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Missing Cohorts of Caregivers Among American Indian and Alaska Native Communities

Mario D. Garrett, PhD, Professor, Chair, Department of Gerontology, San Diego State University, San Diego, California; Dave Baldridge, BA, Principal Investigator, Executive Director, American Association for International Aging, Albuquerque, New Mexico; William F. Benson, BA, Principal, Health Benefits ABCs, Consultant to CDC's Healthy Aging Program, Silver Spring, Maryland; and Lisa C. McGuire, PhD, Health Scientist, Healthy Aging Program, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, Atlanta, Georgia

Declines in the number of children and in mortality, along with increasing life expectancy in the United States will ensure that the US aging population will grow rapidly over the next two decades. The aging population is often portrayed using predictable scenarios. Almost invariably, these scenarios include an increasing number and proportion of older adults compared to diminishing resources -- including lack of services, major strains such as insolvency of Social Security and Medicare, and the scarcity of caregivers, both voluntary and paid. Regardless of what the reality of these fears may prove to be, caregivers are and will remain the linchpin of the support system for frail older adults. A demographic analysis, conducted in 2003 in California, calculated the balance in the population between older adults (70 years and older) and potential caregivers (defined as those between the ages of 40 - 65 years) and found that in 2000 there were four caregivers for every older adult. Notably, by 2050, this balance is expected to change to 2.6 potential caregivers for every older adult.[1]

Although the impact of these changes has been examined at national and state levels, the details of these changes remain to be investigated at the local level, especially for urban vs. rural areas, and in different racial and ethnic groups. As might be expected, with the continued interest in health disparities affecting racial and ethnic groups, the hidden factors affecting the aging of these populations might result in dramatic negative consequences for some groups, complicating existing inequities.

American Indian and Alaska Native (AI/AN) people have long maintained separate and distinct communities. Federal allocations of reservations -- lands set aside for Indian people with sovereign rights -- have allowed some communities to function separately from the mainstream US. Approximately 275 Indian land areas in the US are administered as Indian "reservations" (reservations, Pueblos, rancherias, communities, villages, etc.). On each reservation, the tribe serves as the local governing authority. Within these mostly small but independent communities, the aging of populations can have devastating results. Overall, AI/ANs have higher rates of mortality and morbidity from heart disease, injuries, cancer, and diabetes, while rates of these and other conditions including communicable diseases, infant mortality, and kidney disease exceed those of the general population.[2,3]

A pilot project funded by the Centers for Disease Control and Prevention (CDC) is looking at the demographic changes across all AI/AN communities using the US Census 2000. The US Census collects information on any AI/AN area as defined by the federal government.[4] These include both federally recognized tribes and also state (but not federally) recognized tribes. Although 561 tribes have federal recognition,[5] the US Census gathers data from 650 tribal areas. Most of these tribal areas are comprised of small communities. More than 190 have AI/AN populations of fewer than 50, while more than half (367) have AI/AN populations of less than 250. Only ten communities have populations greater than 10,000 and within

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these, only one has an AI/AN population of more than 100,000. AI/AN populations in these designated areas are smaller than tribal enrollment.

Older adults in AI/AN communities have always depended heavily on their families for care.[6] Although families remain the primary providers of long-term care services to older adults for all races and ethnicities,[7] AI/AN communities exhibit changing dynamics that will further affect families' capacity to provide such care in the future. Identifying these dynamics becomes an important component of planning because if caregivers -- especially those in small communities -- are less available, it behooves local planners to search for mechanisms of external support to meet the needs of their frail and disabled older adult constituents.

Despite more than 4.3 million AI/AN identified as of July 1, 2002 -- 1.5 percent of the total US population[8] -- AI/ANs are often perceived as not needing assistance or as a population too small for statistical inclusion.[9]

Our Approach

The analysis, using 2000 Census data, involved extracting demographic variables for each of the 650 individual AI/AN and Native Hawaiian communities that are enumerated by the US Census. Of these, 345 communities had complete demographic data that enable this analysis to be performed. In order to define the level of need, two computations were made. One was to create an estimate of the number of frail elders -- a factor determining the level of care needed. The second variable -- the number of potential caregivers -- partially defines the level of resources available to meet caregiving needs.

Older adults are more likely to have problems with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) with increasing age.[10] Among AI/AN communities, a national initiative, funded by the US Administration on Aging, conducted older adult needs assessments in select AI/AN communities that have Title VI (Older Americans Act) programs.[3] The study found that for AI/ANs between the ages of 65 - 74, about 6% of the population had problems with two or more ADLs (the definition of frail elder). This percentage increased to 8.5% by age 75 - 84, and continued to increase to 12% of AI/ANs age 85 years and older.[11] These proportions were applied to the 65+ AI/AN populations from the 2000 US Census to obtain the number of potential frail elders.

A national representative sample of caregivers among eighty-three AI/AN communities with a total of 8,560 respondents[12] found that although the majority of caregivers are female (85.8%), men do perform caregiving duties in AI/AN communities (13.5%).[13] Men are usually not the primary caregivers, but there are some who do perform this function. Among women, the highest participation (21%) of all caregivers is for those between ages 55 - 64, followed by the 65 - 74 and the under 35 year old age group (16%). These proportions were applied to the data to define the number of potential caregivers. This project then identified the ratio between older frail elders and potential caregivers among all AI/AN communities.

The Caregiver Ratio Index (CRI) is the number of potential caregivers divided by the number of potentially frail elders. The ratio identifies how many potential caregivers exist for every frail elder. The higher the CRI the higher the number of potential caregivers there are to each frail elder.

What we found

By ranking the CRI, the results allow us to identify AI/AN communities that have more frail older adults than caregivers, and communities that have adequate numbers of caregivers. The analysis was performed on 345 communities that had demographic data (see Table). Interestingly, the CRI does not correspond to the size of the communities.

As expected, the results indicate that the pattern of population aging is not consistent across communities. The index runs from 0 (no caregivers) to 148 (148 potential caregivers to 1 frail elder). The mean is 13, with a median of 10 and a standard deviation of 16. The majority of communities (92%) have between 1 to 25 caregivers per frail older adult. Only four communities have a ratio greater than 100, most of which are small (less than 500 residents) and all have fewer than 10 adults age 65 years and older in the community. At the other extreme, 13 communities have a CRI of 0 with populations of less than 500, except one such community with more than 50,000 members. The wide range of the index shows the huge variability between tribes. The very high and low indices for some communities indicate how precarious these small communities are in terms of the balance of their populations. A few large tribes that have an AI/AN population of greater than 4,000 have a CRI of less than 5, which should be of some concern.

Implications

The CRI is a valuable tool for identifying communities where, on the basis of the population structure alone, there exists a potentially diminished capacity to meet the caregiver needs of the older adult population. By identifying a "missing cohort" -- an age segment of the population that is no longer living in the community -- this tool shines a light on gaps in the supply of both current and emerging caregivers. Ludtke and McDonald[14] argued that one reason why AI/AN caregivers tend to adapt better than the general population might be because the AI/AN caregivers were (are) younger. If, however, this younger cohort is diminished in the future, then this advantage among AI/AN caregivers will be lost, and we will be seeing fewer caregivers looking after an increasing number of chronically disabled, community-dwelling, older adults, as is currently the trend in the general population.[15]

Those tribes with a low CRI might consider establishing or enhancing day care centers, more case management and

respite services, coordination of transportation, an expansion of the community health representative (CHR) system, and strategies for employing caregivers. Such developments will require involvement from all sectors of the community and will truly need to be a community and an intergenerational effort. Population aging is an enduring phenomenon. US populations will never be as young as they are today, and younger cohorts will experience more dramatic shortages than have been identified in this study.

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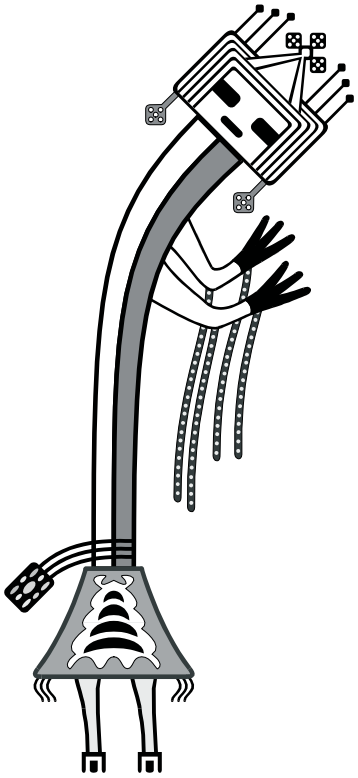


Table. Native Lands and Caregiver Ratio Index (CRI). Only communities that had all data to compute the CRI are included. Listed in alphabetical order by area name. Native lands include American Indian and Alaska Native lands and native Hawaiian Home Lands.

Tribal and Native Lands	CRI
Acoma Pueblo and Off-Reservation Trust Land, NM	10
Adais Caddo SDAISA, LA	1
Agua Caliente Reservation, CA	10
Akiachak ANVSA, AK	2
Akiak ANVSA, AK	26
Akutan ANVSA, AK	13
Alabama-Coushatta Reservation, TX	8
Alakanuk ANVSA, AK	1
Aleknagik ANVSA, AK	1
Algaacig ANVSA, AK	5
Allegany Reservation, NY	8
Ambler ANVSA, AK	6
Andreafsky ANVSA, AK	14
Angoon ANVSA, AK	4
Aniak ANVSA, AK	24
Annette Island Reserve, AK	11
Anvik ANVSA, AK	20
Apache Choctaw SDAISA, LA	2
Bad River Reservation, WI	15
Barona Reservation, CA	18
Battle Mountain Reservation, NV	7
Bay Mills Reservation and Off-Reservation Trust Land, MI	37
Benton Paiute Reservation, CA	3
Big Cypress Reservation, FL	6
Big Pine Reservation, CA	5
Big Sandy Rancheria, CA	4
Bishop Reservation, CA	11
Blackfeet Reservation and Off-Reservation Trust Land, MO	15
Blue Lake Rancheria, CA	3
Bois Forte Reservation, MN	13
Brighton Reservation, FL	11
Campbell Ranch, NV	11
Campo Reservation, CA	13
Carson Colony, NV	17
Catawba Reservation, SC	9
Cattaraugus Reservation, NY	9
Celilo Village, OR	1
Chehalis Reservation, WA	9
Chemehuevi Reservation, CA	9
Cherokees of Southeast Alabama SDAISA, AL	112
Cheyenne River Reservation and Off-Reservation Trust Land, SD	16
Chickahominy SDAISA, VA	0
Chignik Lake ANVSA, AK	3
Chitimacha Reservation, LA	14
Clark's Point ANVSA, AK	3
Clifton Choctaw SDAISA, LA	29
Cochiti Pueblo, NM	6
Cocopah Reservation, AZ	7
Coeur d'Alene Reservation, ID	10
Coharie SDAISA, NC	1
Cold Springs Rancheria, CA	9
Colorado River Reservation, AZ--CA	10
Colville Reservation and Off-Reservation Trust Land, WA	11
Copper Center ANVSA, AK	4
Craig ANVSA, AK	0
Creek-Seminole joint use area OTSA, OK	10
Crooked Creek ANVSA, AK	20
Crow Creek Reservation, SD	19
Crow Reservation and Off-Reservation Trust Land, MO	24
Deering ANVSA, AK	5
Dillingham ANVSA, AK	1
Douglass ANVSA, AK	0
Dresslerville Colony, NV	16
Duck Valley Reservation, ID--NV	8
Duckwater Reservation, NV	6
Eastern Cherokee Reservation, NC	10
Echota Cherokee SDAISA, AL	3
Elko Colony, NV	10
Emmonak ANVSA, AK	3
Fallon Paiute-Shoshone Reservation and Off-Reservation Trust Lands, NV	6
Flandreau Reservation, SD	17
Flathead Reservation, MT	17
Fond du Lac Reservation and Off-Reservation Trust Land, MN	16
Forest County Potawatomi Community & Off-Reservation Trust Land, WI	23
Fort Apache Reservation, AZ	23
Fort Belknap Reservation and Off-Reservation Trust Land, MO	14
Fort Berthold Reservation, ND	17
Fort Bidwell Reservation, CA	4
Fort Hall Reservation and Off-Reservation Trust Land, ID	14

Fort Independence Reservation, CA 1
Fort McDermitt Reservation, NV--OR 6
Fort McDowell Reservation, AZ 36
Fort Mojave Reservation and Off-Reservation Trust
Land, AZ--CA--NV 15
Fort Peck Reservation and Off-Reservation Trust Land, MO 19
Fort Yukon ANVSA, AK 1
Fort Yuma Reservation, AZ--CA 15
Four Winds Cherokee SDAISA, LA 28
Galena ANVSA, AK 0
Gambell ANVSA, AK 11
Gila River Reservation, AZ 19
Golovin ANVSA, AK 0
Goodnews Bay ANVSA, AK 4
Goshute Reservation, NV--UT 4
Grand Portage Reservation and Off-Reservation Trust Land, MI 16
Grand Traverse Reservation and Off-Reservation Trust Land, MI 9
Grayling ANVSA, AK 11
Gulkana ANVSA, AK 6
Haliwa-Saponi SDAISA, NC 4
Hannahville Community and Off-Reservation Trust Land, MI 13
Havasupai Reservation, AZ 19
Ho-Chunk Reservation and Off-Reservation Trust Land, WI--MN 8
Hollywood Reservation, FL 9
Holy Cross ANVSA, AK 3
Hoonah ANVSA, AK 4
Hoopa Valley Reservation, CA 13
Hopi Reservation and Off-Reservation Trust Land, AZ 8
Hualapai Reservation and Off-Reservation Trust Land, AZ 13
Inalik ANVSA, AK 3
Indian Township Reservation, ME 14
Indians of Person County SDAISA, NC 148
Ione Band of Miwok TDSA, CA 1
Isabella Reservation and Off-Reservation Trust Land, MI 14
Isleta Pueblo, NM 9
Jemez Pueblo, NM 10
Jicarilla Apache Reservation, NM 19
Kake ANVSA, AK 0
Kaktovik ANVSA, AK 28
Kalaupapa Home Land, HI 1
Kalispel Reservation, WA 9
Kalskag ANVSA, AK 10
Kaltag ANVSA, AK 10
Karuk Reservation and Off-Reservation Trust Land,CA 10
Kasigluk ANVSA, AK 1
Kaw-Ponca joint use area OTSA, OK 4
Kenaitze ANVSA, AK 3
Kiana ANVSA, AK 108
Kickapoo (KS) Reservation, KS 13
Kickapoo (TX) Reservation, TX 23
Kickapoo OTSA, OK 10
King Cove ANVSA, AK 13
Kiowa-Comanche-Apache-Fort Sill Apache OTSA, OK 2
Kiowa-Comanche-Apache-Ft Sill Apache-Caddo-Wichita, OK 4
Kipnuk ANVSA, AK 13
Kivalina ANVSA, AK 31
Klawock ANVSA, AK 8
Knik ANVSA, AK 12
Kobuk ANVSA, AK 90
Kokhanok ANVSA, AK 4
Kongiganak ANVSA, AK 3
Kootenai Reservation, ID 4
Kotlik ANVSA, AK 10
Kotzebue ANVSA, AK 3
Koyuk ANVSA, AK 111
Kwethluk ANVSA, AK 2
Kwigillingok ANVSA, AK 14
Kwinhagak ANVSA, AK 3
La Jolla Reservation, CA 18
Lac Courte Oreilles Reservation and Off-Reservation Trust
Land, WI 11
Lac du Flambeau Reservation, WI 16
Laguna Pueblo and Off-Reservation Trust Land, NM 7
Lake Traverse Reservation, ND--SD 18
L'Anse Reservation and Off-Reservation Trust Land, MI 17
Laytonville Rancheria, CA 10
Leech Lake Reservation and Off-Reservation Trust Land, MN 13
Levelock ANVSA, AK 3
Lone Pine Reservation, CA 8
Los Coyotes Reservation, CA 3
Lovelock Colony, NV 7
Lower Brule Reservation and Off-Reservation Trust Land, SD 19
Lower Elwha Reservation and Off-Reservation Trust Land, WA 11
Lower Kalskag ANVSA, AK 0
Lower Sioux Reservation, MN 14
Lumbee SDAISA, NC 0
Lummi Reservation, WA 15
Makah Reservation, WA 14
Manley Hot Springs ANVSA, AK 9
Manokotak ANVSA, AK 1
Maricopa (Ak Chin) Reservation, AZ 9
Marshall ANVSA, AK 19
Mashantucket Pequot Reservation and Off-Reservation Trust
Land, CT 10

McGrath ANVSA, AK 12
Meherrin SDAISA, NC 4
Mekoryuk ANVSA, AK 0
Menominee Reservation and Off-Reservation Trust Land, WI 20
Mescalero Reservation, NM 40
Miami-Peoria joint use area OTSA, OK 56
Mille Lacs Reservation and Off-Reservation Trust Land, MN 13
Minto ANVSA, AK 1
Mississippi Choctaw Reservation and Off-Reservation Trust Land, MS 17
Mooretown Rancheria, CA 4
Morongo Reservation, CA 15
Mountain Village ANVSA, AK 5
Muckleshoot Reservation and Off-Reservation Trust Land, WA 51
Nambe Pueblo and Off-Reservation Trust Land, NM 9
Nanticoke Indian Tribe SDAISA, DE 2
Nanticoke Lenni Lenape SDAISA, NJ 4
Napakiak ANVSA, AK 0
Napaskiak ANVSA, AK 5
Navajo Nation Reservation and Off-Reservation Trust Land, AZ--NM--UT 11
Nenana ANVSA, AK 1
New Koliganek ANVSA, AK 7
New Stuyahok ANVSA, AK 4
Newhalen ANVSA, AK 11
Newtok ANVSA, AK 21
Nez Perce Reservation, ID 13
Nightmute ANVSA, AK 16
Nikolai ANVSA, AK 6
Ninilchik ANVSA, AK 1
Nooksack Reservation and Off-Reservation Trust Land, WA 20
Northern Cheyenne Reservation and Off-Reservation Trust Land, MT 14
Nuiqsut ANVSA, AK 5
Nulato ANVSA, AK 9
Nunapitchuk ANVSA, AK 3
Omaha Reservation, IA--NE 15
Oneida (WI) Reservation and Off-Reservation Trust Land, WI 10
Onondaga Reservation, NY 16
Osage Reservation, OK 11
Otoe-Missouria OTSA, OK 0
Ottawa OTSA, OK 2
Ouzinkie ANVSA, AK 2
Pala Reservation, CA 41
Pamunkey (state) Reservation, VA 4
Pascua Yaqui Reservation, AZ 18
Pawnee OTSA, OK 6
Pechanga Reservation, CA 6
Penobscot Reservation and Off-Reservation Trust Land, ME 9
Peoria OTSA, OK 27
Picuris Pueblo, NM 5
Pilot Station ANVSA, AK 2
Pine Ridge Reservation and Off-Reservation Trust Land, SD 16
Pleasant Point Reservation, ME 16
Poarch Creek Reservation and Off-Reservation Trust Land, AL 7
Point Hope ANVSA, AK 1
Point Lay ANVSA, AK 29
Pojoaque Pueblo, NM 18
Pokagon Band of Potawatomi TDSA, IN--MI 6
Ponca OTSA, OK 9
Poospatuck (state) Reservation, NY 1
Port Gamble Reservation, WA 12
Port Graham ANVSA, AK 0
Port Lions ANVSA, AK 2
Port Madison Reservation, WA 15
Prairie Band Potawatomi Reservation, KS 9
Prairie Island Indian Community and Off-Reservation Trust Land, MN 9
Puyallup Reservation and Off-Reservation Trust Land, WA 19
Pyramid Lake Reservation, NV 18
Quapaw OTSA, OK 5
Quileute Reservation, WA 17
Quinault Reservation, WA 18
Red Cliff Reservation and Off-Reservation Trust Land, WI 16
Red Lake Reservation, MN 16
Redding Rancheria, CA 2
Reno-Sparks Colony, NV 17
Rincon Reservation, CA 8
Rocky Boy's Reservation and Off-Reservation Trust Land, MT 20
Rosebud Reservation and Off-Reservation Trust Land, SD 14
Round Valley Reservation and Off-Reservation Trust, CA 8
Russian Mission ANVSA, AK 9
Sac and Fox OTSA, OK 3
Sac and Fox/Meskwaki Reservation and Off- Reservation Trust Land, IA 18
Salt River Reservation, AZ 26
Samish TDSA, WA 12
San Carlos Reservation, AZ 21
San Felipe Pueblo, NM 24
San Ildefonso Pueblo, NM 11
San Juan Pueblo, NM 10
San Pasqual Reservation, CA 10
Sand Point ANVSA, AK 7
Sandia Pueblo, NM 16

Santa Ana Pueblo, NM 11
Santa Clara Pueblo, NM 10
Santa Rosa Rancheria, CA 11
Santa Rosa Reservation, CA 2
Santa Ynez Reservation, CA 4
Santa Ysabel Reservation, CA 6
Santee Reservation, NE 14
Santo Domingo Pueblo, NM 14
Sault Ste. Marie Reservation and Off-Reservation Trust Land, MI 26
Savoonga ANVSA, AK 7
Saxman ANVSA, AK 37
Scammon Bay ANVSA, AK 14
Selawik ANVSA, AK 6
Seminole OTSA, OK 13
Seneca-Cayuga OTSA, OK 70
Shageluk ANVSA, AK 7
Shaktoolik ANVSA, AK 3
Shinnecock (state) Reservation, NY 0
Shishmaref ANVSA, AK 3
Shungnak ANVSA, AK 13
Siletz Reservation and Off-Reservation Trust Land, OR 8
Skokomish Reservation, WA 14
Soboba Reservation, CA 22
Sokaogon Chippewa Community and Off-Reservation Trust Land, WI 15
South Fork Reservation and Off-Reservation Trust Land, NV 9
Southern Ute Reservation, CO 16
Spirit Lake Reservation, ND 25
Spokane Reservation, WA 13
Squaxin Island Reservation and Off-Reservation Trust Land, WA 17
St. Croix Reservation and Off-Reservation Trust Land, WI 30
St. Michael ANVSA, AK 7
St. Paul ANVSA, AK 14
St. Regis Mohawk Reservation, NY 10
Standing Rock Reservation, ND--SD 16
Stebbins ANVSA, AK 4
Stevens Village ANVSA, AK 23
Stockbridge-Munsee Community, WI 6
Susanville Rancheria, CA 13
Swinomish Reservation, WA 9
Table Mountain Rancheria, CA 0
Tama (state) Reservation, GA 17
Tanana ANVSA, AK 4
Taos Pueblo and Off-Reservation Trust Land, NM 6
Teller ANVSA, AK 0
Tesuque Pueblo and Off-Reservation Trust Land, NM 27
Tetlin TDSA, AK 25
Togiak ANVSA, AK 3
Tohono O'odham Reservation and Off-Reservation Trust Land, AZ 13
Toksook Bay ANVSA, AK 11
Tonawanda Reservation, NY 4
Tonkawa OTSA, OK 26
Torres-Martinez Reservation, CA 6
Trinidad Rancheria and Off-Reservation Trust Land, CA 3
Tulalip Reservation, WA 13
Tule River Reservation, CA 26
Tuluksak ANVSA, AK 11
Tuntutuliak ANVSA, AK 25
Tuolumne Rancheria and Off-Reservation Trust Land, CA 3
Turtle Mountain Reservation and Off-Reservation Trust Land, ND 16
Tuscarora Reservation, NY 9
Uintah and Ouray Reservation and Off-Reservation Trust Land, UT 19
Umatilla Reservation, OR 13
Unalakleet ANVSA, AK 0
Unalaska ANVSA, AK 32
United Houma Nation SDAISA, LA 0
Ute Mountain Reservation and Off-Reservation Trust Land, CO 19
Viejas Reservation, CA 5
Waccamaw Siouan SDAISA, NC 83
Wainwright ANVSA, AK 8
Walker River Reservation, NV 5
Warm Springs Reservation and Off-Reservation Trust Land, OR 15
White Earth Reservation and Off-Reservation Trust Land, MN 12
White Mountain ANVSA, AK 6
Wind River Reservation and Off-Reservation Trust Land, WY 14
Winnebago Reservation and Off-Reservation Trust Land, NE 19
Wyandotte OTSA, OK 11
Yakama Reservation and Off-Reservation Trust Land, WA 15
Yakutat ANVSA, AK 8
Yankton Reservation, SD 17
Yavapai-Apache Nation Reservation, AZ 10
Yavapai-Prescott Reservation, AZ 6
Yerington Colony, NV 6
Ysleta Del Sur Pueblo and Off-Reservation Trust Land, TX 14
Yurok Reservation, CA 8
Zia Pueblo and Off-Reservation Trust Land, NM 9
Zuni Reservation and Off-Reservation Trust Land, AZ 13

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

" What is research but a blind date with knowledge."

Will Henry

Articles of Interest

Estimating the effectiveness of screening for scoliosis: a case-control study. *Pediatrics*. 2008 Jan;121(1):9-14.

Does screening for scoliosis lead to earlier detection and decrease the need for surgical treatment? The answer to the first question is "yes." Disappointingly, the answer to the second question appears to be "no."

This was a case control study done in the Netherlands. Patients who underwent screening were diagnosed with scoliosis at an earlier age (10.8 years versus 13.4 years) but earlier detection did not decrease the eventual need for surgical treatment. This also calls into question whether earlier detection and bracing is effective. The authors suggest that a randomized controlled trial of screening and bracing is needed to definitively resolve this question.

Editorial Comment

Screening programs for scoliosis have been around for over 30 years. In the United States 26 states actually mandate school screening for scoliosis. The belief is that with early detection, treatment of scoliosis may be instituted sooner, thereby reducing the number of patients who will require surgery or have crippling deformities.

To screen in such a manner that no one with scoliosis is missed, many individuals are identified falsely as having scoliosis and are referred for confirmation by the pediatrician or orthopedist. Because so many patients are identified falsely, the true cost of screening is unacceptably high. There may also be significant emotional baggage in being identified incorrectly with scoliosis or with scoliosis that is clinically trivial. Given that the benefits are unproven, and that the economic and emotional costs are high, school screening programs for scoliosis have been discontinued in Great Britain and Canada. The American Academy has no policy specifically addressing school screening for scoliosis but does endorse scoliosis evaluation as part of well child care for teens.

Until a definitive, randomized controlled trial demonstrates the benefit of school screening for scoliosis, it is perhaps better to focus our efforts on screening and treatments with proven benefits.

Infectious Disease Updates.
Rosalyn Singleton, MD, MPH

Here's recent news highlights from the world of vaccines:

1. The Advisory Committee on Immunization Practices recommended in February to expand recommendations for yearly flu vaccine to all children 6 months to 18 years. An additional 30 million children will be recommended to receive flu vaccine. *Comment: This makes sense from a disease transmission standpoint. The Japanese showed an overall decrease in influenza illness among all ages when school-aged children were required to receive flu vaccine. While this is welcome news, I find this a little daunting because of all the shots we currently give. Could be a strong case for nasal FluMist®.*
2. Merck's ProQuad Vaccine linked to more seizures. A study presented to the ACIP last month has found that the Merck combination MMR-Varicella vaccine has been associated with higher rates of fever-related convulsions in children. The study found a two times higher rate of seizures in children who received the vaccine than in those who received separate MMR and Varicella. The excess number of seizures was estimated at 5 per 10,000. Although researchers could not isolate factors causing increased rates of fever-related convulsions, they did note that *ProQuad* contained five times more varicella antigen than Varivax®.*I can't comment on this issue since we haven't used ProQuad in Alaska (we don't have a way to keep it frozen in transit here in the cold north)*.
3. Two recent measles outbreaks in the US underscore the need to maintain high vaccination coverage, and the impact of "vaccine refusals." A Japanese ballplayer traveled while sick with measles to the Little League World Series, causing measles to erupt in Pennsylvania, Michigan and Texas. In a second incident, a child traveling from Switzerland to San Diego exposed numerous children at schools, parks, circuses, and clinics, resulting in 11 confirmed cases of measles. Health officials say the outbreak should

prompt parents to get their children vaccinated, as all of the confirmed cases involve children who did not receive the measles shot due to their young age or whose parents opted not to have them vaccinated.*Comment: I think it's important for folks who refuse vaccines out of fear to understand some of the risks. These are great lessons!*

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

Reingold A, Hadler, J, Farley MM, et al. Invasive Pneumococcal Disease in Children 5 Years After Conjugate Vaccine Introduction---Eight States, 1998-2005. *MMWR Morb Mortal Wkly Rep*. 2008 Feb 15;57(06);144-148.

This study investigates invasive pneumococcal disease (IPD) trends in children five years and younger pre- and post-introduction of 7-valent pneumococcal conjugate vaccine (PCV7) in eight states from 1998 to 2005 through analysis of CDC's Active Bacterial Core (ABCs) surveillance data (population and laboratory-based surveillance data). Their results indicate that the incidence of IPD among children <5 years in 1998-1999 (pre-PCV7 vaccine years) were 98.7 cases per 100,000 while in 2005 the rate was 23.4 cases per 100,000, giving an overall rate reduction of 77%. Rates of IPD declined across all age groups with the largest absolute rate reduction [175.7 per 100,000 (82%)] in children aged 1 year (largest baseline rate).

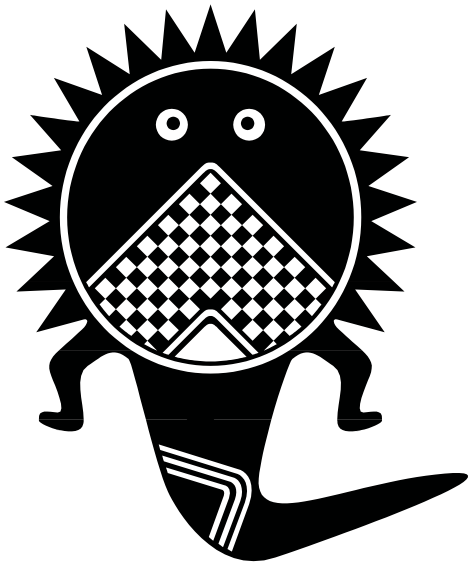
The painted picture may not be "so rosy." Non-PCV7 IPD appears to be on the rise. Further evaluation of the data indicates a leveling off of IPD rates from 2002 to 2005. This steady state is in large part due to non-PCV7 IPD, particularly the 19A serotype. In 2005, the incidence of 19A serotype IPD was 9.3 cases per 100,000; an increase from 2.6 cases per 100,000 in 1998-1999. In 2005, 40% of IPD were related to non-PCV7 serotypes.

Singleton et al[1] illustrated a similar trend in IPD in Alaska Native children. For Alaska Native children less then two years of age, the overall all IPD rate reduction was 67% (from 403.2 cases per 100,000 in the pre-PVC7 vaccine years of 1995 through 2000 to 134.3 cases per 100,000 in 2001-2003). The rate of IPD attributed to PVC7 covered serotypes (PVC7 IPD) in 1995-2000 was 275.3 per 100,000. After introduction of PCV7 there was a 92% reduction to 23.4 per 100,000 by 2001-2003 in PVC7 IPD. By 2004-2006, the rate reduced further to 10.6 PVC7 IPD cases per 100,000. These advances in rate reduction were offset by increases in non-PVC7 IPD seen in the Alaska Native children population. The rate of non-PVC7 IPD prior to introduction of PVC7 in children less than two years was 95.1 per 100,000. Through 2006, this rate increased by 140% to 228.6 cases of non-PVC7 IPD per 100,000. This rate more than doubled between 2001-2003 and 2004-2006. A majority of these non- PVC7 IPD cases were caused by serotype 19A.

Both studies support the development of expansion of the valency of conjugate vaccines to protect against serotypes not included in the current PCV7 vaccine, especially serotype 19A. Time will tell whether expansion will be beneficial in further reducing IPD rates, elimination of health disparities as it relates to IPD, and improvement in the health status of AI/AN children. As Dr. Esposito would say, "I will try to keep you posted."

Reference

1. Singleton RJ, Hennessy TW, Bulkow LR, et al. Invasive pneumococcal disease caused by nonvaccine serotypes among Alaska Native children with high level of 7-valent pneumococcal conjugate vaccine coverage. *JAMA*. 2007;297:1784-1792. *http://www.ncbi.nlm.nih.gov/pubmed/17456820?ordinalpos=2&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum*.



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

High prevalence of HPV infection in American Indian women of the Northern Plains

Objectives: Cervical cancer is the leading gynecological malignancy worldwide, and the incidence of this disease is very high in American Indian women. Infection with the human papillomavirus (HPV) is responsible for more than 95% of cervical squamous carcinomas. Therefore, the main objective of this study was to analyze oncogenic HPV infections in American Indian women residing in the Northern Plains.

Methods: Cervical samples were collected from 287 women attending a Northern Plains American Indian reservation outpatient clinic. DNA was extracted from the cervical samples, and HPV-specific DNA was amplified by polymerase chain reaction (PCR) using the L1 consensus primer sets. The PCR products were hybridized with the Roche HPV Line Blot assay for HPV genotyping to detect 27 different low- and high-risk HPV genotypes. The Chi-squared test was performed for statistical analysis of the HPV infection and cytology diagnosis data.

Results: Of the total 287 patients, 61 women (21.25%) tested positive for HPV infection. Among all HPV-positive women, 41 (67.2%) were infected with high-risk HPV types. Of the HPV infected women, 41% presented with multiple HPV genotypes. Additionally, of the women infected with oncogenic HPV types, 20 (48.7%) were infected with HPV16 and 18, and the remaining 21 (51.3%) were infected with other oncogenic types (i.e., HPV59, 39, 73). Women infected with oncogenic HPV types had a significantly higher ($p=0.001$) frequency of abnormal Papanicolaou smear tests (Pap test) compared to women who were either HPV negative or positive for non-oncogenic HPV types. The incidence of HPV infection was inversely correlated ($p<0.05$) with the age of the patients, but there was no correlation ($p=0.33$) with seasonal variation.

Conclusions: In this study, we observed a high prevalence of HPV infection in American Indian women residing on Northern Plains Reservations. In addition, a significant proportion of the oncogenic HPV infections were other than HPV16 and 18.

Bell MC, Schmidt-Grimminger D, Patrick S, Ryschon T, Linz L, Chauhan SC. There is a high prevalence of human papillomavirus infection in American Indian women of the Northern Plains. *Gynecol Oncol*. 2007 Nov;107(2):236-41.

OB/GYN CCC Editorial Comment

Multiple HPV subtypes seen in Northern Plains and Alaska Natives: Keep up screening efforts

Bell et al's findings of multiple co-infections with high risk HPV subtypes in American Indian women of the Northern Plains mirrors Sebbelov's data among Alaska Native women in which multiple genotypes were found in 36.5% of patients. Sebbelov's retrospective study examining the HPV genotypes in tissue specimens from 52 patients diagnosed with cervical cancer from 1980 to 1989, identified HPV type 16 in 79%, type 33 in 32%, type 31 in 21%, and type 18 in 4%. Infections with multiple genotypes were found in 36.5% of Alaska Native women, much higher than among Greenland Native patients (4%) and Danish Caucasian patients (7%) in the study. These finding suggest that up to 83% of Alaska Native cervical cancers are caused by the HPV types targeted in the vaccine, although the high prevalence of multiple high risk genotype infections raises concern for how effective the currently available HPV vaccine may be in preventing cervical cancer in this population

A few caveats: both studies are small, and although they found that half of the women were infected with oncogenic HPV infections other than HPV16 and 18, the other half were infected with HPV16 and 18, and thus would have received protection from the current HPV vaccine, Gardasil. Please do not read Bell et al and Sebbelov et al and then decide that there is no benefit in providing the current vaccine to AI/AN women in the Northern Plains or Alaska Natives. Realize that significant protection can be provided by the vaccine. Our goal as providers should be to educate women about the need to continue to receive regular screenings, even if they receive the

quadravalent vaccine.

Sebbelov AM, Krüger DM, Kjaer S, Jensen H, Gregoire L, Hawkins I, Parkinson AJ, Norrild B. Comparison of human papillomavirus genotypes in archival cervical cancer specimens from Alaska natives, Greenland natives and Danish Caucasians. *Microbes Infect*. 2000;2(2):121-6.

From Your Colleagues

David Gahn, Tahlequah

Afghanistan Update

On January 12, 2007, an Indian Health Service team deployed to Kabul, Afghanistan as part of the HHS Afghanistan Health Initiative. Dr. Pat O'Connor, MD (Pediatrics, Tuba City, AZ), Dr. Brandon Taylor, PharmD (Tahlequah), and I endured 6 weeks of a brutal Afghanistan winter working at Rabia Balkhi Women's Hospital (RBH).

We encountered what we expected – a hospital staff overwhelmed with pathology in the face of lack of supplies and training. We all tackled our problem lists and worked on providing sustainable training, bedside teaching, and making recommendations to the Office of Global Health Affairs (OGHA) and the Centers for Disease Control and Prevention (CDC) on equipment needs, staffing, and training while providing epidemiological data on the patients.

Two non-governmental organizations (NGOs) are currently working at RBH under cooperative agreements with HHS. International Medical Corps is focused on providing training to the hospital staff in general areas (e.g., infection prevention) as well as specific clinical training to physicians, nurse midwives, laboratory personnel, etc. Cure International is responsible for developing the administration of RBH as well as the supply chain issues. The NGOs are experts at what they do and, partnering with OGHA, CDC, and IHS, they have made a significant impact on the morbidity and mortality occurring at RBH.

Dr. O'Connor, Dr. Taylor, and I spent a majority of our time at the bedside with the physicians and pharmacists, conducting clinical teaching and modeling the team approach to patient care. As I mentioned in a previous article, RBH houses an Ob/Gyn residency training program. The residents lack a strong foundation in basic sciences, but have superb clinical skills due mainly to the amount of pathology that presents to the hospital. The focus of the project is developing the residency training program, but naturally that involves the entire hospital from housekeeping to the blood bank. Each system presents challenges for improvement, but the hospital staff is eager to move forward.

In January 2008, OGHA and IHS entered into an interagency agreement to allow for IHS clinicians to deploy to Kabul. Money has been identified by OGHA to reimburse individual service units through IHS headquarters. I have been assigned to work on the project full time, and we are assembling another team to deploy in June 2008 to continue the work. We are currently searching for an Ob/Gyn physician to deploy for four weeks, and have identified potential candidates in anesthesia, pediatrics, and an operating room nurse.

If you are interested in the project or have any questions, please contact *david.gahn@IHS.gov*. The work is exciting, incredibly rewarding, and very challenging.

Hot Topics

Obstetrics

Cesarean delivery during nursing change of shift is associated with increased complications

Results: Physician change of shift had no measurable effect on maternal and neonatal outcomes. Neonatal facial nerve palsies were increased at nursing change of shift (5 vs 0) as were hysterectomies (33 [0.24%] vs 23 [0.53%]; P= .007). Nursing change of shift had no impact on composite maternal morbidity after controlling for age, race, insurance, medical problems, prior incision type, weekend day, and prenatal care (odds ratio = 0.98; 95% confidence interval = 0.89-1.08).

Conclusion: Physician change of shift does not appear to be associated with an increase in morbidities. However, cesarean delivery during nursing change of shift is associated with increased risk of neonatal facial nerve palsy and hysterectomy. Further investigation is needed to understand the cause of this association.

Bailit JL, Landon MB, Lai Y, et al; for the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal-Fetal Medicine Units Network Cesarean Registry: impact of shift change on cesarean complications. *Am J Obstet Gynecol*. 2008;198:173.e1-173

Gynecology

Co-Occurrence of Pelvic Floor Disorders May Be High in Women

Methods: Stress urinary incontinence (SUI), overactive bladder (OAB), pelvic organ prolapse (POP), and anal incontinence were assessed using a validated questionnaire among 25 - 84-year-old women.

Conclusion: Although the prevalence of pelvic floor disorders in a community-dwelling population is high, age was not a significant contributor after adjustment for confounders. The high co-occurrence of pelvic floor disorders suggests that physicians seeing women seeking care for one condition should inquire about symptoms of other disorders. Level Of Evidence: II.

Lawrence JM et al. Prevalence and co-occurrence of pelvic floor disorders in community-dwelling women. *Obstet Gynecol*. 2008 Mar;111(3):678-685.

Child Health

Maternal grandmothers' alcohol use linked to FAS in the Northern Plains

Introduction: Characteristics of Northern Plains American Indian maternal grandmothers who had grandchildren with fetal alcohol syndrome (FAS) or incomplete FAS are described to more effectively prevent fetal FAS and alcohol use during pregnancy.

Methods: Study 1 had 27 maternal grandmothers who had grandchildren with FAS and Study 2 had 18 grandmothers with grandchildren who had incomplete FAS (cases) which were compared with 119 maternal grandmothers who had grandchildren without FAS (controls). The grandchildren were born between 1981 and 1993 on the Northern Plains. Medical records were manually reviewed for each case and control grandmother. Data were analyzed using Mantel–Haenszel chi square.

Results: Study 1 case grandmothers were more likely to experience medical problems (70.4%) including trauma (48.1%) and injuries (51.9%) than the controls. Most of the Study 1 and 2 case grandmothers (92.6% and 77.8%, respectively) had alcohol use documented in their medical records compared to less than half of the control grandmothers. Seven (15.6%) of the case grandmothers had more than one grandchild in either Study 1 or Study 2.

Conclusion: Maternal grandmothers who had grandchildren with FAS had significantly higher rates of alcohol use and alcohol-related medical problems than control grandmothers. Antenatal care providers should screen pregnant women for alcohol use at their first visit. The provider needs to ask the women who are using alcohol about their mothers' use of alcohol to provide appropriate care and counseling for the women and prevent FAS.

Kvigne VL, Leonardson GR, Borzelleca J, Welty TK. Characteristics of grandmothers who have grandchildren with fetal alcohol syndrome or incomplete fetal alcohol syndrome. *Matern Child Health J*. 2008 Jan 15.

Comments from the Authors, Tom Welty, Valborg Kvigne

When a child is diagnosed with FAS the mother should be evaluated for a FASD

Over a decade ago we conducted a case control study of children with FAS and incomplete FAS in northern Plains Indian communities. The recently published report of grandmothers of the case children indicates a familial pattern of alcohol use during pregnancy that we hope will help with the understanding and prevention of FAS. The report emphasizes the importance of screening for substance use at the first antenatal visit and for interventions to help women who are drinking to stop. Evaluation of the family situation is a critical component of promoting abstinence throughout pregnancy in pregnant women who are drinking. The pregnant mom herself may be adversely affected by fetal alcohol exposure and need considerable support to cope with her social situation. A multidisciplinary approach to such cases will likely be the most successful. Reduction or elimination of fetal alcohol exposure will give the offspring of such pregnancies the best chance of being productive citizens in their communities. It seems that that when a child is diagnosed with Fetal Alcohol Syndrome, perhaps the mother needs to also be evaluated for a Fetal Alcohol Spectrum Disorder.

Chronic disease and Illness

Low-dose aspirin is linked to lower risk for all-cause mortality in women, especially older women

Conclusions: In women, low to moderate doses of aspirin are associated with significantly lower risk of all-cause mortality, particularly in older women and those with cardiac risk factors. A significant benefit is evident within five years for cardiovascular disease, whereas a modest benefit for cancer is not apparent until after ten years of use.

Practice Pearls

- Women who take low to moderate doses of aspirin (1 - 5 tablets per week) have lower risk for mortality from all causes.
- Women who take low to moderate doses of aspirin have lower risk for mortality from cardiovascular disease within five years and lower risk for mortality from cancer after ten years.
- However, current clinical practice should not be changed yet based on the results from this observational study.

Chan AT, et a; Long-term aspirin use and mortality in women. *Arch Intern Med*. 2007 Mar 26;167(6):562-72.

Features

American College of Obstetricians and Gynecologists

Treatment of Urinary Infections in Nonpregnant Women

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

- Screening for and treatment of asymptomatic bacteriuria is not recommended in nonpregnant, premenopausal women.
- Resistance rates higher than 15 - 20% necessitate a change in antibiotic class.
- In all cases of acute pyelonephritis, whether treatment is on an inpatient or outpatient basis, 14 days of total antimicrobial therapy should be completed.
- A 3-day antimicrobial regimen is the preferred treatment duration for uncomplicated acute bacterial cystitis in women, including women age 65 years and older.

The following conclusion is based on limited or inconsistent evidence (Level B):

- The initial treatment of a symptomatic lower UTI with pyuria or bacteriuria or both does not require a urine culture.

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

- Beta-lactams, such as first-generation cephalosporins and amoxicillin, are less effective in the treatment of acute uncomplicated cystitis than those antimicrobials listed in a table that accompanies the article.
- To diagnose bacteriuria, decreasing the colony count to 1,000–10,000 bacteria per milliliter in symptomatic patients will improve the sensitivity without significantly compromising specificity.

ACOG Practice Bulletin No. 91: Treatment of Urinary Tract Infections in Nonpregnant Women. *Obstet Gynecol*. 2008 Mar;111(3):785-94.

AHRQ Agency for Healthcare Research and Quality
Care quality is not necessarily better with electronic health records

Electronic health records (EHR) do not automatically guarantee higher quality care in medical settings, a new study finds. Researchers from Harvard and Stanford looked at the effect EHRs had on 17 indicators of quality, including disease management, antibiotic use, preventive counseling, screening tests, and drugs prescribed for elderly patients. They found EHRs improved performance for two indicators, worsened performance for one, and offered no real advantage for the remaining 14.

Physicians using EHRs scored well in not prescribing sedatives (benzodiazepines) to depressed patients and avoiding routine urinalyses at general medical visits. In addition, when researchers limited the study sample to primary care and heart physicians, those who employed EHRs more often counseled smokers to quit. Yet, doctors who had EHR systems didn't do as good a job in prescribing medication for patients with high cholesterol as those who didn't use EHR systems, notes Jeffrey A. Linder, MD, MPH. Dr. Linder and colleagues used 2003 to 2004 data from more than 50,000 patient records collected by the National Ambulatory Medical Care Survey of patient visits to US physician practices. Electronic health records were used in 18 percent of about 1.8 million ambulatory medical visits during the study period.

The authors note that performance for both groups -- with and without EHRs -- was below par, indicating there is room for improvement across the board. They stress that no one should assume that quality improves as EHR use widens. Earlier studies conducted by the Agency for Healthcare Research and Quality, however, found that EHRs can boost the amount of care that meets with guidelines, improve care through clinical monitoring, and curtail medical errors.

The authors recommend that physicians adopting EHR systems consider ones that include clinical decision support and use that feature to improve care. This study was funded in part by the Agency for Healthcare Research and Quality (HS14563 and HS11313).

Linder J, Ma J, Bates D, et al. Electronic health record use and the quality of ambulatory care in the United States. *Archives of Internal Medicine*. July 9, 2007:1400-1405.

Ask a Librarian Diane Cooper, MSLS/NIH
Women's Health Resources

A new Web resource providing scientists and consumers with the latest information on significant topics in women's health research from scientific journals and other peer-reviewed sources is now available through the National Library of Medicine (NLM). The NLM Division of Specialized Information Services, Office of Outreach and Special Populations has partnered with the NIH Office of Research on Women's Health (ORWH) to create this one-stop resource.

The 2008 National Institutes of Health (NIH) Research Priorities for Women's Health were used to identify overarching themes, specific health topics, and research initiatives in women's health. Within each section of the website are topics with links to relevant and authoritative resources and research initiatives for women's health.

Women's Health Resources from the NLM website can be found at *http://sis.nlm.nih.gov/outreach/womenshealthoverview.html*.

Behavioral Health Insights
Peter Stuart, IHS Psychiatry Consultant
School Refusal
Elise Fatimi, MD

This month's column is provided by Elise Fatimi, MD, a child and adolescent psychiatrist with long experience in IHS in the southwest. She currently presides over the Greater Phoenix Chapter of the Academy of Child and Adolescent Psychiatry. She mixes clinical acumen and patient advocacy exceedingly well.

It is estimated that up to 4% of children refuse school because of anxiety. Ten- to 14-year-olds are especially prone to school refusal. These children may go on to be less likely to ever marry or have children, and are at increased risk for future anxiety disorders and depression. Because anxiety is strongly hereditary, a parent may be too fearful to set firm limits in the face of their child's panic. With each day's unexcused absence it grows harder to reestablish regular school attendance.

Sometimes the goal of returning to full attendance is abandoned, and a child may be home-schooled, or provided home-based instruction by the school. This may maintain academic achievement, but social confidence and age-appropriate friendships often suffer. It takes a strong

commitment of time and social networking for a parent to engage with other home-schooling families. For working parents, or those with anxiety problems of their own, this is a tall order.

A child who refuses school may have a real illness or a good reason to worry (e.g., a depressed parent, a bully in the playground). But when these have been ruled out with reasonable confidence, explore for anxiety symptoms. Have other separations been difficult? Is the child a 'worrier'? Have there been past attempts at school refusal after holiday breaks or illnesses? Is there a family history of anxiety?

There are many "flavors" of anxiety. Children who refuse school may have separation anxiety disorder. A child may also have generalized anxiety disorder, with worries about illness, worst-case scenarios, or far-off events, and physical symptoms such as headaches and stomach aches. In social anxiety disorder, children are fearful of embarrassment, scrutiny, or interacting with unfamiliar people.

I consider school refusal to be a genuine psychiatric emergency, much like heavy bleeding. A child's confidence in his ability to "make it" is, in a sense, hemorrhaging. Time is of the essence. Here are some elements of an effective treatment plan:

1. *Educate the whole family*. Explain clearly that the goal is a return to full attendance, but that you will work hard to make this tolerable. Avoid bargaining ("let's wait until after spring break, it's only another week") or granting of retroactive medical excuses. Get permission to contact school staff. Refer for therapy as needed to develop and follow a plan for reintroduction to school; children with more severe problems may start with a class period and increase steadily to a full day.
2. *Work with school staff*. Most principals will allow a child to use a 'time-out' in the nurse's office is he/she is too upset to stay in class. Ask the nurse not to send the child home before the agreed time unless there is objective evidence of illness. Devise a specific strategy for morning drop off at school. Parents should keep goodbyes brief. Avoid parent-child phone contact during the school day, as it tends to exacerbate anxiety.
3. *Medication may be indicated* when a child is severely anxious. Short-term use of benzodiazepines (e.g., clonazepam at bedtime before a school day) can help with anticipatory anxiety and insomnia. If the child is sleepy in the morning, reassure parents and teachers that "asleep at school is better than awake at home" at the start of treatment. Ongoing treatment of anxiety disorders is best achieved with SSRI medications (e.g., fluoxetine, sertraline). Self-injurious or aggressive behavior may (rarely) require inpatient management.

Most children can resume full school attendance within days to weeks, and many seem to forget the episode in a little while. In overcoming this challenge, the whole family will build confidence and skills for the future.

Here's a link to the American Academy of Child and Adolescent Psychiatry that has information on this topic as well as a large range of other psychosocial/mental health-related ones: *http://www.aacap.org/cs/root/facts_for_families/children_who_wont_go_to_school_separation_anxiety*.

Breastfeeding
Suzan Murphy, PIMC
What makes a good idea work?

The concept of supporting breastfeeding is agreeable to most of us. The immunological impact and long term health benefits for both mom and baby make breastfeeding a sound and reasonable behavior to encourage. However, when the findings that breastfeeding can also significantly reduce risk of obesity/overweight and type 2 diabetes are added to the rationale, supporting breastfeeding becomes an important tool in tackling a daunting and far reaching public health problem.

So, what will increase initiation and duration? Baby Friendly Hospital Initiative (USA) and Baby Friendly (UNICEF/WHO) have similar steps that promote breastfeeding perinatally. Generally they are:

1. Maintain a written, well-communicated hospital breastfeeding policy.
2. Train clinical staff to effectively implement policy.
3. Inform all pregnant women about benefits and management of breastfeeding.
4. Help mother initiate breastfeeding ½ hour (UNICEF/WHO)/1 hour (USA) after birth.
5. Show mothers how to continue breastfeeding, even if they are separated from their babies.
6. Do not supplement babies unless medically indicated.
7. Practice rooming in – mother and infants remain together 24 hours/day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants
10. Foster the establishment of breastfeeding support groups and refer mothers to them at discharge.

Research indicates that when these steps are implemented, breastfeeding initiation can increase by as much as 400%. Federal agencies surveyed women who planned to breastfeed and experienced five of the ten steps – early breastfeeding initiation (step 4), no supplementation unless medically indicated (step 6), rooming in (step 7), unrestricted breastfeeding encouraged (step) 8, and no pacifiers or artificial nipples used (step 9). Families who did not experience any of the steps were 8 times more likely to stop breastfeeding before 6 weeks. The more steps experienced, the more likely the family was to continue breastfeeding to 6 weeks and beyond.

The strongest risk factors for stopping breastfeeding early were late breastfeeding initiation (missing step 4) and supplementing the baby (missing step 6). For more information, please see DiGirolamo AM, Grummer-Strawn LM, Fein S. Maternity care practices: implications for breastfeeding. *Birth*. 2001;28:94-100.

National goals help support breastfeeding. Watch for upcoming information about Healthy People 2020 goals that enlist the community at large. New points of focus include increasing the number of:

- Women who take family medical leave
- Employers with workplace lactation programs
- Baby Friendly hospitals
- Mothers who see lactation consultants in hospital
- Maternity staff receiving 18 hours of lactation training
- Mothers seen by appropriately trained lactation care providers post discharge
- Third party payers and employers who cover lactation care and services
- Number of hospitals that make donor human milk available

Another goal is reducing the number of breastfed neonates receiving supplemental formula that is not medically indicated.

Supporting breastfeeding is sometimes about a paradigm shift -- big and little changes that may not be easy. It is also about education and choice. For our families it is about improving wellness now and later. Go to *www.babyfriendlyusa.org*.

Frequently asked questions

Does anyone have an EHR template that is IHS approved for obstetrical patients?

I am new to IHS, but does anyone have an EHR template for obstetrical patients that is IHS approved? (From Maureen Sullivan CNM, WHNP, MS, Rosebud)

We have a template that we use just for the initial intake visit. Please contact Mary Morphet-Brown, Yakama Indian Health Center Public Health Nursing, at *Mary.Morphet-Brown@ihs.gov*.

Information Technology

Clinician's Information Management Technology Advisory Council (CIMTAC) is seeking input from the field

What do you see as the most important issues or needs at this time? What do you see as our future needs? CIMTAC has been in existence for a number of years. We have been the clinicians (doctors and nurses) PSG - Professional Specialty Group. Requests for RPMS packages and enhancements filter through us for approval and/or prioritization. We are going to be taking a more active role in strategic planning for RPMS. We would appreciate your input.

Contact Kathy Ray at *Kathy.Ray@ihs.gov* with your suggestions and input.

International Health Update

Claire Wendland, Madison, WI

Routes to TB treatment in rural Nepal

Tuberculosis remains a serious problem in many low and middle-income countries, and as readers of this newsletter well know, it can also be an issue in impoverished parts of wealthy countries. Several factors associated with poverty make TB more likely: overcrowded living conditions, immune suppression (for instance due to HIV or substance abuse), chronic malnutrition. Besides increasing the chances of acquiring TB, poverty affects the likelihood of getting it properly diagnosed and treated.

A new qualitative study from Nepal explores just how people who develop symptoms of TB find their way to diagnosis and therapy. A team of Dutch and Nepalese researchers interviewed a convenience sample of twenty-six patients undergoing TB treatment at various public health centers – some remote, some more central – in lowland Nepal. They found that all of these patients had consulted more than one provider before beginning therapy. When patients decided where to seek help, their decisions were based on a combination of economic factors, their perceptions of whether the symptoms were serious or not, and the reputations and perceived quality of the providers. The opinions of family members or friends influenced their choices as well. Most patients reported that they began their journeys at a private practitioner's facility. Lines were long at the free public clinics, these clinics were often far away, and they were known to run short on medications. Patients knew they could get quicker care at nearby private clinics. Many of these places were "medical shops," places where one can buy drugs with no medical consultation or physical exam. Others were staffed by providers (sometimes medically trained, sometimes not) who offered consultation for a fee.

Unfortunately, only one of these private providers referred a patient to someone more qualified, a problem the authors suggest may relate to financial incentives to keep patients. Most patients self-referred elsewhere only when treatment failed or they lost trust in the competence of their providers. The delay introduced by this chain of referrals lasted an average of seven months before a TB diagnosis was made. (The one positive finding was that once anyone entertained the possibility of TB, appropriate referral for diagnosis and initiation of treatment was quite prompt.)

This article has significant limitations. Chief among these: the sampling strategy means we cannot know what is happening to those who do *not* find their way to the national treatment program. Nonetheless, these researchers uncovered several practical and counter-intuitive findings for health system planners. First, reputation of the public clinics deterred many people from seeking care there, at least initially, even

though the care was free. Second, educational strategies intended to improve TB case-finding will probably need to involve private practitioners. Third, not one person interviewed mentioned anything that could be considered a "cultural barrier" to care, though these are often assumed to be significant in public health programs targeting the underserved.

Ten Asbroek AH, Bijlsma MW, Malla P, Shrestha B, Delnoij DM. The road to tuberculosis treatment in Nepal: a qualitative assessment of 26 journeys. *BMC Health Serv Res*. 2008 Jan 11;8:7.

MCH Headlines

Judy Thierry HQE

Maternal, Infant and Child Health Capacity Needs Assessment

In an effort to better understand the maternal, infant and child health (MICH) services available to urban American Indians and Alaska Natives (AI/AN); the Urban Indian Health Institute (*www.uihi.org*) conducted a Maternal, Infant and Child Health Capacity Needs Assessment with 34 urban Indian health organizations (UIHO) funded through Title V of the Health Care Improvement Act. The purpose of the assessment was to assist in identifying specific assets, limitations, or gaps in the urban Indian health program as a whole.

The findings of this capacity needs assessment highlight current areas of strength and need in providing MICH care to urban AI/AN. Findings document a need for additional pregnancy and infant health services at many sites. Increased resources to support MCH services offered by UIHOs may effectively reduce observed MCH disparities among urban AI/AN in the risk of adverse birth outcomes and infant mortality.

Go to *http://www.uihi.org/publications/reports/*. Please contact the Project Coordinator, Shira Rutman, with any questions or comments, at *shirar@uihi.org* or (415) 374-7868.

Medical Mystery Tour

You know how to treat yeast infections, right?

Which of the following statements are true about vulvar pruritus?

1. It is important to ask patients presenting with vulvar pruritus if symptoms vary with their cycles.
2. *Candida glabrata* tends to respond to intravaginal boric acid therapy
3. Nystatin successfully treats the majority of patients with tinea cruris.
4. Topical steroid ointments at the correct treatment for lichen sclerosus
5. Classic psoriasis occurs often on the vulva

Please think about the above scenarios. The answers, with discussion and references, will be available in next month's CCC Corner Medical Mystery Tour.

Midwives Corner

Lisa Allee, CNM, Red Mesa, Arizona

Midwives Excel at Keeping Birth Normal, and Midwife-Provided Acupuncture Helps With PROM

Amy Romano, CNM, with the Lamaze Institute for Normal Birth presents four fabulous studies in a review of research that further support the extensive benefits of normal birth.

The first study convincingly shows that midwifery care is more effective in keeping birth normal and, thus, women healthier. The study focused on care for women at moderate obstetrical risk. This prospective cohort study made use of an intriguing new tool called the "Optimality Index-US" which assesses care processes as well as outcomes, giving better information than just mortality and morbidity. The study found provider type to be predictive of optimality with midwifery care having higher scores. For example, "The cesarean-section rate was 13% among women in the midwife group versus 34% in the physician group, a difference that also was not explained by health status alone. (The rates were 5.6% and 15.6%, respectively, after excluding women with preexisting chronic medical conditions.) In various statistical analyses, only type of provider accurately predicted cesarean rates in the two groups."

As to why this may have been true, some of the processes of care looked at included the following: "Compared to women in the physician group, women in the midwife group were more likely to drink or eat (95% vs. 80%); maintain mobility in labor (68% vs. 28%); and use nonpharmacologic methods of pain relief (88% vs. 51%). Epidural use was lower in the midwife group than in the physician group (31% vs. 51%), as was use of any pharmacologic pain-relief methods (64% vs. 82%)."

Romano concludes her review with the following: "In this and other studies, midwifery care has been associated with high optimality, demonstrating appropriate use of interventions and good outcomes given the individual women's clinical situations. Midwives are often assumed to care for only low-risk women, but many midwives also care for women at moderate or high risk. This study finds that midwifery may be optimal for a moderate-risk population by promoting good outcomes with less reliance on technological and surgical intervention and greater attention to the care practices that support normal birth." This certainly rings very true for midwifery in the Indian Health Service; we care for women of all risk levels and have impressive outcomes, and I would bet "optimality" scores as well. Anyone ready to do the research with this new tool?

The second study looked at third and forth degree perineal tears and again found the less interventionist path to be the preferred route. They looked at six modifiable factors: forceps, vacuum, episiotomy, prolonged second-stage labor, fetal occiput posterior position during crowning, and epidural, and

found that avoiding these individually and definitely in combination helped prevent third and forth degree tears. In her assessment of this study in regards to normal birth, Romano says, "Third- and fourth-degree anal tears are highly associated with pain and incontinence in the postpartum period and contribute to long-term pelvic floor dysfunction. Unfortunately, this argument has fueled the debate about the rights of women to choose medically unnecessary cesarean surgeries rather than prompting examination of the obstetric management practices that contribute to excess risk of anal sphincter damage in vaginal births. This study provides evidence of a strong link between modifiable obstetric practices such as episiotomy, epidural use, and instrumental vaginal birth, and anal sphincter tears. This study also reinforces that when instrumental vaginal birth becomes necessary, episiotomy should be avoided, and vacuum extraction is less likely to injure the anal sphincter than forceps birth. Although some instances will always occur when these interventions are necessary for fetal or maternal well-being, their overuse contributes to excess maternal morbidity with long-term consequences. Care practices such as avoiding routine interventions, promoting comfort in labor through mobility and nonpharmacologic techniques, and encouraging physiologic, spontaneous pushing in nonsupine positions (none of which were assessed in this study) minimize the risk of severe lacerations both directly in the case of spontaneous nonsupine pushing, and indirectly, by reducing the need for epidural, promoting optimal positioning of the fetus, and reducing forceps and vacuum use." Again these are all aspects of the midwifery model of care.

The third study looked at midwives providing a 20-minute acupuncture treatment to women with PROM. The women in the treatment group had significantly shorter active labor, 4.4 hours vs. 6.1 hours, and the relationship was even stronger when they controlled for parity, epidural use, and infant birth weight. For women who were induced, the active phase in the control group was *twice* as long as in the acupuncture group, and acupuncture was associated with less augmentation of labor as well. This study was small but the results are impressive.

Romano draws some very meaningful conclusions as to the relevance of this to the promotion of normal birth: "Although the majority of women will go into labor on their own after membranes rupture at term, many providers encourage pharmacologic induction out of concern about infection. Minimal evidence suggests that a policy of routine induction for PROM prevents infection, and several studies report an increase in cesarean rates with induction for PROM versus expectant management. Furthermore, pharmacologic induction always requires other interventions such as intravenous lines, electronic fetal monitoring, and restrictions on mobility in labor, transforming a normal birth into a medicalized one and introducing potentially unnecessary risks. Low-risk techniques to encourage labor to start may be beneficial in preventing complications of both prolonged membrane rupture and aggressive induction protocols. This small but well-designed study suggests that acupuncture treatment influences labor initiation and progress in women with PROM. A larger trial may be able to confirm an effect on mode of birth, rates of induction, and likelihood of infection. However, in the meantime, the fact that acupuncture has not been shown to be harmful to birthing women or their newborns suggests that it is an optimal first-line approach when the option of encouraging labor to start is desirable." Some IHS sites are providing acupuncture services (finally!) for patients. I think it behooves midwives to work with acupuncture providers in IHS and/or outside IHS to get trained in this technique of promoting labor.

The forth study was published in the ACNM journal and looked at the experience of women in early labor. The study's results and Romano's comments are very encouraging for all of us to examine how we prepare and care for women in early labor. Romano says, "For women who choose hospital birth, mounting evidence suggests that their likelihood of achieving vaginal birth is strongly influenced by how long they stay home. However, simply advising women to stay home until active labor is well established may contribute to anxiety and confusion if they are not equipped with appropriate information, support, and anticipatory guidance. This small study suggests that women spend energy and time in early labor sorting out their expectations, devising new plans, managing mixed emotions, and second-guessing decisions. Providing women with strategies to anticipate and deal with gaps between expectations and experiences may help them adapt better to early labor and have confidence in their management strategies. Reassessing how childbirth educators teach women to self-diagnose labor -- or introducing models that include home visitation or outpatient early-labor assessment and support, as proposed by the study authors -- may help women who choose hospital birth to optimize the timing of hospitalization to achieve normal births." I highly recommend that each midwifery service in IHS read this study, examine how early labor is talked about with patients in classes, groups, or clinic, and how early labor triaging and care is provided for in the labor and birthing areas.

Romano A. Research summaries for normal birth. *J Perinat Educ*. 2007 spring;16(2):47-50.

Navajo News
Jean Howe, Chinle
Sexual Assault Nurse Examiner (SANE) Training Course, June 9 - 13, 2008

This five-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. The training will be held at the Navajo Nation Museum, Window Rock, Arizona.

This course is being co-sponsored 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*).

IHS and tribal sites throughout the Four Corners area are working with the Northern Arizona Center Against Sexual Assault to formulate an integrated approach to sexual assault. This training is a part of that effort. The goal is to have SANE and SART services available throughout the Four Corners area.

Barbara Stillwater
Alaska State Diabetes Program
Link between type 2 DM in adults and type 1 DM or pregnancy-related diabetes in their mothers

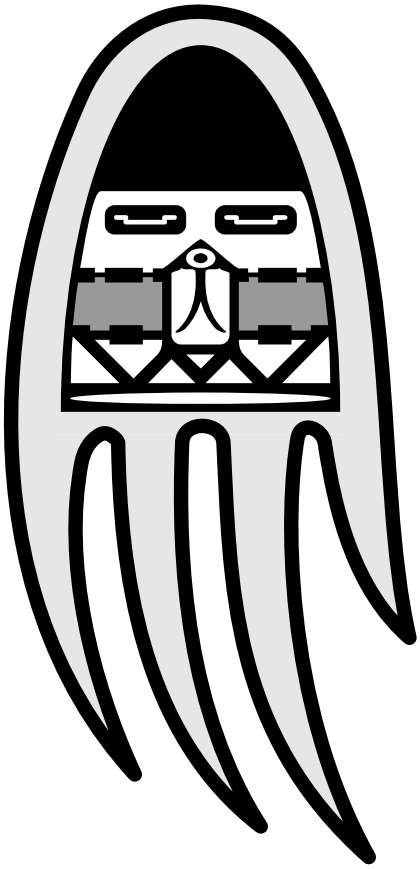
The rate of diabetes or pre-diabetes was 21 percent in subjects born to mothers who had pregnancy-related diabetes (termed gestational diabetes), 12 percent in those whose mothers had a genetic predisposition for diabetes, 11 percent when the mothers had type 1 diabetes, and 4 percent in subjects born to women with no history of gestational or other types of diabetes. The findings support the idea that exposure to high blood sugar levels in the womb contributes to the development of type 2 diabetes in adulthood, the researchers conclude. Aiming for normal blood glucose levels in pregnant women "may reduce the risk of type 2 diabetes in future generations."

Conclusions: A hyperglycemic intrauterine environment appears to be involved in the pathogenesis of type 2 diabetes/pre-diabetes in adult offspring of primarily Caucasian women with either diet-treated GDM or type 1 diabetes during pregnancy.

Clausen TD et al. High prevalence of type 2 diabetes and pre-diabetes in adult offspring of women with gestational diabetes mellitus or type 1 diabetes: the role of intrauterine hyperglycemia. *Diabetes Care*. 2008 Feb;31(2):340-6.

Women's Health Headlines
Carolyn Aoyama, HQE
Sacred Circle Handouts, Slides, and Training Materials available

The slides really condense and explain the effect of colonial power on indigenous culture and families. The slides came from Sacred Circle and they were used in a presentation by Sarah Deer at the Tribal Law and Policy Institute. Contact Carolyn Aoyama for copies at *Carolyn.Aoyama@ihs.gov*.

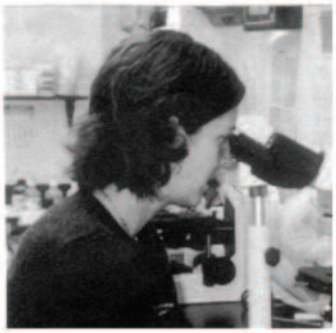


Join us in Tucson, Arizona on May 31, 2008 for a FREE STD UPDATE: EMPHASIS ON SYPHILIS

Co-sponsored by
California STD/HIV Prevention Training Center
and the Arizona AIDS Education & Training Center

TO REGISTER or for more information on other courses, visit our website: **www.stdhivtraining.org**

Contact us directly at:
CA STD/HIV PTC
300 Frank Ogawa Plz, Ste. 520
Oakland, CA 94612
Phone (510) 625-6043; or 625-6000
Fax (510) 836-0239
Maxine.Haytin@cdph.ca.gov



LEARN ABOUT:

♦ Diagnosis & management of syphilis ♦ Syphilis in special populations ♦ STD/HIV prevention ♦ Local & national STD epidemiology & public health perspectives ♦ Chlamydia & gonorrhea ♦ Case studies

ACHIEVE THESE OBJECTIVES:

- ✓ Describe current **epidemiology** of common reportable STDs (**chlamydia, gonorrhea, & syphilis**) in Arizona and the United States.
- ✓ Discuss recent **changes in treatment** of **gonorrhea & chlamydia,** as recommended in the updated **CDC 2006 STD Treatment Guidelines**.
- ✓ Describe **diagnostic & management strategies for syphilis.**
- ✓ Outline **decision algorithm** for evaluating a patient with a **positive serologic test** for **syphilis.**
- ✓ Respond with **appropriate management** decisions to **syphilis case reviews.**
- ✓ Discuss **suppressive & episodic treatment options** for patients with **HSV**.
- ✓ Determine the correct use for high-risk DNA HPV tests.
- ✓ State 3 **evidence-based prevention strategies** to address **STD & HIV transmission.**

Who Should Take This Course?
* Physicians
* Nurses
* Physician Assistants
* Clinicians in public & private settings, including those in STD control & prevention programs.

STD UPDATE: EMPHASIS ON SYPHILIS covers epidemiology, diagnosis, treatment, and management of STDs for the practicing clinician. This day-long course is presented in an interactive format and incorporates case discussions. Course fee: FREE. CMEs 6.5/ FREE | Nursing Contact Hours: 7.8 /FREE

Course Faculty: Sharon Adler, MD, MPH; Heidi Bauer, MD, MS, MPH; Linda Creegan, MS, FNP; Melanie Taylor, MD, MPH

For local information contact Floyd Meeks at fmeeks@email.arizona.edu or 520-626-8043

Visit the CA PTC website at www.stdhivtraining.org

This activity has been planned and implemented in accordance with the Institute for Medical Quality and the California Medical Association's CME Accreditation Standards (IMQ/CMA) through the Joint Sponsorship of the Center for Health Training (CHT) and the California STD/HIV Prevention Training Center. CHT is accredited by IMQ/CMA for issuing *AMA PRA Category 1 Credit(s)*™ for physicians. CHT designates STD Update with an Emphasis on Syphilis for a maximum of 6.5 *AMA PRA Category 1 Credit(s)* ™ Physicians should claim credit commensurate with the extent of their participation in these activities. The California STD/HIV Prevention Training Center is approved by the California Board of Registered Nursing, Provider

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.*

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/ Medical Programs/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.

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

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

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

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

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

Electronic Subscription Available

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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

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.

Pediatrician
Fort Defiance Indian Hospital; Fort Defiance, Arizona

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

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

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

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

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

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

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

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

The Crow Tribe is a close, proud people. They maintain their own buffalo herd and proudly display their cultural heritage during events such as the well-known Crow Fair. Other points of cultural interest in the "Tipi Capital of the

World" are The Little Big Horn Battlefield National Monument, Chief Plenty Coup State Park, and the Little Big Horn College.

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

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

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

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

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

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

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

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

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

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

Psychiatrist
SouthEast Alaska Regional Health Consortium;
Sitka, Alaska

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

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

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

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

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

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

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

Pediatrician
Nooksack Community Clinic; Everson, Washington

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

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

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

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

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

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

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

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

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

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

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

Internist
Northern Navajo Medical Center; Shiprock, New Mexico

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

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

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

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

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

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

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

Physician Assistant

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Family Practice Physician
Ilanka Community Health Center; Cordova, Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WIHCC offers an awesome mix of professional, cultural, and recreational opportunities. It is located just seven miles from the breathtaking beauty of Navajoland and its people, and 50 miles from Flagstaff – a university town with extensive downhill and cross-country skiing, where several of our employees choose to live. Attractive salary and benefits, as well as a team oriented, supportive work environment are key to our mission to recruit and retain high quality professional staff.

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

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

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

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

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

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

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has an opening for a full-time primary care physician starting in January 2008. This is a family medicine model hospital and clinic providing the full range of primary care -- including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults)

and obstetrics -- with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 14 physicians, one PA, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

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

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

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

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

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

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

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

The facility is a multispecialty clinic providing services in obstetric/gynecology, internal medicine, and family practice. It also includes dental, optometry, pharmacy, behavioral health, community health aides, and other services. Our referral region includes 43 villages in interior Alaska covering an area the size of Texas. Fairbanks has an outstanding school system and university. We offer a very competitive salary with a great benefits package and a loan repayment plan. Commissioned Corps positions are also available. Contact Jim Kohler at (907) 459-3806 or *james.kohler@tananachiefs.org*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

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

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

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

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

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

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

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

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

Family Practice Physician
Hopi Health Care Center; Polacca, Arizona

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

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

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

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

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

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go to the website at *http://www.ihs.gov/FacilitiesServices/Area Offices/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 *audrev.jones@.gov*; telephone (406) 247-7126.

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

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

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

Nelson, MS, CCC-A at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*.

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

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

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

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

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

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

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

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

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

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

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

The Tuba City Regional Health Care Corporation, a 73-bed hospital with outpatient clinics serving 70,000 residents of northern Arizona, is recruiting for full-time generalist medical

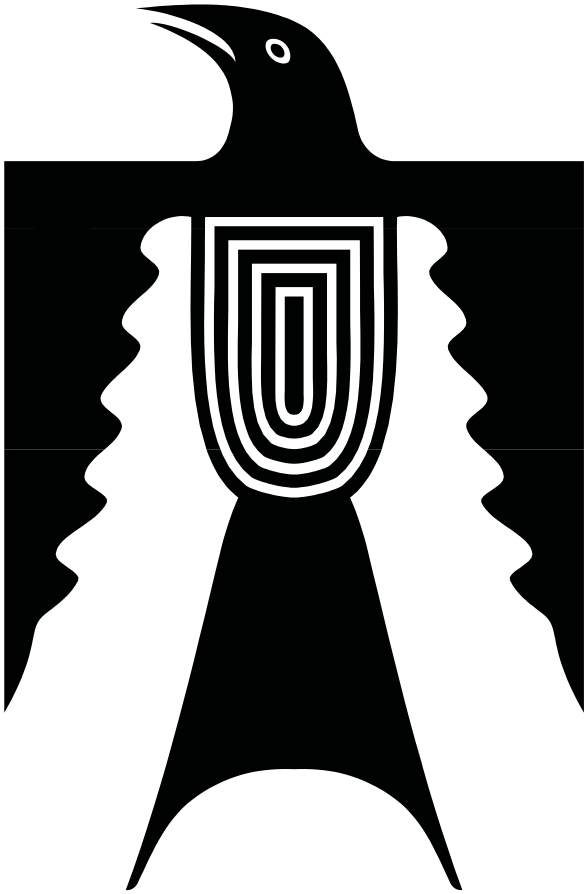
technologists. The laboratory has state-of-the-art equipment. We offer competitive salary, based on experience. Relocation benefits are available. New graduates are encouraged to apply for this position. Tuba City is located on the western part of the Navajo reservation approximately 75 miles north of Flagstaff, Arizona, with opportunities for outdoor recreation and cultural experiences with interesting and adventurous people.

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

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

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

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



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

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