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The Common Road

Bruce Finke, MD, Nashville Area Elder Health Consultant, IHS Elder Care Initiative; Nashville Area Chronic Care Initiative Team; and Acting Chief Medical Officer for the Nashville Area; Northampton, Massachusetts

Over the years, a number of promising elder care programs have been presented in these pages. In this issue the Fort Defiance Indian Hospital (FDIH) Home Based Care program reports on their recent progress. This well organized and well staffed program carries through on the promise of coordinated, interdisciplinary care for the frail elders and their families. The FDIH Home Based Care program has supported many elders to live until they die; to remain in their home, on their land, with their families.

This program and others presented previously in these pages represent programmatic case studies of a sort, and as such they are valuable. They open up possibilities to us and remind us that there are solutions available; there are ways of providing the kind of care we know to be right. They also highlight for us some of the key elements of good elder care: care coordination or case management, reliance on the interdisciplinary team, a focus on support for the family caregiver, the importance of quality of life as perceived by the elder, and strict attention to the important details of geriatric medicine. We look to these programmatic case studies to understand how we might implement services like these in our own setting. What are the staffing patterns, reimbursement and sustainability strategies, policies and protocols used? The Fort Defiance Home Based Care program has provided us with some of that information, and we can expect more in the future.

But these case studies in care have another value. They prompt the question, "*How do we ensure that every elder in our health system has access to the care they need?*"

How, indeed? Having spent the last decade promoting the development of geriatric specific services in the Indian health

Annual Elders Issue

This May 2007 issue of *The IHS Provider*, published on the occasion of National Older Americans Month, is the twelfth annual issue dedicated to our elders. We are grateful for the opportunity to honor our elders with a collection of articles devoted to their health and health care. Indian Health Service, tribal, and urban program professionals are encouraged to submit articles for the May 2008 issue on elders. We are also interested in articles written by Indian elders themselves giving their perspective on health care issues. Inquiries can be addressed to the attention of the editor at the address on the back page of this issue.

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system (IHS, tribal, and Urban Indian health programs), I have come to understand that this is not the way to ensure reliably high quality care for every elder. We are a primary care-based health system with limited resources and the responsibility of providing care across conditions and across the age spectrum for the entire population we serve. The solution to ensuring reliably high quality care of elders is in ensuring reliably high quality care for everyone.

The principles of good elder care are the same principles that drive good care of chronic conditions in patients of every age (including the very young); a health system designed to provide reliably high quality care of chronic conditions will provide excellent care for every elder. Community-based primary prevention strategies offer benefit to every elder now and the promise of healthier elders in the future. Systematic integration of behavioral health into primary care provides the only reasonable way to reliably identify and address depression in every affected elder or to identify and support the vulnerable caregivers of elders with dementia.

Does this mean that we don't have to try anymore to improve services for the elderly? Are we done? Hardly! The task is larger than ever. The solutions to improving care of the elderly lie in broadening our focus to look at the prevention and care of chronic conditions across all ages. Elsewhere in these pages, CDR Christopher Lamer introduces the Patient Wellness Handout, an RPMS application that prints out personalized health information for patients, including their medication list. Right now the fields are limited, but the possibilities are limitless. This is a tool that can be built into the system of care to put critical information into the hands of patients and that supports the active engagement of patients in their own health care. This is good care, and especially good elder care.

This also does not mean that we no longer need the specialty services represented by programs like the FDIH Home Based Care program. A key to efficient delivery of care for a population is the ability to tailor the intensity of the services to the need of the patient. Not all elders require the intensive services of the FDIH Home Based Care, but those who do benefit greatly. A real strength of this program is its design as a common pathway of care for patients of all ages who need intensive case management and home-based care. Indeed Dr. Domer reports that the program has provided care for pediatric as well as elderly patients at end of life.

We cannot expect to improve outcomes for patients with chronic conditions by simply working harder, and we cannot rely on geriatric-specific services to meet every elder's health care needs. We need to build into our primary care the design features that support the delivery of care within relationships and across time, that really, truly support patient-driven health care, and that allow us to tailor the services provided to the care needed. Reliably high quality care for our elders will be a property of a health system that is designed to provide quality care, reliably, across the age span and across conditions. We will all walk down the same road; let's build it together.

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Aging and Disability Resource Centers

M. Yvonne Jackson, PhD, Director, Office for American Indian, Alaskan Native and Native Hawaiian Programs, Administration on Aging, Washington DC

The Aging and Disability Resource Center Program (ADRC) is a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to nationwide effort to restructure services and supports for people with disabilities, which builds on the Olmstead Decision, a 1999 Supreme Court ruling directing states to administer programs, services, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities,[1] and the New Freedom Initiative, a 2001 Presidential initiative aimed at removing barriers to community living for persons with disabilities.[2] The goal of the ADRC Program is to empower individuals to make informed choices and to streamline access to long term support. Long term support refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help older adults and individuals with disabilities.

In many communities, long term support services are administered by multiple agencies and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services is difficult. A single, coordinated system of information and access for all persons seeking long term support minimizes confusion, enhances individual choice, and supports informed decision-making. It also improves the ability of state, tribal, and local governments to manage resources and to monitor program quality through centralized data collection and evaluation.

The ADRC initiative supports state efforts to develop "one-stop shopping" programs at the community level to provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients, and individuals planning for their future long term care needs. They also serve as the entry point to publicly administered long term supports, including those funded under Medicaid, the Older Americans Act, and state revenue programs. ADRC grantees must target services to the elderly and at least one additional population of people with disabilities (i.e., individuals with physical disabilities, serious mental illness, and/or developmental disabilities).

Since the ADRC Program began in fall 2003, 43 states and territories have received competitive grants to establish ADRCs. ADRC grantees must meet several requirements, including provision of three main ADRC functions — information and awareness, assistance, and access. Other major requirements include the following:

- Promote public awareness of both public and private long term support options, as well as awareness of the ADRC, especially among underserved and hard to reach populations;
- Provide information, and counseling as needed, on all available long term support options;
- Facilitate programmatic eligibility determination for public long term support programs and benefits, including level of care determinations for Medicaid nursing facility and home- and community-based services (HCBS) waiver programs;
- Assist individuals in determining their potential eligibility for public long term support programs and benefits;
- Provide short term assistance or case management to stabilize long term supports for individuals and their families in times of immediate need before they have been connected to long term supports;
- Provide information and referral to other programs and benefits that can help people remain in the community (i.e., health promotion or disease prevention programs, transportation services, and income support programs);
- Help people plan for their future long term support needs; and
- Organize, simplify, and ensure "one-stop shopping" for access to all public long term support programs.

While states are only required to pilot their ADRC in at least one community, they are all striving to replicate the program across the entire state. Tribes are encouraged to form partnerships with the state ADRCs to facilitate better coordination of long term supports for American Indian and Alaska Native elders and individuals with disabilities.

Additional ADRC information is available on the AoA website at *http://www.aoa.gov/prof/aging_dis/aging_dis.asp* and the CMS website at *http://www.cms.hhs.gov/newfreedom*.

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The Fort Defiance Home-Based Care Program

Timothy Domer. MD, Home-Based Care and Elder Programs, Fort Defiance Indian Hospital, Fort Defiance, Arizona

In summer 2005, the Fort Defiance Indian Hospital (FDIH) Home-Based Care (HBC) program admitted its first patient. The HBC program grew out of the need to provide post acute-hospital care; subacute and chronic care of certain high risk outpatients; and hospice and palliative care in the home. There are no formal home care or hospice programs near Fort Defiance. Before the program started, patients requiring these services were either kept in the hospital for long periods, were transferred far from home, or did not receive these necessary services.

The HBC program has expanded dramatically since June 2006. At present we have four social workers, three nurses, a coder, a biller/business manager, a patient registration clerk, and a secretary. Three supervisors – an MSW social worker and two registered nurses – oversee their respective programs within the HBC program: social services, home-based nursing, and the diabetes program. A clinical psychologist is assigned full time as well.

To date, over 160 patients have been enrolled in the program, 46 of whom are high risk diabetic patients. The gender breakdown is approximately 55% female and 45% male.

The social workers are involved with nearly all of these patients. In addition, they regularly pick up and follow high risk elders seen through our weekly Comprehensive Elder Assessment clinic.

In the hospice portion of the program, there have been 25 deaths. Seven of these deaths (28%) occurred in the home, at patient and family request. We have enrolled five pediatric patients, three of whom have passed away.

The goal is to provide direct care services to the highest risk patients in their homes and through the Home-Based Care clinic. Our interventions are reducing or eliminating hospitalizations in this high risk patient population.

Four Examples

AA is a 72 year-old with advanced rheumatoid arthritis who has had frequent hospitalizations for sepsis, pneumonia, and poor pain control. She was enrolled in the HBC program in November 2006. In the year prior she had had five hospitalizations, including an ICU admission. In the six months since enrollment, she has had no infections, much improved pain control, no hospitalizations, and a new outlook on life.

BB is an 86 year-old male with end-stage cardiomyopathy and congestive heart failure (CHF). He has had 22 hospital admissions in the past ten years, most of these occurring within the past five years. Since his enrollment in the HBC program, his CHF has been well controlled, and his need for visits to the outpatient clinic and Emergency Department have decreased. He has had four admissions in the past year for recurrent hand cellulitis and pneumonia. His admissions were kept relatively short because his CHF was under control at the time of admission, and thus did not contribute to a prolonged stay. In addition, the HBC nurse was able to pick up on medical problems early, reducing the severity of the infections. His discharge home also occurred earlier because of the availability of close follow-up in the home by a nurse.

CC is an 86 year-old male with advanced chronic obstructive pulmonary disease (COPD) and end-stage CHF. In the year prior to his admission to the HBC program, he was hospitalized with acute exacerbations on four occasions. Since his admission to the program in October 2005, he has not required hospital admission. His need for outpatient evaluations has decreased, his functional level has improved, and he remains happily at home, rather than in a long term care facility.

DD is a 53 year-old male who was transferred from a tertiary hospital back to Fort Defiance hospital with end-stage liver disease in November 2006. He had developed liver failure, coagulopathy, anasarca, and encephalopathy, and was not expected to live. He and his wife were told to prepare for his imminent passing.

He was enrolled in the HBC program to receive hospice care. Now, five months later, he is at his dry weight, his coagulopathy has essentially resolved, his liver function tests are markedly improved, and his mental status is normal as long as he does not miss a dose of his medication. The HBC nurses have worked extensively with him and his wife. Our psychologist has intervened and the mental health and outlook of both patient and wife are much improved. He and his wife are receiving all the benefits to which they are entitled because of the intervention of social services and the benefits coordinator. He has taken up his craft of carving and selling beautiful ceremonial gourds. He has not been hospitalized in the five months since his return. As long as he does not take another drink, there is no reason he cannot live for many years.

We believe that the best and most efficient way to provide timely services and interventions to the highest risk patients, especially those with advanced illness, out of control diabetes, complex social issues, and end-of-life needs, is through a tightly knit, interdisciplinary team coordinating services from IHS, tribal, and private programs. We also believe that this is a model that can be developed in every service unit in the Indian Country.

If you have questions, please feel free to contact the author at *tim.domer@ihs.gov*.

Guidelines for Palliative Care in the Indian Health System Are Now Available

Bruce Finke, MD, Nashville Area Elder Health Consultant, IHS Elder Care Initiative; Nashville Area Chronic Care Initiative Team; and Acting Chief Medical Officer for the Nashville Area; Northampton, Massachusetts

The World Health Organization has defined palliative care as "the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families."

The National Consensus Project states that "Palliative care ideally begins at the time of diagnosis of a life-threatening or debilitating condition and continues through cure, or until death, and into the family's bereavement period. It can be delivered concurrently with life-prolonging care or as the main focus of care."

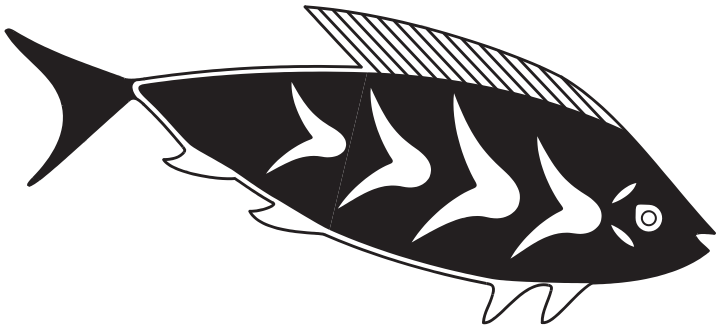
American Indians and Alaska Natives are now living longer, and for the most part, dying of chronic diseases. Those we serve need and deserve quality palliative care to ensure comfort and quality of life as they near the end of life. Yet, formal palliative and end-of-life care services have been largely unavailable to the majority of users in the Indian health system (tribal, IHS, and Urban Indian health programs), and services that have been available have been largely *ad hoc* and improvised. There is no common understanding of what constitutes the basic essentials of palliative care in a comprehensive health system.

These *Guidelines for Palliative Care in the Indian Health System* are intended as a tool to help us think about what kind of palliative and end-of-life care is available in our setting and to provide a framework for the core palliative and end-of-life services that are an essential part of a comprehensive set of health care services. The guidelines rely heavily on the *Clinical Practice Guidelines for Quality Palliative Care* developed by the National Consensus Project for Quality Palliative Care (released in May 2004) but were adapted specifically for programs delivering care within the unique circumstances of the Indian health system. Dr. Mary Jo Crissler (White Earth) led the national development workgroup, and this effort was significantly supported by the National Institutes of Health and the National Cancer Institute, Division of Cancer Control and Population Sciences, through the Quality of Cancer Care Committee (QCCC).

The guidelines provide minimum standards for palliative care as a basic health care service. The target populations for these services are those living with a life-threatening or debilitating illness, or a persistent or recurring condition, that adversely affects their daily functioning or will predictably reduce life expectancy. Health centers, clinics, hospitals, and service units, in consultation with their tribes and communities, have the flexibility to target these palliative care services to those in highest need in their individual communities.

We hope that these guidelines will help you as you develop services so that those seeking care in our hospitals and clinics can receive compassionate and competent care when they need it most.

You may access this and other sets of guidelines at *http*//: *www.ihs.gov/NonMedicalPrograms/NC4/nc4-clinquid.cfm*



This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"Far and away the best prize that life offers is the chance to work hard at work worth doing."

Teddy Roosevelt

Articles of Interest

A randomized, controlled trial of acetaminophen, ibuprofen, and codeine for acute pain relief in children with musculoskeletal trauma. *Pediatrics*. 2007 Mar;119(3):460-7. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

The goal of this study was to determine which of three oral analgesics given as a single dose provided the best pain control in children presenting with an acute musculoskeletal injury. The final diagnoses of injuries were contusions, sprains, or fractures. Patients were excluded if they required an intravenous line, which biased the study towards less severe injuries. The outcome was decrease in pain at 60 minutes and 120 minutes after treatment. Patients in the ibuprofen group had significantly greater relief from pain compared to patients receiving acetaminophen or codeine.

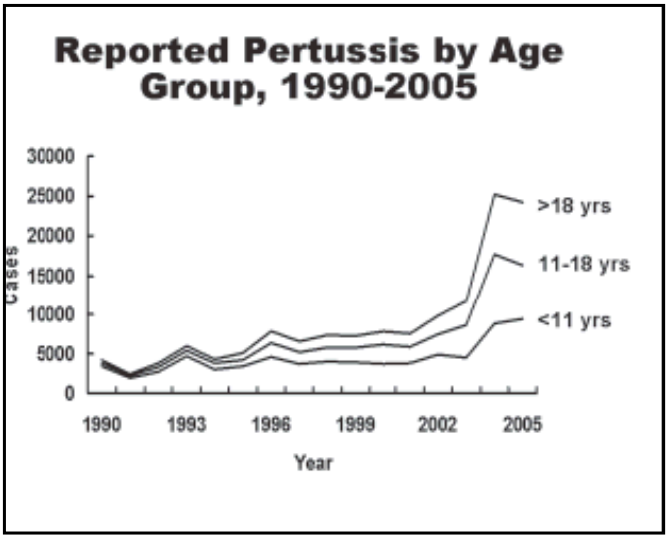
Editorial Comment

"Yankees versus Red Sox" . . . "Dodgers versus Giants" . . . "Paper versus plastic" . . . "Miller versus Budweiser." The list of timeless debates is nearly endless. A longstanding issue was whether acetaminophen or ibuprofen offered the best pain relief. It was usually assumed that codeine was superior to the other non-prescription pain relievers. This study looked only at acute pain relief but showed superiority of ibuprofen compared to acetaminophen and, surprisingly, codeine, also. It is of note that, even though ibuprofen was superior to acetaminophen and codeine, 48% of patients receiving ibuprofen failed to get adequate analgesia at 60 minutes. Ibuprofen may be the best first choice for acute musculoskeletal pain, but many patients may require further medication for adequate pain relief.

Infectious Disease Updates.
Rosalyn Singleton, MD, MPH
Pertussis: Secular Trends in the United States

In the pre-vaccine era, an average of 175,000 cases of pertussis was reported annually in the US. After vaccination, the average annual number decreased to a low of 2,900 in the 1980s. However, since 1990 the number of cases has increased until it reached a high of 25,827 in 2004. The reasons for the increase are not entirely clear, but one contributing factor has been waning immunity in adolescents and adults. In 2004 - 2005, 60% of reported pertussis cases were in persons 11 years or older. Although pertussis leads to significant disease in adults, they also transmit disease to vulnerable young infants. An estimated 75% of infants got their disease from a household contact.

Will Tdap vaccine have an impact on pertussis disease rates in AI/AN infants? The jury is still out, but the inexorable rise in pertussis cases in the US was finally reversed in 2005, when the number of cases declined below 25,000. What is known about pertussis infection rates in AI/AN children? Recently, CDC and IHS authors described trends in AI/AN infants. During 1980 - 2004, 483 pertussis hospitalizations were documented among AI/AN infants (132/100,000 /year). The rate declined during the 25 year period to 100/100,000/year in 2000-2004, but remains higher than the rate estimates in the general US infant population (69/100,000/year).



Recent literature on American Indian/Alaskan Native Health

Doug Esposito, MD

Pressley JC, Barlow B, Kendig T, Paneth-Pollak R. Twenty-year trends in fatal injuries to very young children: the persistence of racial disparities. *Pediatrics*. 2007 Apr;119(4):e875-84. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=17403830&query_hl=4&itool=pubmed_DocSum*

Summary. The authors embark on a 20 year odyssey through injury data in order to assess the effectiveness of injury prevention strategies in minority populations. To accomplish this, they rely on the National Vital Statistics registration system, which is based on death certificate data, and on census data with inter-census population estimation. The data evaluated were for the years 1981 - 2003. Deaths from all-cause, unintentional, and intentional injuries occurring in children 0 - 4 years of age were examined. Mechanism-specific mortality rates (motor vehicle traffic (separated to include occupant, pedestrian, and unspecified), drowning, residential fires, suffocation, poisoning, falls, and firearms) are also reported for white, black, AI/AN, and Asian/Pacific Islander children. The Hispanic designation only became available in 1990, and so is missing for prior years. In order to assess relative change over the 20 year time period, mortality rate ratios are reported for each minority group, with white children serving as the comparison group.

Here are some of the points most relevant to those of us who care for AI/AN children:

1. Overall, the all-cause injury mortality rate declined over the 20 year period, but remained approximately twice that of white children (i.e., fewer AI/AN kids are dying of injury now than before but the AI/AN-to-white disparity remains static). The decline can be attributed to a decline in unintentional injury alone.
2. Intentional injury mortality rates remained static over time and almost three-fold higher for AI/AN children than for white children.
3. Overall, the all-cause motor vehicle injury mortality rate (occupant, pedestrian, and unspecified) declined, but remained nearly three times that of white children. Additionally, there appears to be a recent trend toward increased mortality for AI/AN children and a widening of the disparity due to all-cause and occupant motor vehicle injury mortality. We are losing ground in the car seat/booster seat battle in Indian country!
4. AI/AN children still have the highest overall mortality rates of any other racial designation for all-cause injury, unintentional injury, motor vehicle (all-cause) injury, motor vehicle occupant injury, firearm injury, and drowning.
5. There has been longitudinal improvement in mortality rates and a narrowing of the AI/AN-to-white disparity with regards to pedestrian motor vehicle injury, drowning, residential fires, poisonings, and falls over the 20 year period.
6. Firearm injury mortality declined, but remained three-fold higher among AI/AN children and as noted above, was higher for AI/AN children than for any other racial designation.
7. No significant trend in mortality from suffocation was observed over the 20 year time period except for a slight worsening toward the end of the study period, with a nearly two-fold disparity being maintained between AI/AN and white 0 - 4 year old children.

Editorial Comment

This article reports important trends over a 20 year time period in injury mortality for minority children 0 - 4 years of age. Unfortunately, this important study appears in the e-pages of the journal *Pediatrics*, making it particularly hard to find and doomed to a life in relative obscurity. Please take the time to read this paper for yourself. It is well worth the effort of anyone interested in better understanding the number one killer of children and loss of productive life-years in our AI/AN communities.

One important comment should be made about an issue that was unfortunately left out in the authors' discussion of study limitations. The reader of this article must understand that there exists a significant bias that shifts the reported injury rates downward (they look better than they actually are) in the AI/AN population. The database from which these statistics originate is constructed from death certificate data that are highly susceptible to the effect of racial misclassification.[1,2,3] This issue was introduced in some detail in the September 2007 issue of the *IHS Child Health Notes* related to cancer incidence and survival in AI/AN adolescents and young adults.[4] It might be worth a look, just to refresh your memory.

The authors are keenly aware of this issue, and had a section on racial misclassification, ethnicity, and missing e-codes in the original manuscript (Personal communications with Dr. Pressley, May 2007). However, due to space constraints, they had to remove this element from the final paper. They had considered removing Native American-specific reporting in its entirety from the final manuscript, but went ahead anyway, "because we felt it did not overstate the problem and that it would inform injury prevention health personnel of areas where additional efforts are needed." I am glad they did. Despite the fact that the true situation is likely at least a little worse than suggested, I believe the data as presented offer an important glimpse into the successes and failures of injury prevention efforts targeting AI/AN communities. The bottom line: health disparities exist and persist, and, despite some notable achievements, the disparities are actually worsening in some arenas. As for the number one killer of AI/AN children, we have come a long way, but we certainly have an even longer way to go.

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IHS Elder Care Initiative Grants

Kay Branch, Elder/Rural Health Services Planner, Alaska Native Tribal Health Consortium Office of Community Health Services; Anchorage, Alaska

The IHS awarded a new round of long term care grants in September 2006. The aim of this grant program is to support the development of medical long term care services by tribes, tribal organizations, and urban Indian health programs. This new round of grantees will be supported for up to two years; ten grant awards will support assessment and planning activities and two awards will support program implementation. Grants were awarded to Aleutian Pribilof Island Association, Cherokee Nation, Ho-Chunk Nation, Intertribal Council of Arizona, Kenaitze Indian Tribe, Mount Sanford Tribal Consortium, Native American Community Health Center, San Carlos Apache, Southeast Alaska Regional Health Consortium, Tucson Indian Center, Yukon-Kuskokwim Health Corporation, and Yurok Tribe.

Many of the grantees are in the early stages of identifying unmet needs, identifying available resources, and developing a vision for long term care services; others have been providing LTC services with tribal dollars and are developing mechanisms for reimbursement, expansion, and sustainability. The grantees are looking within their own organizations and communities to see the scope of services provided to elders by their programs, as well as collaborating with outside agencies providing services to tribal elders. One organization is in the implementation phase of an urban adult day health center, where at-risk tribal elders will be cared for with medical supervision. Another organization is developing a business plan to support the delivery of personal care home care services in tribal elder housing.

Dr. Bruce Finke is working with Kay Branch at the Alaska Native Tribal Health Consortium to provide ongoing technical assistance to the grantees. Grantees are participating in regular teleconferences to share information and learn from each other, as well as learn about topics relevant to long term care service delivery, such as the Program for All-inclusive Care for the Elderly (PACE) model under development by the Cherokee Nation. All grantees will be able to meet each other face-to-face at the Third Annual AI/AN Long Term Care Conference in Albuquerque, September 5 – 7, 2007.

This is an exciting cohort of programs, working hard to improve access to long term care services for their elders. We anticipate a new round of funding in FY ’08 and expect the announcement to look very similar the one issued for FY ’06.

Northwest Arctic Elders Council Language and Culture Program

Mary Schaeffer; Kotzebue, Alaska

Elders' Councils were established in many communities in the early 1980s to promote Inupiat Ilitqusait, the Inupiat Cultural preservation program. These councils took on new life in October 2004, when the four major regional organizations formed a collaborative effort to address the priority regional issue of culture and language preservation. With the help of the Elders' Councils, the organizations are now working to establish Language and Cultural Programs. I am a part of that effort, which has included developing close ties with the Maori people in New Zealand.

The Maori have a very successful language and cultural revival program. In 2005 I had the opportunity, along with forty other Inupiaq people, including elders, youth, and the Inupiaq teachers, to travel to New Zealand and spend ten days learning how the Maori were able to reintegrate their language and culture into all parts of their lives. Then in July 2006, seven Maori spent a week in Kotzebue with our elders and language experts in order to help us begin our own cultural revival.

Levi Cleveland, president of the regional Elders Council, said that it was time to "focus on how our ancestors supported families through all sorts of hardships and find that way again." We learned from the Maori that to develop a successful program we had to work on our personal, positive relationships with each other. This required establishing spiritual contact with our ancestors and asking forgiveness from each other. We knew that without loving each other, we could not re-establish our contact with our Creator, land, ancestors, families and our tribe. About eighty elders and Native language teachers learned from our Maori visitors.

We are currently planning new programs we learned from the Maori, such as "language nests." Maori elders realized that language training must begin with the babies, since they can learn easily during the first five years of life, and simple exposure to the language from birth to five years can positively impact the children. The Maori now have over 800 language nests, where mothers and babies meet in elders' homes and are immersed in the language for several hours each day. We will be doing this also, as well as working with the school district for language training for older age groups. Our elders also plan to create our first qagri (tribal house), after years of living without this important community gathering place. In this way, we can begin to work through some of the hardships brought on by change and create more vitality in our communities.

The Mayan tribal scientists from South America have warned us that great changes will happen in the next five years. Many people will die due to great changes being made to the earth. We must be prepared to live like our ancestors did in the past, without outside help. We must learn our cultural ways now. God bless you and give you strength to survive the next five years.

Mary Schaeffer was born and raised in Kotzebue. She is on the Tribal Council and has worked in many roles, including Senior Center Director and Family Wellness Coordinator, at Maniilaq Association, the regional tribal health organization. The Northwest Arctic Borough is located in northwest Alaska thirty-three miles north of the Arctic Circle. The Borough encompasses approximately 36,000 square miles, and has a population of approximately 7,300 living in 11 remote villages, with Kotzebue serving as the regional hub.

The Chief Clinical Consultant's Newsletter (Volume 5, No. 5, May 2007) is available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month
Social Change Might Save More Lives than Medical Advances

The basic notion that more lives would be saved by eliminating education-associated excess mortality than by medical advances is sufficiently robust to justify a change in policy priorities. In the past few decades, there have been heavy investments in technological advances intended to reduce morbidity and increase life expectancy. However, the pace of progress has been modest. Minority groups have higher mortality rates than whites, and people of low socioeconomic status have higher mortality rates and poorer health status than the general population. This article explores the possibility that addressing social determinants of health might do more to save lives than the incremental advancements in the technology of care that consume the bulk of societal investments in health. The authors examined death rates among adults with inadequate education, a group known to have excess mortality rates.

The authors examined mortality data for 1996 through 2002 reported by the National Center for Health Statistics. They compared 1) the maximum number of deaths averted by the downward secular trend in mortality and 2) the number of deaths that would have been averted had mortality rates among adults with less than a high-school education (LHS adults) been the same as those among adults with some college education.

The authors found that

- The downward secular trend in age-adjusted mortality rates in the United States saved an average of 25,456 lives per year during 1996 through 2002.
- Each year, an average of 195,619 deaths would have been averted if mortality rates among LHS adults had been the same as mortality rates among college-educated adults.
- Disparities in education-associated excess mortality were more acute among LHS adults than among those with a high-school education (but no college diploma). Nonetheless, because high-school graduates outnumber LHS adults, a majority of the lives saved by eliminating education-associated excess mortality — 870,286 (63.6%) of the 1,369,335 averted deaths — would involve adults with a high-school diploma.

These data suggest that correcting the conditions that cause people with inadequate education to die in greater numbers will do far more to save lives than making incremental improvements in the technology of medical care.

OB/GYN CCC Editorial Comment

The United States, the richest country in the world, currently ranks 27th in the health of its citizens, lagging behind not only most of the rich countries, but a few poor ones as well. Fifty years ago, the US was among the top five. What happened in the past five decades to cause this decline?

Stephen Bezruchka*, in his lecture "Womb to Tomb," explains that an increasing stratification between the rich and the poor plays a major role. Life spans and infant mortality rates depend very much on the hierarchal structure of a society. New research shows that half of what influences our health as adults is largely determined before the age of five. What can we learn from other countries whose citizens live longer and healthier lives?

In Indian Country we should use our expertise as public health advocates to improve the whole of Indian 'health,' not just direct health care.

* Stephen Bezruchka teaches at the University of Washington and works as an emergency room physician in Seattle. His particular areas of research are population health and societal hierarchy and its application to health. He is author of numerous articles and essays. His most recent contribution is to Sickness and Wealth, a collection of essays on the effects of global corporatization on health.

Woolf SH, Johnson RE, Phillips, RL, et al. 2007. Giving everyone the health of the educated: An examination of whether social change would save more lives than medical advances. *Am J Public Health*. 2007 Apr;97(4):679-83.

From Your Colleagues
Amy Groom, Albuquerque
New HPV Brochures for Clinicians, CDC

The CDC recently updated their HPV brochure for clinicians and posted four sets of counseling messages to assist providers in their HPV-related discussions with patients. The counseling messages address 1) information for parents about

the HPV vaccine, 2) information for women about the Pap and HPV tests, 3) information for women who receive a positive HPV test result, and 4) information for patients receiving a genital warts diagnosis.

These materials are now available online as separate PDF files at the link below. They are also being printed as a package (brochure with counseling insert cards) for free online ordering. We will let you know as soon as they are available in print. In the meantime, they hope you find these resources useful and ask that you please share them with other providers in the field. As always, they welcome your feedback and thank you for your continued efforts in HPV education and the prevention of HPV-associated diseases.

Hot Topics

Obstetrics

More Stillbirths after Previous Cesarean Delivery

Conclusion: Pregnancies in women following a pregnancy delivered by caesarean section are at an increased risk of stillbirth. In our study, the risk appears to be mainly concentrated in the subgroup of explained stillbirths. However, there are sufficient inconsistencies in the developing literature about stillbirth risk that further research is needed.

Gray R, Quigley MA, Hockley C, et al. Caesarean delivery and risk of stillbirth in subsequent pregnancy: a retrospective cohort study in an English population. *BJOG*. 2007;114(3):264-70.

Gynecology

Young Women with CIN: Any Treatment Increases the Risk of Preterm Delivery - LEEP

Conclusion: Any treatment for CIN, including loop electrosurgical excision procedure, increases the risk of preterm delivery. It is important to emphasize this when treating young women with CIN. LEVEL OF EVIDENCE: II.

Jakobsson M, et al. Preterm delivery after surgical treatment for cervical intraepithelial neoplasia. *Obstet Gynecol*. 2007;109(2 Pt 1):309-13.

Child Health

Public Opinion vs. Science Concerning Sex Education

Results: The study population included 1,096 participants with a mean age of 46.8 years. The race/ethnicity of the respondents was similar to other nationally representative surveys. The percentage of individuals supporting a combined abstinence and contraception educational program was 82 percent. Support for teaching of proper condom use was about 68 percent. An abstinence-only program was supported by 36 percent of the respondents and received the highest level of opposition. Most individuals in each political ideology group supported abstinence plus contraception programs, with the conservative group agreeing 70.0 percent of the time, the moderate group 86.4 percent, and the liberal group 91.6 percent.

Conclusion: Public opinion supports the combination of abstinence plus contraception education programs in schools. This support demonstrates that the scientific community and the public do not support the federal policy of abstinence-only programs.

Bleakley A, et al. Public opinion on sex education in US schools. *Arch Pediatr Adolesc Med*. November 2006;160:1151-6.

Chronic disease and Illness

Smoking Ban Has Health Benefits for Workers

Conclusion: The authors conclude that, although the participants had been bar workers for an average of nine years, health improvements were apparent just one month after a smoking ban, as measured by objective and subjective symptoms. The most marked improvements occurred in participants with asthma. An accompanying editorial notes that mandating smoke-free workplaces also results in higher rates of smoking cessation. However, there still is a high rate of exposure to secondhand smoke, especially among children and non-Hispanic blacks.

Menzies D, et al. Respiratory symptoms, pulmonary function, and markers of inflammation among bar workers before and after a legislative ban on smoking in public places. *JAMA*. October 11, 2006;296:1742-8.

Eisner MD. Banning smoke in public places: time to clear the air [Editorial]. *JAMA*. 2006;296:1778-9.

Features

ACOG, American College of Obstetricians and Gynecologists

Premature Rupture of Membranes

Summary of Recommendations and Conclusions

The following recommendations and conclusions are based on good and consistent scientific evidence (Level A):

- For women with PROM at term, labor should be induced at the time of presentation, generally with oxytocin infusion, to reduce the risk chorioamnionitis.
- Patients with PROM before 32 weeks of gestation should be cared for expectantly until 33 completed weeks of gestation if no maternal or fetal contraindications exist.
- A 48-hour course of intravenous ampicillin and erythromycin followed by 5 days of amoxicillin and erythromycin is recommended during expectant management of preterm PROM remote from term to prolong pregnancy and to reduce infectious and gestational age-dependent neonatal morbidity.
- All women with PROM and a viable fetus, including those known to be carriers of group B streptococci and those who give birth before carrier status can be delineated, should receive intrapartum chemo-prophylaxis to prevent vertical transmission of group B streptococci regardless of earlier treatments.

- A single course of antenatal corticosteroids should be administered to women with PROM before 32 weeks of gestation to reduce the risks of RDS, perinatal mortality, and other morbidities.

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

- Delivery is recommended when PROM occurs at or beyond 34 weeks of gestation.
- With PROM at 32 - 33 completed weeks of gestation, labor induction may be considered if fetal pulmonary maturity has been documented.
- Digital cervical examinations should be avoided in patients with PROM unless they are in active labor or imminent delivery is anticipated.

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

- A specific recommendation for or against tocolysis administration cannot be made.
- The efficacy of corticosteroid use at 32 - 33 completed weeks is unclear based on available evidence, but treatment may be beneficial particularly if pulmonary immaturity is documented.
- For a woman with preterm PROM and a viable fetus, the safety of expectant management at home has not been established.

Premature Rupture of Membranes. ACOG Practice Bulletin No. 80. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2007;109:1007–19.

Breastfeeding
Suzan Murphy, PIMC
Breastfeeding - it's all about synergy

Research has shown that adults who breastfed as infants appear to have less risk of type 2 diabetes. Now there is evidence that breastfeeding can also reduce maternal risk. In November 2005, JAMA published "Duration of Lactation and Incidence of Type 2 Diabetes," by Stuebe et al. The studies described in this article associated longer duration of breastfeeding with reduced incidence of type 2 diabetes for mothers.

Stuebe et al examined two Nurses's Health Studies (NHS and NHS II) to determine the impact of feeding choice upon subsequent maternal risk of diabetes. In 1976, NHS began by enrolling 121,700 women (30 - 55 years old) from 11 states. In 1989, NHS II began with 116,671 women (25 - 42 years old) from 14 states. In each group, participants completed similar, detailed baseline questionnaires. Every two years, participants completed follow-up questionnaires about medical diagnosis and related topics like pregnancy history, breastfeeding history, diet, exercise, medication, and smoking.

Until 1997, the standards used to confirm reported diagnosis of type 2 diabetes were the National Diabetes Data Group criteria. After 1997, the standards were updated as the American Diabetes Association clinical practice recommendations were implemented.

In each study, the covariates were family history of diabetes, activity level, diet, multi-vitamin use, smoking history, and BMI at 18 years and for each biannual reporting period.

Results:

- In general, for each year of breastfeeding for women with births 15 years prior, there was a decrease in risk of diabetes of 15% (NHS) and 14% (NHS II).
- Both cohorts consistently indicated a reduction in the incidence of type 2 diabetes with each year of breastfeeding. Controlling for diet, exercise, smoking, and multi-vitamin use did not significantly change the association of breastfeeding reducing risk.
- Maternal BMI did not appear significantly altered by lactation, suggesting that the reduced maternal risk for diabetes is related to improved maternal glucose homeostasis.
- Exclusivity was associated with greater benefit. After controlling for age and parity, the NHS II cohort data showed that each year of lifetime exclusive breastfeeding was associated with a 37% type 2 diabetes risk reduction compared to 24% for each year of any breastfeeding.
- Longer continuous breastfeeding appeared to have greater risk reduction benefit than the same amount of lifetime breastfeeding shared by two or more children. To clarify, one year of continuous breastfeeding with one child was associated with greater risk reduction when compared to two children breastfed for six months each.
- In NHS II, higher BMI at age 18 was linked with shorter breastfeeding duration. In both cohorts, the duration of breastfeeding was inversely related to family history of diabetes. Gestational diabetes did not appear to impact duration.
- For women with a history of gestational diabetes (NHS II only), the covariates of lactation history, present activity level, and diet did not appear to effect diabetes risk. The consistent predictors of diabetes risk were BMI at age 18, current BMI, and family history of diabetes.
- For women who did not breastfeed, the use of medication to suppress lactation was associated with increased risk of diabetes compared to those women who did not receive lactation suppression medication.

Stuebe, et al. Duration of lactation and incidence of type 2 diabetes. *JAMA*. November 2005; 294:(20):2601-10.

International Health Update
Claire Wendland, Madison, WI
Ethics of Medicine with Economically Vulnerable Populations: Second in the Series

Last month I wrote about current controversies in the recruitment of clinical trials subjects from impoverished international sites. This month's focus is another ethical controversy in international health: the global organ trade.

In most countries where organ transplantation is done, the list of patients waiting for kidney transplants is far longer than the number of donors. The shortage of organs, the desperation of those waiting for transplants, and the money to be made in transplantation combine to produce a situation in which ethical rules get broken, or at least bent, frequently. At least one government times prisoner executions to maximize organ harvest; rumors of organ stealing, though not substantiated, course through the Third World. In fact, though selling a kidney is almost universally illegal (it is legal in Iran, quasi-legal in India), and is widely condemned by medical societies and professional organizations, there is a well-documented black-market trade in kidneys sold by poor "donors" for cash. Some ethicists, health economists, and transplant surgeons argue that since this trade is happening anyway, it should be legalized and regulated – in part to protect would-be kidney sellers from surgery done in unsafe conditions. Others believe this is one ethical line that should not be crossed: that selling a kidney is substantially different than selling semen or plasma, and that the potential for exploitation of the poor by the rich is too great.

Tarif Bakdash, a Syrian bioethicist, and Nancy Scheper-Hughes, an American anthropologist (and director of an NGO that monitors the organ trade), debate the question of whether kidney sales should be made legal in a thought-provoking recent article in PLoS Medicine. Bakdash believes that poor people often sell their kidneys for altruistic reasons, as a last-ditch effort to provide basic needs for their families (and the social science literature backs him up on this point). It is arrogance, even hypocrisy for the wealthy to try to "protect" the poor from selling their organs, he argues: poor people "are always exploited from the day they are born, and in all avenues of life. The only thing of value left for some of them is their bodies." Scheper-Hughes believes that such sales make human life itself the ultimate commodity, dehumanizing everyone who comes in contact with the organ trade. She sees the polarization of the world that allows some people to be seen as sources of spare parts for others as "a medical, social, and moral tragedy of immense and not yet fully recognized proportions." Readers may be left with a disturbing conundrum: is it possible that a poor person's sale of a kidney may be an ethical act, while a rich person buying one is unethical?

Bakdash T, Scheper-Hughes N. Is it ethical for patients with renal disease to purchase kidneys from the world's poor? *PLoS Medicine*. October 2006;3(10):e349.

Medical Mystery Tour
Which Indian Health Facilities Lead the Entire US in National Obstetric Benchmarks?

And better yet, how can we translate that success to other Indian health sites? Benchmarking is a method for comparing your facility's care processes to those of the practices in the field that demonstrate the best outcomes. Identifying "best practices" through benchmarking allows all who participate in the process to improve and adapt the care they provide in order to obtain superior outcomes: high satisfaction, patient safety, effectiveness and efficiency.

The purpose of the American College of Nurse-Midwives (ACNM) Benchmarking Program is to provide a midwifery-specific mechanism to improve and maintain the superior quality of midwifery care provided to women and children by promoting member awareness of "best practices." To facilitate this, members are encouraged to participate in benchmarking their practice against other midwifery practices in the country.

If your facility is not one of facilities I am going to announce next month, then you should attend the 2007 National Indian Women's Health and MCH Conference. The Conference will be in Albuquerque, NM August 15 - 17, 2007. The theme of the meeting is "Improve the System: Improve the Outcome" so it will explore how we can all work together to raise the AI/AN health status to the highest possible level.

There will be national benchmark organizations (Institute for Healthcare Improvement, American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, Kaiser Family Foundation, etc.), internationally known speakers, and a rather extensive clinical Program. The meeting is held only every three years, so you and a team from your facility should try to attend. You can either use your local facility funds, because there is a program review function, or use your CME /CEU funds. In addition, limited scholarships are available.

Collins-Fulea C, et al. Improving midwifery practice: the American College of Nurse-Midwives' benchmarking project. *J Midwifery Womens Health*. 2005 Nov-Dec;50(6):461-71.

Midwives Corner
Lisa Allee, CNM, Chinle
Ultrasound Affects Mice Brains in Negative Ways: First, Do No Harm

I was flipping through the November/December issue of *Mothering* magazine and found a citation of an interesting research article on the effects of ultrasound on mice brains. It has scary findings for an intervention that is often considered routine and benign by providers and patients.

Eugenius, et al, found that when fetal mice are exposed to 30 minutes or more of ultrasound that "a small but statistically significant number of neurons fail to acquire their proper position and remain scattered within inappropriate cortical layers and/or in the subjacent white matter. The magnitude of dispersion of labeled neurons was variable but systematically increased with duration of exposure to USW." This means that cells in the brain are not all in the right place. Okay, you're saying these are mice, not humans. In their discussion the authors discuss this — it might not apply to humans, but then again it might in a big way:

First it may not be applicable because ". . . the distance between the exposed cells and transducer in our experiments is shorter than in human. Furthermore, the duration of neuronal production and the migratory phase of cortical neurons in the human fetus lasts some 18 times longer than in mice (between 6 and 24 weeks of gestation, with the peak occurring between 11 and 15 weeks), compared with the duration of only about 1 week (between E11 and E18) in the mouse. Thus, an exposure of 30 min represents a much smaller proportion of the time dedicated to development of the cerebral cortex in human than in mouse and, thus, could have a lesser overall effect, making human corticogenesis less vulnerable to USW" (ultrasound mwaves.)

But on the other hand, "There are also some reasons to think that the USW may have a similar or even greater impact on neuronal migration in the human fetal brain. First, migrating neurons in the human forebrain are only slightly larger than in the mouse, and, with the acoustic absorption provided by the tissue stand-off pad, the amount of energy absorbed within a comparable small volume of tissue during the USW exposure was in the same general range. Second, the migratory pathway in the convoluted human cerebrum is curvilinear and at least an order of magnitude longer. Thus, the number of neurons migrating along the same radial glial fascicle, particularly at the later stages of corticoneurogenesis, is much larger and their routes are more complex, increasing the chance of a cell going astray from its proper migratory course. Third, the inside-to-outside settling pattern of isochronously generated neurons in primates is more precise than in rodents and thus, the tolerance for malpositioning may be smaller. In addition, different functional areas in the primate cortex are generated by different schedules so that exposure to USW may potentially affect selective cortical areas and different layers, depending on the time of exposure, potentially causing a variety of symptoms."

These effects of ultrasound are hard to study in humans because the testing to find ectopic cells in the brain cannot be done in humans, according to the authors. There are some things that are known and are concerning: "even a small number of ectopic cells might, as a result of specific position and inappropriate connectivity, be a source of epileptic discharge or abnormal behavior. Although we have not as yet generated behavioral data, previous studies in rodents and primates indicate that prenatal exposure to USW may affect higher brain function of the offspring. Furthermore, there are numerous human neuropsychiatric disorders that are thought to be the result of misplacement of cells as a consequence of abnormal neuronal migration." The authors go on to say that their research supports the recommendation by the FDA that medically non-indicated commercial ultrasound videos should not be done.

I find this research concerning for more than just ultrasound videos offered in malls. I wonder about repeated ultrasounds for medical indications, dating ultrasounds during the most vulnerable periods of cell migration in the brain, antenatal testing that has never been shown to improve outcomes, and, the biggest of all, continuous fetal monitoring during labor for hours on end. Remember: the ultrasound to create pictures is pulsed—only 1/100th of the time is actual exposure to ultrasound—whereas the fetal monitor on labor and delivery is a continuous deluge of ultrasound — it is not pulsed; the whole time is exposure to ultrasound, and the effects these researchers found increased with time. Yes, most monitoring is after the time of migration of neurons cited above, but we do know that the human brain continues to develop in a big way for the rest of intrauterine life and a long time after, so there may be are other effects on the brain cells. Anyone heard tell of increased rates of autism, depression, bipolar disease, behavioral problems?

Eugenius, et al. citation available from *Lisa.Allee@ihs.gov.*

Navajo News
Jean Howe, Chinle
BTL: Nearly One Half of Women Under 25 Years Old Request Information on Reversal

It seems that hardly a month goes by without a woman coming in to our clinic asking about how she can "get her tubes untied." This continues to happen, despite the intensive counseling that we conduct prior to the procedure. Thus I was intrigued by a recent article in the journal *Contraception*, "Consent to Sterilization section of the Medicaid-Title XIX form: is it understandable?" The authors assessed the readability and comprehension characteristics of the current "Consent to Sterilization" form using a tool specifically designed for informed consent documents (Readability and Processability Form or RPF). The current sterilization consent scored in the poor range when assessed with this tool. A Fry reading level assessment corresponded to ninth grade level. The authors also presented a proposal for a revised form, which scored in the excellent range with an RPF assessment and had a Fry reading level of sixth grade.

Of course informed consent for sterilization doesn't involve solely the use of the federal permit. A second operative consent, specific to the planned procedure, is also required. And true informed consent isn't just about signing papers; it must involve a careful and thorough discussion of the planned procedure, the alternatives, and the risk of sterilization failure, and the possibility of regret. The permanence of the procedure is emphasized throughout this process. Yet life is unpredictable and a woman's circumstances may change. A woman who is

completely sure that she wishes to proceed may return later, asking about sterilization reversal and sharing a compelling story of previous domestic violence or depression or of a new marriage.

Information about the risk of regret is available from the US Collaborative Review of Sterilization (CREST) study, which followed 11,232 women aged 18 - 44 who had sterilizations between 1978 and 1987, for up to 14 years. One analysis, by Hillis, et al, clearly showed that the risk of regret is highest in the youngest women. As part of the study, follow-up visits were conducted over 14 years and participants were asked at each visit "Do you still think tubal sterilization as a permanent method of birth control was a good choice for you?" and found that, for women under 30 at the time of sterilization, the risk of regret was 20.3%. For women 30 or older at the time of sterilization, the risk of regret was 5.9%. Another study of the same population assessed the likelihood of regret by analyzing who requested information about reversal. In this analysis, Schmidt, et al again found the highest risk of regret amongst the youngest women. When analyzed by age, 40.4% of women who were under 25 at the time of sterilization requested information about reversal. This decreased with age as follows: 15.6% for women ages 25 - 30, 8.2% for women ages 31 - 35, and 4.4% for women over 35 years old. Non-white race, < 12 years of formal education, unmarried status, a history of induced abortion, and postpartum sterilization, especially after vaginal delivery, were all associated with a higher incidence of regret, as was sterilization performed within seven years of the birth of the youngest child. Interestingly, the number of living children did not correlate with the risk of regret. In some cases the probability of regret was cumulative, for example women who were both under 25 and unmarried at the time of sterilization had a 49% risk of regret. Ultimately 1.1% of the study population obtained a tubal reversal procedure; this was 8-fold more likely for women who were sterilized at less than 30 then over 30 years of age.

One could view this information from the opposite perspective; 94% of women over 30 and almost 80% of women under 30 did not regret their decision to be sterilized. Even amongst the youngest age cohort, almost 60% of women under 25 did not express regret about sterilization during up to 14 years of follow-up. Yet the fact that almost half of women sterilized at a young age subsequently regretted the procedure is compelling. Sterilization is one of many contraceptive options that we can make available to our patients but it deserves a special status because of its permanence. The same level of protection against unplanned pregnancy can be achieved with an IUD which both avoids the morbidity and risks of surgery and is completely reversible.

I am encouraged by Zite and her colleagues efforts in reassessing the federal sterilization consent form. Although we are unlikely to see new forms anytime soon, this serves as another reminder of the need to both simultaneously respect our patients' autonomy in making contraceptive and sterilization decisions for themselves and their families and to equip them with proper tools to make these decisions. These tools include both well-written and understandable consent forms and extensive pre-procedure education that includes thorough discussions of the alternatives to sterilization, the permanence of the procedure, and the possibility of regret.

References: Online

Deputy OB/GYN CCC Editorial comment
How Are You Going to Solve Your Dilemma of First Trimester Screening in a Rural Setting?

Last month I wrote about new recommendations from ACOG for first trimester genetic testing and the challenges that rural facilities face in trying to comply with these recommendations. I had hoped to follow-up this month with some possible solutions to this dilemma but this issue is proving to pose quite a challenge. Again, if you work at a rural facility and have found a way to offer first trimester screening, or combined first/second trimester screening, please share! Also, if you have created or found a low-literacy patient education sheet for this testing, please let me know. My e-mail address is *jean.howe@ihs.gov.*

Perinatology Picks
George Gilson, MFM, ANMC
Preconception Counseling for Women With Diabetes and Hypertension: What Should the Primary Care Provider Do About Their Prescription Medications?

Case #1. AD is a 25 y/o nullipara with newly diagnosed type 2 diabetes mellitus and moderate essential hypertension. She also has been trying to become pregnant. Her blood sugars have been fairly well controlled with diet and exercise, but her blood pressure is persistently greater than 140/90. Because of her dual problem, would it be appropriate to start an angiotensin converting enzyme (ACE) inhibitor? Could we then discontinue it when she becomes pregnant? Or would it be safer to start another medication that would be safer in pregnancy since she is not using any form of contraception?

Case #2. RYC is a 34 y/o G3P3 with known type 2 diabetes mellitus. Her blood sugars have been fairly well controlled with diet and metformin. She has recently remarried and is trying to conceive. On her most recent evaluation she is found to have the new onset of significant, but not nephrotic syndrome range, proteinuria (1.5 g/24 h). Would it be wise to start her on an ACE inhibitor, or an angiotensin receptor blocker (ARB), at this time?

Case #3. IN is a 22 y/o nullipara who has hyperlipidemia. There is a strong family history of coronary artery disease, and her cholesterol has not been able to be brought below 250 mg/dL despite diet and exercise. Her triglycerides and LDL are also elevated, but her HDL is normal. Her BMI is 34 kg/m^2. She desires to become pregnant within the year and does not wish to use any method of contraception. Would it be appropriate to start her on an HMG-CoA reductase inhibitor (a "statin") at this time?

Discussion

The women in the above case vignettes are commonly encountered in primary care practice, and present somewhat of a management dilemma. Good guidelines for the use of common primary care therapies in women of child-bearing age with diabetes, hypertension, and hyperlipidemia are not readily available. Nevertheless, such problems are being more commonly encountered as the "obesity epidemic" progresses, especially in our population. Is the risk of adverse cardiovascular events the same in these young women as it is in their over 50 year old counterparts? What is the risk of teratogenicity if they should become pregnant on the various medicines we prescribe?

The angiotensin converting enzyme inhibitors (ACEI) such as lisinopril, enalapril, etc., are contraindicated in pregnancy. Because they relax the glomerular afferent arteriole, they enhance glomerular blood flow and thus reduce the incidence and severity of proteinuria and hypertension in diabetic and hypertensive patients, a desirable effect. However, in the fetus, they can create a situation of such persistent glomerular high flow that destruction of the delicate fetal glomerular capillary network may result. This can then result in fetal renal failure and oligohydramnios. This may be seen during the latter half of pregnancy, or in the newborn period. While this situation may be reversible if the ACE is stopped, that cannot be assured. These same effects have unfortunately also been described with the angiotensin receptor blockers (ARB), such as candesartan. More recent data have now demonstrated that ACEI are also first trimester teratogens, and are associated with congenital defects of the cardiovascular (atrial and ventricular septal defects) and central nervous system and skeleton (spina bifida, microcephaly, calvarial hypoplasia). Their use in the peri-conceptional period is therefore no longer recommended. ACE also appear in small quantities in breast milk. While I could not find any evidence of adverse neonatal effects in breastfed infants whose mothers were on ACEI, I could likewise not find any pediatricians who were comfortable with that situation.

OB/GYN CCC Editorial comment
Is the Glass Half Empty or Half Full?

The fact that so many of our AI/AN patients have diabetes and/or hypertension at younger ages is one of our greatest challenges. On the other hand, their diabetes and hypertension are well controlled enough that they can successfully pursue pregnancy. The above discussion is a helpful first step. We will develop this discussion further, so keep your eyes peeled for an upcoming Perinatology Corner module on this topic. In the meantime, I think you will find the link in the online version helpful as it combines risks and benefits beginning with rare events such as rhabdomyolysis, moving on to myalgia, and other systems effects and the overall benefits to statin's use as indicated in risk reduction of CVD which is the number one killer of AI/AN women.

STD Corner
Lori de Ravello, National IHS STD Program
HIV/AIDS Among AI/AN Fact Sheet

A CDC Fact sheet, updated from the previous version, is available at *http://www.cdc.gov/hiv/resources/factsheets/aian.htm*.

HIV/AIDS Protective Factors Among Urban American Indian Youths

This research examined how family and individual factors influence three HIV/AIDS risk behaviors: having more than one sexual partner in the last three months, substance use at last sexual intercourse, and condom non-use at last sexual intercourse. The sample includes 89 sexually active American Indian adolescents living in a large southwestern US city. Logistic regression results revealed that family communication acts as a protective factor against HIV risk through a lower reported substance use during last sexual intercourse, but it did not appear to affect the number of multiple recent sex partners. Family and personal involvement in American Indian cultural activities, both low on average in this urban sample, had no effect on outcomes. This study advances knowledge on sexual health risk and protective factors among American Indian adolescents, an understudied group, and provides implications for prevention intervention with American Indian youths and their families.

Marsiglia FF, Nieri T, Stiffman AR. HIV/AIDS protective factors among urban American Indian youths. *Journal of Health Care for the Poor & Underserved*. 17(4):745-58, 2006 Nov.

Women's Health Headlines
Carolyn Aoyama
Continuing Education - Quadrivalent Human Papillomavirus Vaccine: Recommendations of the Advisory Committee on Immunization Practices

This activity has been approved for 1.75 contact hours (continuing nursing education); a maximum of 1.75 hours in category 1 credit (continuing medical education credit for nonphysicians); a maximum of 1.75 hours of category 1 credit (continuing medical education); and 0.15 continuing education units. Go to *http://www2a.cdc.gov/ce/CourseDetails.asp?ActivityId=56-02&ProgramName=MMWR#Fees*.

Obtain Full-Text Articles While Searching the Pubmed Database

Diane Cooper, Biomedical Librarian/Informationist, Health Services Research Library, National Institutes of Health Library, Bethesda, Maryland

You can do it the hard way. Go to the traditional PubMed website, do your search, review abstracts, select the articles you want to read in full, then try to find a source for the full text article (maybe the hospital library has it? maybe you can request it through an interlibrary loan?) then make a copy. Maybe you can get someone else to copy it for you.

Or you can do it the easy way. Use PubMed within the HSR Library website. You may be able immediately to download your selected article. If the article you want is not immediately available, you can order it through HSR Library's Document Delivery Service with a few clicks and entering your name. Either way, it is fast and easy.

Here is what you need to do. Go to the HSR Library website at *http://hsrl.nihlibrary.nih.gov*. Scroll down the left panel on the homepage to PubMed. Conduct your search as you would normally. Now as you view the abstracts you will see an icon at the end of the abstract.

Click on this icon to see if a full text version of the article is available. If it is, you will be taken to the article for PDF downloading format. If not, a screen will appear asking if you want to order it through Document Delivery. If you do, just click on the Document Delivery link and a form will appear. The form is automatically completed with the information for the article you want. All you have to do is enter you name and e-mail address. Remember, you must have an ihs.gov e-mail address to obtain document delivery services.

Too much trouble? Ask an oldtimer about going to a physical library, searching Index Medicus by hand, writing down citations of interest, going to the shelves, finding the bound journal, finding the issue and pages you need, taking it to a photocopier, standing there and copying it, then going retrieve another citation. The HSR Library Document Delivery Service is easier and faster too! Call me at (301) 594-2449 and I can help walk you through the steps if you wish.

1: Ann Epidemiol. 2007 May;17(5 Suppl):S43-5.

Moderate alcohol consumption and risk of developing dementia in the elderly: the contribution of prospective studies.

- **Letenneur L.**

  Moderate alcohol consumption, after controlling for potential confounding factors, has been found to be associated with a lower risk of developing dementia in several prospective epidemiological studies from Europe, the United States, and China.

  PMID: 17478325 [PubMed - in process]

The Patient Wellness Handout

CDR Christopher Lamer, PharmD, BCPS, CDE, Office of Information Technology, Medical Informaticist for Health Education

Progression of chronic diseases and increased complexity of medication regimens often accompany the aging process. This increases the patient's need for access to their pertinent personal health information for a variety of reasons: to remind them of the medications they are taking, encourage them to receive preventative health care services, or share their health information with health care providers. The Patient Wellness Handout (PWH) is a new RPMS application released by the Office of Information Technology in September 2006 as a part of the PCC Health Summary Patch 15 (APCH) that helps patients gain access to this essential information. The PWH 1) provides patients with personal health information to enable them to make appropriate health decisions, 2) serves as a tool that a patient can use to improve collaboration with providers, and 3) promotes patient centered care (see Figure 1 on next page).

Comments from a recent patient focus group acknowledge the benefit of having easily accessible personal health information when working with health care providers. Access to this information bridges barriers of communication and reduces the risk of medical error.

- "For some of our elders, if the EMT goes to their house, then someone can give them the form and they don't have to force them to talk; sometimes they don't know or can't talk."
- "My son was sick and he had to see so many doctors, and this could have helped . . . it's easier to carry a record, instead of trying to remember all the information."
- The PWH can provide patients with medication lists, allergies, recommended immunizations, as well as some vital sign information including blood pressure and weight. Doing so may encourage patients to be proactive in seeking preventive services and enables more complete recall of medications and allergies for ensuring medication reconciliation.
- "Medications listed (are) helpful because it (is) hard to remember the names of them."
- "(The hospital doesn't) give you a list of drugs you are taking. What if you go to another doctor and you don't have a list? If you have a list it will be helpful, and if you go on trips then you have something to fall back on."

Literacy skills are the strongest predictor of an individual's health status; this makes clear communication between patients and providers critical for achieving healthy outcomes. Older adults are one of the populations most likely to be at risk of low health literacy.[1] Patient education is an effective process of raising health literacy; however, patients generally retain only about 20% of the information provided at the time of a visit. Patient literature is an effective method to supplement patient education by providing information that the patient can take home and read later.

One user commented, "All good points on the handout - good if you have this record at home." The PWH, when reviewed between the patient and the health care provider, can help the patient point out information that does not appear in their IHS medical record, such as when immunizations may have been administered at a location outside of the facility, or medications they are taking that do not appear on their medication list. The PWH is a tool to improve communications between patients and health care providers and improve health literacy.

Patient Centered care is the respectful and responsive care provided to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.[2] Recognizing patients as the ultimate decision makers in their health care is the first step towards improving outcomes. "A good relationship between the patient and health care provider, which features encouragement and reinforcement from the provider, has a positive impact on adherence" to a treatment plan.[3] Using tools such as the PWH can help to improve patient understanding of their conditions and better prepare them to make the most appropriate health care decisions.

The OIT is currently receiving feedback on the PWH from clinicians as well as patient focus groups conducted throughout the IHS by the Health Promotions and Disease Prevention (HPDP) program. Plans to develop a second version based upon the responses provided are underway. Some of the ideas for a future version include the ability to customize handouts, add more information from the patient's medical record, and to enable alteration of the handout wording. The use of tools, such as the PWH, will provide elders with increased health information to improve health literacy, enhance patient education, and improve collaboration between clinicians and the patient to ultimately result in better health outcomes.

Figure 1. Sample Patient Wellness Handout

PATIENT MEDICAL HANDOUT Report Date: April 16, 2007

FOREST GUMP HRN: 168711
200 2ND STREET
ADAIR, OKLAHOMA 74330
888-333-4444

IHS Medical Center
SMITH, JAMES, MD
(918)342-6200

Hello Mr. Gump,

Thank you for choosing IHS Medical Center.

This sheet is a new way for you and your doctor to look at your health.

Immunizations(shots). Getting shots protects you from some diseases and illnesses.

1 Immunization Due
INFLUENZA

Weight is a good measure of health - and it depends on how tall you are.
You are 5 feet and 7 inches tall.
Your last weight was 204 pounds on Sep 01, 2004.
You should have your weight rechecked at your next visit
Your Body Mass Index on Sep 01, 2004 was 32.0.
You are above a healthy weight. Too much weight can lead to lots of health problems - diabetes, heart disease, back pain, leg pains, and more. Ask your provider about things you can do to fix your weight.

Blood pressure is a good measure of health.
Your last blood pressure was 120 over 82 on Oct 07, 2005.
Your blood pressure is too high. Easy ways to make it better are eating healthy foods and walking or getting more physical activity.
If you take medicine to lower your blood pressure, be sure to take it every day.

Allergies, reactions that you've had to medicines or other things are very important. Below are the allergies that we know. If anything is wrong or missing, please let your provider know.

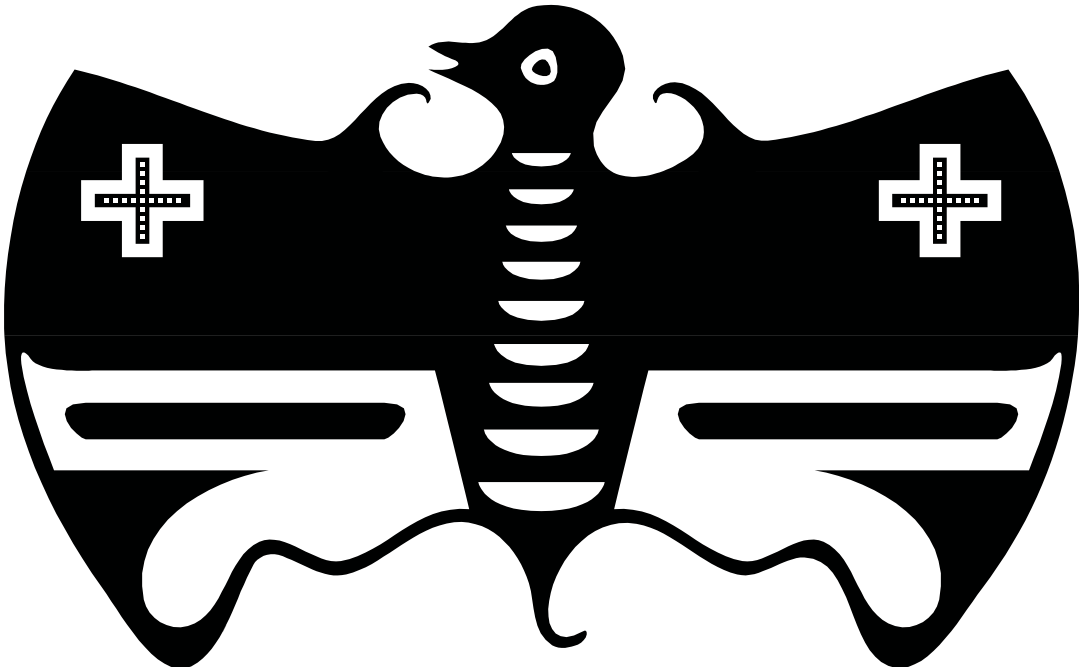
From Allergy Tracking System:
OREO COOKIES
DIPHENHYDRAMINE

Here is a list of the medicines you are taking:

HYDROXYZINE 25MG TAB
Directions: TAKE 1 TABLET EVERY 4 HOURS IF NEEDED FOR ITCHING
TRIAMTERENE 50MG CAP
Directions: TAKE 1 CAPSULE DAILY

References

1. AHRQ Report — Literacy and Health Outcomes (2004): *http://www.ahrq.gov/clinic/epcsums/litsum.htm*.
2. Institute on Medicine, Committee on Quality of Health Care in America. (2001) Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press.
3. Krueger KP, Felkey BG, Berger BA. Improving adherence and persistence: a review and assessment of interventions and description of steps toward a national adherence initiative. *J Am Pharm Assoc*. 2003;43:668-79.



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.*

19th Annual IHS Research Conference
June 4 - 7, 2007; Phoenix, Arizona

The 19th Annual IHS National Research Conference, "Multiple Perspectives on AI/AN Research Policy," will enhance our ability to ensure benefits of research to Native communities and peoples. The conference will also examine in depth the impact of research policies on the research activity in American Indian and Alaska Native (AI/AN) communities. This three-day conference will bring together many stakeholders in AI/AN research activities, including clinicians, health administrators, educators, consumers, researchers, and community and tribal government leaders across the nation.

The hotel site for the conference is the Sheraton Crescent Hotel, 2620 West Dunlap Avenue, Phoenix, Arizona 85021; telephone (602) 943-8200; fax (602) 371-2857. The room rate is $74.00 per room, per night, plus tax, single/double occupancy (this is the approved Federal government rate). Be sure to mention the "Indian Health Service" when making your reservations. Deadline for making room reservations at the conference rate is May 2, 2007. The hotel's toll free number is 1-800-423-4126, or book your room online at *http://www.starwoodmeeting.com/StarGroupsWeb/res?id=0702026635&key=90F25*.

The conference is sponsored by the Indian Health Service and the IHS Clinical Support Center (the accredited sponsor).

For more information about the conference program, please contact Alan Trachtenberg, MD, MPH, IHS Conference Co-Chair (*atrachte@hqe.ihs.gov*) or Donald Warne, MD, MPH, NRN Conference Co-Chair (*donald.warne@asu.edu*). For more information about registration or continuing education, please contact Dora Bradley (*theodora.bradley@ihs.gov*) or Gigi Holmes (*gigi.holmes@ihs.gov*) at the IHS Clinical Support Center, or call (602) 364-7777.

2007 National Council of Nurse Administrators (NCONA) Conference
"Fulfilling the Needs of the World with the Passion of Nursing"
June 18 - 21, 2007; Spokane, Washington

IHS, tribal, and urban nurses are encouraged to attend the annual NCONA Meeting and Conference to be held at the Red Lion Hotel in the Park, 303 W. North River Drive, Spokane, Washington 99201; telephone (509) 326-8000 ext.7219; fax (509) 777-6313. Please make your room reservations by May 17, 2007 by calling the toll-free number 1-800-733-4566 and ask for the "NCONA or IHS" group rate. Single occupancy rate is $70.00 per night plus tax ($90 for double or $109 for triple). Check-in is 3 pm and check-out is 12:00 noon. The IHS Clinical Support Center is the accredited sponsor for this meeting. For on-line registration and access to the most current event agenda, please visit CSC's website at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*. For more information about the event, contact LT Lisa Palucci at the IHS Clinical Support Center, (602) 364-7777 or e-mail *lisa.palucci@ihs.gov*, or visit the NCONA website at *http://www.ihs.gov/MedicalPrograms/ncona*.

Clinical Update on Substance Abuse and Dependency (Formerly known as the Primary Care Provider Training on Chemical Dependency)
June 26 - 28, 2007; Portland, Oregon

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 Red Lion Hotel on the River, 909 N. Hayden Island Drive, Portland, Oregon, 97217. Please make your hotel room reservations by June 4, 2007 by calling (503) 283-4466 or 1-800-RED LION. Be sure to ask for the "Indian Health Service" group rate. Conference room rates are $98.00 per night plus tax (single/double). Check-in is 3 pm and check-out is 12 noon. Reservation requests received after the cut-off date will be at prevailing rates based on availability. 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.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.

Office Based Opioid Treatment Course
June 29, 2007; Portland, Oregon

The IHS invites all physicians and nurses to register for its

upcoming Office Based Opioid Treatment (OBOT) Course to be held Friday, June 29, 2007 at the Red Lion Hotel on the River in Portland, Oregon. The course faculty features the top clinicians and researchers in the field. This new treatment modality reduces the regulatory burden on physicians who choose to practice opioid addiction therapy. It is open to all physicians and nurses, including federal, state, and military. For more information, contact Dr. Anthony Dekker at (602) 263-1200 or *anthony.dekker@ihs.gov*.

2007 PAIHS Methamphetamine Health Summit: "Taking Back Our Families"
July 24 - 26, 2007; Scottsdale, Arizona

The purpose of this 2007 Phoenix Area Indian Health Service Health Summit is to provide a continuing platform for discussion and action on how to take back our families from the devastation of methamphetamine. The summit will focus on the impact of methamphetamine on our families, community, and environment, and will present the latest trends and data at the national, state, tribal, and local levels, and highlight best practice prevention strategies and treatment models. The goals of this conference support the IHS Director's Health Initiatives. The seminar will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, AZ 85258; telephone (480) 949-1414. Please make your room reservation early by calling the toll free number, 1-800-528-1456. Mention you are a participant of the "IHS CE Seminar" to get the federal group rate of $74 single/$84 double. The deadline for making room reservations is June 23, 2007. Check-in is 3 pm and check-out is 12:00 noon. The IHS Clinical Support Center is the accredited sponsor of this meeting. For on-line registration, please visit CSC's website at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*. For more information about the event, contact LTJG Shannon Beyale at (602) 364-5155; or e-mail *shannon.beyale@ihs.gov*.

2007 Native Women's Health and MCH Conference
August 15 - 17, 2007; Albuquerque, New Mexico

Do you provide care to Native American women of all ages? Are you interested in the latest program/clinical updates? If so, you should seriously consider attending the Native Women's Health and MCH Conference in Albuquerque, New Mexico August 15 - 17, 2007. The theme is "Improve the System: Improve the Outcome." It will feature internationally known speakers, as well as national benchmark organizations, e.g., Institute for Healthcare Improvement and Kaiser Family Foundation.

The Conference also has a program review function, so there should be a team from each facility that provides care to women of any age, whether outpatient only, or full spectrum care. This meeting only happens every three years.

Conference coordination is by the University of the New Mexico Department of Continuing Education. The Program is available at *http://www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Aug07*. For questions, contact Kathy Breckenridge at UNM CME at *KBreckenridge@salud.unm.edu*, or call (505) 272-3942. Other questions, contact Neil Murphy at *nmurphy@scf.cc*.

Seventh International Conference on Diabetes and Indigenous Peoples
August 29 - September 1, 2007; Ottawa, Ontario, Canada

The Seventh International Conference on Diabetes and Indigenous Peoples: Learning From the Past to Restore Balance, hosted by the National Aboriginal Diabetes Association (NADA) will be held in Ottawa, Ontario, Canada, on August 29 - September 1, 2007. The conference will provide an exciting and positive opportunity for indigenous people from around the world to exchange experiences and learn about advances in all areas of diabetes prevention and treatment.

The international planning committee is currently searching for presenters who are willing to share their innovative programs, research efforts, and diabetes related initiatives with conference participants. For more information, please visit the NADA website at www.nada.ca or contact the Hunter-Courchene Consulting Group at 1-866-778-4610. The deadline for the call for presentations is May 31, 2007.

Ninth Annual American Indian Elders Conference
September 5 - 7, 2007; Oklahoma City, Oklahoma

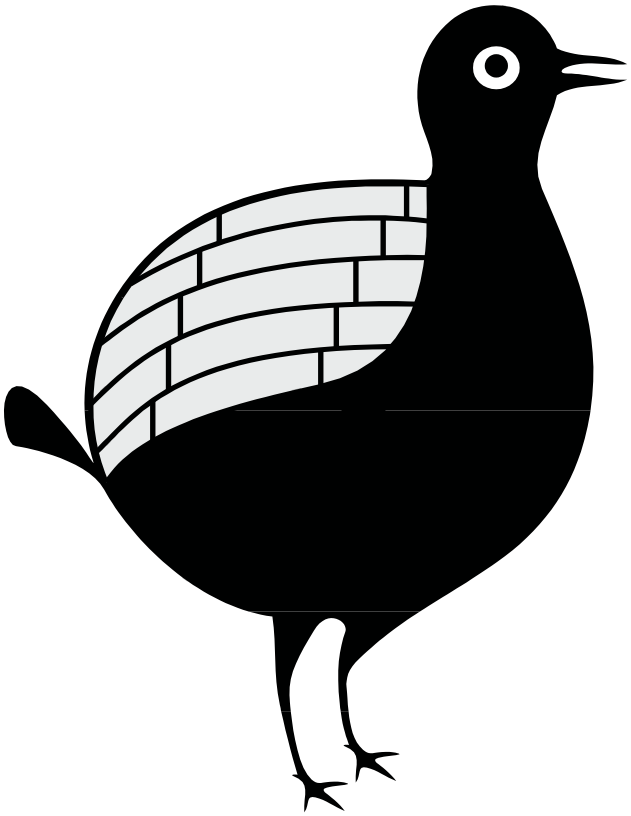
The Indian Health Service is once again sponsoring the Annual American Indian Elders Conference; this year's theme is "Enjoying the Circle of Life." Participants will explore new pathways for better health and provide positive examples for generations to follow. The conference will be held September 5 - 7, 2007 at the Crowne Plaza, Oklahoma City, Oklahoma. Onsite registration will begin in the afternoon on Tuesday, September 4.

The American Indian Elders Conference provides information on health education and wellness and recognizes the need to keep traditions and traditional values alive. Each year the planning committee selects issues affecting elders and invites participation from American Indian Communities across the nation. Presentations will focus on various health-related issues including fitness, cancer, heart disease, diabetes, and mental health. Social issues such as domestic violence in Indian country and grandparenting will also be addressed. In addition, Veterans issues will be explored and recognition will be given for their many sacrifices.

For more information visit *www.katcommunications.net/conferences*, where you may register for this conference and subscribe to receive conference updates by e-mail. Alternatively, you may call KAT Communications at (888) 571-5967.

The AHRQ Annual Meeting for Health Information Technology
September 26 - 28, 2007; Bethesda, Maryland

Designed for physicians, nurses, and researchers, the Agency for Healthcare Research and Quality's (AHRQ) Annual Meeting is a CME/CEU accredited meeting that will feature AHRQ's work across several programs, and provide an opportunity to network with peers/colleagues on health IT, patient safety, and quality of care issues, update knowledge of current health trends and issues, enhance skills to improve patient care, and receive accredited continuing education. The program will offer continuing education designed to meet the needs of those providing primary and specialty care to special populations in the US, including the uninsured and Medicaid populations, women and children, persons with chronic illnesses, and racial and ethnic minorities including American Indians and Alaska Natives. The seminar will be held at the Bethesda North Marriott Hotel and Conference Center, 5701 Marinelli Road, Bethesda, Maryland 20852; telephone (301) 822-9200. The CME/CEU accredited sessions will be offered on Wednesday, September 26. The meeting agenda will include plenary and concurrent sessions on a variety of topics. Registration information will be available soon.



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 on an organizational letterhead to: Editor,* THE IHS PROVIDER, *The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, 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. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Primary Care Physicians
(Family Practice, Internal Medicine, Med-Peds)
Chinle Service Unit; Chinle, Arizona

Got Hózhó? That's the Navajo word for joy . . .. Here on the Navajo Reservation, there's a great mix of challenging work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work (naanish) and enjoy living in our small, collegial community. Our 60-bed, acute care hospital is located in Chinle, Arizona – the heart of the Navajo Nation.

At work we see unique pathology, practice evidence-based medicine, and are able to utilize the full scope of our medical training. Together, we enjoy learning in an atmosphere of interdepartmental collaboration, supported by an established network of consulting specialists across the southwest. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients.

During our time off, many of us explore the beautiful southwest, bike on amazing slick rock and ski the slopes of the Rocky Mountains. It's a great life – combining challenging and interesting work with the peaceful culture of the Navajo people and the beautiful land of the southwest.

We're looking for primary care physicians to join our team. If you're interested in learning more about a place where "naanish baa hózhó" (work is joyful), contact Heidi Arnholm, Medical Staff Recruiter, Chinle Service Unit, telephone (928) 674-7607; e-mail heidi.arnholm@ihs.gov.

Clinical Director, MD or DO
Puyallup Tribal Health Authority; Tacoma, Washington

The Puyallup Tribal Health Authority, a tribally operated ambulatory clinic located in Tacoma, Washington, is recruiting for a clinical director. PTHA is an urban based clinic located 30 miles south of Seattle, just off of Interstate 5. Our campus houses three buildings providing mental health, a 30-day inpatient chemical dependency program, a 13-chair dental department, dental lab, physical therapy, x-ray, pharmacy, community health, medical, medical lab, and a dedicated pediatrics department. The medical department currently has nine physicians, one PA, and five RNs.

The clinical director will be responsible for directing and managing all Puyallup Tribal Health Authority's medical clinic operations, ensuring delivery of effective health care as well as providing professional health care services directly to PTHA patients. PTHA is accredited by AAAHC, CARF (Behavioral Health), and COLA (Medical Lab). For more information, please e-mail *hr@eptha.com*; website *www.eptha.com*; fax (253) 593-3479; or call (253) 593-0232, ext. 516. The mailing address is Puyallup Tribal Health Authority, attention: Human Resources, 2209 E 32nd St, Tacoma, Washington 98404.

Family Practice Physician
Family Practice Medical Director
Tanana Chiefs Conference, Chief Andrew Isaac Health Center; Fairbanks, Alaska

We are seeking a board certified family practice physician, preferably with obstetrics skills for a full-time position. We will have openings in the summers of 2007 and 2008.

The facility is a multispecialty clinic providing services in obstetric/gynecology, internal medicine, and family practice. It also includes dental, optometry, pharmacy, behavioral health, community health aides, and other services. Our referral region includes 43 villages in interior Alaska covering an area the size of Texas. Fairbanks has an outstanding school system and university. We offer a very competitive salary with a great benefits package and a loan repayment plan. Commissioned Corps positions are also available. Contact Jim Kohler at (907) 459-3806 or *james.kohler@tananachiefs.org*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

Full Time, Fantastic Benefits! We are recruiting for a family practice physician to join our team at the Seattle Indian Health Board in Seattle, Washington. We are a multiservice community health center for medical, dental, mental health, substance abuse, and community education services. We are looking for a physician who is familiar with health and social issues facing American Indians/Alaska Natives and a desire to promote the delivery of appropriate health services to this population.

Seattle Indian Health Board (SIHB) physicians are responsible for the delivery of quality, culturally sensitive primary medical care to the SIHB's patient population. This position provides general medical care (including diagnosis, treatment, management, and referral) to SIHB patients with acute, chronic, and maintenance health care needs. The physician chosen will also participate in the medical on-call rotation schedule and other responsibilities such as consulting

and coordinating care with other practitioners, nursing, pharmacy, laboratory, and outside referral sites. He or she will provide clinic preceptorship of mid-level practitioners and patient care instruction to nurses, pharmacists, and other SIHB clinical staff. The incumbent will precept for residents for the outpatient continuity family practice clinics. In addition to supervising patient care, preceptors engage in didactic activity to enhance resident learning. The physician will also participate in quality assurance, program development, community health education/screening, and related activities. He or she will document all patient care information/treatment in problem-oriented format in the patient's medical records, as well as complete and submit encounter forms and related materials according to established procedure. Finally, the person selected will comply with SIHB policies and procedures, and the AAAHC Standards of Care.

Qualifications include board certification in family medicine and a Washington State medical license. All applicants will be required to complete a background check. Please visit our website at *www.sihb.org* for more information, or you can call Human Resources at (206) 324-9360, ext. 1123.

Primary Care Physicians
USPHS Claremore Comprehensive Indian Health Facility; Claremore, Oklahoma

The USPHS Claremore Comprehensive Indian Health Facility has openings for full-time positions for an emergency medicine physician, a surgeon, an anesthesiologist (or nurse anesthetist), an OB/GYN physician, and an internal medicine physician.

The Claremore hospital is a 50-bed specialty based comprehensive care facility, providing care through nine organized clinical services: community health, dentistry, optometry, emergency medical services, general surgery, internal medicine, obstetrics and gynecology, pediatrics, and radiology. In addition, the hospital has a six-bed intensive and coronary care unit and CAT scan equipment with 24 hour teleradiology support. The facility maintains several academic affiliations, and has a professional staff consisting of 36 staff physicians, approximately 60 contract physicians, five dentists, three nurse practitioners, a physician assistant, an optometrist, and an audiologist.

Claremore is a town of 18,000 just 21 miles northeast of the very metropolitan city of Tulsa, with a US Census county population of 560,431. Tulsa has a major airport with international flights and destinations in most major US cities, and was ranked in the top 10 southern cities in Southern Living magazine and Fodor's Travel Publications as one of its outstanding travel destinations. Tulsa's cost of living is 8 percent below the national average and has a county per capita income 11 percent above the national average. If you prefer rural living, there are many opportunities nearby. The facility is located 10 minutes from a major lake, and only one hour from a lake with over 1,100 miles of shoreline.

For more information, contact Paul Mobley, DO at (918)342-6433, or by e-mail at *paul.mobley@ihs.hhs.gov*. CVs may be faxed to (918) 342-6517, Attn: Paul Mobley, DO.

Family Practice Physician
Hopi Health Care Center; Polacca, Arizona

The Hopi Health Care Center currently has openings for family practice physicians and family nurse practitioner or physician assistants. The Hopi Health Care Center is a small, rural IHS hospital providing full spectrum family practice medical services including ambulatory care, adult/peds inpatient care, low risk obstetrics, and ER care. We currently staff for 12 full time physicians, and four full time FNP/PA positions. Our facility is located in northern Arizona, 90 miles northeast of Flagstaff and 70 miles north of Winslow, on the Hopi Indian Reservation. Services are provided to both Hopi and Navajo reservation communities. The reservation is located in the heart of the southwest; within a 90 mile radius are abundant mountain areas, lakes, forests, and archeological sites. The Hopi Health Care Center is a new facility established in 2000 with a full ambulatory care center environment including a dental clinic, physical therapy, optometry, and behavioral health services. We are a designated NHSC site, and qualify for the IHS Loan Repayment Program.

For more information, please contact Kelly Reese, MD at (928) 737-6147 or e-mail *ke1ly.reese@ihs.gov*. Additionally, you may contact Darren Vicenti, MD, Clinical Director at (928)737-6141 or darren.vicenti@ihs.gov. CVs can be faxed to (928) 737-6001.

Medical Director
Family Practice Physician
Lower Brule, South Dakota

The Lower Brule Health Center in Lower Brule, South Dakota, is a free-standing ambulatory care facility with an immediate opening for a Medical Director/Family Practitioner. This facility is located next to the beautiful Missouri River. One position will be responsible for the development; implementation, and oversight of the medical services as well as medical/administrative tasks. The other position will be a staff position. Services offered at this Health Center include primary care, obstetrics and gynecology, pediatrics, and audiology. Other services include diabetes education, nutrition, pharmacy, lab and x-ray. For more details regarding this exciting opportunity, please contact Georgia Amiotte, CEO at (605) 473-5544 or 473-8248.

Registered Nurse
Santo Domingo Health Clinic, Santo Domingo, New Mexico

The Santo Domingo Health Clinic in Santo Domingo, New Mexico is seeking applicants for two registered nursing positions for individuals with outpatient care experience to work in small and rural community clinics. The positions are

based at the newly constructed Santo Domingo Health Clinic which opened in October 2006. These positions require assignments to the Cochiti Health Clinic outpatient department, which is located in the Cochiti Pueblo, Cochiti, New Mexico, for three days a week.

The Santo Domingo Health Clinic offers pharmacy, dental, outpatient care, limited optometry, behavior health, and audiology services. The Cochiti Health Clinic is a very small ambulatory clinic that offers outpatient, pharmacy, and limited dental services.

We extend an invitation for applicants to come and visit our health clinics and the Pueblos of Santo Domingo and Cochiti. For more information, please contact Wayne Lahi, Health Center Director, at (505) 946-3060 or Evelyn Calvert at (505) 465-5774; or e-mail *wayne.lahi@ihs.gov* or *evelyn.calvert@ihs.gov*.

Nurse Practitioner or Physician Assistant
Sam Hider Community Clinic; Jay, Oklahoma
Wilma P. Mankiller Health Center; Stilwell, Oklahoma

The Sam Hider Community Clinic in Jay and the Wilma P. Mankiller Health Center in Stilwell both have immediate openings for a full-time nurse practitioner or physician assistant. These two facilities are two of six rural ambulatory clinics operated by the Cherokee Nation. Other services offered at these facilities include dental, radiology, public health nursing, in-depth diabetes program, pharmacy, and laboratory. Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, no weekends, no call, and relocation expenses are available.

If interested in this exciting opportunity, please submit a completed Cherokee Nation application along with copies of degrees and/or certificates to Cherokee Nation Health Administration Office, Attn: Kathy Kilpatrick or Angie Cone, PO Box 948, Tahlequah, Oklahoma 74465; telephone (918) 453-5000; fax (918) 458-6174; or e-mail *kathy-kilpatrick@cherokee.org* or *angie-cone@cherokee.org*. We would also like to extend an invitation to come and visit our clinic – we feel confident you'll love our charming southern hospitality!

For more detailed information regarding job listings and for an application, log onto our website at *www.cherokee.org*. Applicants with Indian preference must submit a copy of their Certificate Degree of Indian Blood (CDIB) along with their application. All applicants will be required to pass a pre-employment drug screen and complete a background check.

Directors of Nursing
Chief Redstone Health Center, Fort Peck Service Unit; Wolf Point, Montana
Verne E. Gibbs Health Clinic, Fort Peck Service Unit, Poplar, Montana

We are announcing job opportunities for Directors of the Nursing Departments at the Chief Redstone Health Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana as well as the Verne E. Gibbs Health Clinic, Indian Health Service, Fort Peck Service Unit, Poplar, Montana. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. The service unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community to encourage a "Healthier Community."

We are looking for RNs with well rounded clinical skills and some hospital nursing experience. This person will be responsible for establishing and implementing long and short-term policies, and programs for nursing care and services; monitoring the nursing program plans; ensuring compliance with standards such as HIPAA, Privacy Act, OSHA, Infection Control and national accrediting bodies (AAAHC, CMS, OIG); keeping abreast of changing developments, health care policies, directions, or practices and the changing health care needs of the population served; maintaining a budget for the Nursing Department; planning and adjusting work schedules and operations to meet organizational objectives, priorities, deadlines, and standards of care for the delivery of nursing services; and ensuring that all nursing staff members maintain 100% compliance with licensure requirements. Duties would include planning, organizing, and assigning unit work; providing in-services to staff; performing triage assessment and assignment of appropriate triage level; documenting all data accurately; ability to start IVs; and giving immunizations to pediatric and adult patients. Applicants must have more than basic computer skills.

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 to the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. Northeast 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*.

Family Practice Physician
Chief Redstone Health Clinic, Fort Peck Service Unit, Wolf Point, Montana

We are announcing a job opportunity for a family practice physician at the Chief Redstone Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. This is a unique opportunity for a physician 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 northeast 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 a 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. Tribal Health 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 to the website at *http://www.ihs.gov/FacilitiesServices/Area Offices/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*. Northeast 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*. Alternatively, you can contact Dr. Craig Levy at (406) 768-3491, or e-mail *craig.levy@ihs.gov*, or the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or e-mail *audrey.iones@ihs.gov*. We look forward to communicating with you.

Pediatrician
Family Practice Physician
Pharmacist
Obstetrician/Gynecologist
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, 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, an active diabetes program, 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 offers 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 medical team, contact Dr. Peter Reuman at *peter.reuman@ihs.gov* or telephone (406) 338-6150; or contact the Physician Recruiter, Audrey Jones, at *audrey.jones@ihs.gov* or telephone (406) 247-7126. We look forward to hearing from interested candidates.

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

The Fort Belknap Service Unit is seeking a family practice physician and pharmacist candidates 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 physicians, two nurse practitioners, and one physician assistant, 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 an equally dedicated staff of nurses, lab and x-ray personnel, pharmacists, dentists, administrators, housekeepers, supply specialists, physical therapist, and contract practitioners to provide the best possible care to patients. The staff works as a 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. Robert Andrews at *robert.andrews@ihs.gov* or telephone (406) 353-3195; or contact the Physician Recruiter, Audrey Jones, at *audrev.jones@.gov,* telephone (406) 247-7126.

Family Nurse Practitioner or Physician Assistant
Fort Peck Service Unit; Poplar, Montana

We are announcing a job opportunity for a family nurse practitioner and/or physician assistant at the Verne E Gibbs Health Center in Poplar, Montana and the Chief Redstone Health Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. The Fort Peck Service Unit is located in the northeast 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. The 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 a very active Diabetes Department that includes one nurse educator, one FNP, and one nutritionist. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community 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 to the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. We are looking for an applicant with well rounded clinical skills. Two years experience is preferred but new graduates are welcome to apply. Northeast 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*.

Family Practice Physicians
Crownpoint, New Mexico

The Crownpoint IHS facility has openings for three family practitioners with low risk obstetric skills. Our service unit follows a Family Medicine model for providing full-spectrum care to our patients, with a dynamic medical staff that finds the work here quite rewarding. With a high HP5A rating, we are a NHSC-eligible site for payback and loan repayment.

Crownpoint is a town of about 2,500 people in the Four Corners region of New Mexico. We serve a traditional community of 25,000 Navajo people, many of whom speak only Navajo and live in traditional homes with no running water, electricity, or phone service. Our hospital has a six bed ER, a 17 bed med/peds unit, a labor and delivery/post-partum unit, and a large outpatient clinic. We have dental, optometry, and mental health services, as well as on-site pharmacy, laboratory, radiology, and ultrasonography. Our medical staff is a collegial and supportive group including ten family physicians, two pediatricians, an obstetrician/gynecologist, a psychiatrist, four PAs, three NPs, and a podiatrist. We have a very exciting, full-spectrum medical practice that includes high-risk prenatal care, low-risk labor and delivery, emergency room care with management of trauma and orthopedics, and an interesting inpatient medicine and pediatric service.

As primary care physicians in a rural setting, we manage a wide variety of medical problems. We care for many patients with diabetes and hypertension, but we also see some unusual illnesses such as plague, Hantavirus, and snake bites. There are many opportunities for outpatient and ER procedures including suturing, therapeutic injections, closed reductions of fractures and dislocations, para/thoracentesis, chest tubes, LPs, colposcopy, sigmoidoscopy, and OB ultrasound.

While Crownpoint is small, there is a lot to do in the surrounding area. There are two junior colleges in town where many of us have taken Navajo language, weaving, and history classes. Some have gotten involved with local churches and children's activities. Outdoor activities are plentiful, with downhill and cross-country skiing, camping, and fishing all nearby. There are several excellent mountain biking and hiking trails, as well as Anasazi ruins that are right in Crownpoint. Albuquerque is two hours away and is our nearest large city with an international airport. Other destinations that are within an afternoon's drive include Santa Fe (three hours), Durango and the Rocky Mountains (two hours), Taos (four hours), Southern Utah's Moab and Arches/Canyon lands National Parks (four hours), Flagstaff (three hours) and the Grand Canyon (five hours).

To reach the Crownpoint Hospital, call (505)786-5291.

Family Practice Physician
Pediatrician
Bristol Bay Area Health Corporation, Dillingham, Alaska

Bristol Bay Area Health Corporation (BBAHC) is a mature tribal compact located in scenic southwestern Alaska. The Bristol Bay Area Service Unit encompasses 44,000 square miles of Alaska country bordering the Bristol Bay region of the state. Over 400 employees provide primary care to 28 villages including two sub-regional villages, and a primary care hospital, Kanakanak, located in Dillingham, Alaska. The Medical Staff consists of nine family physicians, a pediatrician, a nurse midwife, four dentists, a physical therapist and an optometrist, all providing primary care. The patient population consists of Yupik Eskimo, Aleut, and Athabascans who have been residents of the area for hundreds of years. Family physicians provide a broad spectrum of practice including obstetrics, inpatient medicine, emergency care and procedures such as colonoscopy, EGD, flexible sigmoidoscopy, colposcopy, and treadmill services in a very collegial and supportive atmosphere. Our solo pediatrician is allowed to practice full spectrum pediatrics with an extremely interesting patient mix and some very high risk and rare genetic disorders unique to this area. The pediatrician works in a collegial manner with family physicians and is not required to perform any adult medicine or obstetrics, but solely pediatrics.

BBAHC was the first hospital in the country to establish a 638 contract and has an extremely good working relationship

with their Board of Directors. Of note, the practice here in Alaska is unique, and air travel to outlying villages is required, since continuity care to the villages is very important to our care here and is uniquely rewarding. BBAHC has an extremely competitive salary and benefits package.

If interested, please contact Arnie Loera, MD, Corporate Medical Director, at (907) 842-9218, Kanakanak Hospital/Bristol Bay Area Health Corporation, PO Box 130, Dillingham, Alaska 99576. You may also contact him by e-mail at *aloera@bbahc.org*. CVs can be faxed to (907) 842-9250, attn: Arnie Loera, MD. You may also view our website for information about our corporation at *www.bbahc.orq*.

Family Practice Physician
Santa Clara Indian Health Service Health Center; Espanola, New Mexico

The Santa Clara Indian Health Service Health Center is recruiting for a family practice physician for a full-time position. The medical department is staffed with three providers: one full-time family practice physician, one half-time family practice physician, one half-time internal medicine physician, and one full-time nurse practitioner or one full-time physician assistant position. This ambulatory care clinic is primary care-oriented with outpatient, dental, behavioral health, laboratory, radiology, optometry, psychiatry, podiatry, pediatrics, women's health, and other services. The referral facility is Santa Fe Indian Hospital in Santa Fe, New Mexico, located 30 miles away, from where many of the staff commute.

The Santa Clara Health Center is located in the Pueblo of Santa Clara in Northern New Mexico. This area is renown for its famous black pottery and Puye cliff dwellings and has outdoor activities including their very own Big Rock Casino and Golf Course, skiing nearby at Santa Fe, Taos, or Angelfire, fishing, river rafting, biking, hiking, rock climbing, feasts, pow-wows, and many others. We are located approximately 80 miles northwest from Albuquerque, the largest city in New Mexico. The University of New Mexico is also located in Albuquerque.

The position is available as either Commissioned Corps or Civil Service (US citizens and Status Candidates). For more information, please contact Bindu Smelser, MD or Chico Livingston MD at Santa Clara Health Center, (505) 753-9421, or apply on the open continuous announcement number AAO-OC-602 to Albuquerque Area Indian Health Service, Division of Human Resources, 5300 Homestead Road, NE, Albuquerque, NM 87110; telephone (505) 248-4510. Contact Raelyn Pecos at (505) 248-4106 or *raelyn.pecos@ihs.gov* for a copy of the job announcement, or go to *www.usajobs.gov*, USAJOBS control number 806649.

Medical Technologist
Tuba City Regional Health Care Corporation; Tuba City, Arizona

The Tuba City Regional Health Care Corporation, a 73-bed hospital with outpatient clinics serving 70,000 residents of northern Arizona, is recruiting for full-time generalist medical technologists. The laboratory has state-of-the-art equipment. We offer competitive salary, based on experience. Relocation benefits are available. New graduates are encouraged to apply for this position. Tuba City is located on the western part of the Navajo reservation approximately 75 miles north of Flagstaff, Arizona, with opportunities for outdoor recreation and cultural experiences with interesting and adventurous people.

For more information, please contact Minnie Tsingine, Laboratory Supervisor, at (928) 283-2716 or *minnie.tsingine@tcimc.ihs.gov*. For an application, please contact Human Resources at (928) 283-2041/2432 or *mfrancis@tcimc.ihs.gov*.

Northeastern Tribal Health Center
Miami, Oklahoma

The Northeastern Tribal Health Center is seeking a full-time family practice dentist and a family practice Nurse practitioner or physician assistant for an ambulatory health care center with close proximity to the Grand Lake area, as well as thirty minute interstate access to Joplin, Missouri. The facility offers competitive salaries, excellent benefits, loan repayment options, no weekends, and no call. To apply, please submit a current resume, certifications, and State of Oklahoma license. Applicants claiming Indian preference must submit proof with their resume. Applicants will be required to pass a pre-employment drug screen and complete a background check. Indian preference applies, but is not absolute. To apply, send requested documents to Northeastern Tribal Health Center, P.O. Box 1498, Miami, Oklahoma 74355, to the attention of Personnel. The phone number is (918) 542-1655.

Family Physician
Winslow Indian Health Care Center; Winslow, Arizona

The Winslow Indian Health Care Center (WIHCC) in northern Arizona is currently looking for a family practice physician who is interested in a broad scope of practice, preferably including obstetrics. We have a staff of 12 physicians, including a surgeon, and eight family nurse practitioners. We offer comprehensive ambulatory and urgent/emergent care to patients at our health center in Winslow, where we are currently completing construction on a state-of-the-art, seven bed Urgent Care Center. WIHCC also operates two field clinics five days a week on the Navajo Reservation, at Leupp and Dilkon. Our physicians provide inpatient care at the local community hospital, the Little Colorado Medical Center, where obstetrical back-up is readily available. Winslow offers an awesome mix of professional, cultural, and recreational opportunities. We are located just seven miles from the breathtaking beauty of Navajoland and its people, and 50 miles from Flagstaff — a university town with extensive downhill and cross-country skiing, where several of our staff choose to live.

WIHCC became an ISDA 638 contracted site in 2002, and has experienced steady growth and enhancement of programs

and opportunities since the transition from a direct IHS program. Please contact Frank Armao, MD, Clinical Director, if you are interested in pursuing an opportunity here. E-mail *frank.armao@wihcc* or telephone (928) 289- 6233.

Family Physician
Juneau, Alaska

We are looking for a family practice physician to join our group of eight family practice physicians. This is a full time position, and includes obsterics and call, 1:8. Outpatient work is primarily continuity care for your panel of patients, with some time in the walk-in clinic as well. Inpatient work is at the local (non-IHS) community hospital. We offer a competitive salary and excellent benefits.

Juneau is located in beautiful southeast Alaska; it has a population 30,000, with a temperate climate, and incredible outdoor recreation opportunities. For more information, contact Janice Sheufelt, MD, medical director, at (907) 463-4057; e-mail *janices@searhc.org*; or see our website at *www.searhc.org*.

Family Medicine Physicians
Phoenix Indian Medical Center, Phoenix Arizona

The Family Medicine Department is recruiting for BC/BE family physicians at the Phoenix Indian Medical Center and the satellite clinic at Salt River for Summer 2007. The positions are predominantly outpatient with limited hospital inpatient activity; OB optional. Join eight physicians, one nurse practitioner, one physician's assistant, and a number of part-time providers. PIMC is one of the largest IHS sites, with over 100 providers and 70 active beds. We have been using PCC+ and in part EMR. There are great opportunities socially, culturally, professionally, and educationally living in the Phoenix metropolitan area. The IHS has a great benefits package for Civil Service and Commissioned Corps. For more information, please contact/send CV to Eric Ossowski MD, Family Medicine Department, Phoenix Indian Medical Center, 4212 N 16th Street, Phoenix Indian Medical Center, Phoenix, Arizona 85016. Telephone (602) 263-1537; fax (602) 263-1593; or e-mail *eric.ossowski@his.gov*.

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*.

Medical Director/Primary Care Physician
Cherokee Elder Care Program of All-Inclusive Care for the Elderly (PACE)
Cherokee Nation Comprehensive Care Agency; Tahlequah, Oklahoma

In preserving seniors with their independence, Cherokee Nation Comprehensive Care Agency is pleased to announce an opening for a Medical Director/Primary Care Physician. This position would be responsible for the development, implementation, and oversight of the program's primary care services and all clinical aspects of care and related administrative tasks. Minimum requirements include graduate of an accredited school of medicine, geriatrics training preferred, license to practice medicine in Oklahoma, and at least 2 – 3 years clinical, supervisory and administrative experience.

Interested applicants may e-mail resumes to *resumes@cnhhs.org* or contact the Personnel Office at (918) 456-5051, extension 223. For more information please contact Cherokee Nation Home Health Services at *www.cherokeehomecare.org*.

Physician
Wilma P. Mankiller Health Center; Stilwell, Oklahoma

The Wilma P. Mankiller Health Center has an immediate opening for a full-time family medicine or internal medicine physician. This 37,300 sq. foot facility is one of six rural ambulatory clinics operated by the Cherokee Nation. Other services offered at this facility include dental, radiology, public health nursing, an in-depth diabetes program, physical therapy, pharmacy, and laboratory. Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, no weekends, no call, and relocation expenses are available.

If interested in this exciting opportunity, please submit a completed Cherokee Nation application along with copies of degrees and/or certificates to Cherokee Nation Health Administration Office, Attn: Kathy Kilpatrick or Angie Cone, PO Box 948, Tahlequah, OK 74465; telephone (918) 453-5000; fax (918) 458-6174; or e-mail *kathy-kilpatrick@cherokee.org* or *angie-cone@cherokee.org*. We would also like to extend an invitation to come and visit our clinic – we feel confident you'll love our charming Southern hospitality!

For more detailed information regarding job listings and for an application, log onto our website at *www.cherokee.org*. Applicants with Indian preference must submit a copy of their Certificate Degree of Indian Blood (CDIB) along with their application. All applicants will be required to pass a pre-employment drug screen and complete a background check.

Physician
Redbird Smith Health Center; Sallisaw, Oklahoma

The Redbird Smith Health Center has an immediate opening for a full-time family medicine or internal medicine physician. This facility, located in Sallisaw, is one of six rural ambulatory clinics operated by the Cherokee Nation. Other services offered at this facility include dental, radiology, public health nursing, in-depth diabetes program, pharmacy, and laboratory. Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, no weekends, no call, and relocation expenses are available.

If interested in this exciting opportunity, please submit a completed Cherokee Nation application along with copies of degrees and/or certificates to Cherokee Nation Health Administration Office, Attn: Kathy Kilpatrick or Angie Cone, PO Box 948, Tahlequah, Oklahoma 74465; telephone (918) 453-5000; fax (918) 458-6174; or e-mail *kathy-kilpatrick@cherokee.org* or *angie-cone@cherokee.org*. We would also like to extend an invitation to come and visit our clinic – we feel confident you'll love our charming southern hospitality!

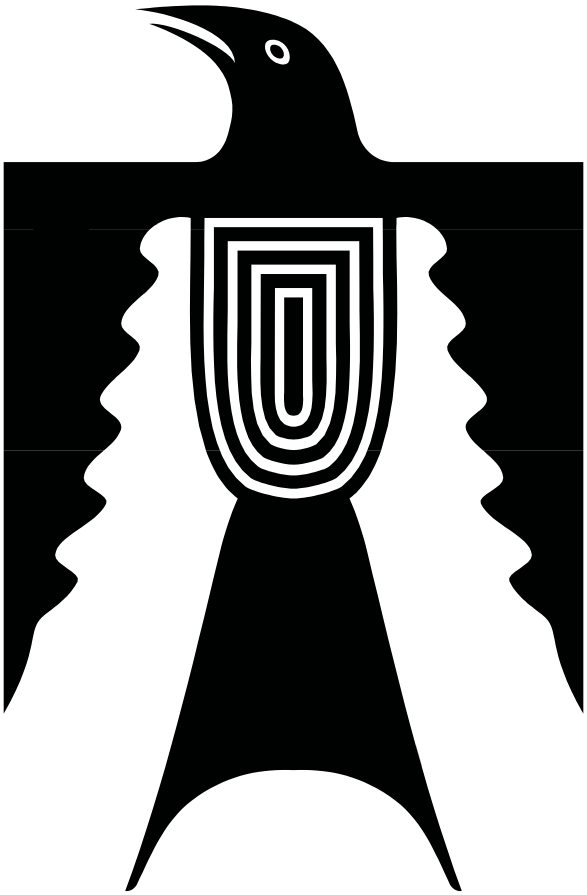
For more detailed information regarding job listings or for an application, log onto our website at *www.cherokee.org*. Applicants with Indian preference must submit a copy of their Certificate Degree of Indian Blood (CDIB) along with their application. All applicants will be required to pass a pre-employment drug screen and complete a background check.

Physician
AMO Salina Health Center; Salina, Oklahoma

The AMO Salina Health Center has an immediate opening for a full-time family medicine physician or pediatrician. This facility, located in Salina, is one of six rural ambulatory clinics operated by the Cherokee Nation. Other services offered at this facility include radiology, public health nursing, in-depth diabetes program, pharmacy, and laboratory. Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, no weekends, no call, and relocation expenses are available.

If interested in this exciting opportunity, please submit a completed Cherokee Nation application along with copies of degrees and/or certificates to Cherokee Nation Health Administration Office, Attn: Kathy Kilpatrick or Angie Cone, PO Box 948, Tahlequah, Oklahoma 74465; telephone (918) 453-5000; fax (918) 458-6174; or e-mail *kathy-kilpatrick@cherokee.org* or *angie-cone@cherokee.org*. We would also like to extend an invitation to come and visit our clinic – we feel confident you'll love our charming southern hospitality!

For more detailed information regarding job listings or for an application, log onto our website at *www.cherokee.org*. Applicants with Indian preference must submit a copy of their Certificate Degree of Indian Blood (CDIB) along with their application. All applicants will be required to pass a pre-employment drug screen and complete a background check.



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THE IHS PRIMARY CARE PROVIDER

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

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

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