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National Colorectal Cancer Awareness Month: an Update from Indian Country

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March is National Colorectal Cancer Awareness month and an appropriate time to remind ourselves of the importance of colorectal cancer screening, improve our understanding of the impact of colorectal cancer in American Indian and Alaska Native (AI/AN) communities, and share activities underway to increase colorectal cancer screening in these populations.

Colorectal cancer (CRC) is the second leading cause of cancer mortality for AI/AN males and females combined. An estimated 1.7% of all American Indians (1 in 60), and 2.8% of all Alaska Natives (1 in 36) will die from this disease.¹ Variability by geographic region is a prominent feature of CRC incidence and mortality rates in AI/AN populations.^{2,3} Compared to the US population as a whole, AI/ANs in both Alaska and the Northern Plains have significantly higher CRC mortality rates, whereas AI/ANs in the southwest have significantly lower rates.³ During 1997 - 2006, CRC mortality trends decreased for men in all racial and ethnic groups except AI/AN men, and CRC death rates decreased for all women except those who were Hispanic or AI/AN.⁴

In the absence of primary prevention for CRC, screening is the key tool available to us to decrease the CRC burden. Appropriate screening tests, such as high-sensitivity fecal occult blood tests (FOBT) and fecal immunochemical tests (FIT), flexible sigmoidoscopy, and colonoscopy (Table 1), can detect CRC at an early and more curable stage, and, in the case of colonoscopy, can even prevent incident CRCs by removing adenomatous polyps discovered during screening.

Despite CRC screening effectiveness, the percentage of AI/AN patients being screened in IHS, tribal and urban (I/T/U) clinics remains low. Colorectal cancer screening became a Government Performance and Results Act (GPRA) clinical performance measure in 2006 when a baseline screening prevalence of 22% was reported. This proportion has increased every year since 2006, and in 2009, 33% of eligible

patients had appropriate CRC screening (Figure 1) and nine of the twelve Indian Health Service (IHS) Areas met, or exceeded, the national target of 29%. The Alaska Area even exceeded the Healthy People 2010 screening goal of 50 percent in 2009.⁵ However, the overall proportion of eligible Indian health system patients being screened for CRC is still below the proportion of patients currently being screened for other types of cancer; such as mammography (45%) to detect breast cancer and Pap smear (59%) to detect cervical dysplasia and cervical cancer.

In response to the heavy burden of CRC in Alaska Natives, and to address limited CRC screening capacity in remote facilities serving them, several initiatives have been introduced. Several of these projects are funded through an Inter-agency Agreement between the IHS and the Centers for Disease Control and Prevention (CDC). The Alaska Native Epidemiology Center collaborates with the Department of Surgery at the Alaska Native Medical Center in Anchorage to send itinerant endoscopy teams to regional tribal health facilities to conduct screening colonoscopies, giving priority to patients who have never been screened or who have a family history of CRC. The Alaska Native Epidemiology Center is also conducting a study evaluating the potential of the Fecal Immunochemical Test, a newer type of FOBT, to screen Alaska Natives. Guaiac-based FOBTs are not utilized for CRC

In this Issue...

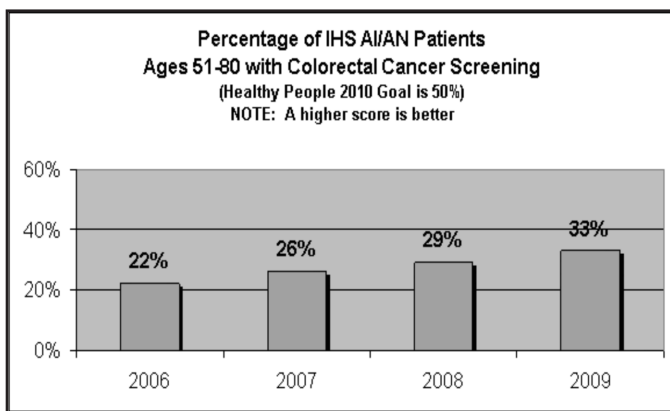
- 52 National Colorectal Cancer Awareness Month: an Update from Indian Country
- 55 What You Need to Know About Meaningful Use
- 57 Pioneers in the Indian Health Service:
Dr. Annie Dodge Wauneka
- 59 Helping A People To Understand
- 67 IHS Child Health Notes
- 69 Meetings of Interest
- 73 Position Vacancies

Table 1. Summary of United States Preventive Services Task Force (USPSTF) colorectal cancer screening test recommendations for average-risk individuals

Screening test	Description	USPSTF recommendation
High sensitivity Fecal occult blood test (FOBT)* and fecal immunochemical test (FIT)*	Examination of the stool for traces of blood not visible to the naked eye	Annually for ages 50-75
Flexible sigmoidoscopy*	Internal examination of the lower part of the large intestine	Every 5 years with high sensitivity FOBT every three years for ages 50-75
Colonoscopy	Internal examination of the entire large intestine	Every 10 years for ages 50-75

screening by most providers serving Alaska Natives due to false positive FOBT results, likely related to a high prevalence in this population of chronic *H. pylori* infection and associated low grade gastric bleeding. The Alaskan CRC Screening Navigator Project is being implemented to coordinate patient outreach, recruiting, scheduling, tracking, and follow-up for CRC screening. A first-degree relative database has also been developed and is used to conduct outreach to first-degree relatives of CRC patients.

Figure 1. Annual GPRA colorectal cancer screening rate



Several other projects are planned or are being implemented that are intended to have a broader, national scope. A demonstration project involving seven tribes in the Albuquerque Area aims to integrate Community Health Representatives (CHRs) into CRC screening programs by serving as patient navigators through the CRC screening process. The first of three colorectal health workshops was held with CHRs in December 2009. Materials developed from

this project will eventually be incorporated into CHR programs nationally. An interactive, CRC focused CD-ROM is being developed and will be a resource that CHRs and health educators nationwide will be able to use in their communities and health facilities to create awareness about CRC and the importance of screening. An endoscopic capacity survey of I/T/U facilities is projected to begin later this year and will inform the development of a tool to assess the ability of health facilities to deliver CRC screening services. Another assessment that is nearing completion is validating the GPRA CRC measure by determining the sensitivity and specificity of GPRA to ascertain screening status and the proportion of procedures captured by GPRA that are done for diagnostic vs. screening purposes. Regional CRC summit meetings are also convening tribal, clinical, and public health partners to discuss ways to increase CRC screening and awareness. The first of these summit meetings took place in Rapid City, South Dakota in October 2009, and was attended by federal, state, tribal, and urban representatives from the Aberdeen Area states. Many of the states that were awarded CDC funding in 2009 to start CRC screening programs have substantial AI/AN populations. One outcome of the Aberdeen Area meeting was laying the groundwork for a regional AI/AN application in anticipation of future CRC funding from CDC or elsewhere.

In May 2007, the Prevent Cancer Foundation sponsored the *Dialogue for Action AI/AN Working Meeting on Colorectal Cancer Screening*, in which ten AI/AN teams from around the country assembled and discussed ways to increase CRC awareness, education, and screening. Each of these teams was awarded seed money to implement CRC screening projects in their communities. Outcomes from the work of these teams included development of culturally appropriate educational materials on CRC screening, men's cancer screening clinic days, elder luncheons, tracking the return of FOBT kits, and

media campaigns, to name a few. A few of these teams have secured additional funding, allowing them to continue their CRC projects. For example, the team from Aberdeen received a grant from Spirit of Eagles to continue cancer screening clinics and educational workshops on CRC in six communities while expanding to two additional communities, and the Oglala Lakota CRC team collaborated with the National Cancer Institute funded program, *Walking Forward*, to provide follow-up care to patients who received positive FOBT results.

Through the IHS Chronic Care Initiative, 14 pilot sites began work on the Innovations in Planned Care (IPC) in 2007.

These sites implemented a set of changes designed to improve care across (for multiple) conditions. Colorectal cancer screening is one of the indicators for measuring change at these sites. In 2009, another 25 sites joined in the next phase of IPC (now called Improving Patient Care). Many of these sites have been able to significantly increase their CRC screening rates by incorporating changes at their facilities, from empanelling patients with iCARE, to using electronic health records to produce patient and provider reminders. Lessons learned during IPC will be disseminated nationwide in the coming year.

While attempting to increase CRC screening and awareness, we should avoid misuse and overuse of screening tests. Our survey of IHS and tribal providers revealed that providers frequently recommend colonoscopy at too-frequent intervals, and many are conducting FOBT using a single, in-office stool sample after a digital rectal exam, instead of the recommended take-home test. Guidelines for CRC screening often utilize a “menu of options” approach. This can be confusing for both patients and providers. In 2008, both the United States Preventive Services Task Force (USPSTF) and a joint committee of the American Cancer Society, the US Multi-society Task Force, and the American College of Radiology updated their guidelines for average-risk individuals. The IHS colorectal cancer task force recommends following the USPSTF screening guidelines (Table 1). Unlike USPSTF, the ACS-Multi-society task force guidelines include screening with computed tomography colonography and fecal DNA tests.

The IHS colorectal cancer task force agreed that it is premature to recommend these tests as routine screening options. The IHS colorectal cancer screening task force was established to determine the most effective steps to address low screening rates among AI/AN, and to increase the priority of CRC screening within the Indian health system. The Task Force priority areas are provider education, public education and awareness, policy development, and screening capacity.

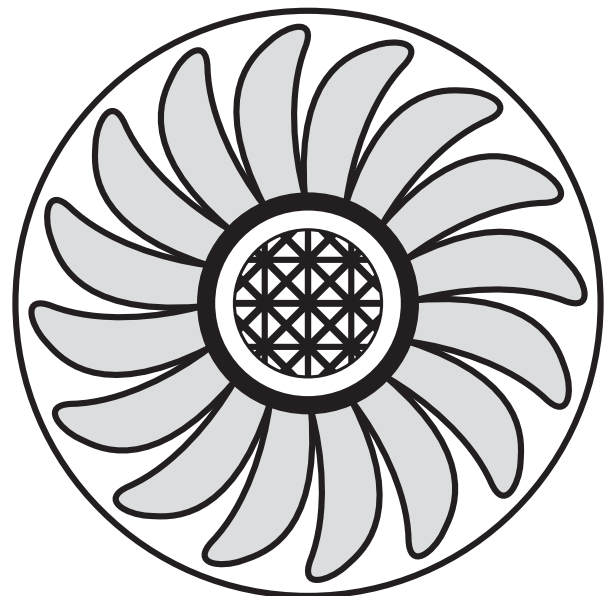
The barriers to providing appropriate CRC screening are many, but we can see from the GPRA rates that progress is being made. All of the projects and efforts mentioned here can contribute greatly to the goals of increasing screening and decreasing the number of people in Indian Country who either develop CRC or die from this preventable disease.

If you have questions or would like more information,

contact Don Haverkamp at donald.haverkamp@ihs.gov. For discussion on CRC screening efforts, subscribe to the IHS colorectal cancer listserv at <http://www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=110&startrow=1>.

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What You Need to Know About Meaningful Use

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Note: The information presented in this article is subject to change, is provided for planning purposes only, and should not be considered final.

Meaningful Use is a new health initiative

Meaningful use is the name of a new initiative to improve the health of the nation. The meaningful use project was assigned to the Office of the National Coordinator (ONC) and the Centers for Medicare and Medicaid Services (CMS) through the American Recovery and Reinvestment Act of 2009 (ARRA). The ONC is creating criteria for what an electronic health record (EHR) should be able to do. CMS is creating guidelines on how EHRs should be used by health care providers and hospitals to improve the quality, safety, and efficiency of the health care system. To achieve meaningful use, health care providers and hospitals must meet the criteria created by the ONC and CMS.

Shown below are the links to the ONC and CMS guidelines.

ONC EHR Guidelines

<http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf>

Proposed CMS Meaningful Use Guidelines

<http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>

The ONC requires EHRs to be certified

EHRs must be able to provide a secure environment for sharing information with other health care providers. They must also be able to give patients access to their health information. To demonstrate this, electronic health records must be tested and certified. The IHS will apply for certification for the IHS Resource and Patient Management System (RPMS) EHR in fall 2010.

CMS requires meaningful use of EHRs

CMS must make sure that EHRs are being used to improve patient safety and health care services. CMS will require reporting of two types of performance measures to show that providers and hospitals are making this happen: health information technology (IT) functionality measures and clinical quality measures.

Meaningful use will provide benefits

It is anticipated that the adoption of meaningful use will modernize and extend health information throughout Indian Country and the United States. Adoption of meaningful use will also provide financial incentives from both Medicare and Medicaid starting in the year 2011. Incentives will be available to hospitals and providers who are eligible to receive the additional money. CMS expects everyone to achieve meaningful use by the year 2015. Hospitals and providers that do not achieve meaningful use by 2015 will receive penalties in their Medicare reimbursement starting that year.

Meaningful use will happen in three stages

Meaningful use will happen in three stages. This will help programs to get the necessary work done over time. Stage 1 will begin in 2011. In 2013, Stage 2 will begin. Stage 2 will add more requirements and new reports. Stage 3 will begin in 2015 and is expected to add more requirements.

Meaningful use Stage 1

The first steps in achieving meaningful use are to have a certified electronic health record (EHR) and to be able to demonstrate that it is being used to meet the requirements. The IHS expects the RPMS EHR will be certified in 2010. The RPMS EHR will include new reports to assist health care providers and hospitals monitor how well they are meeting the meaningful use requirements.

For Stage 1, providers and hospitals will need to report their performance on the two types of measures described below.

- 1) *Health IT Functionality measures.* These measures show how well a provider or hospital is using the EHR. For Stage 1 meaningful use there are 25 provider measures and 23 hospital measures. Most of the measures require the provider or hospital to meet a certain target. Two examples are shown below.

Stage 1 Measure for eligible Providers	Stage 1 Measure for Hospitals
At least 80% of all orders must be entered directly into the EHR by the provider	At least 10% of all orders must be entered directly into the EHR by the provider

Some of the Health IT Functionality measures show how well the patient's information can be shared with other health care systems. This is known as "interoperability." Increased interoperability among EHRs where information is exchanged according to established national standards will ultimately allow health care providers to have access to a complete view of the patient's medical history, rather than a snapshot of the care that has occurred only at the provider's own health care facility.

- 2) *Clinical Quality measures.* These measures show how meaningful use and other initiatives have improved the care that patients receive. These measures will be reported for each provider and hospital. For Stage 1, Medicare requires providers to report on three core measures and three to five additional measures that vary depending on the provider's specialty of care. Hospitals are required to report on a set of 35 Medicare inpatient measures and potentially eight Medicaid inpatient measures. For Stage 1 meaningful use, providers and hospitals are not required to meet any targets. Two examples are shown below.

Stage 1 Measure for eligible Providers	Stage 1 Measure for Hospitals
Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.

OIT's responsibilities to achieve meaningful use

The IHS Office of Information Technology (OIT) is working to ensure the RPMS EHR is certified in 2011, is capable of achieving meaningful use, and is deployed by January 1, 2011. OIT is responsible for communicating the ONC and CMS requirements to the tribes to ensure the tribes have a clear understanding of the responsibilities of IHS, the Area Offices, and the providers and hospitals in order to achieve meaningful use.

IHS OIT meaningful use web site

To keep you informed, we have created a Meaningful Use website, which includes a calendar of events related to meaningful use. Visit this site for the latest information at:

http://www.ihs.gov/recovery/index.cfm?module=dsp_arra_meaningful_use

Subscribe to RSS

The Meaningful Use website also now has an RSS feed that you can subscribe to so you can stay informed as the site is updated. Subscribing is easy:

1. Click the "Subscribe" link at the top of the web page.
2. When the subscribe page opens, click the "Subscribe to this feed" link.
3. In the dialog box that appears, click the "Subscribe" button.

Area and provider/hospital responsibilities to achieve meaningful use

Achievement of meaningful use will not be accomplished only through the steps taken by the IHS OIT. Rather, actions must also be taken by the Area Offices, providers, and hospitals to achieve meaningful use, as described below.

- Review all IHS meaningful use presentations.
- Visit the IHS meaningful use website at: http://www.ihs.gov/recovery/index.cfm?module=dsp_arra_meaningful_use
- Review the ONC and CMS guidelines to understand the details of the requirements.
- Ensure each EHR site has a clinical applications coordinator (CAC).
- Ensure all relevant staff have received training on the appropriate methods for using and documenting in the EHR.
- Change business processes as needed to achieve meaningful use. For example, ensure that providers enter at least 80% of all orders with computerized provider order entry (CPOE).
- Conduct the interoperability tests.
- Determine incentives eligibility and apply for the incentives.
- Talk to your state health information organization to determine requirements for exchanging information (e.g., immunization, patient summary record). Notify the IHS OIT of the state's requirements.
- Talk to your state Medicaid program to determine if additional requirements are needed to achieve meaningful use. Notify the IHS OIT of the state's requirements.
- Use the tools that will be added to RPMS for reporting of health IT functionality and clinical quality measures and know how the information needs to be reported to CMS and/or the state Medicaid programs.

Summary

Achieving meaningful use does not simply mean installing a certified EHR. Rather, that is just the beginning. Meaningful use will only be achieved by the collaborative work between the IHS OIT, the Area Offices, and providers and hospitals that will apply for the incentives. The requirements for achieving meaningful use are not final yet and are subject to change. However, we cannot wait until they are finalized to begin work – we must start *now!*

Pioneers in the Indian Health Service: Dr. Annie Dodge Wauneka

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Annie Wauneka providing TB education, 1953. NARA-College Park, Still Picture Branch, Record Group 75

This is the second in a series of *Provider* articles highlighting some of the fascinating people who were pioneers in the history of the Indian Health Service (IHS). Dr. Annie Dodge Wauneka was a tribal leader of the Navajo Nation and a public health activist, who gained national prominence in her tireless work to improve the health and welfare of the Navajo Tribe as well as national support for Indian health. Annie Wauneka's skill as a communicator and her life's journey were captured in a classic Indian health article first published in *The American Journal of Nursing*, July 1962, and is reprinted in this issue of *The Provider* with permission of the AJN.¹

Annie Wauneka was born in 1910 in a hogan and was raised in the traditional Navajo culture. Her father, Henry Chee Dodge, was the first tribal council chairman of the Navajo Nation. When she was eight, while attending boarding school on the reservation, a tragic event occurred that helped shape the rest of her life: the 1918 influenza epidemic. Thousands of Navajos, including many of Wauneka's classmates, died. Wauneka escaped with a mild case of influenza and helped cared for those who were too ill to feed themselves.

After graduation and marriage to George Wauneka, Annie traveled with her father, then tribal chairman, observing the

poverty and disease that plagued most of the Navajo people. She was elected to the tribal council in 1951 and became a member of the tribe's Health and Welfare Committee. She became chair of that committee in 1953.

Annie Wauneka led the Tribe's fight against tuberculosis. She was instrumental in bringing infectious disease experts from Cornell University to the Navajo reservation where they successfully field tested their new drug isoniazid, or INH, in the treatment of TB.² She went on to forge the tribe's partnership with Cornell in the establishment of the Many Farms Project, an experimental health delivery project that bridged the gap between traditional and western medicine, and pioneered the field of community medicine.³

Her weekly radio broadcasts in Navajo explained how modern medicine could help improve health among the Navajo. She also worked on other health issues, including improved sanitation, better care for pregnant women and new babies, regular eye and ear examinations, and alcoholism. She was a vocal and visible spokesperson on national Indian health issues, and served on advisory boards of the US Surgeon General of the US Public Health Service.

In 1963, Wauneka became the first Native American to receive the Presidential Medal of Freedom. In 1976, The University of Arizona awarded Annie Wauneka an honorary Doctorate in Public Health, and *Ladies' Home Journal* selected her as their Woman of the Year. In 1984, the Navajo Council designated her "The Legendary Mother of the Navajo Nation."⁴



Annie Wauneka, Susie Yellowtail, and Emery Johnson, IHS Director at an IHS advisory board meeting, 1970. Indian Health Service Historic Photo Collection

Shortly after her death in 1997, former IHS Director Emery Johnson reflected on the pioneering role of Annie Wauneka and Indian women leaders in a letter to Ray Shaw, the first Director of IHS, as follows:

The death of Annie Wauneka this fall marks the end of an era.

I remember the remarkable Indian women - Annie Wauneka, Suzie Yellowtail, Eunice Larrabee, Mary Riley, Agnas Savilla, Phoebe Downing, Eva Nichols - who were our major sources of support in the Indian communities in those early years. Now of course, health has become a fashionable program for the elected tribal leaders; back then, these women were the key to achieving change in their communities.⁵

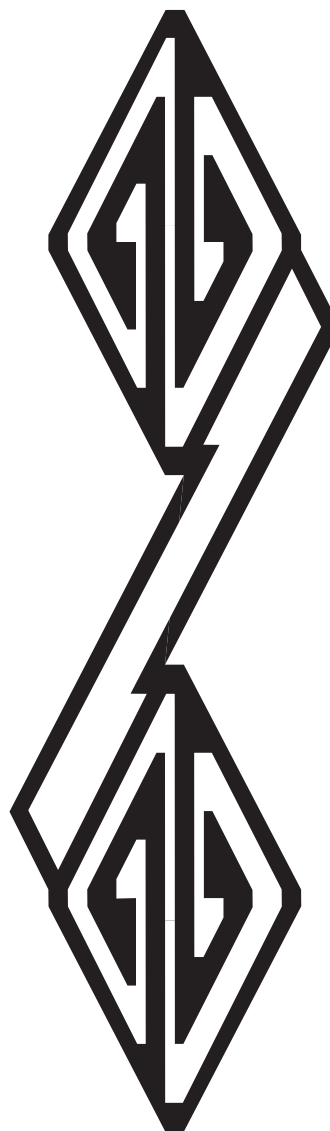


Annie Wauneka and Everett Rhoades, IHS Director at the Bicentennial Celebration of the U.S. Public Health Service's, 1989. Indian Health Service Historic Photo Collection.

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Helping A People To Understand

A Navajo leader taught herself and then others how to fight tuberculosis

Annie D. Wauneka

Mrs. Wauneka is the only woman member of the Navajo Tribal council and is chairwoman of the council's Committee on Health and Welfare. She has received many honors for her work in this area. In 1959, she was cited by the Arizona Public Health Association as the state's outstanding worker in public health. Also in 1959, she was presented the Indian Council Achievement Award.

The author wishes to express her appreciation for the help she received in the preparation of this article from Henrietta Smellow, nurse officer in the Public Health Service at the Window Rock Sub-Area Office, Window Rock, Arizona.

In 1951, my first year on the Navajo Tribal Council, one of the doctors reported on the difficulties of helping Navajo patients with tuberculosis. At that time, although Navajo patient were flown to sanatoriums, some of which were located out of the state, once there, they often refused treatment. Some even walked out in their pajamas and went home by whatever transportation was available. Sometimes, when visiting, parents took their children home with them. This caused quite a disturbance among the health workers and, of course, members of the Tribal Council were concerned that their own sick people were refusing services.

I was appointed by the council to look into this problem and see if I could find a way to convince Navajo patients to remain in the sanatoriums for treatment. It was thought that a woman and mother could better understand their problems.

The doctors had told patients that tuberculosis was caused by a germ that could be transferred from one individual to another through contact. But this idea was not understood by many Navajo, especially those who were uneducated. Even today, out of 100 Navajo people, 85 are illiterate.

It was difficult for me to realize that I would be working among my people on the prevention and treatment of tuberculosis, because I was just as unknowing about the disease as any Navajo on the reservation. I admit that I was definitely afraid to tackle the problem. I told my husband of the appointment and explained what I was supposed to do. He immediately objected saying that I would contract the disease and the rest of the family would get it. We were all afraid of tuberculosis.

I thought about the problem for a long time. I did not know anything about tuberculosis, how to talk about it, whether it really was caused by a germ, or whether the doctors had made

up the whole story about "bugs." To explain to other Navajo about tuberculosis, to know what I was talking about, to convince sick Navajo to return to the sanatoriums, I had to find out all about it -- what it could do to a human being, where it came from.

I spent a lot of time talking to doctors about it and, over a period of several months, visited the laboratory. I wanted to see with my own eyes what kind of bugs the doctors were talking about. I had to know that there actually were germs.

When I understood enough about tuberculosis, when I learned that tuberculosis could affect not only the lungs but many parts of the body, when I knew I could answer questions, then I was prepared to tell my people that only "white man's medicine" could cure tuberculosis.

But first I spoke to the medicine men on the reservation about what I had learned. In turn, the medicine men explained to me the old Navajo beliefs about what causes illness. It was hard for me, but I had to learn both the old and the new to be able to interpret to the Navajo.

Beliefs and Customs

Today, when a Navajo becomes ill, he must choose between the white man's doctor and his own medicine man. He has to decide which one will cure him. In the past, the Navajo people did not believe in the spread of disease, and this is still true today with a majority of them.

There is no word for "germ" in our language. This makes it hard for the Navajo people to understand sickness, particularly tuberculosis.

I asked the medicine men what they thought caused the lungs to be destroyed; what caused the coughing and the spitting up of blood. According to the stories learned from their ancestors, tuberculosis is caused by lightning. If lightning struck a tree and a person used that tree for firewood or anything, it would make him sick, cause blisters to develop in his throat and abscesses in his lungs. There are other beliefs besides this.

It is difficult for the Navajo people to believe that tuberculosis is not caused by lightning but by a germ that multiplies.

To talk about tuberculosis or health care to a Navajo, one must approach him with courtesy and respect. When we enter a hogan or visit with patients in the sanatoriums, we first talk about each other's relations. This is particularly necessary with the elderly Navajo people. By beginning in this way we show that we are friendly and interested in the person and have respect for him and that we are, in a fashion, related.

Next we talk about everyday chores, how the family is getting along, whom they visit, how they are making out with the livestock or other sources of income. We ask if they are getting any kind of help. This leads to talk about welfare, sanitation, and finally, about tuberculosis.

We explain to the whole family how tuberculosis is spread and how the bugs can actually be seen through a microscope. We describe how the sick person starts to lose weight, how he coughs, then starts spitting up blood. We tell about x-rays, that taking them is just like taking a picture of anyone. They usually listen eagerly.

It takes them a long time to answer, because they are thinking about what we have said. They tell us about their family problems and ask who will take care of their loved ones at home, who will look after the sheep and horses if they go to the sanatorium. We discuss these problems and tell them that their families will be taken care of when they go to the sanatorium.

In most cases, it is not necessary to look for help outside the family group, because Navajo families are closely united, and not only in blood lines. They live close by one another. Married daughters, aunts and uncles, and in-laws usually are available to help.

This encouragement we give makes patients less reluctant to go back to the hospital for treatment and cure. It is very hard for the Navajo, especially the older ones who have tuberculosis, to go far from home, because they have never been off the reservation or far from their loved ones.



Mrs. Wauneka can help the patient understand why he should stay in the hospital because she is at home with medical concepts of both tribe and white man. (Photos: Gene Price. Navajo tribe)

Adjusting to Hospitals

A hospital is totally strange to them -- strange people, strange food, strange ways of treating the sick. Bathing facilities, running water, electric lights, and thermometers are all strange.

Among other things, the Navajo do not like to have their persons touched. They do not like someone looking at their bodies without their consent. The Navajo do not like to expose their bodies. Bed rest is also strange to them, particularly if they are at home. They know that they must make a living, take care of the children, take care of the sheep. They do not understand what good it will do to stay in bed and take certain foods and medicine.

All this must be explained. Such foods as vegetables, fish, chicken, or pork are not part of the regular Navajo diet; so this is something else they must learn. The value of these foods must be explained, as well as the value of the drugs and treatment the doctor recommends.

The Navajo does not understand why the doctor in the sanatorium does not come to see him every day the way he does in a general hospital. The patients like to see their x-rays to see if they are "making their way to a cure."

It is the responsibility of the health committee to help the Navajo people understand about diseases, how they are spread, and how they can be prevented. The only way this can be done is through people who are interested and dedicated.

The members of the health committee talk to the doctors in the sanatoriums, so they can explain the progress to the patients. The patient who must stay longer must be encouraged in a way he understands. We explain to him that it will take a lot of effort on his part, as well as on the part of the doctors to accomplish the cure.

Part of our job is to remind families that patients like to get letters from home, to know about how the children are getting along, and who is looking after the sheep. We tell them that patients like happy letters.

The ones who receive all kinds of complaints from their families want to go home to take care of the problems. When families write such letters, we explain why happy letters are needed.

When patients must be persuaded to return to the sanatorium, we point out what improvement has already been made. The patients admit they feel better in the hospital. They say, too, that they would like to return and will return after the problems at home have been cared for. The health committee emphasizes the danger to the family and how, in the long run, it will be better to be cured of tuberculosis.

It is important to listen to and understand the patient's problems, how he feels about being so far away from home, and just what it means to him to be in the sanatorium.

Another thing that must be clearly explained to the Navajo is that tuberculosis is not a disease peculiar to the Navajo but that it is a world problem, a community disease, and that all

health services such as the U.S. Public Health Service are working very hard to stamp out this dreadful disease. We explain that tuberculosis is a disease of long standing and that it is the duty of the Navajo people to help cure themselves.

In the past, the Navajo were not told about tuberculosis in just this way. They were never warned or taught about this disease or that it could be prevented. The only things Navajo patients learned were that, if they were sick, they went to the hospital, got treated, and came home.

I have made films on tuberculosis with the narrative in the Navajo language, which we have shown in many communities. These help to teach the Navajo about tuberculosis, what can be done about this dreadful disease that is killing off our people. The Navajo are interested and active in planned programs throughout the reservation. Through the health committee, they are learning more of what we need to do to raise our children in better health and to safeguard them from disease.



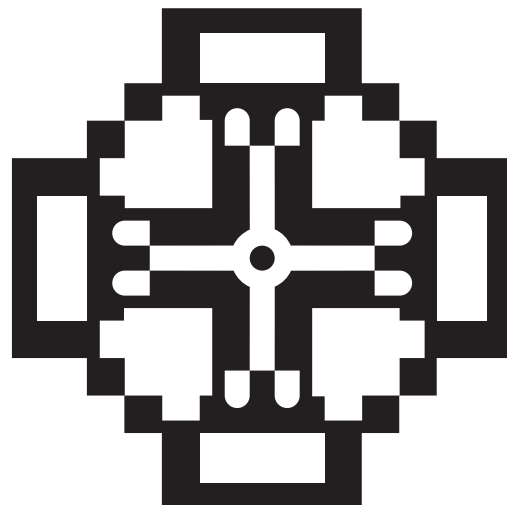
When the author (seated right) visits a patient's hogan - here with public health nurse, Dolores Young, and practical nurse student, Zelda King - hosts and guests observe etiquette by first asking about each other's relatives.


The Blessing Way

When a Navajo patient returns from the sanatorium, a ceremony called "The Blessing Way" is performed. It is a beautiful ceremony performed for those who have been away for months or years, perhaps in the hospital or even in the armed forces. The Blessing Way gives them moral support; it is a happy reunion with a happy spirit. The Navajo knows he is home, that he is welcome, and that he and his family are on a happy journey and wished every prosperity and good health.

I am glad to report that tuberculosis has decreased from first to seventh place as a leading cause of death among the Navajo people. We still have patients who should go to the sanatoriums, who still need to have it explained that tuberculosis is actually caused by a bug discovered by the white man, and that the white man has also discovered the medicine to cure it.

The Navajo patients learn many lessons in the sanatorium and, when they return home, improve their homes because they know that in the hogan with a dirt floor with its uncleanness, tuberculosis can be developed again. They also bring the message of better health teaching to their families and communities. Now attitudes are changing.





CIRCLES OF CARE:

PROVIDING CHOICES TO ELDERS & FAMILIES

MAY 4-6, 2010

Embassy Suites Hotel/Phoenix-Scottsdale • Phoenix, AZ


This conference is intended to support the development of long term care systems for Elders throughout Indian Country.

Participants will benefit from the experiences of successful program directors as well as learning from each other about how to create and develop sustainable programs and cultivate federal, state and private resources. All workshops, plenary sessions and site visits are designed to help program directors, staff and tribal leaders respond to the unique long term care needs of their community.

To make your hotel reservations please contact the Embassy Suites Phoenix-Scottsdale at 602-765-5800 by April 3, 2010 and mention code "Long Term Care (LTC) Conference."

For updated conference information, visit:
www.aianlongtermcare.org

This conference is a collaborative effort of the following: AoA, IHS, VA, CMS, UND NRC, NSAIE, NICOA, NMGEC, CDC, Native American Health, ANTHC, Pueblo of Jemez, Laguna Pueblo, Yurok Tribe, Pueblo of San Felipe, ITCA, Blackfeet Eagle Shield Center, and SEARHC.



The 15th Annual Elders Issue

The May 2010 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the fifteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and

their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

Changes in *The IHS Provider* Distribution

As most of our readers know, we are still having problems with the timely distribution of paper copies of *The Provider*. The transition to the UFMS has proved more difficult than anticipated, and we realize that these problems may persist for the coming year. We have instituted the following changes.

We will continue to publish monthly issues with all articles, meetings, announcements, position vacancies and so on, but we will distribute these electronically, using the *Provider* listserv to let those subscribed to that service know when issues are published to the website. This will assure that all who are interested can receive all of this information in a timely manner. Currently, about 15% of our readership has subscribed to the listserv (see the instructions elsewhere in this issue about how to do this) and the list has been growing at an annual rate of about 20 percent.

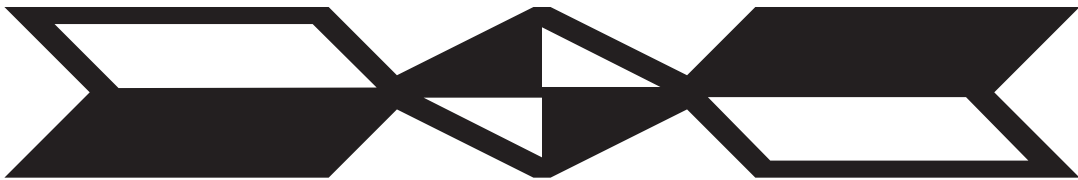
We will publish and mail paper issues on a quarterly basis (March, June, September, and December), and these will contain only the *articles* for the past three issues. This will assure that those without Internet access will still be able to see all of the clinical information, although these paper issues will not include the time-sensitive information described above.

A significant proportion of the cost of publishing *The Provider* is the postage needed to distribute the 6000 copies that go out monthly, and so, by mailing only quarterly issues, we will be able to save the agency money, as well.

We are interested to hear feedback from readers to know if this idea poses any hardships, or if there are suggestions about how to revise this plan to better meet the needs of our readers. Send these by e-mail to john.saari@ihs.gov.

Help us Update Our Mailing List

If you see copies of *The Provider* being delivered to your facility addressed to individuals who have left, please take a moment to e-mail cheryl.begay@ihs.gov to let her know so that she can remove these individuals from the mailing list. This will save us postage and printing expenses, and eliminate a minor inconvenience in your mailroom.



The Indian Health Service Alcoholism and Substance Abuse Program,
the IHS Division of Behavioral Health,
and the IHS Clinical Support Center (the accredited sponsor) present the

TARGET AUDIENCE

This training is available to Indian health physicians, physician assistants, nurses, and advanced practice nurses.

ACCREDITATION

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse Midwives.

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

COURSE COORDINATORS

Anthony Dekker, DO

Acting Director, Office of Health Programs,
Phoenix Area IHS
anthony.dekker@ihs.gov

David Eppheimer, MD

Specialist in Addiction Medicine
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Peter Stuart, MD

Psychiatry Consultant
Chinle Comprehensive Health Care Facility
peter.stuart@ihs.gov

For information to register, please contact:

Cheryl Begay
IHS Clinical Support Center
Phone: (602) 364-7777
Email: cheryl.begay@ihs.gov



2010 Clinical Update on Substance Abuse and Dependency

PURPOSE

The 2010 Clinical Update on Substance Abuse and Dependency (formerly known as the Primary Care Provider Training on Chemical Dependency) is an intensive, interactive training course that has been offered to Indian Health Program providers for the past twenty years. It has evolved into one of the best opportunities available to develop specific skills related to caring for substance abusing Native American clients and their family members who are also affected by the abuser's behavior.

DATE:

June 1 - 3, 2010

LOCATION:

Native American Connections, Inc.
4520 North Central Avenue, Ste 600
Phoenix, AZ, 85012
Phone: (602) 254-3247
Fax: (602) 256-7356

DATE:

June 22-24, 2010

LOCATION:

LaQuinta Inn and Suites
1425 E. 27TH Street
Tacoma, Washington 98421
Phone: (253) 383-0146
Fax: (253) 627-3280

AGENDA

Tuesday

Registration	7:30 am
Welcome & Course Overview	8:00 am
Presentations	8:45-5:00 pm

Wednesday

Overview of the Day	8:00 am
Presentations	8:15-5:00 pm

Thursday

Overview of Final Day	8:00 am
Presentations	8:15-4:45 pm
Program Review and Q&A	4:45-5:00 pm

OBJECTIVES

After completion of this activity, participants will be able to:

- Develop skills for motivating, evaluating, and properly treating patients with chemical dependency.
- Identify the components of treatment in order to improve the care within their community.
- Learn how opiates can be safely prescribed without abuse or addiction.
- Participate with recovering people in discussions and sweat lodge ceremonies.
- Become a local resource and advocate for patients with chemical dependency.

COURSE INFORMATION

2010 Clinical Update on Substance Abuse and Dependency *(Formerly the Primary Care Provider Training on Chemical Dependency)*

Since 1988, the Indian Health Service (IHS) Alcoholism and Substance Abuse Program Branch (ASAPB), utilizing the IHS Primary Care Provider Curriculum: *Clinical Training in American Indian/Alaska Native Alcohol and Other Drug Abuse*, has offered three days of intensive workshops which include both didactic and experiential training. The curriculum is updated annually with the most current nursing, addiction medicine, and prevention information. In Fiscal Year 2010, the following trainings will be offered:

June 1-3, 2010 Clinical Update on Substance Abuse and Dependency (CUSAD) in Phoenix, Arizona.
June 22-24, 2010 Clinical Update on Substance Abuse and Dependency (CUSAD) in Tacoma, Washington.

This intensive, interactive training course has been available to Indian Health Program providers (physicians, physician assistants, advanced practice nurses, and nurses) for the past 21 years. It has evolved into one of the best opportunities available anywhere to develop specific skills related to caring for substance abusing Native American clients and their family members who are also affected by the abuser's behavior.

One group of approximately 30 providers (preferably teams of physicians or physician assistants and nurses from the same hospital or clinic) will attend classroom training. All Indian health facilities are encouraged to carefully select an interested and qualified team to send to this course in order to gain the most from the experience and to better implement a local substance abuse prevention and treatment program when they return to their facility. Training will consist of lecture, discussion and interactive exercises focusing on addressing negative provider attitudes about chemical dependency, and enhancing prevention, screening, intervention, detoxification and treatment skills. Training includes several sessions which cover issues of prescription drug abuse and addiction. Utilizing primarily American Indian/Alaska Native (AI/AN) treatment programs, providers will have the opportunity to observe clients/patients in addiction treatment groups, learn about specific treatment modalities, and discuss treatment issues for American Indian/Alaska Native programs. Providers will be able to participate in talking circles and sweat lodge ceremonies to enhance their understanding of the spiritual component of treatment for AI/AN (bring swimwear or appropriate attire for the sweat, if you choose to participate).

Native American Connections, Inc. (NAC) serves the urban Indian population and tribal communities throughout the Southwest. NAC provides comprehensive behavioral health services, and transitional and permanent affordable housing to low income individuals and families. NAC manages a primary chemical dependency residential treatment program for both men and women designed for a 30-60 day treatment stay; however, individual lengths of stay are clinically determined. Guiding Star Lodge is the women's facility and can accept pregnant women and clients with small children. The Intensive Outpatient program offers an eight (8) week, four (4) days a week, group and individual treatment program. Case management is provided for all clients during their treatment of NAC. Upon completion of primary treatment, clients are given a variety of options including transitional living, outpatient or aftercare counseling, referral to other long-term care facilities, or to their local tribal alcohol program for follow-up.

Travel days will be Monday and Friday of the week, as the course begins at 8:00 a.m. on Tuesday and ends at 5:00 pm on Thursday. The Clinical Support Center will provide travel arrangements and will reimburse for lodging and per diem for non-contracted/compacted participants.* Scholarships are sponsored by the IHS Division of Behavioral Health.

*Employees of P.L. 93-638 compacted or contracted tribal facilities who have taken tribal shares, from the ASAPB and/or the CSC, may be charged a tuition fee of \$350.00 to attend the training session and will be expected to provide for their own travel and per diem expenses.

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

“Who loves, raves -- 'tis youth's frenzy -- but the cure is bitterer still.”

Lord Byron

Articles of Interest

Parental Refusal of Varicella Vaccination and the Associated Risk of Varicella Infection in Children. *Arch Pediatr Adolesc Med.* 2010 Jan;164(1):66-70.

The authors attempted to quantify the increased risk of varicella infection in children whose parents refuse the vaccination. Using a case control study, they found an eight-fold higher risk of having a medically attended case of varicella if the varicella vaccine was refused. Overall 5% of the medically attended varicella infections were in children whose parents declined the vaccine.

Editorial Comment

Many parents fear the potential adverse effects of vaccination more than the real danger of actual infection. In addition, many parents perceive varicella as a mild illness for which vaccination is unnecessary. This study shows that declining varicella vaccination markedly increases a child's risk of acquiring the disease.

A similar study was reported in the June 2009 issue of *Pediatrics* with regards to Pertussis. Pertussis is less common than chickenpox, but the risk of infection with pertussis was over 20-fold higher if parents refused vaccination. The full report can be found at: Parental refusal of pertussis vaccination is associated with an increased risk of pertussis infection in children. *Pediatrics.* 2009 June; 123(6): 1446-51. <http://pediatrics.aappublications.org/cgi/content/abstract/123/6/1446>

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

Pprevnar 13™ vaccine to provide expanded protection against invasive pneumococcal infections.

Rates of invasive pneumococcal disease (IPD) in Australian aboriginal, Navajo, White Mountain Apache, and Alaska Native children are among the highest in the world. Although Pprevnar has been very effective in controlling IPD caused by the seven vaccine serotypes, disease caused by non-

vaccine pneumococcal serotypes has increased in some indigenous populations, leading to continued disparity in disease.

An expanded-valency Pprevnar, Pprevnar 13™, is poised for FDA licensure. Pprevnar 13™ includes the seven serotypes in Pprevnar, and six additional serotypes, including serotype 19A which has become notorious for its increased antibiotic resistance. Approximately two-thirds to three-fourths of the current IPD in Alaska Native and southwest American Indian children is caused by serotypes contained in Pprevnar 13™.

The vaccine schedule for Pprevnar 13™ is identical to Pprevnar. Children <12 months who have received a partial series of Pprevnar will just continue the series with Pprevnar 13™. Children ≥12 months who had received 2 - 3 doses of Pprevnar in their first year of life will just need one dose of Pprevnar 13™. Children 14-59 months who have completed their Pprevnar series will be recommended to receive a supplemental dose of Pprevnar 13™.

Pprevnar-13 Transition Schedule (proposed)

Primary Infant Series			Booster	Supplemental
2 mo	4 mo	6 mo	≥ 12 mo	14-59 mo
PCV7	PCV13	PCV13	PCV13	
PCV7	PCV7	PCV13	PCV13	
PCV7	PCV7	PCV7	PCV13	
PCV7	PCV7	PCV7	PCV7	PCV13

Recent literature on American Indian/Alaska Native Health

Michael L. Bartholomew, MD

Taalii M, Bush N, Bowen DJ, Forquera R. Adaptation of a Smoking Cessation and Prevention Website for Urban American Indian/Alaska Native Youth. *J Cancer Educ.* 2010 Jan 16.

http://www.ncbi.nlm.nih.gov/pubmed/20082169?itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum&ordinalpos=1

Multiple studies have shown that tobacco use among American Indian and Alaska Native youth continues to be

disproportionately high as compared to their Caucasian counterparts. Efforts to decrease tobacco use among AI/AN youth tend to be focused on those residing on reservations. Strategies to use the Worldwide Web as a method to provide smoking cessation support continue to be developed, though none have specifically targeted urban AI/AN youth. The purposes of this two phase pilot study were to collect data, via focus groups, on urban AI/AN youth's perceptions of tobacco use and to modify an existing web-based youth smoking prevention and cessation resource (SmokingZine) for urban AI/AN youth based on their perceptions. The authors of this study noted similar ideas about tobacco among urban AI/AN youth and youth from other cultures. Overall, the focus groups were receptive to a web-based intervention program. Additionally, the input from the focus groups illustrated that a culturally matched intervention program may have a more significant impact. This study is not without limitations. Since

the focus groups were composed of members of many different tribal communities in one urban site, the authors caution generalization of the study results to those specific tribes. The intervention tool also necessitates that the user has computer access, which may not be possible in some AI/AN settings. The success of this study allows for further investigations in multiple youth groups in both urban and rural AI/AN settings.

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, tribal or urban facility that you'd like for us to publicize (i.e., AAP website or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to indianhealth@aap.org or complete the on-line locum tenens form at <http://www.aap.org/nach/locumtenens.htm>.

Electronic Subscription Available

You can subscribe to *The Provider* electronically. Any reader can now request that he or she be notified by e-mail when the latest issue of *The Provider* is available on the Internet. To start your electronic subscription, simply go to *The Provider* website (<http://www.ihs.gov/Provider>). Click on the "subscribe" link; note that the e-mail address from which you are sending this is the e-mail address to which the electronic notifications will be sent. Do not type anything in the subject or message boxes; simply click on "send." You will receive an e-mail from LISTSERV.IHS.GOV; open this message and follow the instruction to click on the link indicated. You will receive a second e-mail from LISTSERV.IHS.GOV confirming you are subscribed to *The Provider* listserv.

If you also want to discontinue your hard copy subscription of the newsletter, please contact us by e-mail at the.provider@ihs.gov. Your name will be flagged telling us not to send a hard copy to you. Since the same list is used to send other vital information to you, you will not be dropped from our mailing list. You may reactivate your hard copy subscription at any time.

MEETINGS OF INTEREST

Advancements in Diabetes Seminars Monthly; WebEx

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

The accredited sponsors are the IHS Clinical Support Center and IHS Nutrition and Dietetics Training Program.

Upcoming seminars include:

Date and Time	Topic	Speaker
February 17 at 1 pm MST	Improving Diabetes Care: The Diabetes Audit	Dr. Ray Shields, Dr. Ann Bullock, and Karen Sheff, MS
March 17 at 1 pm MST	Chronic Kidney Disease: Screening and Laboratory Tests	Dr. Ann Bullock
April -- TBA	Update on Diabetes Guidelines	Dr. Kelly Acton
March -- TBA		

For information on upcoming seminars, go to www.diabetes.ihs.gov, (<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=home>) and click on **Advancements in Diabetes Seminar**.

For information about previous seminars, including the recordings and handouts, click on the following link and visit Diabetes Seminar Resources: <http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars>.

Available EHR Courses

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

The 2010 Meeting of the National Councils for Indian Health

March 21 - 26, 2010; Phoenix, Arizona

The National Councils (Clinical Directors, Chief Executive Officers, Chief Medical Officers, Oral Health, Pharmacy, and Nurse Consultants) for Indian health will hold their 2010 annual meeting March 21 - 26, 2010 in Phoenix, Arizona. Engage in thought-provoking and innovative discussions about current Indian Health Service/tribal/urban program issues; Identify practical strategies to address these health care issues; Cultivate practical leadership skills to enhance health care delivery and services; Share ideas through networking and collaboration; and receive accredited

continuing education. Indian health program Chief Executive Officers, clinico-administrators, and interested health care providers are invited to attend. The meeting will be held at the Hyatt Regency Phoenix, 122 North Second Street, Phoenix, Arizona 85004. Please make your hotel room reservations by March 1, 2010 by calling 1-(800) 233-1234 or (602) 252-1234. Be sure to ask for the "Indian Health Service" group rate. On-line registration and the

conference agenda will be available late December at the Clinical Support Center web page at <http://www.csc.ihs.gov>. The IHS Clinical Support Center is the accredited sponsor for this meeting. For more information, contact Gigi Holmes or CDR Ed Stein at (602) 364-7777; or e-mail gigi.holmes@ihs.gov.

Native Fitness Trainings

March 25 - 28, 2010; San Diego, California

April 19 - 20, 2010; Norman, Oklahoma

The American Indian Institute at the University of Oklahoma is offering two Native Fitness Trainings in San Diego, California, March 25 - 28, 2010, and Norman, Oklahoma, April 19 - 20, 2010. This is an introductory level training designed for anyone interested in fitness, those who have never had any fitness training, and for those who work in tribal wellness programs. Topics covered during the training include anatomy and physiology, biomechanics, nutrition, exercise and weight management, instructional skills, class development, marketing, injury prevention and safety, special populations, choreography, and legal considerations. Continuing education units and a certificate will be offered by the University of Oklahoma. All participants must have current CPR certification. For more information, please

contact Chelsea-Southerland@ou.edu or visit www.aii.ou.edu.

Ninth Annual Native Women and Men's Wellness Conference

March 28 - April 1, 2010; San Diego, California

The American Indian Institute at the University of Oklahoma will be presenting the Ninth Annual Native Women and Men's Wellness Conference in San Diego, California, March 28 - April 1, 2010. Areas of focus include diabetes prevention and care, gender specific health, wellness, and spirituality. The conference will provide both personal and professional development, and activities to inform and inspire tribal community leaders, health advocates, and health consumers in best practices. Continuing education units will be offered by the University of Oklahoma. There will be no registration fee for presenters. For more information, please contact Chelsea-Southerland@ou.edu or visit www.aii.ou.edu.

2010 American Indian Prevention Services Conference

April 21 - 22, 2010; Norman, Oklahoma

The American Indian Institute will be presenting the 2010 American Indian Prevention Services Conference in Norman, Oklahoma from 8 am – 5 pm, April 21 - 22, 2010. This conference will bring together the expertise of prevention, public health, and wellness professionals to assist in the exploration, development, and sustainability of our individual and community strengths. Workshops will cover a broad range of topics to enhance the community-building foundation upon which prevention is built, such as strategic and community planning; services for returning veterans and their families; problem and compulsive gambling; substance abuse issues and prevention; suicide prevention; domestic violence prevention; chronic disease and diabetes prevention; culturally relevant methods for American Indians; and developing inter-agency and inter-tribal relationships. There will be no registration fee for presenters. Continuing education units will be offered by the University of Oklahoma. For more information, please contact Chelsea-Southerland@ou.edu or visit www.aii.ou.edu.

Second Annual International Telehealth Palliative Care Symposium

April 27 - 29, 2010; via webcast

Registration is open for the Second Annual International Telehealth Palliative Care Symposium to be held April 27 - 29, 2010; everyone is invited to join by webcast. This is a palliative care symposium for doctors, mid-level practitioners, nurses, pharmacists, social workers, and other health care providers. Join us in person at selected sites or via webcast for an hour, a day, or all three days. Online registration is now open. Registration and CME/CE are available at no cost. To register online, go to <http://palliativeak.org/civcrm/event/info?id=6&reset=1>.

2010 palliative care topics include

- So many patients die after we get close to them: how

do we heal ourselves?

- Best practices for palliative pain and symptom management: How can I confidently change from dosing for cure to dosing for palliative care?
- What can I do when access to high-level care is limited?
- Who cares? What people near the end of life say about caring
- Maintaining hope and trust: How can I be honest with a patient about their prognosis?
- Managing delirium for a peaceful end-of-life journey
- Traditional healing among the Inupiaq: importance of caring for the body, mind, and spirit

See the agenda and speaker web pages for more details at: <http://www.palliativeak.org/>. For more information contact palliativesymposium@anthc.org.

Advances in Indian Health

April 27 - 30, 2010; Albuquerque, New Mexico

The Advances in Indian Health Conference, April 27 - 30, 2010 will be held at the Sheraton Uptown in Albuquerque, New Mexico. "Advances" is IHS's primary care clinical conference and attracts over 350 clinicians from across the Indian health system. The conference covers many primary care topics with special emphasis on diabetes, mental health, substance abuse, women's health, geriatrics, pediatrics, and the EHR. With low tuition and a government rate available for the conference hotel, Advances is a low cost way for clinicians to receive up to 28 hours of CME/CE on issues of particular importance to Indian health patients and practices. The conference brochure will be available in early 2010 on the UNM Office of CME website: http://hsc.unm.edu/som/cme/2010_Conferences.shtml. For more information, contact the course director, Ann Bullock, MD, at ann.bullock@ihs.gov.

2010 Long Term Care Conference: Circles of Care: Providing Choices to Elders and Families

May 4 - 6, 2010; Phoenix, Arizona

The 2010 Long Term Care Conference entitled *Circles of Care: Providing Choices to Elders and Families* will be held May 4 - 6, 2010 at the Embassy Suites Scottsdale (Phoenix). This conference is intended to support the development of long term care systems for elders throughout Indian Country. Participants will benefit from the experiences of successful program directors as well as learning from each other about how to create and develop sustainable programs and cultivate federal, state and private resources. All workshops, plenary sessions, and site visits are designed to help program directors, staff, and tribal leaders respond to the unique long term care needs of their community. The conference is a collaborative effort of agencies including AoA, IHS, VA, CMS, UND, NRC, NSAIE, NICOA, NMGEC, CDC, Native American Health,

ANTHC, Pueblo of Jemez, Laguna Pueblo, Yurok Tribe, Pueblo of San Felipe, ITCA, Blackfeet Eagle Shield Center, and SEARHC.

For updated conference information, visit: www.aianlongtermcare.org.

**The IHS Southwest Regional Pharmacy Continuing Education Seminar (the “Quad”),
June 6 - 8, 2010; Scottsdale, Arizona**

The largest annual meeting of Public Health Service pharmacists and technicians, and pharmacists from tribally operated programs, this seminar provides up to 15 hours of ACPE approved pharmacy continuing education credit. Hosted by the IHS Phoenix and Navajo Areas, the target audience is made up of pharmacists and technicians working in Indian health system clinics and hospitals. It will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258. For more information, look for “Event Calendar” at <http://www.csc.ihs.gov/> or contact CDR Ed Stein at the IHS Clinical Support Center by e-mail at ed.stein@ihs.gov.

**Introduction to Social Marketing
June 25 - 29, 2010; Santa Fe, New Mexico**

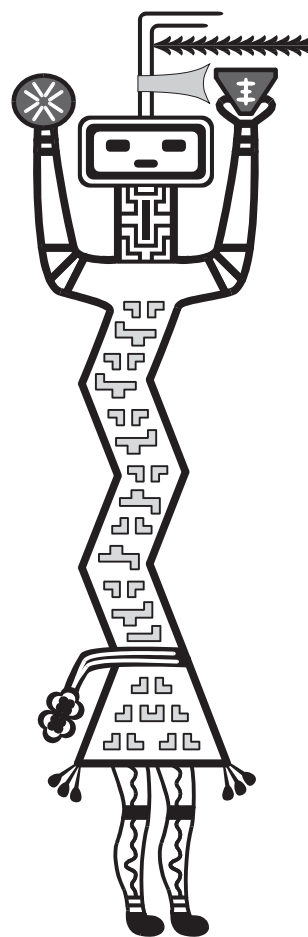
The American Indian Institute will be offering the “Introduction to Social Marketing” training in Santa Fe, New Mexico, June 25 - 29, 2010. This training is designed for tribal health administrators and directors who are interested in the field of social marketing. The course will include an overview of social marketing, focus group research, program design, and implementation. This is the first course in a series of four that will include 1) Introduction to Social Marketing; 2) Advanced Social Marketing, for those who are in the process of implementing a project; 3) Program Evaluation; and 4) Focus Group Research. Continuing education units will be offered by the University of Oklahoma. For more information, please contact Chelsea-Southerland@ou.edu or visit www.aii.ou.edu.

The Pharmacy Practice Training Program: a program in patient-oriented practice (PPTP)

August 2 – 5 or August 23 - 26, 2010; 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. It will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258. For more information, look for

“Event Calendar” at <http://www.csc.ihs.gov/> or contact CDR Ed Stein at the IHS Clinical Support Center by e-mail at ed.stein@ihs.gov.

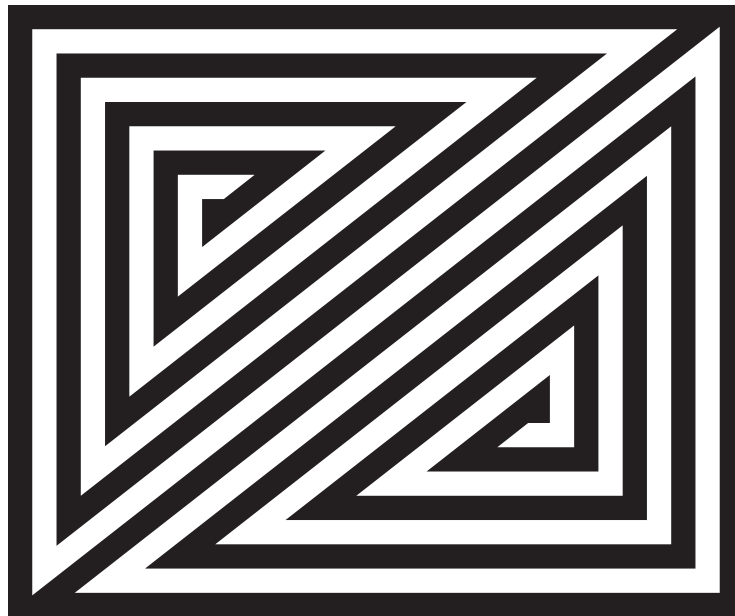


Sources of Needs Assessment Data That Can Be Used to Plan CE Activities

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

In this issue, the article on colorectal cancer screening cites statistics that show just how well we are doing when it comes to meeting performance benchmarks for screening for this condition. There are comparisons of the incidence of this cancer based on ethnicity and geographic location. The article

also offers some ideas about what has worked to improve screening performance in many locations throughout Indian Country. The same website that is cited as the source of the GPRA data (<http://www.ihs.gov/NonMedicalPrograms/quality/index.cfm?module=home>) presents performance data on many other conditions, as well. These are the types of data that can be cited in your needs assessment when you are planning your continuing professional education activities.



POSITION VACANCIES

Editor's note: As a service to our readers, THE IHS PROVIDER will publish notices of clinical positions available. Indian health program employers should send brief announcements as attachments by e-mail to john.saari@ihs.gov. Please include an e-mail address in the item so that there is a contact for the announcement. If there is more than one position, please combine them into one announcement per location. Submissions will be run for four months and then will be dropped, without notification,, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service (\$100 for four months). The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

Family Physician

SouthEast Alaska Regional Health Consortium

The SEARHC Clinic in Juneau, Alaska has an excellent opportunity for a family physician with obstetrics skills to join a medical staff at a unique clinic and hospital setting. Have the best of both worlds in a practice where we share hospitalist duties and staff an outpatient clinic, all with an excellent quality of life. We have the opportunity to practice full spectrum family medicine. Southeast Alaska has amazing winter and summer recreational activities. Enjoy Alaska's capital with access to theater, concerts, and annual musical festivals. Now a NHSC Loan Repayment Site. For information contact Dr. Cate Buley at (907) 364-4485; e-mail cbuley@searhc.org; or visit the website at www.searhc.org. (2/10)

Family Physician

Kodiak Area Native Association; Kodiak, Alaska

Come practice on Alaska's Emerald Isle. Looking for a board certified or board eligible family physician to join Kodiak Area Native Association in providing comprehensive family medicine. Coastal temperatures and endless outdoor recreation. Contact Robert Onders, MD with further questions or, to send a CV, at Robert.Onders@kanaweb.org. KANA is an EOE employer exercising Native preference in accordance with PL 93-638. For a complete list of job qualifications, description, and application, please contact Kodiak Area Native Association Human Resources Department by e-mail at Samuel.towarak@kanaweb.org; mailing address 3449 E. Rezanof Drive, Kodiak, Alaska 99615; telephone (907) 486-9805; or fax (907) 486-9896. (2/10)

Physician

Puyallup Tribal Health Authority; Tacoma, Washington

The Puyallup Tribal Health Authority is currently recruiting a full time physician to join a team of nine other physicians. PTHA is a tribally operated ambulatory clinic located in Tacoma, Washington, and is accredited by AAAHC, CARF and COLA. This position will evaluate, diagnose, and treat medical, obstetric, psychiatric, and surgical diseases and emergencies as credentialed and privileged; oversee the medical evaluation, diagnosis, and treatment of patients by other medical professionals, including precepting midlevel providers as needed; perform histories and physicals, and direct the evaluation, diagnosis, and treatment of PTHA patients in local hospitals, including participation in scheduled rounding; make referrals to specialists as per PTHA protocol and follow-up to assure quality care; provide on-site health education and counseling to patients and staff; participate in after-hours on-call duty as scheduled; provide back-up consultation to other on-call PTHA providers as scheduled; and participate in utilization review studies and quality improvement committee work as assigned.

Minimum requirements include a Doctorate of Medicine or Osteopathy from an accredited institution; board certified (or eligible to sit for exam) in family practice or appropriate field; licensed to practice medicine in the State of Washington; and current certification in ACLS.

PTHA offers a competitive salary, benefits, and a generous time off schedule. To apply, a completed PTHA employment application is required (resume optional). Please submit applications to the Human Resource Department prior to the closing date. Indian hiring preference by law. Telephone (253) 593-0232 ext 516; fax (253) 593-3479; e-mail hr@eptha.com; website, www.eptha.com. The mailing address is PTHA Human Resource Department, KCC bldg #4, 1st Floor, 2209 E. 32nd St., Tacoma, Washington 98404. (2/10)

Family Medicine, Internal Medicine, Emergency Medicine Physicians

Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible family medicine or internal medicine physician to join our experienced medical staff. The SSU is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells, Arizona and three health centers: San Xavier Health Center, located in Tucson, Arizona, the Santa Rosa Health Center, located in Santa Rosa, Arizona, and the San Simon Health Center located in San Simon, Arizona, with a combined caseload of approximately 100,000 outpatient

visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self-management education.

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

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. Commuter van pool from Tucson is available for a monthly fee. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at Peter.Ziegler@ihs.gov. (2/10)

Family Practice Physician Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("Basket-maker") Apache community with a population of 3,500. Our clinic has an opening for a board certified/eligible family practice physician for purely outpatient care with a 40 hour work-week. Our site qualifies for IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. Our staff currently consists of a family practice physician, an internist, a pediatrician, a part-time FP physician (who focuses on prenatal care), three family practice mid-levels, an optometrist, and two dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with profits from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility with free personal training, a modern supermarket, a Best Western Hotel and Casino, and more. We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass. We welcome you to visit our facility in person. To take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to <http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx>. Please call Dr. Cecilia Chao at (575) 759-3291 or 759-7230; or

e-mail cecilia.chao@ihs.gov if you have any questions. (01/10)

Registered Nurse Yavapai-Apache Nation; Camp Verde, Arizona

The Yavapai-Apache Nation has an immediate opening for a clinic nurse. This nursing opportunity is for a registered nurse at the Yavapai-Apache Health Center, in Camp Verde, Arizona. The position is in a tribally run facility, with an IHS provider, and IHS public health nurse. The clinic is an outpatient facility, built in 1998, with family medicine, dental, optometry, and behavioral health services. We work closely with Phoenix Indian Medical Center and local specialists. We expect to have telemedicine capabilities in the near future. The clinic fully utilizes the IHS Electronic Health Record. We work regular hours, and have 15 paid holidays. Full benefits are included.

The facility is located in the beautiful Verde Valley, home to the Yavapai-Apache Nation. The Yavapai-Apache Nation has about 2300 enrolled tribal members. We are located 90 miles north of Phoenix. The Verde Valley offers many outdoor activities such as hiking, canoeing, and fishing; other mountain and desert activities are just a short drive away. The applicant should be an outgoing, energetic, team player who is compassionate and focused on patient care.

For more information and an application, contact the Yavapai-Apache Nation, Human Resources, at (928) 567-1062. (12/09)



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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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