



THE IHS PRIMARY CARE PROVIDER



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Special Emergency Medical Services Issue

EMS from a Headquarters Perspective

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Perhaps one of the most rewarding aspects of any job is the opportunity to work with dedicated and enthusiastic people. Such has been the case with my position as a public health advisor with the title National Director of Emergency Medical Services (EMS) Program and Community Health Representatives (CHR) Program. I have been truly blessed to be surrounded by colleagues whose commitment to the communities they serve and passion about what they do are surpassed only by their willingness to educate, mentor, and encourage coworkers and the public about their vital roles in those communities.

My goal in this introductory article is to provide you with a brief overview, from the Headquarters perspective, of a few of what I consider major components of EMS activities at the national level. Biased or not, I think they're worthy of celebration and . . . a reality check. Before introducing any of those elements, let me offer the following facts and observations, which should act as a philosophical launching point at the very beginning of your journey through this publication's compilation of EMS articles.

Here comes the first part of the reality check. Every IHS employee should be well aware of the alarmingly and disparately high mortality and morbidity rates due to injuries, be they intentional or unintentional, in Indian Country.¹ All these scenarios require immediate medical response, whether they result from car crashes, vehicle-pedestrian crashes, domestic violence, drowning, heart attacks, or other disease- or

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injury-related causes. The incidents creating such high rates increasingly burden our existing medical system, including prehospital providers whose care may result in the difference between life and death, treating a patient or transporting a corpse; and whose training and available resources have a tremendous impact upon the status and prognosis of patients once they finally reach the hospital.

Here's the second half of that reality check: as quantified in the IHS and Tribal EMS Unmet Needs Study of 2000, EMS Programs are understaffed and underfunded.² What is the significance of that statement to tribal communities – to husbands and wives, parents and children, grandparents and siblings? It means that in order to provide essential health care needs on a daily basis for emergent and non-urgent medical transport, additional resources are needed to build sufficient EMS infrastructure.

It means that the people who currently answer those calls for help work far more hours than the standard forty hour workweek in service to their communities than a number of their rural or urban community counterparts. And while they're at it, tribal Emergency Medical Technicians (EMTs) organize fundraisers to purchase supplies and equipment to provide direct care in those ambulances, and to obtain administrative supplies and software so they can attempt to start billing for reimbursement.

It means that just as the Injury Prevention Program within the Office of Environmental Health has been leading the way for years to encourage prevention of the event that leads to injury through effective knowledge, awareness, and planning, and just as injury prevention, as one of the fourteen attributes of EMS is receiving increasing emphasis, we as a medical care system need to dedicate continued, additional resources not only to injury prevention activities, but also to improved trauma care capability when prevention fails or the situation mandates.

It means that in order to appropriately prepare for any mass casualty incidents (regardless of cause) or large scale public health emergencies, which might involve local, county, state, or federal government response, local EMS programs must be able to meet their service population's daily needs – and that requires infrastructure built on sufficient resources.

EMS Programs are understaffed and underfunded. What is the significance of that statement to the Federal government and the Indian Health Service? It means that to ensure necessary patient-focused, high quality, and safe health care services to people who require it outside the four walls of the medical facility, we must integrate and support prehospital providers into the I/T/U medical care system, regardless of who "operates" the service. This integrative, inclusive approach is promulgated by the Rural and Frontier EMS Agenda for the Future.³ In fact, it means we all have our work cut out for us to develop the kinds of EMS programs that AI/AN communities need and deserve.

That said, as you peruse the articles in this issue, please also take a moment to review the references, for they are rich in content.

“Federal and state funding should support state EMS offices in developing incentives for local EMS programs to become more integrated into the larger health care system. These incentives should focus on the continuum of care and communication from emergency event through rehabilitation, as well as addressing gaps in community health services.”

**Kevin K. McGinnis, MPS, WEMT-P,
*Rural and Frontier Emergency
Medical Services Agenda for the
Future, 2004, National Rural Health
Association***

The following, then, are items worth celebrating.

The IHS and the General Service Administration (GSA) still work closely together to provide the IHS-GSA Shared Cost Ambulance Program to supply ambulances to tribal EMS Programs. In addition, the IHS utilizes the TRANSAM Program to make excess ambulances available free of charge to tribes for use as backups. The EMS community owes a tremendous debt of gratitude to Pete Decker, a retired IHS employee, who began this project over 25 years ago. He now serves as an ambulance consultant whose incomparable knowledge and excellent working relationships have proven priceless. Our appreciation also extends to Curtis Begay and Carl Craft of the Nashville Area Office for their tireless efforts and advocacy; and to Paula Williams and her staff in the Office of Tribal Self-Governance (OTSG), which has generously provided additional funding, among other IHS Headquarters programs.

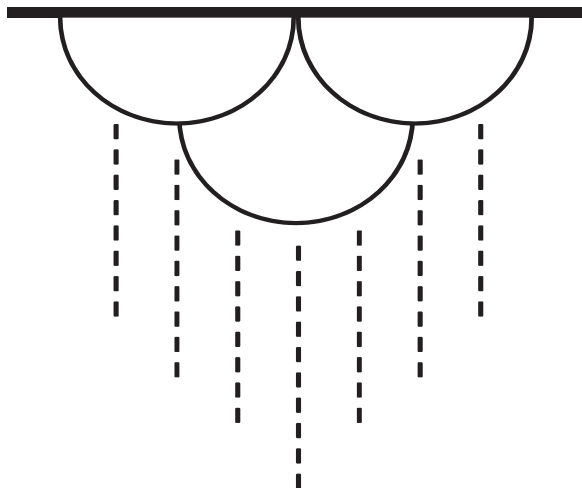
The IHS and the Health Resources and Services Administration (HRSA) continue an Interagency Agreement which focuses on EMS for Children (EMSC). LT Betty Hastings, EMSC Coordinator, is guiding that effort to ensure appropriate pediatrics training and equipment for EMS providers; raise awareness of EMS pediatric needs throughout the I/T/U, state, and local health care providers; and integrate with EMS and emergency preparedness endeavors. None of those is any small task. Our thanks go to CAPT David Heppel and CDR Dan Kavanaugh for their foresight and dedication to EMS for Children in tribal communities.

The IHS and the Veterans Administration (VA) maintain an interagency agreement that is the basis for a unique health care education partnership. The Mountain Plains Health Consortium (MPHC) operationalizes this partnership by serving as the primary EMS continuing education and initial training entity for IHS in over 37 states. Larry Richmond, lead instructor at MPHC, directs an amazing group of selfless, unwaveringly committed professionals (educational, administrative, and support) who all reflect his grace and humor. Numerous tribal EMS staff members have reported to me how much they appreciated Larry's style, sensitivity, and teaching manners. Larry and MPHC staff provide not only high quality education programs, but also HQ EMS Program support.

Because of Larry's research and advocacy efforts, Dr. Grim and IHS management became convinced of the remarkable advantage that Human Patient Simulators (HPS) would bring for enhanced EMS training. Upon the IHS Director's approval to authorize funding proffered by the Office of Tribal Self Governance, MPHC now utilizes this equipment in appropriate courses. The EMS Program wishes to especially acknowledge Paula Williams, OTSG, for her vision and financial commitment to better serve tribal communities by improving training resources for EMTs and other health care professionals.

I need to recognize Dr. Grim's forward-looking leadership as well. The EMS Program appreciates his continued accessibility and participation at the annual National Native American EMS Association (NNAEMSA) conference last November, and for IHS' ongoing financial support.

The IHS and the Administration for Native Americans (ANA) have an interagency agreement that has focused on Weapons of Mass Destruction (WMD) training for EMTs and First Responder training for community health representatives (CHRs). This year it will also include providing executive order-mandated National Incident Management System (NIMS) and Incident Command System (ICS) training to tribal leaders and EMS/EM program staff as well as First Responder and CPR/AED training to tribal youth groups.



The IHS and the NNAEMSA share a cooperative grant agreement in which NNAEMSA organizes and coordinates continuing education and certification training through its annual conference, for I/T/U EMS and other medical providers, and provides a quarterly newsletter on EMS issues and information. NNAEMSA also nurtures good working relationships with other federal, state, and private national entities, targeting EMS-related organizations. Historically the EMS Medical Director's course occurs with the annual conference under the superb and experienced management of Dr. Jim Upchurch. Dr. Upchurch also maintains licensure as a paramedic through the National Registry of EMTs (NREMT).

National EMS organizations, EMS Programs, and divisions within the state and federal government emphasize collaboration. A few significant collaborative efforts with the following groups must be recognized here:

- The National Native American Law Enforcement Association (NNALEA) whose President, Gary Edwards, a stalwart EMS advocate, ensured that NNALEA include IHS EMS as a federal partner for the Tribal Border Security Pilot Project;
- The National Highway Traffic Safety Administration (NHTSA) EMS Division, with particular thanks for the sage counsel and tribal advocacy of Susan McHenry and Drew Dawson;
- The HRSA Trauma and EMS Systems Program;
- The National Association of State EMS Directors (NASEMSD);
- The National Council of State EMS Training Coordinators (NCSEMSTC);
- The Federal Interagency Coordinating Council on EMS (FICEMS); and
- The I/T/U EMS Work Group, which meets quarterly and provides input and guidance to the National EMS Program.

Just as the 1996 "EMS Agenda for the Future" became the blueprint for development of EMS systems, so too policy and decision makers should consider as their beacon for rural EMS needs the "Rural and Frontier EMS Agenda for the Future," a 2004 publication mentioned previously. It was funded by the Office of Rural Health Policy within HRSA and spearheaded by the National Rural Health Association, the National Office of State Offices of Rural Health, and the NASEMSD, in cooperation with subject matter experts from all levels of government and business. In that document you will find an appendix on tribal EMS; the illustrative scenario used throughout the text also spotlights tribal and local EMS service integration. A prime focus is incorporation of EMS into the medical care system via expanded scopes of work for EMTs and effective service provision for all rural communities. Dr. Jim Flaherty, EMS Medical Director, represented tribal/IHS EMS as an author and editor. I'd like to acknowledge his gifted contributions to that collective

landmark manuscript. Indeed, Dr. Flaherty's integrity and unquestionable ethics, his superb clinical abilities, and his passion for our most vulnerable patients — children — have provided Headquarters with inspiration and medical leadership that have enriched and expanded every project undertaken — and there have been many.

To truly appreciate how far EMS efforts have come, one should know history. Space precludes any detailed account for the purposes of this article, but please review "History of Tribal EMS" in this publication. I would be remiss, however, to overlook the outstanding efforts of certain individuals identified below who labored to ensure that EMS would be established, so that it was able to withstand decentralization efforts, lean budget years, and tribal contracting pursuant to P.L. 93-638. In 1969, Charles A. Benson, Aberdeen Area IHS, gave initial approval to the expenditure of funds for the first contract under P.L. 93-638; and John Emelio and Dr. James Felson acted as support staff to establish a contract with the Rosebud Sioux Tribe. Rev. Webster Two Hawk, then Chairman, and Floyd Reynolds, Tribal Ambulance Director, were the groundbreakers among the tribes to contract for an EMS Program, basically "birthing tribal EMS."

Dr. George Browning and Dr. Emery Johnson granted approvals. Joe Exendine was instrumental in establishing an EMS presence at Headquarters. The following individuals provided countless hours of toil and effort to ensure the administrative and operational needs of EMS were at least considered: Dr. Lou Jordan; Robert Hawley; Ms. S. Gail Dubs; Dr. Stu Rabeau; Dr. Rice Leach; Dr. Ernie Johnson; and Dr. Ted Herbelin.⁴ Furthermore, Jerry Rousseau, inducted in 2003 into the "EMS Hall of Fame," and Pete Decker, whom Dr. Grim honored for over 25 years of exceptional service to tribal EMS at the 2004 NNAEMSA annual conference, played significant roles in sustaining the EMS Program. Admiral Rick Broderick also deserves great thanks for his creativity in maintaining EMS functions through the merger between Black Hills Training Center and MPHIC, and for his continued advocacy efforts behind the scenes.

Finally, the restructuring initiative has enabled splitting of the dual position I now hold. I will remain as CHR Program National Director but will participate in orientation for the person who fills the new EMS/EP Coordinator position (please see the article entitled "New OCPS Staff Office Established: Emergency Preparedness and Emergency Medical Services" in this issue). The unique health care providers of EMS and their roles get into one's blood, so I don't anticipate ever being too far away.

I have appreciated the support of IHS leadership and am convinced that the person who replaces me will enjoy full support as well. I am honored and thankful for the opportunity to have served in some small way with many of the finest, most dedicated professionals I've ever known — people at every level in EMS.

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4. E-mail, Personal correspondence from Cyril J. (Jerry) Rousseau to Peter Decker, Saturday, February 05, 2005.



New OCPS Staff Office Established: Emergency Preparedness and Emergency Medical Services

Bernie Dailleboust, MBA, Acting Director, EPEMS, Albuquerque Area; Jim Flaherty, MD, EMS Medical Director, Navajo Area; and CAPT Kevin Molloy, MSEH, Special Assistant, Nashville Area

Introduction

As a result of the Fiscal Year (FY) 04 restructuring initiative,¹ the Staff Office of Emergency Preparedness and Emergency Medical Services (EPEMS) was established within the Office of Clinical and Preventative Services (OCPS), Indian Health Service (IHS), beginning in FY 05. The Department of Health and Human Services (DHHS) has placed a high priority and ever-increasing emphasis on public health emergency readiness and response. This new office has been created in response to that demand. The functions of the new office were announced in the *Federal Register Notification* on July 12, 2004 (see text box page 31).² The EPEMS staff has responsibility for coordination and resource allocation for IHS-wide emergency preparedness (EP) and emergency medical services (EMS) functions; these distinct but complementary functions will be elaborated upon below.

The EPEMS staff includes four positions: the Director; two senior staff — one with a primary focus on EP, and one with a primary focus on EMS, and a program assistant. The EMS position in EPEMS will be transferred from the former combined position of EMS and CHR Coordinators in the Division of Nursing. The work of the EPEMS staff is also supported by designated personnel throughout other Divisions and Area Offices within IHS, and/or through pertinent interagency agreements. These include:

1. Betty Hastings, MSW, IHS EMSC Program Coordinator, IHS Headquarters, Office of Environmental Health and Engineering
2. Jim Flaherty, MD, EMS Medical Director Consultant, California Area
3. John Smart, MPH, REHS, Environmental Health Consultant, IHS Headquarters, Office of Environmental Health and Engineering
4. Kevin Molloy, MSEH, Emergency Management Consultant, Nashville Area
5. Pete Decker, MEA, IHS EMS Consultant and IHS/GSA Ambulance Program Coordinator, Phoenix, Arizona

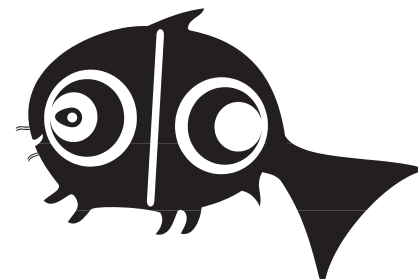
The EPEMS Staff will continue historical EP and EMS activities that have occurred at HQE, the Area Offices, and service units. In addition, it will incorporate and coordinate new federal directives, and identify and develop key resources for EP and EMS at all three levels of the organization, as well as for tribal EMS.

Emergency Preparedness Functions

The emergency preparedness activity refers to the emergency management (EM) functions of preparing for, mitigating, responding to, and recovering from an emergency. These four functions or phases are analogous to the public health care model that emphasizes disease prevention, but yet addresses treatment, acknowledging that episodes of the disease will occur and that we must be ready to react. Not all emergencies can be eliminated, but their effects can be minimized through planning and preparation. The EPEMS Staff will work to improve the capability of IHS and tribal programs to manage emergencies of all types, whether they are natural disasters, human influenced emergencies or medical emergencies, as well as other significant events such as mass gatherings of people or disease outbreaks impacting public health.

Emergency Management is a comprehensive function that develops, coordinates, and oversees activities relating to emergency preparedness and response for the IHS and tribal health programs and communities. This function is responsive to the DHHS and directs IHS activities in emergency management for the DHHS.

The EM function establishes the architecture for a systematic, coordinated, and effective health response to disasters and emergencies through agency emergency management plans. The IHS has direct responsibilities under the National Response Plan, as well as for events that are not part of a Federal Declaration of an Incident of National Significance.



Emergency Medical Services (EMS)

The function of Tribal and IHS Emergency Medical Services has been to ensure provision of all components or attributes of EMS to American Indian/Alaskan Native (AI/AN) communities as an integrated part of the local and regional health care delivery systems. In order to perform the essential and visible daily functions of prehospital emergency response and interfacility transport, EMS programs require adequate resources for daily operation and additional resources for continued development of EMS system infrastructure. Adequately resourced infrastructure provides for delivery of appropriate daily services, allows for progressive expansion of those services, and ensures improved capability in community disaster response. Disaster planning and response is one of the fourteen attributes of EMS. Surge capacity during a disaster depends on the degree of daily capacity. Effective daily operation and ongoing system development of EMS in tribal communities is achievable through the coordinated effort of IHS HQE, Area Offices, tribal EMS Programs, Tribal Departments of Health and/or Public Safety, state governments, and professional EMS organizations.

The IHS assists tribal programs in providing comprehensive emergency medical services for adults and children through advocacy and a shared resource commitment. The EPEMS Director and his/her staff, assisted by the Area EMS coordinators, provide technical assistance and resources for compacting and contracting, ambulance and equipment acquisition, and training for IHS and tribal staff. The EPEMS staff directs the administration of the EMS budget, and identifies and allocates additional, nonrecurring resources for system operation and development (e.g., developing capacity of tribal programs to bill for EMS services). The staff develops and revises IHS EMS policies consistent with current national practice standards. The EPEMS staff recognizes that injury is the leading cause of death for AN/AI people ages 1 - 55, and emphasizes the importance of injury prevention and optimal care of the injured patient. With regard to these emphases, the staff collaborates with the injury prevention activities of the Office of Environmental Health and Engineering, and the activities of other federal agencies and programs involved in injury prevention, EMS, EMS for Children (EMSC), and trauma. The staff also administers interagency and cooperative agreements with other government agencies and nongovernment organizations. The EPEMS staff responds to congressional, Executive, and IHS leadership queries on all EMS issues, and assists the IHS Director in his/her participation on the Federal Inter-Agency Council on EMS (FICEMS). The staff coordinates a quarterly ITU EMS Work Group of stakeholders to identify and direct activities that enhance EMS capacity.

Tribal programs provide local community EMS response and mutual aid through regulation and oversight from a variety of sources — tribal governments, especially departments of

health and public safety, IHS and tribal facilities, state EMS bureaus, and non-IHS hospitals and physicians. The EPEMS staff provides technical assistance to tribal programs that provide EMS in their communities. The staff seeks to support the role of IHS and tribal facilities in having a pivotal role in medical oversight, coordinated trauma care, and integration of community-based emergency planning and response. The EPEMS staff encourages full participation in state and regional trauma plans by tribal EMS and IHS and tribal facilities. State and county emergency management plans should include the role of tribal EMS programs. The staff collaborates with NNAEMSA and other professional EMS organizations for the purpose of EMS system development.

The successful role of tribal and IHS EMS in Emergency Preparedness and Management is dependent on 1) adequate resources, and 2) collaboration with a broad range of government agencies and organizations. These agencies include IHS and tribal facilities and their community-based programs; tribal Departments of Emergency Management (usually distinct from tribal EMS, and with access to unique resources); county and state governments; federal departments, agencies, and programs (DHHS, NHTSA, FICEMS, HRSA/EMSC, HRSA Office of Special Programs, ACF/ANA, GSA and DOD); and professional EMS and public safety organizations.

Emergency Preparedness and Emergency Medical Services serve reciprocal and interdependent functions that are complementary to each other. The EPEMS staff has responsibility for coordination and resource allocation for IHS-wide EP and EMS functions, as well as the complementary functions that each discipline supports in the declaration of a disaster. While EP activities are directed at planning and response for a large and unpredictable event, EMS activities largely support the daily functions of the health care system in terms of emergency response and patient transport. Disaster planning and response is one of the fourteen components of EMS, and emergency response is one of the four phases of emergency management. Surge capacity during a disaster depends on the degree of daily capacity.

Bibliography

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2. Federal Register Notification, 7-12-04. Department of Health and Human Services, Indian Health Service, Organizations, Functions, and Delegations of Authority. Part G: Indian Health Service. Available at: <http://www.ihs.gov/NonMedicalPrograms/HRG/docs.asp>. Accessed on 1-31-05.

Federal Register Notification, 7-12-04, Department of Health and Human Services Indian Health Service

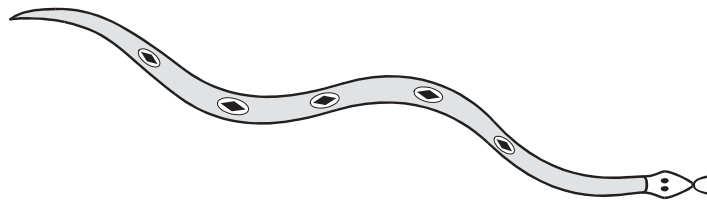
Organizations, Functions and Delegations of Authority
Part G: Indian Health Service, p. 41832

1. Provides overall direction and leadership for the Indian Health Service (IHS) in regard to establishing IHS goals and objectives consistent with those of the Department of Homeland Security and Department of Health and Human Services (HHS), addressing the mission critical elements of emergency preparedness.
2. Provides leadership for the development of emergency preparedness plans, policies and services, including the continuity of operations plans, deployment, public health infrastructure, and emergency medical services.
3. Coordinates IHS activities and resources with the activities and available resources of other government and non-government programs for essential services related to homeland security and emergency preparedness.
4. Advocates for the emergency preparedness needs and concerns of American Indian/Alaska Native (AI/AN) and promotes these program activities at the local, state, national, and international levels.
5. Advocates and coordinates support for tribal emergency medical services programs, including training and equipment.

The 10th Annual Elders Issue

The May 2005 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the tenth 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.



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 3, No. 1, January 2005) available on the Internet at <http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm>. We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Limit use of Depo Provera to two consecutive years only, according to Black Box Warning from the FDA

According to the FDA, "Women who use Depo Provera Contraceptive Injection (CI) may lose significant bone mineral density (BMD). Bone loss is greater with increasing duration of use and may not be completely reversible. It is unknown if using Depo Provera CI during adolescence or early adulthood, a critical time of bone accretion, will reduce peak bone mass and increase the risk for osteoporotic fracture in later life. Depo Provera CI should be used as a long term birth control method (e.g., longer than two years) only if other birth control methods are inadequate."

Objective: To compare longitudinal changes in bone mineral density (BMD) among first-time depot medroxyprogesterone acetate (DMPA) users to women using no hormonal contraception, and evaluate user characteristics associated with that BMD change.

Design: Prospective longitudinal study.

Patients: Women, aged 18 to 35, choosing DMPA for contraception (n = 178) and women using no hormonal contraception (n = 145).

Main Outcome Measures: Hip and spine BMD measured, at three-month intervals for 24 months, by dual energy x-ray absorptiometry.

Results: Mean hip BMD declined 2.8% (SE = 0.034) 12 months following DMPA initiation and 5.8% (SE = 0.096) after 24 months. Mean spine (L1-L3) BMD declined 3.5% (SE = 0.022) and 5.7% (SE = 0.034), respectively, after one and two years of DMPA use. Mean hip and spine BMD of control participants changed less than 0.9% over the same period. Among DMPA users, body mass index (BMI) change was inversely associated with BMD change at the hip, but not at the spine. Calcium intake, physical activity, and smoking did not influence BMD change in either group.

Conclusions: Hip and spine BMD declined after one DMPA injection and this decline continued with each subsequent injection for 24 months. With the exception of increasing BMI among DMPA users, no user characteristics offered protection against DMPA-related BMD loss.

Clark MK, et al. Bone mineral density changes over two years in first-time users of depot medroxyprogesterone acetate. *Fertil Steril*. 2004 Dec;82(6):1580-6.

OB/GYN CCC Editorial Comment:

The FDA Black Box warning was based on one controlled clinical trial in adults and one ongoing open label, non-randomized clinical trial in adolescent females. The loss increases with duration of use and may not be completely reversible. There is evidence, in both adults and adolescents, that the decrease in BMD is at least partially reversible after Depo Provera CI is discontinued and ovarian estrogen production increases. Long term studies on BMD loss in adolescents are not available at this time, but are ongoing.

Please note the FDA does not have data to address whether calcium or vitamin D may lessen BMD loss in women using Depo Provera CI. All patients should have adequate calcium and vitamin D intake. There are also randomized clinical data that estrogen supplementation is protective in adolescent girls (see below). Another approach, if long term Depo Provera CI is deemed essential, is to measure BMD. In adolescents, interpretation of BMD results should take into account patient age and skeletal maturity. Also see other citations below

In summary, until further data are available, the use of Depo Provera CI for longer than two years should be limited, while adequate intake of calcium and vitamin D should be encouraged. If other forms of birth control are inadequate, then BMD should be measured and should take into account patient age and skeletal maturity. Estrogen supplementation can also be considered.

Cromer BA et al. Double-blinded randomized controlled trial of estrogen supplementation in adolescent girls who receive depot medroxyprogesterone acetate for contraception. *Am J Obstet Gynecol*. 2005 Jan;192(1):42-7.

Conclusion: Our results suggest that estrogen supplementation is protective of bone in adolescent girls who receive depot medroxyprogesterone acetate injections.

Kim C, Seidel KW, Begier EA, Kwok YS. Diabetes and depot medroxyprogesterone contraception in Navajo women. *Arch Intern Med*. 2001 Jul 23;161(14):1766-71.

Conclusions: Depot medroxyprogesterone contraception was associated with a greater risk of diabetes compared with combination oral contraceptive use only. Risk was associated with length of use and persisted after adjustment for body mass

index. Additional research is needed for confirmation, but this risk should be considered in contraceptive choice for women at high risk for diabetes.

Cundy T, Cornish J, Roberts H, Reid IR. Menopausal bone loss in long-term users of depot medroxyprogesterone acetate contraception. *Am J Obstet Gynecol.* 2002 May;186(5):978-83.

Conclusion: Women who use depot medroxyprogesterone acetate through to menopause have attenuated rates of bone loss from the lumbar spine and femoral neck, presumably because they have already lost the estrogen-sensitive component of bone.

From Your Colleagues:

George Gilson, Anchorage

Q. Which fetal heart rate and contraction patterns are worrisome with misoprostol?

A. The hyperstimulation syndrome is worrisome and contraindicates further use of the drug.

There are three types of uterine contraction patterns associated with misoprostol use, only one of which is worrisome:

1. tachysystole refers to the occurrence of more than seven uterine contractions in any 15 minute monitoring window,
2. hypertonus refers to two or more uterine contractions lasting more than 120 seconds in any 15 minute monitoring window, and
3. the hyperstimulation syndrome refers to any instance of 1) or 2) accompanied by a nonreassuring fetal heart tracing (i.e., tachycardia, decreased variability, repetitive variables, or lates).

Only the hyperstimulation syndrome is worrisome and contraindicates use of the drug for further attempts at ripening or induction. Its incidence in most studies is usually under 5%. Tachysystole in early labor after use of misoprostol is a common finding and is usually not a cause of either maternal discomfort or fetal intolerance of the process, and does not contraindicate further usage.

Judy Thierry, HQE

Birth Simulator for Shoulder Dystocia — Rubin's maneuver requires the least traction.

Without expeditious and appropriate management, both mother and fetus are at risk for injury, even death. Up to 27% of shoulder dystocia deliveries are associated with brachial plexus palsy, of which 10% are permanent. A novel birth simulator designed by biomedical engineers at Johns Hopkins University in Baltimore, Maryland, helps identify the least traumatic delivery procedure for shoulder dystocia and other problem deliveries and assists in physician training (see details below).

Conclusion: In a laboratory model of initial maneuvers for shoulder dystocia, anterior Rubin's maneuver requires the least traction for delivery and produces the least amount of brachial plexus tension. Further study is needed to validate these results clinically.

Gurewitsch ED, et al. Comparing McRoberts' and Rubin's maneuvers for initial management of shoulder dystocia: An objective evaluation. *Am J Obstet Gynecol.* 2005 Jan;192(1):153-60.

OB/GYN CCC Editorial Comment:

Shoulder dystocia is rare, but can be a devastating problem. Timely application of known maneuvers can reverse the problem instantly. I recommend everyone who provides obstetric care, directly or indirectly, complete the Advanced Life Support in Obstetrics Course (ALSO) at least every five years.

Hot Topics:

Obstetrics

Preterm premature rupture of membranes: is there an optimal gestational age for delivery?

Conclusion: Our findings suggest that expectant management of women at 34 weeks and beyond is of limited benefit.

Lieman JM, Brumfield CG, Carlo W, Ramsey PS. Preterm premature rupture of membranes: is there an optimal gestational age for delivery? *Obstet Gynecol.* 2005 Jan;105(1):12-7.

Gynecology

Passive smoking increases the risk of cervical neoplasia.

Conclusion: The associations were in the direction of increased risk for both passive smoking and current active smoking in both the 1963 and 1975 cohorts, but were stronger in the 1963 cohort. The results of this long-term, prospective cohort study corroborate the association between active cigarette smoking and cervical neoplasia and provide evidence that passive smoking is a risk factor for cervical neoplasia.

Trimble CL, et al. Active and passive cigarette smoking and the risk of cervical neoplasia. *Obstet Gynecol.* 2005 Jan;105(1):174-81.

Child Health

Role of social norms and friends' influences on weight control behavior: adolescent girls.

Social influences — perceptions of friends' dieting and, to a lesser extent, the prevalence of trying to lose weight throughout a school — are associated with UWCBs (unhealthy weight-control behaviors) for a large group of adolescent girls. Dieting is common among adolescent girls, and many practice UWCBs such as fasting, using diet pills/powders/liquids, and vomiting or taking laxatives. School-wide prevalence of girls

trying to lose weight was significantly, although modestly, related to UWCBS for normal-weight and moderately overweight girls. Friends' dieting was significantly related to UWCBS among normal-weight and moderately overweight girls.

Eisenberg ME, Neumark-Sztainer D, Story M. The role of social norms and friends' influences on unhealthy weight-control behaviors among adolescent girls. *Social Science & Medicine* 2005;60(6):1165-1173.

Chronic Disease and Illness

Bariatric surgery may be a viable treatment option for severe obesity.

Conclusions: As compared with conventional therapy, bariatric surgery appears to be a viable option for the treatment of severe obesity, resulting in long-term weight loss, improved lifestyle, and, except for hypercholesterolemia, amelioration in risk factors that were elevated at baseline.

Sjostrom L, et al. Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *N Engl J Med*. 2004 Dec 23;351(26):2683-93.

Bariatric surgery: majority had complete resolution or improvement of co-morbidities

Conclusions: Effective weight loss was achieved in morbidly obese patients after undergoing bariatric surgery. A substantial majority of patients with diabetes, hyperlipidemia, hypertension, and obstructive sleep apnea experienced complete resolution or improvement.

Buchwald H, et al. Bariatric surgery: a systematic review and meta-analysis. *JAMA*. 2004 Oct 13;292(14):1724-37.

Features

Intrauterine Device: ACOG Practice Bulletin Number 59
Conclusions

- Pelvic inflammatory disease complicating IUD insertion is uncommon, and the risk of PID decreases to the background risk after the first 20 days after insertion.
- Nulligravid and multiparous women at low risk of STDs who desire long-term reversible contraception are good candidates for IUDs.

Summary of Recommendations. The following recommendations are based on good and consistent scientific evidence (Level A):

- Routine use of prophylactic antibiotics at the time of IUD insertion confers little benefit.
- The copper T380A is very effective for postcoital emergency contraception and is most effective if inserted within 5 days after unprotected intercourse.

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

- Intrauterine devices may be offered to women with a history of ectopic pregnancy.
- The levonorgestrel intrauterine system may be an acceptable alternative to hysterectomy in women with menorrhagia.

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

- The FDA recommends that IUDs be removed from pregnant women when possible without an invasive procedure.
- An IUD placed for contraception should be removed in a woman who has become menopausal.
- Contraception counseling should include information about risk factors for STDs and PID.

Ask a Librarian: Diane Cooper, MSLS, NIH

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- Next click on Connect To MD Consult

You can use either the generic account, which does not give you everything, or you can set up an individual account. Questions? *E-mail* cooperd@mail.nih.gov.

Family Planning

Consumer Reports Magazine rates condoms, reviews 16 other contraceptive methods.

The group used "standardized tests," including filling condoms with air, to rate the products it examined. *Consumer Reports* also included a "Guide to Contraceptives," which discusses and charts 16 other contraceptive choices, including birth control pills, intrauterine devices, and vasectomy (*Consumer Reports*, February 2005). The report says that IUDs, oral contraceptives, and emergency contraception have become "safer than in previous years." However, Consumers Union said in a statement that "[c]ondoms remain the only family planning and pregnancy prevention method that can help prevent sexually transmitted diseases."

Midwives Corner: Marsha Tahquechi, CNM, GIMC

Midwives serving Indian Country.

The American College on Nurse Midwives (ACNM) has profiled Native American midwives and nurse midwives

serving Indian Country. In September 2004, in conjunction with the opening of the Museum of the American Indian and the 2004 Indian Health Summit, the ACNM set up an exhibit at the summit highlighting the work of midwives serving Indian Country. They also provided a booklet profiling some of the Indian Health Service midwifery practices across the country. The booklet and other information are available at <http://www.midwife.org/prof/display.cfm?id=457>. For relevant links that address some of the health concerns and initiatives to eliminate health disparities among Native Peoples, go to <http://www.acnm.org/prof/midwivesindians.cfm>.

Office of Women's Health, CDC

Marriage may be good for you.

Regardless of population subgroup or health indicator, married adults were generally found to be healthier than adults in other marital status categories. Never married adults were among the least likely to be overweight or obese. Marital Status and Health: United States, 1999-2002, presents prevalence estimates by marital status for selected health status and limitations, health conditions, and health risk behaviors among U.S. adults, using data from the 1999-2002 National Health Interview Surveys.

What's New in STDs?:

Laura Shelby, Albuquerque

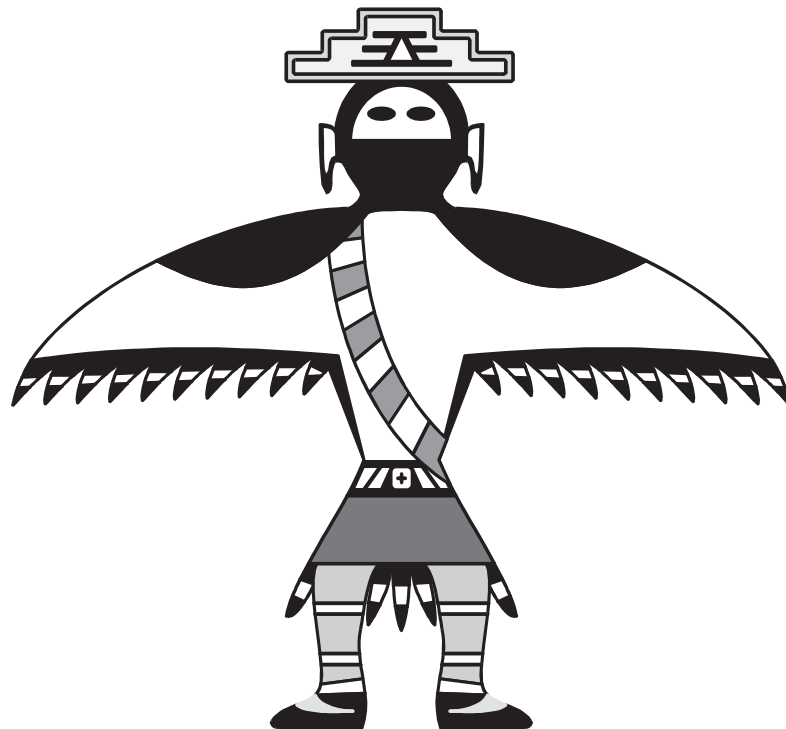
A community-based intervention designed to increase preventive health care seeking among adolescents: the Gonorrhea Community Action Project.

This intervention is noteworthy because the researchers employed a different approach to STD control by embedding STD prevention within a larger message about the importance of comprehensive prevention/reproductive health among adolescents and young adults. The goal of the intervention was to increase preventive health care seeking among female adolescents. Female participants were more likely to make an appointment for a check-up, to have undergone a check-up, and discuss the importance of having a check-up with family and friends. The intervention, however, was less successful on male participants.

Vandevanter NL, et al. A community-based intervention designed to increase preventive health care seeking among adolescents: the Gonorrhea Community Action Project. *Am J Public Health*. 2005 Feb;95(2):331-7.

Finally

The CCC Corner is good way to inform I/T/U providers about recent updates, while decreasing the number of e-mail messages. Let me know if you want to add something to next month's CCC Corner by e-mail at nmurphy@scf.cc or telephone (907) 729-3154 (with voicemail).



Ambulances for Tribal EMS

Peter Decker, MEA, IHS EMS Consultant, Phoenix, Arizona

Introduction

The Indian Health Service (IHS) has assisted tribal EMS programs and IHS service units in obtaining ambulance vehicles through two mechanisms, the IHS/GSA Shared Cost Ambulance Program, to provide primary ambulances, and the TransAm Program to provide ambulances for use as backups. The IHS/GSA program has evolved considerably over the past 31 years, while TRANSAM is a relatively new program. Safety of ambulance vehicle occupants is a concern of the entire industry, and IHS and NNAEMSA are taking steps to improve ambulance occupant safety. The Mountain Plains Health Consortium (MPHC) maintains a directory of tribal and IHS EMS programs that is available on their web site.

IHS/GSA Shared Cost Ambulance Program

The first attempt by IHS at the national level to provide GSA ambulances for tribal and IHS EMS programs happened in 1974, when IHS gave GSA enough funds to purchase approximately 30 ambulances. These ambulances were all Type I (“modular”) units and they were consolidated into GSA’s Interagency Motor Pool System (IMPS). The ambulances were delivered to the respective GSA Motor Pools and then assigned to tribal and IHS programs in the Aberdeen, Navajo, Oklahoma, and possibly Billings and Albuquerque Areas.

In 1978, IHS Headquarters allocated \$364,000 to GSA to purchase 26 new Type II ambulances and to consolidate them into the GSA fleet. At the same time, individual IHS Area/Program Offices committed another \$364,000 to purchase an additional 26 ambulances. The 52 new ambulances were assigned to tribal and IHS programs in eight Areas. IHS and GSA IMPS Headquarters established terms of this consolidation and the rental rates to be charged. They also agreed on future replacement of these ambulances: when these ambulances were replaced, IHS and GSA would share replacement costs; GSA would pay for the basic vehicle, and IHS would pay for its conversion to an ambulance. GSA established Equipment Codes 3195 and 3196, with special reduced rental and mileage rates, to reflect IHS’s contributions to acquisition and replacement costs.

By 1983, one-fourth of the ambulances purchased by 1979 had accumulated over 100,000 miles and were considered worn out. That year, the first five-year Memorandum of Agreement (MOA) was negotiated between IHS and GSA. Funds were transferred for replacement ambulances in that year and subsequent years. In addition to funds, IHS selected the ambulances to be replaced and provided GSA with exact specifications for each replacement ambulance.

Since about 1982, all GSA ambulances assigned to tribal or IHS programs have been monitored by the IHS for age, accumulated mileage, and average miles per month. About every six months, IHS computes the date each is expected to reach 100,000 miles or exceed ten years’ age. New ambulances are also requested to replace those lost in motor vehicle crashes or to accommodate new programs or expansion of existing programs. IHS also uses this ambulance information to arrange transfers of existing GSA ambulances between programs when needed.

Funds for ambulance replacements in the 1980s and 1990s came mostly from IHS and Area residual funds transferred late each Fiscal Year to GSA. In 1999 the then Director of IHS, Dr. Michael Trujillo, designated \$500,000 of equipment replacement funds be transferred annually to GSA for ambulance replacements through the Memorandum of Agreement. About \$1 million, in a combination of equipment replacement and residual funds, has been transferred to GSA each year since then.

At present, there are 149 GSA ambulances in service with 60 tribal and IHS EMS programs in 17 states (a list of all tribal and IHS EMS programs is available at <http://www.heds.org/ambpro10.html>). One or more of these ambulances belong to one of 19 GSA Fleet Management Centers. FY 04 rental rates for all GSA ambulances obtained under the shared cost program are as follows:

Equipment Code	Description	Rate per Month	Rate per Mile
319500	Two-wheel drive	\$285.00	22 cents
319600	Four-wheel drive	\$313.00	22 cents

Today, inflation, improved technology, and increased numbers of features and options on ambulances have caught up with the program. A typical ambulance purchased for a tribal program in 1980 cost about \$25,000; an ambulance purchased recently costs \$75,000. Meanwhile the number of ambulances in service has gone from less than 100 to 150 in the same time span. As a result, the \$1 million transferred from IHS to GSA is no longer adequate to keep up with increased yearly needs. Unfortunately, IHS is limited by Congressional budgetary language to transferring no more than \$1 million each year.

The IHS subsidization of each replacement GSA ambulance is very important to ambulance users. Without it, tribal and IHS users would have to pay as much as \$656 per month and 34 cents per mile. Few user programs are funded well enough to assume this additional burden.

TransAm Program

The EMS Unmet Needs Study done in 1999 - 2001¹ concluded that at least 28 ambulances were needed

immediately by the tribal and IHS EMS programs. The ambulances were needed to provide a second ambulance at locations that had only one ambulance vehicle and to supplement other ambulances in places where existing ambulances were averaging over 500 runs per year. This number was used because the authors believed those services with 500 or more runs per year will have significant time periods in which no ambulance vehicle(s) is/are available to respond to calls, because the ambulance vehicle(s) is/are away from the station, responding to calls, or being serviced.

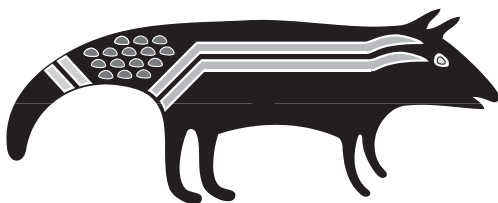
Project TRANSAM has responded to the need for additional ambulances. Project TRANSAM is a Civilian-Military Cooperative Action Program between the IHS and the Department of Defense (DoD). Its purpose is to distribute medical equipment and supplies obtained from closure of military bases and installations. Over the past four years, in addition to several million dollars' worth of useable excess medical equipment and supplies that have been transferred to IHS and tribal programs, Project TRANSAM has supplied over 30 used ambulances and support vehicles from Federal Excess Property and commercial sources. These ambulances are intended for use as backups or for supplemental purposes, rather than as primary or only ambulances.

Ambulance Vehicle Occupant Safety

Dr. Nadine Levick is an emergency physician who has done extensive research about ambulance crashes and what can be done to reduce injuries and fatalities resulting from them. She is presently Director of Research in the Emergency Department of Maimodides Medical Center, Brooklyn, New York. Dr. Levick presented, at the November 2004 Annual Educational Conference of the National Native American EMS Association, an arresting summary of her crash testing of an actual ambulance in a laboratory setting.

Dr. Levick advocates that ground ambulances adopt certain practices that are common in air ambulances:

- All loose equipment such as defibrillators and oxygen tanks should remain firmly anchored to a suitable solid base in the patient compartment.
- All attendants should remain seated and wear seat belts at all times.
- If an attendant must unbuckle temporarily to render patient care while the ambulance is moving, the driver should immediately be notified that a person is unbelted and the driver should slow the ambulance accordingly.
- Attendants in the rear compartment should wear protective helmets.²



As a paper published in 2002 summarizes Dr. Levick's recommendations, "The most crucial and immediate take-home messages from the (ambulance crash) tests so far are:

- Ambulance drivers should use caution and avoid unnecessary speed.
- Restraints should be used by all occupants.
- All equipment should be fastened down securely."³

Other measures to reduce the number of ambulance crashes and severity of injuries resulting from them include improving driver skills and real-time monitoring of driver performance. Driver training is crucial; MPHC and other sources offer Emergency Vehicle Operator Courses (EVOC) that follow a standard curriculum⁴ issued by the National Highway Traffic Safety Administration (NHTSA).

At least one company offers a driver performance-measuring device (commonly known as a "black box") specially made for installation in ambulances. This device, about the size of a cigar box, measures and records vehicle speed, hard acceleration, hard deceleration, distances traveled, use of emergency lights and sirens and turn signals, and other operating parameters. The system provides warning tones to the driver when it detects preset unacceptable values of these parameters.⁵ The IHS intends to have an electronic "black box" monitoring device installed on each new GSA ambulance that is destined to service with tribal and IHS EMS programs.

References

1. Decker PG, et al. Quantifying the Unmet Need in IHS/Tribal EMS (report), US Department of Health and Human Services, Indian Health Service, Rockville, Maryland, 2001.
2. Levick N. Ambulance Safety and Crash Data. Live presentation to a general session of the 13th Annual Educational Conference of the National Native American EMS Association, Las Vegas, Nevada, November 3, 2004.
3. Levick N, Bull M. Occupant Protection for Ambulance Passengers: An Overview. Special Reprint: Ambulance Report. This article is compiled with permission from copyrighted material originally published in the Nov/Dec 2002 issue of Safe Ride News, by Safe Ride News Publications, Shoreline, WA.
4. The Instructor Guide and Participant Manual of the Emergency Vehicle Operator's Course (Ambulance): National Standard Curriculum are available from the Government Printing Office [telephone (202) 512-1800; Instructor Guide stock order 050-003-00434-1; Participant Manual stock order 050-003-00435-9].
5. Road Safety (company), "Road Safety *SafeForce*TM Driving System," (undated brochure), Thousand Oaks, California, supplied in personal correspondence from Mr. Jeff Gompert, Vice-President, January 25, 2005.

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

“If we knew what we were doing it wouldn’t be called research, would it?”

Albert Einstein

Articles of Interest

Rethinking well child care. *Pediatrics*. 2004 Jul;114(1):210-6. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15231930

- Well child care visits were initially set up to mesh with the vaccination schedule.
- Well child care needs may no longer be congruent or fit best with vaccination schedules.
- Well child care should be scheduled to meet developmental needs.
- The author speculates that much of current well child care is inefficient and much that is needed, especially in child development, is left out.

Gaps in the evidence for well child care: a challenge to our profession. *Pediatrics*. 2004 Dec;114(6):1511-21. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15574609

- Almost one-third of visits to pediatricians are for well child care
- Aside from vaccinations, there is virtually no evidence to support what is done in office based well child physical exams, screening, and counseling are effective
- The authors do not deny that screening and counseling are important, only that evidence of their effectiveness is lacking and that this evidence needs to be obtained through well designed clinical trials.

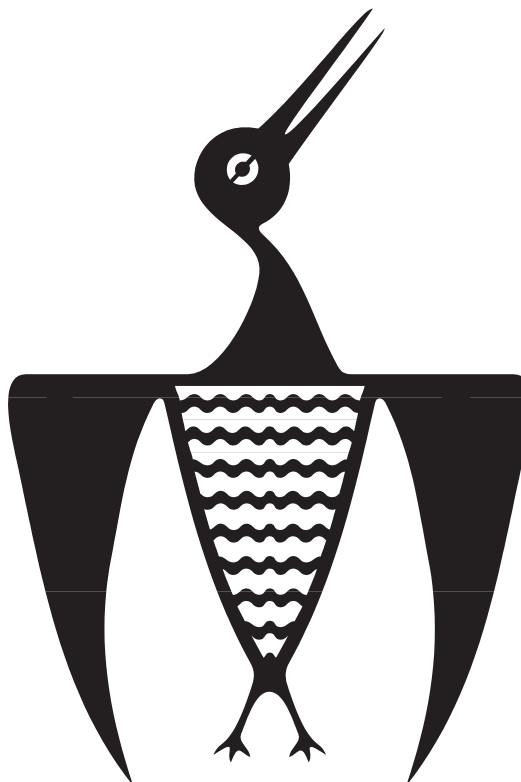
Editorial Comment

These are two thought provoking articles that demonstrate that we have little evidence to justify what we do for well child care. The authors don’t feel that health maintenance is useless, but that it lacks the rigorous evidence we would normally ask for in any other medical intervention. They challenge pediatrics to come up with the data to show “what works” and to then discard what doesn’t work, or worse, causes harm.

Recent literature on American Indian/Alaskan Native Health

Intervention-related bias in reporting of food intake by fifth-grade children participating in an obesity prevention study. *Am J Epidemiol*. 2004 Dec 1;160(11):1117-21. <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed>

- A follow-up to the Pathways study that looked at trying to prevent obesity in American Indian school children.
- The Pathways program increased knowledge about diet and exercise but failed to demonstrate any change in increased physical activity, better diet, or less weight gain.
- The authors believe that children in the intervention group underreported their caloric intake. They point out that this may be an issue in children being counseled on weight loss.



Notes from the Elder Care Initiative

What's New

The Medicare Modernization Act introduced Medicare Part B reimbursement for new preventive care services, beginning January 1, 2005. These new benefits allow us to enhance our elder services or capture new reimbursement for services already being provided.

The initial preventive physical examination (IPPE) is a one-time comprehensive exam provided within six months of enrolling in Medicare Part B, performed by a physician, PA, or NP. The CMS has defined the elements that must be included in the initial preventive exam as follows:

- Comprehensive medical and social history review, including medication review
- Review of risk factors for depression
- Functional ability and level of safety assessment
- Physical exam
- Electrocardiogram (ECG)
- Education, counseling, and referral, including plan for preventive care services

The PCC Comprehensive Elder Exam (IHS 865) is available to help document this exam. Look at a copy of this PCC, or download the PCC+ template derived from it at: http://www.ihs.gov/MedicalPrograms/eldercare/Resources_For_Professionals.asp.

These visits are coded with HCPCS codes G0344 (for the IPPE) and G0366, G0367, and G0368 (for EKG). If a portion of the visit is needed to treat illness or injury, it can be reported with modifier 25 (not so important for most of our sites that bill at the all-inclusive rate). For details in a very readable summary, go to www.cms.hhs.gov/medlearn/preventiveservices.asp.

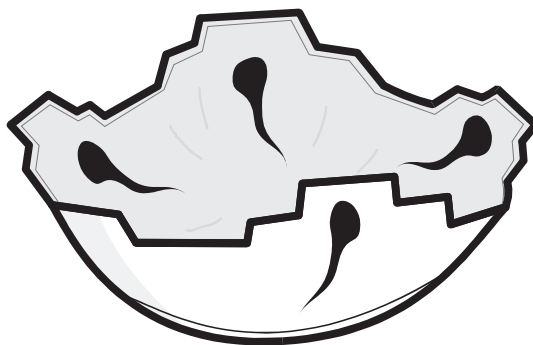
Pearls from the Literature

Sloane PD, Hoeffler B, Mitchell CM, McKenzie DA, Barrick AL, Rader J, Stewart BJ, Talerico KA, Rasin JH, Zink RC, Koch GG. Effect of person-centered showering and the towel bath on bathing-associated aggression, agitation, and discomfort in nursing home residents with dementia: a randomized, controlled trial. *J Am Geriatr Soc.* 2004 Nov;52(11):1795-804.

This is a beautifully designed, randomized, controlled trial of bathing techniques in 73 nursing home residents with dementia who had problems with agitation during bathing. Two specific approaches to bathing, both using techniques designed to make the bath a more comfortable process and tailor it more specifically to the mood and needs of the elder, were tested. Agitation and aggressive behaviors declined significantly in both treatment groups but not in the control group.

Most elders with dementia in Indian country are cared for in the home, in most cases by family members. A terribly difficult aspect of caring for elders with dementia is dealing with anger and agitation, and bathing is an activity that often triggers these responses. Our care for elders with dementia must include ensuring that family members and caregivers receive the specific education they need to provide care in the best way possible. This study confirms that there are specific, teachable techniques that can reduce agitated behavior during bathing. We need to think about how we can provide this information to the caregivers of our elders with dementia.

To subscribe to this monthly e-mail newsletter, subscribe to the Eldercare listserv. Instructions are available at <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm?module=list&option=list&newquery=1>.



Quantifying the Unmet Need in Tribal/IHS EMS: A Synopsis of the 2001 Report

Pete Decker, MEA, EMS Consultant, Phoenix, Arizona; Jim Flaherty, MD, EMS Medical Director, Navajo Area, Tuba City, Arizona; Gerri Lebeau, Administrative Assistant, Mountain Plains Health Consortium, Fort Meade, South Dakota; and Dave Short, EMT-B, EMS Consultant, Willow Creek, California

A report¹ was generated from a survey of tribal and IHS Emergency Medical Services (EMS) Programs that was conducted over an 18-month period, beginning in late 1998. It analyzed complete data from 41 EMS programs with respect to personnel, equipment, ambulances, and funding. Because of the absence of formal annual data collection on 638 contracted EMS programs, the purpose of this survey was to give a quantitative assessment of the unmet need, and make suggestions for future EMS resource allocation by the Indian Health Service (IHS). Prior to this survey, there had been one EMS system evaluation of a moderate sized sample of IHS and tribal EMS programs. It was completed in 1993 by a Technical Assistance Team (TAT) of the National Highway Traffic Safety Administration (NHTSA).² Most of their 67 recommendations regarding ten system components have not been acted upon, and remain applicable in 2005. An interval assessment by NHTSA is being considered.

Background Information

The majority of the 562 federally recognized tribes do not have their own EMS programs. During the study period, 77 tribal and two IHS EMS programs existed within eleven of the twelve IHS Areas. Alaska was excluded because of integration of village EMS with the state health care delivery systems. Historically, tribal EMS programs have been funded by a combination of four main sources: 1) IHS funds through PL 93-638 contracting or self-governance compacting, 2) contributions from tribal general funds, 3) the IHS-GSA Shared Cost Ambulance Program, and 4) collections from third party reimbursement. In addition to the tribal and IHS expenditures for EMS, both IHS and tribal Contract Health Services (CHS) funds contribute to the annual EMS outlay by paying for ground and air medical interfacility transport of individual patients that the local tribal EMS service does not have the resources to perform. IHS funding for EMS contracts have remained static for the last fifteen years; in FY 02, an additional \$1 million was appropriated for EMS. In contrast, the service population has increased an average of 2 - 2.5% per year, and the corresponding run volume has more than tripled

since 1988, reflecting the increasing burden of medical and injury-related disease in tribal communities.

Methodology

A structured telephone interview was used to gather information. A survey tool of 12 questions regarding personnel, ambulances, equipment, and budget was utilized. Two team members contacted 55 programs and completed an individual data form for each. Frequent follow-up calls were required, resulting in an average of three calls per program. The data were collated on Excel spread sheets.

Because no current resource or staffing standards existed for rural EMS systems, the collection of information to assess unmet personnel needs and to project how to meet those needs presented a considerable challenge. The authors attempted to identify staffing and ambulance standards for rural EMS systems in a number of ways, including direct contact of county, state, and federal EMS offices, checking websites, completing a computer literature search, and reviewing published reports. None of the various sources examined could identify rural EMS staffing standards that are widely known, accepted, or utilized in the national EMS community.

With no model to follow or standards to measure against, the authors chose to estimate unmet need for EMS by comparing numbers of personnel in tribal EMS programs with the same data from state EMS offices. The authors compared individual tribal EMS programs with the states in which their primary patient populations reside by creating a mathematical ratio. Ratios of numbers of EMTs per 10,000 population were computed by dividing the number of EMTs at each Scope of Practice by the US Census population of each state, and multiplying by 10,000. Similar ratios for tribal EMS programs were calculated using the IHS user population as denominators. To estimate the cost of achieving EMT parity with states ratios, the cost of an EMT position was calculated for each of the three levels by using the US Civil Service salaries.

Results

The selected results below are reported first by responses to the survey tool, followed by further analysis of the data collected. Of the 77 tribal EMS programs tracked in the Tribal EMS/Ambulance Programs Directory in 1998,³ 64 (83%) of these transport patients. Of the 64 programs that transport patients, 55 (86%) provided at least some data. Complete data

Table 1. EMS funding sources by Area

IHS Area	IHS 638 Contribution	Tribal Contribution	Third Party	Year End Ambulance Funds	CHS (Fiscal Intermediary)
Aberdeen	\$2,501,677	\$245,356	\$607,000	\$315,000	\$1,141,313
Albuquerque	\$572,586	\$620,196	\$265,000	\$103,000	\$638,518
Bemidji	\$151,493	\$572,623	\$125,000	\$0	\$103,735
Billings	\$450,464	\$0	\$143,286	\$29,000	\$1,274,350
California	\$0	\$2,000,000	\$1,000,000	\$0	none
Nashville	\$900,000	\$611,000	\$0	\$0	\$41,076
Navajo	\$3,610,000	\$100,027	\$400,000	\$68,000	\$5,021,389
Oklahoma	\$0	\$2,500,000	\$0	\$0	\$600,293
Phoenix	\$2,108,000	\$1,811,272	\$2,933,871	\$253,000	\$1,949,677
Portland	\$943,347	\$379,285	\$175,250	\$78,000	\$219,147
Tucson	\$492,000	\$0	\$0	\$0	\$349,133
ALL AREAS	\$11,803,626	\$8,839,759	\$5,649,407	\$875,000	\$12,683,189

were received from 41 programs. For these 41 programs, the total EMS outlay was \$33 million in FY 98, with \$5.6 million in third party collections received by 23 of 55 responding programs. This information is compiled in Table 1 by Area.

Including the third party collections, the total expenditure for tribal EMS programs (41 of 77) was \$39.5 million dollars. IHS contracts and compacts, tribal funds and year-end ambulance funds provided \$21 million of the total. In addition, CHS contributed at least another \$12 million (or one-third) toward that expenditure.

With regard to the staffing ratios defined in the methodology, Tables 1 - 3 summarize some of representative calculations. Individual state and tribal staffing ratios can be found in the text of the full report.

Table 2. Ranges and means of state EMT ratios

Level	Highest (State)	Mean	Lowest (State)
EMT-B per 10,000	42.91 (Colorado)	19.45	11.08 (Texas)
EMT-I per 10,000	12.54 (Wyoming)	1.74	0.06 (California)
EMT-P per 10,000	5.63 (Colorado)	3.70	1.31 (Wyoming)

Table 3. Ranges and means of tribal EMT ratios

Level	Highest (Area)*	Mean	Lowest (Area)
EMT-B per 10,000	31.64 (Bemidji)	10.2	3.20 (Tucson)
EMT-I per 10,000	9.82 (Albuquerque)	2.64	0.00 (Bemidji)
EMT-P per 10,000	19.38 (Nashville)	3.35	0.00 (Bemidji)

Table 4. Mean ratio values, tribal v. state

Certification Level	Tribal	States
EMT-Basic/10,000	10.20	19.45
EMT-Intermediate/10,000	2.64	1.74
EMT-Paramedic/10,000	3.35	3.70

When taken in aggregate (mean values), tribal staffing ratios are significantly lower than state ratios, except for EMT-Intermediate. The disparity is most pronounced at the EMT-Basic level. Further analysis of the reported data shows that an additional 1,055 EMTs would be needed for the 41 programs to achieve parity with state ratios. The total salary and benefit cost of achieving this parity for 41 programs using Civil Service (GS 4/5, 5/5, 6/5) pay scale would be \$33 million dollars. It is worth noting that compared with Civil Service and the 2000 Journal of EMS (JEMS) Annual Salary Survey,⁴ mean reported tribal EMT salaries are significantly lower, except when the EMS service is fire department based. Six of the tribal departments surveyed are fire department based.

With regard to ambulance data and needs, 158 ambulances in 11 Areas completed 86,844 runs in 1998; this translates to a mean run rate of 131 runs per 1000 population. The range of runs per 1000 population served was from 11 to 400. The relative percentages of prehospital vs. interfacility transport in these rates were not determined. An immediate need for an additional 28 ambulances, at a cost of \$2.1 million, was identified. This need reflected the fact that many programs operate with a single ambulance.

With regard to equipment, the reported needs were modest (\$127,000), and were determined by the authors to be inaccurate, based on incompletely defined survey questions.

Summary of the Authors' Conclusions

These conclusions are taken directly from the original report; all conclusions and recommendations can be viewed in the full text.¹

- Responses to this survey indicated that tribal EMS programs are understaffed and underfunded, and that there is a continued need for back up and replacement ambulances as well as new and replacement patient care equipment.
- Tribal staffing ratios are significantly lower than corresponding state ratios. The disparity is most pronounced at the EMT-B level.

- For the 41 programs with complete data sets, to reach parity with respective state EMT ratios, an additional **\$33 million** each fiscal year would be needed.
- Allowing comparable projections for the additional 23 programs for which data were not reported, or were incompletely reported, the projected need increases to a total of **\$51.5 million**.
- Looked at in another way, the findings of this assessment of unmet tribal EMS needs are comparable to findings of the 1999 IHS Level of Need Funding Workgroup: the results support a claim of health disparity. Specifically, in terms of staffing alone, tribal EMS programs are presently funded at less than 50% of their level of need.
- Future IHS appropriations should address these unmet needs, and some percentage of these increased appropriations should be set aside for establishing EMS infrastructure, gathering annual data, and performing ongoing program and systems assessments.

Commentary

The Unmet Needs Survey examined EMS resources at a point in time (1998), and was not a comprehensive inventory of tribal or IHS EMS capability. The survey did not evaluate every component that is essential to EMS operation or any information that would be particularly desirable to know in the aftermath of 9/11/01. Specifically, the survey did not evaluate needs relative to resources with regard to level of service, education, medical direction, hazardous materials capability and personal protective equipment, emergency planning and management, or data collection. While the total number of annual runs was reported, stratification by age and chief complaint/diagnosis was not included. Nevertheless, the survey did reveal two very important, consistent features — that there is an overwhelming need for more personnel and a fundamental need for more funding. The latter need can be realized by increased EMS appropriations, and the development or enhancement of billing capability. Both of these features are critical to continued operation and further development of tribal and IHS EMS systems.

The National Highway Traffic Safety Administration's (NHTSA) 1996 *EMS Agenda for the Future*'s⁵ Vision Statement begins as follows: "Emergency Medical Services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system." Adequate Emergency Medical Services are a vital part of the health care continuum, and must be realistically integrated with IHS and tribal community based health services. In the wake of 9/11, the challenge for reservation and similar rural communities is twofold. First, it is to garner the necessary resources to complete the building of the basic EMS infrastructure necessary to meet daily, essential local health care needs. Only then will local EMS services be adequately developed to meet

the second challenge of further preparing for large scale public health emergencies, including terrorist events and potential mass migration from urban areas.

With regard to funding for essential EMS infrastructure, many tribal communities with paid EMS programs are well ahead of similar non-tribal rural communities, the majority of which rely on volunteer EMS services. Paid tribal EMS services are models for rural communities that choose to develop paid EMS systems. NHTSA's *Rural and Frontier EMS Agenda for the Future*, released in the fall of 2004, addresses the resource issues common to rural and tribal EMS. An Appendix on the current status of IHS and tribal EMS is included in that document.

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EMS Medical Direction

*James Upchurch, MD, NREMT-P, EMS Medical Director,
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Medical direction for an ambulance service is important for maximizing the care and capability of the Emergency Medical Services (EMS) system in your area. This physician medical direction comes in two types. One is the physician or physician designee who gives direction to the ambulance provider or Emergency Medical Technician (EMT) via a communication device (phone, radio, etc.) or while actually on scene. This is called direct medical direction or oversight, or on-line medical direction or oversight. The second is indirect medical direction (oversight) or off-line medical direction (oversight) and is rendered by the physician responsible for the overall medical care provided by the EMS service. A laundry list of duties for this medical director includes:

- Training
- Quality improvement
- Dispatch
- Communications
- Protocol review/development
- Continuing medical education
- Direct medical direction
- Critical incident stress debriefing
- Involvement in state and national organization
- Research
- Injury prevention
- Receiving facilities
- Finance

This scope of duties requires a significant commitment from the physician and from the EMS system.

In the Indian Health Service (IHS) and in rural environments in general, there are few residency trained emergency physicians; thus, the majority of medical directors are from the primary care specialties, with little or no background in EMS. These physicians need training in basic EMS medical direction and support from their EMS system in performance of their duties. For the IHS physician, opportunities for training are described below. Additionally, Chapter 17 of the IHS manual outlines the type of support that should be made available to the IHS physician who has agreed to become the medical director for the local EMS system. This can be downloaded from <http://www.out-of-hospital.com/EMS1/documents.htm>.

Individual state-generated training opportunities for the EMS medical director are varied; check with the local state EMS office for what is available. The National Association of EMS Physicians (NAEMSP) offers a three-day medical director's course once or twice a year (any physician who has taken on this task should be a member of the NAEMSP, the only organization dedicated to all who shoulder the responsibility of EMS medical direction). Their web site is <http://www.naemsp.org/>.

The National Highway Traffic Safety Administration (NHTSA) has developed and published a curriculum for training rural EMS medical directors. At this juncture, the curriculum has not been widely implemented. Finally, the IHS offers an annual training program to introduce the subject of EMS medical direction to physicians. The IHS EMS Medical Director's course has been in existence for over ten years and has evolved into a two-part program. The first part of the program is made available on the Internet and offers a brief introduction to EMS systems and to EMS medical direction. You may preview this online segment at <http://www.out-of-hospital.com/EMS1/index.htm>. The second part consists of a one and one-half day face-to-face session and is held each November in Las Vegas, Nevada as part of the National Native American EMS Association annual meeting. The topics covered include:

- The EMS system
- Medical/legal issues in EMS
- EMS for children
- Medical direction
- Injury prevention
- Out-of-hospital research
- Communication and dispatch
- Training and manpower
- Transportation
- Disaster EMS
- EMS quality improvement
- IHS EMS

This course is a basic introduction to EMS medical direction in general and to IHS EMS. Continuing medical education credits are available for the online and face-to-face components.

For IHS physicians, the most important qualification for the medical director's job is an interest. Why should you be interested? Three reasons come to mind.

- *Personal:* it is said we all have at least one ambulance ride in our future. For self, family, and friends, we should invest some time and effort to assure that the out-of-hospital care is all it can be.
- *Professional:* the out-of-hospital care our patients receive impacts the care we subsequently provide; thus, we should desire to maximize the capability of the local ambulance service to initiate the best care possible in a timely manner.
- *Community:* in general, rural health resources are fewer than what are available in urban environments. It is important to maximize all available health care capabilities, including the local ambulance services.

Get interested and get some training so you can reach out to patients outside the physical boundaries of your practice environment.

Mountain Plains Health Consortium: The National IHS EMS Training Resource

*Larry Richmond, NREMT-P, Lead Instructor/Coordinator,
Mountain Plains Health Consortium, Sturgis, South Dakota*

The Mountain Plains Health Consortium (MPHC) is listed in the Indian Health Manual as the primary EMS Continuing Education and Initial Training entity for the IHS; we provide this training in over 37 states, from California to Maine and from North Carolina to Washington State.

MPHC is the operational name of a healthcare education consortium made up of four distinct entities.

- Health Education Development System, Inc. (HEDS). This organization is a 501 (c)(3) non-profit continuing education membership organization. Members include Acute and Long Term Care facilities, pharmacies, clinics, EMS groups and individuals.
- Veterans Administration Black Hills Health Care System (VABHHCS) with medical center campuses located at Ft. Meade, SD (our host agency), and Hot Springs, SD
- Veterans Administration Employee Education System (VAEES) is the educational arm of the Veterans Administration.
- Aberdeen Area Indian Health Service (IHS) is the fourth entity participating in this continuing education consortium. Our EMS responsibilities are IHS-wide.

Initial EMS education courses taught by MPHC personnel include First Responder, Emergency Medical Technician – Basic (EMT-B), Intermediate (EMT-I) and Paramedic (EMT-P). Our courses are open to all, whether Indian or non-Indian; however, priority is given to eligible tribal members or employees of IHS or tribal EMS programs. Graduates of our programs are eligible to take the National Registry of EMTs Exam or the local state licensure/certification exam.

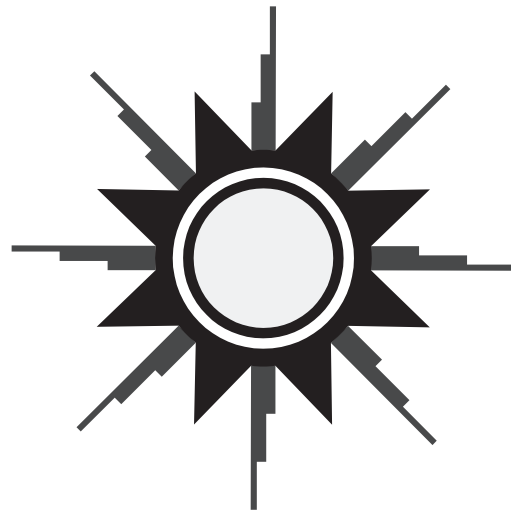
Continuing EMS education courses include: Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS), all from the American Heart Association; from the National Association of EMTs, Pre-Hospital Trauma Life Support (PHTLS), Advanced Medical Life Support (AMLS), and Pediatric Prehospital Care (PPC); From the American Academy of Pediatrics, Pediatric Education for Prehospital Professionals (PEPP); from the American Geriatrics Society, Geriatric Emergency Medical Services (GEMS); and Emergency Vehicle Operator Course (EVOC) and Emergency Medical Dispatch (EMD), both

following national Standard Curricula, and from the University of Maryland, Baltimore County, Critical Care Transport Program (CCEMTP). Other courses are developed and delivered on request, tailored to the specific needs of the local program. In FY 2004 MPHC conducted 133 courses for 1246 students in 17 states.

Additionally, MPHC supports the National Native American EMS Association and the Oklahoma Native American EMS Association with their annual conferences and hosts their web sites. More information about MPHC training activities can be found at <http://www.heds.org>.

We have experimented in the past with teaching didactic elements of our paramedic program via a blended media approach including interactive satellite broadcast of lecture material and web-based discussion assignments and testing. Cost of satellite air time has prevented us from continuing to pursue that option in spite of some very good results from the three courses that were conducted following that format. We are now experimenting with an online EMT-Basic course, and if we have success with this format, we may use what we learn from this course in future paramedic programs.

We are also very excited about the acquisition of adult and pediatric Human Patient Simulators with the assistance of the Director of the IHS. We have already found that using these devices greatly enhances the realism of scenario-based learning for our students. We are currently busy adapting the curricula of several of our current courses to use these new simulators.

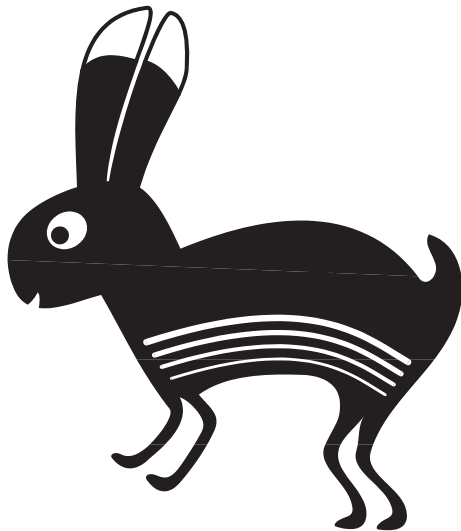


FY 04 EMS courses student totals, by Area

Area	Number of Courses	Students
Aberdeen	24	122
Alaska	0	2
Albuquerque	13	112
Bemidji	7	60
Billings	1	8
Nashville	5	32
Oklahoma	3	30
Phoenix	30	246
Portland	1	8
Tucson	8	54
Total	92	674
Aberdeen Area/EMSC Funded Courses (n=17):		138
Navajo Area/EMSC Funded Courses (n=4):		98
CHR Funded Courses (n=7):		76
In 1 SD State EMS Funded Courses:		3
Local Students Paying Tuition (12 courses):		257
Total Students Trained (133 courses):		1246

FY 04 Total courses and students taught by course type

Course	Number	Students
EMT-P	2	34
EMT-B	2	22
First Responder	5	65
EMT-B Refresher	5	51
EMT-I Refresher	4	19
EMT-P Refresher	6	39
Airway Skills Lab	1	4
BLS HCP CPR & AED	4	18
BLS HCP CPR & First Aid	2	17
CPR Instructor	1	6
ACLS Provider	12	106
ACLS Recert	9	57
ACLS Instructor	2	7
PALS Provider	7	62
PALS Recert	6	49
PALS Instructor	3	3
AMLS Provider	7	53
AMLS Instructor	2	6
PHTLS Provider	12	161
PHTLS Instructor	3	6
PPC Provider	5	61
PPC Instructor	1	5
PEPP Provider	6	49
EMD	3	27
EVOC	9	160
CCEMT-P	2	58
GEMS Provider	3	13
Trauma Assessment/Management	1	4
IM/SQ Medication Skills Lab	1	8
12-Lead ECG	1	5
Pediatric Emergencies	1	6
Geriatric Emergencies	1	20
Airway Skills Lab	1	17
Water Rescue	1	8
EMT Instructor	1	8
Incident Management System	1	12
Totals	133	1246



Emergency Medical Services for Children: The HRSA-IHS Interagency Agreement

Betty Hastings, MSW, IHS EMSC Program Coordinator, Office of Environmental Health and Engineering, Rockville, Maryland

The Emergency Medical Services for Children (EMSC) Program within the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) was established in 1984, and provides federal grant funding to state governments and schools of medicine. The EMSC Program also funds a National Resource Center in Silver Spring, MD, and a National EMSC Data Analysis Resource Center at the University of Utah for the purpose of providing technical assistance to EMSC grantees and other organizations and assisting MCHB in carrying out the goals and objectives of the EMSC Five-Year Plan.

Since the Program's establishment, EMSC efforts have improved the availability of child-size equipment in ambulances and emergency departments. The effort has also initiated hundreds of programs to prevent injuries, and has provided thousands of hours of training to EMTs, paramedics, and other emergency medical care providers. Medical personnel, parents and volunteers, community groups and businesses, national organizations and foundations, and tribal entities all contribute to the effort.

Although HRSA's and individual states' EMSC programs have made great progress in the general population over the years, much remains to be done to ensure American Indian and Alaska Native children and adolescents receive optimal medical care. The IHS EMSC efforts will work to ensure that these successes are brought to tribal reservations and established throughout the country.

Dr. David Heppel, Director of the Division of Child, Adolescent, and Family Health within the HRSA's MCHB, established the first interagency agreement (IAA) between the HRSA and the IHS in 1999. Dr. Heppel held the view that the federal EMSC Program needed to be more responsive to Alaska Native/American Indian children and their families. The language of the first IAA acknowledged the reality that EMSC's goals and activities are an integral component of EMS systems. A specific goal was written into the agreement to enhance relationships between tribal EMS services and state EMS bureaus. These have remained important aspects of every subsequent IAA. The IAA was service unit-based in Navajo Area for the first three years. Beginning in FY 03, it became HQE-based in OEHE, with the new EMSC Coordinator

position being implemented in FY 04.

In October of 2003, Betty Hastings, former Director for HRSA's Federal Traumatic Brain Injury Program, was named Coordinator under the FY 04 IHS EMSC IAA. Jim Flaherty, an IHS pediatric emergency physician, is the program's Medical Director Consultant. Dr. Flaherty, using the HRSA EMSC Five-Year Plan as a template, restructured and tailored the plan to meet the needs of American Indian and Alaska Native communities. Within the plan, six priority objectives were identified: injury prevention; tribal EMS systems; school health; mental health (for providers, children, and families); children with special health needs; and resources, both human and fiscal.

In May 2004, tribal representatives, national organizations, and other state and federal agencies attended the first IHS EMSC National Stakeholders meeting in Washington, DC. The establishment of this group is to provide guidance and input for the direction of the IHS EMSC initiative and IHS EMSC Five-Year Plan. A subsequent meeting will be held in the near future.

The EMSC website, located at www.ems-c.org, provides additional information. The contacts for the IHS EMSC program are Betty Hastings, MSW, Coordinator, Federal Emergency Medical Services for Children Program, telephone (301) 443-1043; e-mail bhasting@na.ihs.gov; or Jim Flaherty, MD, Medical Director Consultant, telephone (928) 273-3025; e-mail jim.flaherty@tcimc.ihs.gov.



The National Native American EMS Association

Peter Decker, MEA, IHS EMS Consultant, Phoenix, Arizona and Bill White, EMT-I, President, NNAEMSA, Ak-Chin, Arizona

The National Native American Emergency Medical Services Association (NNAEMSA) is a national non-profit professional 501(c)(3) organization. For the past five years, NNAEMSA has been partially supported in the amount of \$60,000 annually by a cooperative agreement with IHS. This agreement ends on June 30, 2005. The Association expects to submit a proposal to continue federal support for another five-year period.

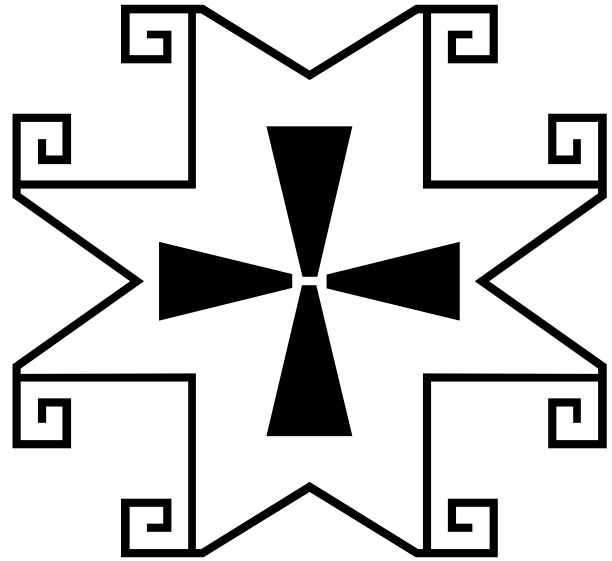
NNAEMSA is the only national organization that specifically serves, supports, and represents EMS providers who work in approximately 80 individual Native American EMS programs. These 80 EMS programs provide prehospital care to over half a million AI/AN people who live on reservations or who live in nonreservation areas (such as portions of Oklahoma and Alaska) that have significant AI/AN populations.

NNAEMSA was initially organized in 1992 and was incorporated (in the state of Arizona) in 1998. It was granted temporary non-profit status by the IRS in 1998 and received a final determination from IRS in 2003. NNAEMSA's principle activity since its inception has been to provide affordable and quality education to EMS providers, such as EMTs, EMS Medical Directors, and administrators, by presenting an Annual Educational Conference.

A Board of Directors, elected to two-year terms by the active membership at large, governs NNAEMSA. Elections for half of the Board positions are held at each Annual Conference. The present Board consists of 13 members from ten tribes in eight states. For several years, NNAEMSA has published a newsletter for its members and friends, with a typical press run of 1,000 copies.

Active memberships are open to EMTs, First Responders, EMS program administrators and/or coordinators, physicians, and nurses who are actively providing EMS to Native American communities, and to all Native American, currently licensed/certified EMS personnel. Associate memberships are available to those who do not qualify for active membership, but who support Native American EMS.

NNAEMSA has established linkages with other professional and Native American organizations; for example, NNAEMSA's President is on the Board of Governors of the National Association of EMTs (NAEMT). These two organizations also regularly have exhibitor's booths at each other's Annual Conferences.



In 2003 NNAEMSA was invited to have a booth at the "Summer Session" conference of the National Congress of American Indians (NCAI). Both organizations are working together to provide outreach training in bioterrorism preparedness for EMTs and other public safety workers, as well as tribal officials, in cooperation with the Mountain Plains Health Consortium (MPHC). MPHC is a non-profit organization that IHS considers its national EMS training entity for IHS, tribal and urban (I/T/U) prehospital providers.

NNAEMSA has established relationships with the Federal Emergency Management Agency, the National Indian Health Board, the National Highway Traffic Safety Administration, the National Association of State EMS Directors, the National Association of EMS Educators, the National Native American Fire Chiefs Association, and the International Fire Chiefs Association.

More than 200 students have now attended the Emergency Medical Services Planning and Operations for Weapons of Mass Destruction (WMD) training taught by the Engineering Extension Office from Texas A & M University and coordinated by NNAEMSA. The Administration for Native Americans (ANA), within the Administration for Children and Families of the US Department of Health and Human Services, provided funds for this training through a Cooperative Agreement with IHS. IHS tasked NNAEMSA to organize training, select sites, coordinate travel, and administer the training activities. As of January 2005, NNAEMSA has conducted WMD courses in New Mexico,

Oklahoma, South Dakota, North Carolina, and Montana. The ANA grant required that 160 students be trained; NNAEMSA, with the assistance of contracted staff from Texas A & M University, has trained 224 participants to date. Additional courses are scheduled in Michigan and Washington state.

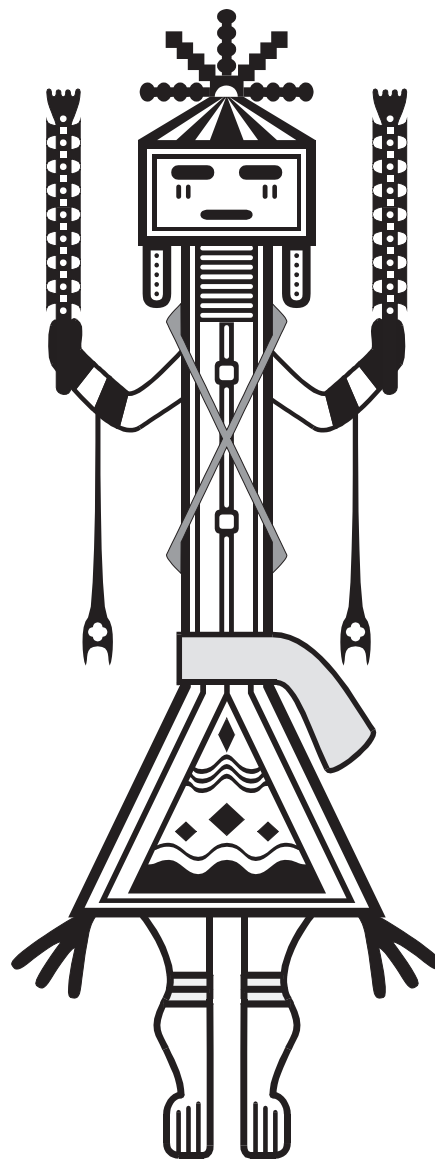
NNAEMSA recently was one of seven national organizations that each received a grant of \$125,000 for a project entitled “Linkages of Acute Care and Emergency Medical Services to State and Local Injury Prevention Programs for Terrorism Preparedness and Response.” The term of the grant period is three years. Funding after the first year, however, is dependent on each year’s budget cycle.

The other six recipient organizations are: The American College of Emergency Physicians, the American Medical Association, the American Trauma Society, the National Association of State EMS Directors, the National Association of EMS Physicians, and the National Association of Emergency Medical Technicians. The Centers for Disease Control and Prevention (CDC), Division of Injury and Disability Outcomes and Program, National Center for Injury Prevention and Control awarded these grants.

The CDC grants are intended to support collaboration between national organizations of professionals in acute medical care, trauma, and emergency medical services with state and local public health programs and CDC in efficiently and effectively responding to mass trauma events resulting from terrorism. NNAEMSA’s involvement will facilitate HRSA/CDC’s goals of effecting coordination with Indian tribes in planning to mount a collective response featuring seamless interaction of event-specific capabilities among state and local health departments, hospitals, and other health care entities.

For the first time, NNAEMSA will be working closely with six other national organizations of health care providers. Participation in this project should lead to NNAEMSA’s becoming more recognized on a national level.

More information on NNAEMSA may be found at its website, <http://www.heds.org/nnaemsa.htm>.





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