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The Value of Injury Prevention Partnerships in Indian Country: A Case Study

Introduction to the July 2009 Special Issue on Injury Prevention

Lawrence Berger, MD, MPH, Clinical Assistant Professor of Pediatrics, University of New Mexico School of Medicine and Academic Director, IHS Injury Prevention Fellowship Program, Albuquerque, New Mexico

This is the third annual special issue of *The IHS Provider* devoted to Injury Prevention. Collectively, the articles clearly illustrate the four guiding principles of the national Indian Health Service (IHS) Injury Prevention Program described in the September 2007 issue of *The Provider*: building tribal capacity to address injuries, gathering and analyzing reliable injury data to guide decisions, promoting partnerships and collaborations, and implementing community-based interventions utilizing effective strategies and best practices. Prompted by the disturbingly high rates of suicide in the Alaska Area, Jason Hymer and his colleagues stepped out of the environmental health comfort zone to become suicide intervention trainers. Robert Letourneau et al describe a community-based motor vehicle crash prevention program funded by the Centers for Disease Control and Prevention. Tribal leaders, community members, a national consultant, and the IHS director of the local mental health program collaborated to address gang violence in a tribal community. Gordon Tsatoke et al relate how partnerships including tribal, IHS, state, and national collaborators have contributed to one tribe's many injury prevention initiatives over more than two decades.

These articles also demonstrate the maturation of the field of injury prevention. Boundaries between disciplines (such as public health, behavioral health, and law enforcement) are being bridged in the interests of community well-being. While unintentional injuries – like falls and motor vehicle crashes -- continue to be addressed, intentional injuries -- like suicide and gang violence -- are receiving the increased attention they deserve.

Gordon Dale Tsatoke Jr., MPH, District Injury Prevention Coordinator, Phoenix Area IHS, Office of Environmental Health and Engineering, Lakeside, Arizona; Stephen R. Piontkowski, MSEH, District Environmental Health Officer, Phoenix Area IHS, Office of Environmental Health and Engineering, Lakeside; and Kenny R. Hicks, MPH, Area Injury Prevention Specialist, Phoenix Area IHS, Office of Environmental Health and Engineering, Phoenix Area IHS, Phoenix, Arizona

Introduction

Injuries, both unintentional and violence-related, are a large public health burden for American Indians and Alaska Natives (AI/AN). Injuries are the leading cause of death for AI/ANs ages 1 to 44; and the third leading cause of death among all ages. The unintentional injury mortality rate for AI/ANs is 1.4 times higher than the US all races rate (2006).[1] To address this complex public health problem, the Indian Health Service (IHS) established a comprehensive injury prevention program characterized by four guiding principles: 1) collecting and analyzing injury data to guide decision-making; 2) implementing community-based prevention initiatives based on effective strategies and best-practices; 3) building tribal capacity; and 4) fostering collaborative partnerships.[2]

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The importance of partnerships has long been recognized as essential to advancing public health. In the 1988 report, *The Future of Public Health*, public health agencies were urged to cultivate relationships with both professional and citizen groups to advance public health initiatives.[3] Mobilization of community partnerships to identify and solve health problems is also one of the ten essential public health services advanced by The Core Public Health Functions Steering Committee.[4] A Centers for Disease Control and Prevention (CDC) report entitled, *Achievements in Public Health, 1900 - 1999 Motor Vehicle Safety: A 20th Century Public Health Achievement*, illustrates the effective use of partnerships to address motor vehicle safety. Despite a ten-fold increase in motor vehicle travel in the United States, the annual motor vehicle-related death rate has declined 90% from 1925 to 1997.[5] This public health success story resulted from the work of many partners and professional disciplines: manufacturers built safer cars; engineers designed road improvements, such as separating oncoming traffic lanes and installing guardrails; legislators passed laws relating to alcohol-impaired driving, seat belt use, and child restraints; and citizen and community-based advocacy groups advocated for community-wide programs addressing impaired driving and child occupant protection.[5] The report concluded that strengthening interagency and multidisciplinary partnerships is necessary to sustain and improve motor vehicle safety in the 21st century.

Cohen and colleagues identified five collaborative forms of partnering that can be applied in injury prevention.[6] These forms of partnering involve advisory committees, commissions, consortia or alliances, networks, and task forces. The following case study will illustrate how a few of these forms of partnerships have impacted injury prevention for one American Indian tribe.

Case Study

The tribe has approximately 13,000 members residing on 3,000 square miles of reservation land. The reservation is one of the ten largest in the US.[7] Tribal enterprises include a hotel and casino resort, several convenience stores and gas stations, a telecommunications company, a construction aggregate supply company, and a saw mill. The unemployment rate in 2007 was 23 percent. Health care is provided by an IHS hospital and a satellite clinic located approximately 30 miles from the hospital.

The tribe has been actively involved in injury prevention initiatives since at least the 1980s. Collaborative partners included many local tribal programs (e.g., health, police, and fire departments; social services; housing authority), federal agencies (e.g., IHS, CDC, Bureau of Indian Affairs), state agencies (e.g., law enforcement, Governor's Office of Highway Safety), county agencies (health department and law enforcement), and the private-sector (public health consultants, a marketing company, non-profits like intertribal councils and the Humane Society of the United States).

The process utilized to initiate and nurture these collaborative partnerships was one that required a long-term perspective, a respect for local values and traditions, and a focus on the benefits of preventing injuries in the community.[8] Raising the visibility of injury prevention as a community health priority through education and training of stakeholders has been an intense and sustained effort. Over the last three decades, more than thirty locally-held injury prevention training courses and workshops were conducted by IHS, CDC, and other groups. Understanding the importance and dimensions of the injury problem, along with building tribal capacity to address these issues, strengthened the tribal injury prevention network and increased their readiness to work together.

One of the earliest injury prevention partnerships developed in the mid-1980s. Studies by the IHS Office of Environmental Health and Engineering identified two major crash cluster sites at hazardous intersections. The data and recommendations were shared with the tribe. A councilman representing the community in which the cluster sites were located decided to champion the issue. He took the findings to the state's department of transportation (DOT), leading to a partnership among the three entities (the tribe, DOT, and IHS). The resulting improvements included a $315,000 engineering project that built turn lanes, expanded roadway shoulders, and eliminated several roadway blind spots.

In the mid-1990s, persons representing several tribal programs successfully petitioned the tribal council to pass a resolution establishing the region's first formal tribal injury prevention coalition (IPC). The resolution granted the coalition authority to act on behalf of the tribe to establish injury prevention priorities, develop prevention initiatives, and pursue grant funds. The tribe's first Governor's Office of Highway Safety grant funded the a driving under the influence (DUI) project, including equipment to support DUI checkpoints. Other early coalition activities were sponsoring a community conference where basic injury prevention principles and local injury data were introduced to new and prospective coalition members. It was at this conference that community participants first identified violence as an injury prevention priority. This led to studies of severe assault injuries and domestic violence on the reservation. The findings provided direction for program development, community awareness campaigns, and violence prevention interventions. The injury prevention coalition and the domestic violence task force remain active in addressing injury prevention issues throughout the reservation.

These first injury prevention advocates continued to collaborate into the 21st century. Their project with the greatest impact was a motor vehicle injury prevention program based in the tribal police department. The program built on the efforts of the original IPC and drew on the many partners involved in injury prevention activities from previous years. The tribe's motor vehicle injury prevention program (MVIPP) was the

result of a formal collaboration between the community's injury prevention advocates and the Centers for the Disease Control and Prevention (CDC). In the first cooperative agreement program of its kind, the CDC provided funds for tribes to implement evidence-based strategies to reduce motor vehicle-related injuries and fatalities. The funds supported a full-time program coordinator and extensive community interventions, including sobriety checkpoints and enhanced seat belt enforcement. Five years of consecutive funding provided a stable framework for planning, implementing, and evaluating the interventions. It provided staff support for coalition activities, and a venue for collaborative relationships to develop involving public health practitioners, law enforcement officers, state agencies, and non-profit organizations. The MVIPP has seen a dramatic decrease in motor vehicle crashes and injuries. In the first four years of the program, there has been a 29% decrease in total crashes, a 27% reduction in nighttime crashes, and a 31% decrease in crashes involving injuries or fatalities.

Since the 1980s, more than $2.3 million from federal, state, and tribal sources has provided training, educational sessions, conferences, and workshops on the reservation; supported more than ten injury studies; and contributed to construction projects and the purchase of equipment. Areas of injury prevention addressed included traffic safety (e.g., driving under the influence prevention, occupant restraint use, roadway improvements, and livestock control), domestic violence, fire safety, and dog bite prevention. There has also been a tremendous amount of in-kind contributions from all partners in the form of volunteer hours, salary support, transportation, equipment, education, advertising, and office supplies.

Discussion

Three themes are especially vital in the development and nurturing of injury prevention partnerships: continuity, commitment, and contributions by the partners.

Continuity: Frequent turnover in representatives has been cited as a common challenge of coalition work.[9] Although the degree of involvement of *individuals* varied in the coalition, stakeholder representation remained consistent over a long period of time. The tribal police department and tribal health educators have been long-standing members of the coalition. Since 1990, four IHS Environmental Health Officers (EHOs) have provided approximately 45 years of combined public health experience and support, as core members, ad hoc members, and technical experts. They also have been a source of "institutional memory," providing historical information about coalition activities and decision-making that allows the coalition to build on a foundation of experience.

Commitment: Dr. Louis Rowitz of the University of Illinois School of Public Health has said:

> The partnering process requires each partner to show respect for the other partners and put personal or organizational agendas aside. The partners, whether from the public or private sector, treat each other as equals. In an effective partnership, the partners share a vision, are committed to the integrity of the partnership, agree on specific goals, and develop a plan of action to accomplish the goals.[10]

Both Tribal law enforcement and public health continue to partner in the tribal motor vehicle injury prevention initiative, more than five years after its initiation. The original founders of this project are still active in its efforts.

Commitment to a coalition can be heightened by providing feedback to members about the progress and accomplishments of the coalition; and by ensuring that members and their organizations receive credit for success.[11] The tribal motor vehicle injury prevention program has received numerous awards and accolades for its success in preventing motor vehicle injuries. This recognition energizes and bolsters the commitment of the partners involved in the "winning" program.

Contributions: Each partner brings unique and important qualities to the partnership. The national, local, and internal partners provided a spectrum of technical knowledge in this tribal motor vehicle safety initiative, from developing culturally-appropriate marketing strategies to tailoring evidence-based strategies from the published scientific literature. Several partners provided the funds to purchase equipment, hire public health and technical consultants, support local program staff, and implement the intervention strategies. Table 1 summarizes the contributions of key partners in the tribe's injury prevention activities over the past two decades.

For real gains to be made in reducing injuries in tribal communities, it is critical to have the support of tribal council and tribal leaders. Their support is necessary to strengthen existing laws and pass new ones, and to make policy changes that can impact entire communities. Because enforcement is a key component of evidenced-based strategies to reduce motor vehicle injuries (for example, by enforcing seat belt laws or conducting sobriety checkpoints), the support of local tribal police departments and leadership is especially vital to traffic safety initiatives.

Conclusions

There are many challenges to injury prevention partnerships, from historical tensions between tribes and government agencies, to interpersonal conflicts, to disputes over the allocation of funding. At the same time, there are excellent resources to promote healthy partnerships. Two especially valuable ones are the Community Toolbox (*http://ctb.ku.edu/en/*) and the Community Anti-Drug Coalitions of America (*www.CADCA.com*). As the field of injury prevention expands to include such complex issues as

suicide, assaults, and other forms of violence, multi-agency and multi-disciplinary partnerships will become even more essential to the success of community-based programs.

Table 1. Key contributions of partners in a successful tribal injury prevention initiative

Partners	Key Contributions
National	
Centers for Disease Control and Prevention	Provided funds, training, and technical assistance on implementing and evaluating evidence-based strategies to reduce motor vehicle-related injuries.
Bureau of Indian Affairs Indian Highway Safety Program	Provided funds for equipment, training, and police officer overtime pay to support enforcement initiatives and other evidence-based strategies.
Public Health Consultants (i.e., external evaluator)	Assisted with evaluation plan preparation; met coalition to discuss and clarify evaluation goals, objectives, procedures, and action steps; reviewed data collection instruments and protocols; conducted data analysis; provided specific recommendations to improve and tailor interventions; co-authored formal reports to public health and law enforcement (e.g., conference presentations, posters, and manuscripts).
Nonprofit Organizations (e.g., Mothers Against Drunk Driving, Inter-Tribal Councils, etc.)	Helped increase public awareness about injury issues such as occupant restraint use and impaired driving in the community (i.e., candlelight vigil) and provided funds for special initiatives.
Local	
Indian Health Service Office of Environmental Health and Engineering	Provided funds, training, and technical assistance with project design, and implementation; enhanced capacity building; conducted activities such as occupant restraint use surveys, injury surveillance, epidemiological studies, data collection and analysis; and served as a core member of the local injury prevention coalition.
Indian Health Service Community Health Representatives, Public Health Nurses, Medical Staff	Provided support for child passenger safety (e.g., became certified child passenger safety technicians) and educational initiatives; members of local injury prevention coalition; and provided key insight to observed injury risks and community injury problems.
Injury Prevention Coalition	Served as central resource and launch site for community injury prevention issues and projects; acquired and assembled data and information for grants; developed project proposals; primary injury prevention advocates; and helped identify organizations and entities to administer injury prevention programs.
Governor's Office of Highway Safety	Provided funds for equipment, training, and police officer overtime pay to support enforcement initiatives and other evidence-based strategies.
Community Members	Victims participated in injury prevention media campaigns; advocated support for more stringent laws; and provided program feedback through focus groups, surveys, and questionnaires to help tailor interventions.

Other Law Enforcement Agencies (e.g., County and Neighboring Tribes)	Provided additional officers for strategies to deter impaired driving and increase occupant restraint use.
Internal	
Tribal Council	Provided support for injury prevention programs and passage of injury prevention laws and policies including 0.08 blood alcohol concentration and a primary enforcement seat belt law.
Tribal Police Department	Applied for traffic safety grants; provided support for passage and enforcement of strong tribal traffic safety laws; and supported officers' increased traffic safety and injury prevention activities.
Tribal Health Department	Provided technical assistance with community events (e.g., public awareness, education presentations, and conferences); and administered a Tribal Injury Prevention Program.
Tribal Injury Prevention Program	Provided technical assistance with community events; administered specific initiatives and programs (e.g., smoke detector education and installation programs, car seat distribution and education initiatives, a conference targeting impaired driving); collected injury data from tribal entities and programs for project proposals; provided assistance with proposal development; and facilitated submission of injury prevention program proposals to funding entities.

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Taking Back Our Communities: Gang Prevention Strategies for Tribal Communities

Janelle Trottier, MSW, LCSW, Education Specialist, Aberdeen Area Indian Health Service, Aberdeen, South Dakota

Introduction

Gangs and gang-related violence are an increasing problem in American Indian and Alaska Native communities.[1] A national survey in 2000 found that 23% of responding Indian communities reported youth gang activity, with 1 to 40 gangs and 4 to 750 gang members per community.[2]

After a series of gang-related incidents at a Plains Indian community, the Tribal Council contracted with an outside expert to help identify the seriousness of the local gang problem and methods to address it. Because I had contact with many youth through my position as director of the mental health program, I was asked to assist the consultant. I became chairperson of the community's gang prevention task force, a position I held for three years. This article describes how we conducted a community assessment, formed a coalition, and implemented programs to reduce gang violence. I also summarize the lessons we learned, and discuss some excellent resources for communities concerned about gang violence.

Approval to publish this work was obtained from the Aberdeen Area Institutional Review Board.

Community Assessment

The National Youth Gang Center has created a detailed guide to assessing a community's youth gang problem. The guide identifies five data domains: community demographics, law enforcement, schools, community perceptions, and resources (Table 1).[3]

We used three approaches to community assessment: conducting community meetings, interviewing key informants, and summarizing existing data. Community meetings were held at each of the tribe's local districts. Their purpose was to elicit the perceptions, attitudes, and experiences of community members regarding local gangs and youth violence. The meetings lasted 90 minutes, and included a presentation, administration of a questionnaire, and a question-and-answer period. Among the key informants we interviewed were tribal and IHS providers in medicine, behavioral health, and substance abuse; tribal judges, attorneys, and law enforcement officers; directors of community programs; school personnel, both teachers and administrators; and social service providers. The Tribal Council granted the consultant permission to collect data on delinquency, truancy, tagging, and reports of drug activity. He compiled data from the tribal housing authority, local schools, law enforcement, and the courts.

Table 1. Assessing community gang problems: data domains

A. Community Demographics: General community descriptive and demographic data to provide a context for the assessment as a whole:
- What are the community's demographics, racially, culturally, educationally, and economically?
- How has the community changed over time?
- What implications will community demographics have on the community's response to gangs?
- What risk factors are affecting local youth, families, schools, and neighborhoods?

B. Law Enforcement: The nature and extent of gang crime and characteristics of local gangs:
- What crimes are gangs committing?
- Who is committing these crimes?
- Who are the victims of these crimes?
- What is the demographic composition of local gangs?

C. Schools: Descriptive data on the climate of local schools, characteristics of school students who are involved in and/or at risk of involvement in gangs, and perceptions of school staff members:
- What gang issues are affecting local schools?
- What do school staff members and agency personnel say about the local gang problem?
- What do students say about the local gang problem?

D. Community Perceptions: Data that describes how key segments of the community are experiencing the gang problem, including community members, parents, community leaders, youth, and gang members themselves:
- How do community members describe the local gang problem?
- How do local community leaders describe the gang problem?
- How do gang members describe the gang problem?

E. Community Resources: Current and historical responses to the gang problem, including gaps in and barriers to services.

"GRIPS": The community's Gang Task Force:

After learning the results of the community assessment, the Tribal Council voted to develop and fund a community-based, task force on gangs. The task force was titled "GRIPS": Gang Reduction through Intervention, Prevention, and Suppression. Many of the task force activities reflected the comprehensive gang model of the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The major components of the model are summarized in Table 2.[4-6]

Table 2. Five strategies in OJJDP's comprehensive gang model

I. **Community Mobilization:** Involvement of local citizens, including former gang-involved youth, community groups, agencies, and coordination of programs and staff functions within and across agencies. Primary prevention programs include improving community conditions and creating academic, economic, and social opportunities; and creating and enhancing early childhood programs, school-based programs, and afterschool activities for all youth.

II. **Opportunities Provision:** Development of a variety of specific education, training, and employment programs targeting gang-involved youth.

III. **Social Intervention:** Involving youth-serving agencies, schools, grassroots groups, faith-based organizations, police, and other juvenile/criminal justice organizations in "reaching out" to gang-involved youth and their families, and linking them with the conventional world and needed services. Examples include Boys & Girls Clubs; violence-free zones; gang summits and truces; emergency room interventions and victim programs; programs to rehabilitate gang members in juvenile detention and correctional facilities; and special school, training, and job programs targeting gang-involved youth.

IV. **Suppression:** Formal and informal social control procedures, including close supervision and monitoring of gang-involved youth by agencies of the juvenile/criminal justice system and also by community-based agencies, schools, and grassroots groups; enhanced police interventions; and prosecution programs, such as curfew and anti-loitering laws

V. **Organizational Change and Development:** Development and implementation of policies and procedures that result in the most effective use of available and potential resources, within and across agencies, to better address the gang problem.

The GRIPS task force operated under the Health Education and Welfare subcommittee of the Tribal Council. The goal of the task force was to create and implement a community-based, collaborative strategy to reduce gang and youth violence. At its peak, the task force had 29 members from the general community, schools, children's protection services, clergy, tribal leadership, tribal courts, housing, law enforcement, and both tribal and Indian Health Service programs addressing substance abuse and behavioral health.

Our first steps were to develop a mission statement and bylaws, and elect the governing board. After reviewing the community assessment and obtaining input from the Tribal Council, the task force established three standing subcommittees: graffiti abatement, community education, and sustainability. Over the next three years, the subcommittees implemented the following activities.

Local Gang Ordinance: The task force worked with the tribe's Law and Order Committee and legal office to develop a tribal ordinance. The ordinance gave schools the authority to create responsive discipline procedures and protocols. It allowed the tribal housing authority to establish tenant agreements for safer environments. The agreements defined unacceptable behaviors and specified incremental consequences, including eviction for serious gang behaviors. The ordinance also enabled tribal courts to hold individuals responsible for gang-related activities, such as recruiting other gang members; and judges could order interventions (such as the Young Warriors and parental notification programs, below) for first-time or minor offenders.

Parental Notification Requests: To involve parents and guardians in gang prevention and intervention, the GRIPS Task Force implemented a Parental Notification System. Community members could contact the Task Force if they were concerned that a young person might be involved with a gang. Their concern might be prompted by a youth who declared membership in a gang, was tattooed with gang indicia, or appeared in gang-related photographs. Referrals were received from parents, teachers, counselors, and program personnel by telephone, e-mail, and confidential conversations. The referrals were reviewed by Task Force members, whose responses included mailing notification letters to parents; distributing brochures with information about gangs and referral resources; conducting meetings with teachers and school counselors; and visiting homes to conduct bedroom inspections, discuss options with at-risk youth and their parents, and provide support and assistance to siblings.

Young Warriors Program: The Task Force developed a two-day "seminar" covering cultural topics (traditional values, ceremonies, and beliefs); information on the risks of gang involvement, substance abuse, and suicide prevention; and skills-building (resolving conflict and resisting peer pressure). With the support of the tribe's Judicial Committee, youth who had been identified as participating in gang-related activities were mandated by the tribal juvenile judge to attend this two-

day "Young Warriors Program" accompanied by their guardians.

Graffiti abatement: Removing or painting-over graffiti supports residents' efforts to "take back" their community and reinforce a sense of community pride. It is an environmental modification strategy to reduce violence because, left untended, gang graffiti "signifies that nobody cares and leads to fear of crime [and] more serious crime."[7,8] Eliminating graffiti is a "physical expression of a social fabric that defends itself."[9]

Youth Basketball Tournament: The GRIPS task force sponsored a Youth Co-ed Basketball Tournament for 45 youth between the ages of nine and twelve. Five teams competed. During the all-day family event, task force members and community members gave presentations, distributed flyers, and made public service announcements concerning the prevention of substance abuse, suicide, and gangs; and the importance of family and cultural values, resisting peer pressure, and ways to find help and support in the community.

Gang Prevention Training: Training sessions were provided by the gang prevention consultant to parents, community members, agency staff, and school personnel. Among the topics were how to recognize the signs and symptoms of gang activity; and how to develop policies and procedures to address it. Students at the local elementary, middle, and high schools received information on the consequences of gang activity and how to avoid involvement with gangs. Workshop participation was documented by sign-in and attendance rosters. Follow-up sessions included prevention options for parents, and community safety and crime prevention strategies.

Grant Workshops: To sustain and expand community programs, the GRIPS task force sponsored two grant-writing workshops. The workshops were directed toward community members and program personnel from local schools, youth services, courts, housing, and social services.

Results

Two years after the inception of the GRIPS task force, we observed a decrease in delinquency and gang-related activity. Simple assaults, disorderly conduct, criminal mischief, truancy, curfew violation, and vandalism decreased between ten and thirty percent. Tribal court actions for gang-related activity decreased from fifty to four.

The parent notification system was used extensively by the courts, parents, school counselors, and other program staff. Parents of suspected gang-involved teens were pleased with the system. Many saw it as a way to open communication and provide education to the family in a manner much less threatening than a visit from a police officer or a court appearance. They were often grateful for the opportunity to intervene before their child suffered legal consequences.

At the Young Warrior seminars, we witnessed numerous families resolving inter-generational conflicts and sharing their desire to learn more about their culture. About 3000 individuals attended the gang-prevention trainings. Over fifty individuals attended the grant writing workshops. Subsequently, participants received funding from the US Department of Education (21st Century Schools and Safe and Drug Free Communities) and from the US Office of Juvenile Justice and Delinquency Programs (Gang Resistance Education and Training or GREAT; and the School Resource Officer program).

The graffiti abatement effort was much less successful. Two major barriers were lack of funding and minimal community participation. The tribe did not provide funds, so task force members approached larger, out-of-town businesses for paint and brushes. When supplies were obtained for a community, the task force members were usually the only individuals to appear on the day of the abatement. Many community members were afraid to participate, out of fear of retaliation by gang members. Without community participation, the graffiti removal project could not be sustained. We also were unable to incorporate the traditional "boy into manhood" ceremony into our program. The spiritual leaders did not support the participation of gang-involved youth because most of the young men had not been exposed to the series of lessons and responsibilities that culminate in this ceremony.

Finally, the task force itself was not sustainable. Lower-than-expected casino revenues eliminated much of the tribal funding for the GRIPS program. Several key members of the task force moved from the community and there were no volunteers to replace them.

Conclusions

My experience with the GRIPS Task Force convinces me that the most effective strategy to reduce youth violence is to establish a multidisciplinary, community-based coalition. The National Youth Gang Center provides training and technical assistance, a Gang Publications Library on CD, and numerous other resources.[10] The Community Anti-Drug Coalitions of America (CADCA) has a series of short brochures ("strategizers") on coalition building, including several that are specifically gang-related ("Youth and gang violence: comprehensively meeting the challenge," and "Gang graffiti: documentation and removal"). CADCA also distributes a 1-hour DVD entitled, "Gangs, Drugs, and Violence." While targeted to community anti-drug coalitions, the superb materials on the CADCA website and CADCA coalition trainings are equally valuable for gang prevention coalitions.[11] Also, I have produced a seven-minute "trigger video" to stimulate discussion about gang violence at community meetings and other gatherings; and an 18-minute training video for coalitions desiring further information about addressing gang problems.[12,13]

Our task force had several outstanding strengths. We had a cohesive group of individuals from a variety of backgrounds

who were committed to serving the same purpose. Operating under the oversight of the Health Education and Welfare subcommittee, we had clear financial, political, and administrative support from the Tribal Council. Much of the program's effectiveness was the result of tribal codes and their enforcement. Mandated participation in services occurred at the level of individuals (youth referrals), families (Young Warriors program, home visits), and the community (graffiti abatement, parental notification system). Tribal sovereignty gives tribes the flexibility to innovate with policies and programs that best serve their members.

The Tribal Council's willingness to hire a knowledgeable, experienced, outside consultant provided us the much-needed guidance and support to develop the task force. We were able to begin intervention efforts early in our inception, rather than spending a lot of time studying approaches and developing protocols, procedures, materials, and trainings. An independent consultant also provides an objective perspective on the challenges facing the community and recommendations for interventions unbiased by local political, economic, or personal ties to the community. Unlike a resident of the community, the outside consultant can state the facts and suggest solutions without the same intense concern for their personal safety.

The GRIPS model is very adaptable to American Indian communities. Our tribal communities are very closely networked. We honor our children as sacred beings. We strive to identify successful means to guide and support our youth in honorable methods and not be harshly punitive. Many gang reduction programs focus on incarceration through juvenile detention centers, rather than rehabilitation. Youth and families were receptive to the GRIPS program because they recognized that staff were sincere in their efforts to help them identify alternatives to violence as a means to resolve difficulties; and provided them assistance in obtaining the resources they needed to be successful.

Acknowledgement:

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Implementing Suicide Intervention Training in Rural Alaska

LTJG Jason D. Hymer, REHS, Injury Prevention Coordinator, Norton Sound Health Corporation, Nome, Alaska; Helen B. Stafford, EdM, Injury Prevention Program Coordinator, Alaska Native Tribal Health Consortium, Anchorage, Alaska; Kyla Hagan, MPH, Injury Prevention Program Manager, Alaska Native Tribal Health Consortium, Anchorage

Introduction

Suicide is the leading cause of injury related death for Alaska Natives living in the Norton Sound region of Alaska,[1] and the fourth leading cause of death overall.[2] Between 1999 and 2005, the age-adjusted suicide mortality rate was 92.9/100,000 for Alaska Natives living in the region, which is 2.5 times the rate for Alaska Natives statewide, and nearly nine times the national average. In addition, there are approximately 22 hospitalizations per year due to suicide attempts by Alaska Native people living in the region.[1]

The stigma and fear surrounding the word "suicide" has deep roots in rural Alaska. This is not only present among rural residents, but also among many rural health care providers. The presence of this stigma and fear makes it difficult for a person at risk of suicide to talk to someone in their community, often further isolating this person. It also makes it difficult to conduct suicide prevention activities in rural communities. Many rural Alaskan residents believe that talking about suicide will cause a person to attempt suicide, even if they had no prior thoughts. Sometimes a person talking about suicide is ignored or not taken seriously. Some at-risk individuals are harshly judged by others in their community, creating feelings of shame. Many village health care providers are reluctant to discuss suicide with patients. For example, there is a depression and suicide screening tool available for these providers, but it is often not used.[3]

The Norton Sound Region of Alaska

The Norton Sound Region is located in northwest Alaska, situated along the Norton Sound and Bering Strait coasts. The total area of the region is approximately 44,000 square miles, extending to the Russian border in the Bering Sea; an area roughly the size of Ohio. The total population of the region was 9,499 in 2008.[4] The region is comprised of 15 rural villages plus the city of Nome, with 20 federally-recognized tribes residing in the region. The city of Nome (pop. 3,500) serves as the regional hub.[5] The Norton Sound area is home to Inupiat, Yup'ik, and Siberian Yup'ik (St. Lawrence Island Yup'ik) Alaska Native peoples.

Norton Sound Health Corporation (NSHC) is the sole health care provider for the region and operates a health clinic in each of the 15 villages. NSHC also operates the Norton Sound Regional Hospital in Nome. NSHC is a non-profit health consortium of the 20 tribes residing in the region. As the only health care provider in the region, NSHC also provides care for non-Native patients living in the area.

The NSHC Injury Prevention Program (NSHCIPP) was founded in 2003 after NSHC was awarded a cooperative agreement grant from the Indian Health Service (IHS). As the only staff person, the Injury Prevention Coordinator is responsible for all aspects of the IPP. In addition to an extremely high suicide rate, the NSHC service area experiences a high rate of unintentional injury death. The leading causes of unintentional injury death are unintentional poisonings, motor vehicle and off-road vehicle crashes, and drowning. Overall, injuries (unintentional and intentional combined) are the leading cause of death for Alaska Natives ages 1-74 living in the NS region.[1]

Choosing Suicide as a Focus Area in Alaska

About five years ago, prompted by data showing the dramatic impact of suicide and suicide attempts on the Alaska Native population,[1,6-8] the Alaska Area Injury Prevention (IP) specialists sought a way to have some impact on intentional injuries. Prior to that time, most IP specialists believed that intentional injuries were beyond the scope of their expertise and were the exclusive responsibility of fields such as mental health and social work.

There seemed to be a growing interest from rural Alaskan tribal health organizations in finding a culturally acceptable way of learning to talk about suicide. Through research of existing suicide prevention strategies and discussion over a period of about three years, we decided on the Applied Suicide Intervention Skills (ASIST) program.

ASIST was developed in the early 1980s by the Canadian Mental Health Association with support from the provincial government of Alberta. This partnership was reorganized in 1991 to form LivingWorks Education, Inc, a non-profit organization based in Calgary, Canada. ASIST is a two-day standardized gatekeeper workshop designed for members of all caregiving groups.[9] The term "caregiver" includes anyone in a community who is in a position of trust by virtue of their job or status in their community. Caregivers can include teachers, mentors, elders, clergy, health aides, etc. ASIST is commonly referred to as "suicide first aid," an analogy to cardiopulmonary resuscitation (CPR). Just as CPR skills make physical first aid possible, suicide intervention skills make

suicide first aid possible.10

The ASIST curriculum is listed as a best practice in suicide prevention by the Suicide Prevention Resource Center.[11] ASIST has been evaluated in several independent studies.[12-17] More than 750,000 caregivers have been trained in ASIST. There are more than 3,000 trainers worldwide.[10] We chose ASIST over other gatekeeper training programs (e.g., Question, Persuade, Refer and the State of Alaska Gatekeeper Training) based on its prior use in Alaska and because it is evidence-based.

IP staff from the Alaska Native Tribal Health Consortium (ANTHC) helped plan the 2005 Alaska Public Health Summit. An ASIST workshop was selected to be given as one of the IP Track workshops. At the time, there were only three qualified ASIST trainers in the State of Alaska. The Health Summit was the first introduction of ASIST to injury prevention specialists in Alaska.

Based on the positive experience at the Alaska Public Health Summit, ANTHC IP decided to include ASIST during the same week as an Introduction to Injury Prevention Course (Level I), ensuring that people who wanted to attend both courses would only have to purchase one ticket to Anchorage. Community health aides, village based counselors and behavioral health aides attended. Response was very positive, and tribal health organizations were excited about the enthusiasm that their staff showed upon returning to their communities.

Methods

Approval to conduct and publish this project was obtained from the Norton Sound Health Corporation.

In September 2008, three IP Specialists (Helen Stafford and Kyla Hagan of the ANTHC (IP) Program; and Jason Hymer of the NSHCIPP) attended a five-day ASIST Training-for-Trainers workshop in Anchorage. We subsequently conducted four ASIST workshops in Northwest Alaska (three in Nome, one in Kotzebue) between October 2008 and April 2009. Caregivers trained during this period included village health aides, village based counselors, social workers, school counselors, mental health clinicians, village public safety officers, and other interested community members.

Results

A total of 79 individuals were trained in ASIST during this 7-month period. Each participant completed a feedback form at the end of the workshop. The results of the feedback forms are listed in Table 1. We also collected valuable qualitative information from participants using this form, such as these two comments from village health aides: “Because I learned to keep "judgmental" out of assisting a person who feels like committing suicide, I learned that making one feel guilty, blamed, shameful, embarrassed, etc., doesn't work when assisting a patient who is hurting and wanting to take their own life.” “The more suicide is discussed, the less likely it will be an option. I have new acceptance of this concept.”

By having trainers employed by the Alaska tribal health network, rather than hiring outside consultant trainers, the cost of an ASIST workshop was lowered dramatically. For example, the cost of an ASIST workshop in Nome was lowered by approximately $3,600 per training, from $6,300 to $2,700. Travel expenses and course materials make up most of the training costs.

Three employees from Maniilaq Association based in Kotzebue, Alaska attended the first ASIST workshop during October 2008 in Nome. Also located in northwest Alaska, the Maniilaq service area (listed as the Northwest Arctic in Figure 1) has a comparable suicide rate of 81/100,000.[1] As a result of these employees attending the workshop, Maniilaq Association decided to send three employees to become ASIST trainers in early 2009, and they held their first workshop in Kotzebue during April 2009, training eleven additional participants.

Just one week after the first ASIST workshop in Nome, a participant used the ASIST model to keep a person at risk safe. The person’s suicide plan was to drink himself into unconsciousness and then freeze to death outdoors. This person was kept safe because of a recently trained caregiver who used the skills learned in ASIST.

Discussion

One major benefit of having IP staff trained as ASIST trainers is their experience living and working in rural Alaska Native communities across the state. Most other ASIST trainers live and work in larger cities in Alaska. As a result, IP staff are likely better able to understand circumstances unique to these communities, such as the tribal health and other resources available. Currently, seven tribal health organizations in Alaska have injury prevention initiatives. The dissemination of ASIST and other suicide prevention strategies will ultimately benefit the entire state, not only northwest Alaska.

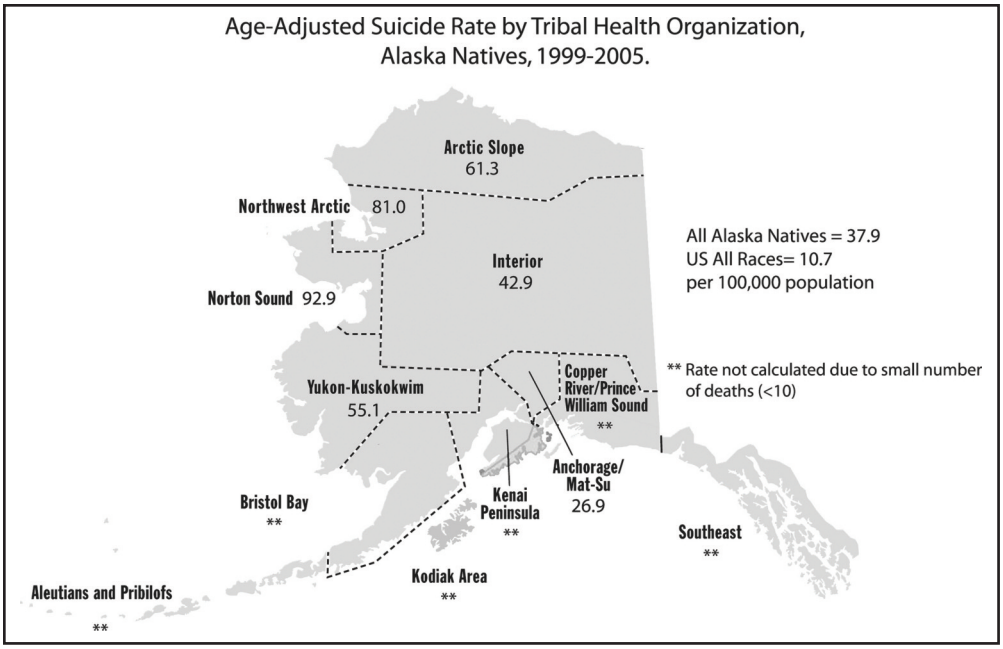
ASIST also helps to decrease the stigma and fear surrounding suicide in rural Alaska. Through comments from the ASIST feedback forms and anecdotal evidence from workshop participants, we believe that many workshop participants go through a behavior change that makes them more accepting of openly addressing suicide with at-risk individuals and as a community issue. There is growing evidence to support the role of stigma reduction as a component of a comprehensive suicide prevention programs.[18-20] ASIST workshops require participants to look at their attitudes about suicide. For many, it is their first time sharing thoughts and feelings about suicide. During one workshop, two village health aides independently reported that they had been deeply affected by the same suicide completion ten years earlier. They both stated that the ASIST workshop was the first time they had ever felt safe enough to share their stories.

ASIST also teaches that suicide is an issue that can be addressed by everybody in a community. Suicide is often

Table 1. Results from ASIST Participant Feedback Summary Forms

	Average Score
On a scale of 1-10, how would you rate ASIST? (1=did not like at all, 10=liked a lot)	9.42 (n=79)
On a scale of 1-10, do you feel better prepared to help a person at risk as a result of completing ASIST? (1=not at all, 10=a lot)	9.20 (n=78)
On a scale of 1-10, would you recommend that others take the ASIST workshop? (1=definitely no, 10=definitely yes)	9.73 (n=79)

Figure 1. Suicide rates by Alaska Regions



made to be an issue that is so complicated that it can only be handled by mental health professionals. This belief re-stigmatizes suicide. This is a particularly important problem when this misconception is held by residents in rural communities of Alaska because the availability of clinical mental health professionals is very limited. As caregivers of all kinds understand that they are able to learn skills to effectively help a person at risk of suicide, the burden carried by local health professionals may be lessened and they may feel more supported in providing care to their communities.

Since our first training-for-trainers course, there have been six other individuals trained as ASIST trainers within the Alaska tribal health network. Three are from Maniilaq Association in Kotzebue, and three from the ANTHC Division of Behavioral Health in Anchorage. Having these additional trainers greatly enhances our ability to conduct future ASIST workshops across the state of Alaska.

After completion of this project, an ASIST workshop was held in Nome on May 14-15, 2009 for the Bering Straits Suicide Prevention Coalition, training an additional 25 caregivers. Most participants (88%) were from rural villages, with the majority being village tribal employees who will return to their villages and start a suicide prevention coalition. Two more ASIST workshops are scheduled in October 2009, one for the NSHC Health Aide Training Center, and one for the Bering Straits School District which operates schools in each of the 15 villages in the Norton Sound region.

Regardless of the setting, the skills taught during an ASIST workshop remain the same. The suicide intervention model is not dependent on speaking a certain language or using a certain vocabulary. In following the steps outlined by the model to intervene with a person in crisis, people can use the language that is authentic to them, whether it is a traditional language or "Village English" (a mixture of traditional Native language and English).

The ASIST Train-the-Trainer course creates an opportunity for IP specialists to address suicide prevention within any community. It provides a framework for the IP specialist to teach a suicide intervention model to any community member age 16 and older, in a two-day workshop. Our experience has been with professionals and paraprofessionals, typically from medical/health or school settings. By teaching specific, concrete suicide intervention skills to community members we open doors for them to intervene supportively and effectively when confronted with a person at risk for suicide.

Incorporating ASIST into injury prevention work has also opened doors to the beginning of a strong collaboration

between the Departments of Behavioral Health and Injury Prevention within several Alaska tribal health organizations. With the expertise of each department working together, the opportunities for more comprehensive suicide prevention efforts are more likely. The NSHCIPP is partnering with Kawerak, Inc., a regional non-profit corporation formed by the Bering Straits Native Association to provide services in the Bering Straits region.[21] Kawerak was recently awarded a $1.5M Garret Lee Smith Suicide Prevention Grant from the Substance Abuse and Mental Health Services Administration.

Injury prevention programs in Alaska are also employing lethal means restriction strategies. Gun locker installation programs and locking medicine cabinet installation programs have been implemented by injury prevention staff in rural Alaska Native communities and are being shown to be a promising strategy as a piece of a comprehensive suicide prevention program.[22,23]

Next steps

Feedback received during the ASIST workshop also provides useful direction for IP programs as they develop more comprehensive suicide prevention programs. The NSHCIPP is planning a media campaign aimed at suicide stigma reduction. Radio public service announcements and newspaper articles will be used to distribute information on resources for a person at risk of suicide; discuss common myths about suicide that contribute to stigma; and open discussion about suicide in villages where it is currently an unspeakable issue. It is our hope that this campaign, combined with other suicide prevention activities, will begin to break down the longstanding stigma and fear of suicide in the region.

Steps to improve response and debriefing after a suicide are needed in the Norton Sound region. Village health aides and village based counselors are commonly the first responders to a suicide completion or attempt. Health aides are also responsible for officially pronouncing each death in a village, including a death by suicide. There are currently no formal procedures in place at NSHC to debrief these employees.

The authors are also developing a follow-up tool to evaluate ASIST long term. After an ASIST workshop, there is currently no method to track its use by participants. This information will be valuable to see how ASIST is being used in Alaska Native communities, and help us to improve the delivery of ASIST.

The ASIST training program alone is not enough to combat the suicide epidemic in rural Alaska. However, ASIST is a valuable part of a comprehensive suicide prevention program (Table 2).[24] It will take time to tell if ASIST is *saving lives*, but it is certainly *changing* lives in rural Alaska.

Table 2. Selected Suicide Prevention Strategies*

Activity	Description
Chain of Care	Providing follow-up care after a suicide attempt through structured collaboration among hospitals, case managers, and multidisciplinary networks.
Curriculum- Based Programs for adolescents	Curricula focusing on improving problem solving, coping with stress, and increasing resilience can enhance protective factors for suicide.
Gatekeeper Education	Educating those who have contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment.
Means Restriction	Restricting access to lethal means such as firearms or medications.
Media	Educating journalists and establishing media guidelines for reporting suicide. Media blackouts on suicide have proven effective.
Pharmacotherapy	Treating mood and other psychiatric disorders.
Physician Education	Educating physicians on the recognition and treatment of depression and suicide risk.
Psychotherapy	Promising reductions in repeat suicidal behavior exist for cognitive therapy, problem solving therapy, intensive care plus outreach, and interpersonal psychotherapy.
Screening	Screening to identify at-risk individuals based on suicidal behavior or risk factors such as depression or substance abuse.

*Adapted from Mann JJ, et al, reference 24.

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

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

Each of the articles in this issue offers some general statistics that demonstrate how great the impact is of injuries in the population we serve. In addition, the references allow one to find more detail about specific types of injuries and subsets of the American Indian and Alaska Native population. These data would be a useful source to cite in the needs assessment process for your continuing education activities that focus on injury prevention.

Increasing Occupant Restraint Use Among Ho-Chunk Nation Members: Tailoring Evidence-Based Strategies to Local Context

Robert J. Letourneau, MPH, Research Associate, Department of Health Behavior & Health Education, The University of North Carolina at Chapel Hill Gillings School of Global Public Health, Chapel Hill, North Carolina; Carolyn E. Crump, PhD, Research Associate Professor, Department of Health Behavior & Health Education, The University of North Carolina at Chapel Hill Gillings School of Global Public Health; Nicole Thunder; Motor Vehicle Injury Prevention Program Coordinator, Ho-Chunk Health Services, Black River Falls, Wisconsin; and Robert Voss, Sanitarian, Ho-Chunk Health Services, Black River Falls

Background and Purpose

Despite progress in recent years to reduce the burden of injury morbidity and mortality among American Indian and Alaska Native (AI/AN) communities throughout the US, the 2005 overall AI/AN motor vehicle (MV) injury death rate was 24.8 compared to the US All Races rate of 15.2 per 100,000 (RR: 1.6).[1] There are eleven federally recognized tribes in Wisconsin (WI), with 0.9% of the population of AI/AN descent.[2] In Wisconsin, the 2005 AI/AN MV death rate (36.0) was 2.3 times higher than Wisconsin All Races rate of 15.6.[3] The 2005 Ho-Chunk Nation (HCN) seatbelt use rate was 46.7%, compared to Wisconsin and nationwide rates that were 73.3% and 82.0%, respectively.[4,5] In fall 2003, child safety seat (CSS) use among HCN children and infants was 31.8%, compared to 2003 WI rates of 89.9% for children 0 - 4 and 2004 National rates of 86% for children 4 - 7 years of age.[6,7]

In September 2004, the Ho-Chunk Nation, along with three tribes in Arizona, received funding (originally four years, a fifth added) from the Centers for Disease Control and Prevention (CDC) Tribal Motor Vehicle Injury Prevention Program (TMVIPP) to reduce motor vehicle-related injuries and deaths using evidence-based, effective strategies identified by the Task Force on Community Preventive Services.[8,9] The HCN MVIPP needed to adapt these strategies because it does not have tribal law enforcement, is located in Wisconsin, which is a state with a seatbelt use secondary enforcement law,[10] and has a dispersed tribal membership.

There are approximately 6,888 enrolled HCN tribal members, with 4,815 living in 14 of 72 Wisconsin counties. The HCN owns 12,897 acres of non-reservation land in 14 counties throughout Wisconsin and has four branches of government (executive, legislative, judicial, general council), two medical facilities (Black River Falls and Wisconsin Dells). Through collaboration with the HCN Law Enforcement Commission (LEC), the Nation relies on local county law enforcement agencies (e.g., sheriff departments) to conduct public/traffic safety enforcement.

Methods

From 2005 to 2009, the HCN MVIPP employed a full time project coordinator, who focused the project's occupant restraint use efforts in five mostly rural Wisconsin counties: Jackson, Juneau, Monroe, Sauk, and Wood. The project's intervention efforts included the following types of activities: 1) general educational events (e.g., crash simulations, safety expositions, health fairs); 2) media awareness (e.g., billboards, radio public service announcements (PSAs), newspaper articles, e-mails, community seatbelt signs); 3) targeted education/training (provision of child safety seats, child passenger safety certification/training, employee incentive campaign); and 4) enforcement/policy (e.g., LEC participation, enhanced Click-It or Ticket campaigns, and employee restraint use policy). Process evaluation activities conducted by HCN staff documented the number and reach of program implementation activities conducted from Year 1 to three-quarters through Year 5 (i.e., spring 2009).

Staff conducted observational surveys to estimate driver and front outboard passenger seatbelt use rates among Ho-Chunk tribal members by following the University of North Carolina/Indian Health Service (UNC/IHS) Seatbelt Use Observational Survey Protocol.[11] Results from a 2005 traffic volume assessment, conducted at locations where an observer would be most likely to observe tribal members, identified the cluster sample size and determined that 46 one-hour seatbelt use observations were needed to have adequate power to detect differences in annual seatbelt usage rates. A randomly selected list of 46 observation location/time of day combinations was developed each year (2005 to 2008; 2009 data are not available) to guide six weeks of annual data collection. Of the total observations (n = 5,431) 3.6% were conducted in Wittenberg, where MVIPP activities only included targeted education through Ride Safe and selected media awareness activities. Completed data collection forms were provided to program evaluators at UNC, who entered data into Excel database spreadsheets and analyzed using Excel and SAS.

Chi-Square analysis was used to examine differences over time for driver, passengers, and overall seatbelt use.

The Ride Safe Program, a Head Start-based child safety seat education and installation program, was implemented at six tribal Head Start Centers (e.g., Indian Mission, Sand Pillow, Tomah, Nekoosa, Wittenberg, and Wisconsin Dells), with only one (i.e., Wittenberg) being outside the five focus counties of the MVIPP. Ride Safe Program child safety seats were purchased through program funding based on annual anticipated Head Start enrollment figures and were provided at no cost to families. At the start and end of each school year, MVIPP staff conducted observational child safety seat use surveys following guidelines outlined by the IHS Ride Safe Program.[12,13] Surveys were conducted for at least 40 minutes per observation location; at a minimum of three Head Start and/or community locations (at which they would be likely to observe local/tribal children, where traffic slows or comes to a stop, and where the observer can clearly see into the vehicles); and at times of day where they would be most likely to observe Head Start-aged children traveling in vehicles. Completed survey forms were sent to the program evaluators at UNC for data entry and analysis, using Excel and SAS. Forty-four infant use observations were collected in years 2003 – 2007; however, they were not included in the analysis. Proc Survey Logistic analysis was used to examine the relationship of year and pre-post status for child safety seats use, adjusting for the complex survey design in which motor vehicles with toddlers were observed in clusters based upon time and location.

Approval for publication of this report was obtained from the Ho-Chunk Nation's Office of Public Relations.

Results

Table 1 summarizes program implementation information for general educational events, media awareness, and targeted educational activities, including project year and the extent to which activities reached the five target counties. The varied educational events and media activities targeted tribal members in all five counties served; however, additional emphasis was placed on membership in Jackson and Sauk counties, which include Black River Falls and Wisconsin Dells, two cities where many tribal members either live or work. In-kind contributions by the tribe increased the reach of Year V radio public service announcements, which included messages recorded by the MVIPP Coordinator.

To conduct enforcement/policy activities, the HCN MVIPP partnered in Years II-III (and will again in Year V) with five local county sheriff departments to enhance/collect data for one-week Click It Or Ticket (CIOT) campaign events conducted on/near tribal lands and/or during local tribal events (e.g., at powwows). In 2006 and 2007, the MVIPP provided law enforcement in the five target counties at a cost of $17,987 to support 348 officers for a total of 909 staff hours to conduct traffic enforcement (Table 2). During these Ho-Chunk specific campaigns, over 150 seatbelt and four child safety seat citations were issued. In Year IV, even though MVIPP funding was not available to support Ho-Chunk specific enforcement, local law enforcement participated in annual national CIOT campaigns.

To enhance policy/enforcement efforts, the MVIPP Coordinator attended quarterly HCN Law Enforcement Commission (LEC) meetings (she serves as its Information Officer) and at these meetings, she collected data from county law enforcement entities and disseminated information about upcoming events. After conducting a five-county law enforcement needs assessment survey in the first year of the program, the MVIPP Coordinator tailored an existing eight-hour Safer Native American Passenger (SNAP) training (developed by Indian Health Service staff) to create a two-hour training designed to increase education and skills among local law enforcement regarding child passenger safety, reaching a total of 28 officers. MVIPP staff also sought to enhance language regarding the tribe's employee restraint use policy and conducted an employee restraint use incentive campaign.

Between 2005 and 2008, seatbelt use increased from 50.5% to 62.7% ($p<.0001$) for drivers and from 32.6% to 56.0% for passenger ($p<.0001$) (Figure 1). For all occupants, the seatbelt use rate increased 31.0 percent from 46.7% in 2005 to 61.2% in 2008 ($p<.0001$). Over 1,100 observations were conducted each year, ranging from 1,795 in 2005 to a low of 1,177 in 2007. Over 900 vehicles (drivers) were observed each year, ranging from 1,451 in 2005 to a low of 944 in 2008, and the number of passengers observed ranged from a low of 221 in 2007 to a high of 344 in 2005. The percent of vehicles with passengers observed ranged from 23% in 2007 to 28% in 2008.

From 2004 to 2008, 13 CPS Technicians, who received initial or recertification training while working with the HCN MVIPP, installed a total of 1,223 child safety seats through two programs: 1) the Tribal Head Start-centered Ride Safe education and installation program (364 seats at an average of 73/school year); and 2) the HCN's Health Division's CSS Program (859 seats at an average of 172/year). In addition, ten separate child safety seat "clinic" events were held, which included proper fitting and installation of approximately 130 child safety seats. Five of six Ride Safe sites and four of six Health Division CSS distribution sites were located within the MVIPP-targeted counties. For the HCN CSS Program, recipients were charged $20/seat and funds from this, along with support from other traffic safety grants, allowed for the purchase of additional child safety seats (funds from CDC could not be used to purchase child safety seats).

Ho-Chunk child safety seat use has increased from a baseline of 26.4% in fall 2003 to 78.4% in spring 2008. The observed toddler child safety seat use reductions between the end of a school year and the start of the next school year were not surprising, given that new children entered Tribal Head Start programs each year (Fig 2). Both year and pre-/post-test status were significant predictors of child safety seat use ($p<.0001$). For each of the ten data collection periods

occurring over five years, observations were conducted at 5 or 6 different locations. Of the 58 total observation periods, 62 percent were Head Start locations and 38 percent were located in the community. There were no significant differences between observations collected at Head Start locations compared to observations at community locations. On average over the five year period, observed toddlers were 2.38 times as likely to be in child safety seats during a post test period as compared to a pre-test period. We also observed a secular trend during the five years in that for each additional year of the program, toddlers observed in cars were 41 percent more likely to be in child safety seats.

Discussion/Conclusions

The Ho-Chunk Nation MVIPP obtained measurable increases in occupant restraint use between 2004 and 2008 despite: a) not having a tribal police department; b) being located in a state with a secondary enforcement seatbelt use law; and c) being a tribe without a land base and having membership spread across 14 counties in central and western Wisconsin. The HCN MVIPP adapted educational and enforcement strategies to address local conditions.[14] This required use of multiple media channels, collaboration with multiple law enforcement entities, and significant travel time to conduct program and evaluation activities.

The HCN MVIPP needed to gain agreement and establish contracts to pay law enforcement entities to conduct enhanced Click It or Ticket enforcement activities on/near tribal lands and at tribal events. The HCN MVIPP had a clear focus due to the funding agency requirement that projects implement evidence-based effective strategies, which emphasized working with police to conduct traffic safety enforcement to increase occupant restraint use.[9] The HCN MVIPP focused its efforts in five counties where the largest concentration of HCN tribal members live (38.7% total) and relationships with county law enforcement had already been established. Funding agencies that require both use of effective strategies and acknowledge the adaptations needed to address regional and contextual differences are able to support traffic safety interventions in a variety of diverse communities.

Seatbelt use observation locations were selected based on the likelihood of observing tribal members; however, the sample probably included non Ho-Chunk members. It is possible that the observed use rate was elevated because some non-tribal occupants, with known higher use rates, were included in the sample.[15] Because observation locations/timeframe combinations were randomly selected annually, any bias from observing non-Ho-Chunk tribal members is equally distributed across time periods. It appears that Ho-Chunk's seatbelt use rates are now higher than AI/AN rates reported by NHTSA in 2005 (55.6%); however, HCN rates are lower than the estimated rural use rate of 78%.[16]

The MVIPP Coordinator presented project results at three national conferences to HCN administrators and leaders (e.g., Executive Director of the HNC Health and Social Services Division, the Health Accreditation Board, and the Ho-Chunk Nation Legislature), and will have a "success story" published on the CDC's National Center for Injury Prevention and Control website in 2009. If the HCN can maintain or further increase its occupant restraint use, the tribe can expect to see reductions in motor vehicle crash injury morbidity/mortality.[9]

In part due to its documented successes, the Ho-Chunk Nation agreed to fund the program an additional year (2009 - 2010) while the program seeks funding to continue and/or expand its traffic safety efforts. The successes achieved by the MVIPP should assist the Ho-Chunk Nation LEC in establishing a tribal law enforcement agency which would in turn enhance and increase enforcement of occupant restraint use laws.

Acknowledgements

We would like to thank the dedicated staff at the Ho-Chunk Nation Division of Health, including community health representatives for their assistance with child safety seat installation activities, and Office of Environmental Health staff for their assistance with observational surveys. We also thank the Ho-Chunk Nation Law Enforcement Commission and law enforcement agencies in Jackson, Juneau, Monroe, Sauk, and Wood counties for their commitment to traffic safety. Special thanks to J. Michael Bowling, PhD and Rachel Willard, MPH from the University of North Carolina Gillings School of Global Public Health for providing assistance with statistical analysis.

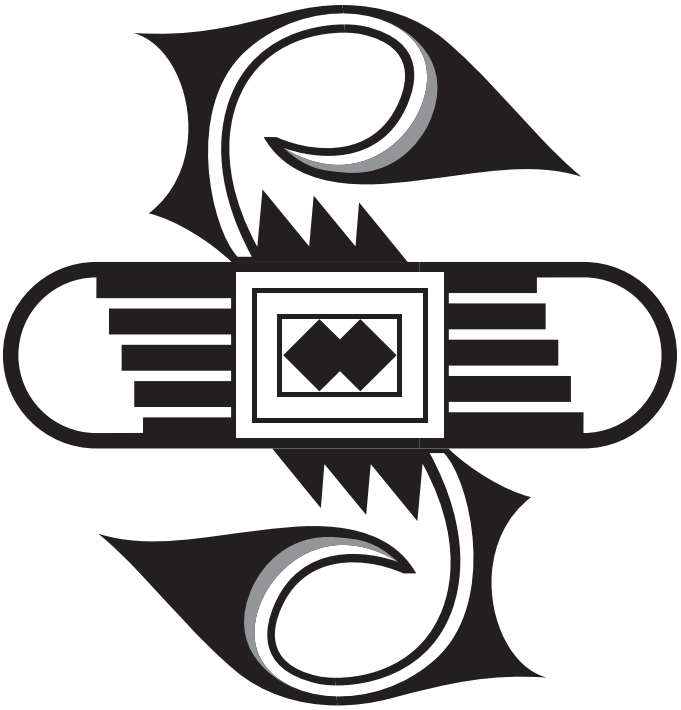


Table 1. HCN MVIPP program implementation summary, fall 2005 - spring 2009

Intervention Activity	Description	Years	Total N	Estimated Reach	County Reached [a]				
					Ja	Ju	M	S	W
Educational Events									
Crash Simulations	Included presentations about crash statistics, Fire/EMS/LE conducted a mock crash, and victims and first responders panel discussions.	I-IV	6	600	3	-	-	1	2
Community Safety Exposition	Day-long public safety event conducted in collaboration with local non-Tribal emergency/law entities.	I-III	3	390	3	-	-	-	-
Community Health Fairs	Included MVIPP activities and educational materials at Tribal program/ community health events.	I-IV	23	1,150	8	-	5	7	3
Media Awareness									
Seatbelt Signs	Installed Ho-Chunk Nation buckle-up signs in Tribal communities in all five counties.	III	42[b]	unk	17	2	2	15	4
Billboards	Posted billboards (n=3) on Highway 54 in Black River Falls (Tribal center) for 12 months each -- two on restraint use and one on impaired driving prevention -- at an average cost of $2,300..	III-IV	3	10,000 (per day)	3	-	-	-	-
Radio PSAs	Included two MVIPP-focused, 60-sec. seatbelt use/click-it or ticket messages airing 408 times/week on average on 22 radio stations across the state of Wisconsin (non-MVIPP funds).	V	2	892,000	✓	✓	✓	✓	✓
Newspaper Articles	Published articles/editor letters in Tribe's bi-weekly newspaper (Hocak Worak)	II-III,V	4	3,750 (per article)	✓	✓	✓	✓	✓
Newspaper Ads	Published paid advertisements announcing Click-It or Ticket enforcement.	III	4	127,720 (total)	✓	✓	✓	✓	✓
Employee GroupWise Emails	Distributed traffic safety multi-media messages using Tribal employee email system.	I-IV	42	1,300 (per email)	✓	✓	✓	✓	✓

Intervention Activity	Description	Years	Total N		County Reached [a]				
					Ja	Ju	M	S	W
Targeted Education/Training									
Safer Native American Passenger (SNAP) Training	Conducted SNAP training for law enforcement to build skills/increase enforcement of state primary child safety seat.	III, V	4	28	TBS[c]	14	6	-	8
Child Passenger Safety Technician (CPST) Certifications	Supported initial or recertification CPST training among Envir. Health, Community Health Representative, and Natural Resources Dept. staff.	I-IV	13	-	✓	✓	✓	✓	✓
Employee Restraint Use Campaign	Provided $20 gift cards to employees 'caught' wearing seatbelts and included photos in Tribal newspaper.	IV-V	20	20	✓	✓	✓	✓	✓

[a] Ja=Jackson; Ju=Juneau; M=Monroe; S=Sauk; W=Wood

[b] Two signs were installed in Wittenberg (Shawano) county.

[c] 2009 SNAP training yet to be conducted.

Table 2. Ho-Chunk Nation enhanced Click It or Ticket mobilization campaign summary, 2005 - 2007

Click it or Ticket Campaign Characteristics	Year II 2005-2006	Year III 2006-2007	Total
Number of campaigns (one-week duration)	7	6	13
Number of Hours Worked	237	672	909
Number of Participating Officers	152	196	348
Total Project Costs	$9,400	$8,587	$17,987
Total Seatbelt Citations Issued (#)	68	83	151
Total Child Safety Seat Citations Issued (#)	1	3	4
Total Number of CIOT campaigns by county (one-week campaigns each)			
Jackson County	1	2	3
Juneau County	1	1	2
Monroe County	1	1	2
Sauk County	2	1	3
Wood County	2	1	3

Figure 1. Ho-Chunk Nation Motor Vehicle Injury Prevention Program Seatbelt Use, 2005-2008

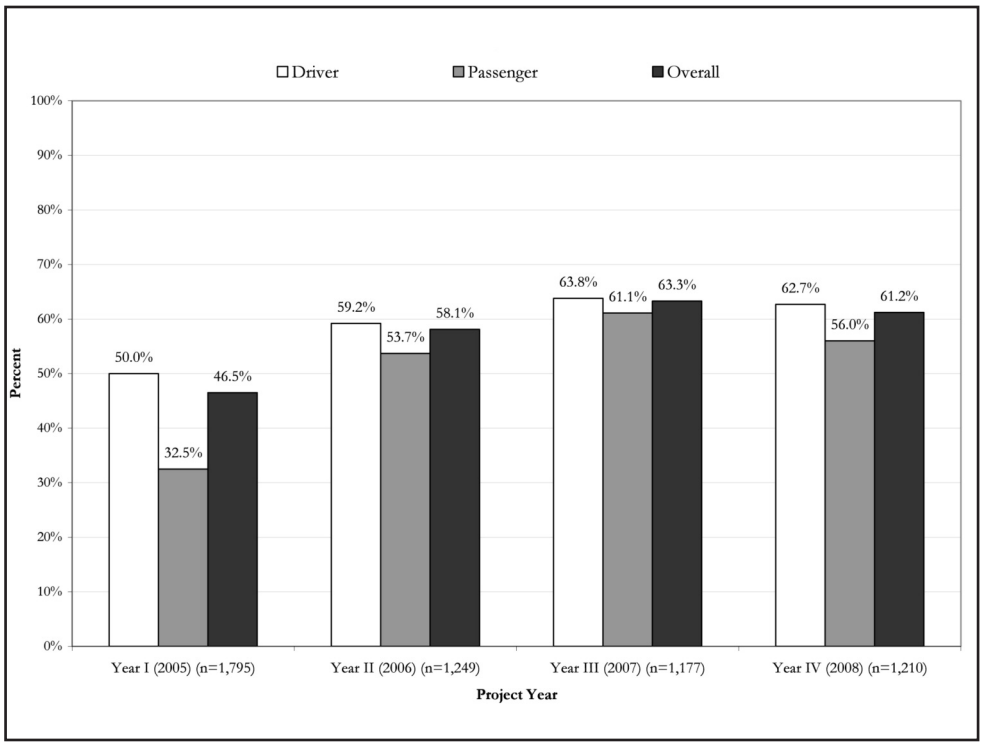
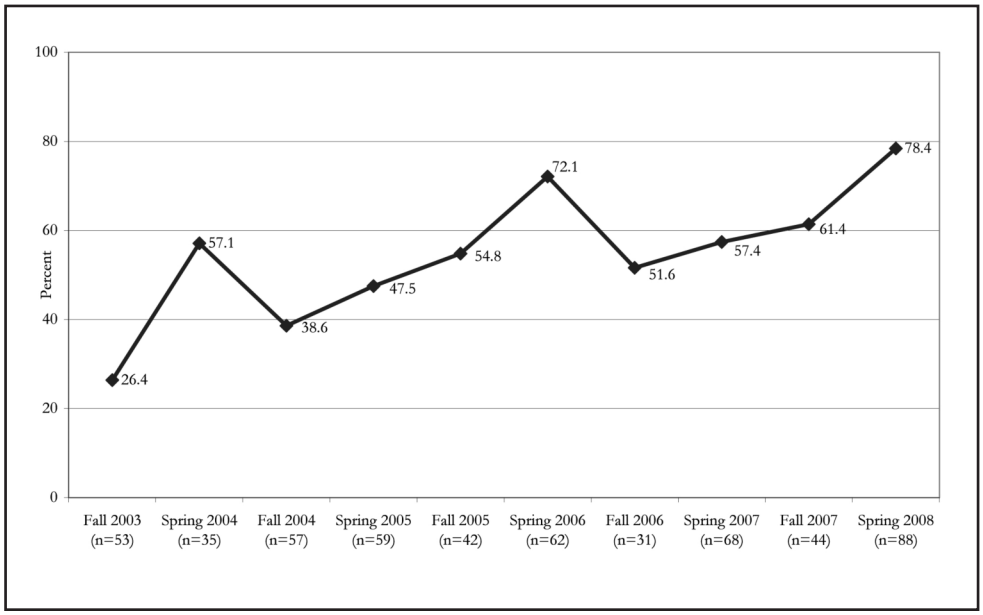


Figure 2. Ho-Chunk Nation Child Safety Use (n=539), 2003-2008



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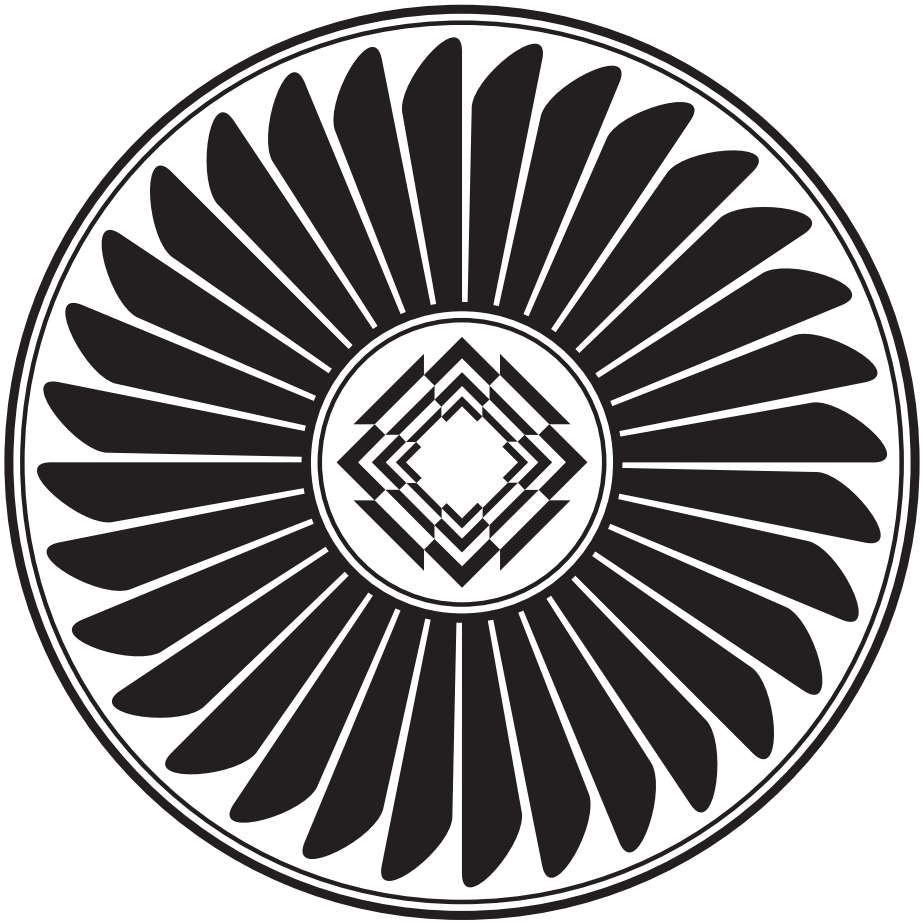

MEETINGS OF INTEREST

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*.

The Pharmacy Practice Training Program: A Program in Patient-Oriented Practice (PPTP)
August 3 - 6, August 24 - 27, 2009; Scottsdale, Arizona

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

NANAINA Summit XV: Preventing Violence against American Indian/Alaska Native Women
August 6 - 9, 2009; Albuquerque, New Mexico

IHS, tribal, and urban nurses are encouraged to attend the NANAINA Summit XV to be held at the Embassy Suites Hotel, 1000 Woodward Place NE, Albuquerque, New Mexico, 87102. To reserve a room at the Embassy Suites Hotel call (505) 245-7100 or (800) EMBASSY. Please be sure to mention NANAINA. A block of rooms has been reserved for NANAINA at the rate of $129 per night/king or double, additional person $10.00. Reservations can also be made online at *www.embassysuites.com*. Insert the dates "August 6 - 9, 2009" and put Convention Code "ANA." Deadline for group room rate is July 7, 2009.

Abstracts for the poster session can be sent to Beverly Patchell at *Beverly-Patchell@ouhsc.edu*. Deadline for poster abstract submission is July 15, 2009. The IHS Clinical Support Center is the accredited sponsor of this meeting. For on-line registration and for more information about the conference, visit the NANAINA website at *www.nanainanurses.org*.

August 2009 Clinical Update on Substance Abuse and Dependency (Formerly known as the Primary Care Provider Training on Chemical Dependency)
August 25 - 27, 2009; Bemidji, Minnesota

This three day intensive workshop includes both didactic and experiential training. The curriculum is updated annually with the most current nursing, addiction medicine, and prevention information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 - 3 person teams from the same facility representing the various disciplines targeted). The conference site is the Hampton Inn & Suites, 1019 Paul Bunyan Drive S, Bemidji, Minnesota 56601; telephone (218) 751-3600. For more information or to register, contact Cheryl Begay at (602) 364-7777 or e-mail *cheryl.begay@ihs.gov*. To register on-line, go to the CSC website at *http://www.csc.ihs.gov*.

Training Conference on the Treatment of Trauma: "Re-Making the World of the Trauma Survivor"
October 2 - 3, 2009; Flagstaff, Arizona

Hosted by The Hopi Foundation, this cutting edge two-day conference has been organized to provide clinical and empirically based techniques and approaches to practitioners working with two sets of population groups affected by trauma: Native American war veterans, and survivors of political torture. Acknowledged world-class experts are providing the training, including Drs. Judith Herman, Maria Yellow Horse Brave Heart, Spero Manson, Richard Mollica, and Terence Keane. Innovative workshop sessions are intensive and present the subject matter in considerable depth offering dynamic, didactic, and interactive learning experiences. The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this educational activity for a maximum of 11 *AMA PRA Category 1 Credit(s)*™. This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse Midwives. The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity is designated 11.0 contact hours for nurses. The Arizona Psychological Association is offering up to 26 Credit Education hours for psychologists and therapists. Continuing Education Units are offered to social workers and counselors by Arizona State University. For more information and conference registration, go to the website at *www.barbarachesteraward.org* or e-mail

information@barbarachesteraward.org.

Second Annual Cardiovascular Disease Update
October 29 – 30, 2009; Scottsdale, Arizona

The Native American Cardiology Program will be presenting the Second Annual Cardiovascular Disease Update at the Chaparral Suites in Scottsdale, Arizona beginning midday on Thursday, October 29 running through Friday afternoon, October 30, 2009. The topic this year is "Successful Management of The Cardiovascular Patient." The conference will provide practical approaches to the evaluation and management of common cardiac conditions encountered by primary providers, including atrial fibrillation, chronic angina, heart failure, arrhythmias, acute coronary syndromes, peripheral vascular disease, and stroke. There will be no registration fee for Indian Health Service or tribal employees. The conference is directed at clinical staff with an interest in cardiovascular disease. Program and registration material will be available by August. The Indian Health Service Clinical Support Center is the accredited sponsor. For more information, please feel free to contact *lkoepke@umcaz.edu* or *bmalasky@umcaz.edu*.

Where Are My Back Issues?

Due to delayed payments to some vendors that have occurred with the transition to the UFMS system, there have been problems with distribution of the mailed issues of The Provider. These have been resolved, and back issues have been mailed. We will do everything in our power to keep things current from this point on. Readers are still encouraged to take advantage of the opportunity to sign up for the listserv that gives notification as soon as the electronic version is posted on our website – usually in the middle of the month. Issues may be read in their entirety as soon as they are posted, and so no time-sensitive information will be missed. To join the listserv, go to *http://www.ihs.gov/PublicInfo/Publications/HealthProvider/provform.asp* and subscribe. You may retain your paper subscription also, if you prefer to receive issues both ways.

New Policy for Position Vacancies

Through the years, the number of position vacancies published every month has grown, such that now it includes as many as 15 pages per issue. In the past, we tried to contact those who submitted these on a periodic basis, but this is very labor intensive, and many failed to respond to confirm that they, indeed, needed their item to continue.

Our plan to try to alleviate this situation is to run all submitted items for four months, and then remove them from the section. Those who wish to continue their position vacancy announcements may resubmit them at this time, and they will run for another four months. We will not be contacting you, though, so we ask that you keep an eye on your announcements to be sure you know when they are about to expire.

This will assure that all vacancy announcements we publish remain “fresh” and current and eliminate items that are no longer necessary.

It is not our intention to remove items that are still pertinent; we are merely trying to encourage those who submit these to assume the responsibility to keep them up to date. As always, if you have suggestions about how we can make this or any other feature of *The Provider* more useful, we want to hear from you.

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
Pharmacist
PHS Clinics; Wind River Service Unit, Wyoming

This is the primo IHS opportunity. Two family physicians will be retiring in January to split a position between them, leaving a hiring opportunity for this progressive and stable seven-physician group (six FP and one pediatrician). We admit patients to the Lander Regional Hospital on a 1/7 on-call basis and staff two clinics on the reservation, along with four nurse practitioners. The Wind River Reservation is home to the Northern Arapaho and Eastern Shoshone Tribes. Local cultural opportunities abound, and the medical practice is fascinating and challenging.

The physicians tend to live in Lander, which is located adjacent to the Wind River Indian Reservation. Lander was featured in Sunset Magazine as one of "The West's Twenty Best Small Towns" and has been featured in the book "Best Small Towns in America." It is located next to the Wind River Mountains, which offer a spectacular chance for world class climbing, hiking, outfitting, fishing, and hunting. Lander is progressive and is the world headquarters for the National Outdoor Leadership School. Next fall, Lander High School graduates will attend MIT, Duke, and Princeton. The IHS physicians enjoy a great relationship with the private physicians in town, and the hospital sports the latest generation MRI, CT, and nuclear medicine capabilities. This is the kind of IHS medical staff that physicians join and end up staying for ten to twenty years. Board eligible/certified applicants only, please. E-mail CV to Paul Ebbert, MD at *paul.ebbert@ihs.gov* or call him at work at (307) 856-9281 or at home at (307) 332-2721.

The Wind River Service Unit also has an opening for a pharmacist. Pharmacists at Wind River enjoy a close professional relationship with the medical staff. There is interest and opportunity for pharmacists to expand their skills into enhanced patient education and management. Interested candidates should contact Marilyn Scott at *marilyn.scott@ihs.gov* or call (307) 332-5948. (6/09)

Family Physician
Staff Dentist
Consolidated Tribal Health Project, Inc.; Calpella, California

The Native American Health Center in northern California wine country is seeking a doctor and a dentist to join our dedicated team. For twenty five years, Consolidated Tribal Health Project, Inc. has been providing health, dental, behavioral health, and community outreach services to the eight consortium tribes of Mendocino County.

We are seeking two providers:

- Family Practice Physician, BC/BE, to provide direct patient care (90%) and administration (10%)
- Staff Dentist to provide comprehensive, public health oriented dental services and all general clinic services

Candidates must currently hold a California license. Qualified applicants, please fax resume, cover letter, and salary requirements to Human Resources at (707) 485-7837. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. Native American preference in hiring; all qualified applicants will be considered. For more information, please contact Annie Kavanagh at (707) 467-5685, or by e-mail at *akavanagh@cthp.org*. (6/09)

Family Medicine Physicians
Internal Medicine Physicians
Emergency Medicine Physicians
Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible family medicine, internal medicine, and emergency medicine physicians to join our experienced medical staff. The SSU is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells and three health centers: San Xavier Health Center, located in Tucson, Arizona, the Santa Rosa Health Center, located in Santa Rosa, Arizona, and the San Simon Health Center located in San Simon, Arizona, with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self-management education.

Sixty miles east of the Sells Hospital by paved highway

lies Tucson, Arizona's second largest metropolitan area, and home to nearly 750,000. Tucson, or "The Old Pueblo," is one of the oldest continuously inhabited sites in North America, steeped in a rich heritage of Indian and Spanish influence. It affords all of southern Arizona's limitless entertainment, recreation, shopping, and cultural opportunities. The area is a favored tourist and retirement center, boasting sunbelt attributes and low humidity, with effortless access to Old Mexico, pine forests, snow sports, and endless sightseeing opportunities, all in a setting of natural splendor.

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. Commuter van pool from Tucson is available for a monthly fee. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at *Peter.Ziegler@ihs.gov*. (6/09)

Family Nurse Practitioners
San Simon Health Center, Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is recruiting for a family nurse practitioner to provide ambulatory care in the recently opened San Simon Health Center and another family or pediatric nurse practitioner to provide ambulatory care in our school health program. The SSU is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells and three health centers: San Xavier Health Center, located in Tucson, the Santa Rosa Health Center, located in Santa Rosa, and the San Simon Health Center located in San Simon, with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self management education.

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Internal Medicine/Hospitalist
Phoenix Indian Medical Center; Phoenix, Arizona

The Internal Medicine department is recruiting for a hospitalist, BC/BE in either Internal Medicine or Family Medicine, at the Phoenix Indian Medical Center; position available now. PIMC is one of the largest sites in the IHS, with over 150 multi-specialty physicians. Our five-member hospitalist group provides both general medical and intermediate level care for approximately 40 hospitalized patients. Very reasonable schedule with 40 - 45 hour weeks. Electronic Health Record is being implemented. This position would be open to either a civil service or Commissioned Corps physician. The Phoenix metropolitan area offers a variety of cultural, sports, educational, and family-oriented opportunities.

For more information, please contact/send CV to Amy Light MD, Chief of Medicine, Phoenix Indian Medical Center, 4212 North 16th Street, Phoenix, Arizona 85016. Telephone (602) 263-1537; fax (602) 263-1593 or e-mail *amy.light@ihs.gov*. (4/09)

Psychiatrist
White Earth Health Center; White Earth, Minnesota

The White Earth Health Center is currently recruiting a psychiatrist to provide psychiatric assessment for diagnosis of mental health disorders for children, adolescents, and adults and provide medication management services to children, adolescents, and adults, in an outpatient setting. The White Earth Health Center is located in central Minnesota. Enjoy four seasons filled with plenty of lakes for fishing, swimming, canoeing, skiing, skating; area fitness centers; shopping, hunting, snowmobiling, four-wheeling, clear skies, golf courses, horse trail rides.

The ideal candidate for this position will be an outgoing, energetic team player who is compassionate and focused on patient care. This individual will be working in a beautiful, modern facility. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. Please contact Darryl Zitzow, PhD, LP, Director, Mental Health Department, telephone (218) 983-6325; fax (218) 983-6336); or e-mail *darryl.zitzow@ihs.gov* for further information. The mailing address is White Earth Health Center, 40520 County Highway 34, Ogema, Minnesota 56569. (4/09)

Family Practice Physician
Nurse Practitioner
Pawhuska IHS Health Center; Pawhuska, Oklahoma

The Pawhuska IHS Health Center has openings for a family practice physician and a nurse practitioner. Our facility is a JCAHO accredited, multidisciplinary outpatient clinic with medical, dental, optometry, behavioral health, an on-site lab, and pharmacy. Our medical staff enjoy regular work hours with no night or weekend call.

Pawhuska is located 55 miles from Tulsa, Oklahoma. It is home to the Osage Nation, with a rich heritage of tribal culture, oil money, and even cowboys. So if you have a passion for small town life on the plains, you may want to check us out.

Interested parties can contact Wehnona Stabler, 715 Grandview, Pawhuska, Oklahoma 74056; telephone (918) 287-4491; or e-mail to *wehnona.stabler@ihs.gov*. (2/09)

Family Practice Physician
Gallup Indian Medical Center; Gallup, New Mexico

The Gallup Indian Medical Center has an immediate opening for a family medicine physician. GIMC is one of the largest Indian Health Service sites. The IHS has great benefits packages for both Civil Service and Commissioned Corps providers. We are an NHSC scholarship and an IHS Loan Repayment site as well. The Department of Family Medicine offers the opportunity for full spectrum family medicine care. There are currently nine physicians, two physician assistants, and one pharmacist clinician in the department. Chronic disease management and prevention are the focus for continued development and expansion of this department and program. The hospital has a multi-specialty group, and family medicine physicians have inpatient privileges at GIMC as well as at the community hospital, Rehoboth McKinley Christian Hospital.

Please contact Dr. Alma Alford, Chief of Family Medicine, if you are interested in pursuing an opportunity here. The address is Gallup Indian Medical Center, 516 E. Nizhoni Blvd., P.O. Box 1337, Gallup, New Mexico 87301-1337; telephone (505) 722-1000; fax (505) 726-8740; office number (505) 722-1280 or 722-1775; e-mail *alma.alford@ihs.gov*. (1/09)

Physicians
Belcourt Comprehensive Health Care Facility; Belcourt, North Dakota

The Belcourt Comprehensive Health Care Facility is seeking experienced pediatric, emergency medicine, obstetrics and gynecology, family practice and psychiatry professionals. Belcourt is located in Rolette County in the north-central part of the state near the Canadian border in rural North Dakota. The Turtle Mountain Reservation has approximately 26,000 enrolled tribal members of the Turtle Mountain Band of Chippewa. The area consists of low rolling hills and a wide variety of trees. About 40% of the land is covered with small ponds and lakes for those who love fishing, boating, and water skiing and, in the winter, snowmobiling, ice fishing, as well as downhill skiing. We are a 27-bed facility with a busy clinic and a 24-hour emergency room, as well as the following services: Family Practice, OB/GYN, Emergency Medicine, General Surgery, Behavioral Health, Mid-Level Services, Dentistry, Pharmacy, Optometry, Physical Therapy, and Nursing.

For more information, contact Kimberlin K. Lawrence, Recruitment Specialist, Aberdeen Area Indian Health Service, Office of Professional Service, 115 4th Ave. SE, Aberdeen, South Dakota; telephone (605) 226-7532; fax (605) 226-7321; e-mail *kim.lawrence@ihs.gov*. (1/09)

Physicians
Eagle Butte IHS Hospital, Eagle Butte, South Dakota

The Eagle Butte IHS Hospital is seeking experienced emergency medicine and family practice professionals. Eagle Butte is located in Dewey County in rural western South Dakota. The Cheyenne River Reservation has about 15,000 enrolled tribal members of the Cheyenne River Sioux Tribe. The mighty Missouri River borders its eastern edge, the rugged Cheyenne forms its southern border, and the Moreau River flows through the heart of the reservation. This land of sprawling prairies and abundant waters is home to the Cheyenne River Sioux Tribe. Hunting opportunities on the Cheyenne River Reservation include elk, whitetail deer, mule deer, pronghorn antelope, duck, goose, turkey, rabbit, and prairie dog. Anglers can catch trout, walleye, salmon, large and smallmouth bass, white bass, northern pike, and catfish. The stark, solitary beauty of the prairie will amaze visitors. In some places, you can drive for miles with only nature and wildlife as company. We are a 13 bed facility with a busy clinic and a 24-hour emergency room, as well as the following services: Family Practice, Emergency Medicine, Mid-Level Services, Dentistry, Pharmacy, Optometry, and Nursing.

For more information, contact Kimberlin K. Lawrence, Recruitment Specialist, Aberdeen Area Indian Health Service, Office of Professional Service, 115 4th Ave. SE, Aberdeen, South Dakota; telephone (605) 226-7532; fax (605) 226-7321; e-mail *kim.lawrence@ihs.gov*. (1/09)

Medical Director
Physician
Mid-Level Provider
Nimiipuu Health; Lapwai, Idaho

Caring people making a difference. Nimiipuu Health is an agency of the Nez Perce Tribe, with ambulatory health care facilities in Lapwai and Kamiah located in beautiful northern Idaho near the confluence of the Snake and Clearwater Rivers, an area rich in history, natural beauty, and amiable communities. We provide excellent benefits and opportunity for personal and professional growth. Nimiipuu Health's caring team is looking for individuals making a difference in the health care field and is now accepting applications for three positions.

Medical Director (Salary/DOE/Full-Time/Lapwai). MD or DO with current certification in family practice or internal medicine. Must have completed an internship, be board certified, with at least five years of clinical experience. Must be licensed to practice medicine in Idaho, or obtain state of

Idaho license within one year of appointment. Must have BLS and ACLS certification. Knowledge of history, culture, and health needs of Native American communities preferred. Must maintain current license and certification, have a valid driver's license with insurable record, and will be required to pass extensive background. Closes 1/09/09. Tribal preference applies.

Physician (Salary/DOE/Full-Time/Lapwai). Idaho licensed MD or DO, prefer board certified in family practice or internal medicine. Incumbent can obtain Idaho license within one year of appointment. Must have DEA number or obtain within three months of appointment. Knowledge of history, culture, and health needs of Native American communities preferred. Must maintain appropriate board certification, have a valid driver's license with insurable record, and will be required to pass extensive background. Closes 1/09/09. Tribal preference applies.

Mid-Level Provider (Salary/DOE/Full-Time/Lapwai). Idaho licensed FNP or PA. Incumbent can obtain Idaho license within one year of appointment. Must have BLS and obtain ACLS within six months of appointment. Knowledge of history, culture, and health needs of Native American communities preferred. Must have valid driver's license with insurable record and will be required to pass extensive background check. Closes 1/09/09. Tribal preference applies.

A complete application packet for these positions includes NMPH job application, copy of current credentials, two reference letters, resume or CV, a copy of your tribal ID or Certification of Indian Blood (CIB), if applicable. Send to Nimiipuu Health, Attn: Human Resources, PO Drawer 367, Lapwai, ID 83540. For more information call (208) 843-2271 or e-mail *carmb@nimiipuu.org*. For more information about our community and area please go to *www.nezperce.org* or *www.zipskinny.com*.

Pharmacist
Juneau, Alaska

The Southeast Alaska Regional Health Consortium has an opening for a staff pharmacist at our Joint Commission accredited ambulatory care facility located in Juneau. Pharmacists interact with medical and nursing staff to achieve positive patient outcomes and are active members of the health-care team. Prescriptions are filled using Scriptpro Robotic Systems. Responsibilities include drug selection, compounding, and dispensing, as well as P&T and other committee participation, formulary management, drug information, education, and mentoring. We also provide pharmacist managed anticoagulation monitoring services.

Experience living in beautiful southeast Alaska. Juneau is located in Alaska's panhandle on a channel of salt water 70 air miles from the open ocean. Juneau is Alaska's capital and the third largest city in Alaska (30,000 people). Vast areas of recreational wilderness and opportunity surround us. Juneau and much of southeast Alaska are located within the Tongass National forest, the largest expanse of temperate rainforest in the world.

The Southeast Alaska Regional Health Consortium is a nonprofit health corporation established in 1975 by the Board of Directors, comprised of tribal members of 18 Native communities in the southeast region, to serve the Alaska Native and Native American people of southeast Alaska. Our clinic is committed to providing high quality health services in partnership with Native people.

Successful candidates should be self motivated and committed to providing excellent patient care. This is a Commissioned Officer 04 billet or a direct hire with a competitive salary and a generous benefit package. For more information please go to *https://searhc.org/common/pages/hr/nativehire/index.php* or contact the SEARHC Human Resources office by telephone at (907) 364-4415; fax (907) 463-6605.

Applications and additional information about this vacancy are available on-line at *www.searhc.org*, or you may contact Teresa Bruce, Pharmacy Director at (907) 463-4004; or e-mail *teresa.bruce@searhc.org*.

Family Practice Physician
Pediatrician (Outpatient and Hospitalist)
Obstetrician/Gynecologist
Anchorage, Alaska

Multidisciplinary teams with physicians, master's level therapists, RN case managers, nurse practitioners and physician assistants. Integrated into the system: family medicine, behavioral health, pediatrics, obstetrics and gynecology, health educators, nutritionists, social workers, midwives, pharmacists, home health, and easy access to specialists. This integrated model also includes complementary health and traditional Native healing. Eligibility verification, insurance, and billing are handled by administrative staff.

Amazing benefits including 4 to 6 weeks of vacation, one week of paid CME time, plus 12 paid holidays. CME funding; excellent insurance coverage – malpractice, health, life, short and long term disability – and subsidized health insurance for family. Employer 401K with matching contribution to retirement, fees paid for medical license, registration, etc.

New, modern state of the art facilities. Innovative practice system featured on front page of New York Times, JAMA, etc. Clinical quality improvement team. Practice management data monthly.

We currently employ 25 family physicians, 16 pediatricians, 10 obstetrician/gynecologists, and 6 psychiatrists, and we are adding additional positions.

Anchorage is a city of 330,000, the largest city in Alaska. Lots of cultural activities including a performing arts center that hosts national and regional troops, the Anchorage Museum of Natural History, and the Alaska Native Heritage Center. Alaska is known as the land of the midnight sun, as we bask in

19.5 hours of daylight on summer solstice. Our summer temperatures reach into the upper 70s, and the landscape transforms into green trees and flower blossoms. On winter solstice, we enjoy beautiful sunrises and sunsets over snowcapped mountains, and darkness brings the possibility of breathtaking displays of the northern lights. Hundreds of kilometers of groomed, interconnected cross country ski trails in town are lit at night by artificial light and the incredible moonlight reflecting off of the snow; these trails are perfect for running and biking in the summer. There are good public schools, good community, and incredible outdoor activity opportunities.

For more specific specialty information please contact Larisa Lucca, Physician Recruiter, Southcentral Foundation; telephone (888) 700-6966 ext. 1 or (907) 729-4999; fax (907) 729-4978; e-mail *llucca@scf.cc*.

Family Nurse Practitioner/Physician Assistant
Family Practice Physician
PharmD
Wind River Service Unit, Wyoming

The Wind River Service Unit has an immediate opening for a family nurse practitioner/physician assistant and a pharmacist (PharmD), as well as a fall 2009 opening for a family practice physician to provide care across the life span and to manage panel of patients from the Shoshone and Arapahoe Tribes on the Wind River Reservation. Located in the central part of pristine Wyoming, climbing, hiking, hunting, fishing, and water sports are minutes away. Out patient care is provided at two sites, one located in Arapahoe and one located in Ft. Washakie. Dedicated, dynamic staff includes ten RNs, six family physicians, one pediatrician, four family nurse practitioners, psychologists, social workers, four dentists, a certified diabetic educator, a diabetes educator, a health educator, five public health nurses, three PharmDs, two pharmacists, and two optometrists. Specialty clinics include orthopedics, podiatry, nephrology, obstetrics, and audiology. An open access model is used. Inpatient care is provided by the physicians at an excellent 83-bed community hospital in nearby Lander, with a fully staffed inpatient psychiatric hospital and rehabilitation unit.

For more information, contact Marilyn Scott at (307) 335-5963 (voice mail), or by e-mail at *marilyn.scott@ihs.gov*.

Tribal Data Coordinator (Level II)
The United South & Eastern Tribes, Inc. (USET)

United South and Eastern Tribes, Inc. is a non-profit, inter-tribal organization that collectively represents its member tribes at the regional and national level. USET has grown to include twenty-five federally recognized tribes in the southern and eastern parts of the United States from northern Maine to Florida and as far west as east Texas. USET is dedicated to promoting Indian leadership, improving the quality of life for American Indians, and protecting Indian rights and natural resources on tribal lands. Although its guiding principle is unity, USET plays a major role in the self-determination of all its member tribes by working to improve the capabilities of tribal governments.

We are recruiting to fill the Tribal Data Coordinator (Level II) position vacancy in the tribal health program support department. Qualifications for this vacancy require a minimum of an Associate Degree in a related discipline (e.g., computer science, statistics, math, biological sciences, education) from an accredited college or university, with relevant job experience. Documented three years experience in a paid position related to the use of health systems in the collection and analysis of health data will be considered in lieu of a degree. The Tribal Data Coordinator position also requires at least two years of RPMS experience as a user.

So if you have at least two years of RPMS experience, this could be a great opportunity for you. The Tribal Data Coordinator provides RPMS software training to USET member tribes. He/she also works on data quality improvement initiatives and provides data collection and analysis.

We offer flexible schedules and a competitive salary and benefit package. Hiring preference will be given to American Indians/Alaska Natives. If you are interested, you can get additional information about USET and the job announcement at our web site, *www.usetinc.org*, or you can contact Tammy Neptune at (615) 872-7900 or e-mail *tneptune@USETInc.org*.

Certified Diabetes Educator
Dietitian
Pediatrician
Chief Medical Officer
Family Practice Physician
Nurse
Medical Technologist
Chief Redstone Health Clinic, Fort Peck Service Unit; Wolf Point, Montana

Fort Peck Service Unit in Wolf Point, Montana is looking for family practice physicians to work at the Chief Redstone Indian Health Service clinic. This unique opportunity allows physicians to care for individuals and families, including newborns, their parents, grandparents, and extended family. Applicants must be culturally conscious and work well within a team environment. The Fort Peck Service Unit is located in the north east corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point.

Our Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social

work, radiology, lab, public health nursing, and very active Diabetes Department. These are ambulatory clinics; however, our providers have privileges in the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. IHS and the private hospital have a cardiac rehabilitation center. By cooperating with IHS, the hospital has been able to get a CT scanner and a mammography unit. The Tribal Health Program has a dialysis unit attached to the Poplar IHS clinic. Customer service is our priority. The IHS has excellent benefits for Civil Service and Commissioned Corps employees. There are loan repayment options, and we are a designated NHSC site. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being closely involved in our population to encourage a healthier community.

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. Fort Peck Tribes also can be found on *www.fortpecktribes.org*, and the Fort Peck Community College on *www.fpcc.edu*. North east Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*. Alternately, you can contact the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or by e-mail at *audrey.jones@ihs.gov*. We look forward to communicating with you.

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

The Fort Belknap Service Unit is seeking family practice physicians and pharmacist to join their dedicated staff. The service unit is home to a critical access hospital (CAH) with six inpatient beds, two observation beds, and a 24-hour emergency room, as well as an 8 AM to 5 PM outpatient clinic. The service unit also operates another outpatient clinic 35 miles south of Fort Belknap Agency in Hays. The Fort Belknap CAH outpatient visits average 39,000 per year. The new clinic in Hays, the Eagle Child Health Center, can adequately serve 13,000 per year. The medical staff includes four family practice positions, two physician assistants, and one nurse practitioner, and has implemented the Electronic Health Record in the outpatient clinic. The service unit also has a full-time staffed emergency medical services program. The staff is complemented by contract locum tenens physicians for weekend emergency room coverage.

The medical staff is supported by and works with a staff of nurses, behavior health personnel, physical therapist, lab and x-ray personnel, pharmacists, dentists, administrators, housekeepers, supply specialists, and contract practitioners to provide the best possible care to patients. The staff works as team to make a difference. Contract (private) hospitals are from 45 to 210 miles from the facility.

There are loan repayment options, excellent benefits, and we are a designated NHSC site. The area is primarily rural, and a friendly small-town atmosphere prevails here. The reservation communities promote various local activities such as rodeos, church socials, and basketball. The tribe also manages its own buffalo herd. Bigger events fill in the calendar as well, such as the Milk River Indian Days, Hays Powwow, and the Chief Joseph Memorial Days, featuring cultural activities and traditional dancing. The Fort Belknap Tribe has hunting and fishing available both on and off the reservation. The Little Rocky Mountains and the Missouri River provides scenic and enjoyable areas for the outdoor-minded. If you are interested in joining our medical team, contact Dr. Dennis Callendar at *Dennis.callendar@ihs.gov* or telephone (406) 353-3195; or contact physician recruiter Audrey Jones, at *Audrey.jones@ihs.gov*; telephone (406) 247-7126.

Family Practice Physician
Emergency Medicine Physician
Nurse Anesthetist
Nurse
PHS Indian Hospital; Browning, Montana

The Blackfeet Service Unit is recruiting for health practitioners who want to join the staff at the PHS Indian Hospital in Browning, Montana. The Blackfeet Service Unit is home to the Blackfeet Community Hospital, a 27-bed hospital, active outpatient clinic, and well-equipped emergency department. Inpatient care includes obstetrics and elective general surgery. We also offer community health nursing, have an active diabetes program, and offer optometry, laboratory, dental, and ENT services along with behavioral and social services and women's health. We are seeking candidates who are committed to improving the health of the local community and being part of a team approach to medicine. The hospital is located 13 miles from Glacier National Park. This area offer spectacular mountains and incredible outdoor activities year round. There are loan repayment options, excellent benefits, and we are a designated NHSC site. If you are interested in joining our team, contact Mr. Timothy Davis at *timothy.davis@ihs.gov* or telephone (406) 338-6365; or contact physician recruiter Audrey Jones, at *Audrey.jones@ihs.gov* or telephone (406) 247-7126. We look forward to hearing from interested candidates.

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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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