THE IHS PRIMARY CARE PROVIDER

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

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A Bridge Across the Quality Chasm in Elder Care

Annual Elders Issue

This May 2008 issue of *THE IHS PROVIDER*, published on the occasion of National Older Americans Month, is the thirteenth 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 2009 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.

Bruce Finke, MD, Nashville Area IHS Elder Health Consultant, Northampton, Massachusetts

A decade of experience working with tribal and IHS sites to improve geriatric care has taught me three things:

1. Clinical care for the elderly will only be as good as the care we provide for prevention and for the management of chronic conditions.
2. Education and training in geriatrics has limited value unless the system we work in is supportive of good geriatric care. It does little good for clinicians to know what should be done but not have the time and support to do it.
3. Intensive focus on elder care with geriatric specific services (e.g., elders' clinics) can improve the care of participating elders; only rarely do we have the capacity and resources in Indian health to provide that level of care for every elder who needs it.

In the May 2007 *Provider* we discussed the challenge of making reliably high quality elder care a property of our primary care system.[1] One year later I can share with you a glimmer of hope that this ideal can be a reality.

Over the past year, the 14 pilot sites of the Chronic Care Initiative have been working with the Innovations in Planned Care (IPC) for the Indian Health Service collaborative to test changes that result in improvement in the prevention and management of chronic conditions.[2] What is emerging from the work of the IPC sites is a set of changes that create a platform for the delivery of proactive, planned care built around the relationship between the care team and the patient and family. It is that platform of care that holds hope for the future of geriatric care. Key features of the platform include:

- A strengthened relationship between the care team and the patient and family through improved continuity and better access to care.
- A method for the care team to plan care for each patient.
- A care team structured such that each member of the team provides care at the highest level of their licensure and abilities
- The use of a registry to track and identify patients who need screening or preventive services
- Attention to integration with community-based programs and services to expand care outside of the walls of the clinic and hospital.
- A focus on understanding, supporting, and meeting the health goals of the patient.

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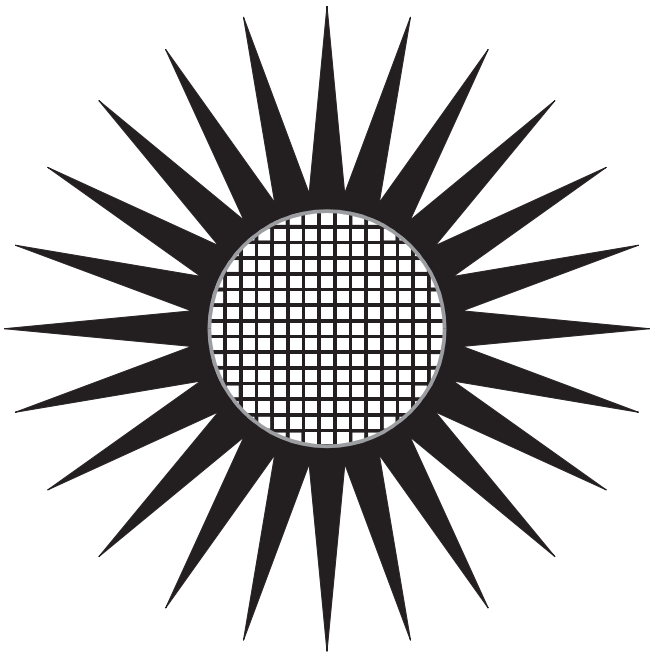
There is specific content to geriatric care, strategies and interventions that have been shown to improve care for the older patient. But the episodic, provider-based visit is not adequate to the task. This content requires a vehicle, a platform for delivery, and it is this platform that the IPC sites are building.

The 2001 Institute of Medicine report *Crossing the Quality Chasm* described an improved health care system as one in which "Patients would experience care that is safer, more reliable, more responsive to their needs, more integrated, and more available, and they could count on receiving the full array of preventive, acute, and chronic services that are likely to prove beneficial."[3]

This is the health care that every elder deserves from their tribal, urban, and IHS clinic or hospital. It is not enough to know what good geriatric care is; we have to have the system in place that can deliver it. The changes being tested by IPC offer the opportunity to integrate into routine primary care the essential components of geriatric care, for every elder.



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1. Finke B. The Common Road. *IHS Primary Care Provider*. May 2007;Vol.32 #5.
2. The Directors Initiatives. *http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm*.
3. Institute of Medicine, Crossing the Quality Chasm: A New Health System for the Twenty-first Century (Washington: National Academy Press, 2001).

IHS Elder Care Initiative Grants

Kay Branch, Anchorage, Alaska

Long term care services support elders and their families with medical, personal, and social services delivered in a variety of settings to ensure quality of life, maximum independence, and dignity. The IHS Elder Care Initiative grant program supports the development of medical long term care services by tribes, tribal organizations, and urban indian health programs. There are eleven grantees in the current two-year cycle that began in August 2006. Proposals for the next cycle are due June 20, 2008, for those submitting letters of intent by May 2, 2008.

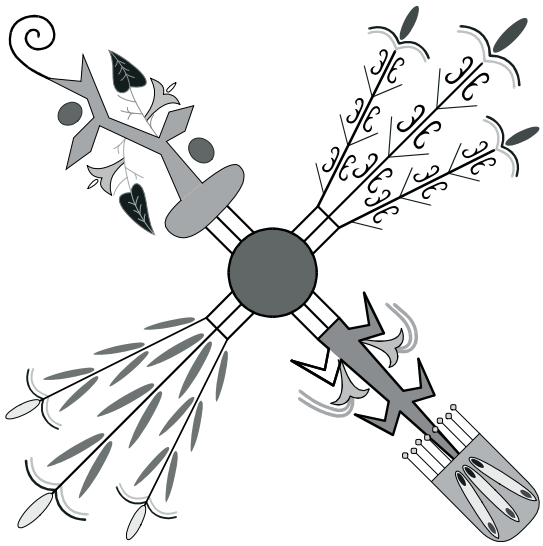
Current grantees are the Aleutian Pribilof Island Association, Cherokee Nation, Ho-Chunk Nation, Intertribal Council of Arizona, Kenaitze Indian Tribe, Mount Sanford Tribal Consortium, Native American Community Health Center, San Carlos Apache, Southeast Alaska Regional Health Consortium, Tucson Indian Center, and the Yurok Tribe. These grantees have made a lot of progress in the last year and a half, and are well on their way to increasing long term care services for elders in their service areas.

The projects for this cohort of grantees can be divided into three categories: initial assessment and planning; tribes currently providing services seeking additional reimbursement to enhance programs; and implementation of new programs. The majority of the projects fall into the first category. Grantees have used a variety of methods to gather information from elders and service providers, one of the most popular being focus groups or community elder meetings. Two grantees, Kenaitze and Ho-Chunk Nation, already provided many services to elders, but were paying for the programs entirely with tribal funds. Ho-Chunk has established a great working relationship with state partners and is creating a home health program that will be reimbursed through Medicare, Medicaid, and private insurance. The Native American Community Health Center in Phoenix, with the only implementation grant, will be opening a tribal adult day center

this summer. Grantees participate in regular teleconferences to share information and learn from each other, as well as learn about topics relevant to long term care service delivery and reimbursement opportunities.

This is an exciting cohort of programs working hard to improve access to long term care services for their elders. Look for a description of the projects on the IHS Elder Care website at *http://www.ihs.gov/MedicalPrograms/ElderCare/*, or meet them in person at the next AI/AN Long Term Care Conference planned for spring 2009.

Kay Branch works for the Community Health Services division of the Alaska Native Tribal Health Consortium in Elder Care Planning. She works with tribal health partners to expand the availability of long term care services throughout the Alaska Tribal Health System, and provides technical assistance to IHS Elder Care grantees.



There's No Place Like Home

Shelly Zylstra, Planning Unit Director for the Northwest Regional Council, Bellingham, Washington

The good news is that American Indian elders are living longer and longer. The better news is that mainstream American communities have developed a variety of long term care models that work well, are less expensive, and are more desirable to elders than skilled nursing facilities. While many tribes seek funding for nursing homes, the good news is that tribal communities throughout the United States have a wide variety of services for long-term care from which to pick.

In northwest Washington State, several tribes are beginning the process of looking at the adult family home as a viable, cost-effective, and desirable alternative to nursing home care. This effort is a direct result of an IHS Eldercare Initiative grant in 2003. A survey of elders indicated that they would prefer to stay in their homes, or at least in their communities to receive long-term care. Some local tribes are considering caring for just a couple of elders in an existing home that has been modified to assure access for disabilities. Others are considering building a large family home specifically to meet the needs of their elders with half-baths in each room, a large accessible kitchen and dining room, a fenced yard, and a "spa" with a commercial bath. While still in the planning stages, it is great that these tribes are considering community-based services. Their populations are small. Some are geographically distant from other alternatives.

Nursing homes have historically been and continue to be an entitlement service provided to Medicaid-eligible elders who require long term care. Although care in most nursing homes is closely monitored and provided safely, there is no question that elders are not clamoring to move in to one. Elders who move into a facility "in town" generally find themselves isolated from their friends and family, culturally cut off from their communities, and lonely. The rural nature of reservations, coupled with the small numbers of elders in most communities, means that skilled nursing facilities are unlikely to be financially feasible in most tribal communities. With an increasing elder population and diminishing long term care dollars, it makes sense for tribes to consider community-based care and services for their elders.

Usually, community based care is provided in the elder's home by a home care agency or provider, or a family member or friend who is trained and contracted to provide the care. A case or care manager who is employed by the tribe, the state, or the local Area Agency on Aging usually manages the care for elders. This case manager reviews the needs of the elder and authorizes services and personal care hours. It is important to remember that while a home care aide can clean the house, do laundry and dishes, and perform household chores, they are primarily there to provide help for the elder to bathe, use the

toilet, prepare meals and eat, walk, transfer, dress, and groom. Without the need for assistance with one or more of these activities, elders are generally not eligible for any type of Medicaid-paid long term care services in the home or elsewhere.

Tribes can seek contracts to provide care for their elders under the Home and Community-based Services (HCBS) Medicaid Waiver program. If they do not operate a home care agency, they could think about what is involved in home care licensure and hiring tribal members to provide the care for their own elders. If this is not possible, tribes can often provide ancillary services to the elders who are enrolled in the Medicaid waiver services. These services vary by state, but can include home-delivered meals, transportation, durable medical equipment, client training, skilled nursing, environmental modifications, and numerous others. Check your state's Home and Community Based Services waiver (HCBS 1915c) to review the menu of services available to elders in your community. Seek contracts to assist with providing the services. This can provide needed reimbursement for activities you are already doing for your elders.

Sometimes an elder needs more care than can be reasonably provided at home. When this happens, transfer to a skilled nursing facility seems likely. However, in most states there are "in-between" living situations which can provide services close to home, where the elder most wants to remain. These small facilities have many names, but are often known as "adult family homes," "adult foster homes," or "adult care homes." They are small (6 - 12 people; this varies by state, and by location within states) family homes where elders live together with a caregiver or a caregiving family. The personal care needs of the elders are met by the caregivers, and other services are provided by resources available in the community (the clinic, transportation providers, housing, senior center) through contracts with the state.

In some ways, this model is perfect for Indian communities. Adult family homes are generally small, with limited staff and licensing requirements, and do not require a large population of elders to make them financially feasible. They keep the elder close to their community. Often reservations are large geographically, and even a tribally operated nursing home may be miles away from an elder's home and family. Finally, because the home operates like a family (meals are served communally, activities are shared, visitors are welcomed), elders thrive together and support one another in their daily lives. In most cases, there is no time when an elder would need to leave an adult family home. As the elder's need for care increases, additional services can be provided, and even Hospice care is generally available to them if it is available in your community.

Consider this model for your community. When it comes to long term care, there is no place like home.

Resources

http://www.aasa.dshs.wa.gov/professional/afh.htm
http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717---,00.html
http://www.dphhs.mt.gov/qad/adultfostercare/index.shtml
http://licenseinfo.oregon.gov/index.cfm?fuseaction=license_seng&link_item_id=14213
http://www.ncbcapitalimpact.org/default.aspx?id=146

New Graduate nursing orientation program at Northern Navajo Medical Center

Northern Navajo Medical Center has implemented an orientation lasting ten weeks for new graduate nurses. The new graduates will be paired with a preceptor to work together in transitioning from school into the nursing profession. The preceptor/preceptee pair are removed from the staffing mix and allowed to take on patients who would be most beneficial for the development of skills and confidence of the new graduates. There is also some cross training and exposure to other departments to deepen skills and expose new graduates to the opportunities available to them.

Call Winifred Howard at (505) 368-6466 or (800) 549-5644; or e-mail her at *winifred.howard@ihs.gov* for more information.

AHRQ's 2007 *Guide to Clinical Preventive Services* Now Available

The Agency for Healthcare Research and Quality has released *The Guide to Clinical Preventive Services 2007*, which highlights recommendations from the US Preventive Services Task Force from 2001 through 2006. These evidence-based recommendations for clinicians address preventive services, including screening tests, counseling, and preventive medications in the primary care setting.

Task Force recommendations have been adapted for the pocket-size book so that clinicians can consult the recommendations in their daily practice. The recommendations are presented in an indexed, easy-to-use format, with an at-a-glance table for matching recommended services to patients -- men, women, pregnant women, and children.

The Task Force, supported by AHRQ, is the leading independent panel of private-sector experts in prevention and primary care. Its recommendations are considered the gold standard for clinical preventive services. It conducts rigorous, impartial assessments of the scientific evidence for a broad range of preventive services.

Recommendation statements and supporting documents from the Task Force are available at the AHRQ Web site at *www.ahrq.gov/clinic/prevenix.htm*. Single copies of the new guide are available free of charge:

- At *www.ahrq.gov/clinic/pocketgd07/pocketgd07.pdf* (PDF File, 1.4 MB, PDF Help; Text Version).
- By calling the AHRQ Publications Clearinghouse at (800) 358-9295.
- By sending an e-mail to *ahrqpubs@ahrq.hhs.gov*.

The IHS Chronic Care initiative, in partnership with the Agency for Healthcare Research and Quality's Prevention and Care Management program, is mailing out several hundred copies of the *Guide to Clinical Preventive Services, 2007* to clinicians throughout the Indian health system. We are excited to be able to provide this useful clinical reference guide and urge all clinicians to use this reference in their daily practice. If you have questions, contact Lisa Dolan-Branton, Senior Clinical Informatics/Improvement Advisor, IHS OIT/CCI, telephone (301) 443-8680; e-mail *lisa.dolan@ihs.gov*.

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

IHS Child Health Notes

Quote of the month

"If you are late, you are a thief of my time."

Anonymous

Articles of Interest

Identification and evaluation of children with autism spectrum disorders. *Pediatrics*. November 2007;120(5):1183-1213.

Management of children with autism spectrum disorders. *Pediatrics.* November 2007;120(5):1161-1182.

These two clinical reports published in *Pediatrics* in November 2007 provide a complete summary for the clinician on autism spectrum disorders (ASDs). This month's review will highlight the first article that covers identification and evaluation of children with autism spectrum disorders. The review next month will describe management strategies.

The authors emphasize that ASDs are not rare. The most recent epidemiology shows that 1/150 children in Europe and North America have an ASD, which is a 10-fold increase in the past few decades. Much debate has focused on whether the increased diagnosis of ASDs represents a true increase in disease and how this may relate to immunizations, especially the MMR vaccine and mercury containing vaccines.

Good evidence show that the increase in diagnosis is due to expanded diagnostic criteria and diagnostic "substitution." The disease category of autism also now includes Asperger syndrome and pervasive development disorder -- not otherwise specified, making the disease now a spectrum disorder with a much broader range of presentations. Secondly, many children who were previously given a diagnosis of "mental retardation" or "emotional disturbance" and even "speech impairment" are now more appropriately place in the ASD.

There is an excellent discussion on etiology. The evidence for/against vaccines as a potential cause of ASDs is reviewed. Often overlooked is that 10% of ASD are part of identified medical conditions such as fragile X, Down syndrome, phenylketonuria and FAS. The heritable nature of ASD is emphasized in that there is a 5 - 6% recurrence risk of ASD in subsequent siblings.

Primary care providers are the key to identifying patients with ASD at an early age. The value of ongoing surveillance for delays in speech or emotional connectedness is reviewed. Screening using an ASD specific screening tool is recommended at ages 18 - 24 months and for any child in whom the diagnosis is entertained. If the diagnosis of ASD is felt likely, then referral to a specialist who works with ASD is suggested, along with enrollment in an early intervention program.

Editor's Note

This one article summarizes the literature of ASD for clinicians and supplies an algorithm for surveillance and screening that is straightforward. ASD is surprisingly common, and it is our job to identify those children who may benefit from early intervention and structured programs at school. For many of us in remote, rural communities, the first problem is how to obtain specialty consultation to confirm a diagnosis. The second and more formidable barrier to be discussed next month is how to find treatment services.

Infectious Disease Updates.
Rosalyn Singleton, MD, MPH
Vaccine Safety Concerns: The Price of Vaccine Success?

The Vaccine Court under the National Vaccine Injury Compensation Program recently awarded a judgment in favor of parents of a child with autism. This has occurred despite the fact that HRSA, CDC, the AAP, and Institute of Medicine have all reviewed the scientific information concerning the allegation that vaccines cause autism and have found no credible evidence to support the claim. Paul Offit offered perspective on how the court could make this award on behalf of a child with autism and an underlying mitochondrial disorder.

Opinion: Inoculated Against Facts
By Paul A. Offit, Infectious Disease, Children's Hospital of Philadelphia
New York Times March 31, 2008
http://www.nytimes.com/2008/03/31/opinion/31offit.html?_r=1&oref=slogin

When the vaccine court was established in 1986, a preponderance of scientific evidence was required for compensation. Because no one could sue vaccine makers without going through this special court, the number of

lawsuits against vaccine makers fell drastically. The system worked fine until a few years ago, when vaccine court judges turned their back on science by dropping preponderance of evidence as a standard. Now, petitioners need merely propose a biologically plausible mechanism by which a vaccine might cause harm -- even if their explanation contradicts published studies. In 2000, when Hannah was 19 months old, she received five shots against nine infectious diseases. Over the next several months, she developed symptoms of autism. Subsequent tests showed that Hannah has a mitochondrial disorder, and this contributed to her autism. An expert who testified in court on the Polings' behalf claimed that the five vaccines had stressed Hannah's already weakened cells, worsening her disorder. Without holding a hearing on the matter, the court conceded that the claim was biologically plausible.

"There is no evidence that children with mitochondrial enzyme deficiencies are worsened by vaccines," Salvatore DiMauro, a professor of neurology at Columbia who is the nation's leading expert on the disorder, told me. Indeed, children like Hannah Poling who are especially susceptible to infections are most likely to benefit from vaccines.

The vaccine court should return to the preponderance-of-evidence standard. But much damage has already been done by the Poling decision. Parents may now worry about vaccinating their children, more autism research money may be steered toward vaccines and away from more promising leads and, if similar awards are made in state courts, pharmaceutical companies may abandon vaccines for American children.

Below are some additional links for more information on vaccine safety:
http://www.cdc.gov/vaccinesafety/concerns/thimerosal.htm
http://www.immunize.org/safety

Recent literature on American Indian/Alaskan Native Health

Michael L. Bartholomew, MD

Letourneau RJ, Crump CE, Bowling JM, et al. Ride Safe: A child passenger safety program for American Indian/Alaska Native children. *Maternal and Child Health Journal*. 2008 Mar 14. [Epub ahead of print].
http://www.ncbi.nlm.nih.gov/pubmed/18340516?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum

The motor vehicle related death rate in AI/AN children is nearly 2½ times higher than the overall US rate. Data from the 2002 National Highway Traffic Safety Administration (NHTSA) show that almost 40% of children under five who died in car crashes were unrestrained. Less is known about the use of child safety restraints in AI/AN populations, although available information suggests very low rates of restraint use in AI/AN infants and children.

In January 2008, the NHTSA released *Child Restraint Use in 2007 -- Demographic Results*.[1] Their analysis indicates that the US child restraint use for children less than 12 months of age was estimated at 98%, while children aged 1 - 3 years was 96%. For children aged 4 - 7 years, the estimated restraint use was 85%. Interestingly, the NHTSA grouped AI/AN into an "Other-Non-Hispanic" demographic along with Native Hawaiians and Pacific Islanders due to insufficient numbers. The 2007 NHTSA child restraint use estimates for "Other Non-Hispanic" for infants, children 1 - 3 years, and children 4 - 7 years were 100%, 95% and 87% respectively. It is painfully apparent that these results do not reflect the child restraint use in Indian Country and are largely misleading.

This new study attempts to define rates of restraint use among AI/AN children before and after implementation of a car safety seat educational intervention program. The program, called Ride Safe, is an evidenced-based injury prevention program designed to increase child safety seat use in children ages 3 - 5 years who are enrolled in 14 different AI/AN Head Start Programs.

Fourteen AI/AN Head Start sites in six different states implemented Ride Safe over four academic school years. The Ride Safe program included education of Head Start staff and parents, distribution and installation of child safety seats, child safety seat certification training, and study training and support. Results show that initially Ride Safe was an effective intervention. After implementation of the Ride Safe Program, children were 2 to 3 times more likely to be observed in a child safety seat. Unfortunately this increase was not sustained over the length of the intervention. Additionally, the rate of child safety seat use ranged from 29.8% to 70.8%, with an overall car seat use rate of 47.5%. This rate is far below the 2006 NHTSA published car seat use rates for infants and children.

Despite the lack of sustainability, the Ride Safe program did produce some positive outcomes. During the study period, 2,916 car seats were provided. Some 78 Head Start staff obtained child passenger safety seat certification training, and 1,744 parents/family members and 358 Head Start staff participated in educational sessions. Parental reasons for not using child safety seats became known, thus allowing for program improvement by focusing on these areas.

Reference

1. Glassbrenner D, Ye T. Child Restraint Use in 2007-Demographic Results. Traffic Safety Facts Research Note DOT HS 810 897, National Highway Traffic Safety Administration, National Center for Statistics and Analysis {online} January 2008.

The Chief Clinical Consultant's Newsletter (Volume 6, No. 3, March 2008) 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

How to increase usage of the HPV vaccine? Let's ask our patients and their family

Alaska Native parental attitudes on cervical cancer, HPV, and the HPV vaccine

In June 2006, the US Food and Drug Administration's Advisory Panel approved Merck's HPV vaccine (GARDASIL®) against the four strains of HPV that are responsible for 70% of cervical cancer cases and 90% of genital warts. The Advisory Commission on Immunization Practices voted to recommend that the HPV vaccine be given routinely to girls age 11 - 12 years old. In an effort to roll out the new vaccine in Alaska, the CDC Arctic Investigations Unit and the Alaska Native Tribal Health Consortium designed and implemented a qualitative study to assess Alaska Native parents' knowledge of and attitudes about cervical cancer, HPV, and the new HPV vaccine. Findings from this study were used to design a tailored educational campaign focused on promoting the HPV vaccine.

We recruited a convenience sample of Alaska Native parents from three different size communities in Alaska (one urban area, two rural towns, and a remote village). All participants were Alaska Native/American Indian, English speaking, and had a 9 - 18 year old daughter/ward. The focus groups, each lasting approximately 60 minutes, were carried out between January through March, 2007. At this time the Merck educational campaign was underway in Alaska; however, the vaccine was not widely available in the Alaska Native Tribal Health System. Participants received a $25 incentive payment for their participation.

Prior to each focus group, each parent filled out a quantitative survey that collected demographic information and asked knowledge questions. During the focus groups, a moderator used a guide that consisted of twelve open-ended questions inquiring about parents' perceptions of cervical cancer, HPV, vaccines in general, and the new HPV vaccine. Eighty percent of those involved in the focus groups were mothers. Approximately 30% of parents were between the ages of 31 - 40 years and 38% were 41 - 50 years old. Thirty-five percent of participants had worked in or had a relative who worked in a medical setting.

Quantitative Survey Findings: Knowledge about Cervical Cancer, Vaccines, HPV, and the HPV Vaccine

The majority of parents (70%) knew that the Pap test is used to screen for cervical cancer. Parents were asked what came to mind when they heard the word "vaccine." Common themes that emerged in all focus groups were a shot, prevention, protection, and a requirement for school. The majority of participants (65%) knew that a vaccine prevents disease and can stop the spread of a disease. Overall, only 56% of parents knew that there was a vaccine for HPV and far less (20%) associated the vaccine with the prevention of cervical cancer. Although many of the parents had heard about HPV before, many were unaware that there was a link between HPV and cervical cancer. Those who had heard about it said they had seen a commercial or heard a news report, or learned about it from working in a medical setting or from a visit to a clinic. Few village-based parents knew how HPV is transmitted (36%) as compared to those from the urban area (63%) and the rural towns (74%). In both the urban and rural communities, a similar percentage of parents (38%) knew there was an association between HPV and genital warts and only 6% of village-based parents were aware of this association.

Qualitative Focus Group Findings – Attitudes and Perceptions about Cervical Cancer, Vaccines, HPV, and the HPV Vaccine

When asked what came to mind when they heard the words "cervical cancer," the comments from participants centered around the following themes: death; personal experiences with cancer; fear; pap smears; hysterectomy; ability to reproduce; and older women. The majority of mothers said that they alone make the decision to vaccinate their child against a disease. Some said that they make the decision in conjunction with their spouse, and a few said that

they involve their daughter and spouse in the decision-making. Many of those who said that they involve their daughters had older teenage daughters. For example, one mother stated "My daughter is 17, and she's the one who went out, did her research on the shot, and she's been patiently waiting for it." The majority of the fathers said that the decision is a joint decision between them and their spouse.

The majority of participants want to vaccinate their daughter due to health and safety concerns; a positive belief that vaccines work; personal experience with the cancer/HPV; or a belief that their daughter is susceptible to HPV. One mother described it this way: "I see it as just part of being a mom and wanting to protect your child against cancer." Another parent stated, "For me, having a strong history of all kinds of cancers in my family, one less cancer . . . the vaccine could protect my daughter from at least that." Another theme that was mentioned by at least one parent in each community is that often a sexual exposure is not under the control of the young woman, as in the case of rape, and this vaccine would offer the young woman protection from HPV. Reasons that participating parents would refuse vaccination include general concerns about vaccines, need for more information, fear of side effects, wanting more research studies, wanting to wait to see if problems develop, and fear of being in an experimental trial. A typical comment about the newness of the vaccine came from a mother who stated, "I don't like to be the first to use a new vaccine. That makes me uncomfortable that it hasn't been used by a lot of people yet. Some side effects may turn up that they don't know about until they vaccinate a whole bunch of kids."

In all the communities, when parents were asked what information should be included in an educational campaign on the new vaccine, parents stressed a focus on prevention, the importance of describing HPV, cervical cancer, and the vaccine; and letting people know that the vaccine is safe. Parents said to keep it simple, to talk about side effects, the shot schedule, the need for continued Pap smears, and how HPV is transmitted. When asked, "Who should deliver the message about the vaccine?" the same answers came up in all regions: providers (nurses, doctors, health aides, children services workers, tribal health workers) and teachers. The parents specified that the faces they want to see on posters should be Alaska Native and some suggested having a girl in the target age for the vaccine, a family oriented picture, an elder, or a multi-generational picture with a grandmother, mother, and daughter.

This study has several limitations. The sample was small and selected in a non-random manner. Thus, the results, including the survey data, should not be generalized to the whole Alaska Native population. Rather, the results should be interpreted as an array of possible findings that are present among some Alaska Native parents.

The findings of this study have been used to design a poster and flyer on the new vaccine oriented towards Alaska Native parents. The pictures on these materials show an Alaska Native teenage girl, her mother, and her grandmother, and the text stresses the safety of the vaccine and the testing that has occurred. The theme of "protection" is present in the headline that reads, "Love her, protect her . . . with a vaccine against cervical cancer." This research is unique in that it was undertaken prior to widespread vaccine introduction and was used to guide educational material development. This approach should be considered for other vaccines or for other populations where vaccine introduction may be controversial or require special attention to cultural or religious sensitivities. Copies of the brochure and poster can be requested by e-mailing Tania Smallenberg, Immunization Nurse Specialist, ANTHC, at *tlsmallenberg@anmc.org*.

OB/GYN CCC Editorial Comment

Melissa Toffolon-Weiss and her colleagues offer a very helpful paradigm on how to query our patients and their families to explore possible barriers to instituting what could be a life saving vaccine intervention. Each facility should consider similar projects for HPV vaccine implementation or other health strategies.

In the meantime we all have been struggling with how to encourage our young women to actually get this vaccine, largely because there is not a common 'well adolescent' visit. Many of these young women get their first HPV vaccine injection at a volleyball physical or similar visit. It is an even greater struggle to make sure our adolescents get the subsequent two injections to complete the three dose series.

We may not be able to lift a direct cookie cutter approach from the success of the infant oriented vaccine strategies, but we need to learn from that approach. Use call back lists or tickler files, or just apply your best public health experience to whatever works. Please let me know if you develop a particularly successful approach to start and complete the HPV vaccine series at your facility.

Hot Topics

Obstetrics

Grief subsequent to an early miscarriage

The paucity of clear information as to the incidence, characteristics, and duration of grief following miscarriage suggests that practitioners can offer only suggestive guidelines as to what constitutes an adaptive or typical reaction to miscarriage. The author found that:

- The affective and behavioral reactions that typically occur following miscarriage seem similar to the affective and behavioral reactions that typically occur following other types of significant loss. At the same time, grief following miscarriage seems somewhat distinct from grief that typically occurs following other losses in the preponderant emphasis on times ahead rather than on remembered times.
- With regard to the percentage of individuals who

experience a grief reaction following miscarriage, no clear guidelines can be formulated. The available literature does suggest that grief reactions are common and that the grief is similar in intensity to grief following other types of losses. In addition, like grief following other types of losses, grief after miscarriage seems to abate in intensity by about six months following the miscarriage.

- Although many variables have been studied to determine their role as moderators of the intensity and duration of grief following miscarriage, few clear conclusions can be drawn. The authors conclude that "the similarity in the results of studies examining the duration and intensity of grief following miscarriage and the duration and intensity of grief following other types of losses supports using the general literature on grief to help guide patient expectations."

Brier N. 2008. Grief following miscarriage: A comprehensive review of the literature. *Journal of Women's Health*

Gynecology

Non-surgical treatment of urinary incontinence and prevention of urinary and fecal incontinence

Background. Urinary incontinence in women is a common problem that adversely affects quality of life.

Conclusions. Moderate levels of evidence suggest that pelvic floor muscle training and bladder training resolved urinary incontinence in women. Anticholinergic drugs resolved urinary incontinence, with similar effects from oxybutynin or tolterodine. Duloxetine improved but did not resolve urinary incontinence. The effects of electrostimulation, medical devices, injectable bulking agents, and local estrogen therapy were inconsistent. Specific estimates of efficacy from available randomized controlled trials included that pelvic floor muscle training would resolve 490 cases of stress incontinence per 1000 cases treated.

This article was accompanied by an NIH “state of the science” statement addressing prevention of urinary and fecal incontinence. Conclusions included that “routine episiotomy is the most easily preventable risk factor for fecal incontinence” and that pelvic floor muscle training may prevent or reduce incontinence in older women, and lifestyle changes, such as weight loss and exercise, may prevent both urinary and fecal incontinence.

Shamliyan TA, Kane RL, Wyman J, Wilt TJ. Systematic review: randomized, controlled trials of nonsurgical treatments for urinary incontinence in women. *Ann Intern Med*. 2008 Mar 18;148(6):459-73.

Child Health

Is Short-term Therapy Effective for Treating Latent TB in Children?

Conclusion. The authors conclude that a three- to four-month course of isoniazid/rifampin combination therapy is well tolerated in children and is as effective as the traditional nine-month course of isoniazid monotherapy. In addition, the shorter treatment courses are associated with higher compliance rates.

Spyridis NP, et al. The effectiveness of a 9-month regimen of isoniazid alone versus 3- and 4-month regimens of isoniazid plus rifampin for treatment of latent tuberculosis infection in children: results of an 11-year randomized study. *Clin Infect Dis*. 2007;45:715-722.

Chronic Disease and Illness

FDA Approves Alternative Dosing Schedule for Combined Hepatitis Vaccine

In April 2007, the US Food and Drug Administration (FDA) approved an alternative schedule for the combined hepatitis A and hepatitis B vaccine Twinrix (GlaxoSmithKline). The vaccine was first licensed in 2001 for vaccination of persons 18 years and older with a schedule of three doses administered at zero, one, and six months. An alternative four-dose schedule can now be used, with doses administered at zero, seven, and 21 to 30 days, and at 12 months. Studies showed that the first three doses of the four-dose schedule provide equivalent protection to the first two doses in the three-dose series, as well as to a single dose of monovalent hepatitis A vaccine and to two doses of monovalent hepatitis B vaccine. The FDA suggests that the four-dose schedule may be useful if vaccination with the combination vaccine has been initiated but potential exposure (e.g., through travel) is expected before the second dose is due, according to the standard three-dose schedule. Additional information is available from the manufacturer's package insert and GlaxoSmithKline Vaccines (telephone, 800-366-8900). *Morbidity and Mortality Weekly Report*, October 12, 2007.

Features

ACOG American College of Obstetricians and Gynecologists

Use of Psychiatric Medications During Pregnancy and Lactation

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

- Lithium exposure in pregnancy may be associated with a small increase in congenital cardiac malformations, with a risk ratio of 1.2 - 7.7.
- Valproate exposure in pregnancy is associated with an increased risk of fetal anomalies, including neural tube defects, fetal valproate syndrome, and long term adverse neurocognitive effects. It should be avoided in pregnancy, if possible, especially during the first

trimester.

- Carbamazepine exposure in pregnancy is associated with fetal carbamazepine syndrome. It should be avoided in pregnancy, if possible, especially during the first trimester.
- Maternal benzodiazepine use shortly before delivery is associated with floppy infant syndrome.

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

- Paroxetine use in pregnant women and women planning pregnancy should be avoided, if possible. Fetal echocardiography should be considered for women who are exposed to paroxetine in early pregnancy.
- Prenatal benzodiazepine exposure increased the risk of oral cleft, although the absolute risk increased by 0.01%.
- Lamotrigine is a potential maintenance therapy option for pregnant women with bipolar disorder because of its protective effects against bipolar depression, general tolerability, and a growing reproductive safety profile relative to alternative mood stabilizers.
- Maternal psychiatric illness, if inadequately treated or untreated, may result in poor compliance with prenatal care, inadequate nutrition, exposure to additional medication or herbal remedies, increased alcohol and tobacco use, deficits in mother–infant bonding, and disruptions within the family environment.

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

- Whenever possible, multidisciplinary management involving the patient's obstetrician, mental health clinician, primary health care provider, and pediatrician is recommended to facilitate care.
- Use of a single medication at a higher dose is favored over the use of multiple medications for the treatment of psychiatric illness during pregnancy.
- The physiologic alterations of pregnancy may affect the absorption, distribution, metabolism, and elimination of lithium, and close monitoring of lithium levels during pregnancy and postpartum is recommended.
- For women who breastfeed, measuring serum levels in the neonate is not recommended.
- Treatment with all SSRIs or selective norepinephrine reuptake inhibitors or both during pregnancy should be individualized.
- Fetal assessment with fetal echocardiogram should be considered in pregnant women exposed to lithium in the first trimester.

ACOG Practice Bulletin No. 92: Use of Psychiatric Medications During Pregnancy and Lactation. *Obstet Gynecol*. 2008 Apr;111(4):1001-20.

Breastfeeding

Kendra Carter, Northern Navajo Medical Center

What do high performance cars and near term neonates have in common? Infants, like high performance cars, require consistent care and unique fuel. Many people understand the car scenario when educated on the characteristics of near-term infants who by definition are of a gestational age between 34-37 weeks. These late premature infants are at higher risk for the following:

- hypothermia due to less body fat and low weight (may actually weigh 1 - 1.5 pounds less than full term infants.)
- hypoglycemia and even dehydration can occur if infants miss feedings.
- infection related to an immature immune system
- hyperbilirubinemia related to immature liver
- uncoordinated ability to feed due to suck, swallow, breathe pattern when breastfeeding adding to fatigue.
- become easily overstimulated, resulting in an unorganized state compounding feeding difficulty.

It is vital that the nursing plan reflect understanding of the above risks and sometimes subtle signs, especially if the infant rooms-in and is breastfeeding.

- Feed baby every three hours and be aware that these infants can rapidly move from a hyper-alert to a deep sleep state and may require waking up techniques to feed.
- Limit total feeding time to thirty minutes to allow infant to rest.
- Allow the mother time to pump afterward as baby sleeps on her lap.
- Teach mothers and family members to look for signs of an effective latch and feeding of the infants. Families can help, awaken infant, change infant's diapers, and provide mothers with a snacks, water and uninterrupted time for breastfeeding.
- Vigorous, rhythmic sucking burst with brief pauses between sucking bursts is a sign of effective suck. No dimpling in baby's cheeks should be seen during sucking. Audible swallows and listen for soft "k" sound
- Supplement five to ten ml of pumped breast milk using a special nurser or syringe feeding techniques.
- Mother is relaxed and comfortable. Like the car scenario, the pit crew is a mom's lifeline. She may need to be reminded to take care of herself and accept help.
- Moms need to drink to thirst; keep healthy drinks, water, and natural juice, watch out for caffeinated drinks. Keep healthy snacks of veggies and protein snacks. This is not the time to diet to lose weight. Let

some else take care of the household chores for the first day or two at home. Nap when baby naps, do not forget sleep is important to you as well.

- Lactation consultants brought in early can anticipate discharge instructions and home follow-ups.
- Use of infant feeding records can reassure and be used for emphasis.
- Baby is having adequate numbers of wet and soiled diapers
- Baby regains birth weight between days ten and fourteen of life.

Elder Care News

Bruce Finke, Elder Care Initiative

Landmark Study on Treatment of Hypertension in the Very Old

This international randomized controlled trial addresses the important unanswered question of the value of treatment for hypertension in men and women age 80 and older. Although treatment of elevated systolic and diastolic blood pressure has clearly been shown to benefit younger elders, prior to this study the data in the older elderly has been inconclusive.

Nearly 4000 elders age 80 and older with systolic blood pressures of 160mm Hg or higher were randomized to receive either placebo or a diuretic similar to HCTZ. An ACE-I was added to the diuretic as needed to reach the target blood pressure of 150/80.

Over a 2 year study period, active treatment was associated with a 30% reduction of stroke (fatal and nonfatal), a 39% reduction in death from stroke, a 21% reduction in death from any causes, a 23% reduction in death from cardiovascular causes, and a 64% reduction in heart failure. There were fewer serious adverse events in the active treatment group than in the placebo group.

Elder Care Initiative Editorial Comment

This is a landmark study that makes clear the benefit of treatment of hypertension, diastolic and systolic, in the very old. I was especially interested in the marked reduction in stroke and heart failure, two conditions with huge implications for the function and quality of life of older people. Treatment of high blood pressure is not just about preventing death, but also about preserving quality of life.

Beckett NS, Peters R, Fletcher AE, et al; the HYVET Study Group. Treatment of hypertension in patients 80 years of age or older. *N Engl J Med*. 2008 Mar 31.

Frequently Asked Questions

First Trimester Down Syndrome Testing

1. Q. Who should be offered first trimester Down syndrome (DS) screening?
   A. Women presenting for prenatal care at less than 14 weeks gestation.
2. Q. Should only high-risk women (over 35 y/o) be offered 1st trimester DS screening?
   A. No, all women who desire the testing are candidates.
3. Q. At what gestational age should first trimester DS screening be scheduled?
   A. Between 11 weeks 0 days and 13 weeks 6 days (by ultrasound).
4. Q. What are the components of the 1st trimester DS screen?
   A. Ultrasound measurement of the nuchal translucency (NT) + blood for PAPP-A (pregnancy-associated plasma protein-A) and free beta HCG. (Most ultrasound exams at ANMC will also include the fetal heart rate, nasal bone, and ductus venosus or tricuspid waveform, if able to be obtained, which increase the sensitivity and reduce the false positives.)
5. Q. I'm pretty good at office ultrasound. Can I do my own NT measurements?
   A. Without certification, unfortunately no. Accurate NT measurements are difficult to obtain without special training. A lot is riding on the results. NT measurement requires a certificate of competency that can be obtained by attending a one-day didactic course, taking a written examination, and submitting 10 ultrasound images for critique and/or acceptance. Following certification, annual certification of competency needs to be accomplished by submitting more images. If interested, the certification process can be initiated at *www.ntqr.org*.
6. Q. I'm happy with our usual 2nd trimester screening. What's the advantage to offering first trimester DS screening?
   A. The advantages are earlier diagnosis, increased sensitivity (91%), and fewer false positives (4%). (This is compared to 2nd trimester screening that has a 78% sensitivity and a 5% FPR for screening in younger women (<35 y/o), and an 85% sensitivity but an 11% FPR in women >35 y/o. Many women will present too late for 1st trimester screening, so 2nd trimester screening will continue

to be an appropriate option.)

7. Q.
   A. What is "integrated screening"?
   Integrated screening is a screening strategy which relies on the results of both the 1st and 2nd trimester testing to give a final risk assessment. (The ANMC contract with our reference lab, NTD Laboratories, is currently not set up to do integrated screening. Also, we felt that most women would want to have the results of an abnormal 1st trimester screen divulged to them right away, and not wait for another several weeks.)
8. Q.
   A. What is "sequential contingent screening"?
   Sequential contingent screening is the strategy that we are currently using at ANMC. If women have an abnormal 1st trimester result, they are informed, and offered the option of immediate invasive testing, or subsequent 2nd trimester testing. If they have a normal result, their DS screening is considered to have been completed.
9. Q.
   A. What are the cut-off values used for 1st trimester screening?
   A 1st trimester cut-off of 1:50 or higher is used to counsel about immediate invasive testing, if the woman so desires. A 1st trimester cut-off of 1:30 or higher is used to recommend a detailed 2nd trimester anatomic ultrasound, and/or possible amniocentesis. According to our current ANMC protocol, women with a screening result of less than 1:30 have completed DS screening. (If the pregnancy is 13 weeks or less, ANMC patients may be referred to Seattle for chorionic villus sampling [CVS], if they so desire. If a woman is beyond 13 weeks, or does not wish CVS, or would prefer amniocentesis, she will need to wait 2 weeks and be referred for amnio after 15 weeks. "Early amnio," between 12 - 15 weeks, has a high [2.6%] pregnancy loss rate, and is not recommended.)
10. Q.
    A. If my client's 1st trimester DS screen is negative, is any further testing necessary?
    If the woman's 1st trimester DS screen is less than 1:30, our strategy of contingent sequential screening does not require any further testing for fetal aneuploidy. However, testing for fetal open neural tube defects (ONTD) still needs to be carried out. (In the current ANMC system, it is unfortunately currently not possible to order a maternal serum alpha fetoprotein (MSAFP) for ONTD screening alone, apart from a quad screen. Following negative 1st trimester screening, 2nd trimester serum screening, if not "integrated," has an unacceptably high false positive rate (17%) for fetal Down syndrome, and is not recommended. However, we are fortunate to be able to order routine fetal anatomic surveys at 16 - 20 weeks, which have a high sensitivity (96%) for fetal ONTD and fetal abdominal wall defects. MSAFP screening only has an 80% sensitivity for ONTD in ultrasound-dated pregnancies (only 65% in LMP-dated pregnancies), so ultrasound is superior in this regard. In order to follow ACOG guidelines, some sort of ONTD screening needs to be done.)
11. Q.
    At 12 weeks 2 days, a woman undergoes 1st trimester screening and has a nuchal translucency (NT) of 2.9 mm, which is >95th percentile for this crown rump length. How should she be counseled?
    A. The NT alone does not determine the screening result. It needs to be combined with the PAPP-A and free beta HCG for a final risk assessment. The NT alone only has a sensitivity for fetal DS of 72%, with a (high) false positive rate of 19%. The NT combined with the biochemistries has a sensitivity of 91% and a FPR of 4%. The full screen result requires both, and it is not prudent to act on the NT measurement alone. (Important exception: If the NT measurement is over 3.5 mm (+3 SD), it is considered a cystic hygroma, and the woman may be counseled about having invasive testing right away, if she so desires. A cystic hygroma raises the risk of aneuploidy to as high as 1:2.)
12. Q.
    I've heard that an enlarged NT can also signal fetal heart defects. How large does the NT have to be to be considered a marker for potential heart defects?
    A. About 1% of patients have an NT>3.5 mm (>99th percentile), which is used as the cutoff for making a referral for fetal echocardiography after 20 weeks. Even if the fetus is found to have a normal karyotype, it should still be screened for cardiac defects. (The sensitivity of a NT >3.5 mm for congenital heart disease is about 40%, but the positive predictive value is only about 4%.)
13. Q.
    What about multiple gestations? Can they undergo 1st trimester screening?
    A. Twins can be screened for fetal aneuploidy in the 1st trimester since nomograms are available to calculate their overall risk. Higher order multiples

however are not able to be accurately screened at present, although an NT >3.5 mm should always raise suspicion.

14. Q. Does 1st trimester screening only screen for fetal Down syndrome, or can other fetal trisomies also be detected?
    A. First trimester combined screening tests screen for trisomy 21 (Down syndrome) and trisomy 18. Trisomy 13 and sex chromosome aneuploidies (Turner syndrome, XO, and Klinefelter syndrome, XXY, etc.) are not efficiently screened with this test. (However, remember, over 50% of fetuses with Turner syndrome will have a cystic hygroma, i.e., NT>3.5 mm.)
15. Q. My client has a negative 1st trimester DS screening result, and a normal 2nd trimester ultrasound, but she still desires amniocentesis. Is that indicated?
    A. Both 1st and 2nd trimester screening is just that, screening, not diagnostic. Screening is able to lower risks, but only an invasive diagnostic test can definitively diagnose fetal aneuploidy. If a woman still wishes invasive testing and understands the risks of pregnancy loss following testing (which are quoted in the literature as ranging from 1:200 to 1:1600), that is her choice. (It would have been more cost-effective if she had decided that earlier and been referred before having any screening!)

OB/GYN CCC Editorial Comment
First trimester screening is a reality

Though first trimester screening a reality, please note that these comments are from George Gilson, MFM, at the Alaska Native Medical Center, so they are based on the resources available in tertiary care center. You may wish to do something different in your service unit, but it is helpful to be aware which direction your clinical care will be heading when the resources are available.

Medical Mystery Tour
You know how to treat yeast infections, right?
Which of these are true about vulvar pruritus ?

Here are the answers to last month's questions

1. It is important to ask patients presenting with vulvar pruritus if symptoms vary with their cycles.
   True. When did the symptoms start in relation to menses? Candida vulvovaginitis often occurs in the premenstrual period, while trichomoniasis often occurs during or immediately after the menstrual period.

2. *Candida glabrata* tends to respond to intravaginal boric acid therapy.
   True. *C. glabrata* has low vaginal virulence and rarely causes symptoms, even when identified by culture. Every effort should be made to exclude other co-existent causes of symptoms and only then treat for yeast vaginitis. Treatment failure with azoles is not uncommon (around 50 percent) in patients with C. glabrata vaginitis. Moderate success (65 to 70 percent) in women infected with this organism can be achieved with intravaginal boric acid (600 mg capsule once daily at night for two weeks). Better results (>90 percent cure) have been achieved with intravaginal flucytosine cream (5 g nightly for two weeks); however, flucytosine cream is not readily available and must be made by a compounding pharmacy. There are no good data regarding use of oral voriconazole for *C. glabrata vaginitis*. Anecdotal reports suggest poor response and rare if any success, and the potential for toxicity. Sobel JD, Chaim W. Treatment of *Torulopsis glabrata* vaginitis: retrospective review of boric acid therapy. *Clin Infect Dis*. 1997 Apr;24(4):649-52.

3. Nystatin successfully treats the majority of patients with tinea cruris.
   False. Tinea cruris (jock itch) is a special form of tinea corporis involving the crural fold. It is a specific fungal infection, but it's a dermatophyte infection, unlike Candida, which is a yeast form. In North America the most common cause is *T. rubrum*. A few cases are caused by *E. floccosum* and occasionally *T. mentagrophytes*. Tinea cruris is far more common in men than women. The disease often begins after physical activity that results in copious sweating, and the source of the infecting fungus is usually the patient's own tinea pedis. Obesity predisposes to tinea cruris. Topical antifungal treatment will suffice for the ordinary case. Failure to treat concomitant tinea pedis usually results in prompt recurrence. Lesions resistant to topical medications can be treated with griseofulvin by mouth, 250 mg three times daily for 14 days, or any of the other systemic agents. Daily application of talcum or other desiccant powders to keep the area dry will help prevent recurrences. Itching can be alleviated by over the counter preparations such as Sarna or Prax, although these can be irritating if applied to inflamed or excoriated skin. Patients should also be advised to avoid hot baths and tight-fitting clothing, and to wear boxer shorts rather than briefs.

4. Topical steroid ointments at the correct treatment for lichen sclerosus
   True. The treatment with the best evidence of efficacy from randomized trials is superpotent topical

corticosteroid ointment. Approximately 95 percent of women will achieve complete or partial relief of symptoms. No specific superpotent steroid or regimen has been shown to be superior to another. We use clobetasol or halobetasol propionate 0.05 percent ointment daily at night for 6 to 12 weeks and then one to three times per week for maintenance. The ointment is applied sparingly in a thin film over the affected area. A 15 g tube of ointment should be prescribed. Diakomanolis ES, et al. Vulvar lichen sclerosus in postmenopausal women: a comparative study for treating advanced disease with clobetasol propionate 0.05%. Eur J *Gynaecol Oncol*. 2002;23(6):519-22.

5. Classic psoriasis occurs often on the vulva.
False. Classic psoriasis rarely presents primarily on the vulva. If it does present on the vulva, it is usually in patients with psoriasis primarily present in the classic psoriasis positions elsewhere on the body. Patients with plaque type psoriasis usually present as young adults with symmetrically distributed plaques involving the scalp, extensor elbows, knees, and back. The plaques are erythematous with sharply defined margins that are raised above the surrounding normal skin. A thick silvery scale is usually present, although recent bathing may remove the scale. The lesions can range from less than 1 to more than 10 cm in diameter. The plaques typically are asymptomatic, although some patients complain of pruritus. Close inspection may reveal pitting of the nail plates and involvement of intertriginous areas such as the umbilicus and intergluteal cleft.

Office of Women's Health, CDC
Factors Associated with Elevated Risk of Postneonatal Mortality Among Alaska Natives

Objective: Compared to non-Natives in Alaska, the Alaska Native population has a postneonatal mortality rate 2.3 times higher (95% CI 1.9, 2.7). The objective of the study was to identify variables that account for this elevated risk.

Results: In stratified analysis, race remained associated with postneonatal mortality within most categories of marital status, maternal education, maternal age, prenatal tobacco or alcohol use, prenatal care utilization, parity and residence. The odds ratio between race and postneonatal mortality was reduced to 1.3 (95% CI 1.0, 1.6) by controlling for education, a composite variable of marital status and the presence of father's name on the birth certificate, and prenatal tobacco or alcohol use.

Conclusions: A small number of potentially modifiable factors explain most of the postneonatal mortality disparity between Alaska Natives and non-Natives, leaving a relatively small increase in risk. These findings suggest that by targeting Alaska Native women who display these characteristics, the postneonatal mortality gap may be reduced.

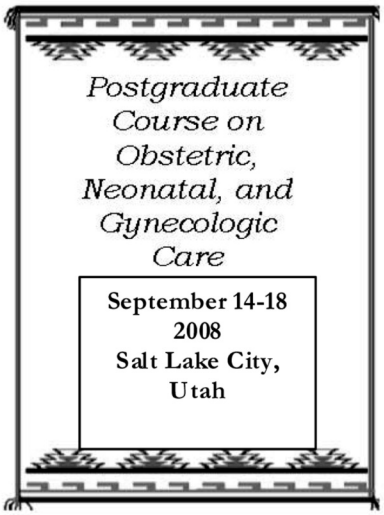
Blabey MH, Gessner BD. Three maternal risk factors associated with elevated risk of postneonatal mortality among Alaska Native population. *Matern Child Health J*. 2008 Apr 4.

Perinatology
Picks George Gilson, MFM, ANMC
Maternal Fetal Medicine Editorial Comment

We would like to clarify a few points from the April Perinatology Picks story entitled: What is this all about the 'minor markers' for Down Syndrome? If women undergo first trimester Down syndrome (DS), and the results are negative (risk <1:300), the system set up at ANMC, "contingent sequential screening," considers them as not requiring further second trimester screening for DS. This is because second trimester quadruple marker screening will increase the number of false positive results if first trimester results are not taken into account. Other screening systems, such as "integrated screening" do use both first and second results do compute a final risk estimate, but this is not the strategy we have chosen to use at ANMC. Despite negative first trimester DS screening, women still need to be screened for open neural tube defects (NTD). We accomplish this at ANMC by having all women undergo a comprehensive fetal anatomic survey at 16-20 weeks. Ultrasound has a 96% sensitivity for NTD, whereas quad screening with maternal alpha fetoprotein (AFP) only has an 80% sensitivity (only 65% in pregnancies not ultrasound dated!). If your service unit is unable to do routine second trimester ultrasounds however, you still must offer women NTD screening with AFP testing, even if they have had negative first trimester DS screening results.

If you have further questions, please contact George Gilson at *gjgilson@anmc.org*.

What is this all about the 'minor markers' for Down Syndrome? April 2008 CCC Corner *http://www.ihs.gov/MedicalPrograms/MCH/M/ob.cfm?module=4_08ft#peri*.



TARGET AUDIENCE

This course is directed to primary care providers, including physicians, clinical nurses, nurse practitioners, nurse midwives, and physician assistants caring for women and infants in Indian Health Service settings and tribally-operated health care facilities.

COURSE DESCRIPTION

The curriculum is designed to encourage a team approach to the care of women and their newborns, with a strong emphasis on the realities and limitations of care in the rural, isolated settings that are common to many Indian health facilities. The text gives a clinically-oriented approach to care in facilities where the nearest specialist may be 50 to 800 miles away. Like the course focus and text, the faculty for the course is experienced with care in the Indian health setting.

OPTIONAL NEONATAL RESUSCITATION PROGRAM (NRP) COURSE

The NRP provider course will be offered in conjunction with the regular course. This four and a half hour course will be held on Sunday morning September 14 from 8am to 12:30pm.

CONTINUING EDUCATION CREDIT

The American College of Obstetricians and Gynecologists (ACOG) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

This activity has been approved for AMA PRA Credit

The Indian Health Service Clinical Support Center (CSC) is accredited as a provider of continuing education for nurses by the American Nurses Credentialing Center (ANCC) Commission on Accreditation.

REGISTRATION

Registration will be on a first come first served basis. Tuition, travel, and per diem expenses are the responsibility of the attendee or the sponsoring Indian health program. Scholarships covering tuition and lodging are available. Register now for the best scholarship opportunity! *Send your completed registration form to* Yvonne Malloy, ACOG, 409 12th Street SW Washington, DC 20024 (phone: 202-863-2580; fax: 202-484-3917).

POSTGRADUATE COURSE ON OBSTETRIC, NEONATAL, AND GYNECOLOGIC CARE

(Please type or print)

☐ PA ☐ CNM
☐ MD/DO ☐ RN
☐ NP ☐ Other _____

Name _____
Last **First**

Work Address _____

Home Address _____

Telephone (Work) _____ **(Home)** _____ **(Fax)** _____

Service unit/health facility name _____

Email Address: _____

Please register me for the postgraduate course to be held September 14-18, 2008. I have checked the appropriate registration boxes below:

☐ **IHS employee:**
☐ **Physician $350**
☐ **Other health professional $250**
☐ **Non-IHS employee:***
☐ **Physician $450**
☐ **Other health professional $350**

☐ **Please enroll me in the NRP course for an additional early registration fee of $75.**

*** Employees of tribes that have not withdrawn their tribal shares should use the IHS scale. If you are uncertain of share status, verify with Carolyn Aoyama at (301) 443-1840. Applications received after session is filled will be placed on alternate list.**

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In collaboration with Veteran Affairs Medical Center, Albuquerque and Indian Health Service Elder Care Initiative

Present

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MEETINGS OF INTEREST

Available EHR Courses

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

The Pharmacy Practice Training Program (PPTP): A Program in Patient-Oriented Practice
July 14 - 17 and August 4 - 7, 2008; Scottsdale, Arizona

The goal of this four-day training program for pharmacists employed by the Indian Health Service or Indian health programs is to improve the participant's ability to deliver direct patient care. This program encompasses the management of patient care functions in the areas of consultation, communication, interviewing techniques, laboratory test interpretation, conflict resolution, physical assessment, and disease state management. The course is made up of case studies that include role playing and discussion, and provides 27 hours of pharmacy continuing education. For more information, contact CDR Ed Stein at the IHS Clinical Support Center; e-mail *ed.stein@ihs.gov* or look for "Seminars & Training" at *http://www.ihs.gov/MedicalPrograms/ Clinical SupportCenter/*. The meeting will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258.

Summer Geriatric Institute
June 19 - 21, 2008; Albuquerque, New Mexico

The New Mexico Geriatric Education Center (NMGEC) announces the Summer Geriatric Institute to be held at the Radisson Hotel and Conference Center, 2500 Carlisle Blvd. NE, in Albuquerque, New Mexico. CME/CEUs are available. The theme this year is Better Outcomes, Healthier Elders: Collaboration in Management of Chronic Disease. National speakers will provide the latest in evolving best practices for heart disease, cancer, diabetes, arthritis and related disorders, dementia, osteoporosis, fibromyalgia, and polypharmacy in the older adult. The last half day of the institute will be provide information from experts on assessing the health literacy of your patient so that communication leads to improved compliance and understanding of the chronic disease process. The Summer Geriatric Institute's registration form can be downloaded at the NMGEC website at *http://hsc.unm.edu/som/fcm/gec* or call (505) 272-4934.

Sexual Assault Nurse Examiner (SANE) Training Program
July 21 - 25, 2008; Aberdeen Area Office
August 18 - 22, 2008; Oklahoma Area Office

The Sexual Assault Nurse Examiner (SANE) workshop is an intensive five-day course to familiarize health care providers with all aspects of the forensic and health care processes for sexual assault victims. This course emphasizes victim advocacy and the overall importance of being a member of the interdisciplinary Sexual Assault Response Team (SART) in the investigative, health care, and prosecution processes. Lead faculty for this course will be Linda Ledray, PhD, RN, a certified SANE trainer and Director of the Sexual Assault Resource Service (SARS) of Hennepin County Medical Center in Minneapolis, MN. Dr. Ledray is a nationally recognized expert and pioneer in the area of forensic nursing. These courses are open to Indian Health Service health care professionals, including nurses, advanced practice nurses, physician assistants, and physicians. For more information about the event, contact LCDR Lisa Palucci at the IHS Clinical Support Center, (602) 364-7777, e-mail *lisa.palucci@ihs.gov*, or visit the CSC website at *http://www.ihs.gov/ Medical Programs/ClinicalSupportCenter/*.

Tenth Annual American Indian Elders Conference
September 3 - 5, 2008; Oklahoma City, Oklahoma

The Indian Health Service is once again sponsoring the Annual American Indian Elders Conference; this year's conference on better health and wellness will look to recognize the wisdom and contributions of "Our Teachers, Our Protectors, Our Elders." Participants will explore pathways for better health and provide positive examples for generations to follow.

The conference will be held September 3 - 5 2008 at the Clarion Meridian Hotel and Convention Center, Oklahoma City, Oklahoma. Onsite registration will begin in the afternoon on Tuesday, September 2.

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.

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

ACOG/IHS "Denver" Course (Now in Salt Lake City, Utah)
Obstetric, Neonatal and Gynecologic Care
September 14 - 18, 2008; Salt Lake City, Utah

This annual women's health update for nurses, advanced practice clinicians, and physicians provides a four-day schedule of lectures, workshops, hands-on sessions, and team building. The large interdisciplinary faculty collaborates to teach clinical and practical topics as they apply in Indian health settings. Many faculty members are your colleagues in IHS and tribal facilities; private sector faculty also bring a wide range of experience providing Indian health care.

Learn the latest evidence-based approaches to maternal and child health services, and share problems and solutions with your colleagues from across Indian country. The course can also serve as a good foundation for professionals who are new to women's health care or new to the Indian health system.

In addition to the basic course, you may sign up for the Neonatal Resuscitation Program, and come away with your certificate from this convenient pre-course program. The opportunity to fulfill continuing education requirements in a concentrated format is significant: with the optional NRP, we can document your participation in seven half-days of education.

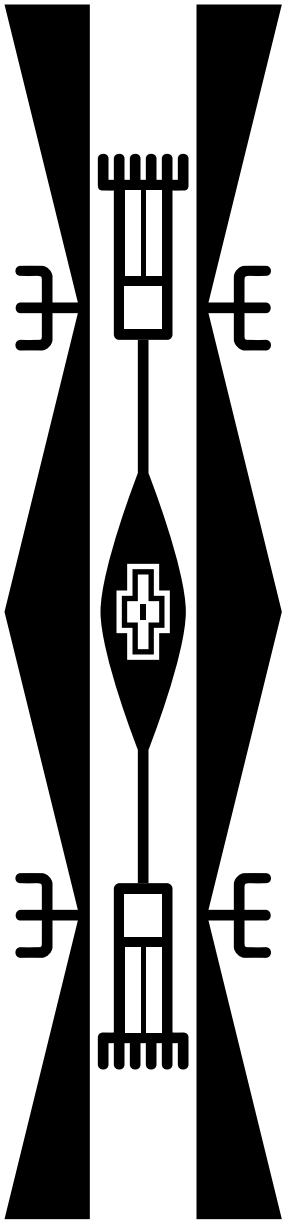
Sign up early! You'll have first chance for support from your facility and coverage for your time in Salt Lake City. Getting these benefits lined up takes time, so don't delay and miss out! In addition, early registration holds your place, and puts you in line for possible availability of scholarship funds.

Watch your mail for the course brochure and registration form. For more information, contact Yvonne Malloy at *ymalloy@acog.org*.

Childhood Obesity/Diabetes Prevention in Indian Country: Making Physical Activity Count!
December 2 - 4, 2008; San Diego, California

The target audience for this national conference includes health care providers, diabetes educators, school nurses, nutritionists, coaches, physical education teachers, fitness program directors, and other individuals involved in community or school based physical activity for Indian children and youth. Faculty for the conference includes a cross section of experts who will address successful physical activity interventions, technology in measuring physical activity outcomes, and selected programs that are successfully addressing childhood obesity and diabetes in Indian country. CME/CEUs will be available. Those interested in proposing a presentation or a poster on their success in addressing physical activity with American Indian children and youth are especially encouraged to apply.

The conference will be held at the Town and Country Resort and Convention Center. Sponsors of this conference include the Indian Health Service, Bureau of Indian Education (BIA), Active Living Research Center at San Diego State University, LIFESCAN, and the University of Arizona. To learn more about the conference, to register for the conference and/or to propose a paper or poster, visit *http://nartc.fcm.arizona.edu/conference*. Alternatively you can also call Ms. Pandora Hughes at the Native American Research and Training Center at (520) 621-5075 for additional information.



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.

Family Practice Physician
Tulalip Tribes Health Clinic; Tulalip, Washington

The Tulalip Tribes Health Clinic in Tulalip, Washington, is seeking two family practice physicians to join our Family Practice Outpatient clinic. We are a six physician outpatient clinic which sits on the edge of Tulalip Bay, 12 miles east of Marysville, Washington. Tulalip is known as an ideal area, situated 30 miles north of Seattle, with all types of shopping facilities located on the reservation. Sound Family Medicine is committed to providing excellent, comprehensive, and compassionate medicine to our patients. The Tulalip Tribes offer an excellent compensation package, group health plan, and retirement benefits. For more information, visit us on the web at *employment.tulaliptribes-nsn.gov/tulalip-positions.asp*. Please e-mail letters of interest and resumes to *wpaisano@tulaliptribes-nsn.gov*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

Live, work, and play in beautiful Seattle, Washington. Our clinic is located just south of downtown Seattle, close to a wide variety of sport and cultural events. Enjoy views of the Olympic Mountains across Puget Sound. The Seattle Indian Health Board is recruiting for a full-time family practice physician to join our team. We are a multiservice community health center for urban Indians. Services include medical, dental, mental health, nutrition, inpatient and outpatient substance abuse treatment, onsite pharmacy and lab, and a wide variety of community education services. Enjoy all the amenities a large urban center has to offer physicians. Our practice consists of four physicians and two mid-level providers. The Seattle Indian Health Board is a clinical site for the Swedish Cherry Hill Family Practice Residency program. Physicians have the opportunity to precept residents in both clinical and didactic activities. The Seattle Indian Health Board is part of a call group at Swedish Cherry Hill (just 5 minutes from the clinic). After hour call is 1 in 10. Program development and leadership opportunities are available.

Seattle is a great family town with good schools and a wide variety of great neighborhoods to live in. Enjoy all the benefits the Puget Sound region has to offer: hiking, boating, biking, camping, skiing, the arts, dining, shopping, and much more! Come join our growing clinic in a fantastic location. The Seattle Indian Health Board offers competitive salaries and benefits. For more information please contact Human Resources at (206) 324-9360, ext. 1105 or 1123; contact Maile Robidoux by e-mail at *mailer@sihb.org*; or visit our website at *www.sihb.org*.

Psychiatrist
Psychiatric Nurse Practitioner
Four Corners Regional Health Center; Red Mesa, Arizona

The Four Corners Regional Health Center, located in Red Mesa, Arizona is currently recruiting a psychiatrist. The health center is a six-bed ambulatory care clinic providing ambulatory and inpatient services to Indian beneficiaries in the Red Mesa area. The psychiatrist will provide psychiatric services for mental health patients. The psychiatric nurse practitioner will provide psychiatric nursing services. The incumbents will be responsible for assuring that basic health care needs of psychiatric patients are monitored and will provide medication management and consultation-liaison services. Incumbents will serve as liaison between the mental health program and medical staff as needed. Incumbents will work with patients of all ages, and will provide diagnostic assessments, pharmacotherapy, psychotherapy, and psychoeducation. Relocation benefits are available.

For more information, please contact Michelle Eaglehawk, LISW/LCSW, Director of Behavioral Health Services at (928) 656-5150 or e-mail *Michelle.Eaglehawk@ihs.gov*.

Pediatrician
Fort Defiance Indian Hospital; Fort Defiance, Arizona

Fort Defiance Indian Hospital is recruiting for pediatricians to fill permanent positions for summer 2008 as well as *locum tenens* positions for the remainder of this year. The pediatric service at Fort Defiance has seven physician positions and serves a population of over 30,000 residents of the Navajo Nation, half of which are under 21 years old! Located at the historic community of Fort Defiance just 15 minutes from the capital of the Navajo Nation, the unparalleled beauty of the Colorado Plateau is seen from every window in the hospital. With a new facility just opened in 2002, the working environment and living quarters for staff are the best

in the Navajo Area.

The pediatric practice at Fort Defiance is a comprehensive program including ambulatory care and well child care, inpatient care, Level I nursery and high risk stabilization, and emergency room consultation services for pediatrics. As part of a medical staff of 80 active providers and 50 consulting providers, the call is for pediatrics only, as there is a full time ED staff. Pediatrics has the unique opportunity to participate in the health care of residents of the Adolescent Care Unit, the only adolescent inpatient mental health care facility in all of IHS, incorporating western medicine into traditional culture. Our department also participates in adolescent health care, care for special needs children, medical home programs, school based clinics, community wellness activities, and other public health programs in addition to clinical services.

Pediatricians are eligible for IHS loan repayment, and we are a NHSC eligible site for payback and loan repayment. Salaries are competitive with market rates, and there are opportunities for long term positions in the federal Civil Service system or Commissioned Corps of the USPHS. Housing is available as part of the duty assignment.

While located in a rural, "frontier" region, there is a lot that is "freeway close." The recreational and off duty activities in the local area are numerous, especially for those who like wide open spaces, clean air, and fantastic scenery. There are eight National Parks and Monuments within a half day's drive, and world class downhill and cross country skiing, river rafting, fly fishing, organized local hikes and outings from March through October, and great mountain biking. Albuquerque, with its unique culture, an international airport, and a university, is the nearest major city, but is an easy day trip or weekend destination. Most important, there are colleagues and a close knit, family oriented hospital community who enjoy these activities together.

For more information, contact Michael Bartholomew, MD, Chief of Pediatrics, at (928) 729-8720; e-mail *michael.bartholomew@ihs.gov*.

Internal Medicine, Family Practice, and ER Physicians
Pharmacists
Dentists
Medical Technologists
ER, OR, OB Nurses
Crow Service Unit; Crow Agency, Montana

The Crow Service Unit is seeking health practitioners to come work with their dedicated staff on the Crow Indian Reservation. The Crow Service Unit consists of a small 24-bed hospital located in Crow Agency and two satellite clinics, Lodge Grass Health Center, located approximately 20 miles south of Crow Agency, and Pryor Health Station, located about 70 miles northwest of Crow Agency.

The hospital is a multidisciplinary facility that includes inpatient, outpatient, urgent care, emergency room, dental, behavioral health, substance abuse, public health nursing, physical therapy, pharmacy, dietary, obstetrics, surgery, and optometry services. Our medical staff includes nine family practice positions, two ER physician positions, one general surgeon, two obstetrician/gynecologists, one podiatrist, one internist/pediatrician, one pediatrician, one radiologist, one nurse midwife, and six mid-level provider positions (NP or PA). Family practice physicians and the internist share the hospitalist responsibilities, and each primary care physician shares the daytime ER call duties. The staff is complemented by contract *locum tenens* physicians for nighttime, weekend, and holiday coverage. OB call is shared between the obstetrician/gynecologists, the midwife and the FP physicians. The two outlying clinics in Lodge Grass and Pryor are primarily staffed by midlevel providers.

The Crow Tribe is a close, proud people. They maintain their own buffalo herd and proudly display their cultural heritage during events such as the well-known Crow Fair. Other points of cultural interest in the "Tipi Capital of the World" are The Little Big Horn Battlefield National Monument, Chief Plenty Coup State Park, and the Little Big Horn College.

For those who enjoy the outdoors, Red Lodge Mountain Resort offers great skiing. The Big Horn Canyon National Recreation Area offers great fishing, camping, and boating fun. The area offers spectacular mountains and mountain activities, and world class hunting and fishing. Billings, Montana, a city of 100,000, is less than an hour away.

For additional information, please contact Audrey Jones, Physician Recruiter, at *Audrey.jones@ihs.gov*; telephone (406) 247-7126; or Dr. Michael Wilcox at *Michael.wilcox@ihs.gov*; telephone (406) 638-3309.

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

The Warm Springs Health and Wellness Center has an immediate opening for a board certified/eligible family physician. We have a clinic that we are very proud of. Our facility has been known for innovation and providing high quality care. We have positions for five family physicians, of which one position is open. Our remaining four doctors have a combined 79 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs in Central Oregon. We have a moderately busy outpatient practice with our doctors seeing about 16 - 18 patients per day under an open access appointment system. Currently we are a pilot site for the IHS Director's Initiative on Chronic Disease Management. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our

Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626.

Primary Care Physicians (Family Medicine/Internal Medicine)
Santa Fe Indian Hospital; Santa Fe, New Mexico

The Santa Fe Indian Hospital is expanding its primary care department and is currently seeking three to four board certified family physicians and general internists to join its outstanding medical staff. We provide care to a diverse population of nine Pueblo communities in north central New Mexico, as well as an urban population in and around Santa Fe, New Mexico. The current primary care staff of five family physicians, three pediatricians, one internist, and three PA/CNP providers work closely with one another to give full spectrum ambulatory and inpatient services. Three nurse midwives, one OB-Gyn, one general surgeon, one podiatrist, one psychiatrist, and one psychologist are also on site.

Family physicians and general internists at the Santa Fe Indian Hospital all have continuity clinics, and are collectively responsible for covering a moderately busy urgent care and same day clinic seven days a week. They also participate in a rotating hospitalist schedule. When fully staffed, these providers will take one in eight night call and will work approximately two federal holidays per year. In our "work hard, play hard" approach to scheduling, hospitalist weeks are followed by scheduled long weekends off, with scheduled days off during the week in compensation for other weekend shifts.

This is an opportunity for experienced primary care physicians to have the best of two worlds: providing care to a fantastic community of patients *and* living in one of the country's most spectacular settings. Santa Fe has long been recognized as a world-class destination for the arts and southwestern culture, with nearly unlimited outdoor activities in the immediate area. As a consequence, our staff tends to be very stable, with very little turnover. Ideal candidates are those with previous experience in IHS or tribal programs who are looking for a long-term commitment. For more information, please contact Dr. Bret Smoker, Clinical Director, at (505) 946-9279 (e-mail at *bret.smoker@ihs.gov*), or Dr. Lucy Boulanger, Chief of Staff, at (505) 946-9273 (e-mail at *lucy.boulanger@ihs.gov*).

Chief Pharmacist
Staff Pharmacist
Zuni Comprehensive Healthcare Center; Zuni, New Mexico

The ZCHCC, within the Indian Health Service, is located on the Zuni Indian Reservation in beautiful western New Mexico. ZCHCC is a critical access hospital with an inpatient unit consisting of 30 plus beds, labor and delivery suites, emergency department, and a large outpatient clinic. The center serves the Zuni and Navajo Tribes. Housing and moving expenses available for eligible applicants. The Zuni are a Pueblo people with rich culture, customs, and traditions. Applicants may contact Cordy Tsadiasi at (505) 782-7516 or CDR David Bates at (505) 782-7517.

Psychiatrist
SouthEast Alaska Regional Health Consortium; Sitka, Alaska

Cross cultural psychiatry in beautiful southeastern Alaska. Positions available in Sitka for BE/BC psychiatrist in our innovative Native Alaskan Tribal Health Consortium with a state-of-the-art EHR in the coming year. Join a team of committed professionals. Inpatient, general outpatient, telepsychiatric, C/L, and child/adolescent work available. Excellent salary and benefit pkg. Loan repayment option. Live, hike, and kayak among snow capped mountains, an island studded coastline, whales, and bald eagles. CV and questions to *tina.lee@searhc.org* or (907) 966-8611. Visit us at *www.searhc.org*.

Family Practice Physician
Sonoma County Indian Health Project; Santa Rosa, California

The Sonoma County Indian Health Project (SCIHP) in Santa Rosa, California is seeking a full-time BC/BE Family Practice Physician to join our team. SCIHP is a comprehensive community care clinic located in the northern Californian wine country. Candidates must currently hold a California Physician/Surgeon license. Inpatient care at the hospital is required. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. For more information, please contact Bob Orr at (707) 521-4654; or by e-mail at *Bob.Orr@crihb.net*.

Family Practice Physician/Medical Director
American Indian Health and Family Services of Southeastern Michigan; Dearborn, Michigan

American Indian Health and Family Services of Southeastern Michigan (*Minobinmaadziwin*) (AIHFS) is a non-profit ambulatory health center, founded 1978. AIHFS provides quality, culturally integrated, medical and preventative dental care in addition to comprehensive diabetes prevention and treatment. All of AIHFS programs integrate traditional Native American healing and spiritual practices with contemporary western medicine in both treatment and prevention.

AIHFS is seeking a full time primary care and family practice physician/medical director. This involves the delivery of family oriented medical care services as well as general professional guidance of primary care staff. The incumbent will also function as the Medical Director, who will collaborate with fellow physicians and the Executive Director on administrative operations of the medical, dental, and behavioral health services.

Please send a cover letter (include the position that you are

applying for, a summary of your interests and qualifications for position), minimum salary requirement, resume, and a list of three professional references with contact information to American Indian Health and Family Services of Southeastern Michigan, Inc., Attn: Jerilyn Church, Executive Director, P.O. Box 810, Dearborn, Michigan; fax: (313) 846-0150 or e-mail *humanresources@aihfs.org*.

Pediatrician
Nooksack Community Clinic; Everson, Washington

The Nooksack Community Clinic in Everson, Washington is seeking an experienced pediatrician to take over the successful practice of a retiring physician. The clinic provides outpatient care to approximately 2,000 members of the Nooksack Indian Tribe and their families. The position includes some administrative/supervisory duties as well as part-time direct patient care. We are seeking a dedicated, experienced pediatrician with a special interest in child advocacy and complex psychosocial issues. This is a full time position with a competitive salary and benefits. There are no on-call, no inpatient duties, and no obstetrics. We currently are staffed with one family practitioner, one internist, one pediatrician, and one nurse practitioner. Additionally we have three mental health counselors, a state-of-the-art four-chair dental clinic, a nutritionist, a diabetic nurse educator, and an exercise counselor. We provide high quality care in an environment that prides itself on treating our patients like family.

The clinic is located in a very desirable semi-rural area of Northwest Washington, renown for its scenic beauty, quality of life, and year 'round outdoor recreation. The beautiful city of Bellingham is 20 minutes away. Vancouver, Canada is less than 90 minutes away, and Seattle is approximately a two-hour drive away. St. Joseph Hospital in nearby Bellingham offers a wide range of specialist and inpatient services, an excellent hospitalist program, as well as emergency care, lab, and imaging services, all easily accessible for our patients.

For further information, please send your CV or contact Dr. MaryEllen Shields at *nooksackclinic@gmail.com*, or write c/o Nooksack Community Health Center, PO Box 647, Everson, Washington 98247; telephone (360) 966-2106; fax (360) 966-2304.

Nurse Executive
Santa Fe Indian Health Hospital; Santa Fe, New Mexico

The Santa Fe Indian Hospital is recruiting for a quality, experienced nurse executive. The 39-bed Santa Fe Indian Hospital is part of the Santa Fe Service Unit providing services in the clinical areas of general medical and surgical care, operating room, urgent care, progressive care, and preventive health. The purpose of this position is to serve as the top level nurse executive for all aspects of the nursing care delivery. As Director of Nursing (DON) services, manages costs, productivity, responsibility of subordinate staff, and programs, as well as providing leadership and vision for nursing development and advancement within the organizational goals and Agency mission.

The Nurse Executive is a key member of the SFSU Executive Leadership Team and has the opportunity to coordinate clinical services with an outstanding, stable, and experienced Clinical Director and Medical Staff. The SFSU includes the hospital and four ambulatory field clinics primarily serving nine tribes. The SFSU earned 2006 Roadrunner Recognition from Quality New Mexico. The hospital is located in beautiful Santa Fe, New Mexico, filled with cultural and artistic opportunities.

Contact CAPT Jim Lyon, CEO at (505) 946-9204 for additional information.

Director of Nursing
Acoma-Canoncito Laguna Hospital; San Fidel, New Mexico

Acoma-Canoncito Laguna Hospital has an opening for a director of nursing. The Acoma-Cononcito Laguna Service Unit (ACL) serves three tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500) and the Canoncito Navajos (1,100). The ACL Hospital is located approximately 60 miles west of Albuquerque, New Mexico. The hospital provides general medical, pediatric, and obstetric care with 25 beds. The director of nursing is responsible for planning, organizing, managing, and evaluating all nursing services at ACL. This includes both the inpatient and outpatient areas of the service unit. The director of nursing participates in executive level decision making regarding nursing services and serves as the chief advisor to the chief executive officer (CEO) on nursing issues. Other responsibilities include management of the budget for nursing services. For more information about the area and community, go to *http://home.Abuquerque.ihs.gov/serviceunit/ACLSU.html.* For details regarding this great employment opportunity, please contact Dr. Martin Kileen at (505) 552-5300; or e-mail *martin.kileen@ihs.gov*.

Primary Care Physician
(Family Practice Physician/General Internist)
Family Practice Physician Assistant/Nurse Practitioner
Kyle Health Center; Kyle, South Dakota

Kyle Health Center, a PHS/IHS outpatient clinic, is recruiting for the position of general internal medicine/family practice physician and a position of family practice physician assistant/nurse practitioner. The clinic is south of Rapid City, South Dakota, and is located in the heart of the Badlands and the Black Hills – an area that is a favorite tourist destination. It is currently staffed with physicians and mid-level practitioners. It provides comprehensive chronic and acute primary and preventive care. In-house services include radiology, laboratory, pharmacy, optometry, podiatry, primary obstetrics/gynecology, diabetic program, and dentistry. There

is no call duty for practitioners. We offer competitive salary, federal employee benefits package, CME leave and allowance, and loan repayment. For further information, please contact K.T Tran, MD, MHA, at (605) 455-8244 or 455-8211.

Internist
Northern Navajo Medical Center; Shiprock, New Mexico

The Department of Internal Medicine at Northern Navajo Medical Center (NNMC) invites board-certified or board-eligible internists to interview for an opening in our eight-member department. NNMC is a 75-bed hospital in Shiprock, New Mexico serving Native American patients from the northeastern part of the Navajo Nation and the greater Four Corners area. Clinical services include anesthesia, dentistry, emergency medicine, family practice, general surgery, internal medicine, neurology, OB/Gyn, optometry, orthopedics, ENT, pediatrics, physical therapy, and psychiatry. Vigorous programs in health promotion and disease prevention, as well as public health nursing, complement the inpatient services.

The staff here is very collegial and unusually well trained. A vigorous CME program, interdepartmental rounds, and journal clubs lend a decidedly academic atmosphere to NNMC. Every six weeks, the departments of internal medicine and pediatrics host two medical students from Columbia University's College of Physicians and Surgeons on a primary care rotation. In addition, we have occasional rotating residents to provide further opportunities for teaching.

There are currently eight internists on staff, with call being about one in every seven weeknights and one in every seven weekends. We typically work four 10-hour days each week. The daily schedule is divided into half-days of continuity clinic, walk-in clinic for established patients, exercise treadmill testing, float for our patients on the ward or new admissions, and administrative time. On call, there are typically between 1 and 4 admissions per night. We also run a very active five-bed intensive care unit, where there is the capability for managing patients in need of mechanical ventilation, invasive cardiopulmonary monitoring, and transvenous pacing. The radiology department provides 24-hour plain film and CT radiography, with MRI available weekly.

The Navajo people suffer a large amount of diabetes, hypertension, and coronary artery disease. There is also a high incidence of rheumatologic disease, tuberculosis, restrictive lung disease from uranium mining, and biliary tract and gastric disorders. There is very little smoking or IVDU among the Navajo population, and HIV is quite rare.

Permanent staff usually live next to the hospital in government-subsidized housing or in the nearby communities of Farmington, New Mexico or Cortez, Coloado, each about 40 minutes from the hospital. Major airlines service airports in Farmington, Cortez, or nearby Durango, Colorado. Albuquerque is approximately 3½ hours away by car.

The great Four Corners area encompasses an unparalleled variety of landscapes and unlimited outdoor recreational activities, including mountain biking, hiking, downhill and cross-country skiing, whitewater rafting, rock climbing, and fly fishing. Mesa Verde, Arches, and Canyonlands National Parks are within a 2 - 3 hour drive of Shiprock, as are Telluride, Durango, and Moab. The Grand Canyon, Capitol Reef National Park, Flagstaff, Taos, and Santa Fe are 4 - 5 hours away.

If interested, please contact Thomas Kelly, MD, by e-mail at *Thomas.Kelly@ihs.gov* or call (505) 368-7037.

Physician Assistant
Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc. (dba Native Health) is a non-profit, community focused health care center centrally located in the heart of Phoenix, Arizona. Native Health has been providing health care services to the urban Indian community in metro Phoenix, since it was incorporated in 1978. Native Health is currently seeking a physician assistant (PA). The PA is a key element in providing quality health care services to patients of all ages. Native Health offers competitive and excellent benefits. For more information, contact the HR Coordinator, Matilda Duran, at (602) 279-5262 or *mduran@nachci.com*.

Family Practice Physicians
Medical Clinic Manager
North Olympic Peninsula, Washington State

The Jamestown Family Health Clinic is seeking two BC/BE full spectrum family practice physicians with or without obstetrical skills. The clinic group consists of five FP physicians, two OB/GYN physicians, and five mid-level providers. The clinic is owned by the Jamestown S'Klallam Tribe and serves tribal members and approximately 9,000 residents of the north Olympic Peninsula. The practice includes four days per week in the clinic and inpatient care at Olympic Medical Center. OMC is family medicine friendly with hospitalists who cover nighttime call and are available to assist with most hospital rounding. Our practice fully utilizes an electronic medical record system (Practice Partner) and participates in the PPRI net research affiliated with Medical University of South Carolina. The clinic serves as a rural training site for the University of Washington Family Medicine residency.

The Jamestown S'Klallam Tribe provides a competitive salary and unbeatable benefit package including fully paid medical, dental, and vision coverage of the physician and family. The north Olympic Peninsula provides boating opportunities on the Strait of San Juan de Fuca, and hiking, fishing, and skiing opportunities in the Olympic Mountains and Olympic National Park. Our communities are a short distance from Pacific Ocean beaches, a short ferry ride away from Victoria, BC, and two hours from Seattle.

Send CV to Bill Riley, Jamestown S'Klallam Tribe, 1033

Old Blyn Highway, Sequim, Washington 98382, or e-mail *briley@jamestowntribe.org*.

The Medical Clinic Manager is responsible for management and staff supervision of the multiple provider clinic in Sequim, Washington. Clinic services include primary care and OB/GYN. Send cover letter and resume to Jamestown S'Klallam Tribe, 1033 Old Blyn Highway; Sequim Washington 98382, Attn: Bill Riley; or fax to (360) 681-3402; or e-mail *briley@jamestowntribe.org*. Job description available at (360) 681-4627.

Chief Pharmacist
Deputy Chief Pharmacist
Staff Pharmacists (2)
Hopi Health Center; Polacca, Arizona

The Hopi Health Care Center, PHS Indian Health Service, is located on the Hopi Indian Reservation in beautiful northeastern Arizona. HHCC is a critical access hospital with an inpatient unit consisting of four patient beds plus two labor and delivery suites, emergency room, and a large outpatient clinic. The HHCC serves the Hopi, Navajo and Kiabab/Paiute Tribes. Housing, sign-on bonus and/or moving expenses are available for eligible applicants. The Hopi people are rich in culture, customs, and traditions and live atop the peaceful mesas. Applications are available on-line at *www.ihs.gov*, or contact Ms. April Tree at the Phoenix Area Office at (602) 364-5227.

Nurse Practitioners
Physician Assistant
Aleutian Pribilof Islands Association (APIA); St. Paul and Unalaska, Alaska

Renown bird watcher's paradise! Provide health care services to whole generations of families. We are recruiting for mid-level providers for both sites, and a Medical Director for St. Paul and a Clinical Director for Unalaska, Alaska.

Duties include primary care, walk-in urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Graduate of an accredited ANP or FNP, or PA-C program. Requires a registration/license to practice in the State of Alaska. Credentialing process to practice required. Knowledge of related accreditation and certification requirements. Minimum experience 2 - 3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Alaska Native Tribal health Consortium. Positions available immediately. Work 37.5 hours per week.

Salary DOE + benefits. Contractual two year commitment with relocation and housing allowance. Job description available upon request. Please send resumes with at least three professional references to Nancy Bonin, Personnel Director, via email at *nancyb@apiai.org*.

Family Practice Physician
Dentist
Northeastern Tribal Health Center; Miami, Oklahoma

The Northeastern Tribal Health Center is seeking a full-time Family Practice Dentist and a Family Practice Physician to provide ambulatory health care to eligible Native American beneficiaries. The Health Care Center is located in close proximity to the Grand Lake area, also with thirty minute interstate access to Joplin, Missouri. The facility offers expanded salaries, excellent benefits, loan repayment options, no weekends, and no call. To apply please submit a current resume, certifications, and current state 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. To apply, send requested documents to Northeastern Tribal Health Center, P.O. Box 1498, Miami, Oklahoma 74355, attention: Personnel. The phone number is (918) 542-1655; or fax (918) 540-1685.

Internal Medicine and Family Practice Physicians
Yakama Indian Health Center; Toppenish, Washington

Yakama Indian Health Center in Toppenish, WA will soon have openings for internal medicine and family practice physicians. The current staff includes four family physicians, two pediatricians, one internist, five nurse practitioners, and a physician assistant. The clinic serves the 14,000 American Indians living in the Yakima Valley of south central Washington. Night call is taken at a local private hospital with 24/7 ER coverage. The on-call frequency is about 1 out of 7 nights/weekends. The area is a rural, agricultural one with close proximity to mountains, lakes, and streams that provide an abundance of recreational opportunities. The weather offers considerable sunshine, resulting in the nearest city, Yakima, being dubbed the "Palm Springs of Washington." Yakima is about 16 miles from Toppenish, with a population of 80,000 people. There you can find cultural activities and a college. For further information, please call or clinical director, Danial Hocson, at (509) 865-2102, ext. 240.

Family Practice Physician
Ilanka Community Health Center; Cordova, Alaska

The Ilanka Community Health Center has an immediate opening for a board certified/eligible family practice physician. Position is full-time or part-time with flexible hours.

Ilanka is a tribally-owned clinic that also receives federal Community Health Center funding. We serve all members of the community. Cordova also has a 10-bed Critical Access Hospital with on-site long-term care beds. Physicians and physician assistants provide services in the clinic and in the hospital emergency department, as well as inpatient and long-

term care.

This is a very satisfying practice with a nice mix of outpatient, ER, and inpatient medicine. Sicker patients tend to be transferred to Anchorage. The clinic provides prenatal care to about 20 patients a year, but the hospital is currently not doing deliveries.

Cordova is a small, beautiful community situated in southeast Prince William Sound. It is a very friendly town. The population of Cordova is 2,500 in the winter and around 5,000 in the summer. The population is 70% Caucasion, 15% Alaska Native, and 10% Filipino, with an influx of Hispanic patients in the summer.

Most of the town is within easy walking distance to the clinic/hospital. The community is off the road system, but connects to roads by ferry and has daily flights to Anchorage and Juneau. This offers the advantages of remoteness with the benefits of connectivity.

We have tremendous access to outdoor sports and activities including excellent hiking, cross country skiing, alpine skiing, ice skating, boating, world class kayaking, heli-skiing, fishing, and hunting. This is the source of Copper River Salmon!

We offer flexible schedules, competitive salary and benefits, and loan repayment options. We would like to hear from you if you are excited about being an old style, small-town, family doctor.

Get more information about Cordova at *www.cordovaalaska.com*, *www.cordovachamber.com*, and *www.cordovaalaska.net/cordovarealty/*. For more information , please contact Gale Taylor, at (907) 424-3622; or *gale@ilanka.org*.

Emergency Department Physician/Director
Kayenta Health Center; Kayenta, Arizona

Kayenta is unique in many ways. We are located in the Four Corners area on the Navajo Indian Reservation as part of the Indian Health Service/DHHS. We have challenging assignments, beautiful rock formations, movie nostalgia, ancient ruins, and wonderful clientele to care for. We are within one hundred and fifty miles from the Grand Canyon and one hundred miles from Lake Powell, which offers boating, fishing, water skiing, and camping. World class skiing resorts and winter sports are just a few hours away in Colorado and Utah. Kayenta is a great place to raise a family with stress free living in a small hometown setting.

Working for Kayenta Health Center provides a unique opportunity. Because of our remote location and underserved population, you may be eligible for loan repayment and can be making a real difference in the world.

We are currently recruiting for a BC/BE emergency department physician and director to work in our 24-hour, eight bed facility. This is a great opportunity to join our multi-specialty ten member medical staff and nursing team. This position will be supported by dynamic outpatient clinical services, including dental, optometry, mental health, public heath nursing, pharmacy, radiology, environmental health services, and nutrition.

If interested in this exciting employment opportunity, please contact Stellar Anonye Achampong, MD, Clinical Director, at (928) 697-4001; e-mail *stellar.anonye@ihs.gov*; or send CV to Human Resources/Melissa Stanley, PO Box 368, Kayenta, Arizona 86033; telephone (928) 697-4236.

Multiple Professions
Pit River Health Service, Inc.; Burney, California

Pit River Health Service is an IHS funded rural health clinic under P.L.93-638 in northern California that provides medical, dental, outreach, and behavioral health. We are seeking several professional positions to be filled. We are looking for a Health Director to administer and direct the program to fulfill the Pit River Health Service, Inc.'s primary mission of delivering the highest possible quality of preventative, curative and rehabilitative health care to the Indian people served; a Dental Director to plan and implement the dental program and supervise dental staff; a Public Health Nurse or Registered nurse seeking a PHN license to provide public health nursing and to coordinate and supervise Community Health Services program; a Behavioral Health Director/LCSW as an active member of an interdisciplinary team providing prevention, intervention, and mental health treatment services to clients; and a Registered Dental Assistant.

Burney is located about 50 miles northeast of Redding, California in the Intermountain Area. The Intermountain Area offers plenty of recreational opportunities such as fishing, hiking, camping, boating, and hunting, with a beautiful landscape. Snow skiing is within an hour's drive away. The Intermountain Area is a buyers market for homes, as well. All available positions require a California license and/or certification. To apply for employment opportunities and for more information, please contact John Cunningham; e-mail *johnc@pitriverhealthservice.org*; or telephone (530) 335-5090, ext. 132.

Family Practice Physician
Internal Medicine Physician
Psychiatrist
Winslow Indian Health Care Center; Winslow, Arizona

The Winslow Indian Health Care Center (WIHCC) in northern Arizona is currently looking for primary care physicians in family practice, internal medicine, and psychiatry. We have a staff of 12 physicians, including a surgeon, and nine family nurse practitioners and physician assistants. We offer comprehensive ambulatory and urgent/emergent care to patients at our health center in Winslow, which includes a state-of-the-art, seven-bed Urgent Care Center completed in 2006. WIHCC also operates two field clinics five days a week on the Navajo Reservation, at Leupp and Dilkon. Our FPs and internist also provide inpatient

care at the local community hospital, the Little Colorado Medical Center, where the FPs provide obstetrical deliveries with excellent back-up from the local OB-Gyn group. The psychiatrist works as part of a team consisting of one full-time psychiatric nurse practitioner, another (part-time) psychiatrist, and five Navajo counselors, providing primarily outpatient services with occasional hospital consults.

WIHCC offers an awesome mix of professional, cultural, and recreational opportunities. It is 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 employees choose to live. Attractive salary and benefits, as well as a team oriented, supportive work environment are key to our mission to recruit and retain high quality professional staff.

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, at *frank.armao@wihcc.org*; telephone (928) 289-6233.

Family Practice Physician
Peter Christensen Health Center; Lac du Flambeau, Wisconsin

The Peter Christensen Health Center has an immediate opening for a board certified family practice physician; obstetrics is optional, and call will be 1/6. The facility offers competitive salaries, excellent benefits, and loan repayment options; all within a family oriented work atmosphere.

The Lac du Flambeau Indian Reservation is located in the heart of beautiful northern Wisconsin. The area's lakes, rivers, and woodlands teem with abundant wildlife, making it one of the most popular recreational areas in northern Wisconsin. The area boasts fabulous fishing,
excellent snowmobiling, skiing, hunting, golf, and much more. Four seasons of family fun will attract you; a great practice will keep you.

For specific questions pertaining to the job description, call Randy Samuelson, Clinic Director, at (715) 588-4272. Applications can be obtained by writing to William Wildcat Community Center, Human Resource Department, P.O. Box 67, Lac du Flambeau, Wisconsin 54538, Attn: Tara La Barge, or by calling (715) 588-3303. Applications may also be obtained at *www.lacduflambeautribe.com*.

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

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has an opening for a full-time primary care physician starting in January 2008. This is a family medicine model hospital and clinic providing the full range of primary care -- including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics -- with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 14 physicians, one PA, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

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

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page), or by e-mail at *john.bettler@ihs.gov*. CVs can be faxed to (505) 782-4502, attn: John Bettler.

Primary Care Physicians (Family Practice, Internal Medicine, Med-Peds, Peds)
Psychiatrists
Pharmacists
Nurses
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 highly qualified health care professionals 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 (970) 882-1550 or (928) 674-7607; e-mail *heidi.arnholm@ihs.gov*.

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 Darren Vicenti, MD, Clinical Director at (928) 737-6141 or *darren.vicenti@ihs.gov*. CVs can be faxed to (928) 737-6001.

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/AreaOffices/Billings/FtPeck/index.asp*. Fort Peck tribes also can be found on *www.fortpecktribes.org*, and the Fort Peck Community College on *www.fpcc.edu*. 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.jones@ihs.gov*. We look forward to communicating with you.

Pediatrician
Family Practice Physician
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 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 positions, two physician assistants, and one nurse practitioner, and has implemented the Electronic Health Record in the outpatient clinic. The service unit also has a full-time staffed emergency medical services program. The staff is complemented by contract locum tenens physicians for weekend emergency room coverage.

The medical staff is supported by and works with a staff of

nurses, behavior health personnel, physical therapist, lab and x-ray personnel, pharmacists, dentists, administrators, housekeepers, supply specialists, and contract practitioners to provide the best possible care to patients. The staff works as 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 *audrey.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
Dentists
Pharmacists
Crownpoint Comprehensive Healthcare Facility; Crownpoint, New Mexico

The Crownpoint IHS facility has openings for two family practitioners with low risk obstetric skills (we will consider candidates without OB skills), two pharmacists, and two general dentists. 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 HPSA 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 a total of 16 dental chairs, optometry, and mental health services, as well as on-site pharmacy, laboratory, radiology, and ultrasonography. Our medical/dental staff is a collegial and supportive group including ten family physicians, two pediatricians, an obstetrician/gynecologist, a psychiatrist, three PAs, three FNPs, four dentists, 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/Canyonlands

National Parks (four hours), Flagstaff (three hours) and the Grand Canyon (five hours).

For more information, contact Harry Goldenberg, MD, Clinical Director, at (505)786-5291, ext.46354; e-mail *harry.goldenberg@ihs.gov*; or Lex Vujan at (505) 786-6241; e-mail *Alexander.vujan@ihs.gov*.

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.org*.

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 *michelle.francis@tchealth.org*.

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*.

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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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