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Native Vision: A Focus on Improving Behavioral Health of California Native Americans

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There is an old Indian joke, its origins and author unknown, which goes something like this: “There was an Indian man going through mental health difficulties from too much stress who felt he was losing his mind. So he decided to see a psychiatrist at the Native clinic. He told the doctor ‘You’ve got to help me; sometimes I think I am a tipi and sometimes I think I am a wigwam.’ The psychiatrist looked at him quietly and calmly as the Indian man hysterically repeated the question whether he was a tipi or a wigwam. The doctor responded ‘You are neither; you’re two tents’ (too tense).” Although humor is “good medicine” and is an important coping and prevention mechanism for psychological issues, our California Native American communities continue to face behavioral health related disparity.

California is home to the largest population of Native Americans in the US, with well over 100 federally recognized and unrecognized tribes within the state (US Census 2010, CTEC 2009). American Indians and Alaska Natives in California have elevated rates of poverty, violence, substance abuse, depression, and other psychological maladies when compared to non-Hispanic whites (CTEC 2009, PPIC 2009). In addition, California Native Americans show significantly more difficulty than non-Hispanic whites when receiving or accessing mental health care (CTEC 2009).

Community Defined Evidence is defined as “a set of practices that communities have used and determined to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically, but have reached a level of acceptance by the community” (Martinez, 2011). Community defined evidence is particularly important among Native communities in California, as the reach of current mental health services has failed to eliminate mental health disparities in the state. Behavioral health programs should use scientifically documented and proven, evidence-based practices in the

provision of mental health services. Despite the increase in the use of evidence-based practices, disparities have continued. This indicates a need to examine alternative evidence and approaches for addressing these issues in our Native communities.

Methodology

Six Native American-specific, community defined, indigenous-based behavioral health practices were identified as promising practices and effective models within California. This was achieved through talking circles, focus groups, and one-on-one communication with staff in the Family and Child Guidance Clinic at the Native American Health Center in Oakland, California. The author and staff have a long history of American Indian-specific mental health wellness experience,

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public health advocacy, and positive interaction with county, state, tribal, and urban Indian behavioral health programs and/or professional staff throughout California. In addition, the Family and Child Guidance clinic has continued a positive relationship with the California Department of Mental Health through their sponsored conferences, committees, and direct interactions.

Staff contributed to a statewide Native American-specific needs and strengths assessment report funded through the Mental Health Services Act (UC Davis, 2009). The report initiated the need to promote recovery and wellness for persons with mental illness, eliminate disparities in mental health, and bring culturally competent prevention and early intervention mental health services to American Indians and Alaska Natives living in California. This effort will be funded through the Mental Health Services Act to identify community-defined evidence within California Native American communities.

Promising Practices and Effective Models

Aunties and Uncles Program. The Aunties and Uncles Program was developed by the Sonoma County Indian Health Project in Santa Rosa, California (SCIHP). The program has three main goals: 1) reduce the stigma related to mental health problems; 2) build the capacity of mentors; and 3) systematically incorporate a youth depression screening tool into medical visits at the local Native American health clinic. The project was started by the local Native American community and clients of the health clinic. The program name was chosen for the important role that aunties and uncles, along with other extended family members, have within indigenous Native cultures. Aunts and uncles have the ability to address both challenging and encouraging words to youth and parents.

The reduction of stigma is addressed through media outreach and a speaker series. The media portion utilized a poster contest promoting wellness and culture, suicide prevention, and destigmatization. Selected posters with culturally appropriate messages for promoting wellness were displayed throughout the health clinic. Community gatherings hosted guest speakers who presented on wellness and the strength of family and community.

Developing mentors in the program means something different from mainstream society's definition. Mentors take on the role more closely associated with that of an aunt or uncle by interacting with youth in a traditional manner, while emphasizing community values and teaching adults techniques to provide support and guidance to youth. Mentors also took part in learning mental health first aid; the primary concept behind this training is to properly address depression and anxiety while stabilizing everyday "ups and downs."

A depression screening tool was implemented at youth health clinic check-ups. This then acted as a mechanism, if needed, for clinic physicians to discuss mental health issues and make referrals. The primary focus of the tool is to help prevent suicide among youth.

Gathering of the Lodges. The Native American Health Center's annual Gathering of the Lodges event has taken place for the past ten years in Oakland, California (NAHC). It is a powerful event that provides a place for Natives in recovery to celebrate their sobriety maintenance in the hope that future generations will look at alcoholism and substance abuse as obstacles that were overcome by their parents and grandparents. Each Gathering of the Lodges event has a theme, with a sobriety grand entry, keynote speakers, an honoring of each of the lodges (communities) in attendance, a luncheon, entertainment, and an honoring sobriety countdown (75 years to 1 day). The typical theme for the event is "Culture = Prevention," with a keynote address to acknowledge the value of culture as prevention, and the continued work of substance abuse prevention, early intervention, and treatment within the Native community.

Gathering of Native Americans. The Gathering of Native Americans (GONA) is a methodology consisting of a curriculum that provides a structured format for Native Americans to address substance abuse issues in a cultural context (SAMHSA). The GONA curriculum was developed by a consensus of Native American professional educators and clinicians convened by the Center for Substance Abuse Prevention (CSAP) in the early 1990s to assist Community Partnership grantees in support of community efforts to reduce and prevent alcohol and other drug abuse in American Indian communities. Needs assessments were conducted that included eight focus groups and one national planning meeting to determine the parameters of this curriculum. A Core Curriculum Committee of Native American substance abuse professionals provided Native thought, perspective, and ownership of the curriculum through a consensus process.

The Gathering of Native Americans curriculum focuses on substance abuse and mental health issues underlying addictions and self-destructive behaviors. Community healing from historical and cultural trauma is a central theme of the GONA approach. This includes an understanding and healing of self, family, and community. The curriculum focuses not only on alcohol and substance abuse, but the many underlying issues that may lead to individuals, families, and communities becoming at risk for addictions and self-destructive behaviors. The curriculum recognizes the importance Native American values, traditions, and spirituality play in healing from the effects of historical trauma and substance abuse. The four themes (Belonging, Mastery, Interdependence, Generosity) of the curriculum reflect the four levels of life's teachings.

Positive Indian Parenting. Positive Indian Parenting (PIP) is an eight-session curriculum that provides a structured format for Native Americans to develop and incorporate traditional Indian practices into modern day childrearing. The PIP curriculum was developed by the National Indian Child Welfare Association (NICWA) and is based on a philosophy that values traditional child-rearing practices through the strong emotional connection between parent and child, values

set by parents and tribal traditions, encouraging parents to take care of themselves, and discouraging the use of alcohol. PIP has been in existence and steady use since 1987 and is widely used throughout the US.

The Positive Indian Parenting curriculum is designed to provide a brief, practical, culturally-specific training program for Indian parents. The curriculum sessions include the following topics: Traditional Parenting, Lessons in Storytelling, Lessons of the Cradleboard, Harmony in Child Rearing, Traditional Behavior Management, Lessons of Mother Nature, Praise in Traditional Parenting, and Choices in Indian Parenting. The first goal of the curriculum is to help Indian parents explore the values and attitudes expressed in traditional Indian child-rearing practices and then to apply those values to modern skills in parenting. Since there is no one tradition among Indian people for child rearing, several examples from numerous tribes are used as examples.

The concept of traditional varies among people; they are referred to as old ways or historical ways.

Material can be tailored to fit the community.

There are some universal values, attitudes, or customs that may be expressed differently in local communities, which give the trainer a basis to build on. These universals include the oral tradition, story telling, the spiritual nature of child rearing, and the role of extended family. It is the assertion of this curriculum that valuable lessons are to be learned from the old ways, and that Indian parents can find strength in cultural traditions.

Peers Offering Wisdom, Education and Respect (POWER). This program has been administered through United Indian Health Services in Arcata, California and is a ten-week adolescent group curriculum that includes topics of concern for Native youth such as substance abuse, violence, social, and health issues (UIHS 2010). It is a voluntary program, although referrals come from the juvenile justice system, children's services, health clinics, and peers. The teens are a mix of leaders and those who are having trouble and may need a new peer group. Both groups benefit by expanding friendships and helping each other. POWER connects the teens to traditional ways, support to sobriety, team building, and group belonging exercises within the first two weeks. During the following eight weeks each participant takes a turn being in the spotlight. They are asked questions that evoke memories that are both good and traumatic. Trust is built as they take turns self-disclosing and they discover that they have things in common. They increase their understanding of their behavior and family experiences. The support of the other members is healing, as the adolescents receive honest feedback about their decision making and how they handle themselves.

Important elements in the success of the program are

transportation and food. The van driver must be attentive and nurturing, as much of the group process happens in the van. Food is crucial as teens are picked up at their various schools and do not return home until mid-evening. Cultural advisors from the community come to talk about aspects of tribal culture and lead participants in traditional activities. Staff encourages youth participation in traditional spiritual activities and assist teens in those activities. POWER also teaches basic communication skills, decision-making skills, life coping skills, leadership skills, and ceremonial bonding. Much of what is taught is done through the use of stories, humor, games, and songs.

During the seventh week of POWER, participants are prepared through prayer and symbolism to gather their feelings of hurt, anger, and grief, and release them to the ocean.

The teens then gather at the beach to talk about their own "releasing" ceremony. The

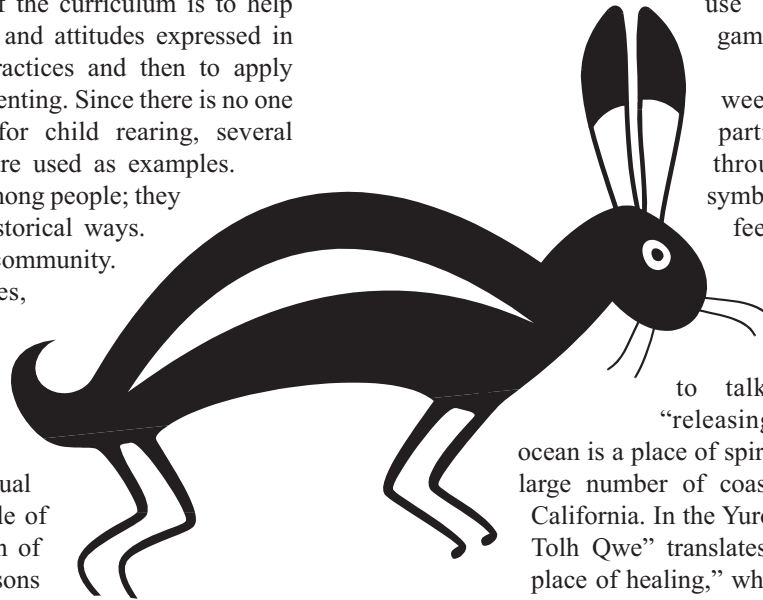
ocean is a place of spirituality and peace for a large number of coastal tribes of northern California. In the Yurok language "May Gay Tolh Qwe" translates to "Bring me to my place of healing," which the ocean has been

for thousands of years. The tenth week is the closing ceremony, which is closely tied to the beliefs of local tribal peoples, and is held at or near sacred tribal grounds.

Traditional Indian Health Gathering. Administered through the California Rural Indian Health Board in Sacramento, California (CRIHB), the annual Traditional Indian Health Gathering has taken place in California tribal communities for the past 31 years. Each year the Committee for Traditional Indian Health develops the gathering for Native health clinic staff and Native American community members interested in including or furthering traditional Indian healing methods in the health care system to benefit American Indian clients. Agenda items include workshops on providing traditional American Indian health care, including topics on behavioral health and substance abuse. Other event activities include medicinal plant demonstrations, tribal ceremonies, traditional foods for healthy nutrition, talking circles, Native crafts, and demonstrations by traditional tribal singers and dancers.

Conclusion

This report has highlighted six community defined practices that improve behavioral health in California Native Americans. These are only a handful of community defined



evidence practices that are unique to a community or which can be replicated and tailored to specific communities. There are many other cultural-based activities and traditional/ceremonial practices that are effective within the state. Some of these important practices include the sweat lodge ceremony, talking circles, traditional basket weaving, and tribal-specific indigenous dances and gatherings. The preservation and revitalization of cultural practices in our California Native American communities is imperative for mental health wellness.

It is important to recognize Native American community mobilization through a Holistic approach with the promotion of community centers. It would be beneficial to expand and open new centers in tribal and urban Indian locations that do not have them. In the process of collecting the information presented here, it has become clear that Native American community members need a gathering location that is safe and family oriented, promotes cultural activities, offers opportunity for job skills and education, and encourages intergenerational interaction and other community-specific activities which in turn promote mental well-being in an alcohol and drug free environment.

Recently the California Department of Mental Health, through the Mental Health Services Act, has funded the California Reducing Disparities Project to develop population-specific reports (strategic plans) in five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ); and Native Americans (OMS 2010). The Family and Child Guidance Clinic at the Native American Health Center in Oakland, California will develop the Native American population-specific report. The final strategic plan will articulate a comprehensive assessment of successful approaches toward the reduction of behavioral health disparities. This will include culturally appropriate strategies for access to care and services, recommendations for improved quality of care, and promising community defined evidence practices. The Native American population-specific reducing disparities report will be completed by March 2012. The final report can be obtained by contacting the author or the Office of Multicultural Services at the California Department of Mental Health.

A limitation of this report is that it does not include all community defined evidence and successful practices utilized by California Native American communities. Programs identified in this report are a starting point to illuminate what is working to reduce mental health disparities from a grassroots perspective. Behavioral health community defined evidence and the successful implementation of these practices in California Native American communities are an admixture of disciplines. It should be noted that Native communities do not have a "one size fits all" for each individual practice. Moreover communities will use a combination of indigenous-based cultural practices and western based practices to fit each community's unique and changing needs. Addressing co-

occurring disorders, substance abuse, historical trauma, and lower socioeconomic status, as well as many other intersecting issues beyond mental health alone, will be key in healing entire communities and maintaining wellness balance.

Acknowledgements

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Case Report of Acute Glomerulonephrosis Following Treatment Of Secondary Syphilis With Benzathine Penicillin Injection

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The Case

A 30-year-old male presented to a local urgent care facility complaining of a rash. He was otherwise feeling well. He had noted a 2 - 3 week history of papules and small excoriations on the penis and the region of the mons pubis. He reported an unprotected sexual contact outside his marriage about one month prior to onset of the rash. There were no other symptoms except slight itching at the site of the lesions. Past medical history was remarkable for no surgeries or chronic medical conditions. Prior evaluation for sexually transmitted infection had been done about one year prior and was negative for gonorrhea, chlamydia, syphilis, and human immunodeficiency virus (HIV). His social history was negative for injection drug use; alcohol use was described as an occasional heavy binge drinking episode that had led to heterosexual contact outside his marriage once or twice yearly. Family history was remarkable for type 2 diabetes; there was no kidney disease.

Physical examination at initial evaluation revealed normal vital signs (BP 122/74). A significant finding was a papular rash about the pubic region; papules were 1 - 3 mm, no vesicles (1 or 2 papules appeared umbilicated). Several papules were noted on shaft of the penis; some appeared excoriated. Initial diagnosis was molluscum contagiosum; cultures of several excoriated lesions were obtained for bacteria and herpes simplex virus. Urine for gonorrhea and chlamydia was obtained. Blood was drawn for HIV and syphilis testing. A referral for dermatology evaluation was ordered, and topical imiquimod was ordered, to be applied in the usual fashion to individual papules. He was advised to avoid all sexual contact until follow up.

The following day a positive total syphilis antibody test was reported. RPR subsequently was noted to be 1:64. The patient was contacted by phone and referred to local sexually transmitted disease (STD) clinic for results and treatment.

The patient was seen by this provider three days after initial evaluation. He reported no new symptoms. He had not used imiquimod. On exam his vital signs were normal. He had a faint macular rash about his trunk and feet, including soles. The papular rash about his genitals, as previously noted in

urgent care, had evolved to the point where all lesions were now scabbed over. There were no vesicles. The remainder of a complete physical exam was normal.

A contact interview done then was remarkable for sexual contact with his wife and one unknown female contact met at a bar about six weeks prior. The total number of partners was approximately 15 in his lifetime, all female.

At this point he was diagnosed with secondary syphilis and was treated with benzathine penicillin 2.4 million units after it was confirmed he had no known drug allergies. His wife was also treated. He was educated about the possibility of symptoms common with a Jarisch-Herxheimer reaction. He agreed to recheck if any new symptoms occurred. He was educated about the necessary follow up with syphilis treatment and the importance of following the RPR to assure adequate treatment.

Ten days later he presented to the emergency department (ED) with complaints of abdominal pain, body aches, and total body swelling. He reported a fever occurring about six hours after the penicillin injection with associated body aches that resolved by the next morning. He then enjoyed two normal days followed by rapidly progressing aches, abdominal pain, and swelling that seemed to begin in his feet and travel up his legs to involve his abdomen and upper extremities. Vital signs at the ED visit: BP 154/97, pulse 88, afebrile. He had no visible rash, sclerae were not injected, and there was no icterus. Pitting edema (2 mm) of the feet and ankles was noted; trace edema at mid tibia and trace edema of the hands was seen. There was no periorbital edema.

Laboratory evaluation showed normal blood count, including differential. Chemistry panel revealed a creatinine = 1.4, total protein = 4.9 gm/dl, and albumin 1 gm/dl. Sodium was 127, glucose normal, transaminase levels normal. Urinalysis showed >600mg/dl protein, moderate blood, 10 rbc/HPF, and numerous hyaline casts, with no red cell casts.

He was transferred to care of a nephrologist. He was treated with furosemide, and a 24-hour urine showed a creatinine clearance of 70 ml/min and protein excretion 6.7 gm/24 hours. Complement C3 was low at 15, C4 normal at 155. He was discharged from the hospital after diuretic therapy was initiated and it was confirmed that his creatinine was stable at 1.4.

Two-week follow up with his primary care provider was

with normal UA including negative protein. Serum protein and albumin had returned to normal. Serum creatinine was 0.9. His edema had resolved and he was feeling normal.

Three-month follow up with 24-hour urine collection was performed. Physical examination, including blood pressure, was entirely normal. Creatinine clearance was 138 ml/minute; 24-hour protein excretion was 158 mg.

Syphilis and kidney disease

The association of syphilis with various kidney diseases is described throughout medical literature. The kidney lesions associated with syphilis range from acute glomerulonephritis with prompt full recovery to rapidly progressing crescentic glomerulonephritis leading to chronic kidney disease. The most common sign of kidney disease in syphilis is proteinuria. The incidence is estimated to be as high as 8% in secondary syphilis.¹ It is also reported that proteinuria can resolve without treatment. It is generally accepted that complete recovery of kidney disease is the rule with treatment of syphilis.

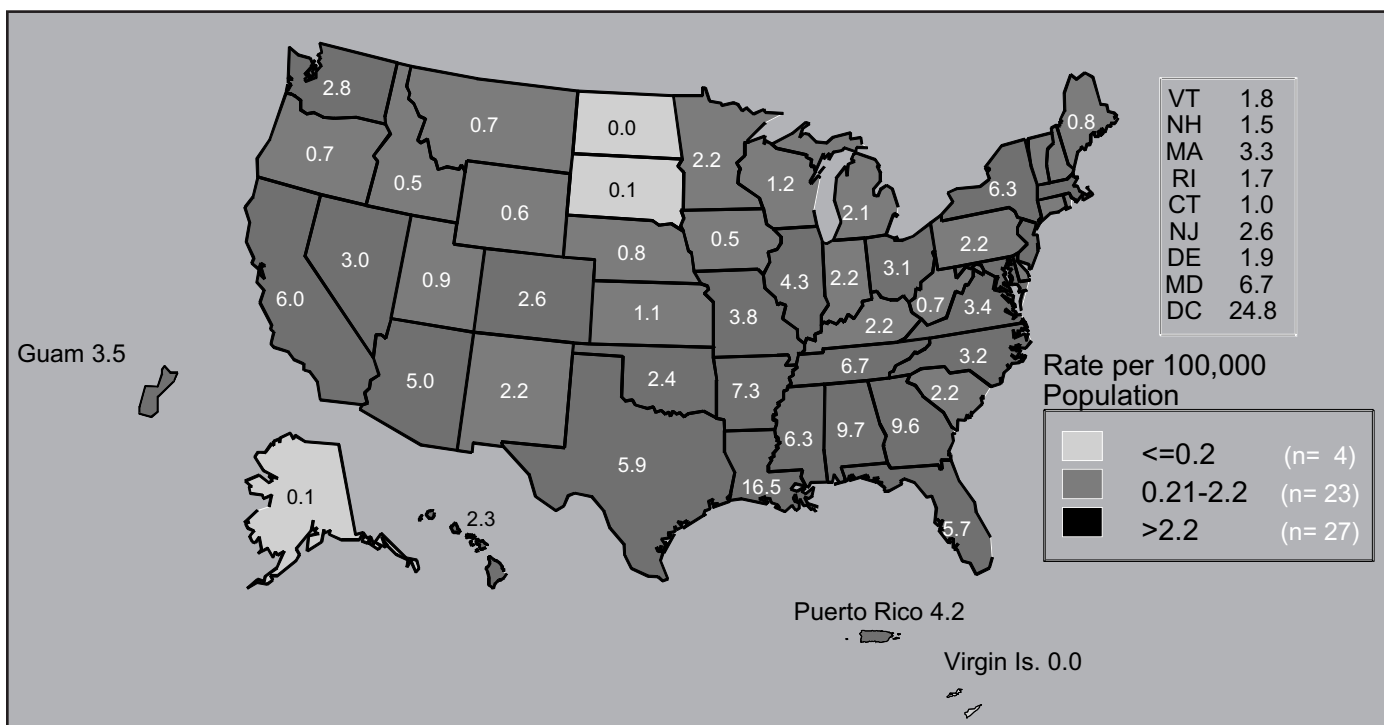
This case was interesting because it appears that the act of treating syphilis was associated with the development of kidney disease — acute glomerulonephrosis — whereas most case reports of kidney disease associated with syphilis describe the discovery of kidney disease leading to diagnosis of syphilis. In this instance, the kidney disease seemed to follow a vigorous Jarisch-Herxheimer reaction.

Jarisch-Herxheimer reaction

The patient in this case report experienced a vigorous Jarisch-Herxheimer reaction. The medical literature describes treatment of secondary syphilis as more likely to result in a Jarisch-Herxheimer reaction, and for that reaction to be more vigorous than in treatment of primary syphilis. A greater load of spirochetes is present in the host at the time of treatment of secondary syphilis than in primary syphilis. This results in more endotoxin release on the death of the pathogen, making for a more vigorous reaction. Endotoxin causes activation of Tumor Necrosis Factor-alpha (TNF-alpha). TNF-alpha is known to mediate local inflammatory reactions and is commonly accepted as a mechanism for kidney damage. Fortunately, in this case, injury was self limited and recovery appears complete.

Descriptions of the Jarisch-Herxheimer reaction date back to the late 19th century when an Austrian physician, Adolf Jarisch, noted an increase in spirochetal disease symptoms with treatment. It has been associated with most infections with spirochetes as the causative agent. The first case of glomerulonephrosis related to Jarisch-Herxheimer reaction was reported in 1947. There is a plethora of publication on the Jarisch-Herxheimer reaction in the years following World War II, the advent of penicillin and effective treatment of syphilis. Little is written since in the context of spirochetal disease. Current science has used the Jarisch-Herxheimer reaction

Figure 1. CDC 2008 Data for prevalence of syphilis.



as a model of toxic shock/sepsis.² TNF-alpha blockade development came of this research. It was initially aimed at treating toxic shock/sepsis. While harm outweighed benefit in treatment of sepsis, TNF-alpha blockade is currently of great benefit in treating numerous autoimmune disorders.

Syphilis today

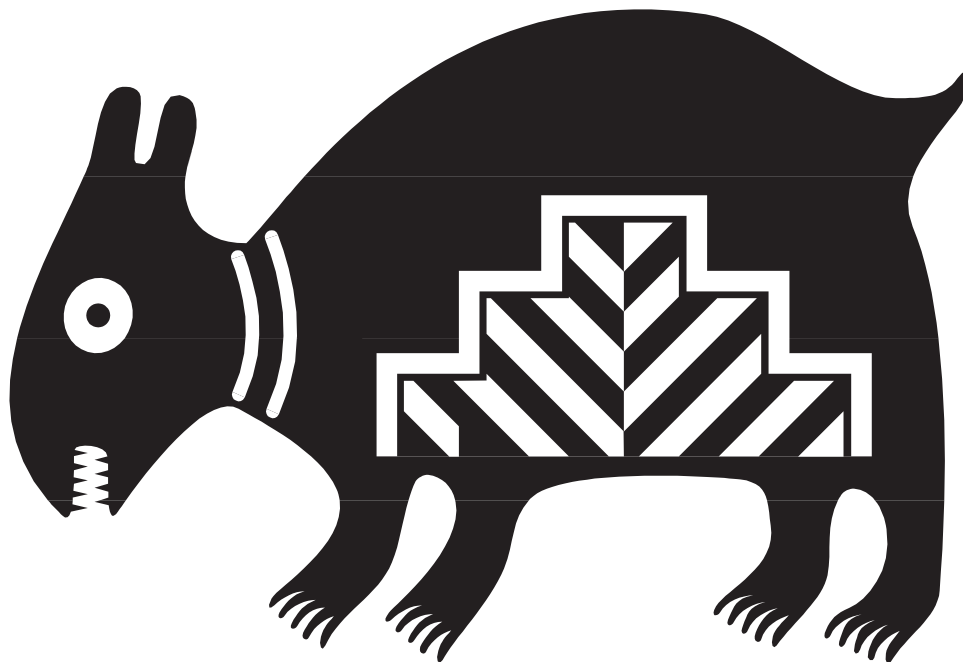
Syphilis is important due to the devastating impact of congenital syphilis, including birth defects and death. There is also good evidence that syphilis infection facilitates HIV transmission when a partner is HIV infected. Finally there are numerous complications of untreated syphilis, including neurosyphilis. Syphilis incidence, primary and secondary stages (infectious), was > 50 cases/100,000 prior to penicillin. By the year 1956, incidence had fallen to 2.3/100,000. In the late 80s there was an uptick in cases, which peaked at 20 cases/100,000 in 1990. It again fell to an all time low of 2.0 cases/100,000 in 2000. Once again it is on the upswing, with the most recent data from 2009 showing 4.6 cases/100,000 for primary and secondary syphilis.

CDC data are available for 2008 regarding prevalence of syphilis, as shown in Figure 1³.

Syphilis is present in our communities. Where there are sexually transmitted infections such as chlamydia, there is syphilis. Treatment can precipitate acute kidney disease. This kidney disease, as a rule is self limited. Secondary syphilis, when treated, is more likely to cause a Jarisch-Herxheimer reaction, and it is more vigorous than when treating primary syphilis.

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Improving Patient Care Through Refill Triage

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The Improving Patient Care Phase 3 (IPC 3) initiative has given pharmacists the opportunity to integrate into the health care team model. It is imperative that pharmacists embrace this opportunity to demonstrate an important facet of our worth as health care professionals. Our profession can procedurally contribute to the efficiency of health care delivery through handling the chief complaint of “medication refills” from patients who are not otherwise presenting for any regular exam or check-up. Proper refill triage can reduce the workload for nurses and primary care providers, as well as reduce the waiting time for the patient requesting refills and other patients requiring a provider visit.

Patients often present to the urgent care (UC) or same day (SD) provider setting for refills of medication that the pharmacy could refill without requiring provider intervention. Rather than contacting the pharmacy directly for refills, the patient involves additional, unneeded health care professionals and resources, which increases their wait time, as well as the wait times for other patients. These patients who present for refill requests without an otherwise scheduled appointment should be identified for pharmacy staff to educate regarding the refill process. This allows the request to be handled in the most efficient manner possible and provides the patient with information that may prevent future presentation to the clinic for the same reason. Some patients have not been instructed about where to look on their prescription label for refills or the prescription number. Other patients may not be able to read or understand the printed label due to language barriers or level of health literacy. Additionally, some may not understand the pharmacy refill process or know the correct telephone number to call. These problems and more can all be identified and addressed by a team pharmacist.

In an IPC model where pharmacists are decentralized from the main outpatient pharmacy, the clinic triage nurse or medical support assistant (MSA) should contact the clinic team pharmacist to look into the appropriateness and availability of medication refills when a patient presents solely for refill requests. This step is critical when working toward the goal of workload reduction for the provider and nurse staff, as this is

the earliest time for pharmacist intervention. If the medications are refillable, the patient or proxy can be directed to pharmacy for pick up. However, some clinic refill requests will result in legitimate denials. Whether approved or denied, the refill information and decision must be conveyed to the patient by the pharmacist, triage nurse, or MSA. Several factors (knowledge of refill process, location of the patient/proxy, workload and workflow, etc.) will dictate who is most appropriate to convey this information. The clinic pharmacist or MSA may provide the education at the check-in desk, a triage nurse may deliver the information in the screening room, or the information may be conveyed to the patient by phone. Regardless, the result will be that the provider(s) see only those patients who truly need to be re-evaluated before medication refills are issued.

The pharmacy should keep track of refill triage data to be analyzed by health care administrators for facilitation of optimization of process flow and staffing needs. Data on the number of approved requests, unapproved requests, and missed opportunities can be tracked for increments of 1 - 3 months, dependent on each site’s patient volume. Periodic assessments of these data furnish functional tools for administrative integrated management flexibility, allowing for identification of efficiencies realized or problems identified by inclusion of pharmacists within the IPC team. Proper refill triage should improve the quality of care and overall health for our patients because providers can focus more of their time on patients with urgent needs. It may even reduce pharmacist workload, as refills are generally quicker to process than new prescription orders. The impact of teamwork can be far reaching in the health care system and rewarding for everyone involved. When pharmacists demonstrate team value, professional relationships and perceptions are improved across the various health care disciplines, opening the door to more clinical opportunities, responsibilities, and positions.

Pharmacists have much to offer to the health care team model. The Northern Navajo Medical Center IPC model demonstrates how the team approach works more efficiently with pharmacists involved in the chief complaint triage process. By identifying and assisting patients not requiring primary provider attention to continue their medications, the health care system realizes efficiency gains in time and resources. Reducing wait times to see a primary care provider and optimizing access to needed medications enhances the health care experience for our patients. Ultimately, the health care system needs to use its resources more efficiently, and pharmacists are key to optimizing access to health care by assisting providers, nurses, and patients in responsive efficiencies of opportunity.

Advancements in Diabetes Seminars

Join us monthly for a series of one-hour live WebEx seminars for health care professionals who work with patients who have diabetes or are at risk for diabetes.

- Seminars are generally held at 1:00 pm Mountain Time.
- 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 care for people with diabetes.
- No cost CME/CE credit is available for every seminar. Accredited Sponsors: IHS Clinical Support Center, the IHS Nutrition and Dietetics Training Program, and the IHS Division of Oral Health.
- Registration for each of the seminars starts approximately two weeks prior to the seminar and goes all the way up until the start of the seminar. Registration and seminar information, including handouts, is available via the following link: <http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingSeminars>
- Upcoming seminars include:
 - January 25, 2012 @ 1:00 pm MST: Update on Diabetes and Nutrition, by Brenda Broussard, MPH, MBA, RD, CDE, BC-ADM.
 - February 22, 2012 @ 1:00 pm MST: Periodontitis and Diabetes, by G. Todd Smith, DDS, MDS.

Web-Based Diabetes Trainings

CME/CE trainings, available 24/7 at no cost. Some of these trainings, based on the live WebEx seminars, include:

- Preventing Amputations, by Greg Caputo, MD (new)
- Diabetes Standards of Care and Treatment Targets, by David Kendall, MD (new)
- Chronic Kidney Disease Screening, by Ann Bullock, MD
- Chronic Kidney Disease Management, by Andy Narva, MD
- Chronic Kidney Disease Nutrition, by Theresa Kuracina, MS, RD, CDE
- Physical Activity and Cardiovascular Risk Reduction, by Ralph LaForge, MSc, Exercise Physiologist
- Prenatal and Early Life Risk Factors, by Ann Bullock, MD
- Diabetes Foot Care, by Stephen Rith Najarian, MD
- Obstructive Sleep Apnea: New Links to Diabetes and Home Sleep Testing, by Kelly Acton, MD, MPH, FACP, and Teresa Green, MD

These trainings and others are located at: <http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingWebBased>

Also, check out training related clinical tools; Quick Guide Cards are available at: <http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsQuickGuides&nav=99>



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

“The art of medicine consists in amusing the patient while nature cures the disease.”

Voltaire

Articles of Interest

Recommendation for the Prevention and Control of Influenza in Children 2011 - 2012. American Academy of Pediatrics, Committee on Infectious Diseases. Sept 2011. <http://pediatrics.aappublications.org/content/128/4/813.full.html#sec-15>

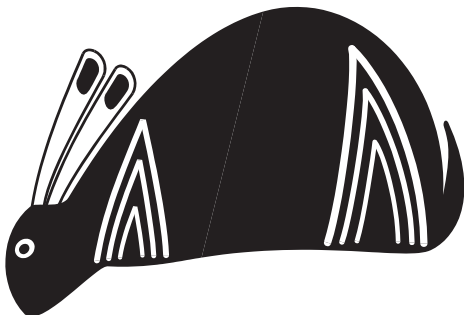
Highlights of the 2011 - 2012 recommendations: The American Academy of Pediatrics (AAP) recommends annual trivalent seasonal influenza immunization for all children and adolescents 6 months of age and older during the 2011 - 2012 influenza season. Special outreach efforts should be made to vaccinate people in the following groups:

- All children, including infants born prematurely, 6 months of age and older with conditions that increase the risk of complications from influenza.
- All household contacts and out-of-home care providers of
 - Children with high-risk conditions and
 - Children younger than 5 years.
- All health care personnel (HCP).
- All women who are pregnant, considering pregnancy, or breastfeeding during the influenza season.

On the basis of ongoing global surveillance data, for only the fourth time in 25 years there is no need to change any of the influenza vaccine strains. The number of trivalent seasonal influenza vaccine doses to be administered this year depends on the child’s age at the time of the first administered dose and his or her vaccine history:

- Infants younger than 6 months are too young to be immunized with influenza vaccine.
- Children 9 years of age and older need only 1 dose.
- Children 6 months through 8 years of age should receive 2 doses of vaccine if they did not receive any dose of vaccine last season. The second dose should be administered at least 4 weeks after the first dose.
- Children 6 months through 8 years of age who received at least 1 dose of the 2010 - 2011 trivalent seasonal influenza vaccine last season need only 1 dose of the 2011 - 2012 influenza vaccine this season.

The neuraminidase inhibitors oseltamivir (Tamiflu [Roche Laboratories, Nutley, NJ]) and zanamivir (Relenza [GlaxoSmithKline, Research Triangle Park, NC]) are the only antiviral medications routinely recommended for chemoprophylaxis or treatment during the 2011 - 2012 season. Though Oseltamivir is not licensed for use in children < 12 months, the FDA did issue an Emergency Use Authorization for this drug in young infants during the 2009 H1N1 season. The AAP, CDC, and the WHO all recommend the use of Oseltamivir in infants < 12 months with documented influenza in the 2011 - 2012 influenza season.



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
Family Nurse
Practitioner
Physician
Assistant
Registered
Dietician (Renal)
Toiyabe Indian Health
Project, Inc.; Bishop,
California**

Toiyabe Indian Health Project is seeking qualified applicants to fill provider vacancies within the organization. We are looking for highly motivated candidates who are California licensed/Board certified and ready to join our team of providers. We offer competitive pay, an excellent benefits package including health insurance, life insurance, long-term disability insurance, 401k, CME, vacation and sick leave, paid holidays, and relocation assistance. Toiyabe is located in the Eastern Sierra Region of California, with abundant outdoor recreational activities such as hiking, biking, skiing, rock climbing, fishing, camping, etc. There are small communities, safe neighborhoods, and great schools/day care facilities. If interested in applying, please contact Sara M. Vance, Personnel Officer, at (760) 873-8464, ext. 224; e-mail sara.vance@toiyabe.us; or visit our website at www.toiyabe.us for complete job descriptions and applications. (12/11)

Physician

**Family Nurse Practitioner
Northern Valley Indian Health, Inc.;
Chico And Willows, California**



Northern Valley Indian Health, a well-established provider for the Glenn and Butte County service area, has immediate openings for a physician and a family nurse practitioner. The vacancies are in our Chico and Willows clinics and present a great opportunity for professional growth. The successful applicants will demonstrate a commitment for excellence and possess well-developed interpersonal skills. You must be a graduate of an accredited United States medical school, and possess current California physician or FNP licensure and DEA controlled substance registration. Great benefits package; salary is commensurate with experience. Student loan repayment programs available. Apply at nvih.org; e-mail jobs@nvih.org; or fax to (530) 896-9406. (11/11)

**Licensed Clinical Social Worker
Medical Clinic Manager
Consolidated Tribal Health Project, Inc.;
Calpella, California**

Consolidated Tribal Health Project, Inc. is a 501(c)(3) non-profit, ambulatory health clinic that has served rural Mendocino County since 1984. CTHP is governed by a board comprised of delegates from a consortium of nine area tribes, eight of which are federally recognized, and one that is not. Eight of the tribes are Pomo and one is Cahto. The campus is situated on a five-acre parcel owned by the corporation; it is not on tribal land.

CTHP has a Title V Compact, which gives the clinic self governance over our Indian Health Service funding allocation. An application for either of these positions is located at www.cthp.org. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (10/11)

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.

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

Available EHR Courses

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

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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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