THE IHS PRIMARY CARE PROVIDER

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Treatment Guidelines Changes for Gonorrhea: Implications for AI/AN Clinical Care Providers

Bradley Stoner, MD, PhD, issouri; and Deloris Rother, MPH,

The primary source for STD training and technical assistance in the country is the CDC-funded STD/HIV Prevention Training Centers. These regional training centers work in partnership with state health departments and universities to increase the knowledge and skills of health professionals in the areas of sexual and reproductive health. The training centers together comprise the National Network of STD/HIV Prevention Training Centers, or NNPTC. The training centers specialize in one or more of three types of training: behavioral, clinical, and partner services. The website for the NNPTC is www.stdhivpreventiontraining.org. *Since 2001, the NNPTC has participated in a workgroup with staff from the Indian Health Service (IHS) National STD Program and other organizations conducting STD, HIV, and/or reproductive health training in Indian Country. The purpose of this workgroup is to identify and address AI/AN STD/HIV training needs, and the idea for this article arose from workgroup discussions.*

To find out more about this workgroup or STD training and technical assistance opportunities, contact Lori de Ravello, IHS National STD Program, at lori.deravello@ihs.gov, *or Sharon Adler, Clinical Faculty, California STD/HIV Prevention Training Center, at* sharon.adler@ucsf.edu.

On August 10, 2012, the Centers for Disease Control and Prevention (CDC) updated the guidelines for treatment of uncomplicated gonococcal infections, essentially moving cefixime "outside the box" and making it an alternative treatment rather than a recommended treatment (*MMWR* 2012; 61(31):590-594). This guideline change has important implications for all health care providers, in particular providers who care for populations with high rates of gonorrhea, including American Indian/Alaska Natives (AI/AN).

Previously, the 2010 Treatment Guidelines recommended that uncomplicated gonococcal infection should be treated with ceftriaxone 250mg single intramuscular dose, or if not an option, cefixime 400 mg single oral dose (along with either azithromycin 1 gm single oral dose or doxycycline 100mg twice daily for 7 days). CDC has been monitoring antimicrobial resistance for more than two decades through the Gonococcal Isolate Surveillance Project (GISP), and a worrisome trend has developed: increasing minimal inhibitory concentrations (MICs) to cefixime. The MIC is a measure of how much antibiotic is necessary to inhibit *in vitro* growth of *N. gonorrhoeae*, and is a good marker of the drug's effectiveness in clinical care. Rising MICs mean that higher

In this Issue…

and higher levels of antibiotic are required for the medication to reliably cure the infection, until the point at which the drug is no longer effective and true antibiotic resistance develops.

The problem with cefixime has been that MICs have crept up in recent years, to the point that the CDC is concerned about its continued efficacy for treating gonorrhea. The Clinical Laboratory Standards Institute (CLSI) considers gonorrhea strains with cefixime MICs ≥ 0.5 µg/mL to have what is termed "decreased susceptibility." Between 2006 - 2011, a total of 15 gonococcal isolates (0.1% of all isolates tested in GISP) had MICs in this range; most (12/15) of these were from men who have sex with men (MSM), and most (12/15) were from western states. The CDC established more stringent MIC breakpoints to monitor changes in cephalosporin susceptibility, reasoning that increasing MICs may predict the emergence of true drug resistance. The CDC now considers MICs ≥ 0.25 µg/mL to be elevated.

Using the new MIC criteria, the trends for cefixime are worrisome. Nationwide, from 2006 through August, 2011, the percentage of gonorrhea isolates with elevated cefixime MICs increased from 0.1% to 1.5%. Western states saw the greatest increase, with 3.2% of all isolates demonstrating elevated MICs. The rate was highest in Honolulu (17.0%), and several other cities also had rates higher than 5%. Cefixime MICs were higher among MSM. Interestingly, MICs for ceftriaxone increased only slightly over the same time period, from 0% in 2006 to 0.4% in 2011.

For this reason, the CDC has re-evaluated its recommendations for treating uncomplicated gonorrhea. A 400mg single oral dose of cefixime does not provide as high or as sustained *in vivo* drug levels as a single 250mg intramuscular dose of ceftriaxone, nor does cefixime provide reliable treatment of pharyngeal gonococcal infection. These data, coupled now with the concern that rising cefixime MICs may be an early harbinger of true gonococcal resistance, have led the CDC to recommend against the use of cefixime as a first-line regimen for the treatment of gonorrhea in the United States. This leaves ceftriaxone 250mg single intramuscular dose (along with either azithromycin 1 gm single oral dose or doxycycline 100mg twice daily for 7 days) as the sole recommended agent for treating gonorrhea. [The alternative regimens now include cefixime with either azithromycin or doxycycline as described above, or azithromycin 2gm single oral dose, which may be given for severe cephalosporin allergy.]

Several important clinical recommendations follow from this change. First, patients who are treated with an alternative gonococcal regimen (i.e., non-ceftriaxone) should return one week after treatment for test-of-cure at the infected anatomic site (ideally with culture, but if culture is not available, then with a nucleic acid amplification test [NAAT]). Second, patients who present with persistent gonococcal infection after receiving the recommended treatment should have culture performed with antimicrobial susceptibility testing, in order to monitor for the possibility of cephalosporin-resistant gonorrhea, and should also be tested again one week after re-treatment for test-of-cure.

This treatment recommendation change has important implications for clinicians who care for AI/AN patients. Rates of gonorrhea are higher than the national average in AI/AN communities, and clinicians serving these populations should be alerted not only to the change in recommended treatment, but also to the need for repeat testing one week after treatment for patients receiving non-ceftriaxone therapy. The need for test-of-cure may place significant strains on health care systems that are already struggling to maintain adequate capacity for routine clinical care, and reimbursement issues may also pose a problem. Moreover, many laboratories no longer maintain gonococcal culture capability, so lab directors and clinic directors need to be made aware of the need for stocking culture kits in clinical care sites. The new recommendations also have implications for expedited partner therapy (EPT) for gonorrhea, since persons receiving EPT will by definition be receiving an "alternative" rather than a recommended agent. The CDC's position on this is reasonable: every effort should be made to ensure that sex partners in the past 60 days receive clinical evaluation and treatment with a recommended regimen, but for heterosexual partners who cannot receive this in a timely fashion, then EPT should be considered. Clinicians caring for AI/AN patients may seek additional training or technical assistance from CDC partners, such as the National Network of STD/HIV Prevention Training Centers, to address any concerns they may have about these important changes in the treatment guidelines for gonorrhea.

Scholarships Available

The University of Arizona announces the Graduate Certificate program in Maternal and Child Health (MCH) Epidemiology. Applications for the program are now available. With funds from the Health Resources and Services Administration (HRSA), the Mel and Enid Zuckerman College of Public Health is offering 10 - 15 scholarships to MCH professionals working with American Indian and underserved communities nationally. These scholarships, valued at $11,685 each, will be awarded for the year 2013/14. The University of Arizona's Graduate Certificate in Maternal and Child Health (MCH) Epidemiology is offered entirely online with no requirements for travel. The deadline to apply for applications to the program is March 1, 2013. All qualified applicants will automatically be considered for scholarship.

For more details about this great opportunity, please visit the program website at *http://www.mch-epitraining.arizona.edu/*. The application form can be found at http://*www.mch-epitraining.arizona.edu/documents/MCH-EPIApplicationForm2013_001.pdf*.

If you need additional information, please feel free to contact Dr. John Ehiri at *jehiri@email.arizona.edu*, or Maribel Tobar at *matobar@email.arizona.edu*.

Our Apologies

We apologize for the delay in the production of this issue. Constraints on funding at the end of the fiscal year made it impossible to complete the preparation of the issue until now. We will catch up with our usual monthly publishing schedule as soon as possible. We are currently accepting submissions for the January issue.

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

"A gentleman is someone who can play the accordion, but doesn't."

Tom Waits

Articles of Interest

N Engl J Med. 2012 Sep 6;367(10):904-12. Epub 2012 Sep 3.

Effect of inhaled glucocorticoids in childhood on adult height.

Background. The use of inhaled glucocorticoids for persistent asthma causes a temporary reduction in growth velocity in prepubertal children. The resulting decrease in attained height 1 to 4 years after the initiation of inhaled glucocorticoids is thought not to decrease attained adult height.

Methods. We measured adult height in 943 of 1041 participants (90.6%) in the Childhood Asthma Management Program; adult height was determined at a mean (±SD) age of 24.9±2.7 years. Starting at the age of 5 to 13 years, the participants had been randomly assigned to receive 400 μg of budesonide, 16 mg of nedocromil, or placebo daily for 4 to 6 years. We calculated differences in adult height for each active treatment group, as compared with placebo, using multiple linear regression with adjustment for demographic characteristics, asthma features, and height at trial entry.

Results. Mean adult height was 1.2 cm less in the budesonide group than in the placebo group (P=0.001) and was 0.2 cm less in the nedocromil group than in the placebo group (P=0.61). A larger daily dose of inhaled glucocorticoid in the first 2 years was associated with a lower adult height (P=0.007). The reduction in adult height in the budesonide group as compared with the placebo group was similar to that seen after 2 years of treatment. During the first 2 years, decreased growth velocity in the budesonide group occurred primarily in prepubertal participants.

Conclusions. The initial decrease in attained height associated with the use of inhaled glucocorticoids in prepubertal children persisted as a reduction in adult height, although the decrease was not progressive or cumulative.

Editor's Note: The reduction in growth seen in the first few years of administration of inhaled corticosteroids persists as lowered adult height, though the absolute decrease of 1 cm in adult height is quite small. The small decrement in height is offset by the well-established benefit of inhaled corticosteroids in controlling persistent asthma. The lowest effective dose should be used to minimize any potential side effects of inhaled corticosteroids on adult height.

Infectious Disease Updates.
Rosalyn Singleton, MD, MPH
2012 - 13 Flu Vaccine has arrived.

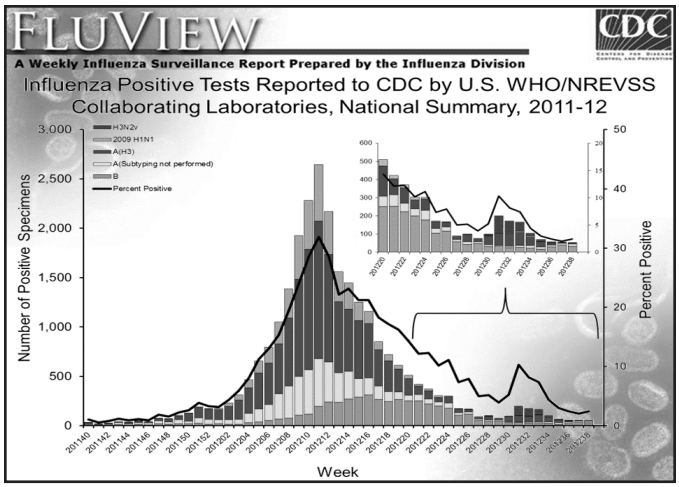
The 2011 - 12 Influenza season was relatively mild and late, with 34 reported pediatric deaths and co-circulation of H1N1, A (H3) and B viruses. For the 2011 - 12 season, 33 - 35% of the active clinical population 6 months and older served by IHS, tribal and urban facilities received a Flu vaccine – similar to the previous year. Among health care providers, the coverage was 75%, a modest increase.

The 2012 - 13 influenza vaccines contain A/California/7/2009 (H1N1)-like, A/Victoria/361/2011 (H3N2)-like, and B/Wisconsin/1/2010-like (Yamagata lineage) antigens (influenza A (H3N2) and B antigens differ from the 2011 – 12 season). Routine annual influenza vaccination is recommended for all persons aged ≥6 months. Don't wait! Vaccine should be offered as soon as available.

Children aged 6 months through 8 years need 2 doses of vaccine in 2012 – 13 unless they have received 2 or more Flu vaccine doses since July 1, 2010; or 2 or more Flu vaccine doses before July 1, 2010 and 1 or more doses of 2009 (H1N1) vaccine; or 1 or more flu vaccine doses before July 1, 2010, and 1 or more doses since July 1, 2010.

Although children with underlying conditions are at increased risk for influenza complications, one group of children with disproportionate risk for influenza complications and death is children with neurologic conditions such as cerebral palsy, intellectual disability, or epilepsy.

The ACIP reiterated last year's recommendation that persons with egg allergy who report only hives after egg exposure can receive injectable influenza vaccine.



Recent literature on American Indian/Alaskan Native Health

Jeff Powell, MD, MPH

Medical Home Access Among American Indian and Alaska Native Children in 7 States: National Survey of Children's Health. *Matern Child Health J.* (2012) 16:S6–S13

This month's review shifts away from an illness-specific focus and towards the disparities in access to the pediatric "Medical Home." Providing a medical home for children has been a growing area of emphasis throughout many models of pediatric health care delivery. The medical home is defined as "family-centered, comprehensive, coordinated, compassionate, culturally effective care, including a personal doctor or nurse and usual care location." A complete overview of the concept is beyond the scope of this review, but, the bottom line is that medical homes offer high quality, excellent care and support to their patients. Medical homes are what we should all strive for our clinics to become.

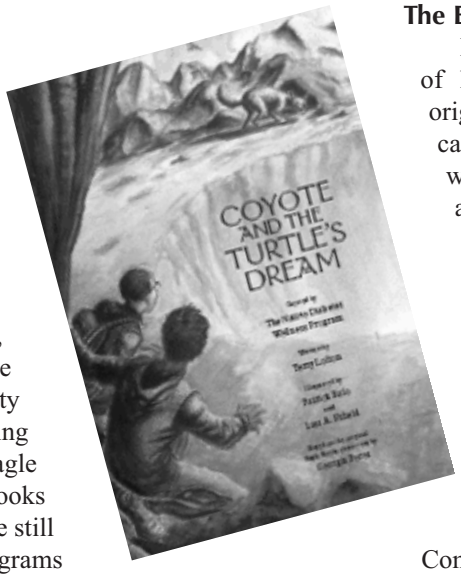
The publication by Barradas, Kroelinger, and Kogan is the first to characterize the availability of the "Medical Home" to American Indian and Alaska Native children. The study uses telephone survey data from the 2007 National Survey of Children's Health. In addition to these data, specific items on utilization of the Indian Health Service for care were completed. Because the study compares American Indian/Alaska Native (AI/AN) with Non-Hispanic White (NHW) children, only states that report AI/AN racial status could be included in this analysis. These states were Alaska, Arizona, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota. These represented 43% of all AI/AN children in the United States.

The study surveyed the caregivers for over 8900 NHW, and 832 AI/AN children. Specific survey questions were used nationally to assess each of the domains of the medical home listed above. This information was combined to determine the presence, or absence, of Medical Home status. These data were subject to multiple statistical analyses to control for demographic factors. The overall, adjusted, prevalence of having a Medical Home showed a large disparity: AI/AN children are 27% less likely to have a medical home (just below 43% for AI/AN children, and just over 58% medical home prevalence for NHW children). In addition, subgroup analyses reveal some interesting further observations. For example, younger age and residence in the state of Arizona are associated with a higher rate of having a medical home. The state of Arizona, in fact, is the one state in the analysis in which AI/AN medical home prevalence is the same as (or anywhere close to) NHW medical home (53% having a medical home). A fascinating finding is the revelation that, among AI/AN children with private insurance, those using IHS are 5 fold less likely to have a medical home. Only 26% of these children had a medical home, versus 68% of privately insured AI/AN children who did NOT use the IHS. The state by state analyses, the full survey item descriptions for medical home assessment, and the results are presented in three tables.

This health services utilization research raises many important questions. First on our list may be, "Why do Arizona AI/AN children have such a higher prevalence of medical home?" As this analysis is not sufficient to answer this question, more work in this area is very much needed. The state specific data show that New Mexico AI/AN children had the lowest prevalence of the medical home. While "southwest US" AI/AN health care is often lumped together, it seems that there are major differences between the status of pediatric medicine in Arizona and New Mexico. The study also raises very important questions about the drop in medical home prevalence when AI/AN children both utilized IHS and have private insurance. Very little is known about why that may be the case. This analysis does not collect enough utilization data to fully clarify the dynamics. However, again, those of us working within IHS need to ask some very difficult questions. What does it mean that my patients who have private insurance may actually suffer when it comes to having a medical home? That reality should be intolerable. Do contract health or other IHS policies adversely affect those with private medical insurance? At the moment, we just do not know the answers to these questions. In the meantime, let's hope that we can all learn from Arizona and move more of our patients into a medical home offering high quality pediatric care.

New Eagle Books Toolkit is Now Available

Dozens of free downloadable Eagle Books posters, games, crafts, flyers, event planning tools, family activities, animations, stationery, and other resources can be found in the Eagle Books Toolkit at the CDC's Native Diabetes Wellness Program site. The toolkit is a free online resource for Eagle Books activity sheets, displays, props, games, how-to instructions, and even more incentives to help educate your community about type 2 diabetes in a fun and entertaining way. Don't forget, the four original Eagle Books for young children and an Eagle Books adventure novel for middle school youth are still completely free for families and for programs serving American Indians and Alaska Natives. Order books at *http://wwwn.cdc.gov/pubs/diabetes.aspx*.



The Eagle Books

Inspired by the wisdom of traditional ways of health in tribal communities, the four original Eagle Books stories feature a colorful cast of animal characters and young children who explore the benefits of being physically active, eating healthy foods, and seeking the wisdom of elders regarding healthy living. In *Coyote and the Turtle's Dream* (2011), and the forthcoming *Hummingbird Squash*, the children are growing up and finding adventures with their middle school friends. Both sets of books are produced by CDC's Native Diabetes Wellness Program of the Division of Diabetes Translation in cooperation with the Tribal Leader Diabetes Committee and the IHS to broaden type 2 diabetes awareness and prevention.

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MEETINGS OF INTEREST

Advancements in Diabetes Seminars
Monthly; WebEx

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

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

Available EHR Courses

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

Print Version of *The Provider* to Cease Publication

The federal government is always exploring ways to reduce costs. One recent initiative is an effort to reduce printing expenses. After the distribution of the next two quarterly print issues for the third and fourth quarters of 2012, we will stop printing and mailing out paper copies.

We will continue to publish the monthly electronic edition of our journal to the CSC website. Currently, about 900 individuals are subscribers to the listserv that notifies them when each monthly issue is posted, and lists the contents of that issue. It is unknown how many readers simply access the website on a periodic basis without relying on the listserv for reminders that the monthly issue is available.

We encourage all our readers to subscribe to the listserv (go to *http://www.ihs.gov/provider/index.cfm?module=listserv*) so that you will receive monthly reminders about when the latest issue is posted to the website. This will also give us an improved count of the number of readers.

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.*

WIC Coordinator
SEARHC; Sitka, Alaska

The WIC Coordinator/RD works as a member of the SEARHC health promotion team to assess for, plan, implement, administer, and evaluate nutrition and health education programming that responds to Goals 8 and 9 in SEARHC's Strategic Plan. The WIC Coordinator also works to ensure high quality WIC services are provided to eligible women, infants, and children throughout southeast Alaska. Additionally, the WIC Coordinator partners with organizations working with the WIC population to make appropriate referrals and to enhance the WIC program.

Baseline Qualification Requirements include a BS in community nutrition/dietetics or a nutrition-related field, and four years of clinical nutrition and/or community nutrition work experience with specific progressive experiences in maternal/child nutrition, outpatient medical nutrition therapy, and program planning and administration. Must be both a registered dietitian and licensed dietitian/licensed nutritionist in the State of Alaska. Must adhere to the American Dietetic Association code of ethics and complete 75 continuing education credits every five years as required by registration and licensure plus keep current on registration and licensing payments. Other/Preferred Qualifications include a valid Alaska driver's license, ability to travel, including to remote southeast Alaska locations, supervision/mentoring training, public policy and advanced nutrition education strategy(ies) training, and MS/MPH in nutrition and/or dietetics or other health promotion related field

Contact Lisa Sadleir-Hart, MPH, RD, CHES, ACE, Community Nutrition Department Manager, SEARHC/Health Promotion, at telephone (907) 966-8735; facsimile (907) 966-8750; or e-mail *lisa.sadleir-hart@searhc.org*. (10/12)

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 4,400. 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 an internist, three family practice physicians, an optometrist, and three 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 revenues from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility, a modern supermarket, a 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 (575) 759-7230; or e-mail *cecilia.chao@ihs.gov* if you have any questions. (10/12)

Clinical Nurse
Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently accepting applications from experienced nurses for positions within our hospital facility. We are particularly interested in nurses with experience in the Labor and Delivery, Emergency Room, and Ambulatory Care settings.

GIMC is a 78-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Our patient population includes Navajos, Zunis, and others. Gallup provides outdoor activities (biking, hiking, rock climbing, and running, to name a few). As a Navajo Area Indian Health Service Hospital, we provide clinical specialties that include Internal Medicine, Cardiology, Anesthesia, Psychiatry, Emergency Medicine, OB/GYN, General Surgery, Orthopedics, Ophthalmology, ENT, Radiology, Pathology, and Pediatrics.

Nurse employment benefits include competitive salary,

comprehensive health insurance, double time pay for holidays worked, night and Sunday pay differential, no census days, and continuing education. Government housing is not available, as we are not located on the Navajo Reservation. Opportunities are available for growth and advancement depending on your personal nursing career goals. We welcome your questions, curiosity, and application submission.

For more information on how and where to apply, contact Myra Cousens, RN, BSN, Nurse Recruiter at (505) 726-8549, or e-mail *myra.cousens@ihs.gov*. (10/12)

Family Practice Physician /OB
Sonoma County Indian Health Project (SCIHP);
Santa Rosa, California

Live, work, play in the Wine Country. Sonoma County Indian Health Project (SCIHP) Santa Rosa, California, is seeking a full-time family practice physician to join our team. SCIHP is a comprehensive community care clinic serving the Native American community of Sonoma County. Medical phone call 1/6 nights required, OB hospital call participation preferred but not required. Candidates must currently hold a California Physician/Surgeon (MD) or Osteopathic Physician/Surgeon (DO) license and be BE/BC in a primary care discipline. For the right candidate we offer competitive compensation. For more information, please contact Human Resources by fax (707) 526-1016; or by e-mail: *welovedoctors.hr@gmail.com*. (10/12)

Pediatrician
Blackfeet Community Hospital; Browning, Montana

This hospital-based government practice is seeking a BC/BE pediatrician to work with another pediatrician and a pediatric nurse practitioner. Practice true primary care pediatrics with inpatient, outpatient, and newborn hospital care. Attractive call and rounding schedule. Competitive salary with federal government benefits. The area provides a wide variety of outdoor recreational activities, being only 12 miles from Glacier National Park. For more information, please contact Dr. Tom Herr at *thomas.herr@ihs.gov* or call (406) 338-6372. (9/12)

Primary Care Physician
Zuni Comprehensive Community Health Center;
Zuni, New Mexico

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has openings for full-time primary care physicians starting in fall 2012. This is a family medicine model hospital and clinic providing the full range of primary care, including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics, with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 17 physicians, two NPs, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

Zuni Pueblo is one of the oldest continuously inhabited American Indian villages in the US, estimated to be at least 800 - 900 years old. It is located in the northwestern region of New Mexico, along the Arizona border. It is high desert, ranging from 6000 - 7000 feet in elevation, and is surrounded by beautiful sandstone mesas and canyons with scattered sage, juniper, and pinon pine trees. Many of our medical staff have been with us for several years, reflecting the high job and lifestyle satisfaction we enjoy in this community.

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page) or by e-mail at *john.bettler@ihs.gov*. CVs can be faxed to (505) 782-7405, attn. John Bettler. (7/12)

Medical Director
American Indian Health and Family Services of
Southeastern Michigan, Inc. (AIHFS); Detroit, Michigan

AIHFS is looking for a qualified candidate for the medical director position at our health center in Detroit, Michigan. A summary of the position is as follows: general professional guidance of primary care staff; collaborates with fellow physicians and executive director on administrative operations of the medical, dental, and behavioral health services; responsibilities for management of all aspects of the program including accreditation, infection prevention and control, patient safety risk management, and emergency preparedness. This position will report to the executive director. We are seeking someone with completion of an accredited medical school, internship, and completion of the certification examination by the medical board of examiners; a permanent current full and unrestricted license to practice medicine or osteopathy in Michigan; board certified or eligible in family practice. If board eligible, must be AAFP or AOA certified within six months from the date of hire. Current medication dispensing license (DEA). Experience and training must have been progressive and responsible, demonstrating good knowledge of current principles, practices, methods, and techniques in the field of medicine. Medical experience in an outpatient family medical clinic including pediatrics, obstetrical/gynecological, medical care, and non-emergency care. Possess current and valid Michigan driver's license with no DUI/DWI or reckless driving convictions in the last five years, having no more than two at-fault accidents in the last three years, and maintain a valid driver license during employment. Must pass a criminal background check with a Class I Fingerprint Clearance Card within the initial ninety days of employment. Must have updated immunization record. Must have a tuberculosis test upon employment and employee health profile updated on an annual basis. Must obtain/

maintain CPR certification and a valid card during employment. Please send a cover letter with resume and references to AIHFS, PO Box 810, Dearborn, Michigan 48121, Attn: Jackie Allison, Administrative Assistant. You can also fax to (313) 846-0150. (7/11)

Certified Diabetes Educator
Salt River Pima-Maricopa Indian Community; Scottsdale, Arizona

Under general supervision from the Health and Human Services Department (HHS) Health Service Division, Diabetes Services Program Manager, provides diabetes preventive care, screening, clinical care, case management, and education to all children, adults, elders, and families within the Salt River Pima-Maricopa Indian Community. This job class is treated as FLSA Exempt.

To apply for this position or to view the full job description, please visit our website at http://www.srpmic-nsn.gov/employment/ then select Employment Opportunities. For additional information, contact Keolani Tynan, HR Recruitment Specialist, Salt River Pima-Maricopa Indian Community at (480) 362-7935. (7/12)

Family Practice Physician (1)
Physician Assistant or Family Nurse Practitioner (2)
United Indian Health Services, Inc. (UIHS), Howonquet Clinic; Smith River, California
and
Family Practice Physician (1)
UIHS, Potawot Health Village; Arcata, California

UIHS is a premier health care organization located in beautiful northern California along the Pacific coast near the majestic redwoods. The organization is a unique nonprofit made up of a consortium of nine tribes, with a mission "To work together with our clients and community to achieve wellness through health services that reflect the traditional values of our American Indian Community." UIHS provides wraparound services that include medical, dental, behavioral health, and community services. Our focus is to empower our clients to become active participants in their care. If you value outdoor adventures such as backpacking, kayaking, biking, fishing, and surfing, and you envision yourself providing services to an underserved but deserving community in a caring and holistic manner, come join our team. Please visit our website at www.uihs.org or contact Trudy Adams for more information at (707) 825-4036 or email *trudy.adams@crihb.net*. (5/12)

Central Scheduler
Medical Clinic Manager
Human Resources Director
Psychiatrist
Physician (Internal Medicine or Family Practice)
Consolidated Tribal Health Project, Inc.; Calpella, California

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

CTHP has a Title V Compact, which gives the clinic self governance over our Indian Health Service funding allocation. An application for any of these positions is located at www.cthp.org. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (5/12)

Hospitalist
Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently seeking energetic and collegial internists for our new hospitalist program. The hospitalists care for all adult inpatients previously taken care of by family medicine and internal medicine physicians, and provide consultation services. We have seven FTEs for hospitalists, and while we are still growing, we enjoy further inpatient staffing support from internal medicine and family medicine.

GIMC is a 99-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Clinical specialties at GIMC include internal medicine, family medicine, critical care, cardiology, neurology, orthopedics, ENT, radiology, OB/GYN, general surgery, ophthalmology, pathology, pediatrics, emergency medicine, and anesthesiology. The hospitalists' daily census is approximately 25 - 30. There is a six bed ICU. Our patient population includes Navajos, Zunis, and others living nearby, as well referrals from smaller clinics and hospitals.

Gallup has a diverse community and is very livable, offering a thriving art scene, excellent outdoor activities (biking, hiking, rock climbing, cross-country skiing), safe neighborhoods, diverse restaurants, national chains and local shops, and multiple public and parochial school options. The medical community is highly collegial, is committed to continuing education, has an on-going collaboration with Brigham and Women's Hospital, and has a high retention rate.

For more information, contact Eileen Barrett, MD, at (505) 722-1577 or e-mail *eileen.barrett@ihs.gov*. Or please consider faxing your CV to (505) 726-8557. (4/12)

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

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

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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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