THE IHS PRIMARY CARE PROVIDER

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Cancer Education: A Catalyst for Dialogue and Action

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"Nobody talks about cancer. People are afraid. It is time to talk. I'm not going to stop talking,"

Words of wisdom shared by a cancer education course participant

A comprehensive curriculum, "*Cancer Education for Community Health Aides in Alaska,"* was inspired by the desires of Alaska's unique primary care providers, Community Health Aides and Community Health Practitioners, to learn more about cancer in order to provide better care for the people in their communities. Community Health Aides and Community Health Practitioners (CHA/Ps) are the village-based primary providers of basic, emergency, and preventive health care in Alaska's 178 small, rural villages. CHA/Ps receive only two hours of cancer education during their 15 week basic training curriculum.

Cancer is now the leading cause of death among Alaska Native people, although it was considered a rare disease as recently as the 1950s. Cancer rates for Alaska Native people are among the highest of any ethnic group in the US, and rates are increasing. Cancer death rates for Alaska Native people (1998 - 2002) are 30% higher than the US White population, and cancer survival rates are 17% lower than for US White people. Data from the Alaska Native Tumor Registry, in existence since 1969, confirm an increase in all cancers. The curriculum was developed with funds from the National Cancer Institute and other cancer organizations.

This project invited CHA/Ps to share their ideas as part of a self-assessment cancer education survey in 2002 and again in 2005. The two-page, paper and pencil needs assessment was developed in collaboration with CHAP Directors and Instructors, and the CHA/Ps themselves. A total of 402 responses were received from 477 CHA/Ps, for an 84% return rate. The results from this survey were published as "Cancer Education for Community Health Aides/Practitioners (CHA/Ps) in Alaska" in the *Journal of Cancer Education* (2005) 20 (2) 85-88. The survey addressed how comfortable CHA/Ps were with their knowledge of cancer-related words and talking with their patients about various aspects of cancer. For many CHA/Ps, their experience was that everyone diagnosed with cancer dies from their disease. Fear, embarrassment, stigma, pain, grief, lack of knowledge, and poor understanding of medical terms affected CHA/Ps' comfort with talking about cancer. As shown in Table 1, there was considerable variability in comfort with discussing cancer topics on the 2002 survey. Less than half of survey respondents indicated they were comfortable with four of the eight topics.

In this Issue…

Table 1. How comfortable are you talking with patients, family, and others about:

Topics	2002 Survey	2005 Survey
Cancer Risk factors	68.3 %	77 %
Cancer Screening	69.6	74.6
Cancer Diagnosis	38.7	44.2
Cancer Treatment/Side Effects	48.4	55.4
Cancer Pain	35.5	49.8
Loss and Grief	34.8	44.7
Surviving Cancer	57.5	69.7
Providing Care and Support for People with Cancer	61.6	70.9

A second survey was conducted in 2005 with a 65% (293/454) response rate. The survey included the same questions as the 2002 survey plus additional items to understand CHA/P learning preferences. CHA/Ps shared the importance of stories, laughter, and the arts as helpful ways to facilitate their learning. Three manuscripts communicate the richness of CHA/Ps' words, adding new dimensions of understanding: "Healing Hearts: Laughter and Learning" *Journal of Cancer Education* (2006)21(2):104-107; "Engaging Adult Learners through the Arts: InterACTIVE Cancer Education" *International Forum of Teaching and Studies* (2007)3(2):17-22; and "Story: The Heartbeat of Learning" *Convergence* (2007)39(4):81-88.

Providing a basic cancer education course

Materials developed for the course included a resource manual "Path to Understanding Cancer," videos/DVDs, CD-ROMS, booklets, and a theatre script. The manual consists of multiple independent modules: 1) Cancer Basics and Cancer Among Alaska Native People; 2) Cancer Diagnosis; 3) Cancer Treatment; 4) Pain Assessment and Management; 5) Cancer Risk Factors; 5a) Cancer and Genetics; 6) Cancer Screening Exams and Early Detection; 7) Loss, Grief, and End-of-Life Comfort Care; and 8) Self Care, Stress, and Burnout issues related to cancer care. Additional sections include a glossary of cancer terms and helpful resources. A variety of interactive, culturally respectful learning activities including games and crafts were developed to facilitate learning.

During the five-year project, the week-long, face-to-face course, also called "Path to Understanding Cancer," was provided 21 times for 168 CHA/Ps from 94 different Alaska communities. Written evaluations were completed by 93% (157/168) of participants, with 100% recommending the course for all community health care providers as well as other interested people. In addition to an increase in cancer knowledge and understanding, participants identified positive ways the course would impact their behavior: 89% (139/157) wrote about healthy ways they intended to take better care of themselves; 90% (142/157) wrote about ways they now felt different about cancer; and 97% (153/157) wrote about how this course would help them improve care of their patients. Select questions from the written end-of-course evaluation and comments are shared below.

Has this course caused you to change your behavior? N=157

Yes	No	Maybe	Blank
89% (139)	8% (13)	1% (2)	2 % (3)

- Eat more fruits/vegetables and drink more water. Practice more moments of peacefulness.
- Eat healthier for myself and my kids.
- Do family exercising together.
- It has really made me think about quitting smoking; my sister who is pregnant wants to quit; I think I may ask her to try quitting together.
- I actually cut way back on smoking! And for me that is a big improvement.
- I scheduled a colonoscopy. I've been putting it off.

Do you feel differently about cancer after taking this course? N=157

Yes	No	Blank
90% (142)	8% (13)	2 % (2)

- Demystify cancer and Treatment.
- It's not contagious; it's not a death sentence.
- As a cancer survivor, I did not know how much resources and support were out there.
- I'm more comfortable saying the word cancer.
- I thought that having cancer was a death sentence right from the start; now I know better.
- It's still scary, but not the end of the world.
- Hearing how other CHA/Ps get more comfortable with their cancer patients and how I can get comfortable myself with our cancer patients.
- I have a much more positive outlook on cancer therapy and clinical trial information.

How will this affect the way you do your job? N=157

97%(153) wrote a response	3% (4) left this question blank

- Able to look at them as patients instead of people [who have] cancer.
- Let me learn how to talk to cancer patients and how we as care providers can help the patients more.
- I understand what it is, won't feel uncomfortable around people who have cancer.
- Can talk about it now. I feel less afraid of cancer,

knowing the different types.

- When I read lab reports I know what they are talking about.
- I have more information to pass on to patients and helps me to deal with my stresses.
- I'll now encourage patients to have their screenings done and explain why they are so important.
- More encouragement to patients who don't want to keep their appointments.
- More confidence about the talks that I have with my patients. Do more patient education.
- Be able to find more resources for patients, get patients in for screenings.

Approximately six months after the course, telephone outreach efforts were initiated for a total of 144 participants who had attended cancer education courses (November 2001 - July 2004). This evaluation component provided an opportunity for project team members to understand the impact of the course over time, after participants had returned to their communities and jobs. Of these 144 course participants, 103 (71.5%) completed a telephone interview. The following summarizes responses to select questions asked during the telephone interviews.

How would you rate your comfort with your knowledge of cancer since taking the course? N=103

Uncomfortable	Ok	Comfortable	Very Comfortable	Not Specified
0	7.2 % (8)	61.2 % (63)	25.2 % (26)	5.8 % (6)

Since taking the course do you do anything differently in the way you take care of patients? N=103

Yes	No	N/A : Not Seeing Patients	Not Specified	Not Asked
68 (70)	14.6 (15)	9.7% (10)	6.8 % (7)	1 % (1)

Seventy respondents indicated they had made one or more changes in patient care practices. The most frequently cited changes included one or both of the following:

- increased patient education (47%)
- increased cancer screening for all aspects of patient encounters (history, exam, consultation, and referral for cancer screening) (37.1%)

Four of the 15 respondents who said "No" to having made post-course changes in patient care practices and who were providing patient care services at the time of interview indicated that prior to the course they had been and continued to provide cancer prevention, cancer risk reduction, and other cancer patient education and/or cancer screening services within the scope of their practice.

Since taking the course, do you do anything differently in the way you take care of yourself? N=103

Yes	No	Not Specified	Not Asked
67 % (69)	29.1 % (30)	3.9 % (4)	0

For the 69 respondents who indicated they had made changes in post-course self-health practices, the most frequently reported changes included one or more of the following:

- dietary changes; e.g., eating increased amounts of fruits and vegetables, cooking with less saturated fat, and dietary changes resulting in weight loss (30.4%)
- regular exercise, such as walking daily (14.5%)
- increased cancer screening, including self-exams as well as clinical screening exams and procedures, such as mammogram and colorectal screening (26.1%)

Notably, 12 (17.4%) respondents had successfully quit using tobacco after participating in the course. Four other respondents had cut down on smoking; three others reported they wanted to quit; and two respondents who had quit after the course reported at time of interview that they were using tobacco, but were now planning to quit again.

Of the 30 respondents who responded "No" to post-course changes in self-care practices, seven stated that prior to the course they already engaged in healthy lifestyle practices, including one or more of the following: healthy nutrition, exercise, no tobacco use, and regular cancer screening, and were maintaining those practices.

Since taking the course, do you do anything differently in the way you take care of family? N=103

Yes	No	N/A : No other family members	Not Specified	Not Asked
65.1 % (67)	28.2 % (29)	1 % (1)	1 % (5)	1 % (1)

Of 67 respondents who reported post-course changes in family health care practices, the most frequently cited changes included one or more of these categories:

- cancer education for family members (49.1%)
- healthy dietary changes (47.8%)
- regular exercise (6 %)
- family member had cancer screening (15%)
- family member stopped using tobacco (12%)

Movies to support cancer understanding

In collaboration with CHA/Ps and the people in their

communities, four 30-minute cancer education movies were developed to share cancer knowledge and understanding and decrease cancer related fear. The movies are available through Native CIRCLE, a cancer resource center for American Indian and Alaska Native peoples (*nativecircle@mayo.edu* or (877) 372-1617). Additionally, the movies can be viewed via video streaming at the Arctic Health website *http://www.artichealth.org/anthcvideos.php*.

"*The Story Basket: Weaving Breast Health into Our Lives"* describes three important choices women can make to find breast cancer early, when it can be best treated. We see a clinical breast exam, a mammogram, and a self-breast exam demonstrating the vertical breast exam pattern. A breast health booklet extends learning.

- It had a natural feel that included all generations. The movie embraces Alaska Native people's cultural values of community, family, spirituality, storytelling, humor, and living traditions.
- Made mammograms less scary.
- Wow, by seeing a real person doing a breast exam it made it a lot easier to do my own exam. I can't wait to share this with my sister.

"Understanding: Stepping into the Light" is a call to action. It is an invitation to come together to engage in meaningful conversations to illuminate possibilities and choice. Cancer among Alaska Native peoples is often not talked about. The play, which was adapted for television to reach rural, Alaska Native communities, enters the silence, making audible the experience of cancer. An all-Alaska Native cast explores many challenging and sensitive cancer-related themes, including emotions associated with a diagnosis, treatment, pain, and the end of life. Healthy lifestyle choices and recommended cancer screening exams are voiced. We hear Alaska Native people's stories of hope and resilience.

- Great for all ages.
- Offers one thing we do not think about with a cancer diagnosis: hope.
- Speaks to all of us. Touches universal themes that are not culture specific.
- The personal stories connect you.
- The movie gives courage and support to people with cancer and their families. It also expands that it is OK to be afraid.
- The terrible part of not talking about it because of fear, shame; take every opportunity to talk about cancer in a normal way.

"*Awakening Choices: Colon Health, Our Stories"* shares the stories of Alaska Native people talking about colorectal cancer and healthy lifestyle choices. Early detection through colorectal screening is highlighted. Stories of wellness and the gift of life are brought out through the beauty of Alaska Native people's songs, dances, and culture. An activity guide and colon health booklet accompany the movie to assist with community cancer education.

- Inspired, motivated, comfortable, relieved, encouraged, hopeful.
- I felt a part of the people in the movie — same fears, same relief.
- I want to go and get colon screening now.

"Staying Strong, Staying Healthy: Alaska Native Men Speak Out About Cancer" was developed in response to the many requests for a movie specifically for Alaska Native men. Alaska Native men whose lives have been affected by prostate, colorectal, and testicular cancer tell their inspiring stories. Men speak out about ways to prevent cancer, ways to decrease cancer risk, and ways to find and treat cancer early. Part two of the movie shows a clinical testicular exam and a young man doing a self-testicular exam.

- This should be seen by all men.
- It felt good to see our Native men speak out and act. It helps all of us to understand.
- I felt encouraged and braver to get checked.

Sharing Stories through Theatre

"*Understanding,"* a 45-minute theatre script, weaves people's stories, experiences, common questions, and concerns related to cancer into the lives of five characters. Between March 2002 and November 2005, "*Understanding"* was performed and evaluated 25 times as a staged performance or a Readers' Theatre. The script was read as part of cancer education courses both face-to-face and over the telephone as well as at community gatherings, school presentations, and a radio show. Approximately 82% (606/738) of people, including both audience and readers, completed a written evaluation. Of those people who completed an evaluation, 95% of people felt more comfortable talking about cancer, 72% of people shared a variety of information about what they learned, and 71% of American Indian and Alaska Native people wrote healthy ways they intended to take better care of their health after seeing the play. Most commonly cited healthy choices included eating more fruits and vegetables, exercising more, quitting tobacco use, and having recommended screening exams. "Using Theatre to Promote Cancer Education in Alaska" was published in the *Journal of Cancer Education* (2005)20(1):45-48.

- Now I have more of an understanding of what the patient endures. Now I can better communicate with patients and their families.
- I learned that we are not alone and we have support when we need it. I have changed how I feel about cancer now.

- My sister died of denial of cancer. I wish she could have seen this 10 years ago.
- I learned I'm afraid! I still have to live. I don't want to get my mass diagnosed. Thanks for letting me know everyone is afraid. I still haven't faced it. After seeing this play, I want to keep going to the doctor. Quit putting it off.
- I can see how this play can break down barriers to discussion around cancer. My favorite part was the individual stories. Interweaving common experiences through single word/short phrase segments.
- I learned the power of the spoken word.

This project worked with Community Health Aides and Community Health Practitioners in Alaska to design, develop, and provide culturally respectful cancer education courses and materials. Alaska Native Peoples' core values of story, humor, and respect for life's interconnections through spirituality, family, community, and elder wisdom provided the foundation for cancer education.

Thank you to the many people who shared their knowledge, understanding, and experiences as we journeyed together to make a difference in the story of cancer among Alaska Native people. For further information contact Melany Cueva by telephone at (907) 729-2441; e-mail *mcueva@anmc.org*; or write to ANTHC-CHAP, 4000 Ambassador Drive, Anchorage, Alaska 99508.

The 13th Annual Elders Issue

The May 2008 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the thirteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

Frequently Asked Questions about Infant Feeding Choice

Stephanie Klepacki, CRS Project Manager/Lead Analyst, Albuquerque, New Mexico

Background Information

Why collect these data? Because they are used in the clinical performance measure called Breastfeeding Rates that is reported in the RPMS Clinical Reporting System (CRS). While this measure is currently not a GPRA measure (one reported to Congress and OMB) it is used in support of the GPRA measure Childhood Weight Control with the goal of lowering the incidence of childhood obesity in the IHS patient population. Additionally, facilities can use these data to track infant feeding patterns and breastfeeding rates within their own patient population.

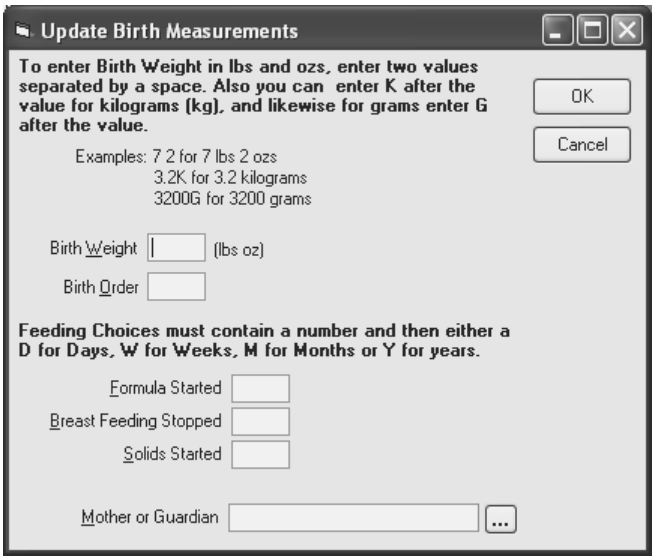
Research indicates that children who were breastfed have lower incidences of overweight or obesity. For additional information, please see the review the article in the March 2007 issue of *The IHS Primary Care Provider at http://www.ihs.gov/PublicInfo/Publications/HealthProvider/issues/PROV0307.pdf.*

How are these data used? They are used in the CRS Breastfeeding Rates topic in several measures that report:

1. How many patients approximately two months through one year of age were ever screened for infant feeding choice.
2. How many patients were screened at the approximate ages of 2 months, 6 months, 9 months, and 1 year.
3. How many patients who were screened were either exclusively or mostly breastfed at those age ranges.

Users may run the CRS Selected Measures (Local) Reports to view all of the breastfeeding performance measures. The report also provides the option to include a list of patients and identifies the dates and ages they were screened and their infant feeding choice values. Click the following link to learn how to run this report in CRS, starting on page 206 (as numbered in the document itself, not in Adobe): *http://www.ihs.gov/misc/links_gateway/download.cfm?doc_id=10716&app_dir_id=4&doc_file=bgp_070u.pdf.*

Are Infant Feeding Choice data the same as the data included in the Birth Measurements section of the EHR and with the PIF (Infant Feeding Patient Data) mnemonic in PCC? No, they are different. The information collected in these sections are intended for one-time collection of birth weight, birth order, age when formula was started, age when breastfeeding was stopped, and age when solid foods were started, all linking to the mother/guardian. Shown below is a screen shot of this section from EHR. While this information is important, *none of it is used in the logic for the CRS Breastfeeding Rates measure; only the Infant Feeding Choice data are used.*



What are the definitions for the Infant Feeding Choices? The definitions are shown below and are the same definitions used in both EHR and PCC.

- *Exclusive Breastfeeding*: Formula supplementing less than three times per week (<3x per week)
- *Mostly Breastfeeding*: Formula supplementing three or more times per week (≥3x per week) but otherwise mostly breastfeeding
- *½ Breastfeeding, ½ Formula Feeding*: Half the time breastfeeding, half the time formula feeding
- *Mostly Formula*: The baby is mostly formula fed, but breastfeeds at least once a week
- *Formula Only*: Baby receives only formula

Who should be collecting this information and how often? It depends on how your facility is set up, but any provider can collect this information. At a minimum, all providers in Well Child and Pediatric clinics should be collecting this

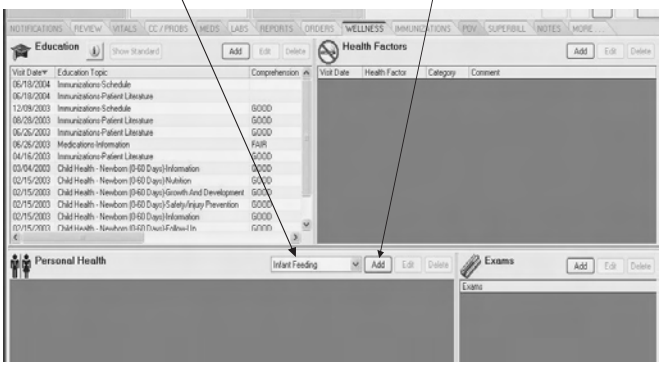
information for patients 45 - 394 days old at all visits occurring during that age range. Public Health Nurses should also be collecting this information. These data can be entered in EHR or PCC/PCC+, as described below.

Entering Infant Feeding Choice Data In EHR

In which version of EHR is Infant Feeding Choice data able to be entered? EHR Version 1.1, which was deployed nationally on October 3, 2007.

How do I enter Infant Feeding Choice in EHR?

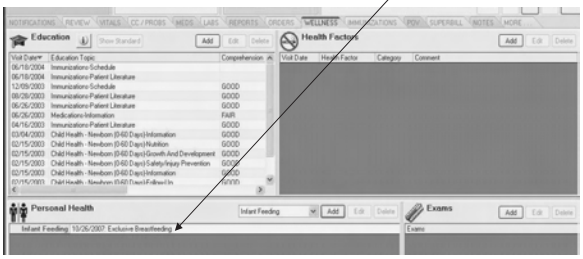
1. After you have selected the patient and the visit, go to the Personal Health section. For some EHR sites, this may be included on the Wellness tab.
2. From the Personal Health dropdown list, select Infant Feeding, then click the Add button.



Note: The age of the patient must be five years or less to be able to select Infant Feeding; otherwise, Infant Feeding will not be listed in the dropdown list.

3. At the Add Infant Feeding Record window, click the appropriate checkbox to select the type of infant feeding, and then click the OK button to save the value.

4. The patient's value for Infant Feeding Choice for this visit is now displayed in the Personal Health section, as shown below.

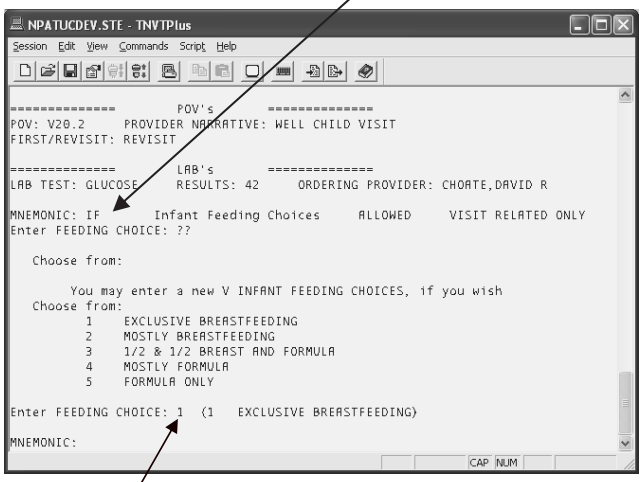


Entering Infant Feeding Choice Data In PCC/PCC+

Which data entry patch do I need? You will need to have data entry patch 8 (apcd0200.08k) installed, which was released on October 19, 2005.

How do I enter Infant Feeding Choice in PCC?

1. Create a new visit or select an existing visit to append.
2. At the Mnemonic prompt, type "IF" (Infant Feeding Choices) and press Enter.



3. Type the number corresponding to the type of feeding and press Enter. If you do not know the number, type "??" and press Enter to see a list of choices.
4. You are returned to the Mnemonic prompt. Continue with data entry of other items.

Save the Dates!

2008 Nurse Leadership in Native Care Conference
May 12-15, 2008

New Directions in the New Frontier: Education, Evidence and Empowerment

Anchorage, Alaska

Jointly sponsored by the Alaska Native Medical Center and the IHS National Nurse Leadership Council.

Hotel Captain Cook
939 West 5th Avenue, Anchorage, AK 99501
(907) 276-6000 www.captaincook.com

AUDIENCE
Designed for nurse administrators, directors of public health nursing, nurses, public health nurses, and advanced practice nurses working for Indian health programs. This CE seminar provides an opportunity to network with peers/colleagues on nursing issues of common concern, update knowledge of current nursing trends/issues and enhance nursing practice to improve patient care, as well as receive accredited continuing nursing education.

CURRICULUM
The agenda will include plenary and concurrent workshop sessions and poster presentations on a variety of clinical and public heath nursing topics focused on leadership, education, evidence-based practice and best practices. On-line access to the agenda and registration materials will be available in late March. Visit the NNLC Conference Website.

ACCREDITED SPONSOR
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 Center's Commission on Accreditation. Provider Number AP-06-002.

LODGING
A block of rooms has been reserved at the Hotel Captain Cook in Anchorage. Please make your room reservation online at www.captaincook.com, by calling the toll-free reservations number, 1-800-843-1950 or call the Hotel Captain Cook directly at (907) 276-6000. Mention "Alaska Native Medical Center" to secure the special single group rate of $105 + tax single or double occupancy per night. The deadline for making room reservations is April 11, 2008. Book early – regularly priced hotel rooms in Anchorage average nearly $200/night + tax in the summer! Note: for those wishing to see some of Alaska, this rate is good for three days before and three days after the conference, on a space available basis.

CONTACT INFORMATION
For more information about this event, contact Casie Williams, Nurse Educator, Alaska Native Medical Center, cwilliams@anmc.org or 907-729-2936 visit the NNLC Conference Website.

REGISTRATION FEES
Indian Health Service, tribal and urban programs employee: $100
Students: $50 (submit copy of current student ID)
All others: $150

Keeping the Circle Strong: Celebrating Native Women's Health and Well-Being

June 9-11, 2008

Albuquerque, NM

A Nation is not conquered until the hearts of the women are on the ground. Then it is finished, no matter how brave it's warriors or how strong their weapons.

- Proverb of the Cheyenne

The National Indian Women's Health Resource Center invites Native women across the country to a two and half day conference celebrating our health and well being. Topics will address the mental, social, physical, and spiritual health of all Native women.

Conference Hotel

Albuquerque Marriott
2101 Louisiana Blvd. NE
Albuquerque, New Mexico 87110
Phone: 1-800-334-2086
Fax: 505-881-1780
www.marriott.com/abqnm
For conference rates on-line the group code is **NIWNIWA**. For conference rates through the 800.334.2086 number the group code is **NIWHRC**.

Room Rates:
Single $75.00
Double $75.00

Registration Fees

$150.00
(Without NIWHRC Membership)*
$100.00
(With NIWHRC Membership)
Membership *Registration available online*

Please visit www.niwhrc.org for more information.

Pathways Into Health

Clinical Laboratory Science Program

What is Pathways Into Health?

Pathways Into Health is a unique and innovative health sciences professional education program focused on the education needs of American Indian and Alaska Native students and the health care needs of American Indians and Alaska Native communities. **Pathways Into Health** is a growing collaboration between Tribes, Tribal organizations, Tribal colleges, the Indian Health Service, Universities and other organizations.

Contacting Ciciley Littlewolf is the best way to answer your questions and review what is required for the program. Contact: Ciciley.Littlewolf@usd.edu or call 701-591-0109

Visit our website @ www.pathwaysintohealth.org

What is the CLS Program?

Clinical Laboratory Scientists (CLS), sometimes referred to as Medical Technologists, are key members of the health care team. They are responsible for the clinical laboratory testing which provides the physician with the necessary information to make an accurate diagnosis.

The medical field is currently experiencing a shortage of these CLS professionals. This shortage promises a bright future for qualified individuals in a fascinating field.

Now what?

The program is flexible enough to meet an individual's unique circumstances, tailored to meet academic requirements, and offers a convenient schedule! If you are interested in medicine and the sciences, it may just what you have been looking for!

Open Door Forum Update

SAVE the DATE for the Indian Health Service
Open Door Forum on Health Initiatives-Forum #7
Quarterly Tele-conference/WebEx

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

Obesity prevention and control will be the focus of this forum and will include National, Area and local presentations on this topic. More information to follow. The accredited sponsor is the IHS Clinical Support Center.

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***

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 6, No. 1, January 2008) 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

What happens if your patient hears her results as Negative? Positive? Normal? Abnormal?

We tested whether adding interpretive labels (e.g., "negative test") to prenatal genetic screening test results changes perceived risk and preferences for amniocentesis.

Study Design. Women (N = 1688) completed a hypothetical pregnancy scenario on the Internet. We randomly assigned participants into two groups: high risk of fetal chromosomal problems (12.5/1000) or low risk (2/1000). After prenatal screening, estimated risk was identical (5/1000) for all participants, but results were provided either alone or with interpretive labels.

Results. When receiving test results without labels, all participants react similarly. With labels, the participants who received "positive" or "abnormal" results reported a higher perceived risk ($P < .001$), greater worry ($P < .001$), and greater interest in amniocentesis (57% vs 37%; $P < .001$) than did the participants who received "negative" or "normal" results.

Conclusion. Interpretive labels for test results can induce larger changes to a woman's risk perception and behavioral intention than can numeric results alone, which create decision momentum. This finding has broad clinical implications for patient-provider communication.

Zikmund-Fisher BJ et al. Does labeling prenatal screening test results as negative or positive affect a woman's responses? *Am J Obstet Gynecol*. 2007 Nov;197(5):528.

Editorial comment

Barry Weiss MD, Tucson

Do you understand everything the networking folks in your IT Department say about your own facility's server?

If you understood everything they said the first time you heard it, then you can probably stop reading right here. On the other hand, have you ever been called on the phone by a friend or relative, who asked you to explain to them something they were told by their doctor but which they didn't understand? You then explain things to your friend or relative in a simple, easy-to-understand way. Did you ever ask yourself why their physician didn't use an easy-to-understand explanation in the first place? Did you ever wonder why we don't all use those simple explanations with our patients every day?

Data from the recent National Assessment of Adult Literacy (NAAL) show that about 1/3 of all American adults have limited health literacy. Such individuals do not understand what you've told them, nor what they are supposed to do in response to advice you have given them. NAAL data show that the rate is even higher -- approaching 50% -- among American Indians and Alaska Natives. So, whether you know it or not, you are seeing patients -- many patients -- every day who have difficulty understanding what you've told them.

Two of the most important things you can do to address this problem are first, explain things to patients using easily understood words, as you might explain them to your grandmother. The other is to use the "teach-back" technique, in which you ask patients to explain back to you what you have just told them. This helps verify that they have understood what they need to know. Zikmund-Fisher et al, above, illustrate a simple point that interpretive labels for test results can induce larger changes to a woman's risk perception and behavioral intention than can numeric results alone, which creates decision momentum.

Clinicians routinely underestimate the prevalence of limited health literacy among their patients and frequently overestimate the ability of individual patients to understand the information they provide. For more information and a helpful perspective, go to Assessing Health Literacy in Clinical Practice, Barry D. Weiss, MD at *http://www.medscape.com/viewarticle/566053*. Other recent Health Literacy resources: Online

From Your Colleagues

David Gahn, Tahlequah, Oklahoma

You can make a big difference in women's and children's lives

Here are some unique opportunities that are available for Indian health staff

The Office of Global Health Affairs (OGHA), within the Department of Health and Human Services (HHS), has invested in improving the level of care at Rabia Balkhi Hospital (RBH), one of four maternity hospitals in Kabul, Afghanistan. HHS/OGHA has also contracted with a few non-governmental organizations (NGOs) to provide expertise in certain aspects of the program, run with the permission of and under the supervision of the Afghanistan Ministry of Public Health (MoPH). HHS partners include the Centers for Disease Control and Prevention (CDC) , the Health Resources and Services Administration (HRSA), the Agency for Health-Care Research and Quality (AHRQ) and the Indian Health Service (IHS).

RBH provides care to women, mostly in obstetrics. There is also a small component of general surgeons, internists, and dermatologists. Some 40 to 60 women a day deliver at RBH. One of the other four hospitals in Kabul, Malalai, is also this busy. Because of the US presence at RBH, it has become the main referral hospital in Kabul, and receives the sickest women for delivery. RBH also houses a residency program in obstetrics and gynecology, with about 50 residents and 14 faculty.

The current focus of the HHS project is a Cesarean section quality-assurance (QA) program. The project is starting at RBH, but will branch out to collaborate with the other hospitals in Kabul. Over the last several years, HHS/CDC has developed a system within the MoPH for collecting data on maternal and child health in Kabul. The current data show an increase in the Cesarean section rate from 4% to 10%, which the Ministry and our partners thought would decrease maternal and perinatal morbidity and mortality. However, the data also show a concurrent *increase* in mortality.

HHS/OGHA is looking for obstetricians/gynecologists and pediatricians to go to RBH to work as advisors to the local physicians, to improve their skills, and to work on the QA programs as well the Cesarean section quality-assurance collaborative. The primary role for HHS/IHS staff would be to serve as advisors, by working at the bedside with the Afghan doctors and residents to improve the level of care.

The role of IHS CNMs has not been completely clarified, but deployment in 2008 is highly likely. I encourage CNMs who are interested to contact me.

The length of the tour would be 1 - 3 months, and could start as early as January 6, 2008. This is a TDY assignment. Candidates must be Federal employees (civil service or Commissioned Corps). HHS/OGHA will pay travel and per diem and will also reimburse service units for the salary. The interagency agreement between HHS/IHS and HHS/OGHA is under negotiation, and should be complete in the next two weeks.

Security in Afghanistan is always an issue. HHS personnel in Kabul will stay on the U.S Embassy compound. Trained security personnel in armored SUVs will accompany HHS staff to RBH. Leisurely travel about town is absolutely forbidden, but HHS staff may go to the army base, the International Security Assistance Force (ISAF) base, and the MoPH.

The US Embassy itself is self-sufficient, and has two post exchanges (PXs), two dining halls, a gym, a swimming pool, etc. The rooms in which HHS staff will stay are converted shipping containers called "hooches." The rooms are relatively small, but include all the amenities: fridge, microwave, TV with cable, DVD player, bed and linens, desk, Internet access, phone, shower, toilet, sink, and hot-water heater.

My role in all of this is to coordinate recruitment and scheduling within HHS/IHS, and to participate in the operational aspects of the project. I will be going to Kabul in January with a pediatrician, a pharmacist, and a scrub tech. If you are interested in going to Kabul, please send me a CV, and we can discuss things over the phone. Afghanistan is an exciting place, and I can promise you a life-changing experience, as well as provide an opportunity to improve some of the highest maternal-mortality rates ever recorded. This is also a chance to contribute meaningfully to international efforts to stabilize Afghanistan.

Hot Topics

Obstetrics

Cesarean delivery on request not recommended if desiring several children

Abstract. Cesarean delivery on maternal request is defined as a primary cesarean delivery at maternal request in the absence of any medical or obstetric indication. A potential benefit of cesarean delivery on maternal request is a decreased risk of hemorrhage for the mother. Potential risks of cesarean delivery on maternal request include a longer maternal hospital stay, an increased risk of respiratory problems for the baby, and greater complications in subsequent pregnancies, including uterine rupture and placental implantation problems. Cesarean delivery on maternal request should not be performed before a gestational age of 39 weeks has been accurately determined, unless there is documentation of lung maturity. Cesarean delivery on maternal request should not be motivated by the unavailability of effective pain management. Cesarean delivery on maternal request is not recommended for women desiring several children, given that the risks of placenta previa, placenta accreta, and the need for gravid hysterectomy increase with each cesarean delivery.

Cesarean Delivery on Maternal Request. ACOG Committee Opinion no. 394. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2007;110:1501-4.

Gynecology

Early feeding within the first 24 hours after major abdominal gynecologic surgery is safe

Selection Criteria: Randomized controlled trials that compared the effect of early versus delayed initiation of oral intake of food and fluids after major abdominal gynecologic surgery were considered. Early feeding was defined as having oral intake of fluids or food within the first 24 hours after surgery regardless of the presence or absence of the signs that indicate the return of bowel function, and delayed feeding was defined as after the first 24 hours following surgery and only after clinical signs of resolution of postoperative ileus.

Conclusions: Early feeding after major abdominal gynecologic surgery is safe and is associated with the increased risk of nausea and a reduced length of hospital stay. Whether to adopt the early feeding approach should be individualised. Further studies should focus on the cost-effectiveness, patient's satisfaction, and other physiological changes.

Charoenkwan K, et al. Early versus delayed (traditional) oral fluids and food for reducing complications after major abdominal gynecologic surgery. *Cochrane Database Syst Rev*. 2007 Oct 17;(4):CD004508.

Child Health

Rapid response team: Implications of findings on mortality rates for children are dramatic

Implementation of an RRT (rapid-response team) in our free-standing, quaternary care academic children's hospital was associated with statistically significant reductions in hospital-wide mortality rates and code rates outside the ICU (intensive care unit) setting.

The authors found that

- A significant decrease in the hospital-wide mortality rate of 18% occurred after RRT implementation. Mean monthly mortality rates preintervention and postintervention were 1.01 and 0.83 deaths per 100 discharges, respectively.
- The rate of codes outside the ICU per 1,000 eligible patient-days decreased by 71.2% after RRT implementation, with preintervention and postintervention rates of 0.52 and 0.15, respectively.
- The rate of codes outside the ICU per 1,000 eligible admissions decreased by 71.7%, with preintervention and postintervention rates of 2.45 and 0.69, respectively.
- The estimated code rate per 1,000 admissions for the postintervention group was 0.28 times that for the preintervention group.

The potential implications of these findings on national mortality rates for children could be dramatic.

Sharek PJ, Parast LM, Leong K, et al. Effect of a rapid response team on hospital-wide mortality and code rates outside the ICU in a children's hospital. *JAMA.* 2007;298(19):2267-2274.

Chronic disease and Illness

Reconsider use of rosiglitazone

A 2004 meta-anylsis concluded that both thiazolidinediones have similar effects on glycemic control and body weight. Both drugs appear to have a beneficial effect on serum lipids. In a meta-analysis comparing the effect of thiazolidinediones on cardiovascular risk factors, pioglitazone produced a more favorable lipid profile. The Proactive study measurement of macrovascular events included all cause mortality and non-fatal stroke with combined endpoints. It was noted the study narrowly achieved statistical significance. Both drugs increased HDL, rosiglitazone increased LDL and had a neutral effect on TG, whereas pioglitazone had a neutral effect on LDL and lowered TG. Rosiglitzone was shown in June and September 2007 issues of JAMA to increase macrovascular events. The first study demonstrated increase risk of MI with rosiglitazone, and the second study displayed increased risk of MI but not death. No head-to-head trials have been conducted to date. In regards to adverse effects, both drugs may cause fluid retention, which may exacerbate or lead to heart failure. Thiazolidinediones are not recommended for patients with NYHA Class 3 and 4 cardiac status. Some clinicians choose to avoid this class of drugs in NYHA Class 2 as well. Edema was more pronounced as a side effect with both drugs: rosiglitazone 4.8% and pioglitazone 4.8% versus placebo 1.3% and 1.2%, respectively. LFT monitoring is recommended for both drugs. Post-marketing experience with rosiglitazone reported some cases of angioedema and urticaria. Rifampin decreased rosiglitazone AUC by 66%, and the clinical significance of this is unknown. Look-alike, sound-alike: Avandia and either Coumadin or Prandin; Actos and Actonel noted by the Institute for Safe Medication Practices. Use of rosiglitazone has changed from 2005 to 2007, from 170 to 119 patients, respectively. Use of pioglitazone has increased from 2005 to 2007, from 66 to 128 patients. Clinical trials have shown similar decreases in A_1C between pioglitazone 15 and 30mg. Based on safety, pioglitazone has been shown to have a better safety profile than rosiglitazone. Dialogue regarding the Accord trial pointed out that the study is still in progress, and results are inconclusive for cardiovascular events. Pioglitazone has a significantly lower risk of death. Today, rosiglitazone is not as cost effective as it was back in 2005. The current data describe a potential increase in cardiovascular events associated with rosiglitazone that has not been seen with pioglitazone.

Conclusion: Reconsider use of rosiglitazone. Patients who are taking rosiglitazone 2 or 4 mg can be switched to pioglitazone 15mg and those taking rosiglitazone 8mg can be switched to 45mg of pioglitazone.

Charbonnel B. Glitazones in the treatment of diabetes

mellitus: clinical outcomes in large scale clinical trials. *Fndam Clin Pharmacol*. 2007 Nov;21 Suppl 2:19-20.

Features

ACOG, American College of Obstetricians and Gynecologists

Human Immunodeficiency Virus

Abstract: Because human immunodeficiency virus (HIV) infection often is detected through prenatal and sexually transmitted disease testing, an obstetrician-gynecologist may be the first health professional to provide care for a woman infected with HIV. Universal testing with patient notification and right of refusal ("opt-out" testing) is recommended by most national organizations and federal agencies. Although opt-out and opt-in testing (but not mandatory testing) are both ethically acceptable, the former approach may identify more women who are eligible for therapy and may have public health advantages. It is unethical for an obstetrician-gynecologist to refuse to accept a patient or to refuse to continue providing health care for a patient solely because she is, or is thought to be, seropositive for HIV. Health care professionals who are infected with HIV should adhere to the fundamental professional obligation to avoid harm to patients. Physicians who believe that they have been at significant risk of being infected should be tested voluntarily for HIV.

Human immunodeficiency virus. ACOG Committee Opinion no. 389. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2007;110:1473-8.

Ask a Librarian Diane Cooper, MSLS, NIH

Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity

In February 2004, the American Medical Association convened a second expert committee to guide the development of three articles that would explore current evidence-based science and form the basis of new recommendations on the assessment, prevention, and treatment of child and adolescent overweight and obesity. Representatives from 15 national organizations formed the second expert committee. The committee used a multidisciplinary model and integrated approaches across disciplines. The conceptual framework is the chronic care model with the goal of achieving family/self-management of childhood obesity.

The product was four articles, one on each of the aforementioned overview areas of the management of obesity and one overarching support document. The articles were written by national experts in the field of childhood obesity who were nominated jointly by the members of the expert and steering committees.

Barlow SE and the Expert Committee. Recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. *Pediatrics*. December 2007;120(Supplement 4):S164 - S192.

Krebs NF et al. Assessment of child and adolescent overweight and obesity. *Pediatrics*. December 2007;120(Supplement 4):S193 - S228.

Davis MM. Recommendations for prevention of childhood obesity. *Pediatrics*. December 2007;120(Supplement 4):S229 - S253.

Spear BA et al. Recommendations for treatment of child and adolescent overweight and obesity. *Pediatrics*. December 2007;120(Supplement 4):S254 - S288.

http://pediatrics.aappublications.org/content/vol120/Supplement_4/index.shtml or *www.pediatrics.org*.

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

Teens, Depression, Black Box Warnings, and Suicide

After a substantial period of gradually decreasing rates of suicide in adolescents, including AI/AN adolescents, recent 2004 data documenting increased suicide rates for adolescents suggest more attention will be coming to adolescent mood problems. The increase in suicides was most dramatic in female populations, with rates rising dramatically in younger female populations ages 10 - 14 (75.9%) and significantly so in older adolescent females ages 15 - 19 (32.3%) and males ages 15 - 19 (9%). The increases coincide with the FDA's black box requirement for many antidepressants that is likely responsible for an overall reduction in the prescription of antidepressants for teenagers. Does this mean decreased antidepressant prescription was causally related to the increase in suicides? We don't know, but the temporal association is suggestive.

Our adolescents are, unfortunately, at the forefront of the suicide curve. Indian country has received significant attention recently due to increasing concern about suicide clusters in adolescent populations and more generally in young adults. Theories abound as to why this is occurring, and, given the low base rates of the event and the high frequency of conditions and behaviors associated with increased risk, real understanding is still some time away.

There is a general consensus, however, that part of the solution lies in identifying and treating depression in primary care. The American Academy of Pediatrics recently released GLAD-PC (Guidelines for Adolescent Depression in Primary Care) I and II which include excellent resources for developing primary care based approaches to management. The full documents can be found at *www.glad-pc.org* and include screening and assessment instruments as well as treatment tracking tools.

The recent publication of further results from the TADS (Treatment of Adolescent Depression Study) is also encouraging, as it suggests that risks related to antidepressant treatment can be mitigated with appropriate therapy and management.

Combined depression regimen appears to reduce suicidality. *Psychiatr News*. Mar 2007;42:28-35.

Some basic recommendations for tackling adolescent depression:

1. Screen using a systematic assessment (screening tool). For those of you familiar with the PHQ-9 there is a slightly modified instrument for adolescents available on *www.glad-pc.org*. Other instruments with established psychometric properties are also available for use and several are free.
2. Develop relationships with your local BH system. You can treat and manage many patients successfully with fairly limited consultative support.
3. Take adequate time – pediatric and primary care schedules are often crazy and packed – this is for better or for worse one of those occasions where time up front reduces emergencies and time later. If you have the opportunity to integrate BH care into your primary care services, your schedule interruptions can be minimized.
4. Treatment works – and while there may be issues with the relative strength of psychotherapy vs. medications, both have demonstrated efficacy over placebo or treatment as usual approaches. Keys to successful treatment include having a plan, reassessing progress frequently, particularly in the early stages of treatment, and getting help if there is no improvement or if improvement plateaus before full resolution.
5. Access to lethal means restriction counseling may reduce risk of self-injury.
6. (see *http://www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf*).
7. The "Medical Home" is an encompassing model that, if applied properly in conjunction with developmentally appropriate preventive counseling, provides maximum opportunity to identify, intervene, and mitigate at least some of the risk for self-destructive behaviors in adolescence – whether that behavior be self-injury, smoking, unprotected sex, or drug and alcohol use.

If you decide to use medications, keep in mind the following:

1. Medications should be used to treat full MH disorders and generally avoided in sub-syndromic states in children and adolescents.
2. Fluoxetine remains the best option to start with for adolescents – it has the best risk profile and is indicated for treatment of adolescent depression.
3. Educate the patient and parents/guardians/family members about use of the medication, including the possible development of agitation, restlessness, and anxiety. These symptoms may portend the development of medication-induced suicidal thinking. The FDA and AACAP guidelines suggest initial weekly face-to-face visits. While this is desirable, it is often not feasible or practical, but the pearl here is to plan regular weekly contact whether in person, by phone, or through other means, with the patient and family, and identify this in your documentation. Follow-up may actually need to be more frequent if there is any significant suicidal ideation or self-harm concerns.
4. Screen for history of bipolar symptoms both in the patient and through the family history. Be very cautious using medications without consultation where there is a history of mania-like symptoms or family bipolar disorder.
5. Stop medications gradually. Risk periods for increased suicidal thinking appear to be both around the time of initiation of antidepressant therapy and after sudden discontinuation.
6. Limit refills. Keep dispensed amounts to only slightly more than necessary to get to the next contact or appointment for the first three months of treatment.

References: Online

Breastfeeding

Suzan Murphy, PIMC

Breastfeeding, it is not just about the baby

According to a 2005 meta-analysis by the Agency for Healthcare Research and Quality (AHRQ), postpartum depression (PPD) is a major depressive disorder that effects between 5 - 25% of women in developed nations. Compared to men, women are twice as likely to experience depression in their lifetime.

Risk factors for PPD include:

- adolescence
- poverty
- family or personal history of depression
- relationship discord
- lack of social support
- unplanned/unwanted pregnancy
- life stress (including child-care issues)
- challenging infant temperment (fussy, colicky)
- low self-esteem

- prenatal anxiety

Symptoms include:

- Loss of interest or enthusiasm for daily activities
- Depressed mood
- Difficulty making decisions or concentrating
- Fatigue
- Appetite disturbance
- Feelings of worthlessness, hopelessness, excessive/inappropriate guilt or shame
- Suicidal ideation
- Somatic complaints such as headaches, GI distress
- Psychomotor disturbance
- Sleep changes

For many reasons, PPD is often undiagnosed. PPD left untreated can be devastating for new mothers and their families. A recent study by Mancini, et al (cited below) described using the Postpartum Depression Screening Scale (PDSS) developed by Beck, et al to screen women in large midwifery and obstetric practice in Albuquerque, New Mexico. The practice saw approximately 2000 deliveries per year, 40% enrolled in the Medicaid program. The goals of the study were to look at prevalence of positive PDSS screen at 6 weeks, determine the benefits and challenges of using the PDSS screening tool, and find demographic and clinical characteristics that were related to positive screens.

In a 12 month period, 755 women were screened, 740 with complete data sets. Data were collected on PDSS score, age, parity, race/ethnicity, education, marital status, infant feeding, type of delivery, and history of depression. The prevalence of a positive screen at six weeks was 16% for major PPD and 20% for symptoms suggesting potential PPD risk. The PDSS was ultimately integrated into the patient care routine, with positive feedback by the staff and patients. A total of 75% of the providers participated, 6 of 11 obstetricians and all of 9 CNMs. They reported a sense of providing more comprehensive care and the opportunity to gently educate about mental illness. Patients reported appreciating the chance to talk about mental wellness issues.

The study found that women who had a positive screen at six weeks postpartum were more likely to not have completed high school, not be partnered, be exclusively bottle feeding, and have a history of depression. The two characteristics that were statistically significant as predictors of a positive PDSS screen were history of depression (risk ratio, 4.8; 95% CI, 4.4-5.2) and exclusive bottle feeding (risk ratio, 2.0; CI, 1.6-2.4). The possible reasons suggested for breastfeeding reducing risk of PPD included decreased maternal stress sensitivity, and enhanced response/action of the parasympathetic nervous system.

Like many other articles about PPD, the authors reiterated the need for more research and attention to timely screening and early intervention.

A side note: Other possible reasons for reduced PPD risk with breastfeeding mothers include increased levels of prolactin and oxytocin, shortened duration of post partum bleeding with enhanced involution, possible delayed return to menses, and so less risk of PMS symptoms, possible weight loss, reduced stress due to less infant illness, and likely increase in maternal self-esteem.

Reference: Online

Featured Website

David Gahn, IHS MCH Portal Web Site Content Coordinator

Preconception Counseling for Women with Diabetes and Hypertension: New module

This is a new module in the Perinatology Corner Series. This particular topic is coming up a lot more frequently in our patients. What can you treat with and not endanger the fetus? What can't you treat with? This module offers good advice on these and many other issues, plus lots of resources, even if you don't want the free CME. *http://www.ihs.gov/MedicalPrograms/MCH/M/PNC/PreconCouns01.cfm*

Frequently asked questions

Q. How should we manage a patient with a previous abruptio placenta?

A. There are significant risks after two previous abruptions or if fetal death resulted.

Short take: In the vast majority of cases, no change in management is required in subsequent pregancies. Reversible risk factors can be modified (e.g., avoid cigarette smoking or cocaine use), and women with nonrecurrent risk factors (e.g., trauma) may be reassured. In selected patients, such as those with two or more prior perinatal deaths or one perinatal death with persistent nonmodifiable risk factors for abruption, offering patients the option of preterm delivery upon documentation of fetal lung maturity is reasonable.

Full answer online at the MCH FAQ site: "How should we manage a patient with a previous abruptio placenta?"http://www.ihs.gov/MedicalPrograms/MCH/M/documents/AbruptioRec12907.doc

International Health Update

Claire Wendland, Madison, Wisconsin

Disparities, Inequalities, or Inequities?

Everyone knows that the average health status of people living in poor countries is generally worse than that of people living in wealthier ones. When health outcomes differ among different population groups, are they health disparities or inequalities? Or, in the only term that implies a moral wrong,

are they health inequities? Inequities based on differential access to a society's resources are difficult to detect without some sort of assessment of wealth. Because of technical problems with the measurement of wealth, and perhaps because of a lack of political will, we've had a real dearth of information on inequality within countries – especially poor countries – until recently. Now a new World Bank report focuses on the correlations between economic status and health within fifty-six poor countries in Africa, Asia, the former Soviet Union, and Latin America. The authors made female-male and rural-urban comparisons as well, but their focus is primarily on economics.

Why are these data so late to the scene? Economic status was neglected in most of the earlier studies of health disparities because it is very hard to measure. Household income may not be in cash at all, especially where unemployment is high; people may be much more reluctant to estimate family income for analysts than to check a box revealing gender or race; and proxy measures like education or occupation did not prove to be good analogues for wealth. All of these problems were magnified in poor countries. In the late 1990s, researchers realized that various assets (for instance bicycles, radios, piped water, or corrugated iron roofing rather than thatch) could be compiled into an "asset index" that worked very well to rank economic status. It's only been in the last decade, therefore, that researchers were able to correlate economic status and health with reasonable accuracy.

I urge you to check out the report itself. For those of us interested in maternal and child health, it includes detailed tables on child and infant health, basic fertility indicators and STD prevalence, and some maternal health indicators (such as deliveries attended by skilled staff). The results are sobering, though preliminary. Infant and child mortality, fertility, and malnutrition are all much greater among the poor than the rich. Immunization, antenatal care, medical treatment of respiratory infections, oral rehydration for diarrhea and other basic health interventions are all less likely to be used (or available) the poorer the household. Even primary health care offers greater benefits to the better-off than to the poor: 12% of benefits accrue to the poorest 20% of the population, 29% to the richest 20%, although it isn't as skewed in this regard as hospital care, where 10% of benefits go to the poorest quintile and over forty percent to the richest. The only indicator in which the poor do better is breastfeeding: in nearly every country surveyed, the poorest were more likely to breastfeed their infants. (Other studies have shown that the richer are also more likely to get unnecessary operations like excess Cesarean sections, and to suffer the associated morbidity. That particular issue is not addressed in this report.)

Most sobering of all, the authors predict that as new health improvements find their way into poor countries, inequalities are likely to worsen. Whether it is antiretrovirals for HIV or surfactant for prematurity, the rich have means to learn about these improvements and to access them long before the poor do. Average health status may improve even as inequalities – and inequities – worsen. As the authors conclude, "Much more will be needed if the global health community is to move beyond platitudes about improving the health of the poor to effective action that can do so."

Gwatkin DR, Rutstein S, Johnson K et al. Socio-economic differences in health, nutrition, and population within developing countries: an overview. Washington DC: World Bank. 2007

MCH Headlines

Judy Thierry, HQE

Oral Health for Head Start Children: Best Practices

This 12-page document provides evidence-based approaches and interventions to improve the oral health of Head Start children and their families. The best practices are divided into three key points of intervention;

- pregnancy,
- birth through two years, and
- two years through five years of age.

Readership should include Head Start administration and staff, and medical, dental, and community health staff who will need to work together to effectively improve the future oral health of American Indian and Alaska Native children. IHS Head Start Program website: *www.ihs.gov/nonmedicalprograms/headstart/*. You can also find current information and bulletins on oral health as it relates to Head Start at the Head Start Bureau Learning Center at the followingwebsite: *http://www.eclkc.ohs.acf.hhs.gov/hslc*.

Medical Mystery Tour

What is the Presenting Part?

You may recall we last presented the case of a 20 year old gravida 4 para 1,0,2,1 at 40 2/7 weeks in active labor. The patient had had a 39 pound weight gain throughout her otherwise unremarkable prenatal care. The patient's obstetric history was significant for one previous vaginal delivery of a term 9 pound 15 ounce infant. Laboratory testing was essentially unremarkable. On admission the patient's exam was cephalic presentation, 4 cm dilation, -1 station. The cervix was soft and in a mid position. External fetal monitoring was reassuring. Sixty second contractions were noted every five minutes.

At 01:30 the CNM noted that patient had progressed nicely in labor to 7 cm dilated and 100% effaced. The presenting part was still at -1 station. The membranes were intact. The CNM was unable to completely identify the presenting part. The FHR tracing was reassuring. The CNM noted that a suture line and fontanelle were palpable, but other tissue may have been present. The MD on call was asked to perform a bedside ultrasound to confirm the presenting part. The bedside ultrasound confirmed a cephalic presentation

which was slightly oblique. The physician proceeded to perform a digital exam.

What did the physician find on digital exam?

In the interim since the physician had been initially called, the patient's membranes had ruptured and the FHR remained reassuring. The physician noted several long loops of umbilical cord presenting. Otherwise the fetus was in cephalic presentation with complete cervical dilation and effacement. The CNM then elevated the fetus's head out of the pelvis with her hand and the patient was moved to the operative suite in an expeditious manner while in knee-chest position.

As the obstetric team reached the OR table before the anesthesia team was ready and the patient was completely dilated, an attempt was made at funic reduction. This manuever was only successful for part of the prolapsed cord, but loops remained distal to the fetal skull.

The maternal skin incision was made within 13 minutes of anesthesia's notification and the fetus was delivered within one minute as a Joel-Cohen technique was used. The infant female was delivered from an occiput posterior position and weighed 3450 g with Apgars of 8 and 9. At the time of surgery the cord was felt to be clinically 'long' plus had a true, but loose, knot with no proximal edema. A generous section of umbilical cord was obtained for possible cord gases. The arterial pH was 7.17 with a base excess of -5.4. The venous pH was 7.23 with a base excess of -4.0. Of note, the arterial C02 was 70.5 (mmHg) (49.2 to 50.3) so some cord occlusion had begun shortly before delivery.

Examination of the placenta in the pathology department the next day revealed a somewhat eccentric umbilical cord insertion, 4 cm from the placental margin. Even after formalin fixation and not measuring either the portion of the umbilical cord sent for cord blood gases, nor the area remaining on the infant at surgery, the cord was still 53 cm. There was a true knot at 17 cm from the insertion. As you will see below, the most accurate measurement of cord is actually done in the delivery suite, not after formalin fixation and other incisions for cord gases, etc.

Both the patient and her new daughter had unremarkable hospital courses for two days prior to discharge.

So, what was the presentation the CNM had noted?

The patient had a funic presentation prior to SROM. In this case there was so much cord that it essentially filled the pelvic outlet. By the time the physician performed a digital exam after SROM and the ultrasound exam, the patient had been in an unrecognized cord prolapse with reassuring FHRs for approximately 10 - 15 minutes.

Long umbilical cord

Cord length increases with advancing gestational age. The average length at term is 55 cm (22 inches), with a wide normal range (35 to 80 cm) (14 – 32 inches) (Rayburn). The length should be noted and compared with published standards (Table below). Umbilical cord accidents were most frequent in the presence of a long cord (20 of 32 cases, 62%). In addition, mothers with a history of an excessively long umbilical cords are at increased risk of a second long cord.

The length measurement should include the portion of cord on the infant after cord transection at delivery as well as the part remaining with the placenta; thus it is best determined in the delivery room. Cord length is determined in part by hereditary factors, but also by the tension the fetus places on the cord when it moves. For this reason, short cords are associated with fetal inactivity related to fetal malformations, myopathic and neuropathic diseases, and oligohydramnios. Long cords may be caused by a hyperactive fetus and have been associated with cord accidents, such as entanglement, knotting, and prolapse (Rayburn). Long cords are also associated with placental lesions indicative of intrauterine hypoxia, as well as fetal death, fetal growth restriction, and long term adverse neurologic outcome (Baergen). A very helpful discussion of the risks for and management of prolapse umbilical is available online

Navajo News

Jean Howe, Chinle

Informed Refusal, Leaving Against Medical Advice, and Asking Questions

A recent article in the "Clinical Practice" series of the New England Journal of Medicine addresses the assessment of patients' competence to consent to (and decline) treatment. This series uses a case vignette and discussion to address common clinical problems. In this case, a 75 year old woman with type II diabetes, peripheral vascular disease, and a gangrenous foot ulcer who refuses a recommended amputation is described. The patient states that she "prefers to die with her body intact" and the provider is concerned about apparent increasing confusion and possible depression limiting her ability to provide informed consent. Legally relevant criteria for evaluating decision-making capacity are outlined for the patient's tasks of communicating a choice, understanding the relevant information, appreciating the situation and its consequences, and reasoning about treatment options. Approaches to assessment and the consequences of a finding of incompetence are reviewed. The lack of formal practice guidelines for assessment of competence to consent is highlighted.

Refusal of treatment is also the focus of an overview of hospital discharge "against medical advice" in this month's American Journal of Public Health. This database audit of over 3 million discharges from US non-federal acute care hospitals identified a rate of 1 in 70 (1.44%) of "self-discharges." Higher rates were associated with young age, male gender, African American race, and low socio-economic status.

Because this study is a database review only, no information is available on the reasons for AMA discharge. The authors discuss possible reasons, including frustration with administrative delays in the discharge process, pressing domestic or social concerns, and disagreement with their physician's assessment of their health status. They also discuss the public health significance of these discharges and the importance of addressing shortcomings of the health care system that may place underserved patients at higher risk for this event.

Meanwhile, the Agency for HealthCare Research and Quality is launching a campaign called "Questions are the Answer" encouraging patients to ask questions about their health care as a safety measure and in an effort to improve overall health through greater understanding and ownership of health care decisions. Their sample questions for patients and more information about this campaign, including video clips of singing and dancing health care workers are available at the AHRQ website.

I happened to encounter all three of these articles/information on the same day and was struck by the increased attention to patient autonomy and recognition that medical advice may be rejected, ignored, or poorly understood. We, as health care providers, have an ongoing duty to encourage our patients' understanding and ownership of their health and their right to make informed decisions about their care.

Vulnerable groups may benefit from additional attention to their needs, whether for respectful assessment of decision-making capacity or for culturally appropriate hospital care that minimizes the risks of "self-discharge." I'm not sure if the singing health care workers in the AHRQ videos will help, but we must continue our efforts to welcome, encourage, and respect our patients' efforts to make truly informed health care decisions.

Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment, *N Engl J Med*. 2007 Nov 1;357(18):1834-40.

Ibrahim SA, Kwoh CK, and Krishnan E. Factors associated with patients who leave acute care hospitals against medical advice. *Am J Public Health*. 2007 97:2204-2208, 10.2105/AJPH.2006.100164.

AHRQ. *http://www.ahrq.gov/questionsaretheanswer/index.html*.

CCC Editorial Comment

What Are The Elements of Patient Decision Making?

This is a very timely topic as ACOG has just released the three Committee Opinions below that relate to a patient's decision making process. We need to have made all efforts possible to assure that the decision is informed, on the patient's actual educational level, as well as ethical. Please also note this month's Abstact of the Month and Dr. Weiss's comments on Health Literacy, above.

Health Literacy. ACOG Committee Opinion no. 391. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2007;110:1489-91.

The Limits of Conscientious Refusal in Reproductive Medicine ACOG Committee Opinion no. 385. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2007;110:1203-8.

Ethical Decision Making in Obstetrics and Gynecology*. ACOG Committee Opinion no. 390. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2007;110:1479-87.

Perinatology Picks

George Gilson, MFM, ANMC

Fewer errors with more standardization of corticosteroid regimens

Repeat vs single dose corticosteroids did not differ significantly, except NS cerebral palsy

Conclusions: Children who had been exposed to repeat as compared with single courses of antenatal corticosteroids did not differ significantly in physical or neurocognitive measures. Although the difference was not statistically significant, the higher rate of cerebral palsy among children who had been exposed to repeat doses of corticosteroids is of concern and warrants further study.

Wapner RJ et al. Long-term outcomes after repeat doses of antenatal corticosteroids. *N Engl J Med*. 2007 Sep 20;357(12):1190-8.

Editorial comment: George Gilson,MFM

It would probably be good if we all standardized our use of antenatal corticosteroids for fetal lung maturation. I have seen various regimens being used, but the one below is the one recommended by ACOG on the basis of the available evidence. Steroids are given over a 48 hour interval. Their maximum effect is maintained for seven days, although a lesser, but still significant, effect is seen for a considerably longer interval. Giving the doses at closer intervals will not speed up the fetal lung maturation process, even though you think the baby needs to deliver sooner than later. The regimens are:

> Betamethasone 12 mg IM x2 at 24 hour intervals, or
> Dexamethasone 6 mg IM x4 at 12 hour intervals

Steroids are appropriate between 24 and 34 weeks gestation (some authorities would restrict their use to 32 weeks or less in women with PPROM). There is no consensus on whether betamethasone or dexamethasone is better, so either regimen is fine. Steroids should ideally only be given once, so you should carefully consider if they are really needed at the time. (One "rescue" dose later, while not recommended, has

not been associated with significant adverse neonatal effects, and is also acceptable on an individualized basis.)

Antenatal corticosteroid therapy for fetal maturation. ACOG Committee Opinion No. 273. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2002;99:871-873.

Women's Health Headlines

Carolyn Aoyama, HQE

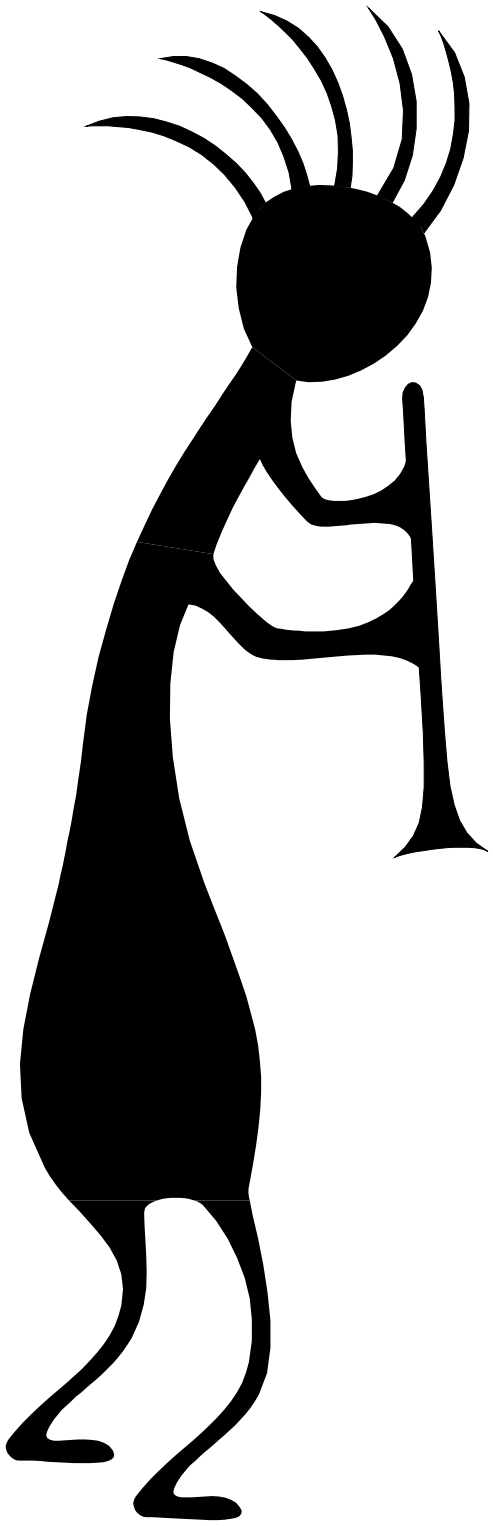
Making a Business Case for Investing in Maternal and Child Health

Health care services for children and pregnant women account for $1 out of every $5 large employers spend on health care. A substantial proportion of employee's lost work time can be attributed to children's health problems, and pregnancy is a leading cause of short- and long-term disability and turnover for most companies. Yet most companies don't have a strategy for promoting the health of mothers and children.

In November, the Business Group released a new toolkit aimed at improving employer-sponsored health benefits and programs for children, adolescents, and pregnant women. The core component of this toolkit is the Maternal and Child Health Plan Benefit Model, which outlines 34 evidence-informed health, pharmacy, vision, and dental benefits recommended by the Business Group. A webinar provides an overview of the new toolkit. The speakers also discuss:

- The business case for investing in healthy pregnancies and healthy children.
- Benefit design recommendations.
- Recommended cost-sharing strategies to promote appropriate utilization and incentive for prevention.
- Data on the cost-offsets associated with prevention.
- "Lessons learned" from Marriott on communicating health benefits and engaging beneficiaries in health promotion and disease prevention.

To view Investing in Maternal and Child Health: An Employer's Toolkit, visit: *http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/index.cfm*.



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 (CUSAD)

(Formerly known as the Primary Care Provider Training on Chemical Dependency)

March 11 - 13, 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 expected to be announced in January; it will be in downtown Phoenix. Be sure to ask for the "Indian Health Service" group rate when the venue is confirmed. For more information or to register, contact Cheryl Begay at (602) 364-7777 or e-mail *Cheryl.Begay@ihs.gov*. To register online, go to the CSC website at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.

Office Based Opioid Treatment Course

March 14, 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, March 14, 2008 at the CUSAD venue in Phoenix. 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) 762-1908 or *anthony.dekker@ihs.gov*.

2008 Education in Palliative and End-Of-Life Care-Oncology/IHS (EPEC-O/IHS)

March 25 - 27, 2008; Bloomington, Minnesota

The 2008 Education in Palliative and End-Of-Life Care-Oncology/IHS (EPEC-O/IHS) will be held March 25 - 27, 2008 in Bloomington, Minnesota. This intensive, interactive training course is a joint effort between the IHS and the National Cancer Institute and is evolving into one of the best opportunities available to develop specific skills related to caring for patients and families who are facing cancer and other serious chronic illnesses, and those facing the end of life.

The faculty features the top clinicians in the field. Participation is open to all physicians, nurses, social workers, and pharmacists across the Indian health system. All Indian health facilities are encouraged to support interested physicians, nurses, social workers, pharmacists, and others to attend this course. If a facility wishes to send a team, that would be ideal.

The National Cancer Institute has provided funds to cover travel costs and the *per diem* for about 35 attendees for this course. We will accept applications on a first request, first served basis. Please contact Timothy Domer, MD by e-mail at *timothy.domer@ihs.gov*.

A second training session will be held in Flagstaff, Arizona April 22 - 24. The location of that training will be forthcoming shortly. You may apply to attend that course using the same e-mail address.

The March training will be held at the Holiday Inn Select International Airport, 3 Appletree Square, Bloomington, Minnesota 55425. Please make your hotel room reservations by March 3, 2008 by calling 1-800-465-4329 or (952) 854-9000. Be sure to ask for the "Indian Health Service" group rate. For online registration and the most current conference agenda, please visit the Clinical Support Center web page at *http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*.

The IHS Clinical Support Center is the accredited sponsor for this meeting. For more information on CME/CEU, contact Gigi Holmes or CDR Dora Bradley at (602) 364-7777 or e-mail *gigi.holmes@ihs.gov*.

Lifesavers 2008 National Conference on Highway Safety Priorities

April 13 - 15, 2008; Portland, Oregon

Lifesavers is the premier national highway safety meeting in the United States dedicated to reducing the tragic toll of deaths and injuries on our nation's roadways. The conference addresses a wide range of safety topics, from child passenger safety and occupant protection to roadway and vehicle safety and technology. It offers the state-of-the-art information on

advances in highway safety, highlights successful programs, and draws attention to emerging safety. Conference attendees come from the public and private sectors representing a multidisciplinary audience including child passenger safety professionals, EMS, nurses, physicians, social workers, injury prevention advocates, researchers, law enforcement, judicial officials, and consumers. Each year, the Lifesavers Conference has become even more relevant and timely, providing a forum that delivers common-sense solutions to today's critical highway safety problems.

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

8th Annual Advances in Indian Health

April 29 – May 2, 2008; Albuquerque, New Mexico

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

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

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

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

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/*.

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).

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.*

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 a,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 Positions

Riverside-San Bernardino County Indian Health Inc.; Banning, California

Internal medicine physician: two years experience in an ambulatory care patient setting. MD degree, current California medical license, current DEA license, board certified.

Public health nurse: bachelor of science degree in nursing from an accredited school of nursing. Must possess a current California nursing license and public health nurse certificate; valid California driver's license and safe driving record.

RN charge nurse: current California RN license, current CPR certification, current California driver's license. Experience with computerized medical management system desirable. Two years experience in ambulatory care, urgent care, or similar setting.

Registered Dietitian & Public Health Nutritionist: bachelor of science degree in foods and nutrition, applicable master's degree in nutrition or masters in public health or RD. At least two years professional experience required. A California driver's license and a current DMV printout are required.

Quality management/credentialing assistant: applicant must possess a high school diploma or equivalent. Must have two years experience in the coordination of quality management and credentialing services for the professional staff. Must have strong written and oral communications skills.

All applicants must be able to work with the Indian community and be sensitive to the Indian culture and its needs. Please fax resumes to Human Resource Department at (951) 849-3581; or e-mail *msouvenir@rsbcihi.org*.

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 preferrural living, there are many opportunities nearby. The facility is located 10 minutes from a major lake, and only one hour from a lake with over 1,100 miles of shoreline.

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

Family Practice Physician

Hopi Health Care Center; Polacca, Arizona

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

including a dental clinic, physical therapy, optometry, and behavioral health services. We are a designated NHSC site, and qualify for the IHS Loan Repayment Program.

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

Family Practice Physician

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

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

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

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

Pediatrician

Family Practice Physician

Pharmacist

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 *mfrancis@tcimc.ihs.gov*.

Family Medicine Physicians
Phoenix Indian Medical Center, Phoenix Arizona

The Family Medicine Department is recruiting for BC/BE family physicians at the Phoenix Indian Medical Center and the satellite clinic at Salt River. The positions are predominantly outpatient with limited hospital inpatient activity; OB optional. Join eight physicians, one nurse practitioner, one physician's assistant, and a number of part-time providers. PIMC is one of the largest IHS sites, with over 100 providers and 70 active beds. We have been using PCC+ and in part EMR. There are great opportunities socially, culturally, professionally, and educationally living in the Phoenix metropolitan area. The IHS has a great benefits package for Civil Service and Commissioned Corps. Loan payback is an option. For more information, please contact/send CV to Eric Ossowski MD, Family Medicine Department, Phoenix Indian Medical Center, 4212 N. 16th Street, Phoenix Indian Medical Center, Phoenix, Arizona 85016. Telephone (602) 263-1537; fax (602) 263-1593; or e-mail *eric.ossowski@ihs.gov*.

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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