THE IHS PRIMARY CARE PROVIDER

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

March 2008 **Volume 33 Number 3**

A Look into the Future of Continuing Professional Education

John F. Saari, MD, Physician Educator, IHS Clinical Support Center, Phoenix, Arizona

This brief article will describe the strengths and weaknesses of the continuing professional education activities and programs in the Indian health system. Changes occurring on the national level and their potential impact on our environment and practices will be described. We will offer recommendations for change in the Indian health system that will keep us at the forefront of CE endeavors. Although this is written from the perspective of physician continuing medical education, the discussion applies in greater or lesser measure to all health professions, particularly nursing and pharmacy.

We are all very aware of the shortcomings of the CE effort in Indian health. First and foremost, there is not much funding for CE. Very few service units have much if any funding for CE, and space and equipment are often less than ideal. Some IHS Programs have funding for courses, and, if participants can meet the travel and per diem expenses, the courses are almost always offered for no cost.

Those who volunteer or are chosen to coordinate CE activities must do this as an additional duty or even on their own time. Turnover is high, and so new coordinators need to learn the process all over again. Secretarial and administrative assistance may not be available, nor the technology to support this work. CE is not a priority at some facilities, and so they do not have a CE program or even support participation in outside activities.

The good news is that many facilities have vigorous, ongoing CE programs with one or more hourly series of lectures on a weekly or monthly basis, periodic one-or two-day courses, and/or national courses such as Advanced Cardiac Life Support (ACLS) and such. Many national, Area, or Program courses are available, and these are tailored precisely for those who practice in Indian Country (see the Meetings of Interest Section at the back of this issue). There is often a culture that believes CE is a necessity and/or a champion who is willing to spearhead the effort. Members of the medical staff believe that it is important to attend and serve as organizers or presenters, and the administration supports the effort, if not with funding, then with time and resources. This, of course, is a great strength of the program, since it is conducted by and designed by and for those who attend. Those who present are most knowledgeable about the needs of the audience and the environment in which they practice. Because it is based on volunteerism, there is no need for outside funding, which presents its own problems (more of that later). The response time when an educational need arises can be quite short.

No research has been conducted to try to find out why some facilities sustain an active CE program year after year, while others do not choose to do so. Although larger facilities usually support several endeavors, even small facilities are represented. There may be disproportionately less participation by tribal facilities, but that is anecdotal.

Another remarkable strength of the CE activities in Indian health programs is their multidisciplinary nature. Few health care practice environments rely so much on a health care team, and it is fortunate that most CE efforts offer the opportunity for all members of the team to learn side-by-side, while featuring presentations by a variety of disciplines.

CME is evolving rapidly. Revised accreditation criteria were announced by the Accreditation Council for Continuing Medical Education (ACCME) in 2006; these were not the first changes in the criteria, and we know they will not be the last.

In this Issue…

73 A Look Into the Future of Continuing Professional Education
76 The 13th Annual Elders Issue
80 IHS Child Health Notes
82 OB/GYN Chief Clinical Consultant's Corner Digest
92 Meetings of Interest
95 Position Vacancies

Briefly, the changes require that sponsors of CME like the CSC must assure that activities address the educational needs (knowledge, competency, or performance) that underlie the professional practice gaps of our learners and that evaluation efforts should assess the extent to which the gaps in knowledge, competency, or performance have been remedied by CME activities.

Hearings by the Senate Finance Committee led to discussions with the ACCME about the influence of pharmaceutical companies on CME. More and more evidence is being published that suggests that CME supported by drug companies can and does change physician practices, and not always in a rational way. Public opinion seems to be shifting as people learn how much of the nations health care dollars go to efforts to influence physicians' prescribing decisions.

In November 2007, the Josiah Macy, Jr. Foundation held a conference that invited the leaders of continuing professional education to sit down together. Citing the lack of focus on patient outcomes, a failure to embrace innovative learning methods, poor interprofessional collaboration, and undue reliance on commercial support, the participants created a list of recommendations for the future of CE. Among other things, they advocated 1) more attention to individual learning needs and practice-based improvements, more use of the Internet and other technology, more point-of-care learning, and less reliance on lectures; 2) more attention to the learning needs of the collaborative team and the system of care in which it takes place; 3) more attention to the performance of physicians, and more accountability to the public; 4) a systematic effort to evaluate and promote best practices in CME; and 5) elimination of commercial support as a source of funding for CME.

How do these recommendations square with our efforts in the Indian health system? Because of our defined patient care population and the fact that many receive most of their care within the system, this is an ideal research medium. More so than in most other environments, there is an opportunity to assess the impact of CE on performance and even patient outcomes. Although it may be impossible to remove the influence of other, confounding factors, our robust data system should be able to detect improvements in outcomes over time. The problem is, of course, that there is not a lot of funding for such research, and we are all busy enough with our clinical responsibilities. Perhaps the best opportunity is in the field of diabetes mellitus, since there is substantial separate funding for this disease, and outcomes are relatively measurable.

These same factors make assessment of needs easier in some ways. Abundant data exist on a national, Area-wide, and even local level that compare our patients' health status and disease outcomes to national data, and among Areas. The IHS Chart Series can be harvested for solid evidence of health care issues that need our attention. RPMS data and reports can show us where we need to focus our CME efforts. Quality management programs at all levels can not only teach us about our needs, but can measure our outcomes.

The fact that much of our learning is already interdisciplinary and practice-based gives us an advantage. The intimate environment in which much of our learning takes place makes it easier to try formats other than lectures. Funding for technological innovation may be limited, but partnerships with universities and other outreach organizations may provide some relief.

While more than half of the funding for CME taking place in hospitals and schools of medicine is derived from commercial support, only 0.3% of all such funding goes to military and government sponsors of CME. The facts that the Federal Standards for Ethical Conduct make it difficult, if not impossible for those in the IHS to accept commercial funding, and that there is virtually no reliance on it in the IHS to begin with, give us an advantage in some ways: since we don't depend on it, it isn't hard to give it up. In much the same way that the Indian Health Service led the country when many of its facilities declared themselves smoke free some years ago, we could now make a commitment to forswear any and all commercial support for our continuing professional education at the facility and program level. The Macy report has recommended that a five-year "phase out" be instituted now to reach this goal for the nation at the end of this time period. This would in no way be such a momentous decision as the achievement of smoke free facilities; nevertheless, it would set an example in the world of continuing professional education.

Given the recent and upcoming changes in continuing professional education, what are some of the things that we can be doing in the Indian health system? Here are a few suggestions:

1. Those facilities without an active continuing professional education program are encouraged to begin one. Go to *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/continuingEducation.cfm* to find out how to get started.
2. Those facilities who are not able to start a CE program should contact the CSC to let us know what barriers exist to getting started.
3. Learn about the growing number of web-based opportunities for Indian health specific activities (e.g., The Director's Health Forum and EHR courses described elsewhere in this issue).
4. Those doing CE are encouraged to partner with internal and external entities that measure things. Quality assurance, epidemiology, and data collection efforts at the local, Area, state, or national level are excellent sources of information about gaps in the knowledge, competency, or performance of clinicians, as well as the most common conditions affecting our patient population.
5. CSC will make available on its website evaluation forms that meet the new requirements to assess the impact of

continuing education on knowledge, competency, and performance; all are encouraged to begin using these. Those programs that have the capability to examine the impact of continuing education on patient outcomes are encouraged to do so.

6. Be aware of the new ACCME Standards for Commercial Support. Changes include the requirement that all planning committee members complete the disclosure process, and now, not only must all financial relationships be disclosed to the audience, but, if they pose a conflict of interest, this conflict must be resolved prior to the activity.
7. Facilities and programs are encouraged to continue to avoid the use of commercial sources for continuing education funding.

If you have questions or comments, you are encouraged to send them either as a personal correspondence to the author, or as a letter to the editor.

The 13th Annual Elders Issue

The May 2008 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the thirteenth 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.

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 at the Clinical Support Center website *(http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/)*. To start your electronic subscription, simply go to *The Provider* website *(http://www.ihs.gov/publicinfo/publications/healthprovider/provider.asp)* and complete the subscription form. This address can easily be reached from the Clinical Support Center website by clicking the "Publications" link and then clicking the "How To Subscribe" link. You are encouraged to try downloading the current issue to see how well this works at your site.

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 often 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.

SAVE THE DATE

*** Challenges in Indian Health Care ***
*** Health Care Budgets & Financing ***
*** Data and Information Technology ***
*** Law ***
*** Integrity and Ethics ***
*** Negotiation ***

Session One: May 5 - 9, 2008
Session Two: June 16 - 20, 2008
Session Three: July 21 - 25, 2008

You can be a part of the 2008 Class of the Executive Leadership Development Program (ELDP)!

The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian health care executives, whether they work in Federal, tribal, or urban settings.

Look for the registration material in January on *http://www.ihs.gov/nonmedicalprograms/eldp/* .

ELDP Coordinators:
Gigi.Holmes@ihs.gov* and *Wesley.Picciotti@ihs.gov

Open Door Forum on Health Initiatives - Forum #7

Indian Health Service Quarterly Tele-conference/WebEx

When: **April 24, 2008**
Time: **12:00 p.m. to 2:00 pm EDT**
Toll free number: **888-455-6771**
Pass code: **042408**
Leader: **Candace Jones**

This is part 1 of 2 forums focusing on Obesity Prevention and Control. Part 2 will be May 20, 2008 from 12 noon to 2 PM EDT.

On April 24, 2008, please join the Indian Health Service (IHS) for our seventh quarterly teleconference/WebEx Open Door Forum. This forum will focus on agency-wide efforts in obesity prevention and control. IHS Director, Robert McSwain, will provide an update on the status of current national obesity prevention and control. Four programs will share their innovative work in obesity prevention across breastfeeding, Head Start, nutrition, and school-based programs. We will also hear from nationally known obesity prevention expert, Dr. Scott Gee, Medical Director for Prevention and Control with Kaiser Permanente North Region. Join us on this informative two-part series as we share resources, create learning communities, and showcase best and promising practices for obesity prevention and control.

PowerPoint presentations will be available on the Director's Health Initiatives website approximately two weeks prior to the teleconference – please download the presentations so you can follow along during the teleconference. There will be time for dialogue at the end of the presentations. A survey monkey will also be available for feedback after the forum. Following the call, a transcript will be available at the Directors' Initiatives website for those who miss this event. Presentations will also be available during the WebEx, and the WebEx will be recorded if you miss this Forum.

Questions? Contact these Director's Three Initiatives Leads:

Health Promotion/Disease Prevention, Alberta Becenti at *Alberta.Becenti@ihs.gov*
Chronic Care, Dr. Ty Reidhead at *Charles.Reidhead@ihs.gov*
Behavioral Health, Gary Quinn at *Gary.Quinn@ihs.gov*

As a result of having participated, the learner will be able to do the following:

Describe how their work in caring for American Indian and Alaska Native (AI/AN) patients, families, and communities aligns with the goals of the Director's three Health Initiatives in Health Promotion/Disease Prevention, Behavioral Health, and Chronic Care.

Integrate materials and tools provided through the Director's Health Initiatives in to the care of AI/AN patients, families, and communities.

Give examples of programs and practices that integrate efforts to increase participants' awareness of the magnitude of the obesity epidemic across the life stages.

Increase knowledge of best practices of obesity prevention and control in AI/AN populations based on current evidence and guidelines.

Describe I/T/U approaches across the lifespan that may have national or regional application.

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 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

"For every complex problem there is an answer that is clear, simple, and wrong."

H. L. Mencken

Articles of Interest

Symptom profile of common colds in school-aged children. *Pediatr Infect Dis J*. 2008 Jan;27(1):8-11.

Effect of honey, dextromethorphan, and no treatment on nocturnal cough and sleep quality for coughing children and their parents. *Arch Pediatr Adolesc Med*. 2007 Dec;161(12):1140-6.

The past few weeks we have been swamped in pediatric clinic with fever, cough, and runny nose. Parents' first concern is, "does my child have pneumonia?" When my answer is "no" (which it is, most of the time) the next question is, "how long will he/she be sick?" The first article above tries to answer that question for school-age children.

Healthy school-age children were screened as part of a study on the effects of viral URI on middle ear pressure. Nasal aspirates were obtained; about half of the patients had rhinovirus recovered. Approximately 1/3 had pathogenic bacteria such as Moraxella or Haemophilus species. The authors gave families preprinted sheets listing common signs and symptoms of colds.

Not surprisingly, cough and congestion were the most common symptoms. Fever usually resolved in 4 to 5 days. What was noteworthy was that most (73%) of patients still had some symptoms after 10 days; 40% still had cough. A previous study of children ages 0 - 3 years with colds suggested a mean duration of symptoms of 7 days. Previous studies in adults suggested that cold symptoms resolved by 10 days.

Parents frequently return to clinic with healthy children zooming around the exam room but concerned that their child is still coughing after 4 or 5 days of illness. This study is helpful in counseling parents about the expected duration of cold symptoms in their children.

The second article suggests that honey may be the answer to cough and the common cold. Investigators compared honey to dextromethorphan and placebo and found it superior in cough suppression and improvement in sleep quality. Possible mechanisms of action for honey to reduce cough include antioxidant and antimicrobial effects or it may be as simple as honey's demulcent properties. Given the recent FDA warning on cough medications for children under age 5 years there is a cough treatment vacuum waiting to be filled. Look for this study to be repeated to see if the results hold up.

Recent literature on American Indian/Alaskan Native Health

Douglas Esposito, MD, MPH

Editor's Note: This is the last review by Dr. Esposito. After a distinguished 13. year career in pediatrics in the Indian Health Service, Doug is joining the CDC in the Epidemiological Investigation Service. Our loss is their gain. My hope is that at the completion of his epidemiology training, he will return to the IHS. I suspect he will continue to worry, argue, fuss, and be cranky at the CDC in the same beneficial way he has done so in Fort Defiance, Anchorage, and on these pages. Most physicians as they mature get middle-aged, boring, and predictable. Doug has remained enthusiastic and committed about improving AI/AN health, and we and his patients are the beneficiaries of his passion.

Article

Singleton RJ, Bruden D, Bulkow LR. Respiratory syncytial virus season and hospitalizations in the Alaskan Yukon-Kuskokwim *Delta. Pediatr Infect Dis J*. 2007 Nov;26(11 Suppl):S46-50.
http://www.ncbi.nlm.nih.gov/pubmed/18090200?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum

By the time you read this, it is likely that those of us working with AI/AN kids in the lower 48 will be emerging from the depths of a pretty severe RSV year. Unfortunately, if history is any indication, our snow-bound colleagues in Alaska will still be holding their breath. They are likely to be in the thick of things, continuing to battle against RSV bronchiolitis and thick nasal secretions for at least another couple of months. In fact, they might not even have seen the worst of it yet.

This report, authored by our own Ros Singleton, looks at RSV hospitalization rates for Alaska's Y-K Delta population, assesses the risk factors associated with RSV-related hospitalizations there, identifies the impact of Synagis

prophylaxis on high risk Y-K Delta infants, and documents the prolonged annual RSV season in Alaska that simply makes me shudder (for those of you who are unaware, I was a pediatric hospitalist at the Alaska Native Medical Center in Anchorage for four years, and just barely made it out alive!).

Here are a few important points made in this report:

1. The RSV hospitalization rate for Y-K Delta infants is five times the rate of the general US population.
2. The RSV season is prolonged in Alaska, with the median onset and median offset (mid-October and late-May, respectively) being well outside the range seen in the lower 48 (late November to late March or early April). In fact, the median RSV season in Alaska is twice as long as that experienced in the lower 48 (31 weeks vs. 15 weeks), with around 13% of the yearly RSV hospitalizations occurring in summer (June through September).
3. The median peak RSV season in Alaska occurs in late February, but ranges from mid-December to early May.
4. Crowding, lack of running water and flush toilets, lack of breast feeding, tobacco smoke exposure, and underlying medical conditions were associated with RSV hospitalization in the Y-K Delta. Wouldn't you know it, overcrowding and smoking rates are high, and access to running water and flush toilets low in Yup'ik Eskimo villages.

This paper expertly documents the rationale behind altering the Synagis protocol in Alaska as compared to standard practice in the lower 48. Additionally, factors leading to the high rates of RSV-associated hospitalization seen in kids living in the Y-K Delta region and what might be done to address this disparity are explored.

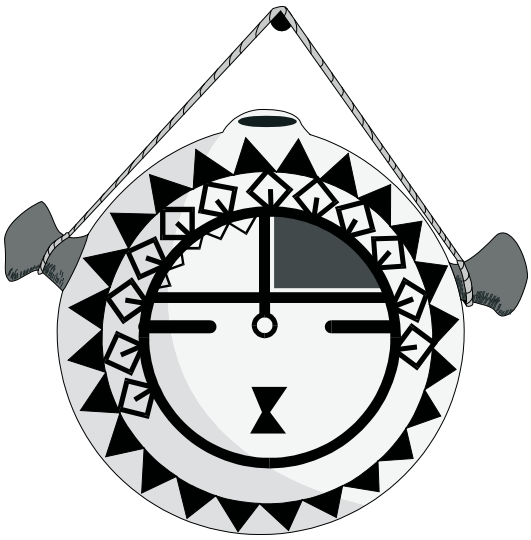
A Final Word

I began as a regular contributor to the IHS Child Health Notes back in September 2005. Now, after subjecting you all to more than two-and-a-half years of liberal ranting and nonstop pleas for health equity and the elimination of health disparities among the populations we are privileged to serve, I will be passing on the torch to two very competent and dedicated pediatrician colleagues and friends. So, please welcome Drs. Michael and Margaret Bartholomew to next month's Notes. I know that the two of them will offer excellent reviews of superior insight and objectivity, and perhaps even grammatical correctness and literary appeal. With two of them splitting the job, it should be twice as good, right?

Back in September 2005, Dr. Holve introduced me to you all with the expectation that I would "add knowledge and breadth, and possibly wit, to these pages." I cannot say that I have performed as billed, but I can say that writing these notes has been fun, rewarding, and enlightening. I am grateful for the opportunity to have been able to critically explore the growing body of literature related to AI/AN child health in a manner and depth that I otherwise would not have endeavored to do.

The progress that has been achieved over recent decades related to health status gains for Native American populations has been staggering. And, compared to other races and ethnicities in the US, the velocity and magnitude of this change has no equal. This, I am convinced, is testament to the amazing dedication and talent of you, the many wonderful individuals and groups working in partnership with Native American communities toward a common, necessary, and noble goal.

But, there is, of course, some bad news. Forward progress has stalled recently, with health disparities persisting and in some cases, sadly widening. The quest to achieve true health equity for Native Americans sometimes seems impossibly distant, with so much remaining to be done. So, I say to all of you, please continue your wonderful work and thank you for the amazing things you do each and every day. It all truly matters.



The Chief Clinical Consultant's Newsletter (Volume 6, No. 3, March 2008) is available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@scf.cc.*

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Minorities underrepresented in both public and private umbilical cord blood banking

Two types of banks have emerged for the collection and storage of umbilical cord blood: public banks and private banks. Public banks promote allogenic (related or unrelated) donation, analogous to the current collection of whole blood units in the US. Private banks were initially developed to store stem cells from umbilical cord blood for autologous use (taken from an individual for subsequent use by the same individual) by a child if the child develops disease later in life. If a patient requests information on umbilical cord blood banking, balanced and accurate information regarding the advantages and disadvantages of public versus private banking should be provided. The remote chance of an autologous unit of umbilical cord blood being used for a child or a family member (approximately 1 in 2,700 individuals) should be disclosed. The collection should not alter routine practice for the timing of umbilical cord clamping. Physicians or other professionals who recruit pregnant women and their families for for-profit umbilical cord blood banking should disclose any financial interests or other potential conflicts of interest.

Umbilical Cord Blood Banking. ACOG Committee Opinion No. 399. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2008;111:475–7.

OB/GYN CCC Editorial Comment

Providers should give balanced information when discussing cord blood banking

Minorities, especially American Indians and Alaska Natives, are particularly underrepresented in both modalities of banking. This deficiency could have significant implications for our (now) young patients later in their lives. The Indian health system should cooperate fully with both groups of banking methods.

The MCH Frequently Asked Questions page has long had a discussion of the advantages and disadvantages of AI/AN cord blood banking that includes a template Disclaimer Form. Go to *http://www.ihs.gov/MedicalPrograms/MCH/M/documents/CordStem4206.doc*. ACOG recommends providers give balanced information to their pregnant patients who are considering cord blood banking, presenting both the advantages and disadvantages of public and private cord blood banks. ACOG also advises physicians who recruit patients for for-profit cord blood banking to disclose their financial interests or other potential conflicts of interest to pregnant women and their families.

Blood from a newborn's umbilical cord, once considered a waste product that was routinely discarded along with the placenta, is now considered to contain potentially life-saving stem cells. Private banks were initially developed to store cord blood stem cells from newborns, for a fee, for potential future use by the same child or a family member if he/she developed disease later in life. Today, there are public banks that store, for free, stem cells that can be used by anyone needing them, similar to how public blood banks work.

"Patients need to be aware that the chances are remote that the stem cells from their baby's banked cord blood will be used to treat that same child -- or another family member -- in the future," said Anthony R. Gregg, MD, chair of ACOG's Committee on Genetics. ACOG's Committee Opinion is a joint document produced by the Committee on Obstetric Practice and the Committee on Genetics.

Although ACOG takes no position for or against cord blood banking, it recommends that physicians disclose that there is no reliable estimate of a child's likelihood of actually using his or her own saved cord blood later. Some experts estimate this likelihood at 1 in 2,700, while others argue the rate is even lower. Physicians should also disclose to their patients that it is unknown how long cord blood can successfully be stored.

Pregnant women should be aware that stem cells from cord blood cannot currently be used to treat inborn errors of metabolism or other genetic diseases in the same individual from which they were collected because the cord blood would have the same genetic mutation. "Cord blood collected from a

newborn that later develops childhood leukemia cannot be used to treat that leukemia for much the same reason," said Dr. Gregg.

Federal legislation was passed in 2005 that provides funding for continued growth of a national cord blood registry in the US. Several states have laws requiring physicians to inform patients about cord blood banking options. Physicians should consult with their state medical association for more information about their individual state laws.

From your colleagues

Melissa Toffolon-Weiss, Anchorage

HPV brochure for AI/AN: available for broad dissemination

We have developed a brochure for Alaska Native parents to inform them about the new HPV vaccine. We also have a poster. If you would like hard copies of these materials sent to you, please contact me at:

Melissa Toffolon-Weiss, PhD, MPH
Alaska Native Epidemiology Center
Alaska Native Tribal Health Consortium
4000 Ambassador Drive
Anchorage, AK 99508
(907) 729-4561
mmtoffolonweiss@anmc.org

Hot Topics

Obstetrics

Evidence Favors Late Cord Clamping in Infants

Results: Of 37 studies identified, eight randomized trials and seven nonrandomized trials, six of which were rated as high quality, were included. Early clamping was defined in most studies as clamping within the first 10 seconds of birth, and late clamping was defined as occurring with cessation of cord pulsations or at three minutes (two minutes was the minimal cutoff for definition of late clamping in this meta-analysis).

Of 1,912 newborns represented in the 15 studies identified, 1,001 underwent late clamping and 911 underwent early clamping. Hematocrit levels, as measured at hours or days after delivery, were higher with late cord clamping, but the difference was not significant at six months. Similarly, the higher hemoglobin levels found with late cord clamping were no longer significant at two to three months of age. Blood volume in infants with late clamping was higher in some trials and not significantly different in others, especially with increasing passage of time. Three trials reported higher blood viscosity with late clamping. Mean bilirubin levels were similar regardless of clamping approach. Several trials found higher ferritin levels and iron stores with late clamping. In terms of clinical outcomes, infants with late clamping had lower risk of anemia at 24 to 48 hours and at two to three months of age. When ferritin levels were considered, infants were at lower risk of anemia at six months as well. There were no differences in rates of jaundice. Polycythemia risk within the first few days of life was greater in infants who underwent late cord clamping. Clamping approach had no apparent effect on tachypnea or respiratory distress, or neonatal intensive care unit admission.

Conclusion: Late cord clamping had a beneficial effect on infants' anemia risk and iron stores, an effect that lasted well into the neonatal period. Increased viscosity and polycythemia were associated with late clamping, but did not appear to have any clinical adverse effects. The authors conclude that these findings are particularly important in geographic areas with few resources, where late cord clamping would be the most beneficial approach.

Hutton EK, Hassan ES. Late vs early clamping of the umbilical cord in full-term neonates: systematic review and meta-analysis of controlled trials. *JAMA*. March 21, 2007;297(11):1241-1252.

OB/GYN CCC Editorial Comment

Similar finding in preterm infants

A study published in the March 2007 issue of *Pediatrics* looked at the effects of late cord clamping on cerebral oxygenation in preterm infants. The study of infants at a median age of 30.4 weeks found that infants with late cord clamping had similar cerebral blood volumes but higher tissue oxygenation than infants delivered in the conventional manner. Although this study did not evaluate the clinical impact of this finding, it does identify another high-risk group that could benefit from late cord clamping.

Baenziger O, Stolkin F, Keel M, et al. The influence of the timing of cord clamping on Postnatal cerebral oxygenation in preterm neonates: a randomized, controlled trial. *Pediatrics*. 2007;119(3):455-459.

Gynecology

Biofeedback Reduces Psychological Burden in Older Women with Urge UI

In older women with urge urinary incontinence (UI), biofeedback (BFB) therapy significantly improved psychological burden, especially in those with a history of depression.

Conclusion: In older women with urge UI, BFB significantly improves psychological burden, especially in those with a history of depression, in whom psychological burden is linked to change in perception of control. Psychological factors are relevant outcome measures for UI, and these data suggest that focusing on UI frequency alone may have underestimated BFB's efficacy and additional therapeutic benefits.

Tadic SD, et al. Effect of biofeedback on psychological burden and symptoms in older women with urge urinary incontinence. *J Am Geriatr Soc*. 2007 Dec;55(12):2010-5.

Child Health

Sex education: Providers need to fill gaps in adolescent knowledge

Results: Representing 91.3% of sampled schools, the teacher survey response rate was 62.4%. The most frequently taught topics included HIV/AIDS (97%), STDs (96%), and abstinence-until-marriage (89%). The least frequently taught topics were emergency contraception (31%), sexual orientation (33%), condom (34%) and other contraceptive (37%) use, and abortion (39%). Abstinence-only curricula were used by 74% of teachers, but 33% of these teachers supplemented with "other" curricula. Overall, two thirds met comprehensiveness criteria based on topics taught. Curricular material availability was most commonly cited as having a "great deal" of influence on topics taught. Thirty percent had no training in sex education; training was the only significant predictor of providing comprehensive sex education in multivariable analysis.

Conclusion: Illinois public school-based sex education emphasizes abstinence and STDs and is heavily influenced by the available curricular materials. Nearly one in three sex education teachers were not trained. Obstetrician-gynecologists caring for adolescents may need to fill gaps in adolescent knowledge and skills due to deficits in content, quality, and teacher training in sex education.

Lindau ST et al. What schools teach our patients about sex: content, quality, and influences on sex education. *Obstet Gynecol*. 2008 Feb;111(2):256-66.

Editorial Comment: Beth Crow, Anchorage

Learning about sexuality is really important for children's health, safety, and confidence

In order to offer something that our schools lack, I teach Our Whole Lives (OWL), which is an age appropriate sexual health curriculum developed by the Unitarian Universalists of the US and Canada in conjunction with the United Church of Christ. Although there is a supplemental spiritual curriculum, the core OWL curriculum is secular. There is a male and female teaching team for each class. The teachers are trained for whatever age group they want to teach. Our training was at Planned Parenthood with municipal HIV educators and Planned Parenthood staff. The curriculum includes communication, gender identification, gender roles, sexual health and safety, anatomy, contraception, intercourse (when age appropriate), etc. The curriculum is available for 5 - 6 year olds, 9 - 11 year olds, junior high, and senior high school students. Parents are involved in initial meetings and with home links, but the students are in class with peers and their teaching team.

I think many European countries, in particular, Scandinavia, have comprehensive sexual health programs, which results in a fraction of the teen pregnancies and STIs that we have in the US. In addition to universal access to health care and contraception, their schools have age-appropriate sex education curricula from a very early age.

I do believe that this should be a universal curriculum, and not just for children of interested parents. Parents often can't or won't talk to their children about sexuality, so children learn about sexuality from the media, school, other children, etc. These, even the schools, are not reliable sources, as the article by Landau shows. The sequelae of inadequate sex education is an increasing rate of teen STIs, sexual violence, and pregnancy. The US needs to be proactive about our health care spending by instituting a universal, comprehensive, age-appropriate, sexual education. This will lead to a healthier, more confident, safer young population.

Phipps MG. Consequences of inadequate sex education in the United States. *Obstet Gynecol*. 2008 Feb;111(2):254-5.

Chronic disease and Illness

Diuretics most effective blood pressure medicine for people with metabolic syndrome

Conclusions: The ALLHAT findings fail to support the preference for calcium channel blockers, alpha-blockers, or angiotensin-converting enzyme inhibitors compared with thiazide-type diuretics in patients with the metabolic syndrome, despite their more favorable metabolic profiles. This was particularly true for black participants.

Wright JT Jr. Clinical outcomes by race in hypertensive patients with and without the metabolic syndrome: Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). *Arch Intern Med*. 2008 Jan 28;168(2):207-17.

Features

ACOG, American College of Obstetricians and Gynecologists

Fatigue and Patient Safety

Abstract: It has long been recognized that fatigue can affect human cognitive and physical function. Although there are limited published data on the effects of fatigue on health care providers, including full-time practicing physicians, there is increasing awareness within the patient safety movement that fatigue, even partial sleep deprivation, impairs performance. Most of the current literature reviews resident function after recent work reform changes. However, the information available from many studies in health care and other occupations can be applied to the work habits of practicing obstetrician/gynecologists.

Fatigue and Patient Safety. ACOG Committee Opinion No. 398. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2008;111:471–3.

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

PTSD: A technique that works for me, by Dr. James Lagattuta*

Editor's Note: Dr. Jim Lagattuta is a long-time therapist in Indian country and has been a pioneer in adapting exposure-based therapies for helping AI/AN patients recover from traumatic incidents. The following tale highlights how he approaches this complicated issue and demonstrates how it is not always "talking" about traumatic life events that takes the sting out. Readers should also note that not all therapy requires multiple sessions – in this particular case a good outcome was achieved with one session of focused work.

I would like to share with you a technique I use routinely to work with clients experiencing trauma. TIR, or Traumatic Incident Reduction, is a systematic method of locating, reviewing, and resolving traumatic events (see the link at *http://www.healing-arts.org/tir/*).

With its roots in psychoanalytic as well as desensitization/exposure literature, it is highly "person-centered, non-judgmental, and non-evaluative" in its treatment of the client. The provider becomes a very active listener gently only asking the client to state when, where, how long, and what the initial feeling was about the "incident" that happened, followed by asking that it be first viewed in mind, and then told to the provider, and then repeated and repeated. At a certain point the client is asked if they feel "heavier (H)" or "lighter (L)." If lighter, then this incident is "the" root trauma and work on it continues. If "heavier," than "is there an earlier, similar incident" which seems to immediately come to mind, and one goes there and work continues, with the "H" v "L" question continuing to search out "the" root incident to which the other trauma, including the presenting one, is linked. Once this incident is located and neutralized, energy involved with subsequent trauma is freed. This would occur if the presenting trauma involved a battle incident, or the case I shall describe. Some details have been altered to ensure confidentiality.

After the Christmas holidays a mother asked if I would see her 18 year old son for a severe depression. The depression started after a multiple car fender-bender with no physical injuries on an icy road. It had been over a month since the incident and the beginning of the second semester of his HS senior year. He had stopped driving, had not returned to school, was missing assignments, and was having difficulty with his role as Captain of the wrestling team. He had already gotten early selection to a prestigious college. I explained what I would do during our session to mother, asking her to explain it to her son and seek his permission to work together.

When the son arrived, I reviewed the procedure and asked him to select an incident to work on. He chose the recent accident. We proceeded in the TIR manner and I asked the "H" v "L" question and his response was "H." He then jumped to a fender-bender in which he was involved as he was driving with his mother with a learner permit at 14.

I asked, "Heavy or Light?"

He responded, "Heavier."

He jumped to another fender-bender at age 9 when his mother was driving.

As I was getting to a time when I would have asked the "H" v "L" question he suddenly said, "and I was curled up in a ball and watched the car run over me."

I responded, "How old were you?"

He said, "Three."

I stated, "Go there to the beginning."

Instead of responding directly he immediately replied with the following story. "My brother and I were in the back seat of the car. It was parked at an incline facing down the hill leading to our house. Dad went into the house for something. I jumped out and went to the front of the car . . . was told later my brother jumped into the driver seat, released the emergency brake and pretended to drive. I saw the car rolling toward me, curled up into a ball and looked up watching the car roll over me."

Then he suddenly said, "That SOB! Dad came out of the house yelling at us, blaming us for what was happening and then punished us . . . and when I was 9 he said nearly the same things, and at 14 and last month, too! I never realized how angry I've been at him all these years. "

I asked, "Heavy or Light?"

He said, "Very light!"

He returned the next week, having driven himself to the appointment, had gone back to school and activities, caught up with all work. He had a direct talk with dad about his feelings that he had held in over the years. He felt he had completed his work and did not need further assistance, and went on to graduate with honors.

Though simple compared with some more seemingly more painful and complex trauma, this procedure can at times deal with significant traumas in as little as one session.

Elder Care News

Bruce Finke, Elder Care Initiative

Exciting opportunity to develop new resources in geriatrics

Applications are being accepted until April 2 for the Practice Change Fellows Program. This program, sponsored by The Atlantic Philanthropies and The John A. Hartford Foundation, is designed to expand the number of health care leaders who can effectively promote high quality care to older adults in a wide range of health and health care organizations. The short-term goal of this program is to transform health care professionals working within the broadly defined delivery system into effective leaders. These leaders will have strong management skills and content expertise to effectuate practice improvement within their organizations to better meet the needs of older adults. The long-term goal is to establish a vigorous network of health care practice change specialists with the capacity to influence care for this population on a national scale.

The Practice Change Fellowship is open to nursing, social

worker, and physician leaders. Leaders in local health systems (tribal, Federal, or urban), and those working at an Area or regional tribal level, as well as those working at a national level would be eligible. The fellowship comes with funding to support the leadership and improvement activities ($45,000 per year for two years) and requires a strong commitment of support from leadership of the home organization.

You can find the details on the fellowship at *http://www.practicechangefellows.org/*

I know that the Advisory Board for the Fellowship Program is very interested in supporting improvement in geriatric care in the Indian health system, and I believe that they would look favorably on strong proposals from IHS, tribal, and urban applicants.

Dr. Robert Schreiber, a geriatrician who has volunteered for a number of years at Rosebud and has helped Rosebud develop a strong clinical geriatrics program, is involved with the Practice Change Fellowship program and has offered to provide guidance and advice to potential applicants.

Please let me know if you have interest or have a candidate at your facility, office, or tribal program who might have interest and who you see as an effective leader who can help build your geriatric program. Feel free to contact me with questions:

Bruce Finke, MD
IHS/Nashville Area Elder Health Consultant
Chronic Care Initiative
(413) 584-0790

Family Planning

Ringing Endorsement: Women Prefer Contraceptive Ring Over Patch

In the first study to directly compare a contraceptive vaginal ring and skin patch, more women indicated overall satisfaction with the vaginal ring, researchers report.

Conclusion: Women satisfied with combined oral contraceptives and interested in a nondaily method are more likely to continue using the contraceptive ring than the contraceptive patch. LEVEL OF EVIDENCE: I.

Creinin MD et al. Multicenter comparison of the contraceptive ring and patch: A randomized controlled trial. *Obstet Gynecol*. 2008 Feb;111(2):267-277.

International Health Update

Claire Wendland, Madison, WI

Good intentions and unintended consequences

At the turn of the twenty-first century, activists, politicians, and academics pushed hard for a major increase in international funding to solve seemingly intractable health problems in the Third World. Two results are the GAVI Alliance, formed in 2000 to expand mass vaccination programs (particularly for children), and the Global Fund, created in 2002 to tackle HIV/AIDS, tuberculosis, and malaria. Most observers agree that both organizations have been very successful at bringing together government, industry, and other private funds – at a scale larger than imagined possible in the past – and directing them to programs, private or governmental, that address these pressing health issues in poor countries. Two recent analyses, however, raise concerns about some unintended side effects.

At issue is a shift in the concept of sustainability. Conventional ideas of sustainability meant that recipient countries would need to gradually take over any internationally funded health intervention. Because the cost of vaccines and AIDS drugs is so high, programs involving treatment of AIDS or prevention of childhood infections were clearly not going to be sustainable by this definition anytime soon. An innovation of the new funders was to consider programs "sustainable" if they could be paid for indefinitely at the international level. If wealthy countries made long-term pledges to buy drugs and vaccines, the poorest recipients would only have to be sustainably responsible for provision of basic health system needs like transport, nutritional support, and health care staffing. And therein lies the rub.

The "vertical" programs (those targeted toward a specific problem rather than general primary health care) funded through these new mechanisms keep their staff lean and their programs efficient by refusing to integrate other kinds of care. Where transport is difficult, as in much of the Third World, villagers may walk for hours to bring a sick or starving child in for a mass vaccination campaign, but be unable to speak to anyone about their child's malnutrition, seizure disorder, or diarrhea – not to mention the mother's new pregnancy. These primary health tasks shift downward to untrained laypeople, or to no one at all, and health systems become more fragmented.

Perhaps even more problematic are the effects on public health sector staffing. When vertical programs such as those providing antiretrovirals are part of the public health system, donors pay for the drugs but not the new staff needed to distribute them and monitor patients. When these programs are non-governmental, they hire qualified nurses and doctors away from the public sector, because they can afford to pay more than the local salary. Most of the time, both types of programs are funded in any given country. A ministry of health must train, recruit, and pay salaries for new staff even as existing doctors and nurses are being hired away by better-funded employers. But governments are required by the international financial institutions from which they borrow to keep civil service salaries at a pre-specified cap. Ministries of health are left with two ugly choices. They can violate the salary cap to recruit and retain health workers, but lose all development loans (which may amount to half a country's total budget), or they can keep salaries low and risk ongoing hemorrhage of qualified health professionals into the non-governmental sector – not to mention the strikes, retirements, and emigration that take their toll on the well-being of patients in public hospitals and clinics.

The jury is still out on the actual impact of these big new funding programs on the health problems they target. (Expect early reports for the Global Fund by later this year.) But it's already clear that in some of the most heavily targeted areas, maternal and child health indicators are deteriorating even as vaccination rates rise and deaths from AIDS begin to plateau. As a doctor in Malawi told me flatly, talking about hospital staffing and maternal deaths in that country, "these NGOs are killing us." It may be time to think again about what sustainability really means, and whose responsibility it really is.

Ooms G et al. 2007 Medicines Without Doctors: Why the Global Fund must fund salaries of health workers to expand AIDS treatment. *PLoS Medicine*. 4(4):e128.

MCH Headlines
Judy Thierry, HQE
Findings from the National Survey of Children's Health includes Native Americans

The authors set out to examine racial/ethnic disparities in medical and oral health, access to care, and use of services in a national sample. They used the National Survey of Children's Health, which was a telephone survey in 2003 - 2004 of a national random sample of parents and guardians of 102,353 children 0 to 17 years old. Disparities in selected medical and oral health and health care measures were examined for white, African American, Latino, Asian/Pacific Islander, Native American, and multiracial children. The authors found many significant disparities. For example:

- Uninsurance rates were 6% for whites, 21% for Latinos, 15% for Native Americans, 7% for African Americans, and 4% for Asians or Pacific Islanders
- The proportions of children with a usual source of care were as follows: whites, 90%; Native Americans, 61%; Latinos, 68%; African Americans, 77%; and Asians or Pacific Islanders, 87%
- Many disparities persisted for one minority group in multivariate analyses, including increased odds of suboptimal health status, overweight, asthma, activity limitations, behavioral and speech problems, emotional difficulties, uninsurance, suboptimal dental health, no usual source of care, unmet medical and dental needs, transportation barriers to care, problems getting specialty care, no medical or dental visit in the past year, emergency department visits, not receiving mental health care, and not receiving prescription medications
- Certain disparities were particularly marked for specific racial/ethnic groups: for Latinos, suboptimal health status and teeth condition, uninsurance, and problems getting specialty care; for African Americans, asthma, behavior problems, skin allergies, speech problems, and unmet prescription needs; for Native Americans, hearing or vision problems, no usual source of care, emergency department visits, and unmet medical and dental needs; and for Asians or Pacific Islanders, problems getting specialty care and not seeing a doctor in the past year
- Multiracial children also experienced many disparities

The authors conclude that minority children experience multiple disparities in medical and oral health, access to care, and use of services. Certain disparities are particularly marked for specific racial/ethnic groups, and multiracial children experience many.

Flores G, Tomany-Korman SC. Racial and ethnic disparities in medical and dental health, access to care, and use of services in US children. *Pediatrics*. Vol. 121 No. 2 February 2008, pp. e286-e298.

Medical Mystery Tour
St. John's wort for depression in a young woman

You may recall last month when we posted this question: A 28-year-old female with severe major depression has achieved partial symptom remission with a selective serotonin reuptake inhibitor (SSRI) but complains of persistent diarrhea and loss of libido. She asks you about using St. John's wort to treat her depression. Appropriate advice would include which of the following? (Select all that are true.)

- St. John's wort may be effective in milder forms of major depression.
- St. John's wort is more effective than placebo in patients with severe major depression.
- St. John's wort is better tolerated than prescription antidepressants.
- The combination of St. John's wort and SSRIs is safe and effective for major depression.
- St. John's wort may reduce the efficacy of combined oral contraceptives.

The answers are:

- St. John's wort may be effective in milder forms of major depression.
- St. John's wort is better tolerated than prescription antidepressants.
- St. John's wort may reduce the efficacy of combined oral contraceptives.

The data on efficacy of St. John's wort in treating depression are confusing, mixed, and subject to criticism over concerns about lack of standardized preparations, adequacy of blinding of patients, short study duration, and inclusion of patients not meeting criteria for major depression. Most studies show benefit compared with placebo for mild depressive syndromes (including many patients without major depressive disorder who may not require treatment with medication). However, evidence is mixed when analyses of St. John's wort compared to placebo are restricted to patients with

major depressive disorder. Some studies, however, do suggest that St. John's wort is as effective as SSRIs and low-dose tricyclic antidepressants for patients with mild to moderate major depression. Most head-to-head studies show that patients are less likely to discontinue St. John's wort because of side effects, compared with standard antidepressants. The combination of St. John's wort and SSRIs has not been studied; combining them poses an increased theoretical risk for serotonin syndrome. St. John's wort may induce the metabolism of oral contraceptives containing ethinyl estradiol, possibly resulting in an unplanned pregnancy.

Midwives Corner
Lisa Allee, CNM, Chinle
Perineal warm packs reduce 3rd and 4th degree lacerations, pain, and urinary incontinence

Conclusions: The application of perineal warm packs in late second stage does not reduce the likelihood of nulliparous women requiring perineal suturing but significantly reduces third- and fourth-degree lacerations, pain during the birth and on days 1 and 2, and urinary incontinence. This simple, inexpensive practice should be incorporated into second stage labor care.

Dahlen HG et al. Perineal outcomes and maternal comfort related to the application of perineal warm packs in the second stage of labor: a randomized controlled trial. *Birth*. 2007 Dec;34(4):282-90.

Navajo News
John Balintona, Shiprock
Adnexal Masses during Pregnancy

The presence of adnexal masses during pregnancy is not uncommon at 0.5% to 2%. Discovery of an adnexal mass during pregnancy can prove to be a management dilemma for the obstetric provider. The clinician must develop and communicate a plan of expectant management versus intervention that exposes the patient to the least amount of morbidity. Prior to the routine use of ultrasound in early pregnancy, most masses were found incidentally or were symptomatic and this often led to prompt surgical intervention. Now with the near universal prenatal ultrasound, the majority of masses are found earlier allowing for more conservative management.

Diagnosis

Adnexal masses have nongynecologic causes, however most are gynecologic and benign in nature. The age of the patient, prior medical history, and gestational age may be useful in determining the likely etiology of the mass. The most common cause is leiomyoma, which may be uncovered in review of the past medical history. Corpus luteum cysts are common in the first trimester of gestation. Benign ovarian entities like functional cysts, benign teratomas, and serous cystadenomas are found in younger patients. The potential for ovarian malignancy does rise as the patient ages.

Ultrasound is the primary imaging technique used to detect adnexal masses and to assess the risk of malignancy. Some experts suggest the MRI may be useful in the evaluation, especially if the ultrasound diagnosis is uncertain. Various morphologic characteristics found on ultrasound may be useful in determining the risk of malignancy in adnexal masses.

Low Risk	**Moderate - High Risk**
Cystic, unilocular	Cystic, multilocular
Size: 5 cm or smaller	Size: greater than 5 cm
	Complex mass
	Solid mass
	Thick septations
	Nodules
	Persists past 16 weeks EGA

Laboratory tests are of limited use in the evaluation of adnexal masses as many of the tumor markers, e.g., CA-125, AFP, BHCG, etc. may be elevated in normal pregnancy. Occasionally the patient will present with signs and symptoms due to the mass. These patients may have abdominal pain, back or flank pain, or digestive disorders; furthermore, the patient may appear to have a gestational size greater than expected due date. The rate of torsion can be up to 20% and rupture rate can be as high as 10%. Some suggest that the risk of torsion is increased in masses between 6 cm and 10 cm in size.

Management

The main management option for the clinician is in choosing expectant management versus intervention. Expectant management decreases the potential for invasive procedures; however, it can expose the patient for potential torsion, mass rupture, or obstruction of labor. Surgical intervention carries its own inherent risks of adverse outcome for mother and fetus. A rational decision can be made based on natural history, malignancy risk, and presence of symptoms.

Most ovarian cysts discovered during pregnancy will resolve spontaneously prior to 16 weeks EGA. This is especially true if the cyst is less than 5 cm. Observation for small cysts is recommended. It is reasonable for the obstetric provider to recommend surgical intervention for cysts that persist after 16 weeks EGA and surgery be indicated for any adnexal mass that may be causing symptoms such as pain or digestive difficulties.

Adnexal masses that have morphologic characteristics that are consistent with a low risk of malignancy may be observed throughout pregnancy. Less than 1% of adnexal masses found in pregnancy prove to be malignant and even in these cases, the majority are low-grade disease. Nevertheless, any mass that is deemed moderate or high risk should be surgically removed. If the clinician has strong evidence that malignancy is likely, it may be prudent to transfer the patient to a facility that can provide the proper staging surgery and expedient

Director for Research on Women's Health and the Director of the Office of Research on Women's Health. The monthly podcast discusses the latest news in women's health research and includes conversations with guests on a variety of subjects.

In the latest podcast, Dr. Pinn talks with Dr. Victoria Cargill, Director of Minority Research and Clinical Studies, Office of AIDS Research, Office of the Director, National Institutes of Health. Dr. Cargill discusses women and HIV/AIDS from the perspective of a researcher and practicing physician in the community. Dr. Cargill emphasized that AIDS continues to be a major health problem for women and that "African American and Hispanic women are almost 80 percent of AIDS cases reported in women." This podcast also discusses differences in how AIDS affects men and women.

"Podcasting" is a relatively new method of distributing audio and video information via the Internet to iPods and other portable media players on demand, so that it can be listened to at the user's convenience. The main benefit of podcasting is that listeners can download content to their media player and take it with them to listen to whenever they want. Because podcasts are typically saved in MP3 format, they can also be listened to on nearly any computer.

To listen to Dr. Pinn's podcast, visit the ORWH homepage at *http://orwh.od.nih.gov/* and click on Pinn Point on Women's Health (podcast). If you need further assistance on how to use podcasts, go to *http://videocast.nih.gov/faq/podcast/default.asp*. For questions, contact Marsha Love at the Office of Research on Women's Health by calling (301) 496-9472 or e-mailing *lovem@od.nih.gov*.

Medicine Dish
2008 Broadcast Schedule

New Programs!
Tune into this series of live interactive monthly satellite and web broadcasts created for Indian Country health providers. These programs serve as a path to open communication, providing information and promoting discussion about Medicare, Medicaid and State Children's Health Insurance Programs (SCHIP), and other issues important to the health of our people.

BROADCASTS ARE SHOWN ON THE 2ND WEDNESDAY OF EVERY MONTH FROM 1:30 P.M. to 2:30 P.M., EASTERN TIME

DATE	TOPIC
FEBRUARY 13	Coding and Billing for Medicare and Medicaid
MARCH 12	IHS special presentation—Office of Resource Access and Partnerships
APRIL 9	Medicare Part B: Requirements, processes for enrollment & participation
MAY 14	Cost reports for I/T/U: How to do them, what is in them, how are they used
JUNE 11	Electronic medical records
JULY 9	CMS website: a tour and how to use it
AUGUST 13	Federally-Qualified Health Centers (FQHC) billing basics
SEPTEMBER 10	Information about the coverage/payment for specific diseases

Tune in Options:

Medicine Dish Satellite Sites
- Channel: 572
- DirecTV Phone Help: (800) 496-4915; account #012019224

Webcast
- Access link: videocast.nih.gov
- Webcast lines are limited, view from CMS satellite dish when available. Real Player is necessary to see the program and can be downloaded free from this website.

Note: Individual program topics are subject to change. Please review the Program Announcement prior to the broadcast for the most recent information. For more information, contact: medicinedish@cms.hhs.gov

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TRIBAL AFFAIRS

MEETINGS OF INTEREST ☐

Available EHR Courses

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

Cardiovascular Disease Update
April 4, 2008; Scottsdale, Arizona

The Native American Cardiology Program is organizing a one-day conference for primary care providers in the Indian Health Service. The conference agenda and registration will be going out by e-mail and fax soon. We are excited to have a group of topnotch faculty to discuss the most up-to-date clinical recommendations for the diagnosis and management of cardiovascular disease. Conference topics include advances in the management of stroke, peripheral vascular disease, and acute MI; evaluation and treatment of atrial fibrillation and heart failure; who needs defibrillators; brief updates on guidelines changes, and advances in cardiac resuscitation. The target audience includes all medical staff with an interest in cardiovascular disease. The IHS Clinical Support Center is the accredited sponsor. The meeting is free to IHS personnel; it will be held at the Chaparral Suites in Scottsdale. For more information, please contact *bmalasky@umcaz.edu* or call our office at (520) 694-7000 or fax requests to (520) 694-6712.

Lifesavers 2008 National Conference on Highway Safety Priorities
April 13 - 15, 2008; Portland, Oregon

Lifesavers is the premier national highway safety meeting in the United States dedicated to reducing the tragic toll of deaths and injuries on our nation's roadways. The conference addresses a wide range of safety topics, from child passenger safety and occupant protection to roadway and vehicle safety and technology. It offers the state-of-the-art information on advances in highway safety, highlights successful programs, and draws attention to emerging safety. Conference attendees come from the public and private sectors representing a multidisciplinary audience including child passenger safety professionals, EMS, nurses, physicians, social workers, injury prevention advocates, researchers, law enforcement, judicial officials, and consumers. Each year, the Lifesavers Conference has become even more relevant and timely, providing a forum that delivers common-sense solutions to today's critical highway safety problems.

For more information visit *www.lifesaversconference.org*; telephone (703) 922-7944; fax (703) 922-7780.

Catching the Vision of Evidence Based Practice (EBP) in our Nursing Practice
April 29 - May 1, 2008; Northern Navajo Medical Center; Shiprock, New Mexico

Shiprock Service Unit's Northern Navajo Medical Center (NNMC) is sponsoring an Evidence Based Practice Seminar April to May 1, 2008. The seminar is free and CEUs will be provided. Sandy Haldane, MSN, RN, IHS Nurse Consultant, and Clare Hastings, RN, PhD, FAAN will provide opening remarks via video.

This is an interactive course on the basics of EBP, what it is, how to ask clinical questions (PICOs), how to ask a clinical research question, and where to find the best evidence. Other skills to be taught include learning to refine a question, learning literature search skills, learning to critically appraise evidence, building critical appraisal skill, and developing strategies for implementing EBP.

A poster presentation and discussion will be available on EBP work completed or in progress from Navajo Area attendees. An additional special skills session will be held May 1 for those needing more help with EBP and literature reviews.

We are fortunate to have the seminar taught by Gwenyth Wallen, PhD, RN. She is the Chief/Clinical Nurse Scientist for Research and Practice Development Service at the National Institutes of Health Clinical Center in Bethesda, Maryland. She and several other NIH nurse scientists provided the initial training on the introduction of EBP in August and September 2006 at NNMC, and we are delighted to have them return for follow-up training. We hope you can join us in this invaluable educational seminar for nurses taught by top-notch leaders and catch the vision of EBP in your nursing practice.

Call Ethel Burke at (505) 368-7407 or e-mail e*thel.burke@ihs.gov* for questions or to register. We ask that registration be completed by April 22, 2008. The mailing address is Northern Navajo Medical Center, Public Health Nursing Department, PO Box 160, Shiprock, New Mexico 87420.

8th Annual Advances in Indian Health
April 29 - May 2, 2008; Albuquerque, New Mexico

The 8th Annual Advances in Indian Health Conference is offered for primary care physicians, nurses, and physician assistants who work with American Indian and Alaskan Native populations at Federal, tribal, and urban sites. Medical students and residents who are interested in serving these

populations are also welcome.

Both new and experienced attendees will learn about advances in clinical care specifically relevant to American Indian populations with an emphasis on southwestern tribes. Opportunities to learn from experienced clinicians who are experts in American Indian health will be emphasized. Indian Health Service Chief Clinical Consultants and disease control program directors will be available for consultation and program development.

The conference format includes three and a half days (Tuesday, Wednesday, Thursday, and Friday morning) of lectures and case discussion workshops. In early spring, the brochure will be posted on the UNM CME website at *http://hsc.unm.edu/cme*. For additional information, please contact Kathy Breckenridge, University of New Mexico Office of Continuing Medical Education at (505) 272-3942, or e-mail the UNM CME Office to request at brochure at *CMEWeb@salud.unm.edu*.

If you would like to review a sample program, you can find it on the National Council of Chief Clinical Consultant's website at *http://www.ihs.gov/NonMedicalPrograms/NC4/nc4-fpAdvances.asp*.

Clinical Update on Substance Abuse and Dependency (Formerly known as the Primary Care Provider Training on Chemical Dependency)
May 6 - 8, 2008; Phoenix, Arizona

This three-day intensive workshop includes both didactic and experiential training. The curriculum is updated annually with the most current nursing, addiction medicine, and prevention information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 - 3 person teams from the same facility representing the various disciplines targeted). The conference site is the Native American Connections, 4520 North Central Avenue, Suite 600, Phoenix, Arizona 85012. For more information or to register, contact Cheryl Begay at (602) 364-7777 or e-mail *cheryl.begay@ihs.gov*. To register on-line, go to the CSC website at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.

Office Based Opioid Treatment Course
May 9, 2008; Phoenix, Arizona

The IHS invites all physicians and nurses to register for its upcoming Office Based Opioid Treatment (OBOT) Course to be held Friday, May 9, 2008 in Phoenix, Arizona. The course faculty features the top clinicians and researchers in the field. This new treatment modality reduces the regulatory burden on physicians who choose to practice opioid addiction therapy. It is open to all physicians and nurses, including federal, state, and military. For more information, contact Dr. Anthony Dekker at (602) 263-1200 or *anthony.dekker@ihs.gov*.

2008 Nurse Leadership in Native Care (NLiNC) Conference "New Directions in the New Frontier: Education, Evidence, and Empowerment"
May 12 - 15, 2008; Anchorage, Alaska

IHS, tribal, and urban nurses are encouraged to attend the NLiNC (Nurse Leadership in Native Care) Conference to be held at the Hotel Captain Cook, 939 West 5th Avenue, Anchorage, Alaska 99501; www.captaincook.com. Please make your room reservations by April 11, 2008 by calling the toll-free number, 1-800-843-1950, or call the Hotel Captain Cook directly at (907) 276-6000; ask for the "Alaska Native Medical Center" to secure the special rate of $105 + tax single or double occupancy per night. Please remember to book early – regularly priced hotel rooms in Anchorage can average nearly $200/night + tax in the summer! This rate is available three days before and three days after the conference, on a space available basis.

Alaska Native Medical Center is an approved provider of continuing education by the Alaska Nurses Association, an accredited approver by the American Nurses Association Credentialing Centers' Commission on Accreditation; Provider Number AP-06-002. For more information about this event, contact Casie Williams, Nurse Educator, Alaska Native Medical Center, at *cwilliams@anmc.org*; or telephone (907) 729-2936. You can also visit the NNLC website at *http://www.ihs.gov/MedicalPrograms/nnlc/*.

The IHS Southwest Regional Pharmacy Continuing Education Seminar (the "Quad")
June 6 - 8, 2008; 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, Navajo, Tucson, Albuquerque Areas, the target audience is made up of pharmacists and technicians working in Indian health system clinics and hospitals. For more information, contact CDR Ed Stein at the IHS Clinical Support Center; e-mail: *ed.stein@ihs.gov* or look for "Seminars & Training" at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*. The meeting will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258.

Keeping the Circle Strong: Celebrating Native Women's Health and Well Being
June 9 - 11, 2008; Albuquerque, New Mexico

The National Indian Women's Health Resource Center, directed by Pamela Iron, will hold their 10th year anniversary celebration conference June 9 - 11, 2008 in Albuquerque, New Mexico. An exciting and informative program is planned to address the physical, mental, social, and spiritual well being of our Native women by keeping the circle of our traditions strong and celebrating what we were taught from those who came

before us. Health educators, nurse practitioners, health administrators, and health care providers interested in women's health should attend. Dr. Kathleen Annette, Bemidji Area Indian Health Service Director, will be the keynote speaker. Other noted speakers include Dr. Cynthia Lindquist Mala, a health and education activist, and Dr. Billie Kipp, University of New Mexico Center for Native American Health. Vanessa Shortbull will provide the entertainment. For more information regarding the agenda, please go to our website at *www.niwhrc.org.*

The meeting will be held at the Marriott Hotel, 2101 Louisiana Blvd. NE, Albuquerque New Mexico 87110. Please make your room reservations by calling 1-(800)-334-2086. You can go online at *www.marrott.com/abqnm* to register for the hotel using the group code NIWNIWA. If you call in your registration, the group code is NIWHRC. The room rates are $75.00 for a single or double. The conference rates are $100 with a NIWHRC membership and $150 without. To register for the conference and become a member, visit *www.niwhrc.org*. For further information on how to register by check or Purchase Order, please call (918) 456-6094 or e-mail *Donita@niwhrc.org*. If you would like to be an exhibitor or arts and crafts vendor, please contact our office. The conference will be accredited by the National Council of Health Education Credentialing (NCHES).

Sexual Assault Nurse Examiner (SANE) Training Course
June 9 - 13, 2008; Window Rock, Arizona.

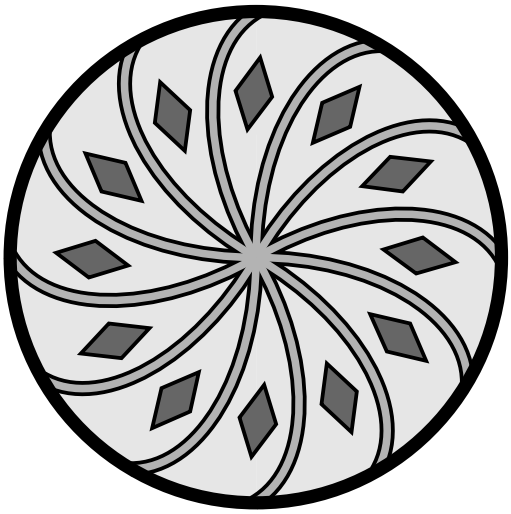
This 5-day intensive training course will focus on the basic forensic medical examination techniques and issues in providing care for adult and adolescent victims of sexual assault. It will provide nurses and other licensed health care professionals with the didactic training necessary for certification as a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) and discuss next steps after training. Strategies for developing a multi-disciplinary Sexual Assault Response Team (SART) will also be reviewed.

This course provides the classroom curriculum portion of SANE/SAFE training. For nurses or other health care professionals who do not routinely perform pelvic examinations, practical experience to acquire pelvic examination skills should be arranged outside of this course. It would be beneficial to begin this process prior to attending the course, if possible. After completion of the course, proctoring is also strongly recommended for the initial forensic examinations performed.

This course is open to Indian Health Service health care professionals, including nurses, advanced practice nurses, PAs, and physicians. A brochure and registration forms will be available soon, as well as information on lodging. There is no fee to attend the course. Transportation, lodging, and per diem are the responsibility of the home health system or individual. This course is being cosponsored by Carolyn Aoyama, Senior Consultant for Women's Health and Advanced Practice Nursing Program at IHS Headquarters, the Chinle Family Violence Prevention Task Force, and the Navajo-Hopi-Zuni SANE/SART Work Group. For questions about content, please contact Sharon Jackson *(Sharon.jackson@ihs.gov)* or Sandra Dodge *(Sandra.dodge@ihs.gov)*. For questions about registration or logistics, please contact Alberta Gorman *(Alberta.gorman@ihs.gov)*.

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

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



POSITION VACANCIES ☐

Editor's note: As a service to our readers, THE IHS PROVIDER *will publish notices of clinical positions available. Indian health program employers should send brief announcements on an organizational letterhead to: Editor, THE IHS PROVIDER, The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

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

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

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

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

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

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

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

The Warm Springs Health and Wellness Center has an immediate opening for a board certified/eligible family physician. We have a clinic that we are very proud of. Our facility has been known for innovation and providing high quality care. We have positions for five family physicians, of which one position is open. Our remaining four doctors have a combined 79 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs in Central Oregon. We have a moderately busy outpatient practice with our doctors seeing about 16 - 18 patients per day under an open access appointment system. Currently we are a pilot site for the IHS Director's Initiative on Chronic Disease Management. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626.

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

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

one psychiatrist, and one psychologist are also on site.

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

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

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

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

Psychiatrist
SouthEast Alaska Regional Health Consortium;
Sitka, Alaska

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

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

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

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

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

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

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

Pediatrician
Nooksack Community Clinic; Everson, Washington

The Nooksack Community Clinic in Everson, Washington is seeking an experienced pediatrician to take over the successful practice of a retiring physician. The clinic provides outpatient care to approximately 2,000 members of the Nooksack Indian Tribe and their families. The position includes some administrative/supervisory duties as well as part-time direct patient care. We are seeking a dedicated, experienced pediatrician with a special interest in child advocacy and complex psychosocial issues. This is a full time

position with a competitive salary and benefits. There are no on-call, no inpatient duties, and no obstetrics. We currently are staffed with one family practitioner, one internist, one pediatrician, and one nurse practitioner. Additionally we have three mental health counselors, a state-of-the-art four-chair dental clinic, a nutritionist, a diabetic nurse educator, and an exercise counselor. We provide high quality care in an environment that prides itself on treating our patients like family.

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

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

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

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

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

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

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

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

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

Kyle Health Center, a PHS/IHS outpatient clinic, is recruiting for the position of general internal medicine/family practice physician and a position of family practice physician assistant/nurse practitioner. The clinic is south of Rapid City, South Dakota, and is located in the heart of the Badlands and the Black Hills – an area that is a favorite tourist destination. It is currently staffed with physicians and mid-level practitioners. It provides comprehensive chronic and acute primary and preventive care. In-house services include radiology, laboratory, pharmacy, optometry, podiatry, primary obstetrics/gynecology, diabetic program, and dentistry. There is no call duty for practitioners. We offer competitive salary, federal employee benefits package, CME leave and allowance, and loan repayment. For further information, please contact K.T Tran, MD, MHA, at (605) 455-8244 or 455-8211.

Internist
Northern Navajo Medical Center; Shiprock, New Mexico

The Department of Internal Medicine at Northern Navajo Medical Center (NNMC) invites board-certified or board-eligible internists to interview for an opening in our eight-member department. NNMC is a 75-bed hospital in Shiprock, New Mexico serving Native American patients from the northeastern part of the Navajo Nation and the greater Four Corners area. Clinical services include anesthesia, dentistry, emergency medicine, family practice, general surgery, internal

medicine, neurology, OB/Gyn, optometry, orthopedics, ENT, pediatrics, physical therapy, and psychiatry. Vigorous programs in health promotion and disease prevention, as well as public health nursing, complement the inpatient services.

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

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

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

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

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

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

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

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

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

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

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

Send CV to Bill Riley, Jamestown S'Klallam Tribe, 1033 Old Blyn Highway, Sequim, Washington 98382, or e-mail *briley@jamestowntribe.org*.

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

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

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

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

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

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

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

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

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

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

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

Family Practice Physician
Ilanka Community Health Center; Cordova, Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Winslow Indian Health Care Center (WIHCC) in northern Arizona is currently looking for primary care physicians in family practice, internal medicine, and psychiatry. We have a staff of 12 physicians, including a surgeon, and nine family nurse practitioners and physician assistants. We offer comprehensive ambulatory and urgent/emergent care to patients at our health center in Winslow, which includes a state-of-the-art, seven-bed Urgent Care Center completed in 2006. WIHCC also operates two field clinics five days a week on the Navajo Reservation, at Leupp and Dilkon. Our FPs and internist also provide inpatient care at the local community hospital, the Little Colorado Medical Center, where the FPs provide obstetrical deliveries with excellent back-up from the local OB-Gyn group. The psychiatrist works as part of a team consisting of one full-time psychiatric nurse practitioner, another (part-time) psychiatrist, and five Navajo counselors, providing primarily outpatient services with occasional hospital consults.

WIHCC offers an awesome mix of professional, cultural, and recreational opportunities. It is located just seven miles

from the breathtaking beauty of Navajoland and its people, and 50 miles from Flagstaff – a university town with extensive downhill and cross-country skiing, where several of our employees choose to live. Attractive salary and benefits, as well as a team oriented, supportive work environment are key to our mission to recruit and retain high quality professional staff.

WIHCC became an ISDA 638 contracted site in 2002, and has experienced steady growth and enhancement of programs and opportunities since the transition from a direct IHS program. Please contact Frank Armao, MD, Clinical Director, if you are interested in pursuing an opportunity here, at *frank.armao@wihcc.org*; telephone (928) 289-6233.

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

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

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

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

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

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

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

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

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

Got *Hózhó*? That's the Navajo word for joy. Here on the Navajo Reservation, there's a great mix of challenging work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work (*naanish*) and enjoy living in our small, collegial community. Our 60-bed acute care hospital is located in Chinle, Arizona, the heart of the Navajo Nation. At work we see unique pathology, practice evidence-based medicine, and are able to utilize the full scope of our medical training. Together, we enjoy learning in an atmosphere of interdepartmental collaboration, supported by an established network of consulting specialists across the southwest. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients. During our time off, many of us explore the beautiful southwest, bike on amazing slick rock, and ski the slopes of the Rocky Mountains. It's a great life – combining challenging and interesting work with the peaceful culture of the Navajo people and the beautiful land of the southwest.

We're looking for highly qualified health care professionals to join our team. If you're interested in learning more about a place where "*naanish baa hózhó*" (work is joyful), contact Heidi Arnholm, Medical Staff Recruiter, Chinle Service Unit, telephone (970) 882-1550 or (928) 674-7607; e-mail *heidi.arnholm@ihs.gov*.

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

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

The facility is a multispecialty clinic providing services in obstetric/gynecology, internal medicine, and family practice. It also includes dental, optometry, pharmacy, behavioral health, community health aides, and other services. Our referral

region includes 43 villages in interior Alaska covering an area the size of Texas. Fairbanks has an outstanding school system and university. We offer a very competitive salary with a great benefits package and a loan repayment plan. Commissioned Corps positions are also available. Contact Jim Kohler at (907) 459-3806 or *james.kohler@tananachiefs.org*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

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

Seattle Indian Health Board (SIHB) physicians are responsible for the delivery of quality, culturally sensitive primary medical care to the SIHB's patient population. This position provides general medical care (including diagnosis, treatment, management, and referral) to SIHB patients with acute, chronic, and maintenance health care needs. The physician chosen will also participate in the medical on-call rotation schedule and other responsibilities such as consulting and coordinating care with other practitioners, nursing, pharmacy, laboratory, and outside referral sites. He or she will provide clinic preceptorship of mid-level practitioners and patient care instruction to nurses, pharmacists, and other SIHB clinical staff. The incumbent will precept for residents for the outpatient continuity family practice clinics. In addition to supervising patient care, preceptors engage in didactic activity to enhance resident learning. The physician will also participate in quality assurance, program development, community health education/screening, and related activities. He or she will document all patient care information/treatment in problem-oriented format in the patient's medical records, as well as complete and submit encounter forms and related materials according to established procedure. Finally, the person selected will comply with SIHB policies and procedures, and the AAAHC Standards of Care.

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

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

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

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

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

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

Family Practice Physician
Hopi Health Care Center; Polacca, Arizona

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

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

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

We are announcing a job opportunity for a family practice physician at the Chief Redstone Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. This is a unique opportunity for a physician to care for individuals and families, including newborns, their parents, grandparents, and extended family. Applicants must be culturally conscious and work well within a team environment. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point.

Our Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and a very active Diabetes Department. These are ambulatory clinics; however our providers have privileges in the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. IHS and the private hospital have a cardiac rehabilitation center. By cooperating with IHS, the hospital has been able to get a CT scanner and a mammography unit. Tribal Health has a dialysis unit attached to the Poplar IHS clinic. Customer service is our priority. The IHS has excellent benefits for Civil Service and Commissioned Corps employees. There are loan repayment options, and we are a designated NHSC site. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being closely involved in our population to encourage a "Healthier Community."

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go to the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. Fort Peck tribes also can be found on *www.fortpecktribes.org*, and the Fort Peck Community College on *www.fpcc.edu*. Northeast Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A, at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*. Alternatively, you can contact Dr. Craig Levy at (406) 768-3491, or e-mail *craig.levy@ihs.gov*, or the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or e-mail *audrey.jones@ihs.gov*. We look forward to communicating with you.

Pediatrician
Family Practice Physician
Obstetrician/Gynecologist
PHS Indian Hospital; Browning, Montana

The Blackfeet Service Unit is recruiting for health practitioners who want to join the staff at the PHS Indian Hospital, Browning, Montana. The Blackfeet Service Unit is home to the Blackfeet Community Hospital, a 27-bed hospital, active outpatient clinic, and well-equipped emergency department. Inpatient care includes obstetrics and elective general surgery. We also offer community health nursing, an active diabetes program, optometry, laboratory, dental, and ENT services along with behavioral and social services and women's health. We are seeking candidates who are committed to improving the health of the local community and being part of a team approach to medicine. The hospital is located 13 miles from Glacier National Park. This area offers spectacular mountains and incredible outdoor activities year round. There are loan repayment options, excellent benefits, and we are a designated NHSC site. If you are interested in joining our medical team, contact Dr. Peter Reuman at *peter.reuman@ihs.gov* or telephone (406) 338-6150; or contact the Physician Recruiter, Audrey Jones, at *audrey.jones@ihs.gov* or telephone (406) 247-7126. We look forward to hearing from interested candidates.

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

The Fort Belknap Service Unit is seeking family practice physician and pharmacist candidates to join their dedicated staff. The service unit is home to a critical access hospital (CAH) with six inpatient beds, two observation beds, and a 24-hour emergency room, as well as an 8 am to 5 pm outpatient clinic. The service unit also operates another outpatient clinic 35 miles south of Fort Belknap Agency in Hays. The Fort Belknap CAH outpatient visits average 39,000 per year. The new clinic in Hays, the Eagle Child Health Center, can adequately serve 13,000 per year. The medical staff includes four family practice positions, two physician assistants, and one nurse practitioner, and has implemented the Electronic Health Record in the outpatient clinic. The service unit also has a full-time staffed emergency medical services program. The staff is complemented by contract locum tenens physicians for weekend emergency room coverage.

The medical staff is supported by and works with a staff of nurses, behavior health personnel, physical therapist, lab and x-ray personnel, pharmacists, dentists, administrators, housekeepers, supply specialists, and contract practitioners to provide the best possible care to patients. The staff works as a team to make a difference. Contract (private) hospitals are from 45 to 210 miles from the facility.

There are loan repayment options, excellent benefits, and we are a designated NHSC site. The area is primarily rural,

and a friendly small-town atmosphere prevails here. The reservation communities promote various local activities such as rodeos, church socials, and basketball. The tribe also manages its own buffalo herd. Bigger events fill in the calendar as well, such as the Milk River Indian Days, Hays Powwow, and the Chief Joseph Memorial Days, featuring cultural activities and traditional dancing. The Fort Belknap Tribe has hunting and fishing available both on and off the reservation. The Little Rocky Mountains and the Missouri River provides scenic and enjoyable areas for the outdoor-minded. If you are interested in joining our medical team, contact Dr. Robert Andrews at *robert.andrews@ihs.gov* or telephone (406) 353-3195; or contact the Physician Recruiter, Audrey Jones, at *audrey.jones@.gov*; telephone (406) 247-7126.

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

We are announcing a job opportunity for a family nurse practitioner and/or physician assistant at the Verne E Gibbs Health Center in Poplar, Montana and the Chief Redstone Health Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point. The Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and a very active Diabetes Department that includes one nurse educator, one FNP, and one nutritionist. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community to encourage a "Healthier Community."

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go to the website at *http://www.ihs.gov/FacilitiesServices/Area Offices/Billings/FtPeck/index.asp*. We are looking for an applicant with well rounded clinical skills. Two years experience is preferred but new graduates are welcome to apply. Northeast Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*.

Family Practice Physicians
Dentists
Pharmacists
Crownpoint Comprehensive Healthcare Facility; Crownpoint, New Mexico

The Crownpoint IHS facility has openings for two family practitioners with low risk obstetric skills (we will consider candidates without OB skills), two pharmacists, and two general dentists. Our service unit follows a family medicine model for providing full-spectrum care to our patients, with a dynamic medical staff that finds the work here quite rewarding. With a high HPSA rating, we are a NHSC-eligible site for payback and loan repayment.

Crownpoint is a town of about 2,500 people in the Four Corners region of New Mexico. We serve a traditional community of 25,000 Navajo people, many of whom speak only Navajo and live in traditional homes with no running water, electricity, or phone service. Our hospital has a six bed ER, a 17 bed med/peds unit, a labor and delivery/post-partum unit, and a large outpatient clinic. We have a total of 16 dental chairs, optometry, and mental health services, as well as on-site pharmacy, laboratory, radiology, and ultrasonography. Our medical/dental staff is a collegial and supportive group including ten family physicians, two pediatricians, an obstetrician/gynecologist, a psychiatrist, three PAs, three FNPs, four dentists, and a podiatrist. We have a very exciting, full-spectrum medical practice that includes high-risk prenatal care, low-risk labor and delivery, emergency room care with management of trauma and orthopedics, and an interesting inpatient medicine and pediatric service.

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

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

For more information, contact Harry Goldenberg, MD,

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

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

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

BBAHC was the first hospital in the country to establish a 638 contract and has an extremely good working relationship with their Board of Directors. Of note, the practice here in Alaska is unique, and air travel to outlying villages is required, since continuity care to the villages is very important to our care here and is uniquely rewarding. BBAHC has an extremely competitive salary and benefits package.

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

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

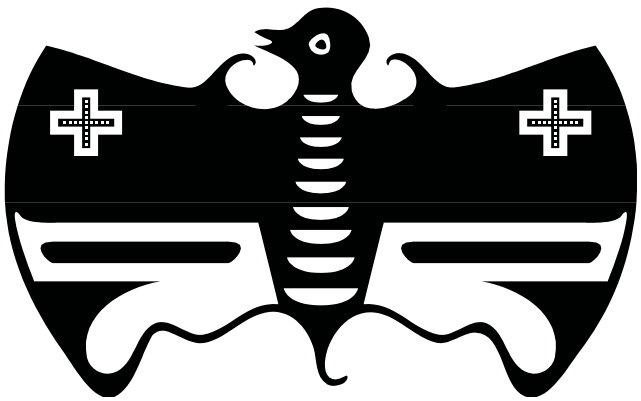
The Tuba City Regional Health Care Corporation, a 73-bed hospital with outpatient clinics serving 70,000 residents of northern Arizona, is recruiting for full-time generalist medical technologists. The laboratory has state-of-the-art equipment. We offer competitive salary, based on experience. Relocation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

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

Family Practice Physician
Gallup Indian Medical Center; Gallup, New Mexico

The Gallup Indian Medical Center has an immediate opening for a family medicine physician. GIMC is one of the largest Indian Health Service sites. The IHS has great benefits packages for both Civil Service and Commissioned Corps providers. We are an NHSC scholarship and an IHS Loan Repayment site as well. The Department of Family Medicine offers the opportunity for full spectrum family medicine care. There are currently nine physicians, two physician assistants, and one pharmacist clinician in the department. Chronic disease management and prevention are the focus for continued development and expansion of this department and program. The hospital has a multi-specialty group, and family medicine physicians have inpatient privileges at GIMC as well as at the community hospital, Rehoboth McKinley Christian Hospital.

Please contact Dr. Alma Alford, Chief of Family Medicine, if you are interested in pursuing an opportunity here. The address is Gallup Indian Medical Center, 516 E. Nizhoni Blvd., P.O. Box 1337, Gallup, New Mexico 87301-1337; telephone (505) 722-1000; fax (505) 726-8740; office number (505) 722-1280 or 722-1775; e-mail *alma.alford@ihs.gov*.



Change of Address or Request for New Subscription Form

Name _____ **Job Title** _____

Address _____

City/State/Zip _____

Worksite: ☐ **IHS** ☐ **Tribal** ☐ **Urban Indian** ☐ **Other**

Service Unit (if applicable) _____ **Last Four Digits of SSN** _____

Check one: ☐ **New Subscription** ☐ **Change of address**

If change of address, please include old address, below, or attach address label.

Old Address _____

THE IHS PRIMARY CARE PROVIDER

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

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov.* Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(http://www.ihs.gov/PublicInfo/Publications/HealthProvider/Provider.asp).*

Wesley J. Picciotti, MPA .....Director, CSC
John F. Saari, MD .....Editor
E.Y. Hooper, MD, MPH.....Contributing Editor
Cheryl Begay .....Production Assistant
Theodora R. Bradley, RN, MPH .....Nursing Consultant
Erma J. Casuse, CDA .....Dental Assisting Training Coordinator
Edward J. Stein, PharmD .....Pharmacy Consultant

Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.

Circulation: The PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

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

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

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

PRESORTED STANDARD
POSTAGE AND FEES PAID
U.S. DEPT. OF HEALTH & HUMAN SERVICES
PHOENIX, AZ
PERMIT NO. 5691

CHANGE SERVICE REQUESTED

_____

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300