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Integrating Environmental Sustainability and Climate Change into Environmental Public Health Services in the Bemidji Area Indian Health Service

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This is not a “problem” that can be deferred to our children. With today’s limited budgets and resources, now is the time to incorporate environmental sustainability into our programs to ensure healthy, resilient communities that can withstand the shocks from climate change and limited and dwindling resources.

Introduction

“Sustainability is crucial to ensuring that we have and will continue to have the resources to protect human health and our environment for generations to come.”¹ While many variations for defining “sustainability” exist, for the most part they relate to energy, water, waste, purchasing, buildings, and individual behaviors so as to protect the environment for ourselves and our children.²

The intertwined adverse effects of climate change and resource depletion (e.g., fossil fuels, water, and other nonrenewable resources) are being felt by both the Indian Health Service (IHS) and the communities we are entrusted to serve. Increasing costs associated with fuel, supplies, electricity, and emergency response are stretching public health budgets and limiting capacity to provide services.^{3,4,5,6,7,8} In 2012 alone, the US experienced multiple extreme weather events, including an extensive and prolonged drought,⁹ a 500-year flood in Minnesota,¹⁰ and mega-storm Sandy,¹¹ all of which have affected thousands of Americans. The economic costs of these events are steadily increasing, as evidenced by the growing number of “billion dollar storms” suffered by the US over the past decade.¹²

In this Issue...

- 39 Integrating Environmental Sustainability and Climate Change into Environmental Public Health Services in the Bemidji Area Indian Health Service
- 43 Our Apologies
- 43 The 18th Annual Elders Issue
- 44 An Intervention for Stress in American Indian Health Care Workers
- 53 Position Vacancies
- 57 Print Version of *The Provider* has Ceased Publication
- 58 Electronic Subscription Available

As an operating division (OPDIV) of the US Department of Health and Human Services (DHSS), IHS has started reducing its contribution to environmental degradation and climate change by addressing Executive Order (EO) 13514: Federal Leadership in Environmental, Energy, and Economic Performance.¹³ The multi-program IHS Sustainability Advisory Board (SAB) oversees the implementation of EO 13514 within the IHS through sustainability implementation plans, benchmarks, and targeted funding of sustainability-related projects in IHS-owned facilities.² Activities conducted in our federal facilities as part of the EO 13514 mandate include increasing energy efficiency; setting greenhouse gas emission reduction targets; water conservation; reducing IHS fleet petroleum consumption; reducing waste; and leveraging federal purchasing power to promote environmentally responsible products and technologies.

While this is a laudable first step, the time has come to move beyond our IHS program operations, and connect with our mission by assessing vulnerabilities and impacts within the tribal communities we serve. Many of the impacts associated with resource depletion and climate change clearly connect with roles of public health professionals. Developing a more holistic or systems approach to the practice of public health involves all IHS programs coming together and recognizing the interconnectedness of our roles. Building these partnerships within the Indian Health Service will better ensure that our mission is achieved. As health professionals, we advocate, educate, and facilitate. We are well equipped to develop partnerships; advocate for more environmentally sustainable practices; provide education where we are knowledgeable; network to bring in subject matter experts; and facilitate the process of tribes building environmental sustainability into their programs, including identifying possible funding sources.

Community public health practitioners are uniquely positioned within the IHS to facilitate this shift in focus by using environmental sustainability to leverage the interconnected nature of the built environment and health. The DEHS Program's community-based services illustrate several examples of how they are integrating environmental sustainability into their work. For example the latest (draft) revision of the IHS Indian Health Manual Part 3, Chapter 11 offers a vehicle for increased activity by adding environmental stewardship (e.g., environmental sustainability) to the list of environmental health program elements falling within its scope.

Local Examples of Environmental Sustainability and Climate Change Programs in Action

The Bemidji Area (BAIHS) DEHS offers an example of a systems approach to environmental sustainability. We developed a "Green Reservation" assessment tool based on the Minnesota GreenStep Cities program.¹⁵ This tool has been used in partnership with a local Ojibwe Tribe's multidisciplinary

Green Team to prioritize environmental sustainability activities on the reservation. The first initiative that resulted from this process involved solid waste management: a reservation-wide composting initiative. A \$16,000 grant from the Minnesota Pollution Control Agency and \$12,000 of funding from IHS paid for construction costs and education of facilities operators and community members.¹⁶ During the first year of operation, an estimated 153,088 pounds of organic waste was diverted from the tribe's waste stream, eliminating 28.3 MTCE (metric tons of carbon equivalent, a measure of greenhouse gas production) from entering the environment. This is not only good for public health; it translates into a savings of \$14,750 in tipping fees for the tribe. Indirect savings include a reduction in chemical fertilizer use, water use, and fossil fuel use during waste hauling. This initiative has also helped raise awareness regarding food production and traditional food systems.

This budding community enthusiasm served as the launching point for the second phase of this initiative: building a local food system, where healthy and culturally relevant foods are produced and consumed within the reservation borders. This second phase was recently awarded \$11,700 from BAIHS to foster understanding of local food systems; map the food shed to identify current and potential agricultural land; improve Anishinaabe sustainable, traditional, agricultural practices while educating the reservation population about traditional food systems; increase access to and consumption of traditional and healthier foods; and expand the tribe's current composting initiative to improve water quality and provide resources for local food production. The success of this initiative is enhanced greatly by the partnerships it fosters. A major goal of the second phase is to expand and strengthen partnerships with the University of Minnesota Extension, the Tribal Health Division, the Division of Resource Management, IHS DEHS, the IHS hospital, the Tribal Food Coalition, the tribal college's community education program, and the new Tribal Master Gardener program. "In a time of peak oil and climate change, compounded by the epidemic of diet related illness in our indigenous communities, the restoration of our traditional foods is an essential strategy for tribal survival."¹⁷

Another way in which the Bemidji Area DEHS is incorporating ES is through incorporating energy efficiency, water conservation, and integrated waste management recommendations into routine facility surveys and plan reviews. Through targeted trainings, such as sustainable building design, renewable energy technology, water conservation, and permaculture, BAIHS DEHS staffs have been able to acquire necessary skills to identify areas in which energy is being lost in facilities, and recommend ways to increase energy efficiency in the buildings they routinely visit. Working with tribes during plan reviews can be one way to incorporate more sustainable technologies into their buildings and grounds. We can also work with community planners in designing healthier communities around these buildings, communities that promote physical activity, provide space for

food production, create community ties, and enhance the public health by reducing or eliminating disease factors. i.e., lack of physical activity and poor diet. A number of tribes and IHS Areas are already using a holistic approach to incorporate climate change and/or environmental sustainability into their programs. Tribes throughout the nation are conducting community vulnerability assessments and/or climate adaptation planning. Depending on a tribe's level of internal technical expertise, the Area Indian Health Service role could include identifying resources to support planning and/or implementation activities, working with community coalitions (or green teams), providing technical input, bringing in subject matter experts, and assisting with planning and/or implementing vulnerability assessments and training needs.

Call for Agency-wide Action

While local examples such as those outlined above can be found in many Indian Health Service Areas, it is not clear to what extent environmental sustainability and climate change have been formally integrated nationally into IHS. Due to the geographic and tribally diverse nature of IHS, climate change and resource depletion are challenging each IHS Area differently. We propose harnessing the interest building around this topic to initiate IHS-wide action in implementing a more holistic or systems approach to the practice of public health, and developing partnerships throughout our Agency and with tribes to meet this unprecedented public health challenge.

Conclusion

“Program managers must constantly evaluate their programs to ensure that program emphasis areas are based on scientific data which has indicated the relevance of those

programs to the elimination of public health risks, as opposed to programs which are based on tradition or the perception of risks.”¹⁸

The Transfer Act of 1954, through Public Law 568, charged the “Surgeon General of the US Public Health Service” with the federal trust responsibility for assuring “healthcare and the conservation of the health of Indians.”¹⁹ In the 1990s, past IHS DEHS Director Tom Crow described a DEHS management philosophy that embraces effective identification and addressing current and rapidly emerging needs in such areas as toxic chemicals, solid and hazardous waste, and pollution of land, water, and air resources. He saw these as challenging, dynamic problems that require a systems approach for solutions, and challenged the IHS environmental health professional to change and expand our approach.

Overwhelming consensus of the scientific evidence points to the intertwined predicament of climate change and declining non-renewable resources posing a clear and present public health risk of unprecedented magnitude. Public health practitioners of every discipline have a role to play in partnering with tribes in developing holistic strategies to build the resilience of American Indian communities to these threats.

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Our Apologies

We apologize for the delay in the production of this issue. Constraints on funding at the end of the fiscal year made it impossible to complete the preparation of the issue until now.

We will catch up with our usual monthly publishing schedule as soon as possible. We are currently accepting submissions for the August issue.

The 18th Annual Elders Issue

The May 2013 issue of The IHS Provider, to be published on the occasion of National Older Americans Month, will be the eighteenth 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.

An Intervention for Stress in American Indian Health Care Workers

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Background

This Doctorate of Nursing Practice (DNP) project addresses stress in American Indian (AI) community health care workers employed by a tribal health department on a rural Indian reservation in the US. Stress is a risk factor for numerous disease conditions and for negative effects on individual health. AI experience stress from difficult life situations that often lead to chronic disease and poor health conditions.^{1,2} The life of an American Indian is often one of socio-economic hardship, racism, discrimination, oppression, violence, tragedy, and health disparity.³⁻⁶

Needs Assessment

A review of tribal demographics and health disparity information conveyed a troubling community picture and suggested possible adverse health outcomes for the tribal health staff who are members of the community. As of 2009, the population of the reservation community of concern was 1,400, with 55 percent female and 45 percent male, and 99 percent AI.³ The population was young, with the median age of 21.4 years old, 42 percent under 18 years old, and 0.5 percent over 65 years old. In the state where the reservation is located, 1.2 percent of the entire population of 5.2 million identified themselves as AI, while the county intersecting the reservation had a higher rate of 20 percent.³

Educational attainment was lower than the national average. In 2009, among those 25 years and older in the reservation community, 68 percent had a high school or equivalent degree and 8.6 percent had bachelor's degrees. The rate for All Americans was 86 percent with a high school or equivalent degree and 27.2 percent with a bachelor's degree.³ Among the nearly 1,000 eligible reservation workers over the age of 16, 27 percent were unemployed.³ The percentage of reservation community families and individuals whose income in the past twelve months (2008) was below the poverty level was 35 percent and 45 percent respectively, while the percentage for all families and individuals in the US was 9.9 percent and 13.5 percent.³ Extended family households were depicted in the household size; in the reservation community, 17 percent of households included seven or more persons in 2000, while the national average was four percent.³

The needs assessment exposed the troubling work and life circumstances and challenging health status that many AIs

experience. There were twenty-five positions in the community health staff amongst a larger health staff of nearly 250 at this tribal health program. Staff had difficulties with working as a tribal health employee while at the same time being members of the community in which they work. Although the tribal health administration supported the staff in keeping work separate from their personal lives as well as honoring the strong value of family, maintaining professional boundaries was a struggle for the community health workers, according to the direct health supervisor. In addition, there were limited work site wellness programs available.

One aspect of the AI troubling life experience is racism and discrimination. Racism has evolved from the overt bigotry and racial hatred since the 1960s to the current and subtle form of microaggression. Sue⁷ explains racism today as being covert and difficult to distinguish, and resonates through racial microaggressions, which are "brief everyday exchanges that send disparaging messages to people of color because they belong to a minority group"(p.273). The effect of such disparaging remarks or actions, especially when they are covert and ongoing, takes a toll on a person. The repetitive occurrences of microaggression may have an affect on AI well-being and stress levels. A community near this reservation is a regional hub for commerce, education, and health care and is where reservation members regularly seek services. A study conducted on race relations in 2009 in the regional community and nearby reservation found that 45 percent of the AIs were dissatisfied with the race relations and 42 percent stated they experienced discrimination on a regular basis.⁶

According to the Agency for Health Care Quality, health disparities, which have stress as a related risk factor,⁸⁻¹⁰ continue to be pervasive for AI. The report revealed that AIs have higher rates of heart disease, cancer, and respiratory disease than Caucasian adults have.¹¹ Nationally, AI experienced higher mortality rates than other Americans due to diabetes, tuberculosis, liver and alcohol-related disease, unintentional injury, homicide, and suicide from 2003 to 2005 and 2004 to 2008.^{1,2} During this time, the reservation community of concern showed similarities in higher mortality rates in four of the six health conditions, with notably higher rates in unintentional injury and suicide.¹ Access to health care is poor for AIs. AIs are eligible for health care as part of the contract obligation that the federal government has with tribal nations. The Indian Health Service (IHS), the federal agency primarily responsible for providing health care to AI, is historically underfunded and provides health care access at less

than 60 percent to the IHS regions in the United States.¹² Also underfunded is the Contract Health Service Program that is designed to cover costs for IHS patient referrals to providers in the private sector. As a result, funds run out before the end of the year in September, and patients have to wait for care they need. With these troubling life circumstances and health disparities, increased levels of stress for AIs is not unexpected but predictable.

Proposed Solution

To some extent, AI communities are returning to their cultural strengths, such as family, community, traditions, and spirituality to improve their health and well-being.¹³ This community effort is vital to AIs, but more work is needed for managing AI's stress. Without culturally acceptable ways to address health disparities, AI may continue with ineffective coping abilities, ongoing suffering, and cumulative disparities in chronic disease and injury. Stress management that embraces culturally relevant approaches to improve coping is needed to address AI health disparities.^{4,5}

Many individuals integrate complementary and alternative medicine (CAM) therapy into their health care regimen for stress management. Although much of the evidence supporting CAM is anecdotal and changing rapidly, CAM therapies may be beneficial for managing stress,^{14,15} including the positive effects of humor and laughter. Since Norman Cousins "Anatomy of an Illness"¹⁶ first described how laughter and optimism healed him from a devastating collagen disease, researchers have turned their attention to understanding humor and laughter's benefits to health. Laughter yoga (LY) is a unique intervention because its fundamental premise is that anyone can laugh without a reason, without jokes, or humor. It combines laughter exercises with yoga breathing. This combination improves oxygenation to body systems and makes a person feel more energetic¹⁷ yet relaxed, and may improve one's coping ability and decrease stress. In this writer's experience, AIs have been noted to see humor in many situations that many others would not, often unexpectedly. Laughter appears to be a way to ease the pain of an abysmal situation, and it seems that if AI did not laugh as much, there would be considerable more despair. Therefore, LY, as a stress relieving strategy, may be a suitable and culturally relevant intervention for AI stress.¹⁸

Literature

The databases of Ovid Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsychInfo, and the Bibliography North Native American Database (BNND) were used for a literature search. Key search terms were "Native Americans," "American Indians," "stress relief," and "laughter therapy." None of the articles in the search identified Native Americans or American Indians with the other search terms. Eleven articles related to humor, laughter, and stress from secondary sources were identified; however,

they too did not include Native Americans or American Indians. All studies were published from 2001 with the exception of one released in 1998. The systems of hierarchal grading, the Evans Hierarchy, the Grades of Recommendation Assessment, Development and Evaluation tool, and the Joanna Briggs Institute Level of Evidence (JBI) were used to rate the eleven articles. There were various types of study designs in this graded grouping, including three systematic reviews,^{17,19,20} two narrative reviews,^{21,22} two cross-sectional surveys,^{23,24} one experimental cluster sampling,²⁵ and three randomized control trial (RCT) studies.²⁶⁻²⁸ The articles were analyzed relevant to the key areas of purpose, study design, sample, data collection, measures, tools, outcomes and strengths/limitations along with the grading by the selected hierarchies of evidence.

The grading of the evidence and analysis of the summary of findings for the eleven study articles revealed there is slowly emerging empirical evidence that laughter can positively affect the immune system, but there are methodological issues and inconsistent findings in much of the humor and laughter literature. There is some evidence showing that self-reported stress reduction and/or health promotion are positively associated with certain types of laughter.

Theory, Design, and Sample

The humor health theory²⁹ states there is a positive link between humor and health that occurs through four different progressions. In the first direct progression, humor creates physiological changes that are positive and conducive to health. A second alternative progression may influence health via positive emotional states such that a person may transcend adverse personal events or enhance therapeutic situations. The third possible progression is that humor may support moderating adverse effects of stress by the person's cognitive perception, which will lead to enhancing coping ability and to dissipating stress's negative effects. The final progression is that humor may indirectly promote health by improving interpersonal skills that leads to increased social support. Two of the four mechanisms were selected to support the laughter yoga intervention: positive emotional states and moderating adverse effects of stress. The project design was one group, pre- and post-intervention with a comparison of each employee's perception of stress and quality of life (QOL). The participants, who were healthy AI, at least 18 years old, and tribal health employees, were a convenience sample available at the tribal worksite setting. Exemption from full review was given by the project leader's university Institutional Review Board (IRB) and from IHS IRB.

Intervention

A physician along with four friends started LY in 1995 in India, and it has expanded to more than 70 countries and over 6500 laughter groups in the world.³⁰ LY is initiated as an exercise in a group, and with eye contact and innocent playfulness, it can turn into authentic and contagious laughter.

Anyone at any age can participate in LY. The LY instructor held weekly LY classes over a four-week period during the participant's workday at a convenient location for participants.

Data Collection

Demographic data included each participant's age, gender, and contact information. The pre- and post-test instruments, Cohen's Perceived Stress Scale (PSS) and Cantril Self-Anchoring Scale (CSAS), were used to collect the stress status and QOL ratings for each participant. PSS was designed to measure the degree to which situations in one's life were appraised by the respondent as stressful³¹ and is a widely used psychological instrument. The PSS had adequate reliability and was correlated with life-event scores in one identified study with college and graduate students.³¹ The QOL appraisal was based on the CSAS, a well-being instrument that asked participants to evaluate their present and future lives on a ladder scale.³² A version of the CSAS was used to assess well-being in children with bowel disease³³ and an adaptation of CSAS was used with healthy individuals and women with cancer to assess self-esteem.³⁴ In both cases, the instrument was found to be reliable and valid. Furthermore, the CSAS has been used by Gallup³⁵ for their regular collection of American's QOL ratings for twenty-five years. A brief LY class questionnaire was also completed by participants to rate their satisfaction with the classes and the instructor. Team members including the tribal community health supervisor and DNP project advisor established face validity for the PSS, CSAS, and class satisfaction questionnaire.

Measures

The goal of the project for AI employees at the tribal health program was to experience improved coping that resulted in stress relief. The process objectives were to achieve a high percentage of staff registering and participating in the classes during the one-month period. Outcome objectives described the changes for participants from the LY intervention to show moderately improved stress relief, improved QOL, and satisfaction with the LY classes for a majority of the participants. The objective measures focused on the tribal health staff participants, on the implementation of the LY classes by describing who would register and participate, when the objectives would be met, and on the changes pre- and post-intervention.

Results and Analysis

Descriptive statistics was utilized for the participant demographics and for analysis of respondent ratings, primarily frequencies and measures of central tendency. Pre- and post-comparisons were made utilizing data from the PSS and CSAS participant responses. Twelve of the nineteen community health staff who registered (63 percent) were American Indian, age 33 to 60 years old, female, had no health issues to contraindicate robust laughter, and were residents of the tribal

community. Five of the twelve registrants completed four classes (42 percent). The average overall participation rate by registered employees was 58 percent. The low participation rate may have been related to holding class during the workday, and although staff was given supervisory approval to participate during work hours, patient visits may still have taken priority. Mobile phones and text messaging may have been a more effective method of class time reminders because the participants did not check email messages routinely, even though the participants had email access available at their work place.

There were two outcomes related to answering the question, Was there a difference in perceived stress and QOL from just prior to the LY classes to immediately after classes? A third outcome focused on the participant satisfaction with the classes to gauge their interest in continuing the classes. Five participants completed the PSS just prior to the first class and after the last of the four classes with each individual ranking their perception of their life stress. Three of the five had decreases in their stress perception scores from pre- to post-intervention (Figure 1) by 17 to 41 percent while the other two had increases, shown by a change of 32 and 114 percent (see

Figure 1. Participant perceived stress scores pre and post intervention

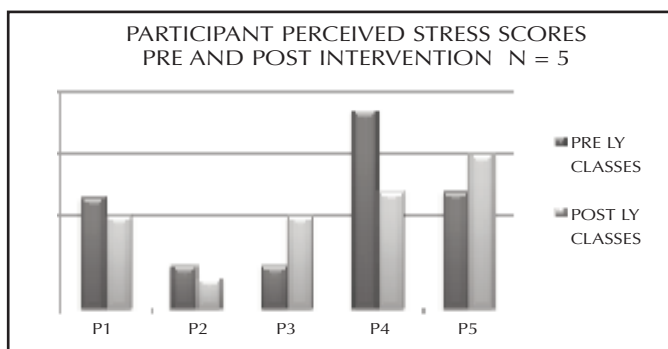


Figure 2. Differences in participant perceived stress scores between pre and post intervention

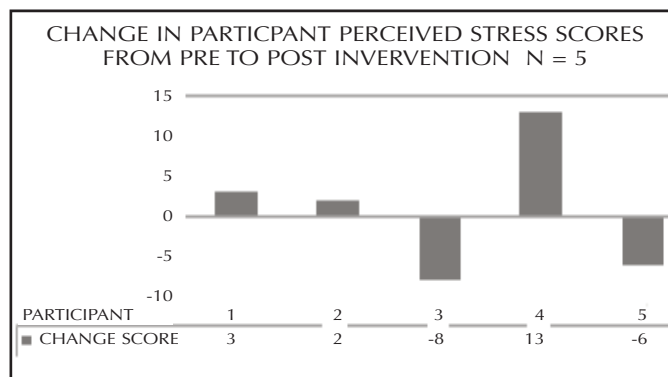


Table 1. Participant scores on perceived stress pre and post LY classes with percent change

Participants	Pre Classes	Post Classes	Change Score	Percent Change
P1	18	15	3	17%
P2	7	5	2	29%
P3	7	15	-8	-114%
P4	32	19	13	41%
P5	19	25	-6	-32%
Mean	16.6	15.8	0.8	-12%
Standard Deviation	10.4	7.3	8.3	

Table 1). Three of the five participants (60 percent) had greater than ten percent improvement in their perceived stress score. The mean change score was 0.8 (negative 12 percent) with a SD of 8.3, which reflected a wide distribution, possibly related to the small sample size. With only five participants, the change of score was heavily influenced by participant three who experienced a 114% increase in stress score. If this participant is removed from our average change in score, there is a 14 percent increase instead, even with the increase in stress from participant five. Overall participants' scores had a wide distribution for change, with three showing small to moderate decreases in perceived stress, one with a moderate increase, and one with a large increase from pre- to post-intervention (Figure 2).

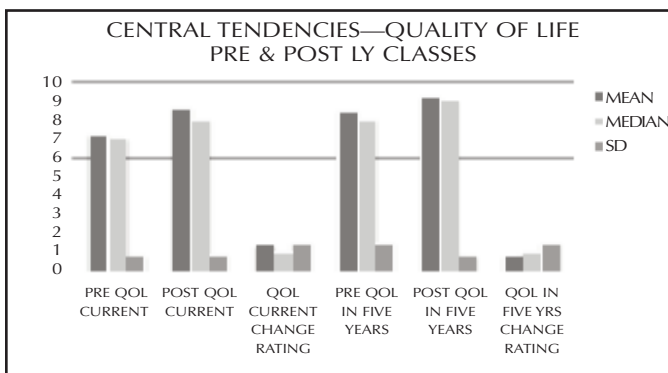
All of the QOL ratings made by participants pre- and post-classes were from 6 to 10 with ratings in the middle of range (4 to 6) of the CSAS considered "struggling," and 7 to 10 rating considered "best possible life" (see Table 2). Four of the five had increases in current QOL ratings ranging in percent

difference from 13 percent to 67 percent, with 67 percent being a significant outlier; one had no change. The mean difference was 1.4 with a mean 22 percent positive change in rating. The mean for scores pre-class (7.2), post-class (8.6) and percent change (1.4) had standard deviation (SD) 0.8, 0.9, and 1.5, respectively. A somewhat wide distribution was shown in the mean percent change of the participants' current QOL responses. However, this is expected after seeing the variable distribution for the stress scores. Participant three, an outlier that suggests a varied sample, appears worse overall than the other four participants do overall. Four of the five participants (80 percent) had greater than ten percent improvement in their current QOL rating.

For the ratings of QOL in five years, three participants' ratings indicated an improved QOL; one rated the future the same; and one rated the future with a decreased QOL (see Table 2). The percentage change in ratings for all participants ranged from pre- to post-intervention was negative 10 to positive 43 percent. The mean difference from pre- to post-responses in the ratings was 0.8, with the mean change percentage of ten percent. The mean, median, and SD are depicted in Figure 3 and indicated a narrow distribution for the mean percent change in the participants' future QOL responses. Three of the five participants (60 percent) had ten percent or greater improvement in the five years in the future QOL rating. Less than 75 percent of the participants had a ten percent improvement in their current and future QOL scores.

All participants completed the satisfaction questionnaire after the four classes were completed and had total overall satisfaction scores ranging from 21 to 27. There were 28 possible points for seven questions, which represented high participant satisfaction with the intervention. The mean for overall satisfaction scoring was moderately high at 23.6 (SD 2.4). Results and mean for questions on satisfaction with the classes and interest in attending more classes are depicted in Figure 4.

Figure 3. Current and future QOL ratings mean, median, and standard deviation pre and post intervention



P - Participant
 LY – Laughter yoga
 QOL - Quality of life

Comparing Participant's PSS with QOL

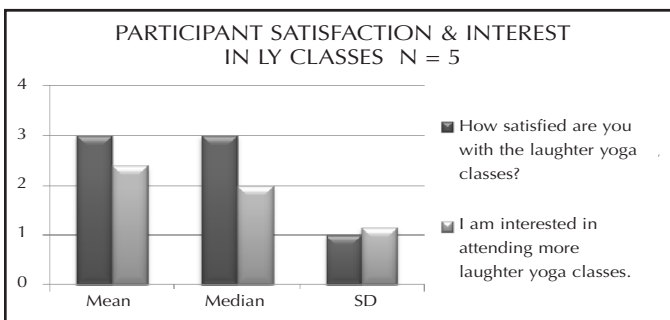
Reviewing each participant's PSS score and current and future QOL revealed that two participants had increased

Table 2. Participant scores current and in five years QOL pre and post LY classes with percent change

Current QOL Ratings CSAS				
Participants	Pre LY Classes	Post LY Classes	Difference in Rating	Percentage Change in Rating
P1	8	9	1	13%
P2	8	8	0	0%
P3	6	10	4	67%
P4	7	8	1	14%
P5	7	8	1	14%
Mean	7.2	8.6	1.4	22%
Median	7.0	8.0	1.0	
Standard Deviation	0.8	0.9	1.5	
Five Years in Future QOL Ratings CSAS				
P1	7	8	1	14%
P2	10	9	-1	-10%
P3	10	10	0	0%
P4	8	9	1	13%
P5	7	10	3	43%
Mean	8.4	9.2	0.8	10%
Median	8.0	9.0	1.0	
Standard Deviation	1.5	0.8	1.5	

P - Participant
 LY – Laughter yoga
 QOL – Quality of life
 CSAS - Cantril Self Anchoring Scale

Figure 4. Central tendencies for questions on participant satisfaction and interest in attending more LY classes



LY – Laughter yoga
 QOL - Quality of life

perception of stress from pre- to post-LY classes and reported improvements in current and five years in future QOL (see Table 3). Two of the three with decreased perception of stress had reports of improved QOL both current and future. The third with the decreased perception of stress (29 percent) had no change in current QOL and a decrease in future QOL (10 percent). It is reasonable to understand that individuals report an improved quality of life when they also perceive that their stress has decreased. Participant two was unique with responses of decreased perception of stress, a stable “thriving” current QOL rating pre- and post-, yet had a decrease of one point pre- to post- on the CSAS ladder scale in the future QOL rating, which is still a “thriving” rating but moving towards the “struggling” range. Participant three (114 percent) and participant five (32 percent) had increased stress perception from pre- to post- responses, yet both indicated improvements in current and future QOL and/or improvements or stability in future QOL ratings (Table 3). It appears incongruent to see

Table 3. Comparison Pre- and Post-PSS and -QOL Ratings by Participant

Participants	Pre PSS	Post PSS	Pre Current QOL	Post Current QOL	Pre QOL in Five Years	Post QOL in Five Years	Percent Change Pre to Post LY Classes
P1	18	15	8	9	7	8	17% decreased perception of stress with improved 10% current and future QOL
P2	7	5	8	8	10	9	29% decreased perception of stress with no change current QOL and 10% decrease in future QOL
P3	7	15	6	10	10	10	114% increased perception of stress with 40% improvement current QOL and no change in future QOL
P4	32	19	7	8	8	9	41% decreased perception of stress with 10% improvement in current and future QOL
P5	7	8	7	10	19	25	32% increased perception of stress with 10% improvement in current and 30% future QOL
PSS – Perceived stress scale QOL – Quality of life P - Participant							

improvements in the participants’ QOL when simultaneously having increased perceptions of stress. Notably, all participant responses in the current and future QOL ratings pre and post were in the “thriving” range. An unambiguous association between the perception of stress and current or future QOL with laughter yoga class participation was not evident in this group of participant responses.

Although participants’ results showed improvements in decreased stress perception (60 percent) and increased current (80 percent) and future (60 percent) quality of life ratings, these measures did not achieve the targets. There was a wide distribution in the mean change score that was likely related to the small sample size with one outlier in increased stress perception heavily weighing down improvement in stress. The

median percent change for participants' current quality of life was 1.4 (standard deviation 1.5) and was similar to future QOL at 0.8 (standard deviation 1.5) indicating improved QOL ratings were reflective of all five participants. Finally, although there was diversity in distribution of class satisfaction scoring, participants appeared to rate the classes well but had less interest in attending more classes.

Management of Project

Management of the project was guided by Wheatley's change theory. This theory strongly associates the elements of chaos, complexity, and sustainable networking relationships.³⁶ Although the tribal health agency appeared hectic, programming was continuously developing and emerging with employee, management, and community involvement. American Indian culture has various aspects of complexity theory in their worldview of circular connections between man and nature and is akin to the inherent non-linearity of complexity. The tribal values of self-determination and family were imperative for the project leader to honor. The management approach was to allow the project to occur with as little control over the agency and participants as needed, to allow the relationship and interactions to occur, to ensure the intervention happened, and see where the results lead.

Discussion

American Indians experience health disparities that may be associated with various factors related to socioeconomics, health care access, racism, discrimination, violence, and other social determinants of health. Stress is a risk factor for many health conditions and often results from the inordinate daily challenges that AIs encounter. The needs assessment revealed high poverty rates, low education levels, higher AI mortality rates in various diseases and conditions, large family households, and elevated perceptions of racism. Furthermore, the AI community health staff had difficult work environments as they attempted to maintain professional boundaries and act as responsible and sensitive heads of households. Worksite wellness was an underlying theme, and it was observed that the current wellness program was limited.

Addressing tribal health staff stress was the foremost objective in the implementation of the laughter yoga intervention in this DNP project. Although the targets for improvement in perception of stress and quality of life were not achieved, participants reported sufficient satisfaction with classes. The small convenience sample size and lack of fidelity to the humor-health theory leaves a questionable empirical link between laughter yoga and stress relief. Not investigating the four progression mechanisms of the humor health theory does not completely test the potential causality between the LY intervention and the health benefit of stress relief. Intervening in American Indian stress was an important step in addressing the well-being of tribal community health workers and one that work site wellness programs could include on an ongoing

basis. It is important that employers support and facilitate employee wellness programming because addressing work-related and personal stress is a strategy that often leads to improved employee health and well-being, increased productivity, and decreased health care costs.³⁷ An in-depth empirical evaluation including all progression mechanisms of the humor-health theory is needed for LY along with larger sample sizes in the AI community and other races as well.

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Tips for better screening rates at your facility

1. Recommend CRC Screening to Patients
 - Discuss multiple screening options with patients (not only colonoscopy)
1. Develop a CRC Screening Policy
 - Fit the policy to your practice
 - ◆ Determine patient risk level
 - ◆ Identify local medical resources
 - ◆ Assess insurance coverage
 - ◆ Consider patient preference
 - ◆ Engage your team in following the policy
3. Be Persistent with CRC Reminders
 - Use patient tools:
 - ◆ Education and cues to action
 - Use provider tools:
 - ◆ Chart prompts
 - ◆ Audits and feedback
 - ◆ Ticklers and logs
 - ◆ Staff assignments
 - ◆ Track test results
4. Measure Practice Progress
 - Have staff conduct a screening audit
 - Establish a baseline screening rate
 - Discuss how the screening system is working

Learn more at: <http://www.ucare.org/providers/Documents/IncreaseCancerScreeningRates.pdf>

Avoid these errors:

- ✗ Not assessing a patient's level of risk for developing CRC, based on personal, family, and medical history, to determine appropriate screening approach.
- ✗ Screening patients with a digital rectal exam (DRE).
- ✗ Screening patients in the clinic with guaiac-based FOBT, using only a single stool sample following a DRE.
- ✗ Not ordering diagnostic colonoscopy for patients with a positive gFOBT, iFOBT, or flexible sigmoidoscopy.
- ✗ Not following up on patients referred for colonoscopy.
- ✗ Recommending screening with colonoscopy at intervals shorter than every 10 years, or flexible sigmoidoscopy at intervals shorter than every 5 years, for average-risk persons.
- ✗ Starting screening earlier than age 50 for average-risk, asymptomatic individuals.
- ✗ Applying recommendations for average-risk persons to patients that are at increased risk for developing CRC.

Adapted from: "How to Increase CRC Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide, 2008", available at: <http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf>

Subscribe to the IHS CRC listserv at:

http://www.ihs.gov/listserv/index.cfm?module=signUpForm&list_id=138

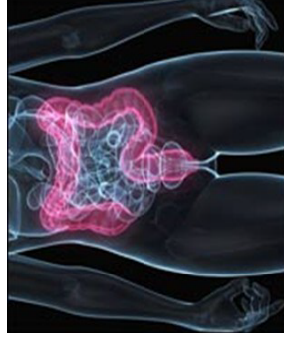
For further information, please contact

Donald Haverkamp, MPH at (505) 248-4422

donald.haverkamp@ihs.gov

Colorectal Cancer (CRC) Screening

A Reference Guide for IHS and Tribal Healthcare Providers



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May 2013



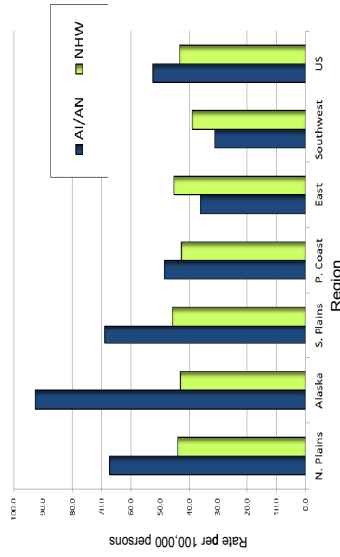
Colorectal cancer in American Indian and Alaska Native (AI/AN) communities

Did you know?

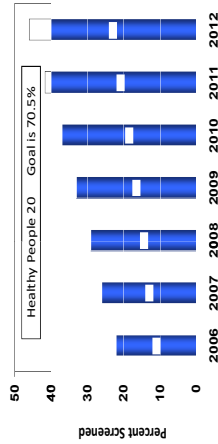
Of all AI/AN men and women who are currently cancer free at age 50, an estimated 4.1% (1 in 24) will develop CRC in their lifetime.

Source: Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov), Div/Can database; "SEER 18 Incidence and Mortality, 2000-2009, with Kaposi Sarcoma and Mesothelioma", National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2012, based on the November 2011 submission.

Colorectal cancer incidence rates, AI/AN and non-Hispanic Whites (NHW), both sexes, 2005-2009



Colorectal cancer screening trend within the Indian Health Service GPR clinical data



Who, how, and how often to screen for CRC

The United States Preventive Services Task Force recommends :

- Average-risk men and women aged 50-75 should be screened using any of the following:

YEARLY: Immunochemical fecal occult blood test (iFOBT) or high-sensitivity guaiac-based fecal occult blood test (gFOBT)

-OR-

EVERY 5 YEARS: Flexible sigmoidoscopy (along with FOBT every 3 years)

-OR-

EVERY 10 YEARS: Colonoscopy

- Routine screening is not recommended for men and women ages 76-85. Decisions about first-time screening in this age group should be made on an individual basis.
- Screening is not recommended for men and women over the age of 85.

Link to USPSTF recommendations:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm>

Ways to encourage patients to get screened

Utilize culturally and linguistically appropriate materials to educate patients. Check the following sites for materials and links to other resources:

- Albuquerque Area Southwest Tribal Epidemiology Center, Tribal Colorectal Health Program— <http://aaahb.org/aastec/tchp/>
- Alaska Community Health Aide Program— Cancer Education— <http://www.akchap.org/html/resources/cancer-education.html>

When recommending FOBT, include an option for immunochemical FOBTs, which offer patients several advantages over traditional guaiac-based FOBTs, including:

- No dietary or medication restrictions before or during screening
- Fewer stool samples needed
- Various stool collection methods (less stool handling)
- Detects only colorectal bleeding

Utilize the Guide to Community Preventive Services, which highlights interventions that can increase cancer screening: <http://www.thecommunityguide.org/cancer/index.html>

POSITION VACANCIES

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

Family Practice Physician 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 4,400. 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 an internist, three family practice physicians, an optometrist, and three 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 revenues from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility, a modern supermarket, a 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 (575) 759-7230; or e-mail cecilia.chao@ihs.gov if you have any questions. (2/13)

Hospitalist Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently

seeking energetic and collegial internists for our new hospitalist program. The hospitalists care for all adult inpatients previously taken care of by family medicine and internal medicine physicians, and provide consultation services. We have seven FTEs for hospitalists, and while we are still growing, we enjoy further inpatient staffing support from internal medicine and family medicine.

GIMC is a 99-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Clinical specialties at GIMC include internal medicine, family medicine, critical care, cardiology, neurology, orthopedics, ENT, radiology, OB/GYN, general surgery, ophthalmology, pathology, pediatrics, emergency medicine, and anesthesiology. The hospitalists' daily census is approximately 25 - 30. There is a six bed ICU. Our patient population includes Navajos, Zunis, and others living nearby, as well referrals from smaller clinics and hospitals.

Gallup has a diverse community and is very livable, offering a thriving art scene, excellent outdoor activities (biking, hiking, rock climbing, cross-country skiing), safe neighborhoods, diverse restaurants, national chains and local shops, and multiple public and parochial school options. The medical community is highly collegial, is committed to continuing education, has an on-going collaboration with Brigham and Women's Hospital, and has a high retention rate.

For more information, contact Eileen Barrett, MD, at (505) 722-1577 or e-mail eileen.barrett@ihs.gov. Or please consider faxing your CV to (505) 726-8557. (2/13)

Clinical Director, Family Medicine Physician Kodiak Area Native Association; Kodiak, Alaska

The Kodiak Area Native Association (KANA) is searching for an adventurous, highly motivated physician to lead our team that is committed to patient-centered care, customer service, quality improvement, and stewardship. KANA is celebrating its 47th year of providing patient and family focused health care and social services to Alaska Natives and other beneficiaries of KANA throughout Kodiak Island. KANA's award winning medical staff is comprised of four physicians who work in conjunction with two mid-level providers, dedicated nurse case managers, and ancillary staff to deliver the highest quality, team based health care to an active user population of 2800 patients. Integrated behavioral health and pharmacy services within the primary care setting also facilitate an advanced support system to ensure our patients' needs are met.

The spectacular scenic beauty of Kodiak Island offers a backdrop for an abundance of outdoor and family activities, including world-class fishing, hunting, wildlife viewing, kayaking, and hiking just minutes from your door. Its

sometimes harsh climate is balanced by mild temperatures and unparalleled wilderness splendor that provide Kodiak's residents with a unique lifestyle in a relaxed island paradise.

KANA offers competitive compensation and an excellent employee benefits package, including medical, dental, vision, flexible spending accounts, short term disability insurance, life insurance, accidental death and dismemberment insurance, 401k with employer contribution, fitness membership, and paid time off.

If you're interested in hearing more about how you can start your journey to an adventure of a lifetime, please visit our website at www.kanaweb.org, give Lindsey Howell, Human Resources Manager, a call at (907) 486-9880, or contact our HR Department at hr@kanaweb.org. Alaska's Emerald Isle awaits you! (2/13)

Pediatrician

Blackfoot Community Hospital; Browning, Montana

This hospital-based government practice is seeking a BC/BE pediatrician to work with another pediatrician and a pediatric nurse practitioner. Practice true primary care pediatrics with inpatient, outpatient, and newborn hospital care. Attractive call and rounding schedule. Competitive salary with federal government benefits. The area provides a wide variety of outdoor recreational activities, being only 12 miles from Glacier National Park. For more information, please contact Dr. Tom Herr at thomas.herr@ihs.gov or call (406) 338-6372. (1/13)

Director, Health and Human Services Ysleta Del Sur Pueblo; El Paso, Texas

The Ysleta Del Sur Pueblo (YDSP) Health and Human Services Department is a team of health care professionals and staff fully committed to their patients' physical, emotional, and spiritual wellbeing, offering a comprehensive range of health and human services that ensure a safe environment, quality service, and accessible health care in an atmosphere of respect, dignity, professionalism, and cultural sensitivity.

YDSP's HHS department is seeking a Director. This person has responsibility and accountability for the development and implementation of a plan to bring HHS to an ongoing operating success. The Director will need the flexibility to make quick and efficient business decisions, while at the same time assuring that operations respect the broad guidelines and, more importantly, the service standards expected by tribal members and tribal leadership. To get more information or to apply, contact Jason S. Booth, CEO, Ishpi, Inc., telephone (651) 308-1023; or e-mail jason@ishpi.biz. (1/13)

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 emergency

room/family physician to join our experienced medical staff. The Sells Service Unit 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. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 295-2481 or by e-mail at Peter.Ziegler@ihs.gov. (12/12)

Family Physician with Obstetrics Skills Pediatrician (or Internal Med-Peds) Physician Ethel Lund Medical Center; Juneau, Alaska

The SEARHC Ethel Lund Medical Center in Juneau, Alaska is searching for a full-time family physician with obstetrics skills and a pediatrician (or internal medicine/pediatrics physician) to join a great medical staff of 14 providers (10 physicians, four midlevels) at a unique clinic and hospital setting. Have the best of both worlds by joining our practice where we share hospitalist duties one week every 6 - 8 weeks, and spend our remaining time in an outpatient clinic with great staff and excellent quality of life. We have the opportunity to practice full spectrum medicine with easy access to consultants when we need them. Maintain all your skills learned in residency and expand them further with support from our tertiary care center, Alaska Native Medical Center.

Clinic is focused on the Patient-Centered Medical Home, quality improvement with staff development from IHI, and adopting an EHR at the clinic and hospital in the near future. We have frequent CME and opportunities for growth, with teaching students and residents and faculty status at University of Washington available to qualified staff. This is a loan

repayment site for the Indian Health Service and National Health Service Corps.

Work in southeast Alaska with access to amazing winter and summer recreational activities. Live in the state capital with access to theater, concerts, annual musical festivals, and quick travel to other communities by ferry or plane. Consider joining a well-rounded medical staff of 14 providers at a beautiful clinic with excellent benefits. For more information contact, Dr. Cate Buley, Assistant Medical Director, Ethel Lund Medical Center, Juneau, Alaska; telephone (907) 364-4485, or e-mail cbuley@searhc.org. *Locum tenens* positions also available. (12/12)

**Director
Center of American Indian and Minority Health
University of Minnesota Medical School;
Duluth, Minnesota**

The University of Minnesota Medical School in Duluth, Minnesota, invites applications for a full-time Director for the Center of American Indian and Minority Health. The Center of American Indian and Minority Health (CAIMH) at the University of Minnesota Medical School strives to raise the health status of American Indian and Alaska Native people. This is achieved in part through programming and activities for American Indian students grade K - 16 and medical school, and partnerships with American Indian communities and organizations. The CAIMH, housed on the Duluth Campus, educates American Indian and Alaska Native students in the field of health care, and more specifically, in American Indian and Alaska Native health, and collaborates on research focused on improving the health of American Indian and Alaska Native people.

For more information about the Center of American Indian and Minority Health, go to <http://www.caimh.umn.edu>.

Required/Preferred Qualifications include an MD/DO degree; however, an alternative terminal degree may be considered in circumstances of exceptional fit. Previous employment experience in medical school. An academic background in a field relevant to medical education. All candidates must have evidence of essential verbal and written communication skills including clarity in the delivery of lectures and the writing of grants and other documents.

The Director position is a full-time time, 12-month appointment. Additional information is available online at <https://employment.umn.edu/> (Req. #182533). Review of applications will continue until the position is filled. The University of Minnesota is an Equal Opportunity Educator and Employer. Apply on-line at <https://employment.umn.edu/> Job Req # 182533. (12/12)

**Clinical Director (Primary Care)
Family Medicine Physician
White Earth Health Center; Ogema, Minnesota**

White Earth Health Center is located in northwestern

central Minnesota on the White Earth Reservation, which is in the heart of lake country. The reservation is 36 by 36 square miles; its largest metropolitan location is approximately 75 miles from Fargo, North Dakota or 235 miles from the Twin Cities. We have a satellite clinic in Naytahwaush (approximately 30 minutes from the WE Service unit) operating on Monday, Tuesday, and Friday, and one in Pine Point (approximately 30 minutes from the WE service unit) that is open on Thursday. The satellite clinics have one full time family practice physician and one family practice nurse practitioner who staff them on a regular basis.

We are a Federal Indian Health Service outpatient/ambulatory care facility that had 115,699 ambulatory visits for 19,494 registered patients this past year. We offer services Monday through Friday 8:00 am to 4:30 pm; on all federal holidays we are closed. Our services include a dental department with three full time dentists; a mental health department that consists of one psychologist, four counselors, one contract psychiatrist and one mental health nurse practitioner; and an optometry department comprised of the chief of optometry, one optometry technician/receptionist, and one contract optometrist.

Our medical staff consists of three full time family practice physicians, one contract family practice physician, one podiatrist, one internal medicine physician, one audiologist, a nutritionist, one pediatrician and three family nurse practitioners. We have pediatric and same day/urgent care clinics. The clinics are operating/implementing the IPC model.

We offer competitive salary, excellent benefits (health, life, retirement) and both sick and vacation leave. For further information, please contact Mr. Tony Buckanaga, Health Professions Recruiter at (218) 444-0486, or e-mail tony.buckanaga@ihs.gov. (11/12)

**Registered Dietitian
Psychiatrist
Consolidated Tribal Health Project, Inc.;
Calpella, California**

Consolidated Tribal Health Project, Inc. is a 501(c)(3) non-profit, ambulatory health clinic that has served rural Mendocino County since 1984. CTHP is governed by a board comprised of delegates from a consortium of nine area tribes, eight of which are federally recognized, and one that is not. Eight of the tribes are Pomo and one is Cahto. The campus is situated on a five-acre parcel owned by the corporation; it is not on tribal land.

CTHP has a Title V Compact, which gives the clinic self-governance over our Indian Health Service funding allocation. An application for any of these positions is located at www.cthp.org. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (11/12)

WIC Coordinator
SEARHC; Sitka, Alaska

The WIC Coordinator/RD works as a member of the SEARHC health promotion team to assess for, plan, implement, administer, and evaluate nutrition and health education programming that responds to Goals 8 and 9 in SEARHC's Strategic Plan. The WIC Coordinator also works to ensure high quality WIC services are provided to eligible women, infants, and children throughout southeast Alaska. Additionally, the WIC Coordinator partners with organizations working with the WIC population to make appropriate referrals and to enhance the WIC program.

Baseline Qualification Requirements include a BS in community nutrition/dietetics or a nutrition-related field, and four years of clinical nutrition and/or community nutrition work experience with specific progressive experiences in maternal/child nutrition, outpatient medical nutrition therapy, and program planning and administration. Must be both a registered dietitian and licensed dietitian/licensed nutritionist in the State of Alaska. Must adhere to the American Dietetic Association code of ethics and complete 75 continuing education credits every five years as required by registration and licensure plus keep current on registration and licensing payments. Other/Preferred Qualifications include a valid Alaska driver's license, ability to travel, including to remote southeast Alaska locations, supervision/mentoring training, public policy and advanced nutrition education strategy(ies) training, and MS/MPH in nutrition and/or dietetics or other health promotion related field

Contact Lisa Sadleir-Hart, MPH, RD, CHES, ACE, Community Nutrition Department Manager, SEARHC/Health Promotion, at telephone (907) 966-8735; facsimile (907) 966-8750; or e-mail lisa.sadleir-hart@searhc.org. (10/12)

Clinical Nurse
Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently accepting applications from experienced nurses for positions within our hospital facility. We are particularly interested in nurses with experience in the Labor and Delivery, Emergency Room, and Ambulatory Care settings.

GIMC is a 78-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Our patient population includes Navajos, Zunis, and others. Gallup provides outdoor activities (biking, hiking, rock climbing, and running, to name a few). As a Navajo Area Indian Health Service Hospital, we provide clinical specialties that include Internal Medicine, Cardiology, Anesthesia, Psychiatry, Emergency Medicine, OB/GYN, General Surgery, Orthopedics, Ophthalmology, ENT, Radiology, Pathology, and Pediatrics.

Nurse employment benefits include competitive salary, comprehensive health insurance, double time pay for holidays worked, night and Sunday pay differential, no census days, and continuing education. Government housing is not available, as

we are not located on the Navajo Reservation. Opportunities are available for growth and advancement depending on your personal nursing career goals. We welcome your questions, curiosity, and application submission.

For more information on how and where to apply, contact Myra Cousens, RN, BSN, Nurse Recruiter at (505) 726-8549, or e-mail myra.cousens@ihs.gov. (10/12)

Family Practice Physician /OB
Sonoma County Indian Health Project (SCIHP); Santa Rosa, California

Live, work and play in the wine country. Sonoma County Indian Health Project (SCIHP) Santa Rosa, CA California, is seeking a full-time –Temporary Ffamily Practice practice Physician physician to join our team. SCIHP is a comprehensive community care clinic serving the Native American community of Sonoma County. Medical phone call 1/6 nights required, OB hospital call participation preferred but not required. Three to six month position—With the possibility of permanent hire. Obstetrics and inpatient care at the hospital required. SCIHP is a comprehensive community care clinic. Candidates must currently hold a California Physician/Surgeon (MD) or Osteopathic Physician/Surgeon (DO) license and be BE/BC in a primary care discipline. For the right candidate we offer competitive compensation. For more information, please contact Human Resources by fax (707) 526-1016; or by e-mail: welovedoctors.hr@gmail.com. (10/12)

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

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has openings for full-time primary care physicians starting in fall 2012. This is a family medicine model hospital and clinic providing the full range of primary care, including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics, with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 17 physicians, two NPs, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

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

For more information, contact John Bettler, MD at (505)

782-7453 (voice mail), (505) 782-4431 (to page) or by e-mail at john.bettler@ihs.gov. CVs can be faxed to (505) 782-7405, attn. John Bettler. (7/12)

Family Practice Physician (1)
Physician Assistant or Family Nurse Practitioner (2)
United Indian Health Services, Inc. (UIHS),
Howonquet Clinic; Smith River, California
and
Family Practice Physician (1)
UIHS, Potawot Health Village; Arcata, California

UIHS is a premier health care organization located in beautiful northern California along the Pacific coast near the majestic redwoods. The organization is a unique nonprofit

made up of a consortium of nine tribes, with a mission “To work together with our clients and community to achieve wellness through health services that reflect the traditional values of our American Indian Community.” UIHS provides wraparound services that include medical, dental, behavioral health, and community services. Our focus is to empower our clients to become active participants in their care. If you value outdoor adventures such as backpacking, kayaking, biking, fishing, and surfing, and you envision yourself providing services to an underserved but deserving community in a caring and holistic manner, come join our team. Please visit our website at www.uihs.org or contact Trudy Adams for more information at (707) 825-4036 or email trudy.adams@crihb.net. (5/12)

Print Version of *The Provider* Has Ceased Publication

The federal government is always exploring ways to reduce costs. One recent initiative is an effort to reduce printing expenses. For this reason, we have stopped publishing and distributing the print edition of *The Provider*.

We will continue to publish the monthly electronic edition of our journal to the CSC website. Currently, about 900 individuals are subscribers to the listserv that notifies them when each monthly issue is posted, and lists the contents of

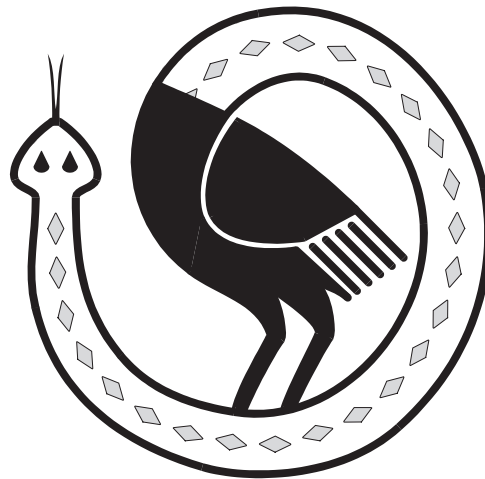
that issue. It is unknown how many readers simply access the website on a periodic basis without relying on the listserv for reminders that the monthly issue is available.

We encourage all our readers to subscribe to the listserv (go to <http://www.ihs.gov/provider/index.cfm?module=listserv>) so that you will receive monthly reminders about when the latest issue is posted to the website. This will also give us an improved count of the number of readers.

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.



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 above or on our website at www.csc.ihs.gov.