THE IHS PRIMARY CARE PROVIDER

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

January 2010 **Volume 35 Number 1**

Taking Care of Your Diabetes: A Patient-Focused Conference Report

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Introduction

This article summarizes the proceedings of a conference entitled "Taking Care of Your Diabetes," co-sponsored by the Nashville Area Indian Health Service (IHS) and the United South and Eastern Tribes, Inc. (USET). The conference focused on the psychosocial aspects of diabetes, and was intended for patients with diabetes. Thirty patients representing six Nashville Area tribes attended. Total attendance (including patients, conference coordinators, and presenters) was at 53. Approval to publish this report was obtained by the Nashville Area Research and Publications Review Committee.

Conference Planning/Coordination

The conference coordinators/planners comprised a multidisciplinary team of five health care professionals from the IHS, USET, and IHS/USET tribes. The team included Palmeda D. Taylor, PhD, Psychologist/Behavioral Health Consultant, IHS; Dianna Richter, RD, CDE, MPH, Diabetes Consultant, USET; Irene Miller, RN, Behavioral Health Director, Mohegan Tribe of Indians of Connecticut; Joanne Wilkinson, RN, Diabetes Coordinator, Mashantucket Pequot Tribal Nation; and Lewis Head, Health Educator, Mashantucket Pequot Tribal Nation. Conference planning occurred over a three-month period, through scheduled conference calls and e-mail exchanges. Ideas for the conference drew largely from the cosponsors' highly successful 2001 conference for Nashville Area patients with diabetes, and the below-referenced citations.

Conference Dates/Location/Accommodations/Travel Support

The conference was held August 24 - 27, 2009 at the Whispering Pines Conference Center, a quiet and distraction-free, country-like setting, located on the W. Alton Jones Campus, University of Rhode Island, West Greenwich, Rhode Island. The IHS provided lodging and meals at no cost to all conference participants, while the participating tribes defrayed all travel costs. Indeed, the accommodations were comfortable, and the meals served were deliciously and exquisitely prepared, with the dietary needs of the conference participants in mind.

Conference Rationale

Diabetes is a self-care disease. Thus, only to the extent that patients with diabetes develop and maintain an effective self-care plan will they achieve optimum health and quality of life. Unfortunately, for many people with diabetes, self-management is persistently problematic, giving rise to a host of physical, emotional, and psychosocial challenges.

More specifically, although emotions do not appear to cause diabetes, they do influence the course of the disease.[1] It is well documented that feelings of hopelessness and helplessness, often associated with depression, may contribute to a disatrous negative cycle of poor self-care, worsening glycemic control, and deepened depression.[2-4] In addition, there is evidence that the natural course of depression is more devastating in patients who have diabetes than it is in individuals who have no medical problems.[5]

Like depression, anxiety disorder may interfere with effective diabetes management.[6] The state of anxiety interferes

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with learning diabetes self-management skills. Acute stress may trigger neuroendocrine responses leading to hyperglycemia.[7] Additionally, anger (often derived from the belief that diabetes is an unfair and overwhelming burden), as well as certain specific fears, e.g., the fear of taking insulin, represent significant barriers to diabetes self-management.[8] Moreover, diabetic patients with chronic frustration and feelings of failure – "diabetes burnout" – tend to have higher blood sugar levels and report significantly poorer self-care.[9]

Clearly, emotions have a lot to do with how individuals cope with diabetes and how well they go about the routines of self-care, such as diet, exercise, and insulin balance. The better patients with diabetes understand and master their feelings, the better they can regulate their blood sugar, and thus prevent or minimize complications. Relatedly, the more open the communication between patients with diabetes and their health care providers, the better the patients' diabetes self-care/treatment compliance.[10]

Conference Goals & Objectives

The primary purpose of the "Taking Care of Your Diabetes" conference was to assist patients with diabetes in identifying and overcoming personal roadblocks to good diabetes self-care.[11] Specific objectives of the conference were as follows:

- To provide a forum for patients to come together and examine their thoughts and feelings, and discuss their concerns about their diabetes self-care.
- To provide overall guidance in helping patients consider how to problem-solve about and improve their diabetes self-care.
- To promote the concept that much of the responsibility for diabetes care rests with the patient.

Conference Presenters

Presenters were a carefully selected panel of health care professionals consisting of a physician, nurses and nurse practitioners, diabetes educators, nutritionists, mental health professionals, and a fitness expert. All presenters had diabetes patient care knowledge and expertise. The presenters included Harry Brown, MD, Chief Medical Officer, IHS; Doris Bonilla, RN, BSN, MS, MPH, Director of Public Health, Cherokee Indian Hospital; Randi Kington, APRN, Diabetes Educator, Joslin Center of Connecticut; JoAnne Wilkinson, RN, Community Health Nurse, Mashantucket Pequot Tribal Nation; Diane Wright, APRN, Addictions Specialist, Mohegan Tribe of Indians of Connecticut; Cathy Berndtson, RN, CDE, Community Nurse Supervisor, Narragansett Indian Tribe; Dianna Richter, RD, CDE, Diabetes Consultant, USET, Inc.; Sky Spears, MSW, LCDP, Behavioral Health Administrator, Narragansett Indian Tribe; Palmeda D. Taylor, PhD, Psychologist/Behavioral Health Consultant, IHS; Karen Thames, PsyD, Staff Psychologist, Narragansett Indian Tribe; and Lewis Head, Health Educator, Mashantucket Pequot Tribal Nation.

Conference Format

The conference was designed to be as interactive and practical as possible. Emphasis was placed on providing patient participants with ample opportunity to share their thoughts, feelings, and frustrations with diabetes. Moreover, information was provided and techniques were taught that participants could "put into action" once they returned home.

An optional "Walk and Talk" began each conference day. Participants were exposed to the remainder of the conference agenda, either in a large or small group setting. (Consistent with *Native thought and practice*, and to facilitate easy discussion, the seating-arrangement approximated a circle.) Large group sessions ranged in length from 60 - 75 minutes each, and covered a variety of educational topics about diabetes, in general, and the psychosocial aspects of diabetes, particularly. Large group session topics included "Basic Facts about Diabetes" (by Dr. Harry Brown), "Understanding Diabetes Burnout" (by Randi Kington), "Psyching Out Those Negative Thoughts and Feelings: Making Health Lifestyle Choices" (by Sky Shuler and Dr. Karen Thames), "A Day Away from Stress" (by Doris Bonilla), "The Impact of Drinking and Drugging on Diabetes Self-Care" (by Diane Wright), "Lifting Mood through Exercise" (by Lewis Head), "Teachings, Tips and Tools for Healthy Eating" and "Making Healthy Changes" (by Dianna Richter), "Strategies for Effectively Communicating with Your Doctor" (by Joanne Wilkinson, and "Telling My Story" (facilitated by Cathy Berndston). Dr. Palmeda Taylor chaired the conference.

A series of questions, answered within the context of hour-long focus groups of 8 - 10 participants each (facilitated by Dr. Palmeda Taylor), wrapped up the conference. The following questions were posed:

1. What is diabetes burnout, and what are some recommended strategies for alleviating it?
2. What are some ways you can master the emotional challenges presented by diabetes?
3. What factors "get in the way" of a successful provider/patient relationship? What steps will you take to improve your relationship with your diabetes care provider(s)?
4. What does living well with diabetes mean to you?
5. What are some healthy choices you will make to improve your diabetes self-care, as a result of this conference experience?
6. Many of your friends/community members with diabetes were unable to attend this conference. What will you say to them about the importance of taking care of their diabetes?
7. What impact might this conference have on your efforts to understand and support your family member(s) who have diabetes?

Participation in all scheduled groups and activities was full and active.

Evaluation

Participants evaluated individual presentations and the conference overall. The conference co-chairs analyzed the results of the evaluations and provided feedback to the presenters. Overall, the conference was highly rated by all who attended with regard to content, presenters' knowledge and style of delivery, relevance to the objectives, and accommodations. The presentations were said to have been both informative and enjoyable. Participants concurred that future patient-focused conferences for Nashville Area patients with diabetes should be held.

Below is a sampling of comments that participants made about the conference in terms of what they liked most and what they learned.

What did you like most about this conference?

- "The diversity of the presenters."
- "Laughing, the agenda (Joann and Palmeda's enthusiasm), and Whispering Pines."
- "Fun, friendly participants and hearing from others."
- "Learning about others and how they deal with diabetes."
- "The openness of all involved, it was very informative and great speakers with plenty of information – overall friendly group of people!"
- "All the happy faces and friendly talks of others and their lives with this sickness we are all dealing with."
- "When all people had some input on the diabetes."
- "Meeting my tribal members who also have this disease and knowing we can work towards wellness."
- "Meeting new people and learning more about diabetes."
- "The speakers and the literature."
- "Participants sharing of their stories and the food was terrific."
- "Everyone communicating together."
- "Very informative – made me realize how I need to take care of myself and be responsible for my own treatment."
- "The support of all the participants."
- "Pretty much everything."
- "Each speaker showed sincere concern about everyone attending and gave very supportive information to help us succeed in our journey."
- "The upbeat way that everyone worked on their presentations."
- "I especially liked the development of the program and I think all of the speakers were excellent."
- "The easy way the teachers told us to deal and take care of our diabetes."
- "Camaraderie – just wonderful, quiet, good food."

List three things you learned from this conference.

- "You can eat whatever you want, that your levels don't have to be perfect between 80-120, and that there are new medications available."
- "Making care a priority, eating a balanced meal and being supportive."
- "Be honest, make better choices with food and be more social."
- "The importance of getting good health care; write down information for your doctor."
- "To be more open with your doctor, you are the main person in control of your diabetes, balance in your life as an individual is the key to control – be it diet, exercise or support."
- "What to eat, don't forget to take medications, walk and be happy with your life."
- "To take care of myself in all that I do, to take my medications, to check my blood sugar and keep myself moving."
- "Eat well, exercise and keep up with my appointments."
- "Exercise is important, diet (portion of food) and communication with the doctor."
- "Taking responsibility for my health, being committed to making changes to my quality of life and continue to actually work on weight loss and exercise."
- "The importance of seeing other doctors regularly, how diet and exercise are crucial and how support is so necessary."
- "That I need to take blood level more often, how to deal with stress and how to deal with diabetes."
- "To keep focused on taking care of self and keeping diabetes under control
- "Tips on getting going on a better meal plan."
- "There's different ways to cope with this disease."
- "Sharing your diabetes with others."

What else participants said:

- "Special thanks to Joanne and Palmeda."
- "Great Job…well done…my hats off to all."
- "I enjoyed all the experiences of all that I heard from."
- "I enjoyed the whole conference…it was probably a high point as it reflected on all of our feelings and learned knowledge."
- "I was fully nourished with each and every topic."
- "I think all grounds were covered very well…all speakers were well prepared."
- "I thought it covered all points to help me improve my diabetes."
- "I think everyone did a great job and I learned more than I thought I would."
- "I thought the conference was very inspiring and it

has encouraged me so much the only improvement I can think of is that I wish more I had taken advantage of being here."

- "I personally think everything was done very professional and I hope you have it again."
- "Rating it 1-10, I would give it a 9 – Job well done."
- "Hope to be invited next year."
- "Thank you!!!"

Follow-up

Most conference sponsors do not have an accurate gauge of what their conference actually produced in terms of value or quantifiable results.[12] This is because, typically, post-conference evaluations are administered to help the sponsors understand how attendees felt about the event. However, we know that a conference can be valuable in shaping and/or changing behavior. We also know that conference payback is realized when conference participants take actions, after the fact,[13] which demonstrate retention of the learning shared. Accordingly, an added component of the "Taking Care of Your Diabetes" conference was participant follow-up or a progressive evaluation.

More specifically, individual conference participants developed a "Making Healthy Changes Plan," i.e., a set of healthy changes they planned to make as a result of this conference experience. Participants will be surveyed as to their overall health and well-being and ability to carry out their plans/sustain their efforts toward good diabetes self-care, every 90 days over the next 12 months. In instances where it is apparent that the patient is struggling with his/her diabetes self-care, the conference coordinators will provide assistance (with the patient's permission) through collaboration with the patient's diabetes care provider(s) at the tribal level.

Conclusion

Based on the focus group and evaluation responses, conference participants learned that they are not alone with respect to their diabetes; that knowledge, family and peer support are powerful in the fight against diabetes; and that looking at what you really feel about the disease is important. Indeed, a patient-focused conference that focuses on the psychosocial aspects of diabetes appears to be an effective health education tool that is worthy of replication.

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The conference format includes three and a half days of lectures and workshops. To view the 2009 brochure and, when available, the 2010 brochure go to the UNM CME web site at http://hsc.unm.edu/cme . For additional information please contact the course director, Dr. Ann Bullock at (828) 497-7455, annbull@nc-cherokee.com or Kathy Breckenridge, University of New Mexico Office of Continuing Medical Education at (505) 272-3942, or email the UNM Office of Continuing Medical Education to request a brochure at CMEWeb@salud.unm.edu. If you have attended the conference in the past *two years*, you are already on our mailing list and a brochure will be mailed to you.

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ACOG Revises Cervical Screening Guidelines: Start At Age 21; Screen Less Frequently

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

The American College of Obstetricians and Gynecologists (ACOG) has issued new guidelines that simplify cervical cancer screening. These recommendations reflect evolving understanding of cervical cancer biology and of the benefits and risks of screening. There is widespread support for these new recommendations, and their simplicity should encourage prompt adoption. The essentials are:

1. Screening should start at age 21, regardless of onset of coitus or pregnancy status.
2. Screen every TWO years through age 29.
3. Screen every THREE years from age 30 to age 65 or 70.

A small group of women should receive ANNUAL screening:

- Women with a prior diagnosis of CIN II (moderate dysplasia) or higher
- Women with HIV
- Women with immunosuppression (such as transplant recipients or those on chronic steroids)
- Women with a history of diethylstilbestrol (DES) exposure

Screening should be discontinued for women who have had a complete hysterectomy (including the cervix) for benign indications and who do not have a history of CINII or higher or DES-exposure. Screening may also be discontinued for women at age 65 to 70 if they have had three normal pap tests and no abnormal test in the past ten years. Inadequately screened elderly women should continue screening until these criteria are met.

Management of abnormal results is not addressed in these guidelines and has not changed. Current protocols for ongoing surveillance and treatment from the American Society for Colposcopy and Cervical Pathology (ASCCP) are available; see the “resources” links below.

Background

Cervical screening is an amazing success story in cancer prevention. Cervical cancer rates have fallen more than 50% in the past 30 years in the United States. The number of cases of cervical cancer (not deaths) was 14.8 per 100,000 in 1975; that rate had declined to 6.5 per 100,000 by 2006. The American Cancer Society estimates for 2009 include 11,270 new cases of cervical cancer and 4,070 deaths. At least 50% of cervical cancer deaths occur in women who have never been screened or whose last screening was more than five years ago. The incidence of cervical cancer increases steadily with age.

American Indian and Alaska Native (AI/AN) women have made similar gains in cervical cancer prevention, but rates remain higher than the national average. Indian Health Service data from 1996-98 demonstrate an overall AI/AN cervical cancer death rate of 5.2 per 100,000; in 1999-2001 the AI/AN rate had decreased to 4.4 per 100,000. The comparable rate for US all races in 2000 was 2.8 per 100,000. Wide variations in cervical cancer incidence across IHS regions are noted; the highest rates are reported in the southern plains (14.1) and northern plains (12.5); much lower rates were noted in the eastern region and the Pacific coast (7.1 and 6.9). Overall, AI/AN women are also more likely to be diagnosed with later stage disease. Regional differences in participation in screening are also noted; for example one study has shown that Alaska Native women have much higher rates of screening (75.1%) than American Indian women living in the southwest (64.6%). Under-screened women in this study tended to be of lower socio-economic status, tobacco users, live in rural areas, and lack regular contact with health care systems.

Human papillomavirus (HPV) infection plays a central role in the development of cervical cancer. There are many strains of HPV; only a few are cancer-promoting. Most women will contract HPV at some point in their lives, however more than 75% of women will clear the virus within 8 to 24 months. Cervical cancer is a slowly progressive disease, with ample time to interrupt its progression in adequately screened women. Dr. Alan Waxman, for many years an IHS physician at Gallup Indian Medical Center and the Chief Clinical Consultant for Obstetrics and Gynecology for the Indian Health Service, served as the lead author for these recommendations:

> "The tradition of doing a Pap test every year has not been supported by recent scientific evidence," says Alan G. Waxman, MD, at the University of New Mexico in Albuquerque and who headed the document developed by ACOG's Committee on Practice Bulletins-Gynecology. "A review of the evidence to date shows that screening at less frequent intervals prevents cervical cancer just as well, has decreased costs, and avoids unnecessary interventions that could be harmful."

Screening may be performed with traditional glass slide collection methods or with liquid-based collection kits. Both modalities are considered to be equivalent, although liquid-based screening facilitates testing for high-risk HPV, which may be helpful if the cytology result is neither normal nor clearly dysplastic; colposcopy may be deferred in those with ASC-US who test negative for high risk HPV. Co-testing with cytology and HPV screening for women 30 and over may be considered but is not mandated.

Focus on Younger Women; Preterm Birth Prevention

Cervical cancer screening should begin at age 21, regardless of sexual history. Screening before age 21 should be avoided as these women are at exceptionally low risk for cervical cancer (1-2 per million in women ages 15 to 19). Teens and young adult women frequently contract HPV, but also promptly clear the virus. Young women may struggle with the news that they are infected with a sexually transmitted virus known to cause cancer, and anxiety about colposcopy and related procedures may ultimately discourage further participation in care. More importantly, if treated with excisional procedures such as loop electrosurgical excision procedure (LEEP) or cone biopsy, the cervix can be weakened, resulting in an increased risk for preterm birth in any subsequent pregnancy. It is estimated that 1 in 18 women who have a LEEP procedure will go on to deliver prematurely. As Dr. Waxman states, "Adolescents have most of their childbearing years ahead of them, so it's important to avoid unnecessary procedures that negatively affect the cervix."

Focus on Elderly Women; Adequate Surveillance a Prerequisite for Discontinuing Screening

For well-screened women, discontinuation of screening at either age 65 or 70 is recommended. Adequate prior screening consists of at least three normal screens and no abnormal results in the prior decade. As women age 65 and older account for nearly 20% of all new cervical cancer cases and more than 36% of all cervical cancer deaths, it is necessary to confirm adequate screening prior to cessation of ongoing surveillance.

Implications for Practice

1. We can stop screening girls and women under 21 immediately. We can redirect resources for young women towards HPV vaccination and other aspects of reproductive health care.
2. Screening every two or every three years can be performed with traditional or liquid-based screening; co-testing with high risk-HPV screening for women 30 and over may be considered but is not mandated.
3. Robust case management systems are needed to track women with abnormal screening results and assure both short-term management and long-term surveillance are prioritized.
4. Outreach efforts are needed to facilitate access for unscreened and under-screened women. To reach these women, creative strategies including offering paps in less traditional settings (urgent care and emergency room visits, community settings, etc.) and outreach education are needed. Some groups have especially poor participation in screening; these include women who smoke, are obese, and are experiencing psychological distress. Enhanced outreach efforts and care for these women may be warranted.
5. While most elderly women will be able to discontinue screening, unscreened or under-screened older women should be a high priority group for surveillance.
6. HPV vaccination should be widely available to women through age 26. Vaccine is available through the "Vaccines for Children" program for all American Indian and Alaska Native women through age 18. For those 19 and over, vaccine is available through a program from Merck. See the article from Amy Groom in *The IHS Provider* ("Financing Adult Vaccines" June 2009; Volume 35, Number 6:172-173) for more information.
7. What about the annual exam? There are many reasons for adolescent girls and adult women to see their health care provider; continuing to offer yearly preventive health care is an opportunity to address an array of health issues including glucose screening, discussion of healthy weight goals, STD screening, contraception, substance abuse, domestic violence, and depression screening, etc. "Annual Exams" can continue to be offered, however the pap test doesn't need to be part of this visit every year.

Resources

ACOG Press Release:
http://www.acog.org/from_home/publications/press_releases/nr11-20-09.cfm

The full ACOG Practice Bulletin:
http://journals.lww.com/greenjournal/documents/PB109_Cervical_Cytology_Screening.pdf

ASCCP Treatment Guidelines:
http://www.asccp.org/consensus.shtml

Information for patients, including Alaska Native and American Indian focused brochures:
http://www.cdc.gov/std/hpv/common/

Programs to help procure HPV vaccine: (Amy Groom, et al. Financing Adult Vaccines. IHS Provider. June 2009. Pages 172-173.)
http://www.ihs.gov/Provider/documents/2000_2009/PROV0609.pdf

Merck Vaccine Patient Assistance Program:
http://www.merck.com/merckhelps/vaccines/home.html

Watch Dr. Waxman's CBS News interview: *http://www.cbsnews.com/video/watch/?id=5727058n*

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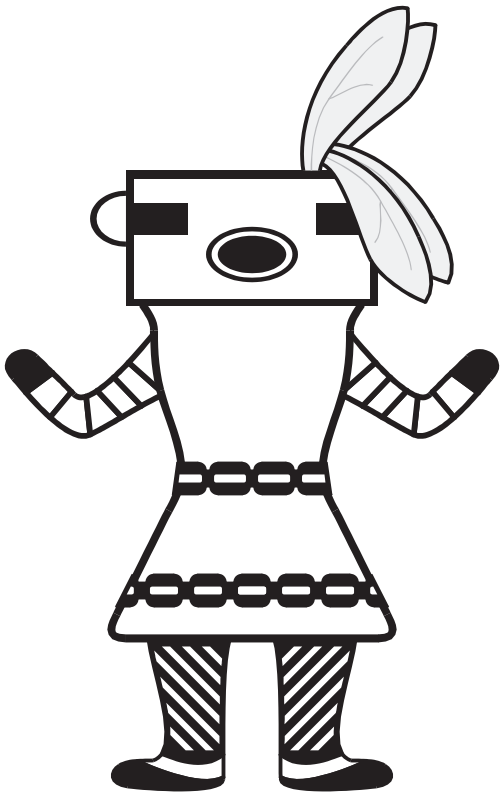
10. *Many have inquired about the new Mammography guidelines. We will discuss Breast Cancer Screening next month.*
11. *The full contents of the IHS Women's Health Notes are available on-line at: http://www.ihs.gov/MedicalPrograms/MCH/index.cfm*



Letter to the Editor

I have found *The Provider* helpful and enjoyable, both now as I re-enter the IHS after a three-year hiatus, and in the past during my years in Crownpoint, New Mexico -- especially the Child Health Notes and Obstetrics and Gynecology Chief Clinical Consultants' columns. I just recently reprinted Dr. Narva's series on management of chronic kidney disease on paper for quicker reference. *The Provider* has contributed to a sense I have of working in a "community" of clinicians who share common goals -- I've either worked with or met at IHS conferences many of the content contributors over the years.

It sounds like the plan to publish a printed quarterly edition with clinical information and to use the electronic version to include more time-sensitive information is the most appropriate "fix" in terms of getting information out to people; however, I couldn't tell from the announcement in the December issue if this change is planned to be permanent.

I personally prefer to read a medical article on paper; I find this more accessible than electronic media in terms of picking it up and putting it down, easier on the eyes, and not dependent on occasionally capricious technology (and having to enter passwords for access). Also, some of the more timely clinical information -- on H1N1 influenza, for example, or an article taking into account very recent but practice-changing study/trial information -- might seem a bit more dated in a quarterly cycle. Granted, there are other avenues for obtaining most of these types of information.

Eric Unzicker, MD
Family Medicine
Santa Fe Service Unit

How to Obtain AAFP Prescribed Credit

Up until several years ago, the Indian Health Service, as a part of the Federal government, was exempt from charges that the American Academy of Family Physicians levied for each course for which AAFP Prescribed Credit was requested. Beginning in 2005, this exemption was lifted, and, since then, there has been another increase in the fees. Because of limited resources, the Clinical Support Center has asked those requesting AAFP credit to reimburse us for this additional expense. In the last year, very few activities have requested submission for AAFP Prescribed Credit.

The Clinical Support Center has made a decision to change the procedure used to submit activities to AAFP. We will ask that, when AAFP sponsorship is sought, the coordinator of the activity recruit a family physician at the local facility who is willing to serve on the planning committee and who is able to complete and sign the AAFP application for Prescribed Credit. This is done on line (go to: *http://www.aafp.org/cmea/online*), where the family physician will create his or her own login/password to access the necessary form and upload the supporting documents. This physician will need to be a member of the AAFP, and the application will need to be accompanied by a check or credit card payment for the appropriate fee.

Please let Ms. Sandra Sorrell (*sandra.sorrell@ihs.gov*) know if you have any questions about how to get started.


Children are precious... so are their teeth
February is Children's Dental Health Month!
The Albuquerque Area Dental Support Center has posters and postcards to share.
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If you also want to discontinue your hard copy subscription of the newsletter, please contact us by e-mail at *the.provider@ihs.gov*. Your name will be flagged telling us not to send a hard copy to you. Since the same list is used to send other vital information to you, you will not be dropped from our mailing list. You may reactivate your hard copy subscription at any time.

Changes in *The IHS Provider* Distribution

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

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

We will publish and mail paper issues on a quarterly basis (March, June, September, and December), and these will contain only the *articles* for the past three issues. This will assure that those without Internet access will still be able to see all of the clinical information, although these paper issues will not include the time-sensitive information described above.

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

We are interested to hear feedback from readers to know if this idea poses any hardships, or if there are suggestions about how to revise this plan to better meet the needs of our readers. Send these by e-mail to *john.saari@ihs.gov*.

A PROGRAM FOR CURRENT AND FUTURE INDIAN HEALTH CARE EXECUTIVES

WHAT?
A concentrated executive leadership program designed specifically for current and future leaders. The program will benefit individuals who are either serving in or aspire to be in leadership positions.

WHO WOULD BENEFIT?
Chief Executive Officer · Service Unit Director · Health Director · Medical/Clinical Director · Nursing Executive · Director of Nursing · Administrative Officer

Individuals who are program coordinators or managers of clinical, community, environmental or engineering programs will find this beneficial. The interactive curriculum includes topics that will be integrated through the use of exercises, case studies, and team projects.

Challenges in Indian Health Care
Change and Transition
Personnel
Motivation
Organizational Skills
Personal Vision and Goal Setting
Law
Financing Health Care
Budgets and Financing
Data and Information Technology
Integrity and Ethics
Conflict Resolution
Critical Thinking
Negotiation
Executive Communications
Partnerships, Collaborations
Decision Making
Visionary Strategic Planning
Building Constructive Relationships

WHY?
The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian health care executives whether they work in Federal, tribal, or urban settings.

WHO?
Faculty for the Executive Leadership Development Program have been selected from the private, public, and academic sectors. They have experience teaching in executive programs and understand the unique needs of the Indian health care system. Coordination of the Executive Leadership Development Program is through the Indian Health Service, *Clinical Support Center* in Phoenix, Arizona in partnership with different universities and foundations.

HOW?
The Executive Leadership Development Program will be presented in three 4½ day sessions over

12 months. Each session builds on the previous session. Participants should anticipate an intense experience to develop and practice skills to be an effective leader. Independent time is used for reading assignments or working with fellow team members on business simulations, cases, or presentations. At the end of each session, participants will receive certificates of accomplishment from the academic institutions that sponsored the training. After all three sessions have been completed, participants will receive a certificate of completion from the Indian Health Service.

WHEN/WHERE*?

Session One (03/10)	**March 15-19, 2010** Western Management Development Center Aurora, Colorado
Session Two (04/10)	**April 19-23, 2010** Western Management Development Center Aurora, Colorado
Session Three (05/10)	**May 24-28, 2010** Western Management Development Center Aurora, Colorado

*Note: Attendees must enroll for all three sessions.

CONTINUING EDUCATION CREDITS ACCREDITATION

The Indian Health Service (IHS) Clinical Support Center is accredited by the *Accreditation Council for Continuing Medical Education* to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this continuing education activity for up to 28 hours of Category 1 credit toward the Physician's Recognition Award of the *American Medical Association.* Each physician should claim only those hours of credit he or she actually spent in the education activity.

The Indian Health Service Clinical Support Center is approved by *the American Council on Pharmacy Education* as a provider of continuing pharmaceutical education.

The Indian Health Service is accredited as a provider of continuing education in nursing by *American Nurses Credentialing Center* Commission on Accreditation, and designates this program for 36 contact hours for nurses.

Continuing Education Units for Chief Executive Officers, Administrative Officers, and Dentists designates this program for 36 CEUs.

TUITION

Tuition for all three sessions is **$4500**. The tuition includes three 4½ day-session, books, instructional handouts, leadership assessments, and continuing education credits. Payment should be by tribal organization check or approved SF-182 Form. Travel and per diem are not included in the tuition.

CONTACT:

Gigi Holmes or Wes Picciotti
Phone: (602) 364-7777
FAX: (602) 364-7788
e-mail: gigi.holmes@ihs.gov
Website:
http://www.ihs.gov/nonmedicalprograms/eldp/

Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004-4424

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

"I stopped believing in Santa Claus when I was six. Mother took me to see him at the department store and he asked me for my autograph."

Shirley Temple

Articles of Interest

Here is a publication that everyone who works with American Indian and Alaska Native children should read. Dr. Rosalyn Singleton of Alaska is co-editor of this work.

New Resource for Pediatricians: the December issue of Pediatric Clinics of North America devoted to Health Issues in Indigenous Children. The December edition of Pediatric Clinics of North America is devoted to indigenous child health. There are a number of articles written by experienced clinicians and public health experts, including several indigenous authors, from US, Canada, and Australia. Chapters include:

- **History, Law and Policy for American Indian and Alaska Native Children** by Judith Thierry, George Brenneman, Everett Rhoades, and Lance Chilton
- **Aboriginal Child Health** by Ngiare Brown
- **An Overall Approach to Health Care for Indigenous Peoples** by Malcom King
- **Indigenous Newborn Care** by Susan Sayers
- **Injuries and Injury Prevention among Indigenous Children and Young People** by Lawrence Berger, David Wallace, and Nancy Bill
- **Skin Disorders, including Pyoderma, Scabies, and Tinea Infections** by Ross Andrews, James McCarthy, Jonathan Carapetis, and Bart Currie
- **Behavioral and Mental Health Challenges for Indigenous Youth** by Michael Storck, Timothy Beal, Jan Garver Bacon, and Polly Olsen
- **Early Child Development and Developmental Delay in Indigenous Communities** by Sheila Gahagan and Matthew Cappiello
- **Undernutrition and Obesity in Indigenous Children: Epidemiology, Prevention, and Treatment** by Alan Ruben
- **Clinical Management of Type 2 Diabetes in Indigenous Youth** by Elizabeth Sellers, Kelly Moore, and Heather Dean
- **Chronic Respiratory Symptoms and Diseases among Indigenous Children** by Gregory Redding and Catherine Byrnes
- **Acute and Chronic Otitis Media** by Peter Morris and Amanda Leach
- **Vaccine Preventable Diseases and Vaccination Policy for Indigenous Populations** by Robert Menzies and Rosalyn Singleton
- **Glomerulonephritis and Managing the Risks of Chronic Renal Disease** by GR Singh
- **Acute Rheumatic Fever and Rheumatic Heart Disease in Indigenous Populations** by Andrew Steer and Jonathan Carapetis
- **Oral Health of Indigneous Children and the Influence of Early Childhood Caries on Childhood Health and Well-being** by Robert Schroth, Rosamund Harrison, and Michael Moffatt

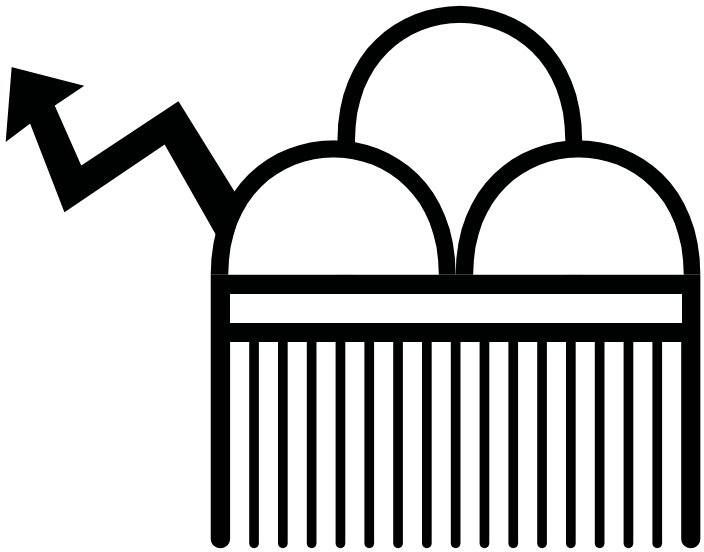
Health Issues in Indigenous Children: An Evidence-based Approach for the General Pediatrician. *Pediatric Clinics of North America* Volume 56, Issue 6, pages 1239-1592 (December 2009). Ordering information available at *http://www.pediatric.theclinics.com/current*.

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

Thiery J, Brenneman G, Rhoades E, Chilton L. History, Law, and Policy as a Foundation for Health Care Delivery for American Indian and Alaska Native Children. *Pediatr Clin North Am*. 2009 Dec;56(6):1539-59. *http://www.ncbi.nlm.nih.gov/pubmed/19962035?itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum&ordinalpos=1*

Dr. Susan La Flesche-Picotte, a member of the Omaha Tribe and the first Native American woman physician, wrote of the difficulties in providing health care to the members of her tribe in a 1907 letter to the Commissioner of Indian Affairs. She writes, "…that if you knew the conditions and circumstances to be remedied you would do all you could to remedy them." This article is an excellent historical review that traces the early beginnings of Indian Health Care right through to the present. Drs. Thiery, Brenneman, Rhoades, and Chilton review the history, dating back to colonial America, of significant federal laws and government policies that impact the health and wellbeing of American Indian and Alaska Native children and their families. The authors explore the earliest

relationships of our Nation's founding leadership (Franklin, Jefferson, and Washington) with Indian leaders. Various Acts including the Snyder Act, the Transfer Act, Indian Self-Determination and Educational Assistance Act, the Indian Health Care Improvement Act, and others are discussed in detail, at times giving the reader a behind the scenes feel. Lastly, the future of American Indian Health Policy is discussed. With health care reform being on the national agenda, a review of the history of health care delivery to American Indian and Alaska Natives through tribal treaty obligations and trust relationships between the federal government and tribal nations is both informative and timely.



MEETINGS OF INTEREST

Available EHR Courses

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

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

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

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

The National Councils (Clinical Directors, Chief Executive Officers, Chief Medical Officers, Oral Health, Pharmacy, and Nurse Consultants) for Indian health will hold their 2010 annual meeting March 21 - 26, 2010 in Phoenix, Arizona. Engage in thought-provoking and innovative discussions about current Indian Health Service/tribal/urban program issues; Identify practical strategies to address these health care issues; Cultivate practical leadership skills to enhance health care delivery and services; Share ideas through networking and collaboration; and receive accredited continuing education. Indian health program Chief Executive Officers, clinico-administrators, and interested health care providers are invited to attend. The meeting will be held at the Hyatt Regency Phoenix, 122 North Second Street, Phoenix, Arizona 85004. Please make your hotel room reservations by March 1, 2010 by calling 1-(800) 233-1234 or (602) 252-1234. Be sure to ask for the “Indian Health Service” group rate. On-line registration and the conference agenda will be available late December at the Clinical Support Center web page at *http://www.csc.ihs.gov*. The IHS Clinical Support Center is the accredited sponsor for this meeting. For more information, contact Gigi Holmes or CDR Ed Stein at (602) 364-7777; or e-mail *gigi.holmes@ihs.gov*.

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

The Advances in Indian Health Conference, April 27 - 30, 2010 will be held at the Sheraton Uptown in Albuquerque, New Mexico. "Advances" is IHS's primary care clinical conference and attracts over 350 clinicians from across the Indian health system. The conference covers many primary care topics with special emphasis on diabetes, mental health, substance abuse, women's health, geriatrics, pediatrics, and the EHR. With low tuition and a government rate available for the conference hotel, Advances is a low cost way for clinicians to receive up to 28 hours of CME/CE on issues of particular importance to Indian health patients and practices. The conference brochure will be available in early 2010 on the UNM Office of CME website: *http://hsc.unm.edu/som/cme/2010_Conferences.shtml*. For more information, contact the course director, Ann Bullock, MD, at *ann.bullock@ihs.gov*.

The 15th Annual Elders Issue

The May 2010 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the fifteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

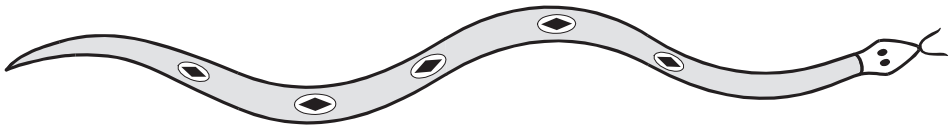
IHS OIT Launches Meaningful Use Web Site

The Office of Information Technology is pleased to announce the launch of a web site dedicated to providing information about "meaningful use." Providers are encouraged to become familiar with "meaningful use" and how it relates to financial incentives authorized by the American Recovery and Reinvestment Act (ARRA), also called the Recovery Act.

The Recovery Act authorizes the Centers for Medicare and Medicaid Services (CMS) to provide a reimbursement incentive for physician and hospital providers who are successful in becoming "meaningful users" of certified electronic health record (EHR) technology. These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the "meaningful use" definition or they will be subject to financial penalties under Medicare.

The new web site was created as a resource that can help answer questions about "meaningful use" and will be updated as new information becomes available. The information presented on this site is subject to change until the CMS rule has been finalized, which was anticipated by 12/31/2009.

The IHS-OIT Meaningful Use web site may be found at *http://www.ihs.gov/recovery/index.cfm?module=dsp_arra_meaningful_use*.



POSITION VACANCIES

Editor's note: As a service to our readers, THE IHS PROVIDER will publish notices of clinical positions available. Indian health program employers should send brief announcements as attachments by e-mail to john.saari@ihs.gov. Please include an e-mail address in the item so that there is a contact for the announcement. If there is more than one position, please combine them into one announcement per location. Submissions will be run for four months and then will be dropped, without notification,, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service ($100 for four months). The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

Family Practice Physician
Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("Basket-maker") Apache community with a population of 3,500. Our clinic has an opening for a board certified/eligible family practice physician for purely outpatient care with a 40 hour work-week. Our site qualifies for IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. Our staff currently consists of a family practice physician, an internist, a pediatrician, a part-time FP physician (who focuses on prenatal care), three family practice mid-levels, an optometrist, and two dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with profits from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility with free personal training, a modern supermarket, a Best Western Hotel and Casino, and more. We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass. We welcome you to visit our facility in person. To take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to *http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx*. Please call Dr. Cecilia Chao at (575) 759-3291 or 759-7230; or e-mail *cecilia.chao@ihs.gov* if you have any questions. (01/10)

Registered Nurse
Yavapai-Apache Nation; Camp Verde, Arizona

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

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

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

Family Physician
SouthEast Alaska Regional Health Consortium Clinic; Juneau, Alaska

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

Mid-Level Provider
Aleutian Pribilof Islands Association, Inc.

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

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

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

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

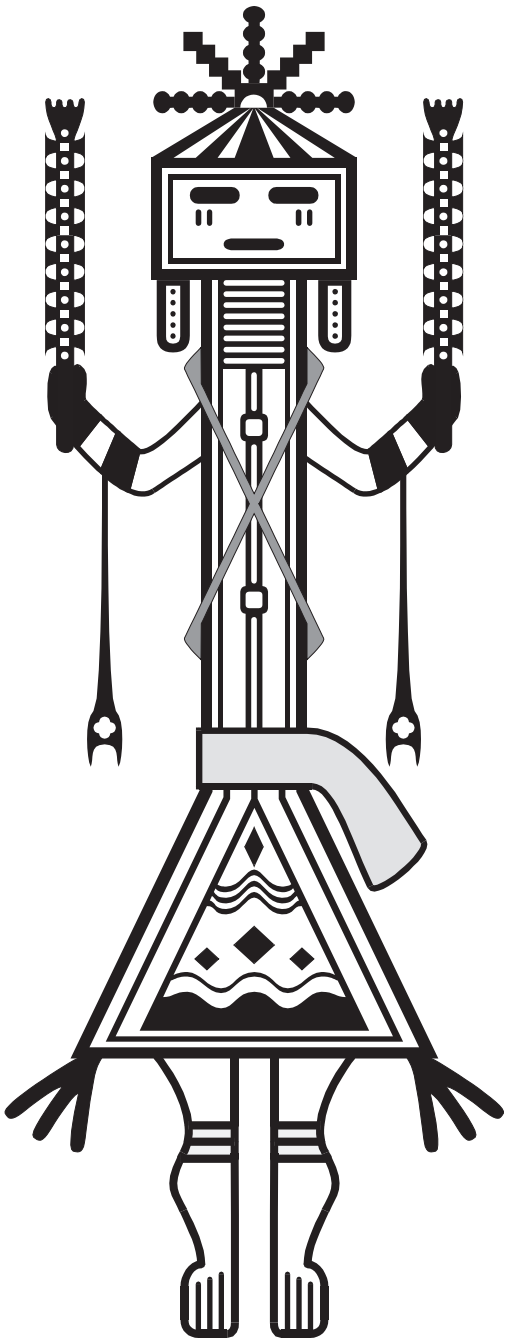
The Omaha Tribe of Nebraska is seeking a full-time, permanent physician medical director for the Carl T. Curtis Health Education Center. The CTCHEC is a comprehensive, tribal community-based ambulatory family medicine facility. Services include primary care, dental, behavioral health, substance abuse treatment, and diabetes. The physician medical director functions as the supervisor of the outpatient clinic, ambulance service, and a 25-bed long term care facility. A 12-chair hemodialysis unit operates within the facility with a contracted nephrologist as medical director. Specialty consultants with regular clinics operating include podiatry, optometry, psychiatry, audiology, endocrinology, physical therapy, and occupational therapy.

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

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

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

The Warm Springs Health and Wellness Center will have an opening for a board certified/eligible family physician starting April 1, 2010. Located in the high desert of central Oregon, we have a clinic that we are very proud of and a local community that has much to offer in recreational opportunities and livability. Our facility has been known for innovation and providing high quality care and has received numerous awards over the past ten years. We have positions for five family physicians, of which one is retiring after 27 years of service. Our remaining four doctors have a combined 62 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs. We have a moderately busy outpatient practice with our doctors seeing about 15 - 18 patients per day under an open access appointment system. We were a pilot site for the IHS Innovations in Planned Care (IPC) project and continue to make advances in how we provide care to our patients. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626. (10/09)



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THE IHS PRIMARY CARE PROVIDER
A journal for health professionals working with American Indians and Alaska Natives

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

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

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

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

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