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All I Wanted Was an Injury Report: Opening the "Pandora's Box" of Contract Health Services

Introduction to the July 2008 Special Issue on Injury Prevention

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In July and September 2007, The Provider published two special issues on injury prevention. Thanks to The Provider s editor, Dr. John Saari, injury prevention will be the focus of each July issue in the future. The articles in this issue illustrate many different facets of the field of injury prevention: epidemiology, health services delivery, economics, and the prevention of intentional and unintentional injuries. Clinicians will be especially interested in the discussions of clinic-based interventions for elder falls prevention, and improving information flow within the contract health care system. Public health advocates will be encouraged to learn of the successes of a school-based bullying prevention initiative. Each article has implications well beyond the arena of injuries. Successful interventions involving collaboration among tribes, IHS, and schools; improved data reporting and reimbursements to tribal health clinics; and self-assessment approaches to enhance preventive services are of interest to everyone who strives to improve the health and well-being of American Indian and Alaska Native communities.

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As a public health nurse and outreach director for a tribal health clinic (Feather River Tribal Health or FRTH), I wanted to develop an injury prevention program targeting the most frequent and serious injuries among the 11,000 American Indians/Alaska Natives in our service population. I immediately discovered that data on the extent and causes of injury were shockingly scarce. During the three years 2004 - 2006, the annual number of injury visits was only 453. More than half (53%) of the injury visits did not have a specific cause of injury listed, but were coded as "other causes in our Resource Patient Management Information System (RPMS) database. When I searched for the reasons underlying this absent information, I opened a Pandora s box of issues surrounding medical data, provider payments, and contract health services (CHS). The single most glaring problem I discovered was that discharge summaries from CHS hospitals, and clinical summaries from CHS referral providers, were not required prior to payment by FRTH.

Contract Health Services

The contract health services (CHS) program provides funds to purchase health care services for eligible American Indians and Alaska Natives (AI/AN) when those services are not available through direct IHS or tribal services. These services include hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services such as ground and air ambulance.[1] Payments for the treatment of injuries are the single largest expenditure for IHS CHS funds.

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The 2002 contract health service expenditure for care of injuries and poisonings was roughly **$54.3 million**. The average cost for each hospitalized (inpatient) injury victim in 2002 was $14,378; the average outpatient cost per patient was $752. Contract health services (CHS) account for about 23% of IHS personal health care benefit expenditures. IHS reports that 17% of all contract care expenses for inpatient care, and 16% for outpatient care, were for the care of injuries and poisonings.[2]

For tribally-operated facilities, the movement of data within the contract health care system depends on whether the facility uses a "fiscal intermediary" or not (Table 1).[3] Table 1 only hints at the complicated nature of CHS. Table 2 is a list of abbreviations to help decipher information about CHS.[4]

Table 1. Data Movement Comparison: Differences between tribally operated (i.e., 638) facilities that use the CHS FI and those that do not use the CHS FI.

Tribally Operated Facilities using CHS/MIS and not the FI	Tribally Operated Facilities using the FI
In the CHS/MIS application, the payment destination is set to "I" (IHS) in order to create the statistical (Type 7) record for NPIRS.	In the CHS/MIS application, the payment destination is set to "F" (CHS FI) in order to create the electronic purchase order (Type 3, 4, and 5 records) for the CHS FI.
The tribe coordinates the benefits and makes payment to the provider.	The Area Office sends a separate file to the FI.
The tribe posts the final payment and medical data into CHS/MIS application.	The CHS FI coordinates the benefits and makes payment to the provider.
CHS data from the facility are sent to the Area Office for consolidation and export to NPIRS.	The CHS FI posts the payment and medical data into its own application (IHSCPS).
	The CHS FI transmits EOBRs to the Area Office.
	The Area Office downloads the EOBRs and transmits them to the respective facilities.
	The facilities upload the EOBRs into CHS/MIS in order to update its existing purchase orders.
	NPIRS receives data in the STATRECS or DENTSTAT export from CHS FI.

Table 2. Contract Health Services (CHS): Abbreviations

EPO	Electronic Purchase Order
FI	Fiscal Intermediary
MIS	Medical Information System
CHS/MIS	A facility-based, automated document and fiscal management system for the IHS CHS Program. It is a component of RPMS.
NPRIS	National Patient Information Reporting System, the current IHS national repository responsible for generating national level reports including user population and workload reports
PCC	Patient Care Component of RPMS. Provides for entry of visit data which forms the core dataset used by most of the RPMS applications.
RPMS	Resource Patient Management System
EOBR	Electronic Explanation of Benefits Reports
STATRECS files	CHS outpatient and inpatient data
DENTSTAT files	CHS dental data
CORE	the IHS finance system
RCIS	Referred Care Information System
IHSCPS	Indian Health Service Claims Processing System

Methods

To get a better understanding of the CHS referral and payment process, and the flow of information, I performed a literature search and conducted numerous interviews. Among those interviewed were the FRTH Chief Executive Officer, RPMS Site Manager, CHS clerks, the California Area RPMS consultant, and the Customer Service Supervisor of Blue Cross/Blue Shield of New Mexico (CHS Fiscal Intermediary). Calls to local health insurance providers (United Health Care and Kaiser) were not returned. I also contacted several other tribal health clinics in the California Area to discuss their CHS policies and procedures.

This project, and its publication, were approved by the Board of Feather River Tribal Health.

Discoveries

The Government Performance Results Act (GPRA) requires FRTH to maintain complete and accurate health care data for the AI/ANs that we serve, including their contract health services. However, it is extraordinarily difficult to get detailed medical information from hospitals and specialty providers. To begin with, there are no hospitals or other health care facilities directly administered by the California Area Indian Health Service (IHS). Therefore, AI/ANs seeking medical treatment in California almost always receive medical treatment for severe injuries through CHS. Contract care hospitalizations for injured FRTH patients occur at six different hospitals spread across three counties. Patients are also transported to one of four more distant trauma centers. Data on hospitalizations of our patients therefore must come from at least ten different hospitals outside the IHS system of care.

Remarkably, the referral hospitals and providers receive

payment from FRTH even if they have not submitted clinical reports or complete documentation of the nature and cause of injuries treated. Hospitals use the HCFA 1500 or UB92 standardized forms for billing. These forms have fields for ICD-9 diagnostic codes. However, hospital coders often enter only a nature-of-injury code (e.g., "broken arm"), but do not include an external cause of injury code (E-code) that would reveal how and where the arm was injured.[5] This is certainly the case when providers do not provide details about the cause of injury in the medical chart. California law requires a discharge summary to include a principle diagnosis and external cause of injury.[6] However, if the patient met CHS eligibility criteria, and notified FRTH within 72 hours of their hospitalization or ER visit, FRTH paid the bill. FRTH did not require a report to accompany the bill for payment. Similarly, FRTH paid the bills submitted by referral specialty providers, regardless of whether any clinical information accompanied the bill, if the referral had been approved by FRTH's CHS office.

Several other factors contribute to incomplete medical data at tribal clinics. If a patient has private insurance, Medicare, or Medi-Cal (California's Medicaid program), FRTH may not ever receive a report of treatment. Another data collection difficulty is the fear of violating "HIPAA" policies. The Health Information Portability and Accountability Act (HIPPA) is an important law that protects patients' private health information. Even though HIPAA restrictions do not apply to treatment, payment, or authorization issues, there is still a fear among medical records and administrative staff that they could lose their job if they release private medical information.

Despite numerous attempts, I could not identify any national IHS or fiscal intermediary CHS bill-paying requirements or quality control procedures. I could not find any national standards for CHS coverage. The Contract Health Services Data Quality Work Group web pages do not refer to requirements for reporting critical information, such as E-codes, to referring tribal facilities.

My discussions with staff at several California tribal health programs revealed a variety of approaches to CHS coverage and payment. Some clinics refused to pay CHS bills if the visit occurred during clinic hours, was not an emergency, or was related to illegal drug use, alcohol abuse, or illegal activity. Several clinics would deny payment if complete reports did not accompany the bill or if forms were not complete, including all relevant ICD-9 codes. Some clinics would refuse to refer patients for follow-up visits until reports were received (a strategy that works only if there are multiple providers serving an area).

Another problem I discovered was the unreliable coding of race/ethnicity in hospital reports to the State of California. Many AI/AN patients are misclassified as other races. The causes for this misclassification are varied. Some hospital registration personnel are uncomfortable asking questions regarding race. They may look at someone and mark the box they feel meets the patient's race and not ask specifically, what race they are. Some hospital systems have previously misidentified patient's race in their records. Therefore subsequent visits are always registered with the race they originally had entered in the system. Trying to correct a patient's misidentified race is a complicated process; most times, my attempts are unsuccessful.

Conclusions and Recommendations

Problems with CHS administration and data collection for injury cases exist within tribal health care entities, the IHS, and their fiscal intermediaries. The resulting misinformation and lack of information impacts the provision of preventative services as well as program planning. Reliable injury information is vital to define the extent of injuries as a community health problem, identify risk factors, and develop effective prevention programs. Timely hospital discharge summaries and referral reports from providers are also critical to quality patient care.

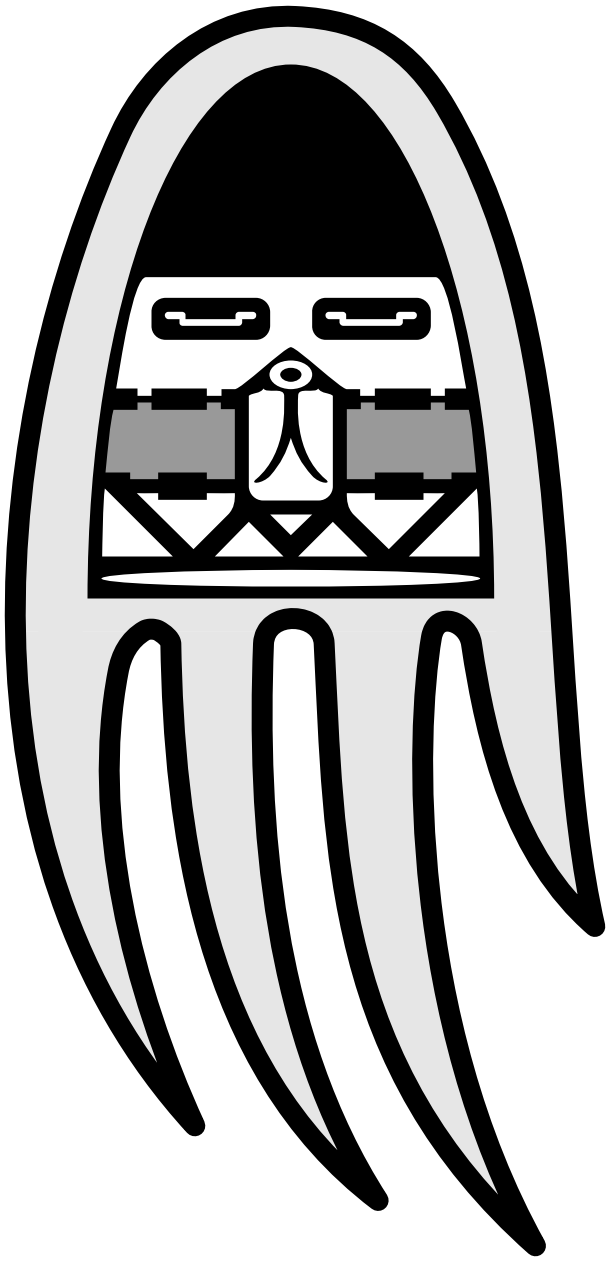
Health programs can address some of these gaps through standardized scrutiny of bill payments, discharge information requirements, and integration of CHS information into existing surveillance systems. The FRTH Health Board now requires hospital discharge reports and emergency room summaries to accompany bills before payment. FRTH also implemented procedures to track CHS hospital visits and admissions. FRTH providers are now required to report ER visits or hospitalizations to CHS clerks for follow-up and to obtain documentation. Reviews of injury reports identify FRTH providers who submit incomplete data (e.g., cause of injury, circumstances, location of occurrence). This information guides educational sessions to emphasize the importance of reliable injury data and the impact of missing data.

Dental providers are being educated about documentation of injuries in the electronic health records (EHR) to better capture visits that are injury-related. Data entry clerks are being trained about how to recognize injury related visits, and what data components should be captured. FRTH recently developed a Referred Care Information System (RCIS) data entry policy for 72 hour notifications. This will help identify missing documentation. We are also looking at implementing and evaluating use of a separate injury reporting form at check-in. This should improve longitudinal patient care for injury victims while providing more complete data on injuries. Coding certification and annual refresher courses for medical records personnel are additional priorities.

Improved coding will result in better data collection and improve data accuracy. Requiring standardized processes for data entry for clerks, medical technicians, nurses and providers will improve injury data collection. Implementing minimum standards of documentation for outside contracted services will also improve overall data collection, along with data related to injury issues. Keeping consistent and complete 72 hour

records may also lead to better data collection.

There are likely to be additional benefits to implementing these steps. Increased documentation will allow for improved reimbursements to FRTH on behalf of patients who qualify for private health insurance or federal health programs such as Medicare and Medicaid. Improved reimbursements can be used to hire additional staff, purchase equipment and supplies, and improve facilities. Saving contract health care dollars by having more accountable mechanisms for payments involving injury victims will mean more money to spend on extending and improving care for clients with other needs, from diabetes services to immunizations.



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Development of a Web-Based Occupant Protection Data Collection and Warehouse System for Use in Indian Country

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Introduction

Motor vehicle injuries continue to be the leading cause of death for American Indians and Alaska Natives (AI/AN) ages 1 - 44 and the third leading cause of death overall.[1] The use of lap and shoulder belts has been shown to reduce the risk of fatal injury to front-seat passenger car occupants by 45 percent and the risk of moderate-to-critical injury by 50 percent.[2] A report by the National Highway Traffic and Safety Administration (NHTSA) estimated that over 76% of fatally injured occupants on tribal reservations were not wearing seatbelts at the time of the crash.[3] National seat belt use rates in Indian Country have been estimated using a sample of reservations.[4,5] However, very limited information for seat belt use rates on tribal reservations and rancherias in California is available.

The Indian Health Service (IHS) has been collecting seat belt use data over the past two decades. During this time there has been increasing need to develop and integrate standardized data collection and reporting methods to ensure validated use rates for comparison at the local, IHS Area, and national levels. Reflecting the importance of motor vehicle injuries as a cause of death and suffering among AI/AN communities, the IHS Injury Prevention Program has established a Government Performance and Results Act (GPRA) Performance Measure for FY 2008 to "administer a recognized occupant protection survey in 11 IHS Areas, in order to establish a baseline for restraint use."

In 2004, the IHS contracted with the University of North Carolina (UNC) Injury Prevention and Research Center to develop a protocol that could be used for all of Indian Country nationwide. This protocol was designed to comply with the NHTSA standards issued in 1998, 23 C.F.R. Part 1340 -- *Uniform Criteria for State Observational Surveys of Seat Belt Use*, and relies on probability-based sampling procedures to determine a use rate that is representative of the desired population. However, a standardized method for recording and reporting seat belt use observation data has not been implemented by the IHS.

In the absence of a dependable electronic data tracking and reporting mechanism, many seat belt use rate records for Indian Country in California have been lost. As a result, the California Area Indian Health Service (CAIHS) has had difficulty in providing this information to IP program planners, state and regional partners, potential funders, or even to the communities where the data were originally collected.

With 109 federally recognized tribes in California and over 30 Indian health programs (service units), the task of coordinating the collection of paper forms and incorporating them into a local or Area level report is not plausible, given current processes. Numerous problems associated with recordkeeping, reporting, and archiving of paper forms makes the establishment of an Internet-based electronic reporting system for seat belt use for reservations in California paramount.

The CAIHS epidemiologist and the IHS Web Development Team developed the Occupant Protection Use System (OPUS) to allow for real time storage and retrieval of survey results. The OPUS has been designed so that observation data can be retrieved by a variety of users at various locations. The OPUS will be used to securely archive observation data and will facilitate the establishment of a baseline rate for seat belt use on Indian lands in California. Exact observation locations can be pinpointed for reference in future restraint use surveys and will provide valid comparisons. The OPUS is an Internet-based system with password security that enables access levels for end-users to be controlled.

A web-based collection and warehouse system with security features would encourage wider participation by AI/AN communities in obtaining usage data; and allow targeted comparisons among reservations and with state and national rates.

Methods

To assist in determining the need for a standardized data repository system within the California Area, site visits were made to two service unit injury prevention programs. The protocols for seat belt surveys, available historical data, completeness of data, and the ability to establish use rates were reviewed. The two programs visited were the only known California Indian health programs to have been collecting seat belt use data for at least five years.

Two data fields were added to the standardized seat belt use form to ensure complete information was captured for

future utilization and flexibility of the OPUS system. The additional data fields capture reservation name, and longitude/latitude. The reservation data field will assist in tracking seat belt use rates for each reservation over time. Prior to the addition of this field there was no specific reference to a reservation but rather an "observation location," which was non-specifically defined in the UNC/IHS protocol. The longitude/latitude data fields can be referenced in the future to determine the exact location that the observation occurred. The accuracy of this information will be critical in future surveys for comparison of data for the 107 reservations within the CAIHS. Additionally, the survey format was modified to match all data fields required within OPUS. Lastly, the mathematical formulas on the data collection form were removed because field testing of observers attempting to manually perform these calculations revealed frequent errors. Use rates are automatically calculated within OPUS.

Key informant interviews and web-based surveys were completed among thirteen Area and local IP coordinators. This provided survey information from 8 of the 12 IHS Areas. These surveys and interviews were used to assess current methods of data storage and reporting and the potential for OPUS utilization across the IHS network. In addition, feedback from IHS injury prevention specialists during IP program meetings was an integral component to the development and implementation of OPUS.

After completing the needs assessment, the IHS Web Development Team in collaboration with the CAIHS epidemiologist, agreed upon overall system use and functionality. Further details were addressed such as individual data fields and their respective structure, report functions and capabilities, user authentication to ensure tribal sovereignty, and implementation of administrative functions for IHS headquarters and Area injury prevention coordinators.

The application building and testing phase occurred over a four-month period. It included extensive structural (alpha) testing to ensure complete system functionality prior to software implementation. Once alpha testing was completed, two California area Indian health programs (service units) beta tested the system. All historical data were entered by the health programs, and select CAIHS field staff also entered observation data.

Results/Uses

The initial needs assessment revealed that observational seat belt use records for the two California tribal programs were incomplete and in various hard copy formats. There were no electronic datasets available to review. Available records consisted mostly of original field survey sheets with summarized data sheets interspersed in hardcopy form. Some of the data that had previously been reported to CAIHS were not retrievable and it is likely that other data that were previously collected, but not reported to CAIHS were also missing. Static maps were developed by one of the programs in an attempt to visually demonstrate the observation site, but the maps were of little value because they did not accurately correspond to the narrative descriptions annotated on the field observation sheets.

The key informant interviews revealed that there was wide variation in the methods of collecting and reporting seat belt observation data across the eight IHS Areas. All the interviewees agreed that an electronic data reporting system that can produce standardized seat belt use rates would be beneficial to their program.

All of the respondents to the web-based survey tool indicated that they perform seat belt observations for their respective Areas and service units (A/SU). Eight of 12 (67%) reported that they follow the UNC/IHS protocol in data collection methods. Of the respondents who do not use this protocol, two are in the process of adopting the protocol while the two others use variations of the protocol (Table 1).

Table 1. Responses concerning observation survey data collection method

	Yes	No	Comments
Does your Area/service unit utilize the UNC/IHS protocol?	8 (67%)	4 (33%)	• "Encourage use, but not required" • "UNC/IHS & IP Level 1 protocol" • "Plan to implement soon" • "Use a one-hour or 100 vehicle count observation of front seat occupants only"

To determine seat belt use rates, five A/SU IP coordinators utilize paper-based methods, five utilize Excel, and two use either mixed methods or other software systems such as EpiInfo. Key informant interviews revealed that the majority of IP coordinators were not satisfied with their current reporting system and expressed interest in the development of a web-based system that would provide a method to consistently track improvements (Table 2).

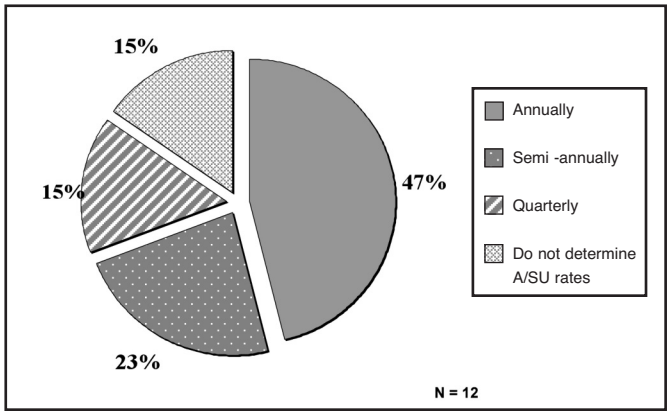
Table 2. Responses concerning satisfaction of methods and data availability

How satisfied are you with your current reporting system?
• "Our current methods are incomplete and do not easily allow for calculation of an Area-wide rate." • "Current IHS system tracks injury prevention activities; original purpose was not intended to determine seat belt use rates." • "…missing data, different formats…." • "…not standardized or consistent…." • "There is a significant need for us to be able to determine a seat belt use rate that is meaningful at the Area and local level."

When asked about the availability of Area-wide or national seat belt use rates for Indian country, 64% of IP coordinators were dissatisfied, and specific comments were made regarding the need and usefulness of this information at the program level. The frequency of determining local seat

belt use rates varied significantly, but the majority of A/SUs calculate rates on an annual basis (Figure 1).

Figure 1. Frequency of conducting seat belt use surveys



The website request process was initiated and completed within three months. Key meetings and planning discussions between the CAIHS epidemiologist and an IHS web developer were conducted to ensure there was agreement as to what data elements were essential to the success of this system and programmatically feasible.

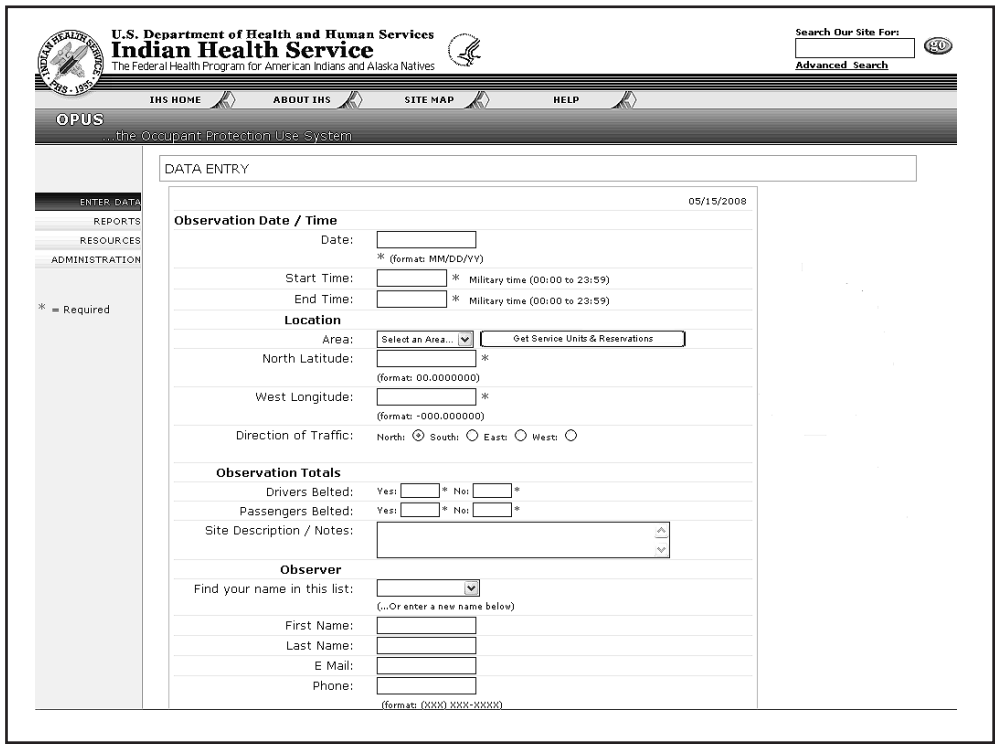
After the system was alpha tested it became available for beta testing within CAIHS for actual observation records and was tested by a variety of field personnel with various levels of education. The system was further refined based on the feedback from this testing process.

Discussion

OPUS is an Internet-accessible data warehouse system that allows for real time storage and retrieval of survey results (Figure 2). The OPUS system is categorized into four main components; data entry, reports, administration, and resources. The data entry section allows users to include all required data fields as annotated on the paper-based field form. The entry screen features pre-formatted data fields (date, time, longitude and latitude) to minimize clerical entry errors. This section offers pick lists for the user to select the corresponding service unit and reservation where the observation occurred. These fields are a key feature to providing queries in the reports section. More importantly, the OPUS eliminates the need for any mathematical calculations by the person entering data. The person simply reports the raw counts for the observations and OPUS performs all of the calculations to determine the rates. In addition, seat belt survey records can be categorized as "interim" or "non-interim" so that observations that are collected for special projects can be distinguished from observations that are used solely to establish local or area seat belt use rates.

The reports section provides a variety of methods to sort the data using specified attributes. General users are able to generate reports by A/SU, by reservation, by specified time period, or by a combination of those parameters. Each record is displayed individually, and point-and-click functionality exists to allow the user full detail of each record, mapping capability, as well as functionality to communicate with the respective observer by e-mail. Reports provide an aggregate display of driver/passenger use trends including totals, averages, min/max, and percent. OPUS also allows users to export the dataset into an excel spreadsheet for additional data analysis and management.

Figure 2. Occupant Protection Use System (OPUS): Data entry screen shot



The administration module allows the data to be managed in a hierarchical manner. Administrators are allowed access to record editing as well as record and activity management. In addition to this function, OPUS incorporates a user-authenticated system that only allows predefined users to view specific data sets. The resources section holds key resources information for IP coordinators, OPUS frequently asked questions, as well as local best practices and announcements related to seat belt observations.

All data fields were carefully considered prior to development and integration. Further planning is necessary to incorporate additional features and utilization. Expansion of the system to include elements such as geospatial tracking of observation locations and traffic volume assessments may be considered as a logical next step. In addition, software to determine statistical significance, the addition of a child restraint tracking component, and the integration of a geographical information system (GIS) component would be well suited.

OPUS provides solutions for myriad problems that had previously hampered efforts to collect and store standardized seat belt use information for reservations and rancherias in California. Data entry for seat belt use observations is now possible by authenticated users from any basic Internet terminal. Results from the surveys will be safely stored and backup in redundant systems maintained by strict IHS security protocols. The resulting database can be used by injury prevention specialists at a variety of levels and can be accessed simultaneously from remote locations for program collaboration and technical assistance.

Conclusions

The development of a data warehousing system is a valuable tool in helping to establish a credible baseline rate for seat belt use for the 109 federally recognized tribes in California.

OPUS could be a model data system for other IHS Areas. It provides easy access to occupant restraint use data, consistency in methods, and allows timely reporting of results to be used by public health practitioners, local communities, and decision makers. The development process for OPUS may have implications for the establishment of other public health data collection systems in Indian Country.

OPUS is not a replacement for cross-sectional surveys that are used to establish national and regional use rates and involve standardized sampling and uniformly-trained observers (just as state vital statistics data cannot replace the US Census). However, OPUS will serve as a credible measurement tool to track program results and engage community leaders in the important issue of occupant protection.

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Lac Vieux Desert Tribe and Watersmeet Township Reduce Physical and Psychological Bullying

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Introduction

Prevention of violence-related injury is a priority for the Bemidji Area Indian Health Service (BAIHS) Injury Prevention (IP) Program. From 1999 - 2004, homicide and suicide accounted for one-third of the years of potential life lost due to injury in BAIHS American Indian communities.[1] They are, respectively, the second and fourth leading causes of injury-related mortality in our Area.

Youth violence cuts across all geographic and socioeconomic boundaries. It is devastating and costly to individuals, families, communities, and society. It disproportionately harms the children, teens, and young adults residing within our communities and attending our schools. Almost thirty percent of youth in the US are estimated to be involved in bullying, either as a bully, a target of bullying, or both.[2] In a recent national survey of students in grades six through ten, thirteen percent reported bullying others, eleven percent reported being the target of bullies, and another six percent said that they bullied others and were bullied themselves.[2]

Bullying takes on different forms in male and female youth. While both male and female youth say that others bully them by making fun of the way they look or talk, males are more likely to report being hit, slapped, or pushed. Females, on the other hand, are more likely than males to spread gossip, encourage others to reject or exclude another girl, and be the targets of rumors and sexual comments.[3]

While many people believe that bullies act tough in order to hide feelings of insecurity, in fact, bullies tend to be confident, with high self-esteem.[4] They are generally physically aggressive, with pro-violence attitudes, and are typically hot-tempered, easily angered, and impulsive, with low tolerance for frustration. Bullies have a strong need to dominate others and usually little empathy for their targets. Male bullies are often physically bigger and stronger than their peers are.[4] Bullies tend to get in trouble more often and tend to dislike or do more poorly in school than their counterparts. Surprisingly, bullies seem to have little difficulty in making friends. Research shows that typically their friends share the same pro-violence attitudes and problem behaviors. Friends of bullies often are followers that do not initiate bullying, but participate in it.[5]

Unlike their counterparts, victims of bulling are usually anxious, insecure, and cautious. They have a low esteem and rarely defend themselves. They are often socially isolated and lack social skills. One study found that the most frequent reason cited by youth for another youth being bullied is that they "did not fit in."[6]

Some research indicates that there is a strong relationship between bullying and later legal and/or criminal problems. In one study, sixty percent of those individuals characterized as bullies in grades six through nine had at least one criminal conviction by age 24.[7] On the other hand, bullying can lead targeted children and youth to feel anxious, insecure, tense, socially isolated, withdrawn, depressed, and afraid. These feelings can affect their performance in school, and even lead them to avoid school altogether. If bullying continues over a long period, it may begin to affect a child's self-esteem and feelings of self-worth. Research has found that, years after the bullying has stopped, victims of bullying have higher levels of depression and poorer self-esteem than their peers.[8]

Local Problem

The Lac Vieux Desert (LVD) Band of Lake Superior Chippewa Indians is located within the Watersmeet Township in the Upper Peninsula of Michigan. The Watersmeet Township population is 1,488 and is comprised of a tribal population of 535. Fifty-four percent of the school's 240 K-12 student enrollment is American Indian.

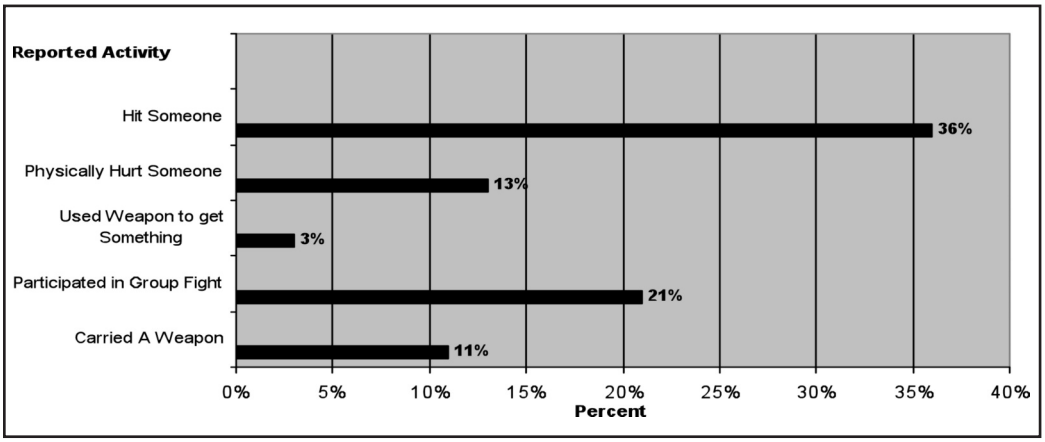
In May 2000, the Watersmeet Township School (WTS) participated in the Search Institute Profile of Student Life: Attitudes and Behaviors survey. Search Institute is a nonprofit organization that promotes positive behaviors and attitudes in communities and youth. Using SEARCH survey tools, school districts and communities can gain a better understanding of their youth and how to protect them from high-risk behaviors. The comprehensive survey is based on the SEARCH 40 Developmental Asset framework that considers external assets (e.g., support, empowerment, boundaries and expectations, and constructive use of time) and internal assets (e.g., commitment to learning, positive values, social competencies, and positive identity).[9] The survey was administered to the 6-12 grade students at WTS with the following results:

- Sixty-nine percent of students felt they did not have a caring school climate
- Twenty-four percent of students reported being victims of one or more incidents of violence the prior year

- Seventy-seven percent of students (grades 9-12) felt the school did not provide clear rules and consequences

The profile documented student-reported violent behaviors, including the fact that over one-third reported that they had hit another person. (Figure 1).

Figure 1. Search Institute Developmental Assets Survey Profile for Watersmeet Township Scool Children Who Reported Engaging in Violence Related Activity or Risk Taking, May 2000



The results of the survey led the LVD Tribe and the Watersmeet Township to collaborate in achieving a common goal: reducing the violence and bullying behaviors of the students within the Watersmeet Township K-12 school and communities. The Tribal Behavioral Health (TBH) Program Director served as the coordinator for the tribe and the assistant principal of the WTS served as the coordinator for the school to achieve this goal.

The co-coordinators worked together to develop and plan a three-year project for the implementation and success of an anti-bullying program. Their goal was to create a safe and caring environment by reducing the incidence of violence within the school youth population. They researched several anti-bullying programs to determine that were proven and effective, and which would fit their local schools needs. Based upon their criteria, the *Creating Caring Communities (CCC) Bully-Proofing Your School (BPYS)* program was selected.

CCC BPYS is a system-wide prevention program that provides a "comprehensive school climate change" in which students can feel safe and secure. BPYS provides three curriculums for elementary, middle, and high schools. It uses a team approach that involves one-hundred percent of the school staff and students and includes parents and the community.

A four-year study completed by the College of Criminal Justice, Sam Houston State University, located in Huntsville, Texas, determined the BPYS curriculum to be a promising intervention at the elementary and middle school grade levels. The National Institute of Justice, Office of Juvenile Justice, and the CDC funded the study. The study found the curriculum to have both short and long-term sustainability for reducing bullying and violence within the schools.[10]

Resources

The IHS IP Program, exemplifying commitment to capacity building, funds competitive cooperative agreements with tribes. These awards have enabled tribes to hire full-time injury prevention coordinators (Part I awards) and to develop, implement, and evaluate evidence-based interventions (Part II awards). During the three funding cycles from 1997 to present, Part I funding totaling over $13.4 million has been provided to 51 tribes/tribal organizations. Nine tribes received three-year Part II awards totaling nearly $300,000 for projects during FY2005 - 2007.

The TBH Program and the WTS collaborated to successfully apply for an IHS Part II Cooperative Agreement of $10,000 per year for three years to implement the BPYS program throughout the rural K-12 WTS during FY 2005 – 2007.

Methods

During summer 2005, two staff from the WTS attended the five-day "Training for Trainers Certification" for the implementation of the BPYS curriculum. This training provided advanced coaching techniques and systematic implementation plans. In early fall 2005, two instructors from CCC conducted a two-day, on-site training for the WTS. All of the school staff (administrators, counselors, teachers, support staff, janitorial staff, kitchen staff, and bus drivers) participated in this training. The training included three components:

1. Created awareness of the local bullying and violence issues through the assessment of school climate, provided this information through staff training, and developed school-wide rules regarding "no tolerance" for bullying.
2. Taught protective skills to classroom groups to help students learn strategies for dealing with bullying and increase resistance to victimization.
3. Initiated the development of an improved school climate by promoting the "caring majority" in standing up for victims with the promise of adult

support, thus converting the "silent majority" into a "caring majority."

The instructors from CCC also held a community meeting to provide information about the program and encourage participation. The instructors also conducted an on-site consultation with school and behavioral health staff on distributing and analyzing the Colorado School Climate Survey (CSCS). The CSCS allows schools and districts starting the BPYS Program to collect baseline and follow-up data to track school-wide changes over time. CCC evaluated these data for WTS.

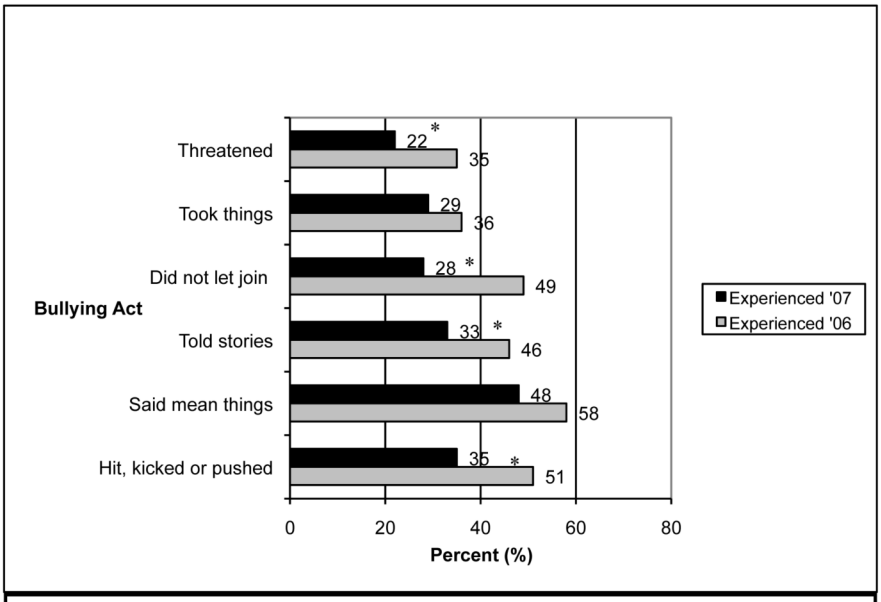
Approval to publish this article was obtained from James Williams, Jr., Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians and from the IHS National IRB.

Evaluation and Results

To date, 44 school staff, 95 parents and community members, and 342 LVD/WTS students have participated in the LVD/WTS BPYS Program. The CSCS was administered annually to the staff and students of the elementary and middle school to determine if the program was having the desired effect. Each year staff training took place, as a refresher, that included any new staff or substitute teachers. Parent and community meetings were held twice a year to ensure the program knowledge was provided to this group.

The BPYS program has shown preliminary success at the WTS. At the end of the second funding year, the WTS achieved a statistically significant decrease in physical and psychological bullying as reported by students in grades K-8 on the CSCS (Figures 2 and 3). Students reported that they *experienced* and *observed* less bullying by being hit, kicked, or pushed; others saying mean things, telling stories, being threatened; or from students taking their things.

Figure 2. Student Experienced Bullying 2006-2007



Significant (X2 with a p<.05) changes in comparison to spring 2006 are noted with an *
1st and 2nd graders responded to these questions by marking 'No' or 'Yes';
3rd graders marked 'never' [was not bullied/did not observe bullying], 'sometimes', and 'always' [both coded as was bullied/observed bullying]; the remaining grades marked 'never', 'less than 1 time per week' [both coded as was not bullied/did not observe bullying], '1 time per week', or '2-4 times per week', and '5 or more times per week' [all coded as was bullied/observed bullying]

The BPYS program is in its third year of implementation and final year of funding from the IHS Part II Cooperative Agreement. The program's preliminary success would not have been possible without the wide range of local support (parents, the tribal police, the tribal council and government) and their dedication to create a safe and caring learning environment for the students. The broad range of continued support was instrumental in finding solutions to challenges during the past three years and necessary in order for the program to continue and succeed. The following is a discussion of a few of the on-going challenges that WTS encountered and how they are being addressed.

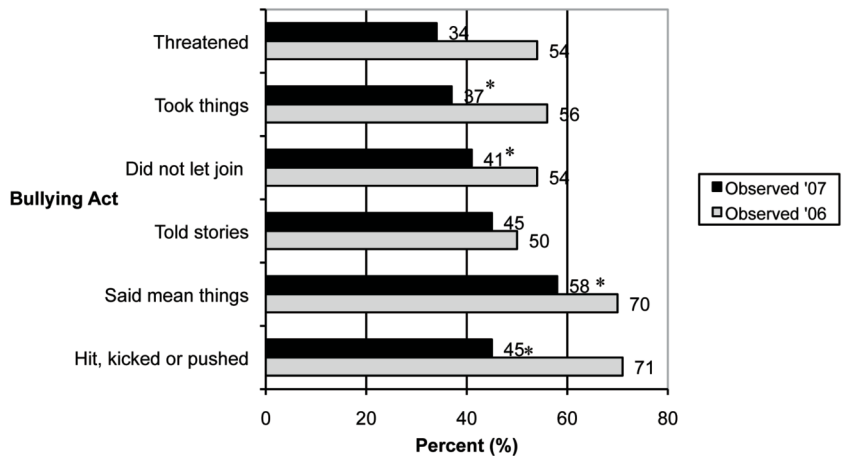
Addressing Challenges

The WTS had several major challenges to overcome to achieve success with this program. The ways WTS addressed these challenges may benefit other schools implementing projects like these.

It was necessary to patrol the areas where bullying is most likely to occur. These are commonly referred to as "hot spots" such as restrooms, playgrounds, lunchrooms, and other areas where supervision is minimal. The noon hour duty and twenty-minute recess times were identified as potential opportunities for bullying. WTS began utilizing the upper grades to monitor the lower grades during recess and noon hour activities. These students were taught what to watch for, how to handle disruptive situations, and when to get a teacher. As shown by Figures 2 and 3, this may have had a role in reducing the bullying events reported or witnessed on the playground and lunchroom. According to the WTS, the high school peer coverage worked well in assisting with patrolling and monitoring the hot spots.

After the initial hot spots were addressed, and the year 2 survey results presented, the WTS identified the problem of bullying occurring on the school buses as a priority. In the initial survey, this hot spot was not evident because the majority of bullying incidents occurred on the playgrounds and lunchrooms. Cameras are installed throughout the facility and playground of the WTS. The installation of cameras on the buses would allow bus drivers to document bullying events. Also,

Figure 3. Student Observed Bullying 2006-2007



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drivers felt that the cameras would deter bullying because students would know they were being taped. In spring 2008, three of the four buses were equipped with cameras (two per bus). All four buses should be equipped with cameras by the end of the 2008 calendar year.

Another challenge was a perceived lack of cultural awareness between Native and non-Native students and teachers. WTS hired an American Indian cultural teacher to assist with this awareness. The teacher also provided American Indian cultural lessons that were open to all students. The school felt this was imperative in order to build cultural bonds and better interactions among the students. Staff noted that cultural issues also arose at sporting events when the school would play non-Native schools. The WTS provided a one day, area-wide, sensitivity training. The school district provided a one-day, teacher in-service cultural awareness training to reduce bullying at sports events. Over 300 teachers and staff from all six area schools attended the training.

Conclusion/Recommendations

The statistically significant reduction in bullying behaviors between years one and two indicate the CCC *"Bully Proofing Your School Program"* is having an impact on changing the climate of the WTS. The staff and student surveys indicate the program is reaching the intended audience, and the curriculum is effective in changing behaviors and attitudes about bullying. Administrative and staff support for continuing the program will promote long-term sustainability. With a new CCC BPYS early childhood curriculum, the LVD Tribe plans to implement the *Bully-Proofing Your School Program* at the LVD Head Start Early Childhood and Youth Center.

The violence prevention program that the Bemidji Area IHS IP Program is developing in partnership with other schools includes two additional components: suicide prevention and peer mentoring programs. Peer mentor groups would give students more ownership of the program. High school and junior high students would mentor younger students by using tools in the CCC Program to generate discussions with the bully about why the bullying occurred; and to help the victim develop skills to cope with or handle the situation in the future.

The Bemidji Area suicide prevention program will target grades 9 – 12 students. It will use two evidence-based strategies: American Indian Life Skills[11] and QPR Gatekeeper Training.[12] Including suicide prevention in a bullying prevention program is a logical approach, since bullying can lead to suicide attempts and completions by both bullies and victims. [13]

The BAIHS Injury Prevention Program is committed to providing resources and technical assistance to tribes to address the complex issues of violence prevention. This requires a systems approach, creative thinking, and concerted multi-disciplinary collaboration. The preliminary success and lessons learned through the school-based LVD project are helping other schools serving American Indians in the Bemidji Area to develop violence prevention programs. While school-based programs are not the sole answer to community violence, they can serve as a basis for expansion into broad-based community efforts to reduce risk factors, strengthen resilience, and change norms. The collaborative approach adopted by the BAIHS IP Program can serve as a model for other IHS Injury Prevention programs to assist tribes and schools in addressing the problems of youth violence and suicide.

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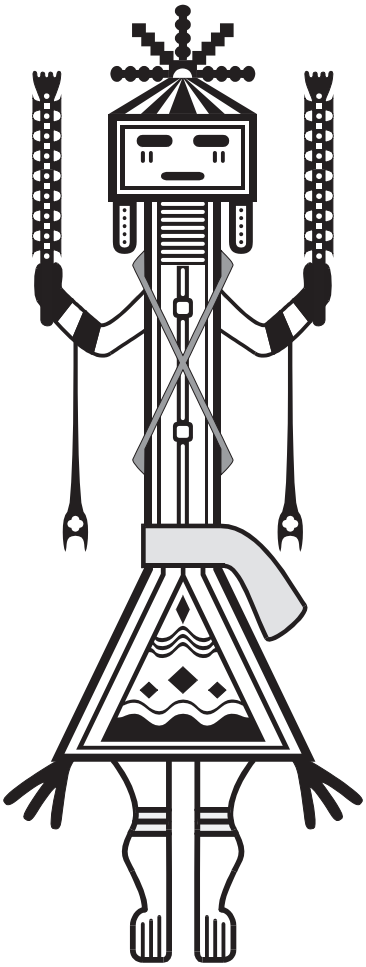
Special thanks to Kathryn Gardner, previous TBH Director. The program would not have been possible without her initiative and continued dedication and support.

In memory of Michael D. Rindal, WTS American Indian Cultural Teacher.



Elder Falls Prevention: A Self-Assessment Tool for Tribal Health Programs

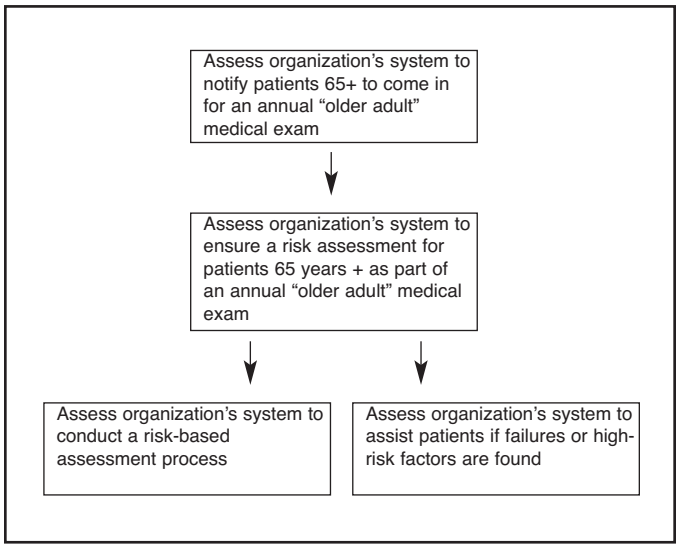
Susan E. Ducore, RN, MSN, California Area Nurse Consultant, Sacramento, California; and CAPT Robert S. Newsad, MPH, California Area Injury Specialist, Sacramento

Introduction

Among people who are 65 years of age and older, falls are the leading cause of injury deaths.[1] Approximately one in three persons living in the community who are age 65 or older report having had one or more falls each year.[2,3] Falls are particularly serious for American Indian/Alaska Native (AI/AN) elders, who experience more co-morbidity and chronic illnesses (such as diabetes and heart disease) than the general population.[4]

Systematic application of fall prevention measures is infrequent in the health care setting. Medical services are often focused exclusively on treating the fall-related injury. The project goal was to develop a comprehensive "Elder Falls Prevention Self-Assessment Tool" (EFP-SAT) for clinic and outreach staff, based on effective strategies and "best practices." The tool would be used to identify current levels of falls prevention services and guide the development of falls prevention efforts within health programs serving AI/AN. It is designed as an organizational assessment tool targeting falls prevention policies and procedures (Figure 2), not as a fall risk assessment tool for individual patients.

Figure 2. EFP-SAT flow chart



Methods

The content of the assessment tool is based on an extensive review of falls-related literature and discussions with subject matter experts. Several studies have emphasized the need for a multi-factorial approach to elder falls prevention.[5-7]

Figure 1. Elder Falls Prevention: Self-Assessment Tool (EFP-SAT)

Step 2: Assess organization's ability to identify and provide services to high risk elders (those patients that have had more than on fall in the past year, failed gait and balance testing, or had a diagnosis of a disease having muscular-skeletal, cradiac, or neurologic impact.)

Component	No Activity	Basic Level	Intermediate Level	Comprehensive/ "Best Practice" Level
Gait & Balance, Muscle Weakness, and Reduced Physical Fitness	☐ No evidence that patients are assessed for gait and balance abnormalities.	☐ (a) Health care staff assess patients for impaired control of balance and gait based on observation of patients walking and rising from chair (i.e. "get up and go test") ☐ (b) Protocol in place for referral for treatment based screening-identified impairment.	☐ (a) *Policies and procedures in place for health care professional* to assess patients for impaired control of balance and gait based on observation of patients walking and rising from chair (i.e. "get up and go test") ☐ (b) Protocol in place for referral for further treatment based on impairment found through screening	☐ (a) *Policies and procedures* are same as for Intermediate Level "a" and "b" of this component and additionally includes: ☐ (b) Use of validated *tool for in-depth screening* ☐ (c) *Referral of patients to individualized exercise programs, developed by trained exercise therapists, for increasing muscle strength, balance, flexibility and coordination (to reduce falls risk and improve mobility)*

The likelihood of falling increases with the number of risk factors.[6] Interventions that address multiple risk factors are much more likely to reduce fall injuries than single-factor interventions, such home safety modifications or exercise programs.[7]

The format of the EFP-SAT reflects the Program Stages of Development Assessment (PSDA) Framework described by researchers from the University of North Carolina.[8] Each assessment component is assessed according to four levels of program activity: none, basic, intermediate, and comprehensive/"best practice" level. The evaluation components are listed in Table 1. Figure 1 shows the level descriptors for assessing the "gait and balance, muscle weakness, and reduce physical fitness" evaluation component. The levels of program activity quantify the nature and extent of existing activities. The assessment considers current staffing and staff training needs; patient and caregiver education; the use of validated clinical tools for assessment; documentation efforts; and whether written guidelines, policies, and procedures are available.

Table 1. Falls prevention evaluation components

Risk factor screening
fall history, gait and balance assessment, vision screen and referral, comprehensive medical exam for muscular-skeletal, cardiovascular (including hypertension), or neurological impairment
Medication review
reduce or eliminate medications that increase fall risk
Gait and balance, muscle weakness, reduced physical fitness
Behavioral risk factors
Alcohol and drug misuse, improper footwear, cognitive impairment
Environmental risk factors
Home environment assessment and safety modifications
History of falls
Visual acuity and depth perception
Documentation
document in chart of assessment, treatment, referral, and service refusals; accurate ICD-9 N and E codes

The EFP-SAT was pilot tested at three health clinics in California serving AI/AN populations. The pilot sites were selected based solely on their expressed interest in strengthening or initiating elder falls prevention activities. The tool was e-mailed to one health professional at each site. Included were a set of instructions for completing the tool, and a request that a group of team members be assembled to provide input (Table 2). Conference calls between the project coordinator (SD) and the project contacts were held to clarify instructions, fill in data gaps, and clarify responses.

Results

Each of the pilot sites was providing some falls prevention services. Most commonly, these services were directed toward reducing fall hazards in the home environment. None of the sites offered routine, age-defined elder fall risk screenings for patients 65 years and older. There were gaps in services in the areas of gait and balance screening and behavioral risk screening. All three health programs were using the Resource Patient Management System (RPMS) for documentation. Barriers to a more comprehensive approach included the absence of written protocols; staff shortages, especially in outreach and pharmacy; communication barriers; patient transportation; lack of funding; and competing priorities.

Table 2. Suggested team members for falls program assessment

Medical providers (physician, mid-level provider)
Pharmacist
Pharmacy consultant
Injury prevention staff
Vocational nurse
Public health nurse
Clinic nurse
Senior nutrition staff
Tribal health program director
Community health representative (CHR)
Medical assistant
Housing director
Environmental health staff

None of the primary respondents convened a team for the purpose of completing the EFP-SAT. Only one of the pilot site contacts had provided the tool to a variety of staff members for their feedback and responses. All of the pilot site contacts requested additional information about elder falls prevention, especially validated assessment tools. They all indicated that the EFP-SAT would be more useful if it were accompanied by a site visit from the project director (SD, California Area Nurse Consultant).

Discussion

The EFP-SAT has the dual purpose of defining gaps in service and providing guidance for development of an evidence-based elder falls prevention program. It allows health care organizations to do a two-step assessment of elder falls prevention activities. Step I is to assess whether the organization offers elder fall risk assessments for all patients age 65 years and older on a routine (at least annual) basis. A Step II Assessment examines whether patients at moderate to high risk for falls receive appropriate services, and at what level of service.

There are several ways to utilize the EFP-SAT: self-assessment by facility staff with phone and e-mail support; a face-to-face, on-site evaluation visit; or self-assessment and an on-site visit. The proposed advantages and disadvantages of each of these options are summarized in Table 3. An on-site visit, including a face to face meeting with a site team, is the best way to foster an "empowerment evaluation," an approach that involves collaboration among program stakeholders and evaluators as a means to improving program effectiveness.[9]

There is clearly a need for additional training on topics such as RPMS documentation and reporting, "validated" assessment tools for individual patient screening and home assessments, and current recommendations regarding "best practices" for fall prevention. Area- or IHS-wide elder fall

prevention trainings could be held in conjunction with other meetings, such as "Best Practices" conferences, nursing meetings, medical directors' meetings, Community Health Representative Coordinator meetings, and/or IHS Community Wellness forums.

Further study is warranted with regard to staffing needs, patient use of fall prevention services, medication assessments, and documentation. There is also a need for advocacy and networking with community partners to help defray costs of home safety modification for elders.

Use of the EFP-SAT is the first step in determining current challenges and opportunities related to elder falls prevention that exist within the health care setting. Another important step is to conduct a community needs assessment to document the extent and impact of falls, the existence of community partnerships to implement programs, and the degree of staff and community commitment to elder falls prevention efforts.

Based on the pilot study, the EFP-SAT format was revised by making the items and categories more clear, and the process of completion more efficient. The revised EFP-SAT will be made available to all California tribal health programs for use in program development. The instrument is a work in progress; however, readers interested in obtaining the current version of the instrument can contact the corresponding author (SD).

Table 3. Comparison of falls prevention assessment formats

Assessment Format	Advantages	Disadvantages	Other
Self-assessment with phone and email support	• Self-paced • Best Practice guidelines in hand • Check box format • Staff more willing to be open with feedback • Low cost, wide distribution	• Clarification may be needed • Language may need interpretation • Excess time spent on deciphering directions • Low staff buy-in/ other priorities • Less opportunity for new ideas to emerge • Less opportunity to hear from multiple informants	• Pre-Assessment and Follow-up phone calls with project lead for clarification is essential
Face to Face/ On-Site Reviewer	• Observational opportunities • Observe staff interactions • Input from multiple • Informants • Greater detail • Opportunities for new ideas to emerge • On-site clarification	• Inconvenient scheduling • Feedback limited to select staff • May come off as punitive/rather than emphasizing collaborative efforts • Labor intensive	• A cadre of staff can be trained as reviewers; however should be health care professionals who can elaborate on "Best Practice" Components
Self- assessment + On-site facilitator	• Emphasis on program development through collaboration • Input from multiple informants • Opportunities for new ideas to emerge • On-site clarification • Opportunity for • community-wide • input - Instructions to entire • group at once	• More site facilitator time away from the office (other work-related duties unattended) • Additional cost (travel)	• Less confusion over directions • Meet with large or small groups to explain directions on EFP-SAT to all staff • Provide on site collaboration as a "Best Practice"

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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 rest, you rust."

Helen Hayes

Articles of Interest

Cardiovascular monitoring of children and adolescents with heart disease receiving medications for attention deficit/hyperactivity disorder: a scientific statement from the American Heart Association Council on Cardiovascular Disease in the Young Congenital Cardiac Defects Committee and the Council on Cardiovascular Nursing. *Circulation* 2008;117;2407-2423; originally published online Apr 21, 2008 at *http://circ.ahajournals.org/cgi/content/full/CIRCULATIONAHA.107.189473/DC1*.

Cardiovascular Monitoring and Stimulant Drugs for Attention-Deficit Hyperactivity Disorder - Policy Statement of the American Academy of Pediatrics. Published online on May 28, 2008 at *http://www.aap.org/new/ecg-adhd.htm*.

American Academy of Pediatrics/American Heart Association Clarification of Statement on Cardiovascular Evaluation and Monitoring of Children and Adolescents with Heart Disease Receiving Medications for ADHD. Published online on June 3, 2008 at *http://americanheart.mediaroom.com/index.php?s=43&item=422*

In late April the American Heart Association (AHA) released new guidelines for children receiving stimulant medication for Attention Deficit Hyperactivity Disorder (ADHD). The AHA recommended that all children beginning treatment with stimulant medications, and those already on stimulant medication, should have an electrocardiogram (ECG) to search for occult heart disease that could place them at increased risk for sudden cardiac death. This recommendation caused anxiety in many parents and frustration in many psychiatrists and pediatricians.

The AHA recommendation has significant procedural and financial implications. It is estimated that 2.5 million children are receiving stimulant medication now. Obtaining an ECG on each one would entail significant costs. For some patients a further barrier was the suggestion that the ECG should be reviewed by a practitioner experienced in reading pediatric ECGs. This would limit the reading of these studies to pediatric cardiologists and a small subset of pediatricians.

Within a month, the American Academy of Pediatrics (AAP) fired back. The AAP published its own policy statement on stimulants and ADHD on May 28, 2008. Highlights included the following:

- Sudden Cardiac Death (SCD) in persons taking medications for ADHD is a rare event occurring at rates no higher than in the general population of children and adolescents
- Stimulant medication can cause mild elevations of blood pressure and heart rate but there is no evidence they increase the risk of SCD
- There is no evidence that the routine use of ECG screening before beginning medication for ADHD treatment would prevent SCD.
- Substantial evidence exists concerning the efficacy and safety of ADHD treatment with stimulant medications.
- Requiring an ECG before stimulant treatment could create a barrier to timely therapy. Limiting children's access to effective treatment for ADHD could have serious implications, because there are substantial risks of not treating ADHD.

The AAP recommended that the cardiac evaluation of children taking stimulant medication should not change from their previous policy in 2000. The recommendations were as follows:

1. The AAP continues to recommend a careful assessment of all children, including those starting stimulants, using a targeted cardiac history (e.g., patient history of previously detected cardiac disease, palpitations, syncope, or seizures; a family history of sudden death in children or young adults; hypertrophic cardiomyopathy; long QT syndrome), and a physical examination, including a careful cardiac examination.
2. Given current evidence, the AAP encourages primary care and subspecialty physicians to continue currently recommended treatment for ADHD, including stimulant medications, without obtaining routine ECGs or routine subspecialty cardiology evaluations for most children before starting therapy with these medications.

To resolve confusion between the two professional societies, the AAP and AHA issued a joint statement on June 3, 2008. The relevant portion is listed below:

- Obtaining a patient and family health history and doing a physical exam focused on cardiovascular disease risk factors are recommended by the AAP and AHA for assessing patients before treatment with drugs for ADHD.
- It is reasonable for a physician to consider obtaining an ECG as part of the evaluation of children being considered for stimulant drug therapy, but this should be at the physician's judgment, and it is not mandatory to obtain one.
- Treatment of a patient with ADHD should not be withheld because an ECG is not done

Editorial Comment

The AAP statement of May 28, 2008 is reasonable guidelines that practitioners should embrace. Patients should be screened by history for potential cardiac risk factors and have a physical exam that focuses on cardiovascular system. Patients with known or suspected heart disease may need an ECG and further specialty evaluation.

Infectious Disease Updates.
Rosalyn Singleton, MD
Teen Vaccines: How are we doing?

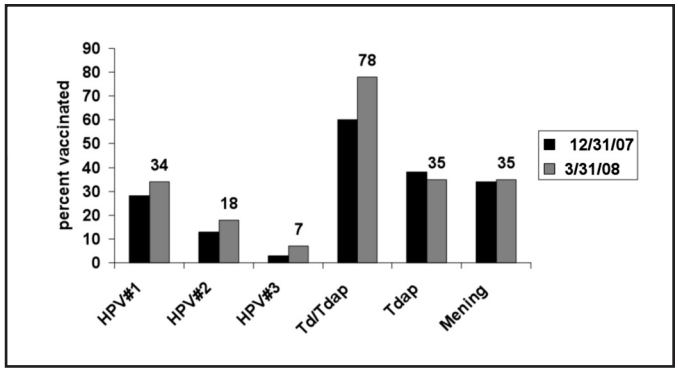
Since 2005, three new vaccines have been licensed and recommended specifically for teens: Tdap, HPV, and meningococcal conjugate vaccine.

- Tdap – for 11 - 18 year olds with >5 years since last Td vaccine,
- HPV – 3 doses for 9 - 26 year old females
- Meningococcal conjugate (Menactra®, MCV4) – for 11 - 18 year olds

CDC published the first estimates of national vaccination coverage among teens aged 13 - 17 years in US for 2006 in August 2007 at *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5634a3.htm*. Among 13 - 17 year olds, 10.8% had received 1 dose of Tdap and 60.1% had received 1 dose of Td or Tdap since age 10 years; 11% had received meningococcal vaccine. According to recent CDC data, 23% of females aged 13 - 17 years had received 1+ doses of HPV vaccine.

The Indian Health Service started reporting Adolescent Immunization rates for American Indian and Alaska Native adolescents 13 - 17 years of age from IHS/contract facilities in December 2007. Adolescent coverage data from 12/31/07 and 3/31/08 are presented in Figure 1. The initial Indian Health Service adolescent vaccine coverage rates for new vaccines compare favorably with national coverage rates; however, the national rates reflect an earlier time period. These rates reflect a robust delivery system; however, it will be challenging to administer 2nd and 3rd doses in a timely manner to teens. Providers can pull up lists of teens due for their 2nd or 3rd HPV doses in the RPMS Immunization Package by running a list of girls who have "received HPV vaccine" and are "due for HPV vaccine."

Figure 1. HPV Vaccination Coverage: AI/AN 13-17 Yr Old Females



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

Murphy TV, Syed SB, Holman RC, et al. Pertussis-associated hospitalizations in American Indian and Alaska Native infants. J Pediatr. 2008;152:839-43. *http://www.ncbi.nlm.nih.gov/pubmed/18492528?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum*.

Before the introduction of the pertussis vaccine in the 1940s, the US incidence of pertussis was approximately 150 cases per 100,000 population or roughly 175,000 cases per year.[1] By the 1980-90s the incidence declined to approximately 1 case per 100,000 population. Since 1980, the incidence of pertussis has steadily increased. Waning immunity in the adolescent and adult populations are felt to be contributing factors to this increase.[2]

This study investigates the burden of pertussis in American Indian and Alaska Native (AI/AN) infants from 1980 to 2004 and 2000 to 2004 through the analysis of discharge/hospitalization data from the Indian Health Service (IHS)/tribal health care system. Infant pertussis hospitalizations were examined by sex, age group (infants less than 6 months and 6 - 11 months) and IHS region (northern plains, southern plains, southwest, and Alaska). Rates of infant pertussis hospitalizations for 2000 - 2004 were compared to the pertussis hospitalizations of the general US infant population in 2003.

In the IHS, there were 483 infant pertussis hospitalizations between 1980 and 2004. This equals an annual pertussis hospitalization rate of 132.7 per 100,000 AI/AN infants (95% CI = 121.3 to 145.2). The highest numbers of hospitalizations were in infants less than 6 months of age (427 hospitalizations); equaling a rate of 234.5 per 100,000 infants.

Rates in males and females were similar by age. The southwest region had the highest rate (187.9 per 100,000) of pertussis hospitalizations as compared to Alaska (92.0), northern plains (103.3) and the southern plains (87.8).

In comparison, the average annual pertussis hospitalization rate for AI/AN between 2000 and 2004 was higher than the 2003 general US infant population pertussis hospitalization rate (100.5 vs. 67.7). Additionally, Alaska (156.9) and southwest (130.9) regions had higher hospitalization rates than the northern (59.1) and southern (59.2) plains during the same time period.

The authors concluded that the burden of pertussis is greatest in AI/AN infants less than 6 months of age, predominantly those residing in the southwest and Alaska regions. Despite levels of immunization rates equal or slightly less than the general population, environmental and social influences likely contribute to the higher disease burden in the AI/AN population, similar to what is seen with respiratory syncytial virus infections in Alaska Native infants.[3] Prevention of pertussis by timely administration of DTaP at 6 to 8 weeks of age and promotion of Tdap vaccination in adults and adolescents are strongly encouraged.

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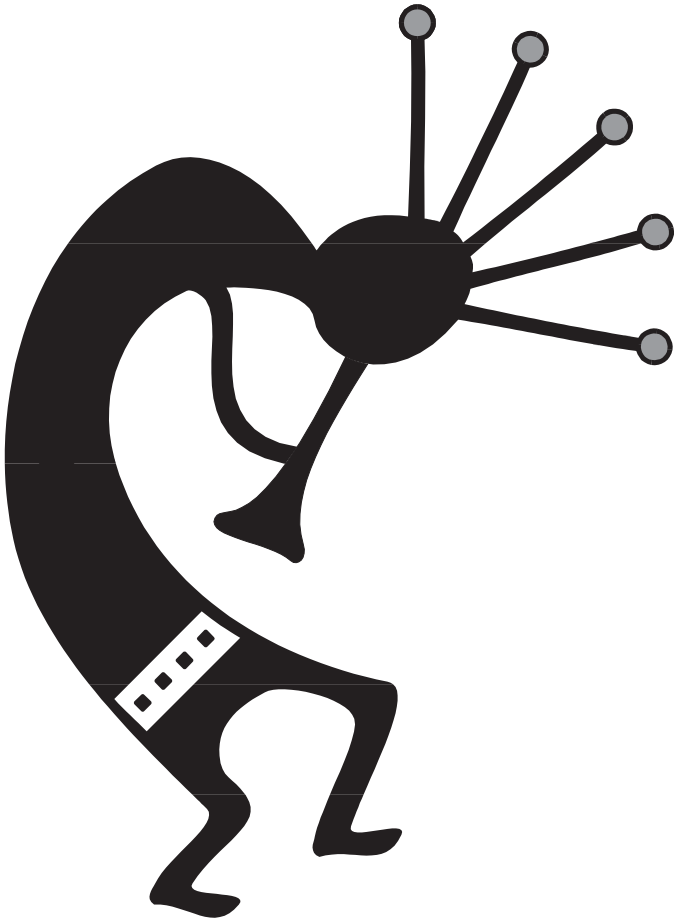
1. Centers for Disease Control and Prevention. *http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/pert.pdf*.
2. American Academy of Pediatrics. Pertussis. In: Pickering LK, Baker CJ, Long SS, McMillan JA, eds. *Red Book: 2006 Report of the Committee on Infectious Diseases*. 27th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2006:498-520.
3. Holman RC, Curns AT, Cheek JE, et al. Respiratory syncytial virus hospitalizations among American Indian and Alaska Native infants and the general United States infant population. *Pediatrics*. 2004 Oct;114(4):e437-44.



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

Scott Giberson, HQE

One of the guiding principles of the IHS HIV/AIDS Strategic Plan is to improve the collaborative nature and transparency of the program to maximize effectiveness. That said, we would like to share two recent announcements.

In April 2008, the IHS HIV Program and the Native Capacity Building Assistance Network (CBA), comprised of the Center for Applied Studies in American Ethnicity (CASAE), the Intertribal Council of Arizona (ITCA), and the National Native American AIDS Prevention Center (NNAAPC) signed a memorandum of understanding (MOU) to continue open communications, collaborate to raise awareness, and mutually augment efforts. This partnership demonstrates mobilization of both the Native community and IHS for HIV prevention efforts.

NNAAPC is offering and funding regional training grants to host trainings on a variety of HIV-related topics. This NNAAPC initiative will assist communities in capacity-building efforts from readiness to grant writing. Additional information is available from NNAAPC at *http://www.nnaapc.org/programs/regionaltraininggrants.htm*.

Elaine Locke and Yvonne Malloy, ACOG

"For American Indians, healthcare needs grow, money doesn't."

Indian health staff were featured in an *ACOG Today* article about American Indian and Alaska Native women's health care and the longstanding IHS/ACOG collaboration. The article pointed out the limited funding that IHS receives and the challenges encountered in providing care to a largely rural population with limited resources. The full front-page article, with lovely photos and quotes from several leaders in Indian women's health, is available at *http://www.ihs.gov/MedicalPrograms/MCH/F/documents/Indian%20Health%20Services%20may%2008.pdf*.

Haffner Native Women's Health Award

The ACOG Committee on American Indian Affairs is raising money for a new award that would recognize an individual who has made a major contribution to improving the health care of American Indians/Alaska Natives. The William H. J. Haffner American Indian/Alaska Native Women's Health Award is named after ACOG Fellow Dr. Haffner, an ob-gyn professor at the Uniformed Services University of the Health Sciences, Bethesda, Maryland. Dr. Haffner worked for the Indian Health Service for many years and has been involved with ACOG's Indian health programs since their inception. To donate to the Haffner Award Fund, please make checks out to "ACOG" and mail to Yvonne Malloy, ACOG, 409 12th St. SW, Washington, DC 20024. *http://www.ihs.gov/MedicalPrograms/MCH/F/documents/Indian%20health%20award.doc*.

Child Health

Obesity and type 2 diabetes risk in midadult life: the role of childhood adversity

Results: The risk of obesity increased by 20% to 50% for several adversities (physical abuse, verbal abuse, witnessed abuse, humiliation, neglect, strict upbringing, physical punishment, conflict or tension, low parental aspirations or interest in education, hardly takes outings with parents, and father hardly reads to child). Adversities with the strongest associations with adiposity (e.g., physical abuse) tended to be associated with glycosylated hemoglobin levels of ≥ 6, but in most cases associations were explained by adjustment for adulthood mediators such as adiposity. Effects of other adversities reflecting less severe emotional neglect and family environment were largely explained by childhood socioeconomic factors.

Conclusions: Some childhood adversities increase the risk of obesity in adulthood and thereby increase the risk for type 2 diabetes. Research is needed to understand the interrelatedness of adversities, the social context of their occurrence, and trajectories from adversity to adult disease.

Thomas C, Hyppönen E, Power C. Obesity and type 2 diabetes risk in midadult life: the role of childhood adversity. *Pediatrics*. 2008 May;121(5):e1240-9. *http://www.ncbi.nlm.nih.gov/pubmed/18450866*.

Chronic Disease

Intensive glucose control does not prevent major cardiovascular events in type 2 diabetes.

Two recent studies published in the *NEJM* addressing intensive glucose control in adults with type 2 diabetes failed to demonstrate a decrease in major cardiovascular events, although the second study did show a decrease in nephropathy.

ACCORD Study Abstract

Background: Epidemiologic studies have shown a relationship between glycated hemoglobin levels and cardiovascular events in patients with type 2 diabetes. We investigated whether intensive therapy to target normal glycated hemoglobin levels would reduce cardiovascular events in patients with type 2 diabetes who had either established cardiovascular disease or additional cardiovascular risk factors.

Methods: In this randomized study, 10,251 patients (mean age, 62.2 years) with a median glycated hemoglobin level of 8.1% were assigned to receive intensive therapy (targeting a glycated hemoglobin level below 6.0%) or standard therapy (targeting a level from 7.0 to 7.9%). Of these patients, 38% were women, and 35% had had a previous cardiovascular event. The primary outcome was a composite of nonfatal myocardial infarction, nonfatal stroke, or death from cardiovascular causes. The finding of higher mortality in the intensive-therapy group led to a discontinuation of intensive therapy after a mean of 3.5 years of follow-up.

Results: At 1 year, stable median glycated hemoglobin levels of 6.4% and 7.5% were achieved in the intensive-therapy group and the standard-therapy group, respectively. During follow-up, the primary outcome occurred in 352 patients in the intensive-therapy group, as compared with 371 in the standard-therapy group (hazard ratio, 0.90; 95% confidence interval [CI], 0.78 to 1.04; P=0.16). At the same time, 257 patients in the intensive-therapy group died, as compared with 203 patients in the standard-therapy group (hazard ratio, 1.22; 95% CI, 1.01 to 1.46; P=0.04). Hypoglycemia requiring assistance and weight gain of more than 10 kg were more frequent in the intensive-therapy group (P<0.001).

Conclusions: As compared with standard therapy, the use of intensive therapy to target normal glycated hemoglobin levels for 3.5 years increased mortality and did not significantly reduce major cardiovascular events. These findings identify a previously unrecognized harm of intensive glucose lowering in high-risk patients with type 2 diabetes.

The Action to Control Cardiovascular Risk in Diabetes study group. Effects of intensive glucose lowering in type 2 diabetes. N Engl J Med. 2008 Jun 12;358(24):2545-2559. Epub 2008 Jun 6. PubMed Abstract: *http://www.ncbi.nlm.nih.gov/pubmed/18539917*.
Free Full Text: *http://content.nejm.org/cgi/content/full/358/24/2545?query=TOC*.

ADVANCE Study Abstract

Background: In patients with type 2 diabetes, the effects of intensive glucose control on vascular outcomes remain uncertain.

Methods: We randomly assigned 11,140 patients with type 2 diabetes to undergo either standard glucose control or intensive glucose control, defined as the use of gliclazide (modified release) plus other drugs as required to achieve a glycated hemoglobin value of 6.5% or less. Primary end points were composites of major macrovascular events (death from cardiovascular causes, nonfatal myocardial infarction, or nonfatal stroke) and major microvascular events (new or worsening nephropathy or retinopathy), assessed both jointly and separately.

Results: After a median of 5 years of follow-up, the mean glycated hemoglobin level was lower in the intensive-control group (6.5%) than in the standard-control group (7.3%). Intensive control reduced the incidence of combined major macrovascular and microvascular events (18.1%, vs. 20.0% with standard control; hazard ratio, 0.90; 95% confidence interval [CI], 0.82 to 0.98; P=0.01), as well as that of major microvascular events (9.4% vs. 10.9%; hazard ratio, 0.86; 95% CI, 0.77 to 0.97; P=0.01), primarily because of a reduction in the incidence of nephropathy (4.1% vs. 5.2%; hazard ratio, 0.79; 95% CI, 0.66 to 0.93; P=0.006), with no significant effect on retinopathy (P=0.50). There were no significant effects of the type of glucose control on major macrovascular events (hazard ratio with intensive control, 0.94; 95% CI, 0.84 to 1.06; P=0.32), death from cardiovascular causes (hazard ratio with intensive control, 0.88; 95% CI, 0.74 to 1.04; P=0.12), or death from any cause (hazard ratio with intensive control, 0.93; 95% CI, 0.83 to 1.06; P=0.28). Severe hypoglycemia, although uncommon, was more common in the intensive-control group (2.7%, vs. 1.5% in the standard-control group; hazard ratio, 1.86; 95% CI, 1.42 to 2.40; P<0.001).

Conclusions: A strategy of intensive glucose control, involving gliclazide (modified release) and other drugs as required, that lowered the glycated hemoglobin value to 6.5% yielded a 10% relative reduction in the combined outcome of major macrovascular and microvascular events, primarily as a consequence of a 21% relative reduction in nephropathy.

The ADVANCE collaborative group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. N Engl J Med. 2008 Jun 12;358(24):2560-2572. Epub 2008 Jun 6. PubMed Abstract: *http://www.ncbi.nlm.nih.gov/pubmed/18539916*.
Free Full Text: *http://content.nejm.org/cgi/content/full/358/24/2560*.

Commentary on both articles in the New England Journal of Medicine:
http://content.nejm.org/cgi/content/full/358/24/2630.
http://content.nejm.org/cgi/content/full/358/24/2633.
http://content.nejm.org/cgi/content/full/358/24/2537.

Behavioral Health Insights
Peter Stuart, IHS Psychiatry Consultant
Chronic Pain Management 101: Saying No to Patients

Ms. Howard has been followed in your clinic for several years for a variety of complaints including chronic neck and arm pain. She has a history of rotator cuff surgery that did not substantially improve her pain status. Her rehab participation could be characterized by the words "erratic to none." She also has a history of periodic drinking episodes, depression and several overdoses while intoxicated, and previous tolerance development to narcotics and drug-seeking behavior. She is involved in a chaotic relationship. You do believe she has some physiologic basis for her pain but her compliance with your recommendations is erratic at best and you have on several occasions assisted her in detoxing from narcotics only to have her go to another provider and be restarted on them. She can be quite dramatic when claiming to suffer from pain and has accused you previously of "not doing enough to help me with my pain." She is also on an antidepressant and gabapentin and cannot tolerate NSAIDs due to GI complications. You have a pain contract in place.

She presents today telling you she needs a refill of her Percocet one week before they were supposed to run out. She has been taking "1 or 2 extra a day because I was cleaning house last week and twisted my shoulder again." She has a fairly recent history of prior "lost meds" that she has been counseled on in line with the pain treatment contract she signed. She appears mildly anxious and exhibits some discomfort with the shoulder even when non-obtrusively observed. The daily quantity is sufficient enough that you are concerned about withdrawal symptoms. At this point most providers start grinding their teeth. How do you approach her? Refer her to the psychiatrist or chronic pain committee (if you're fortunate enough to have either)? What about her current needs?

In the murky world of real human beings, this amalgam of physical, social, and emotional issues is not uncommon. The patient is likely to genuinely need some type of pain management, but is clearly out of control of her life and her self-care. She has demonstrated worrisome tolerance development, and there certainly is an addiction component active. She is clearly stepping outside of the boundaries set by the treatment contract. What is a reasonable goal here?
Do we, as providers, have a commitment to provide compassionate and effective care no matter what the circumstances? If so, what exactly does that look like in this case? Is the appropriate overall approach "harm reduction" or "abstinence-based," or something else?

For me in situations like this, it is helpful to go back to some basic clinical principles. First, the overall clinical situation always trumps any absolute clinical rules about specific issues (i.e., if the pain contract says "no more meds after you lose a prescription"). Borrowing a little from rabbinic tradition, each patient presents a unique set of predispositions, current symptoms, and possible outcomes that require the provider to exercise discernment and judgment in determining what the appropriate course of action is.

For this patient, that means understanding that my goal is long-term pain relief and life management; the path I'm looking for keeps the patient in my practice, but also provides enough incentive for her to make some necessary changes for her benefit. Second, sometimes the right answer is "no." As physicians, the principles of beneficence and minimal malfeasance are in play here. She is presenting in a situation where contingency management can be helpful in shifting behavior. In this case it might be worth using the positive contingency of getting her pain meds to decrease her discomfort both from withdrawal symptoms and pain in order to get her attending rehab and counseling. The challenge here is often a systems one – lack of access to these services at the time of presentation. If the system is broken and doesn't work well, it is incredibly important to acknowledge that reality.

An appointment in rehab is available in three days time. In order to involve her in the process you negotiate with her to walk to rehab, schedule the appointment in person, and return to your office, at which time you will provide her with a prescription for the three days. Further refills will be contingent on showing up at rehab, and will be filled after she has her rehab appointment. Here is where saying "no refill until . . ." can be very important.

Alternatively, you believe the big issue here is that she is not managing her meds appropriately (she is not following the contract, you have given her prior "chances" to learn the system, the system has done its part by providing her with the full prescription when she comes in, and is available to her if she has been debating about increasing her dose at home). In this case, the challenge becomes saying "no" without breaking the treatment relationship.

Third, "no" can be said in a supportive way. The principles for saying "no" in a supportive way are as follows: 1) start with empathizing and putting yourself in the patient's shoes, for example "I hear from what you're saying and can see by looking at you that you are very uncomfortable right now, and I'm guessing you're also worried about what withdrawal is going to be like if you don't get something. Is that close to what's going on?" 2) align yourself alongside the patient and look at the problem together and the potential consequences of different approaches together; for example "Help me look at the options from your perspective. First option – I just refill the meds, no further questions asked, what happens then? And after that? And what's happened before when we've done that? And how was that experience? Second option – I tell you no more meds . . . (repeat). Third option – can you think of a third option?" 3) summarize the options preferably using similar language to the patient; 4) tell the patient what you personally are comfortable doing and why, and 5) acknowledge that the patient may be angry, frustrated, annoyed, scared, etc. and that you appreciate and understand that response and will continue

working with her on her care.

Part 4 is the most difficult part because it is where you may be choosing an option different than the one the patient prefers. It is very important to be prepared for strong reactions. In Ms. Howard's case she initially tells you to "I'll just go somewhere else then." You reply, "Yes, I think I'd be upset and scared too, and at the same time I hope you will continue to work with me." If the strong feelings can be safely tolerated and tested with the patient, you have just successfully improved the relationship bond with the patient and the ability of the patient to tolerate further conflict with you – for the best interest of the patient.

In summary, the key ingredients here are an ability to see the big picture with the patient, to align yourself alongside the patient rather than against, and to support movement towards health sometimes by setting firm limits and boundaries but always in a context of compassion and caring. What else does this approach require? Time and focused attention . . . and if you can't hold the system accountable for providing these basic human needs, you're not going to get far in holding the patient accountable.

Breastfeeding

Suzan Murphy, PIMC

A new look at what works to support breastfeeding in hospitals

On June 13, 2008, the Centers for Disease Control and Prevention (CDC) published in its weekly *Morbidity and Mortality Weekly Report (MMWR)*, "Breastfeeding-Related Maternity Practices at Hospitals and Birth Centers – United States, 2007." The article is the result of the first national Maternity Practices in Infant Nutrition and Care (mPINC – called "m-pink") survey. The survey used questions from seven categories of practice that are known to support breastfeeding, such as those found in the Ten Steps for Baby Friendly Hospitals. The categories and typical questions were:

1. Labor and delivery – Do mothers and newborns routinely experience skin-to-skin contact and early breastfeeding initiation?
2. Breastfeeding assistance – Is assessment, recording, and instruction provided to new families on infant feeding? For example, are pacifiers not provided to breastfeeding infants?
3. Mother-newborn contact – Is the separation of mother and newborn avoided?
4. Newborn feeding practices – What and how are breastfed babies fed while in the hospital or birthing center? For example, is supplementation common and why?
5. Breastfeeding support after discharge – Are resources provided for the new family when they are discharged? Where can they go for assistance if problems or concerns arise?
6. Nurse/birth attendant breastfeeding training and education – What kind of breastfeeding support training and on-going education does staff receive?
7. Structural and organizational factors related to breastfeeding –
   a. Does the facility have a breastfeeding policy and how is it communicated to staff?
   b. Is there support for breastfeeding employees?
   c. Does the facility receive free infant formula?
   d. Is prenatal breastfeeding education available?
   e. Is there coordination of lactation care?

The survey was mailed to 3,143 hospitals and 138 birth centers; of these, 2,690 hospitals and 121 birthing centers responded. The survey was structured to be completed by the person most knowledgeable of the facility's intra-partum practices related to breastfeeding. To encourage true answers to survey questions, the responders and their administration were assured that their location and name would be kept confidential. The only potential identifier was the name of the state where the facility was located. The data were summarized by state and region.

The results of the survey were based on a maximum score of 100. For each category from above, the mean subscale scores from highest to lowest were:

80	2. Breastfeeding assistance
77	4. Newborn feeding practices
70	3. Mother-newborn contact
66	7. Structural and organizational factors related to breastfeeding
60	1. Labor and delivery
51	6. Nurse/birth attendant breastfeeding training and education
40	5. Breastfeeding support after discharge

State survey results strongly correlated with their breastfeeding prevalence rates. This suggests that where there are more evidenced-based breastfeeding support maternity practices in place, there are positive impacts on breastfeeding. Unfortunately, the reverse is also true.

For more information the survey project and survey questions, please see *www.cdc.gov/mmwr*. June 13, 2008/vol 57/No. 23, and *www.cdc.gov/mpinc*.

CDC, Breastfeeding-Related Maternity Practices at Hospitals and Birth Centers --- United States, 2007 MMWR Weekly. June 13, 2008 / 57(23);621-625. *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5723a1.htm*.

Family Planning

Injectable contraception: what should the longest interval be for reinjections?

Background: Progestin-only injectable contraceptives continue to gain in popularity, but uncertainty remains about pregnancy risk among women late for reinjection. The World Health Organization (WHO) recommends a "grace period" of two weeks after the scheduled 13-week reinjection. Beyond

two weeks, however, many providers send late clients home to await menses.

Study Design: A prospective cohort study in Uganda, Zimbabwe and Thailand followed users of depot-medroxyprogesterone acetate (DMPA) for up to 24 months. Users were tested for pregnancy at every reinjection, allowing analysis of pregnancy risk among late comers. Results: The analysis consists of 2290 participants contributing 13,608 DMPA intervals. The pregnancy risks per 100 women-years for "on time" [0.6; 95% confidence interval (CI), 0.33-0.92], "2-week grace" (0.0; 95% CI, 0.0-1.88) and "4-week grace" (0.4; 95% CI, 0.01-2.29) injections were low and virtually identical.

Conclusion: Extending the current WHO grace period for DMPA reinjection from 2 to 4 weeks does not increase pregnancy risk and could increase contraceptive continuation.

Steiner MJ, Kwok C, Stanback J, et al. Injectable contraception: what should the longest interval be for reinjections? *Contraception*. 2008 Jun;77(6):410-4. Epub 2008 Apr 10. *http://www.ncbi.nlm.nih.gov/pubmed/18477489*.

Depo Now: preventing unintended pregnancies among adolescents and young adults

Results: Those randomized to a bridge method were 1.8 (1.1, 2.9) times more likely than Depo Now subjects to return for their 21-day repeat pregnancy test, but only 55% (n = 125) of these young women actually received their first DMPA injection. Continuation rates at the third injection were 29.7% (n = 30) for those in the Depo Now group and 21.1% (n = 49) for those assigned to the bridge method (p = .09). Three factors were significantly associated with adherence to the third injection: randomized to Depo Now group, knowing more women who use DMPA, and returning to clinic for the 21-day repeat pregnancy test visit. Finally, 28 pregnancies were diagnosed during the study period, and those in the bridge method group were almost 4.0 (1.2, 13.4) times more likely to be diagnosed with a pregnancy than those in the Depo Now group.

Conclusions: Immediate administration of DMPA is associated with improved adherence to DMPA continuation and fewer pregnancies.

Rickert VI, Tiezzi L, Lipshutz J, et al. Depo Now: preventing unintended pregnancies among adolescents and young adults. *J Adolesc Health*. 2007 Jan;40(1):22-8. *http://www.ncbi.nlm.nih.gov/pubmed/17185202*.

CCC Editorial Comment

The first article provides reassurance that a woman who is late, even as late as four weeks, for her scheduled Depo-Provera injection faces a low risk of unintended pregnancy and should receive the next injection without additional barriers. The second article provides more support for a "quick start" approach to Depo-Provera initiation. A "quick start" protocol can also be used for resuming Depo Provera use for those who are more than 2 to 4 weeks past the recommended date for their next dose.

International Health Update

Claire Wendland; Madison, WI

New evidence on lead's long-term effects

Lead has been back in the news lately. A potent neurotoxin, lead damages the brain by altering neurotransmitter release in a way that leads to accelerated apoptosis (cell death). It is a known toxin for adults, but appears to be a particularly bad actor in the developing brain. Though it hasn't typically been a problem in the rural parts of Indian country, urban AI/AN people living in dilapidated housing stock are at risk for chronic lead toxicity. Two new articles based on longitudinal research from the Cincinnati Lead Study (CLS) may heighten the stakes of the debate over acceptable childhood lead levels.

The CLS birth cohort was recruited in the womb between 1979 and 1984 from urban inner-city neighborhoods known to have high lead levels. These children got detailed exposure histories from the prenatal period on, frequent neuropsychiatric exams and serum lead levels, and have now been followed into young adulthood. One of the two new reports shows a small but significant correlation between childhood lead levels and adult arrest records in this cohort. After careful adjusting for potential confounders, John Wright and colleagues found that for every 5 mcg/dl increase in prenatal (maternal) and childhood blood lead, total arrests and arrests for violent crime went up by roughly forty percent. In the second report, Kim Cecil and colleagues used MRI to assess brain volume in 157 members of the CLS cohort. Regression analysis demonstrated a linear dose-dependent correlation between childhood serum lead levels and reduction in adult brain volume, a result that was highly statistically significant. Most interesting, the reduction was specific to grey matter in the anterior cingulate cortex and portions of the prefrontal cortex. (White matter and CSF volume were not affected.) These are the regions responsible for judgment, focusing attention, regulation of mood, and executive functions. Grey-matter volume loss in these areas was also much more pronounced among men than women, even at similar lead levels. This finding suggests a mechanism for the links previously explored between childhood lead exposure and adult anti-social behavior, criminal activity, and poor intellectual performance.

Some of you may be scratching your heads over why this is an international health problem. Unfortunately, the measures put in place to mitigate lead toxicity in the United States years ago – screening programs, mandated transitions to unleaded gasoline, abolition of lead-based paints and ceramic glazes – never happened in much of the Third World. In fact, some gasoline sold today in South America, the Middle East and Africa has *more* lead additives than leaded gas in our country ever did; paint sold for residences, toys, and playground equipment still contains high levels of lead in Africa and several countries in Asia. In Central and South

America, unregulated industrial processes are the major culprits. Some experts argue that an unrecognized epidemic of low- to moderate-level lead poisoning is occurring in much of the Third World, and a few small pilot studies of lead levels tend to confirm this assessment. Improvements in screening, policy and enforcement are urgent.

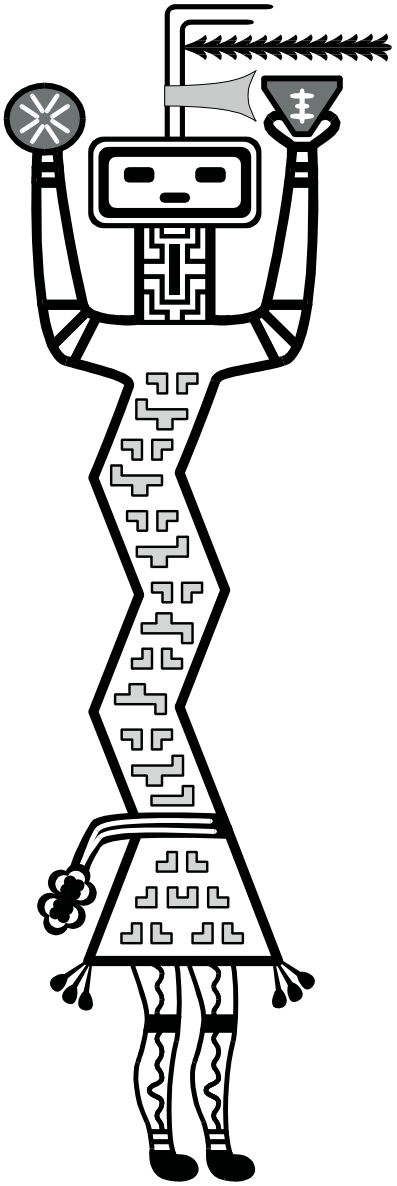
Cecil KM et al. Decreased brain volume in adults with childhood lead exposure. PLoS Medicine. 5(5):e112, 2008 *http://www.ncbi.nlm.nih.gov/pubmed/18507499*.

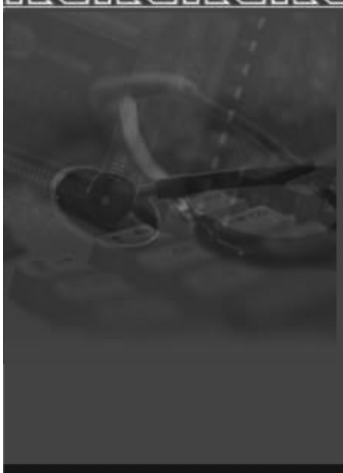
Wright JP et al. Association of prenatal and childhood blood lead concentrations with criminal arrests in early adulthood. PLoS Medicine. 5(5):e101, 2008 *http://www.ncbi.nlm.nih.gov/pubmed/18507497*.

Nurse's Corner
What Is Forensic Nursing?

Forensic Nursing is the application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity, and traumatic accidents. The forensic nurse provides direct services to individual clients, consultation services to nursing, medical, and law related agencies, and expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing.

The above is excerpted from the International Association of Forensic Nurses website. For more information about how to become a Sexual Assault Nurse Examiner (SANE) visit the IAFN web site at *http://www.iafn.org/index.cfm*. Need technical assistance? Visit the Sexual Assault Forensic Examiner Technical Assistance website at *http://www.safeta.org/*.





Save the Dates!

Indian Health Information Management Conference: 2008

"Managing Health Information Technology to Improve Performance and Outcomes"

December 15—19, 2008
Phoenix, Arizona

Who Should Attend?
Anyone interested in the use of IT to improve the health status of American Indian/ Alaska Native people.

Hotel Information:
Hyatt Regency Phoenix
122 North 2nd Street
Phoenix, AZ 85004
(602) 252-1234
http://www.phoenix.hyatt.com/

A limited number of government rate rooms at $102 are available on a first-come basis until **November 21, 2008**. Ask for the *"IHIM Conference":*

For additional information, please visit the conference website at
http://www.ihs.gov/CIO/IHIMC/

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/ClinicalSupportCenter/*. The meeting will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258.

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/MedicalPrograms/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.

Pathways into Health Third Annual Conference
September 9 - 10, 2008; Girdwood Alaska

Achieving Excellence, Harmony, and Balance: Transforming health professions education in American Indian and Alaska Native communities. Pathways Into Health is a grassroots collaboration of more than 200 individuals and organizations dedicated to improving the health, health care, and health care education of American Indians and Alaska Natives (AI/AN). We are combining the expertise, resources, and strength of tribes and AI/AN organzations, tribal colleges, prominent universities, the Indian Health Service and AI/AN communities as we work together to solve a major problem that exists today-the shortage of AI/AN health care professionals.

The purpose of this conference is to bring together a diverse group of individuals to contribute to the development of appropriate and effective educational methodologies for primarily distance-based AI/AN health professions education. Three core concepts that will be illuminated to advance this

process are:

1. Cultural attunement
2. Interprofessional education
3. Distance learning/telehealth technologies

The conference location will be the Alyeska Resort in Girdwood, Alaska; go to *www.alyeskaresort.com*. The sponsor website is *www.pathwaysintohealth.org*. For more information about registration, call for abstracts, call for photos, or sponsorship, please visit *www.pathwaysintohealth .org/conference08/*. If you have questions, contact Lesley Craig at *lesley.craig@hhs.gov*.

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.

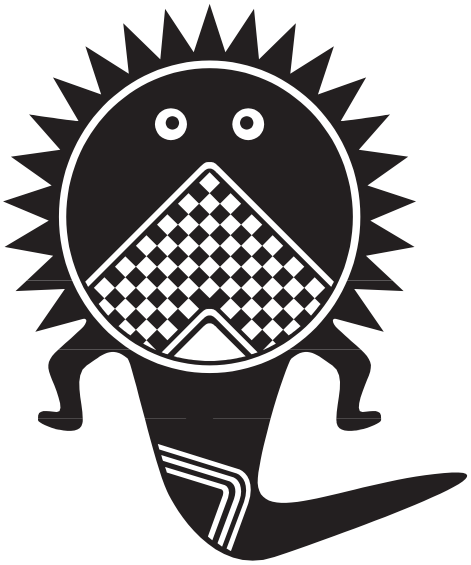
Sign up early! You'll have first chance for support from your facility and coverage for your time in Salt Lake City. Getting these benefits lined up takes time, so don't delay and miss out! In addition, early registration holds your place, and puts you in line for possible availability of scholarship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

Physicians
Emergency Medicine PA-Cs
Family Practice PA-Cs/ Family Nurse Practitioners
Rosebud Comprehensive Health Care Facility; Rosebud, South Dakota

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified family practice physicians, pediatricians, emergency medicine physicians, an internist, and an ob/gyn with at least five years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners. Rosebud is located in rural south central South Dakota west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska boarder. We are a 35 bed facility that has a 24 hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, oral surgery, optometry, dentistry, physical therapy, dietary counseling, and behavioral health. Our staff is devoted to providing quality patient care and we have several medical staff members that have been employed here ten or more years. The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2- 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing, boating, and horseback riding. Steeped in western folklore, Lakota culture, history, and land of such famous movies as "Dances with Wolves" and "Into the West" there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Dr. Valerie Parker, Clinical Director, at (605) 660-1801 or e-mail her at *valerie.parker@ihs.gov*.

Physician/Medical Director
Physician Assistant or Family Nurse Practitioner
Dentist
Dental Hygienist
SVT Health Center; Homer, Alaska

SVT Health Center has immediate openings for a medical director (MD, DO; OB preferred), family nurse practitioner or physician assistant, dentist, and dental hygienist (21 - 28 hours per week). The ideal candidate for each position will be an outgoing, energetic team player who is compassionate and focused on patient care. The individual will be working in a modern, progressive health center and enjoy a wide variety of patients.

The Health Center is located in southcentral Alaska on scenic Kachemak Bay. There are many outdoor activities available including clam digging, hiking, world-class fishing, kayaking, camping, and boating. The community is an easy 4 hour drive south of Anchorage, at the tip of the Kenai Peninsula.

SVTHC offers competitive salary and a generous benefit package. Candidates may submit an application or resume to Beckie Noble, SVT Health Center, 880 East End Road,, Homer, Alaska 99603; telephone (907) 226-2228; fax (907) 226-2230.

Family Practice Physician
Physician Assistant/Nurse Practitioner
Fort Hall IHS Clinic; Fort Hall, Idaho

The Fort Hall IHS Clinic has openings for a family practice physician and a physician assistant or nurse practitioner. Our facility is an AAAHC-accredited multidisciplinary outpatient clinic with medical, dental, optometry, and mental health services, and an on-site lab and pharmacy. Our medical staff includes five family practice providers who enjoy regular work hours with no night or weekend call. We fully utilize the IHS Electronic Health Record and work in provider-nurse teams with panels of patients.

Fort Hall is located 150 miles north of Salt Lake City and 10 miles north of Pocatello, Idaho, a city of 75,000 that is home to Idaho State University. The clinic is very accessible, as it is only one mile from the Fort Hall exit off of I-15. Recreational activities abound nearby, and Yellowstone National Park, the Tetons, and several world class ski resorts are within 2½ hours driving distance.

Please contact our clinical director, Chris Nield, for more information at *christopher.nield@ihs.gov*; telephone (208)238-5455).

Dentist
Staff Physician
Mid-Level Provider
Nimiipuu Health; Lapwai, Idaho

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

Dentist: Requires DDS/DMD degree from an American Dental Association accredited dental school, with two years of experience, preferably in general practice. Must have state licensure in good standing, valid driver's license with insurable record, and pass a background check. Salary DOE; part-time or full-time in Lapwai. Open until filled.

Staff Physician: Requires one to three years experience in family medicine/ambulatory care/prenatal care. Must be board certified or board eligible. Must have Idaho MD or DO license or obtain license within one year of appointment. Must have DEA number or obtain within three months of appointment. Knowledge of history, culture, and health needs of Native American communities preferred. Salary DOE; part-time or full-time in Lapwai. Open until filled.

Mid-Level Provider: Idaho licensed FNP or PA. Incumbent can obtain Idaho license within one year of appointment. Must have BLS and obtain ACLS within six months of appointment. Must have valid driver's license with insurable record, and will be required to pass extensive background check. Salary DOE; full-time in Kamiah. Open until filled.

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

Family Physician/Medical Director
The Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc. (Native Health), centrally located in the heart of Phoenix, Arizona, is currently seeking a skilled and energetic family physician/medical director who would enjoy the opportunity of working with diverse cultures. The family physician/medical director is a key element in providing quality, culturally competent health care services to patients of varied backgrounds and ages within a unique client-focused setting that offers many ancillary services. Native Health offers excellent, competitive benefits and, as an added bonus, an amazing health-based experience within the beautiful culture of Native Americans. Arizona license Preferred. For more information, contact the HR Coordinator, Matilda Duran, by telephone at (602) 279-5262, ext. 3103; or e-mail *mduran@nachci.com*. For more information, check our website at *www.nativehealthphoenix.org*.

Family Medicine Physician
Norton Sound Health Corporation; Nome, Alaska

Practice full spectrum family medicine where others come for vacation: fishing, hunting, hiking, skiing, snowmobiling, dog mushing, and more.

The Gateway to Siberia. The Last Frontier. Nome, Alaska is 150 miles below the Arctic Circle on the coast of the Bering Sea and 120 miles from Russia. It was the home of the 1901 Gold Rush, and still is home to three operating gold dredges, and innumerable amateur miners. There are over 300 miles of roads that lead you through the surrounding country. A drive may take you past large herds of reindeer, moose, bear, fox, otter, and musk ox, or through miles of beautiful tundra and rolling mountains, pristine rivers, lakes, and boiling hot springs.

The Norton Sound Health Corporation is a 638 Alaskan Native run corporation. It provides the health care to the entire region. This encompasses an area about the size of Oregon, and includes 15 surrounding villages. We provide all aspects of family medicine, including deliveries, minor surgery, EGDs, colposcopies, colonoscopies, and exercise treadmills. Our closest referral center is in Anchorage. Our Medical Staff consists of seven board certified family practice physicians, one certified internist, one certified psychiatrist, and several PAs. This allows a very comfortable lifestyle with ample time off for family or personal activities.

Starting salary is very competitive, with ample vacation, paid holidays, two weeks and $6,000 for CME activities, and a generous retirement program with full vesting in five years. In addition to the compensation, student loan repayment is available.

The practice of medicine in Nome, Alaska is not for everyone. But if you are looking for a place where you can still make a difference; a place where your kids can play in the tundra or walk down to the river to go fishing; a place where everyone knows everyone else, and enjoys it that way, a place where your work week could include a trip to an ancient Eskimo village, giving advice to health aids over the phone, or flying to Russia to medivacs a patient having a heart attack, then maybe you'll know what we mean when we say, "There is no place like Nome."

If you are interested, please contact David Head, MD, by telephone at (907) 443-3311, or (907) 443-3407; PO Box 966,

Nome, Alaska 99762; or e-mail at *head@nshcorp.org*.

Family Practice Physician
Central Valley Indian Health, Inc.; Clovis, California

Central Valley Indian Health, Inc. is recruiting for a BC/BE, full-time physician for our Clovis, California clinic. The physician will be in a family practice setting and provide qualified medical care to the Native American population in the Central Valley. The physician must be willing to treat patients of all ages. The physician will be working with an energetic and experienced staff of nurses and medical assistants. Central Valley Indian Health, Inc. also provides an excellent benefits package that consists of a competitive annual salary; group health insurance/life insurance at no cost; 401k profit sharing and retirement; CME reimbursement and leave; 12 major holidays off; personal leave; loan repayment options; and regular hours Monday through Friday 8 am to 5pm (no on-call hours required). For more information or to send your CV, please contact Julie Ramsey, MPH, 20 N. Dewitt Ave., Clovis, California 93612. Telephone (559) 299-2578, ext. 117; fax (559) 299-0245; e-mail jramsey@cvih.org.

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*.

Due to space limitations, we have had to temporarily limit the number of position vacancies we could run in this issue. Newer postings are always listed at the top of the section. For a complete listing of vacancies, please consult the June issue on line at *http://www.ihs.gov/PublicInfo/Publications/HealthProvider/Provider.asp*. We will resume publishing the entire list in August.

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THE IHS PRIMARY CARE PROVIDER

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

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

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at *www.csc.ihs.gov*.

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