 100% protection against severe RGE that required hospitalization and 96% protection against disease that required intravenous rehydration. Surprisingly even one and two doses of vaccine provided 69% and 81% protection, respectively, from severe RGE.

Editorial Comment

RGE hospitalization rates have historically been much higher for AI/AN infants than the general US population. The introduction of the Rotateq® vaccine promises to reduce this disproportionate burden of disease. However, one caveat has been that the product is licensed to be given only up to eight months of age because of liability concerns relating to intussusception. This study provides good news that something is better than nothing. If a child is delayed in vaccination he/she should still get whatever doses of Rotateq® can be administered before eight months of age.

Infectious Disease Updates

Rosalyn Singelton, MD, MPH

Flu Vaccine for all: New Recommendation for Universal Influenza Vaccination

On February 24, 2010, the ACIP voted on recommendations for universal use of trivalent seasonal influenza vaccine for the 2010 - 2011 influenza season. Provisional recommendations are:

- **“Vaccination recommendations for adults were expanded to include all adults beginning in the**

2010 - 11 influenza season. Therefore, all people age six months and older are now recommended to receive annual influenza vaccination.”

- There are no changes to the recommendations for universal immunization of children aged 6 months – 18 years, with a focus on children with underlying medical conditions

Why these new recommendations for universal flu vaccination of 19 - 49 year olds?

- 50% of this population already has an indication for annual influenza vaccination
- The current permissive language in this age group has resulted in low immunization rates
- Discussion of focusing on groups with increased risk in 2009 H1N1 pandemic:
 - Obese adults
 - American Indian/Alaska Native (AI/AN), Hispanic, and African American

What influenza strains do experts expect will appear in the 2010 - 2011 season?

- Expect the 2009 H1N1 strain to circulate in 2010 - 2011 season (ACIP will provide further guidance in June on vaccination of children in 2010 - 11 who received H1N1 in 2009 - 10)
- The 2010 - 11 influenza vaccines will contain A/California/7/2009 (H1N1), A/Perth/16/2009 (H3N2), and B/Brisbane/60/2008 antigens. The A (H1N1) is the same strain used in the 2009 H1N1 vaccine.

Notes:

- *IHS representatives are providing data to encourage prioritization of influenza vaccine for AI/AN people in times of influenza vaccine shortage*
- New adult influenza recommendations may not translate immediately into additional funding for influenza vaccine

Recent literature on American Indian/Alaska Native Health

Michael L. Bartholomew, MD

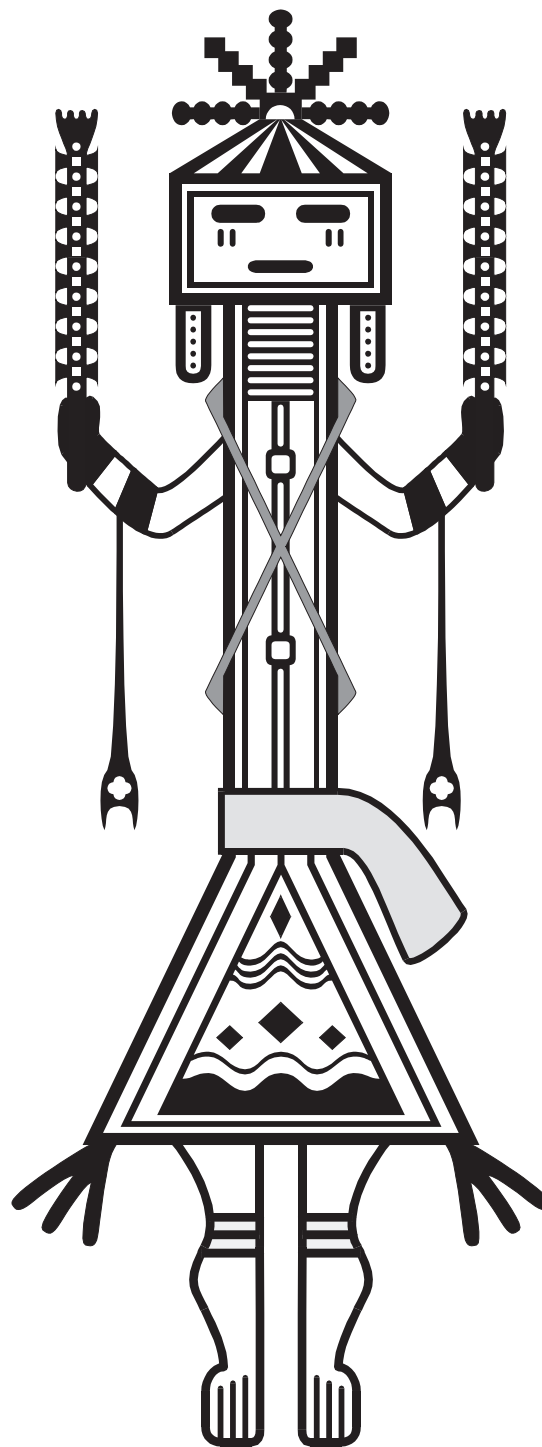
Centers for Disease Control and Prevention (CDC). Syphilis Outbreak Among American Indians - Arizona, 2007-2009. MMWR. 2010 Feb 19;59(06):158-161.

<http://www.ncbi.nlm.nih.gov/pubmed/20168294>

This report details a multiagency, coordinated outbreak investigation of syphilis among American Indians in Arizona from January 2007 to June 2009. A total of 106 cases of syphilis, including six congenital cases, were identified. Prior to this outbreak, the incidence of syphilis among American Indians in Arizona was declining. During 2007, the cases of primary and secondary syphilis identified in this outbreak represented 44% of all cases among American Indians in Arizona. The rate of primary and secondary syphilis in 2007 for this southwest tribe was 75 cases per 100,000 as compared with the overall Arizona rate of 4.8 cases per 100,000.

While the outbreak began in January 2007, an enhanced outbreak response was not initiated until July 2007. As a part of the response, the CDC trained tribal community health representatives (CHRs) and IHS public health nurses on STI case investigations and partner identification. In addition, the enhanced outbreak response group (members of tribal and Pima County health departments, IHS, ADHS, and CDC) developed a new comprehensive STI screening program that included hospital-based, community-based and school-based screening. Educational sessions for medical providers, schools, and the general community were developed. Informational material in the form of print and radio was also distributed. After initiating an enhanced outbreak response, 5,874 persons were tested, resulting in an additional 53 cases being identified.

The authors point out that “inadequate communication among state, county, and tribal health departments and IHS during the initial part of the outbreak contributed to a delayed response to the outbreak.” Additional challenges during this outbreak investigation also included a “lack of an IHS or tribal public health entity to coordinate the outbreak investigation,” limited provider knowledge of STI outbreak investigation, and difficult public health working relationships between the tribe and the IHS. Despite these initial shortcomings, the development of an outbreak response group allowed for improved outbreak control activities/coordination. Better communication and improved ability to conduct STI investigations has improved the community’s ability to respond to outbreaks.



MEETINGS OF INTEREST

Advancements in Diabetes Seminars

Monthly; WebEx

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

The accredited sponsors are the IHS Clinical Support Center and IHS Nutrition and Dietetics Training Program.

Upcoming seminars include:

Date and Time	Topic	Speaker
April 26 at 1 pm MDT	Recent Controversies and "Hot Topics" in Diabetes	Dr. Kelly Acton
May 18 at 1 pm MDT	Peripheral Artery Disease	Scott Gaustad, PT
June 8 at 1 pm MDT	Self-Monitoring of Blood	Dr. Marie Russell
July: TBA	Glucose	

For Information on upcoming seminars, go to www.diabetes.ihs.gov, (<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=home>) and click on **Advancements in Diabetes Seminar**.

For information about previous seminars, including the recordings and handouts, click on the following link and visit Diabetes Seminar Resources: <http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars>.

Available EHR Courses

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

Centering Parenting and Lifecycle Training

June 4 - 5, 2010; Zuni, New Mexico

Sharon Schindler Rising from the Centering Healthcare Institute will be leading a two-day workshop in Zuni, New Mexico June 4 - 5, 2010. The goal of the training is to acquaint participants with the concept of group care throughout the life cycle and focus on the skills needed to provide

facilitative group leadership. The course will focus on applying group visits to well-child, postpartum, diabetes, and end-of-life care. An optional evening session June 3 may be added for those who have not yet completed training in Centering Pregnancy. Registration is free for IHS employees, but is limited to 25 people on a first-come, first-served basis. Participants will be responsible for their own travel, meals, and lodging expenses. Please contact Dr. Nerissa Koehn, Director, Women's Health Program, Zuni Comprehensive Community Health Center, if you are interested in attending or would like more information, at (505) 782-7541 or e-mail nerissa.koehn@ihs.gov.

The IHS Southwest Regional Pharmacy Continuing Education Seminar (the "Quad"), June 6 - 8, 2010; Scottsdale, Arizona

The largest annual meeting of Public Health Service pharmacists and technicians, and pharmacists from tribally operated programs, this

seminar provides up to 15 hours of ACPE approved pharmacy continuing education credit. Hosted by the IHS Phoenix and Navajo Areas, the target audience is made up of pharmacists and technicians working in Indian health system clinics and hospitals. It will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258. For more information, look for "Event Calendar" at <http://www.csc.ihs.gov/> or contact CDR Ed Stein at the IHS Clinical Support Center by e-mail at ed.stein@ihs.gov.

Introduction to Social Marketing

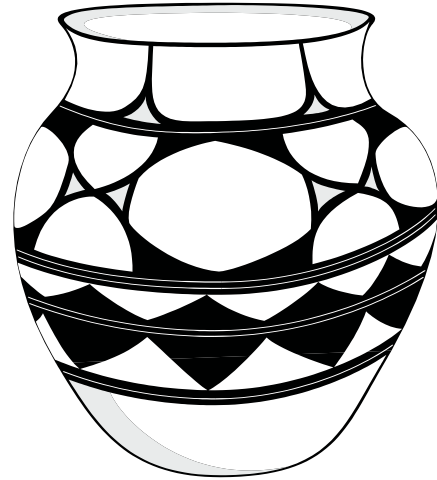
June 25 - 29, 2010; Santa Fe, New Mexico

The American Indian Institute will be offering the "Introduction to Social Marketing" training in Santa Fe, New Mexico, June 25 - 29, 2010. This training is designed for tribal health administrators and directors who are interested in the field of social marketing. The course will include an overview of social marketing, focus group research, program design, and implementation. This is the first course in a series of four that will include 1) Introduction to Social Marketing; 2) Advanced Social Marketing, for those who are in the process of implementing a project; 3) Program Evaluation; and 4) Focus Group Research. Continuing education units will be offered by the University of Oklahoma. For more information, please contact Chelsea-Southerland@ou.edu or visit www.aii.ou.edu.

The Pharmacy Practice Training Program: a program in patient-oriented practice (PPTP)

August 2 – 5 or August 23 - 26, 2010; Scottsdale, Arizona

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



NEW MEXICO GERIATRIC EDUCATION CENTER

JUNE 4, 2010

Information/Registration at: <http://hsc.unm.edu/som.fcm/gec> OR Call: 505-272-4934

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

*This hands-on training is designed for **Physicians, Nurses, PAs, OTs and PTs, Social Workers, Dietitians** and other health care professionals in the early recognition, diagnosis and treatment of dementia.*

ACCREDITATION: The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The IHS Clinical Support Center designates this educational activity for a maximum of **4¾ AMA PRA Category 1 Credit(s)™**. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse Midwives.

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is designated **4.75 contact hours for nurses**.

Janice Knoefel, MD
Neurologist/Geriatician
UNM SOM/Albuquerque Area VA

John Adair, MD
Neurologist
UNM SOM/Albuquerque Area VA

Shelly Leiphart, PsyD
Fellow, Neuropsychology
Albuquerque Area VA

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.

Family Practice Physician

Warm Springs Health and Wellness Center; Warm Springs, Oregon

The Warm Springs Health and Wellness Center has an opening for a board certified/eligible family physician. Located in the high desert of central Oregon, we have a clinic that we are very proud of and a local community that has much to offer in recreational opportunities and livability. Our facility has been known for innovation and providing high quality care and has received numerous awards over the past ten years. We have positions for five family physicians, one of whom recently retired after 27 years of service. Our remaining four doctors have a combined 62 years of experience in Warm Springs. This makes us one of the most stable physician staffs in the IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs. We have a moderately busy outpatient practice, with our doctors seeing about 15 - 18 patients per day under an open access appointment system. We were a pilot site for the IHS Innovations in Planned Care (IPC) project and continue to make advances in how we provide care to our patients. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626. (4/10)

Family Physician

SouthEast Alaska Regional Health Consortium; Juneau, Alaska

The SEARHC Ethel Lund Medical Center in Juneau, Alaska is searching for a full-time family physician with

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

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

Family Practice Physician

Yakama Indian Health Center; Toppenish, Washington

The Yakama Indian Health Center is recruiting for two positions in family practice, pediatrics, or internal medicine to join our staff of four physicians, three ARNP, and two PA-C. We are a modern facility with on-site pharmacy services, an open access appointment system, electronic health records, a moderately busy outpatient practice, and a user population of 18,000 members of the Confederated Tribes and Bands of the Yakama Nation.

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

Base salaries depend upon experience, and range from \$155,000 to \$177,000. Other benefits may include loan payback, retention or recruitment bonuses, and moving expenses. For more information, please call our CEO, Andrew Delgado, or our Clinical Director, Rex Quaempts, at (509) 865-2102. (4/10)

Family Physician

SouthEast Alaska Regional Health Consortium

The SEARHC 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, all with an 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. Now a NHSC Loan Repayment Site. For information contact Dr. Cate Buley at (907) 364-4485; e-mail cbuley@searhc.org; or visit the website at www.searhc.org. (2/10)

Family Physician

Kodiak Area Native Association; Kodiak, Alaska

Come practice on Alaska's Emerald Isle. Looking for a board certified or board eligible family physician to join Kodiak Area Native Association in providing comprehensive family medicine. Coastal temperatures and endless outdoor recreation. Contact Robert Onders, MD with further questions or, to send a CV, at Robert.Onders@kanaweb.org. KANA is an EOE employer exercising Native preference in accordance with PL 93-638. For a complete list of job qualifications, description, and application, please contact Kodiak Area Native Association Human Resources Department by e-mail at Samuel.towarak@kanaweb.org; mailing address 3449 E. Rezanof Drive, Kodiak, Alaska 99615; telephone (907) 486-9805; or fax (907) 486-9896. (2/10)

Physician

Puyallup Tribal Health Authority; Tacoma, Washington

The Puyallup Tribal Health Authority is currently recruiting a full time physician to join a team of nine other physicians. PTHA is a tribally operated ambulatory clinic located in Tacoma, Washington, and is accredited by AAAHC, CARF and COLA. This position will evaluate, diagnose, and treat medical, obstetric, psychiatric, and surgical diseases and emergencies as credentialed and privileged; oversee the medical evaluation, diagnosis, and treatment of patients by other medical professionals, including precepting midlevel providers as needed; perform histories and physicals, and direct the evaluation, diagnosis, and treatment of PTHA patients in local hospitals, including participation in scheduled rounding; make referrals to specialists as per PTHA protocol and follow-up to assure quality care; provide on-site health education and counseling to patients and staff; participate in after-hours on-call duty as scheduled; provide back-up consultation to other on-call PTHA providers as scheduled; and participate in utilization review studies and quality improvement committee work as assigned.

Minimum requirements include a Doctorate of Medicine or Osteopathy from an accredited institution; board certified (or eligible to sit for exam) in family practice or appropriate field; licensed to practice medicine in the State of Washington; and current certification in ACLS.

PTHA offers a competitive salary, benefits, and a generous time off schedule. To apply, a completed PTHA employment application is required (resume optional). Please submit applications to the Human Resource Department prior to the

closing date. Indian hiring preference by law. Telephone (253) 593-0232 ext 516; fax (253) 593-3479; e-mail hr@eptha.com; website, www.eptha.com. The mailing address is PTHA Human Resource Department, KCC bldg #4, 1st Floor, 2209 E. 32nd St., Tacoma, Washington 98404. (2/10)

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 or internal medicine physician to join our experienced medical staff. 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, Arizona, the Santa Rosa Health Center, located in Santa Rosa, Arizona, 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. (2/10)

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. (01/10)



Spirit of EAGLES

American Indian/Alaska Native Leadership Initiative on
Cancer



Artwork Designed by: Chholing Taha

Eighth National Conference

**“Changing Patterns of Cancer in Native Communities:
Strength Through Tradition and Science”**

September 11-14, 2010
Westin Hotel
Seattle, WA

Watch for details coming soon @ <http://www.nativeamericanprograms.org/>

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Indian Health Service
Clinical Support Center
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THE IHS PRIMARY CARE PROVIDER

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



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

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

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