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New Behavioral Health GUI Supports Client-centered Development and Deployment

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Introduction

Behavioral health providers are trained to listen to "client narratives" (their own story in their own words), to "start where the client is," to focus on strengths rather than deficits, and to develop solutions to problems in true partnership with our clients. We have applied this "client-centered" philosophy in the development, deployment, and support of the behavioral health applications as well.

Every phase of software development for the new Behavioral Health Graphical User Interface (GUI) was influenced by the eventual users – our clients. Building on the strengths of existing Resource and Patient Management System (RPMS) applications, behavioral health providers created the requirements for the application, and clinicians worked side by side with developers to make certain these requirements were correctly interpreted. A user-centered design process was informed by on-site observations, interviews, and usability testing. Training activities were uniquely tailored according to the needs of the Areas, and recommendations of attendees were immediately incorporated in order to improve the training experience for others. Throughout the process, the BH GUI project plan remained dynamic, changing as needed to reflect user priorities and industry standards.

BH GUI Released

ITSC released the much-anticipated Behavioral Health GUI (BPC v1.4) in January 2004. BH GUI is the Windows-based graphical user interface to the very robust and widely deployed Behavioral Health System (BHS v3.0). BH GUI and BHS v3.0 are interim application releases on the development path of a fully integrated, electronic behavioral health application. Patch 1 of BH GUI and patch 2 of BHS v3.0 will be released early this summer. The patches include minor modifications to enhance usability as well as several changes and new features designed to increase security and privacy to facilitate compliance with HIPAA. In addition, BHS v3.0 also includes the domestic violence screening exam code.

BH GUI is a component of the IHS Patient Chart, which was initially released in 2001. With the deployment of the

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BH GUI, behavioral health providers can now take advantage of the benefits of integration with multiple RPMS applications in the user-friendly environment offered by Patient Chart. Unique to the BH tab in Patient Chart is the ability to enter clinical notes, record treatment plans and reviews, and document group encounters and administrative activities. Other features include a suicide surveillance tool designed to assist BH programs in the reporting and tracking of incidents of suicide. The GUI facilitates direct provider entry of clinical information, rather than data entry, and providers have commented frequently on the ease of clinical documentation in the new application. For a complete description of the BH GUI please refer to the article, "The IHS Behavioral Health System," in the January 2004 issue of *The IHS Primary Care Provider* (Volume 29, Number 1, pages 1 - 4.)

The Training and Deployment Experience

Graphical user interfaces, by their nature, are more intuitive and user-friendly. This fact has been confirmed by feedback from users during early deployment of BH GUI. However, learning, implementing, and supporting a new application, like any change effort, can produce anxiety, fear, and sometimes, resistance. We discovered during the first BH GUI training that while the students (including clinicians, program managers, data entry personnel, and IT staff) appeared to accept and learn the GUI more easily than the typical RPMS "roll and scroll" application, the pain associated with learning a new application – with change, in other words – was still present. There were also those students who were reluctant to leave behind the application with which they were familiar and which they had finally mastered – the once-dreaded "roll and scroll."

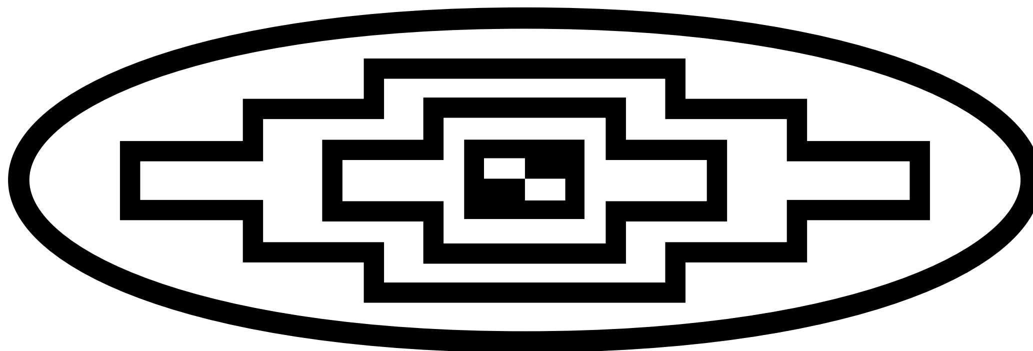
The RPMS BH applications are intended for use by widely divergent IHS, tribal, and urban behavioral health programs. The users are comprised of mental health, social work, and alcohol and substance abuse professionals and paraprofessionals, all with varying degrees of computer literacy and comfort levels. The programs and facilities are equally diverse, with stand-alone, tribally run outpatient mental health clinics, urban residential alcohol and substance abuse treatment facilities, clinic- and hospital-based social work departments and everything in between. As we developed and presented training on the BH GUI, we discovered a number of ways to make the experience more relevant and appropriate for attendees.

Discipline-specific data entry scenarios and exercises were developed with input from clinicians in the field. Self-paced tools for independent learning were designed and distributed widely to support learning outside of the classroom. Training sessions for specific user groups, such as residential alcohol and substance abuse treatment center clinicians and staff, were especially well received and successful. A standard of a minimum of two trainers per 20 students, one being a clinician, was established. The time and energy invested in making frequent changes to training materials and agendas, and in post-session debriefings and analysis of training evaluations, was clearly well spent.

Plans for Future Development and Deployment

Users have tasked us with the development and inclusion of an improved, comprehensive treatment plan module in the BH GUI. This is a priority of future development efforts. Programming is underway now for enhanced group functionality, and work continues toward importing the BH GUI into the IHS Electronic Health Record. While Patient Chart has always been considered an easy-to-use, easy-to-deploy application, implementation of the BH GUI does require a different process than BHS v3.0. Changes to deployment plans include increasing the number of on-site implementation visits as an adjunct to Area training. Also at the request of users, we are hoping to be able to offer on-line training soon and are pursuing continuing education credit for training from the IHS Clinical Support Center.

We are extremely grateful to our clients – the users, potential users, and the Division of Behavioral Health – for partnering with us in the development and deployment process of the BH applications. Behavioral health providers know that it is the client who holds the answers.



PALLATIVE CARE PEARLS ☐

The following article is another in an ongoing series in support of the development of a unified approach to palliative care services for American Indians and Alaska Natives. The series consists of brief, concise facts and information for providers of palliative care.

Palliative Sedation For Dying Patients: A Last Resort

Judith A. Kitzes, MD, MPH, Soros Foundation, Project on Death In America Faculty Scholar, University of New Mexico Health Science Center, School of Medicine, Albuquerque, New Mexico

Goal: achieve comfort in a decreased level of consciousness when intractable symptoms and suffering are present despite appropriate palliative treatment.

"Intentional," "terminal," "total," "controlled," or "palliative" sedation are all terms employed to describe the deliberate and ongoing induction of unresponsiveness or unconsciousness without the intent of euthanasia in dying patients.

Ethical Considerations Include:

Autonomy

- Duty to consult and inform.
- Patient's preferences and role in decision-making.

Beneficence

- Doing everything possible to relieve intractable suffering for the dying patient.
- Acknowledging distress of family and caregivers.

Non-Maleficence

- Intention of provider and caregivers is directed for patient's benefit.
- Principle of double effect applies: accepts all actions may have both positive and negative effects, however decision based on benefit to patient.

Process

1. As soon as refractory symptoms occur or are anticipated, begin open, compassionate communication with patient/family.
2. Consider time-limited trial (1 - 3 days) of sedation.
3. Discuss all concerns of patient, family, staff.
4. Support family and staff.
5. Document communications and decisions.

Pharmacological Principles

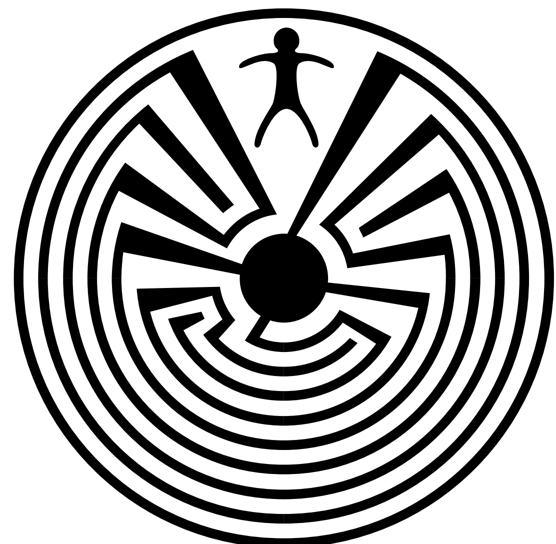
- Review medication history for paradoxical agitation to benzodiazepine or opioids.
- Develop experience with dosing/titration of sedating drugs.
- Use parental route.
- Monitor and reassess frequently.

Medications

- Rapid titration of opioids: base on a proportion of the last dose, and consider 150% - 200% bolus of the hourly rate, then maintain hourly infusion at 50% base dose. Continue to titrate both baseline and rescue doses by 50% - 200% increments to desired level of sedation.
- When opioids are not effective because of toxicity: begin rapid acting adjuvant (chlorpromazine, midazolam, lorazepam, diazepam, phenobarbitol).
- Difficult to achieve sedation: consider midazolam, thiopental, or propofol in a continuous infusion.

References

1. American Academy of Hospice/Palliative Medicine. Pocket Guide to Hospice/Palliative Medicine, 2003.
2. Cowan JD, Walsh D. Terminal Sedation in Palliative Medicine-Definition and Review of the Literature. *Supportive Cancer Care*. 2001;9.
3. Bailey FA. The Palliative Response. Menasha Ridge Press, 2003.



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 2, No. 6 , June 2004) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We want 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@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

News Flash: Last Meeting of its Kind Until 2007

The 2004 Native American Women's Health and Maternity Care conference will be held August 4 - 6, 2004, in Albuquerque, New Mexico. This is great continuing professional education, plus networking opportunities for leaders in health care for Native American women and maternal child care. There will be an internationally known faculty of over 35 in all. The theme is *Prevention in Native Women*, plus there will be tracks on domestic violence, breastfeeding, and several adolescent topics. The target audience is leaders and opinion leaders in primary care, family practice, nursing, advance practice nursing, midwifery, obstetrics and gynecology, and pediatrics.

Abstracts of the Month

Do you offer obstetric delivery at your facility? Or do you have an on-call schedule of any type? Please consider these two topics on practice style.

Improving Competency in the Management of Shoulder Dystocia with Simulation Training.

Objective. To determine whether a simulation training improves resident competency in the management of shoulder dystocia.

Methods. Residents from two training programs participated in this study. The residents were block-randomized by year-group to a training session on shoulder dystocia management that used an obstetric birthing simulator or to a control group with no specific training. Trained residents and control subjects were subsequently tested on a standardized shoulder dystocia scenario, and the encounters were digitally recorded. A physician grader from an external institution then graded and rated the residents' performance with a standardized evaluation sheet. Statistical analysis included the Student t test, chi^2, and regression analysis, as appropriate.

Results. Trained residents had significantly higher scores in all evaluation categories, including timelines of their interventions, performance of maneuvers, and overall performance. They also performed the delivery in a shorter time than control subjects (61 versus 146 seconds, P =.003).

Conclusion. Training with a simulation training scenario improved performance in the management of shoulder dystocia (Level of evidence: I)

Reference: Deering S. Improving resident competency in the management of shoulder dystocia with simulation training. *Obstet Gynecol.* 2004 Jun;103(6):1224-8. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=15172856&dopt=Abstract.*

OB/GYN CCC Editorial comment. This Level I study raises an important point and begs the question of another. Shoulder dystocia is a rare and potentially devastating problem that often presents without warning, even in low risk settings. This study shows the value of individual provider training. Another excellent example is the Advanced Life Support in Obstetrics (ALSO) Provider Course (visit *http://www.aafp.org/also.xml)*

The second related issue is how your team, or facility, reacts to emergency situations. You may have the best trained individual at the bedside, but she/he cannot always succeed alone. It is best to be part of a fully functional team with shared objectives.

This issue will be specifically addressed at the 2004 Native American Maternity Care conference (see above). There will be lectures and workshops on how facilities and teams can develop successful simulations and responses to these types of infrequent emergencies, whether they be obstetric, or of any other type. It is highly recommended that a small team of nurses and providers from your facility attend this meeting.

Middle-aged Women, Regardless of Ovarian Function, Experienced Greater Sleep Disturbance than Do Younger Controls.

Objective. To distinguish aging from menopause effects on sleep architecture, we studied an episode of disturbed hospital sleep in asymptomatic midlife women during the follicular phase of an ovulatory cycle and three control groups differing by age or menopause status.

Methods. Fifty-one studies were conducted in four groups of volunteers: young cycling (YC, 20-30 years, n = 14), older cycling (OC, 40-50 years, n = 15), ovariectomized receiving estrogen therapy (OVX, 40-50 years, n = 12), and spontaneously postmenopausal (PM, 40-50 years, n = 10). Subjects were admitted to the University Hospital General Clinical Research Center (GCRC) for a first-night sleep study conducted during a 24-hour, frequent blood sampling protocol.

Results. Despite similar estrogen concentrations in the YC (28 +/- 4 pg/ml) and OC (34 +/- 6 pg/ml) groups, OC women had reduced sleep efficiency (79% +/- 2%) vs. YC (87% +/- 3%; p = 0.009). In the OVX and PM groups, where estrogen concentrations were markedly different, sleep efficiency was also reduced vs. the YC group (OVX vs. YC, 79% +/- 3% vs. 87% +/- 3%, p = 0.05; PM vs. YC, 75% +/- 3% vs. 87% +/- 3%, p = 0.007). Wake time was longer in the three older groups (103 +/- 10 minutes, 101 +/- 12 minutes, 123 +/- 12 minutes for OC, OVX, PM, respectively) vs. YC (63 +/- 13 minutes, $p < 0.05$). The number of stage shifts was positively associated with advancing age (rho = 0.3, $p < 0.03$) but not with estrogen concentration.

Conclusions. Aging-related sleep deficits in response to an experimental stressor occur in midlife women prior to menopause.

Reference: Lukacs JL, Chilimigras JL, Cannon JR, Dormire SL, Reame NE. Midlife women's responses to a hospital sleep challenge: aging and menopause effects on sleep architecture. *Womens Health* (Larchmt). 2004 Apr;13(3):333-40. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15130262*.

OB/GYN CCC Editorial comment. Lukacs, et al point out some of the effects of stressors on effective sleep. I would also submit that anyone who is cared for, works along-side, or lives with sleep deprived staff of any age or gender, are similarly impacted in ways both subtle, and not so subtle.

The best approach to on-call scheduling is a topic of never-ending debate. Each method should seek to balance quality of care, preservation of the circadian rhythm, and one's life outside the workplace. Should we perform 24 hour shifts? Twelve hour shifts? Eight hour shifts? The data on this topic are vast, although in many cases, staffing decisions are supported by "cherry picking" those articles that seem to best fit individual lifestyles.

This will be another topic at the 2004 Native Maternity Care and Women's Health meeting. Please let us know how you have successfully solved this perennial issue, or not.

From Your Colleagues

From Yolanda Meza, Anchorage

Centering or group prenatal visits: Exciting prenatal management program. Centering is an exciting model of care that we have started utilizing at ANMC and SCF's Women's Clinic within the last year, but it had been utilized at Phoenix Indian Medical Center for quite a while before we started. It is called "Centering" or group prenatal care. There is a national/international organization created and run by Sharon Rising CNM, MSN. If you care to look at the great resources and support offered to providers using the model, go to *http://centeringpregnancy.org/.*

From Chuck North, Albuquerque

Making Evidence-base Medicine Doable in Everyday Practice, by Brandi White. This article is very readable and has excellent references and live links. Go to *http://www.aafp.org/fpm/20040200/51maki.html*

Understanding the Risks of Medical Interventions

You are reviewing a recent lipid panel on John, a 50-year-old man who has been following an exercise and diet program since you discovered a high cholesterol level at his wellness physical six months ago. John's total cholesterol has gone from 315 to 280, his HDL from 40 to 45 and his LDL from 205 to 185. John's wife read an ad in a magazine about a cholesterol-lowering medication that will reduce the risk of heart attack by 30 percent, so he asks you about taking it. What will you tell him?

To start, you will certainly evaluate John's other heart attack risk factors – smoking status, hypertension, family history, and diabetes – but it will also help if you can explain to John and his wife what this 30 percent risk reduction actually means. To do that, you need to understand how risks are calculated. Here are 3 simple methods: *http://www.aafp.org/fpm/20000500/59unde.html*

Evidence-based Obstetrics and Gynecology

Evidence-based Obstetrics and Gynecology helps clinicians to combine the best external evidence from systematic research with individual clinical expertise to make effective decisions about patient treatment and care. For each issue, key articles are selected from the literature and reviewed in the form of a structured abstract and expert commentary. It is in a concise and easy-to-read format. Most reviews are 1 - 2 pages long, not unlike a Cochrane Database Abstract.

A sample issue is available online. Go to *http://www.harcourt-international.com/journals/ebog/.* From the journal's home page above, click on the area along the left border that says "Latest issue, contents and abstracts now available" with the Science Direct logo. On the right-hand side of the page that opens, click on "sample issue online" located below the picture of the journal. On that page click on "Volume 6, Issue one." You will have full-text access to all the articles in that issue. Navigation directions are thanks to Anne Girling, ANMC Librarian, *agirling@anmc.org.*

From Richard Olson, HQE

American Indian and Alaska Native Health Care Needs: Papers sought. The American Journal of Public Health (AJPH), in collaboration with the Henry J. Kaiser Family Foundation, is planning to publish a collection of papers on how the United States can more effectively meet the health care needs of American Indians and Alaska Natives. Deadline to submit is September 1, 2004; apply at *http://submit.ajph.org/.*

From Judy Thierry, HQE

Prenatal classes: What are you doing? Dr. Thierry is interested in learning what you are doing for prenatal classes. What works well and what doesn't work well? Dr. Thierry will collate all the great ideas she hears and get the best practices back to you. Please contact *Judith.Thierry@ihs.gov.*

Hot Topics

Obstetrics

New Perinatology Corner Module available: Syphilis in Pregnancy. Free CME/CEUs available that address the recent increase in syphilis in Indian Country. Go to *http://www.ihs.gov/MedicalPrograms/MCH/M/syphpreg.cfm*

Glucose challenge thresholds > 180 mg/dL are NOT DIAGNOSTIC FOR GDM — Predictive value for GDM only 50%. Data suggest that an elevated glucose challenge test result cannot be used as a single diagnostic tool for gestational diabetes mellitus (GDM) even using high test thresholds. An elevated glucose challenge test result increases the risk of GDM, but even using high glucose challenge test thresholds (more than 180 mg/dL), the predictive value for GDM was only 50%. A threshold of 130 mg/dL may be recommended as a screening threshold for GDM in Mexican-American women. Level of evidence: II-3. Yogev Y, Langer O, Xenakis EM, Rosenn B. Glucose screening in Mexican-American women. *Obstet Gynecol*. 2004 Jun;103(6):1241-1245. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=15172859&dopt=Abstract.*

OB/GYN CCC Editorial comment. A small number of centers have developed practices whereby pregnant patients with glucose challenge levels > 185 - 200 mg/dL are automatically diagnosed and managed as if they actually had GDM without a 3 hour 100gm OGTT. This process of automatically converting a *screening* test result into a *diagnostic* test result has not been borne out well in the evidence. It can lead to many incorrect diagnoses, as pointed out by Yogev above, and is akin to starting radiation therapy for the presumed diagnosis of cervical cancer based solely on a single Pap smear screen.

We iatrogenically expose our patients with gestational diabetes to higher rates of cesarean delivery testing, regardless of birth weight and obstetric outcome, simply based on the diagnosis GDM alone (Naylor). If that GDM diagnosis was incorrect from the outset, there is also the needless discomfort of frequent, ongoing daily capillary blood glucose determinations and numerous other interventions. *http://www.ihs.gov/MedicalPrograms/MCH/M/DP04.asp#top.* (See below: What about screening glucose levels of >185 mg/dL or > 200 mg/dL?)

Gynecology

Test Your Women's Health IQ . . .. (Answers Below)

Questions:

1. Do you know the number one killer of women?
2. Do you know the leading cause of cancer death for women?
3. What is the greatest health epidemic currently facing our nation?
4. True or False? Teenage boys are more likely to smoke than teenage girls.

Answers

1. *Heart disease.* The condition accounted for almost 54 percent of all women's deaths in 2001. According to a recent issue of *Newsweek*, which contained several articles on women's health, a survey by the American Heart Association found that only 13 percent of women consider heart disease their greatest health risk and just over one third say they have spoken with their doctor about heart disease.
2. *Lung cancer* is the leading cause of cancer death for all women, although breast cancer kills more women ages 35 to 44.
3. *Obesity* has reached epidemic proportions, as the majority of Americans are either overweight or obese. Obesity is the second leading cause of preventable death in the U.S. For women, being overweight is associated with a greater risk of developing heart disease, certain cancers, and a number of chronic conditions including diabetes. According to the CDC, physical inactivity, a major contributing factor to obesity, is more common among women than men.
4. *False.* Girls and boys smoke at about the same rate, and one in four high school girls is a current smoker. However, girls are more likely to report that they have tried to quit than boys and are more likely to be successful at quitting when their smoking cessation programs include social support from family and peers.

Source: National Women's Law Center's E-Update. Go to *http://www.nwlc.org/details.cfm?id=1752§ion=infocenter.*

Primary Care Discussion Forum

Next topic: Adult Asthma. On August 1, 2004, thanks to Charles (Ty) Reidhead, Whiteriver, we will start an Adult Asthma discussion. This topic is a special request from the Council of Clinical Directors. Dr. Reidhead is the IHS Internal Medicine Chief Clinical Consultant and will moderate a discussion that uses evidence-based practice to improve patient outcomes for this common problem in Indian country. Also see the summary of the AAP/Indian Health Special Interest Group discussion at *http://www.ihs.gov/generalweb/webapps/sitelink/site.asp?link=http://www.aap.org/nach/asthmasummary.htm.*

Other Coming Topics:

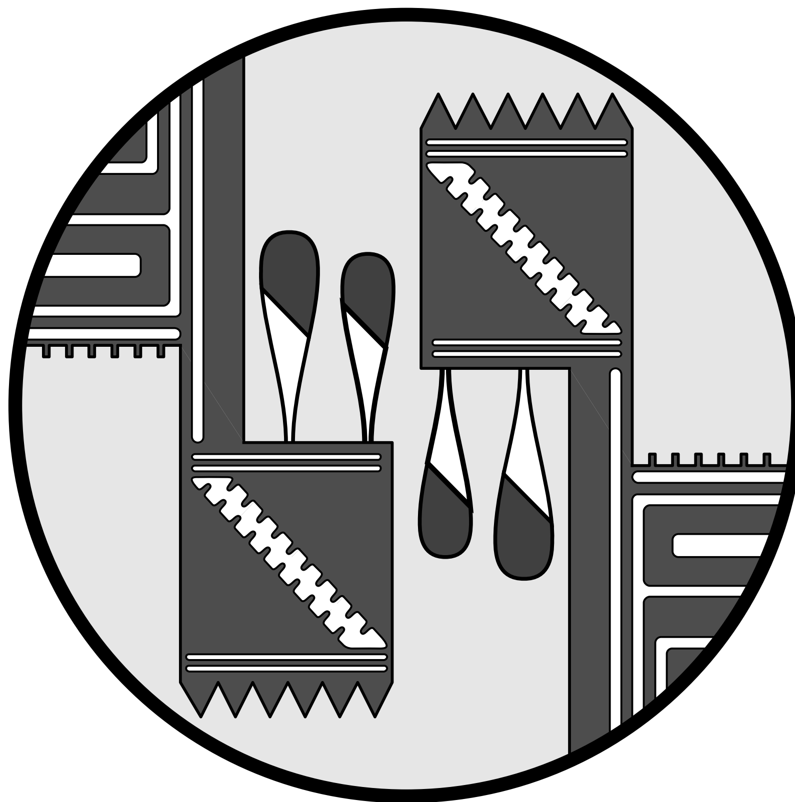
November 1, 2004: Violence against Native Women. Moderator, Terry Cullen. This discussion will include the scope of violence against Native women, tools for patient evaluation, best practice policies and procedures, plus ideas about available resources.

Just Wrapping Up: Adolescent Risk Taking Behavior. On May 1, 2004, Donna Perry in Chinle, began moderating a discussion of Adolescent Risk Taking Behavior on the Primary Care Discussion Forum. This will be a combined listserv discussion with the Indian Health Special Interest Group of the AAP. The Discussion is captured online at *http://www.ihs.gov/medicalprograms/MCH/M/documents/ADODisc6904.doc*. The summary is presented at *http://www.ihs.gov/medicalprograms/MCH/M/documents/ADOSumm6904.doc*

An excerpt of the summary and references are as follows: . . . We have some challenges. I would suggest we consider more adolescent topics at our local, regional, and national meetings. This would be a place for dialogue, increasing our skills, and planning more standardized approaches given our constraints on resources. We need to share programs that work in our communities. We can develop outcomes measures that will help us plan for improving care in our communities. A recent supplement to the journal *Pediatrics* discussed how to measure effectiveness of adolescent health care. How can we apply that to our communities? For those who have school-based or school-linked clinics, IHS headquarters is developing a discussion and work group in which we can participate. We can also commiserate in our struggle to provide increasingly accessible teen health care.

References: A January 2004 supplement to the journal *Pediatrics* 113(1) is focused on measuring the quality of children's health care as a key step in quality improvement. Extensive quality problems have been documented across all sectors of health services for children and adolescents. For example, problems persist in asthma care, well-child and adolescent care, childhood immunization rates, and sexually transmitted disease screening for adolescents. Many other problems in children's health care delivery are not being adequately measured and monitored. See *http://www.ahrq.gov/research/apr04/0404RA15.htm#head1*

To subscribe to the Primary Care Discussion Forum, go to *www.ihs.gov/MedicalPrograms/MCH/M/MCHdiscuss.asp* and click the word "subscribe" in the first paragraph, or contact me, *nmurphy@anmc.org.*



LETTER TO THE EDITOR ☐

Cultural Practices and Breastfeeding

Editor,

I read with interest Carol Dahozy's article, "Cultural Practices and Beliefs of Birth and Death of Southwest Native American Tribes." Given Ms. Dahozy's statement that, "freezing breastmilk is taboo as it takes the life out of the milk," how would she suggest counseling new mothers about pumping and storing their milk in preparation for returning to work? Most of our families require two wage-earners just to get by, so staying home to nurse simply isn't an option. Most local employers don't offer benefits to allow for more than several weeks of paid leave, if any paid leave is offered at all. Thereafter, most mothers switch to formula if they are not educated about the option of giving babies expressed breastmilk.

In the 13 years I've practiced at our facility, I've not become aware of the belief that freezing breastmilk is taboo. In fact, most women with whom I speak seem pleasantly surprised that they can continue offering the benefits of breastfeeding to their babies even if they can't always be physically present to nurse. Obviously, more than education impacts any mother's decision to breastfeed and to continue pumping after her return to work. Family and community supports, like other older, more experienced women who have successfully breastfed their own children, as well as the attitudes of fathers and employers regarding breastfeeding, often determine whether women will breastfeed and whether they have lasting and positive experiences. Offering a breast pump at discharge or at the early discharge follow-up appointment (generally within 48 hours of discharge), after discussing feeding practice options during pregnancy, we are in a position to positively impact the health of our children by significantly extending the time that babies consume breastmilk.

The positive effects of breastfeeding continue to be enumerated in the literature. Can we approach this taboo belief with modern research that unequivocally shows that freezing does not "take the life out of breastmilk"? What other strategies can be employed to assure sustained breastmilk feeding in our Native American populations? I welcome the comments of Ms. Dahozy and any others who might offer information to the providers whose charge it is to help promote and sustain health for our people in a culturally-sensitve manner.

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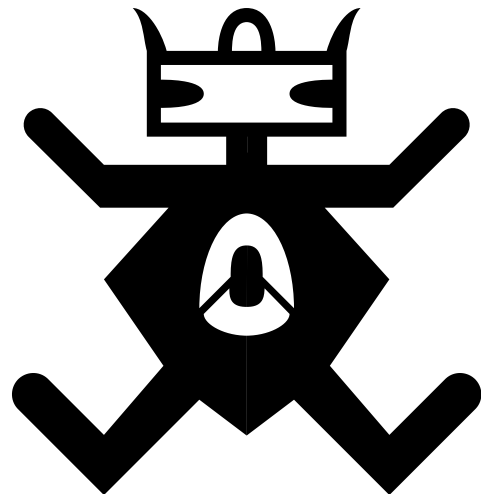


This a page for sharing "what works" as seen in the published literature as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

A Pitch to Join the Indian Health Special Interest Group of the American Academy of Pediatrics (AAP)

As a federal employee you are limited in how you may lobby Congress. Fortunately, the AAP, through its Indian Health Special Interest Group is able to lobby effectively for Indian health needs. You don't need to be a pediatrician to join. Membership is open to anyone who provides health care to children.

If you are already a member of the AAP, the membership fee to join the AAP Section on Community Pediatrics (the umbrella group for the Indian Health Special Interest Group) is $35. If you are not eligible for membership to the AAP, you may become a Section Affiliate Member for $60. For specific instructions about joining, please send an e-mail to Sunnah Kim at *skim@aap.org*. As a special incentive to anyone (pediatrician or nonpediatrician) who is new to the Indian Health Service or to a 638 facility in the past five years, membership is currently being offered *free*. Membership benefits include the following: the opportunity to participate in a dialogue through an e-mail listserv; bimonthly facilitated discussions on topics related to Indian health; and informational e-mail updates on current news, funding opportunities, and resources relating to AI/AN healthcare. If you have any questions, contact Sunnah Kim at *skim@aap.org*.

Another resource available through the AAP is the Committee on Native American Child Health (CONACH). This is a standing committee of the Academy that also lobbies Congress for Native American health needs. In addition, they provide technical support on health issues facing American Indians and Alaskan Natives. Lastly they can serve as a clearinghouse to provide *locum tenens* coverage to IHS or 638 sites that need temporary pediatric coverage.

The home page for the Committee on Native American Child Health is *http://www.aap.org/nach/*.

CONACH has also developed several important technical reports on issues relating to Native American health. These include the following:

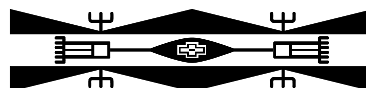
- *Prevention and Treatment of Type 2 Diabetes Mellitus in Children with Special Emphasis on American Indian and Alaska Native Children* was published in October 2003. *http://aappolicy.aappublications.org/cgi/reprint/pediatrics;112/4/e328.pdf*.
- *Ethical Considerations in Undertaking Community Based Medical Research with Vulnerable Populations* was published in January 2004. *http://aappolicy.aappublications.org/cgi/reprint/pediatrics;113/1/148.pdf*.
- *The Prevention of Unintentional Injury Among American Indian Alaska Native Children: A Subject Review* was developed with the Committee on Injury and Poison Prevention, and published in December 2002. *http://aappolicy.aappublications.org/cgi/reprint/pediatrics;104/6/1397.pdf*.
- *Immunizations for Native Americans* was issued jointly with the Committee on Infectious Diseases in September 1999. It contains an excellent summary of the increased risk and the need for particular attention to immunizations in American Indian and Alaska Natives. *http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/3/564*.

Lastly, CONACH runs a website for *locum tenens* pediatricians. As an IHS/638 site, you can post your need for a *locum tenens* pediatrician at *http://www.aap.org/nach/locumtenens.htm*.

Meetings of Interest for Child Health

Adolescent Health Issues in Indian Health; School-Based Health; Sexually Transmitted Diseases; Contraception, and more . . .. These are all available at the Biennial IHS, Tribal, and Urban (ITU) Meeting on Women's Health and Maternity Care, August 4 - 6, 2004 in Albuquerque, New Mexico. Go to *http://www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004*; or contact Neil Murphy, MD for information at *nmurphy@anmc.org*.

International Meeting on Inuit and Native American Child Health, April 29 - May 1, 2005, Seattle, Washington. Visit *www.aap.org/nach* for additional information.



Notes from the Elder Care Initiative

Geriatrics at Your Fingertips Available Online and for PDA FREE

The American Geriatrics Society clinical handbook, *Geriatrics at Your Fingertips* is available online and for PDA/handheld, free of charge. The online and PDA versions of the print pocket-sized clinical reference are designed for medical providers (nurses, physicians, physician assistants, advanced practice nurses) with lots of tables, charts, and formulary information to help in the care of the older patient. Find the online *Geriatrics at Your Fingertips* or download the PDA version at *www.geriatricsatyourfingertips.org*.

Palliative Care Resource for Hospitals and Clinics

The Center to Advance Palliative Care (CAPC) is dedicated to increasing the availability of quality palliative care services in hospitals and other health care settings for people with life-threatening illnesses, their families, and caregivers. A national initiative supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by the Mount Sinai School of Medicine (NY), CAPC provides health care professionals with the tools, training, and technical assistance necessary to start and sustain successful palliative care programs.

At their website, *www.capc.org,* you will find, among other valuable information, the 2004 Crosswalk of JCAHO Standards and Palliative Care, developed to provide hospitals with the policy and administrative foundation for delivering palliative care services that are consistent with JCAHO standards.

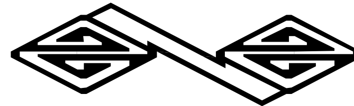
From the Literature

Bone HG, et al. Ten years' experience with alendronate for osteoporosis in postmenopausal women. *N Engl J Med*. 2004Mar18,350:1189-99.

This study reports on the ten year follow-up of 247 postmenopausal women with osteoporosis treated with the bisphosphonate agent alendronate (Fosamax). They were initially part of a larger cohort in a placebo controlled treatment trial reported at three years. This group of women has been followed to evaluate for continued response to alendronate and adverse effects. Women were divided into three branches, those who had five years of treatment and discontinued, those treated with 5 mg a day for ten years, and those treated with 10 mg a day for ten years. The findings were as follows:

- Bone mineral density (BMD) increased in a dose-dependent fashion throughout the treatment period for those treated for ten years, remaining within the normal range.
- Those women treated for five years and discontinued preserved some of their BMD gains after discontinuation but did not experience further increase.
- No insufficiency fractures or fracture malunions were reported, indicating that the bone developed in the presence of the bisphosphonate was functioning normally.
- Adverse effects attributable to the medication were minimal and did not differ between the three groups.

We already know from a number of studies that bisphosphonate treatment for women with low bone mineral density (T-score of less than 2.5, or two standard deviations below the mean for healthy young women) is effective in preventing fracture. This descriptive study suggests that long term treatment with alendronate is safe and effective and that we can carry treatment out at least ten years without concern.



Conferences and Training Opportunities

Prevention in Native Women, August 4 - 6, 2004 in Albuquerque, New Mexico, includes the topics of Preventive Care for Older Women and Osteoporosis. If you care for Native women of any age, then you should attend if you are a physician, advanced practice nurse, physician assistant, or nurse. There will be an internationally known faculty. Information is available at *www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004*.

The annual UCLA Intensive Course in Geriatric Medicine and Board Review will be held September 29 - October 2, 2004 in Marina del Rey, California. This is an excellent, comprehensive review with faculty who are national leaders in geriatrics. It is the perfect course for a primary care clinician willing to serve as the local geriatrics consultant or interested in developing specialty services for elders. There is a highly discounted registration fee for Indian health providers. For conference information and registration, contact Mr. Minh Q. Ly, telephone (310) 312-0531; fax (310) 312-0546; e-mail *mly@mednet.ucla.edu*. For information about the Indian health discounted conference rate, contact Dr. Bruce Finke at *bruce.finke@mail.ihs.gov*.

To subscribe to this monthly e-mail newsletter, subscribe to the Eldercare listserv. Instructions are available at *http://www.ihs.gov/cio/listserver/index.cfm*.

Office-Based Opioid Treatment Course Available

The Indian Health Service and the American Osteopathic Academy of Addiction Medicine are offering an eight-hour course on Office-Based Treatment of Opioid Dependence with Buprenorphine. This activity is recommended for primary care, pain management, psychiatric, HIV, and addiction medicine physicians. Other professionals are also invited but will not be eligible for the waiver.

The Drug Addiction Treatment Act of 2000 permits physicians who are trained or experienced in opioid addiction treatment to obtain waivers to prescribe certain narcotic drugs in Schedules III, IV, or V of the Controlled Substances Act, in their office practices or in a clinic setting, for the treatment of opioid dependence. Both buprenorphine and the combination of buprenorphine with naloxone are approved by the FDA for use in detoxification and maintenance treatment of opioid dependence. To obtain the waiver, physicians without specified experience must complete not less than eight hours of training. Physicians who complete this course will meet the training requirements under the new law and will receive a certificate of attendance suitable to send to the Secretary of HHS along with the request for the waiver. If you give AOAAM permission to do so, AOAAM will report your name directly to the Secretary of HHS within four weeks of the program, thus eliminating the need for you to send the certificate of attendance.

Continuing Medical Education

This program is sponsored by the American Osteopathic Academy of Addiction Medicine (AOAAM) and anticipates being approved for 8 AOA Category 1-A CME credit hours pending approval by the AOA CCME. It is also approved by the AAFP for 8 hours of Prescribed Credit. It is supported the Indian Health Service and the Centers for Substance Abuse Treatment.

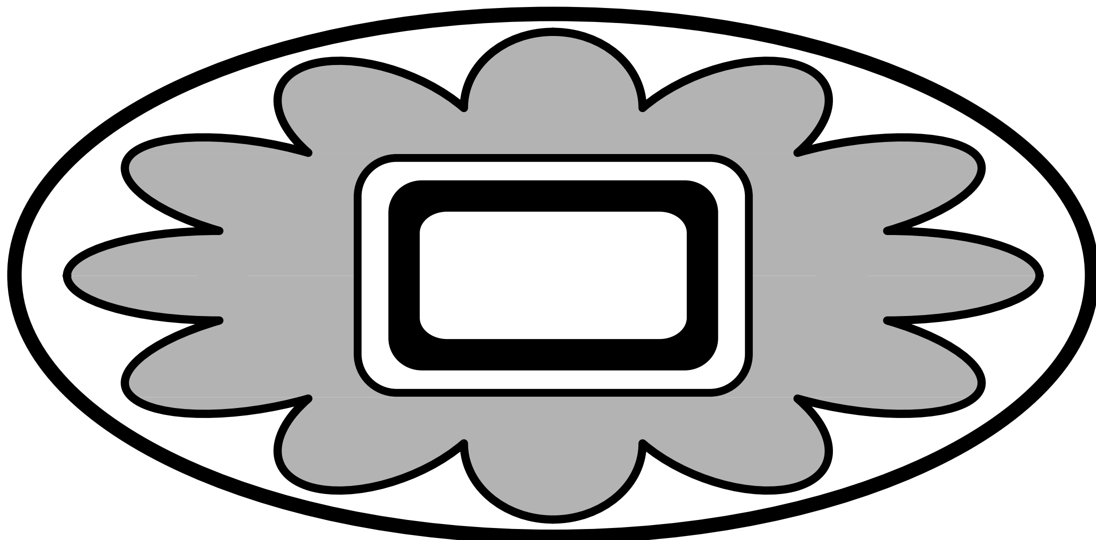
Program Goals

After attending this session participants will be able to:

- Describe prerequisites for a physician to begin to prescribe buprenorphine in office-based practice.
- Discuss clinically relevant pharmacological characteristics of buprenorphine.
- Identify factors to consider in determining if a patient is an appropriate candidate for office-based treatment.
- Describe induction and maintenance protocols.
- Discuss strategies for integrating psychosocial care with office-based pharmacological treatment.
- Discuss treatment strategies for management of chronic and acute pain in patients in maintenance treatment for opioid dependence.

Program Registration

The course will be held August 13, 2004 from 7:30 am to 5:30 pm at the Tacoma (Washington) Sheraton. IHS scholarships are available. Contact the IHS Clinical Support Center at (602) 364-7777 to register.



Correction

What's Up With All the Antibiotics for Pharyngitis?

In Figure 1 on page 85 of the April 2004 issue of *The Provider* (Volume 29, Number 4), there was a small but significant error. When evaluating an adult, if you find that 2 to 4 Centor criteria have been met and you do an RADT, if it is negative, you *do not need to do a throat culture*. For your convenience, the corrected figure is reproduced here; you may copy it and mount it over the incorrect table published in the April issue.

Figure 1. Acute Pharyngitis: Group A Streptococcus (GAS) vs. Viral Pharyngitis

Children

Do rapid antigen detection test (RADT) for GAS

If Positive	**If Negative**
GAS	Viral
Antibiotics	No Antibiotic
Symptomatic tx	Symptomatic tx
TC not needed	Do TC and treat if positive

Adults

Apply Centor Criteria

- History of fever
- No cough
- Tonsillar exudate
- Tender anterior cervical adenopathy

Patients with 0 to 1 criteria = no lab testing and no antibiotics
Patients with 2 to 4 criteria = **do RADT**

Positive	**Negative**
GAS	Viral
Antibiotics	No Antibiotic
Symptomatic tx	Symptomatic tx
TC not needed	TC not needed

Penicillin treatment of choice:

- Pen VK 250 mg B.I.D. or T.I.D. (< 12 years old) X 10 days)
- Pen VK 500 mg B.I.D. (≥ 12 years old) X 10 days)
- LA Bicillin 600,000 units < 27 kg or 1.2 million units if ≥ 27 kg

Erythromycin if penicillin allergic:

- Children = erythromycin 40 mg/kg/day (÷ B.I.D. or T.I.D.) up to maximum daily dose of 1000 mg X 10 days
- Adults = erythromycin 500 mg (delayed release) B.I.D. X 10 days

Retreatment of GAS:

- Children = clindamycin 20 to 30 mg/kg/day (÷ T.I.D.) X 10 days **or** augmentin 40 mg/kg/day (÷ B.I.D. or T.I.D.) X 10 days
- Adults = clindamycin 600 mg/day (÷ B.I.D. or T.I.D.) X 10 days **or** augmentin 500 mg B.I.D. X 10 days
- Adults = LA Bicillin 1.2 million units plus oral rifampin 20 mg/kg/day (÷ B.I.D.) up to maximum daily dose of 600 mg X 4 days

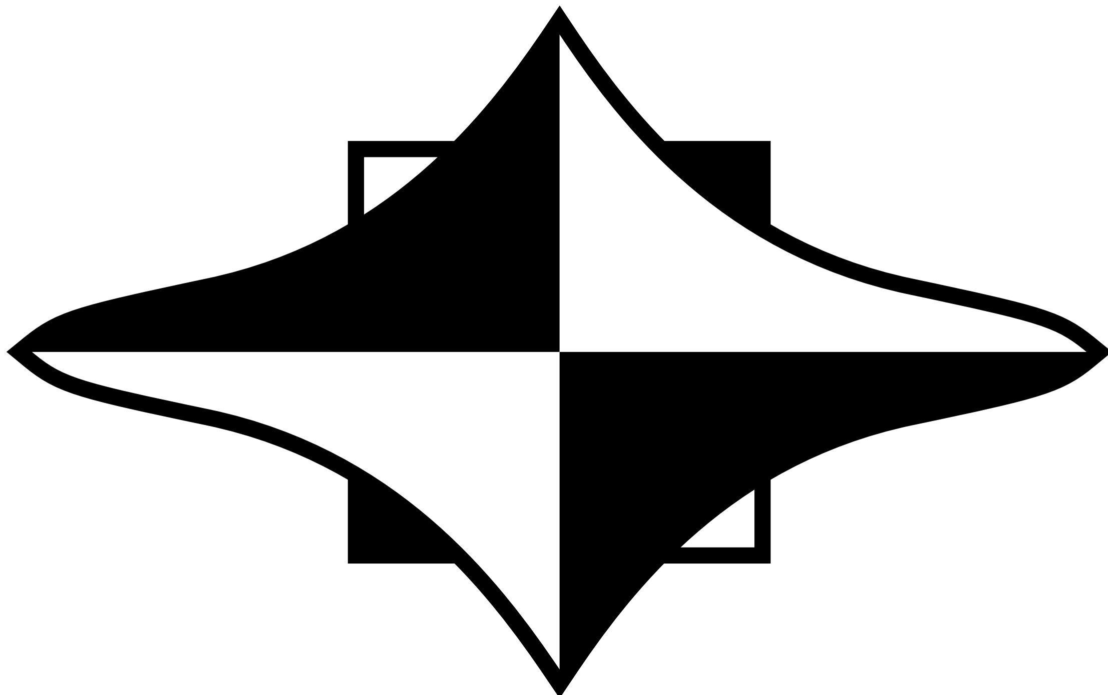
Broad spectrum antibiotics, extended spectrum macrolides and fluoroquinolones are inappropriate for GAS

Although less critical, errors were also found in Table 1 (page 83), and the corrected version of that table is also presented here, as well.

Table 1. Antibiotics Prescribed (335 prescriptions)

Antibiotic	Frequency	Percent	Cost/Dose Children	vs Adults
Pen VK	99	30%	$ 0.15	$ 0.15
Amoxicillin	77	23%	0.03	0.05
Azithromycin	56	17%	3.50	4.10
LA Bicillin	52	16%	3.90	2.87
Erythromycin	14	4%	0.16	0.05
Cephalexin	13	4%	0.05	0.04
Amoxicillin/clavulanate	11	3%	2.25	3.20
Ceftriaxone	6	2%	14.97	23.15
Cefuroxime axetil	3	1%	1.75	8.04
TMP/SMX	1	<1%	0.01	0.01
Cefaclor	1	<1%	0.46	2.84
Cefazolin	1	<1%	2.06	1.67
Doxycycline	1	<1%	0.08	0.03

- 335 antibiotics prescribed
- Four people received two antibiotics
- Cost per dose according to VA pricing to IHS pharmacies as of March 2004



American Indian Health: a New National Library of Medicine Website

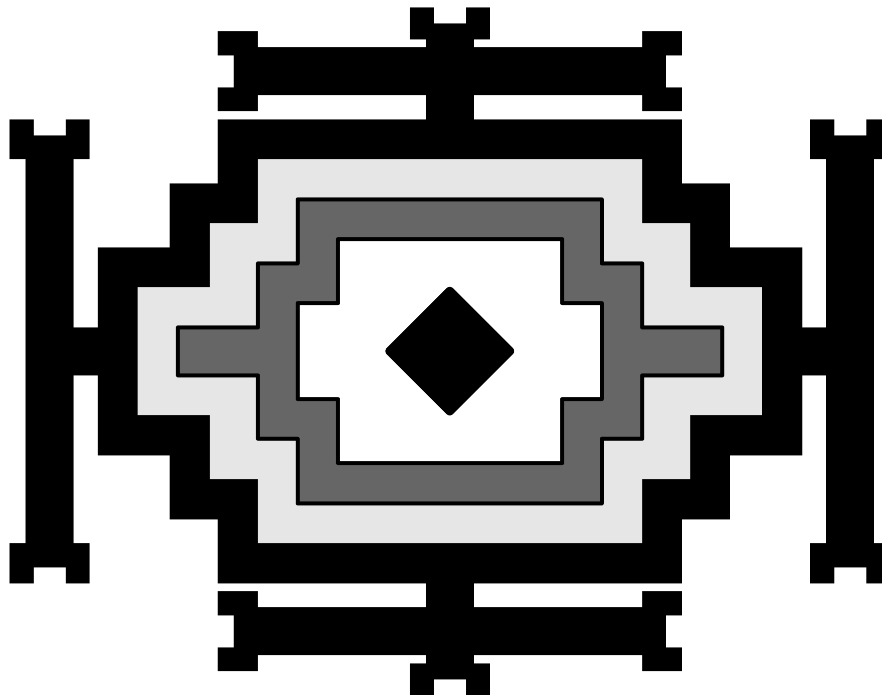
The National Library of Medicine, a part of the National Institutes of Health, announces a new website to address the health concerns of the four million Americans who claim American Indian or Alaska Native ancestry. The site, "American Indian Health," is at *http://americanindianhealth.nlm.nih.gov.*

Because special populations have different health needs, the Library has created several specialized sites, for example, for Asian Americans, those living in the Arctic and far north, senior citizens, and Spanish-speaking Americans. (These are all available from *http://www.nlm.nih.gov/databases.*)

American Indian Health addresses the special needs of this population. Research shows that Native Americans are 2.6 times more likely to have diabetes as non-Hispanic whites of a similar age. American Indians also have a greater mortality risk for tuberculosis, suicide, pneumonia, alcoholism, and influenza than the general population.

American Indian Health brings together pertinent health and medical resources, including consumer health information, the results of research, traditional healing resources, and links to other websites. Much of the information has been assembled from other National Library of Medicine resources, such as PubMed and MedlinePlus.

"The National Library of Medicine is interested in reaching out to populations with special needs," said Donald A.B. Lindberg, MD, Library director. He notes that, for Native Americans, the NLM has a history of attending local powwows and making health information available during those events. The National Library of Medicine, the world's largest library of the health sciences, is a component of the National Institutes of Health, U.S. Department of Health and Human Services.



Women's Health and Maternity Care Biennial IHS, Tribal, and Urban (ITU) Meeting
August 4 - 6, 2004; Albuquerque, New Mexico

The biennial IHS, tribal, and urban (ITU) Women's Health and Maternity Care Meeting is offered for all physicians, nurses, nurse practitioners, nurse midwives, and physician assistants providing care at Indian health system facilities. Medical students and residents who are interested in serving these populations are also welcome. This year's theme is "Prevention and Health Promotion in Native Women."

Topics will include domestic violence; low risk vaginal birth after Cesarean; breastfeeding; emergency delivery: strategies for the whole team; use of HPV and DNA testing; hormone replacement risks; Navajo birthing practices; mental illness in women: relationship to childhood abuse; polycystic ovarian syndrome and insulin resistance; osteoporosis in Indian country; syphilis and HIV in Indian country; urinary incontinence; pessary use; prenatal diagnosis; school based care; adolescent health; perineal repair; preterm labor controversies; cardiovascular disease in women; Internet resources; and case studies in abnormal Pap management.

The meeting will be held at the Holiday Inn Mountain View Hotel, 2020 Menaul, NE, Albuquerque, New Mexico 87107; telephone (505) 884-2511; fax (505) 881-4806. All room rates are subject to state and local taxes, which are currently 10.8125%. The special conference room rates are $55.00 single or double occupancy. The deadline is July 21, 2004.

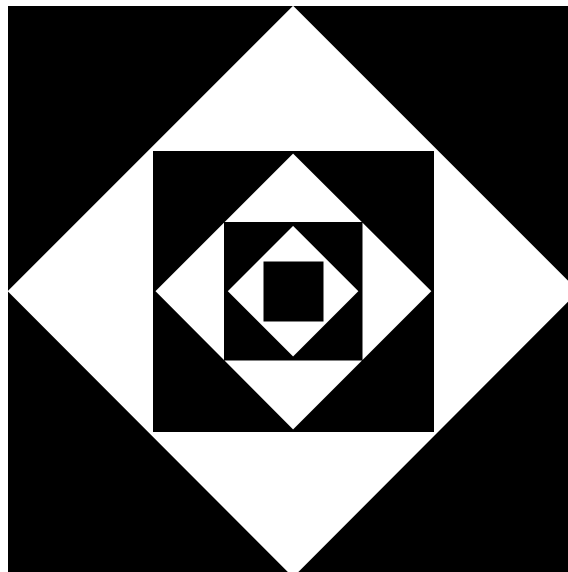
The registration fee will be payable by check, credit card, or institutional purchase order. The brochure is available on the UNM CME website at *http://hsc.unm.edu/cme*. For additional information please contact the University of New Mexico Office of Continuing Medical Education at (505) 272-3942.

IHS Information Technology Fair
August 23 - 27, 2004; Scottsdale, Arizona

This notice is to inform you of the upcoming Indian Health Service Information Technology Fair in Scottsdale, Arizona. This meeting is slated for August 23 - 27, 2004. The theme of the meeting will be "An Electronic Health Record for the Indian Health Service." Topics will include the IHS Electronic Health Record Project, a clinical automation track, RPMS applications and support, HIPPA, security, Self-Governance, workload and user population reporting, data warehouse project, cache conversion, National Help Desk Support, wide area networks and e-mail, wireless technology, and emergency preparedness and continuity planning.

The Indian Health Service (IHS) Clinical Support Center is the accredited sponsor of this activity. The IHS Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The IHS Clinical Support Center is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center Commission on Accreditation.

The host facility is the Doubletree Hotel, Scottsdale, Arizona; telephone (800) 359-5672. For more information, go to *http://www.ihs.gov/adminMngrResources/techconf/*.



Sixth National Conference on Changing Patterns of Cancer in Native Communities
September 9 - 12, 2004; Phoenix, Arizona

Subtitled "Honoring Our Native Families from Prevention to Cure," this conference will focus on cancer epidemiology, control, and survival among Native populations. The goal is to evaluate progress in prevention of cancer in Native groups and in the early diagnosis, treatment, and survival of Native people diagnosed with cancer. The target audience for the conference will be community members, advocates, researchers, clinicians, and other health service providers working with Native populations: American Indians, Alaska Natives, American Samoans, and Native Hawaiians.

Featured topics will include Survivorship, Prevention, Early Detection and Screening, Cultural Sensitivity, Tobacco Issues, Traditional Diet, Men's Cancer Issues, Navigator System, Community Partnerships, and Understanding Cancer Statistics and Registries. Featured Speakers include Wilma Mankiller (Cherokee Nation); Dr. James Hampton (Medical Director, Troy and Dollie Smith Cancer Center); Charles Wiggins (Utah Cancer Registry); Linda Burhansstipanov (Native American Cancer Research; and Marc Heyison (Men Against Breast Cancer).

Hosted by Spirit of Eagles, the conference will be held at the Wild Horse Pass Resort and Spa. For more information, contact the conference planning committee at (877) 372-1617; e-mail: *nativecircle@mayo.edu*; or visit the website at *www.mayo.edu/leadershipinitiative*.

IHS Indian Health Summit
September 22 - 24, 2004; Washington, DC

The First Americans Festival of the National Museum of the American Indian in Washington, DC will celebrate the history and contributions of more the 500 Native Nations across the Americas. The future health of these Nation will be the focus of the Healthier Indian Communities through Partnerships and Prevention Summit Meeting sponsored by the Indian Health Service. The IHS Indian Health Summit will focus on past, present, and future directions of health promotion and disease prevention for American Indians/Alaska Natives. This 2 1/2 day summit is planned to begin the afternoon of Wednesday, September 22 and conclude the afternoon of Friday, September 24, 2004.

The goals of the summit are 1) to create and expand partnerships (federal and non-federal) that will result in enhanced resources for Indian people; 2) to share best practices being implemented in Indian country regarding community and clinical health promotion/disease prevention that will ultimately improve the health status of the AI/AN population; and 3) to demonstrate the agency's commitment to health promotion/disease prevention (HP/DP) to eliminate health disparities.

The target audiences for the summit are DHHS and federal agency employees, tribal leaders, community health leaders, health program coordinators, community members, university partners, foundations, and private corporations. It is estimated there will be 500-750 individuals in attendance. A call for abstracts, poster presentations, and exhibits will be made in the coming months. The IHS Clinical Support Center is the accredited sponsor.

The summit host site is the Renaissance Washington, DC Hotel located at 999 9th Street NW, Washington, D.C., 20001. A room block for the rate of $150.00 plus tax has been arranged for September 22 - 24, 2004 (conference days), and reservations can be made by calling the Renaissance Hotel directly at (202) 898-9000, or via the Internet at *www.renaissancehotels.com/WASRB*. In order to accommodate participants wishing to attend the festivities at the opening of the National Museum of the American Indian, an additional room block has been arranged for those needing overnight accommodations on September 20 and 21, 2004 (pre-conference) at the Homewood Suites Hilton located at 1475 Massachusetts Avenue, NW, Washington, DC 20005. Rates for the Homewood Suite Hilton are $179.00 plus tax. Reservations can be made by calling the Homewood Suites Hilton directly at (202) 265-8000.

Kauffman & Associates, Inc. (KAI) has been awarded a contract to coordinate the Summit. Further information, including an on-line registration form, will be available soon at the IHS HP/DP website at *www.ihs.gov/hpdp/*. For immediate assistance, contact Barbara Aragon, KAI Project Manager, at 425 West 1st Avenue, Spokane, WA 99201-3706; telephone (509) 747-4994; fax (509) 747-5030; or e-mail *Barbara@kauffmaninc.com*. Alternatively, you may contact Alberta Becenti, IHS Office of Public Health, at (301) 443-3024.

2004 Conference on Health Care and Domestic Violence: Health Consequences Over the Lifespan
October 21 - 23, 2004; Boston, Massachusetts

The Family Violence Prevention Fund's (FVPF) National Health Resource Center on Domestic Violence's national conference on Health Care and Domestic Violence will be held October 21 - 23, 2004 in Boston, Massachusetts. This conference provides valuable professional education on the latest research and innovative health care prevention and clinical responses to domestic violence for all health care professionals, including physicians, dentists, nurses, physician assistants, dental hygienists, mental and behavioral health providers, social workers, researchers, domestic violence advocates, alternative health care providers, public health personnel, health care administrators, health policy makers, students, victims/survivors, and others.

The theme of the Third National Conference is *Health Care and Domestic Violence: Health Consequences Over the Lifespan*. Domestic Violence is a health care issue of epidemic proportions in the United States. In addition to posing immediate, acute health consequences, intimate partner violence (IPV) is a significant factor for poor health behaviors that can lead to chronic health problems. Many victims will see a health care provider for regular exams, specific health problems, or for the care of children, elders, and/or other dependants. Therefore, working in conjunction with other systems and domestic violence advocates, health care professionals are in a unique position to respond to domestic violence.

Eleven pre-conference courses will be offered on October 21. One will focus specifically on domestic violence within AI/AN communities and will address how health care providers and institutions can improve their response to domestic violence by adopting "best practice" clinical guidelines. Drawing from a national IHS/ACF Domestic Violence initiative with nine I/T/U health care facilities, the multi-disciplinary team of faculty and experts will discuss their particular approaches to serving AI/AN communities using clinical guidelines and locally-developed educational materials.

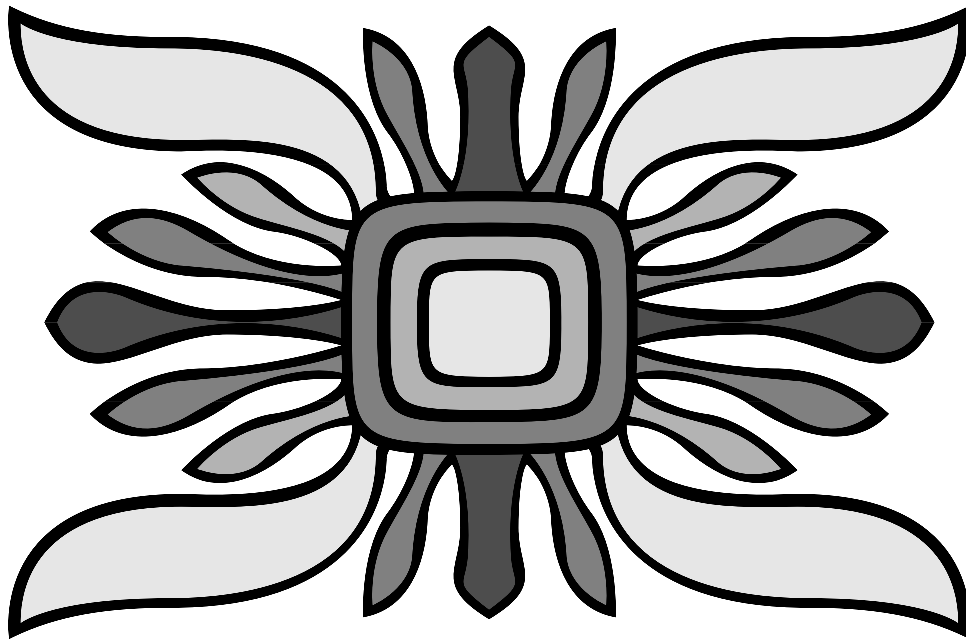
Continuing medical education (CME) credits will be offered to physicians. The FVPF has been approved to offer continuing education credits for psychologists. The FVPF is pursuing continuing education credits for registered nurses and social workers. Registration opens May 15, 2004; go to *www.endabuse.org/health/conference*.

Also, the 13th conference of the Nursing Network on Violence Against Women International (NNVAWI) will be held immediately following the FVPF's conference, October 24-26, 2004 at the Boston Park Plaza Hotel. The NNVAWI was formed to encourage the development of clinical practice that focuses on the health issues relating to the effects of violence in women's lives. For registration and more information, see *www.nnvawi.org*.

International Meeting on Inuit and Native American Child Health: Innovations in Clinical Care and Research Combined with the 17th Annual IHS Research Conference April 29 - May 1, 2005; Seattle, Washington

Join the American Academy of Pediatrics and the Canadian Paediatric Society, in cooperation with the Indian Health Service, for the first ever International Meeting on Inuit and Native American Child Health. Pediatricians, family physicians, residents, other health care professionals, clinical researchers, state and federal public health employees, child advocates, and other professionals and family representatives dedicated to working with First Nations, Inuit, and American Indian/Alaska Native (AI/AN) children should attend. Participants will have the opportunity to share ideas on culturally effective health care delivery models, present research findings, and discuss strategies to improve the health of First Nations, Inuit, and AI/AN children and communities.

For current conference information, visit *www.aap.org/nach*.



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.*

Medstar Research Institute
Chinle, Arizona

Medstar Research Institute is seeking an adult nurse practitioner to work in its Chinle location to help run a research project and act as a clinical coordinator. Duties will include but will not be limited to: assure adherence to good clinical practices for direct patient care and study protocols; review documents as required and prepare patient reports; responsible for multiple projects and must work both independently and in a team environment; must be computer literate with proficiency in MS office. Occasional travel expected. Navajo language skills and research experience in clinical research a plus.

For consideration please call (928) 214-3920 or go to *www.medstarresearch.org*. EOE.

Physician Assistant or Nurse Practitioner/Medical Director
Kake, Alaska

Physician assistant or family nurse practitioner needed for Kake Health Center, staffed by two midlevel practitioners and three community health practitioners. A physician from the referral hospital in Sitka visits approximately every eight weeks. The position is full time, with excellent CME and other benefits. The position is 80% direct patient care, 20% medical oversight of clinic staff.

Kake is an island community of 800 people, 45 minutes by air from Juneau and Sitka. Hunting, fishing, and outdoor recreation opportunities abound. Yearly temperatures range from 60 - 70 degrees in summer to 30 - 40 degrees in winter. Transportation is by small aircraft or the state ferry system. The community is a mix of Native and non-Native, with good K - 12 schools. The economy is predominately fishing, timber, and tourism.

If you are interested, please contact Steve Gage, PA-C, CHAP Director, at (907) 966-8779; or e-mail *steve.gage@searhc.org*. To learn more about the Southeast Alaska Regional Health Consortium (SEARHC), see our website at *http://www.searhc.org*.

Physician Assistant or Nurse Practitioner
Klawock, Alaska

Physician assistant or nurse practitioner needed for Alicia Roberts Medical Center (ARMC) in Klawock, Alaska. ARMC is staffed with two physicians and three midlevel practitioners, and a full complement of nursing and medical assistants, onsite pharmacist, moderate complexity laboratory, and teleradiology. The position is a full time clinical one, with excellent CME and other benefits. The clinic serves as a regional clinic for Prince of Wales Island.

Klawock is located on Prince of Wales Island, approximately 45 minutes by aircraft to Ketchikan, or three hours by daily ferry service. Outdoor opportunities are abundant for deep-sea salmon and halibut fishing, fly fishing for steelhead trout, cold water diving, caving, kayaking, sailing, or hiking the many developed trails. Excellent school system. Economy is predominantly commercial and sports fishing, timber, and tourism.

If you are interested, please contact Kari Lundgren, PA-C, Asst. Medical Director, at (907) 966-8465; or e-mail *kari.lundgren@searhc.org*. To learn more about the Southeast Alaska Regional Health Consortium (SEARHC), see our website at *http://www.searhc.org*.

Family Practice Physician
Chapa-De Indian Health Program; Auburn, California

Chapa-De Indian Health Program, Inc. is seeking a Board Certified/Board Eligible Family Practice Physician to provide outpatient and hospital care to Native Americans and the general public. This is a full-time position. Hospital call is shared with four other Fps. Chapa-De offers medical, dental, behavioral health, and integrative medicine services on site. This is an excellent opportunity to join a well-established group practice in a beautiful and centrally located setting. Auburn is located in the Sierra Foothills within two hours" drive of Lake Tahoe and San Francisco.

Benefit package includes competitive salary, retirement plan, malpractice coverage, paid vacation, health and disability insurance, CME allowance, and paid holidays. There is also an opportunity for loan repayment. For more information, send CV to Darla Clark, Clinical Administrator, Chapa-De Indian Health Program, 11670 Atwood Rd, Auburn, CA 95603; or fax to (530) 887-2849.

Child/Adolescent/Adult Psychiatrist
Gallup Indian Medical Center; Gallup, New Mexico

The Gallup Indian Medical Center Behavioral Health Clinic is seeking a child/adolescent/adult psychiatrist to work with three psychiatrists, three psychologists, one nurse, four social workers, one substance-abuse counselor, one child mental health specialist, and one mental health

technician. Offer includes NHSC-approved scholarship payback and loan repayment. Located in spacious, scenic, four-season northwestern New Mexico, just on the edge of the Navajo Reservation. Contact K.R. Guy, MD at (505) 722-1125.

Physicians, Dentists, Physician Assistants, and Nurse Practitioners
Cherokee Nation; Northeastern Oklahoma

The Cherokee Nation, located in Tahlequah, Oklahoma, is currently seeking full-time health professionals for rural ambulatory care clinics. The Cherokee Nation offers competitive salaries, excellent benefits, loan repayment options, no weekends, and no call. For a current list of job opportunities, log on to the internet at *www.cherokee.org*.

Submit a completed Cherokee Nation employment application along with copies of degrees and or certificates to Cherokee Nation Human Resources, Attn: Loretta McNac, P.O. Box 948, Tahlequah, Oklahoma 74465; telephone (918) 456-0671, extension 2600; fax (918) 458-6125; or e-mail *lmcnac@cherokee.org*.

Applicants claiming Indian preference must submit a copy of their Certificate Degree of Indian Blood (CDIB) with their application. Applicants will be required to pass a pre- employment drug screen and complete a background check.

Family Physician/Nurse Practitioner
Indian Family Health Clinic; Great Falls, Montana

The Indian Family Health Clinic is seeking a part-time family physician and/or nurse practitioner. The incumbent will be responsible for providing primary and episodic (non- emergency) care to a large and diverse urban Indian population in north central Montana. We are looking for an energetic and creative candidate with skills and experience that will contribute to our efforts to protect and improve the health of the local community. This will be a new position joining two nurse practitioners currently in the clinic. The IFHC has been operating for five years and includes a medical clinic, diabetes program, behavioral health/substance abuse programs, and an on-site fitness/wellness center. Please contact Katie Pellett, APRN, NP (*kpellett@3nvers.net*) or D. J. Lott, Executive Director (*d_j_lott@indianfamilyhealth.org*) for additional information, or call us at (406) 268-1510.

Family Practice Physician
Winslow Indian Health Care Center; Winslow, Arizona

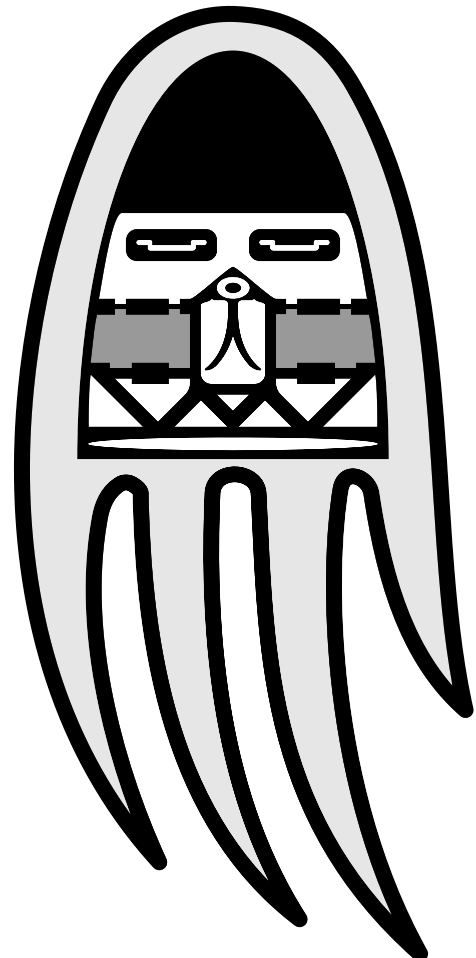
The Winslow Indian Health Care Center (WIHCC) is seeking BC/BE family physicians for an exciting full-scope practice including ambulatory care, UCC/ER coverage, inpatient services, and obstetrics. Located in spacious, scenic, four-season northern Arizona close to Flagstaff and just on the edge of the Navajo Reservation, WIHCC is an Indian Self Determination 638 facility with excellent salary and benefits. Our stable, congenial medical staff includes several physicians with 10-20 plus years of experience at Winslow. WIHCC, and its two field clinics at Dilkon and Leupp, offer NHSC-approved scholarship payback and loan repayment.

Contact Frank Armao at (928) 289-6233; or e-mail *frank.armao@winslow.ihs.gov*.

Psychiatric Nurse Practitioner
Winslow Indian Health Care Center; Winslow, Arizona

The Winslow Indian Health Care Center is seeking a Psychiatric Nurse Practitioner to work with two psychiatrists, four social workers, and a substance abuse counselor on our community behavioral health care team. WIHCC is a 638 facility located in scenic, spacious northern Arizona, close to Flagstaff and the Navajo Reservation, with excellent salary/ benefits.

Contact Frank Armao at (928) 289-6233; or e-mail *frank.armao@winslow.ihs.gov*.



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THE IHS PRIMARY CARE PROVIDER

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

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