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An Introduction to Insulin Pens

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Introduction

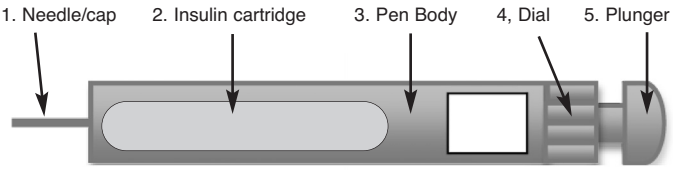
There have been significant improvements in the technology of insulin development and insulin delivery since it was first administered on January 23, 1922 using a needle and glass syringe at Toronto General Hospital. Today, it is estimated that approximately five million Americans use insulin in the management of diabetes, and based on data from the Indian Health Service (IHS) Diabetes Audit, insulin is used by approximately 25% of American Indians and Alaska Natives.

Insulin is a protein that cannot be administered orally as a tablet or liquid because it will be digested in the gastrointestinal tract before reaching the blood stream. Currently, insulin is administered using either a vial and syringe, insulin pen, jet injector, or insulin pump. Inhaled insulin was recently released as a product called Exubera®, but was removed from the market in October 2007 due to poor sales. Additional studies on inhaled insulin as a dry powder and aerosol are being conducted, as well as investigations into the development of an insulin patch and an ultrasound delivery device.

The vial and syringe is the most common delivery method of insulin in the United States, while insulin pens have become the primary delivery method in Europe and Japan.[1] Insulin pen use in the United States has increased from 7% in 1999 to 14% in 2001,[2] compared with greater increases in Europe (157%) and in Japan (456%). Low usage rates of insulin pens in the US may be related to unfamiliarity of the benefits associated with insulin pens or a perception of increased costs associate with insulin pen use. The goal of this article is discuss these issues and to provide a brief overview of the insulin pen.

Overview of Insulin Pens

Figure 1. Insulin pens are composed of five main parts



Insulin pen devices fall into two primary categories: disposable and reusable. To use most insulin pens, patients will rotate the dial to select the number of units of insulin that are to be administered. The amount of insulin is displayed just below the dial. The cap is removed from the needle and the needle is inserted into the skin. Insulin is administered by pushing the plunger. The needle should be left in for about 5 - 6 seconds after injecting the insulin to ensure administration of a complete dose.

Benefits of Insulin Pens

1. *Accuracy*: Insulin pens have many features that facilitate accurate dosing, including audible clicks when the dose is dialed, single- or half-unit dosing increments, clear dials showing the selected dose, and automatic zeroing after administration. Many studies have concluded that insulin pens provide more accurate dosing than conventional vial and syringe delivery.[3,4]

In this Issue...

2. *Convenience and Confidence*: Since they are discreet and portable, and have extremely short needles, pens increase the social acceptability of insulin use and are usually preferred to vial and syringe delivery.[4] Patients using a pen have expressed greater confidence in their ability to achieve glycemic control.[5]
3. *Improved Quality of Life and Acceptance*: Use of insulin pens has demonstrated increased patient acceptance and participation in the treatment plan.[6] A questionnaire-based study showed that patients preferred an insulin pen device for convenience, flexibility, and quality of life; insulin-naive patients reported the greatest preference for pens.[7]

Insulin Pen Cost considerations

1. *Acquisition cost*: Insulin cost is the most commonly stated barrier to the procurement of insulin pens. Examining only the acquisition cost per unit of insulin, based on IHS pricing in 2008, pen insulin cost is greater than the cost of vial insulin (see Table 1). However, this misrepresents the cost implications to IHS of a decision to use vial or pen insulin.
2. *Wastage*: For most insulin preparations, any remainder must be discarded 28 days (exceptions to the 28 day in-use shelf life rule are Detemir (Levemir®): 42 days; Humalog® premix pens: 10 days; and Novolog® premix pens: 14 days) after the stopper is first punctured. Thus, low daily doses can result in considerable wastage. For example, glargine has the greatest extra cost for using pens. A patient using 10 units of glargine daily will use 280 units per 28 days. Using vials, 720 units will be discarded, and cost is $27.88 per 28 days. Using pens, 20 units will be discarded and 28-day cost is $19.93; this affords a saving of $7.95 (29%) for the insulin pen. The actual cost difference depends on the pricing and the doses used.
3. *Needles*: A basal-bolus regimen commonly uses four injections daily, or 96 per 28 days. In 2008, 98 insulin syringe-needle units cost the IHS $4.03, while 98 pen needles cost $7.50.
4. *Special cost issues in institutional settings*:
   a. Using pens will generally reduce nursing time for preparation of the injection.[8,9]
   b. Frequent changes of regimen and short inpatient stays may exaggerate the wastage, increasing the cost savings of using pens.
   c. Pen needles represent less hazardous medical waste for disposal, compared to syringes
5. *Changes in resource utilization*: Patients tend to have greater confidence when using pens and take a more active role in their care. This can reduce both hyperglycemia and hypoglycemia, resulting in fewer visits to clinic and emergency departments.

Cost analyses considering all effects on the health care system, including secondary effects, have generally shown a net cost saving from a switch to insulin delivery via pens.

Other Issues to Consider when Using Insulin Pens

1. *Acceptance*: Although insulin pen devices represent a potentially easier approach to insulin delivery, not all patients will openly accept pen devices. Some patients using insulin vials will prefer to maintain their current method of insulin delivery due to their historical level of comfort. As with any device, non-familiarity with insulin pens coupled with the patient's anxiety and "learning curve" during the syringe-to-pen transition will require an additional time commitment from the diabetes care team. However, the majority of the literature documenting patient preference following transition clearly favors pen device utilization.[4,5,6]
2. *Multiple injections for large doses*: Pen device design presents a limiting factor for patients requiring large individual doses of insulin. Most insulin pens sold in the US have a maximum capacity for insulin delivery of 60-80 units per injection, compared to 100 units for syringes.[10] Patients with insulin requirements exceeding the pen device threshold may require an increased number of daily injections; however, this inconvenience would only pertain to thos patients using more than 80 units, but less than 100 units, per injection.

Table 1. Cost comparison of insulin pens and vials, based on 1,000 units of insulin

Costs and differences per 1,000 units					In-use storage (days)
Insulin product	**10 ml Vial**	**3 ml Pen**	**$ Difference**	**% comparison**	
glulisine (Apidra®)	$44.60	$59.80	$15.20	134%	28
lispro (Humalog®)	$44.36	$50.40	$6.04	114%	28
aspart (Novolog®)	$24.02	$22.76	$3.74	95%	28
glargine (Lantus®)	$27.88	$66.44	$38.56	238%	28
detemir (Levemir®)	$15.29	$26.50	$11.21	173%	42

3. *Appropriate administration technique*: Users must be aware of appropriate insulin pen administration techniques[9]:
    a. The insulin pen must be primed.
    b. Injection time - the mechanism of forcing insulin through small gauge syringe tips creates a pressure gradient which requires prolonged subcutaneous insertion to ensure complete delivery of the desired insulin. Patients will need to be informed that it generally takes 5 seconds after pressing the plunger to make sure the complete insulin dose is injected.
    c. Remove the needle from the cartridge after the injection to prevent passage of undesired air into the insulin reservoir. Unwanted air backfilling the insulin container (by failure to remove the needle between injections) could result in a dosing error.[4,11,12]

Conclusions

Insulin pens provide patients with a number of advantages over a vial and syringe. Some of these advantages can help overcome the major barriers to initiating insulin therapy. Insulin pens are accurate, convenient, and discreet. Insulin pens improve patient satisfaction, fostering increased patient participation in the treatment plan. The increased pharmacy acquisition cost per unit is offset to a variable degree by reduced wastage. Examined from a systems perspective, decreases in overall resource utilization (fewer visits to physician offices, clinics, and emergency departments; fewer hospitalizations; reduced staff time; reduced hazardous waste; and others) with pen utilization have been found to result in a net savings.

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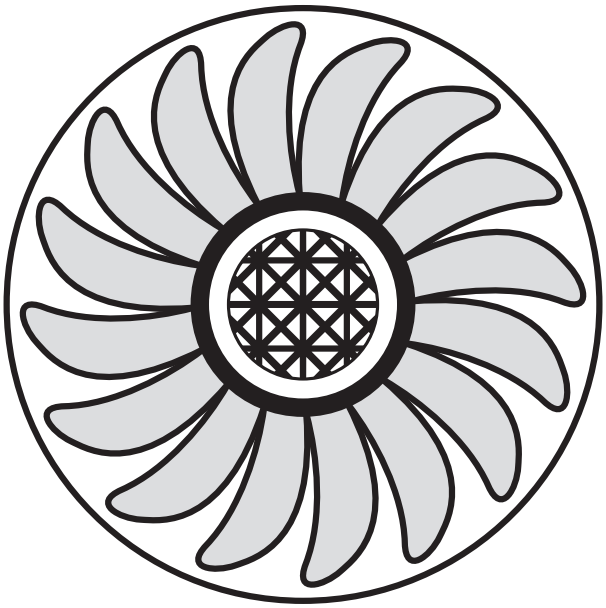

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"The function of the imagination is not to make strange things settled, so much as to make settled things strange."

G. K. Chesterton

Article of Interest

Universal screening for hearing loss in newborns: US Preventive Services Task Force. *Pediatrics*. 2008 Jul;122(1):143-8. *http://pediatrics.aappublications.org/cgi/content/full/122/1/143*

The USPSTF recommends screening for hearing loss in all newborn infants, stating that there is a high certainty that the net benefit is moderate to substantial. This follows on the recommendations of the Joint Committee on Infant Hearing that first recommended newborn hearing screening in 2000.

It is estimated that 1 - 3/1,000 live born infants have significant congenital hearing loss. Previous efforts with targeted screening of high-risk newborns missed over 50% of affected infants, leading to the new recommendation for universal screening. Most programs involve a two-step process in which the first screen is an otoacoustic emission test, and follow-up is done by auditory brainstem response. This procedure yields a screening sensitivity of 0.92 and a specificity of 0.98

There is also substantial evidence that early identification of and intervention for hearing loss before six months of age will result in marked benefits. Children who receive timely intervention services perform 20 - 40 percentile points higher in vocabulary, social adjustment, and behavior at eight years of age. Intervention can include augmentation devices, cochlear implants, or acquisition of sign language.

Editorial Comment

Since the first recommendation in 2000 that infants be screened for hearing loss, the percentage of infants screened at birth has increased from 38% up to 95%. However, almost half of children who fail their first screen do not receive appropriate or timely follow-up care. Ensuring that all infants receive timely intervention is now our greatest challenge in newborn hearing screening. Reviewing the results of newborn hearing screening should be a part of the two-week and six-week well child care visit.

Recent literature on American Indian/Alaskan Native Health

Michael L. Bartholomew, MD

Wood D, Winterbauer N, Sloyer P, et al. A longitudinal study of a pediatric practice-based versus an agency-based model of care coordination for children and youth with special health care needs. *Matern Child Health J*. 2008. *http://www.ncbi.nlm.nih.gov/pubmed/18766431?ordinalpos=4&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum*

Children with special health care needs (CSHCN) is defined as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amounts beyond that required by children generally."[1] Recent estimates indicate that CSHCN account for approximately 14% of all US children (10.2 million) and roughly 70% of all health care expenditures.[1,2] The American Academy of Pediatrics defines the characteristics of the medical home as a primary care delivery model that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[3] Care coordination, as a part of the medical home model, has been proven to be a vital piece of any integrated health services system for CSHCN. Positive outcomes such as patient satisfaction, reduced health care costs, reduced delay in care, and fewer hospitalizations have all been shown to be related to care coordination and the medical home model.[1] In 2008, Robert McSwain, Director of the Indian Health Service, included the development of a "medical home" in his vision statement for improving the health care for patients."[4] Currently, tribal clinics and service units are advancing towards care coordination and the establishment of a medical home.

This prospective cohort study compares agency-based care coordination with practice-based models for CSHCN. Three pediatric practices that utilize an agency-based model of care coordination were compared to three practices that utilize nurse care coordination and received medical home training. Families of CSHCN were monitored over 18 months through baseline and follow-up surveys. Families rated four care coordination measures: 1) help with needed services, 2) support from the care coordinator, 3) satisfaction with care

coordination services, and 4) barriers to getting health services.

Additionally, parents rated pediatric services including treatment by the office staff, communication with the pediatrician, partnering in decision-making, and connecting to outside resources. Parents with higher scale scores at follow-up than at baseline were classified as "improved" whereas scores lower or equal scores at follow-up were labeled as "not improved."

Although practice-based care coordination showed no significant difference in mean change of scores between baseline and follow-up for the four care coordination measures, it had higher percentages of "improved" scores than did the agency based model. Of the ratings of pediatric services, practice based care coordination had a higher percentage of "improved" in one measure (treatment by office staff), while the percentages in the remaining measures were similar.

Despite the study's limitations (transient target population, lack of randomization, and combination of the medical home training and practice-based care coordination in the participating practices possibly influencing favorable responses), the authors conclude that practice-base care coordination leads to increased family satisfaction with the quality of care and the reduction of barriers to care for CSHCN.

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The Chief Clinical Consultant's Newsletter (Volume 6, No. 8, August 2008) is available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Estimation of HIV incidence in the United States

Context: Incidence of human immunodeficiency virus (HIV) in the United States has not been directly measured. New assays that differentiate recent vs. long-standing HIV infections allow improved estimation of HIV incidence.

Objective: To estimate HIV incidence in the US.

Design, Setting, and Patients: Remnant diagnostic serum specimens from patients 13 years or older and newly diagnosed with HIV during 2006 in 22 states were tested with the BED HIV-1 capture enzyme immunoassay to classify infections as recent or long-standing. Information on HIV cases was reported to the Centers for Disease Control and Prevention through June 2007. Incidence of HIV in the 22 states during 2006 was estimated using a statistical approach with adjustment for testing frequency and extrapolated to the US. Results were corroborated with back-calculation of HIV incidence for 1977 - 2006 based on HIV diagnoses from 40 states and AIDS incidence from 50 states and the District of Columbia.

Main Outcome Measure: Estimated HIV incidence.

Results: An estimated 39,400 persons were diagnosed with HIV in 2006 in the 22 states. Of 6864 diagnostic specimens tested using the BED assay, 2133 (31%) were classified as recent infections. Based on extrapolations from these data, the estimated number of new infections for the US in 2006 was 56,300 (95% confidence interval [CI], 48,200-64,500); the estimated incidence rate was 22.8 per 100,000 population (95% CI, 19.5-26.1). Forty-five percent of infections were among black individuals and 53% among men who have sex with men. The back-calculation (n = 1.230 million HIV/AIDS cases reported by the end of 2006) yielded an estimate of 55,400 (95% CI, 50,000-60,800) new infections per year for 2003 - 2006 and indicated that HIV incidence increased in the mid-1990s, then slightly declined after 1999 and has been stable thereafter.

Conclusions: This study provides the first direct estimates of HIV incidence in the US using laboratory technologies previously implemented only in clinic-based settings. New HIV infections in the US remain concentrated among men who have sex with men and among black individuals.

Hall HI, Song R, Rhodes P, et al. HIV Incidence Surveillance Group. Estimation of HIV incidence in the United States. *JAMA*. 2008 Aug 6;300(5):520-9. *http://www.ncbi.nlm.nih.gov/pubmed/18677024*

OB/GYN CCC Editorial comment

Jean E. Howe, MD, MPH

The above study was undertaken utilizing new technology that allows differentiation of recently acquired HIV infection from longstanding infection. By testing serum from recently diagnosed patients collected in 22 states in 2006, the authors were able to provide a more accurate estimate of the number of newly acquired cases of HIV per year in the US than had previously been available. Sadly, where the previous estimate of new infections was approximately 40,000 per year in the US, this study demonstrates that the number of newly acquired cases in 2006 was closer to 56,300 and the incidence rate was 22.8 per 100,000 population. Some 45% of new cases were in African-Americans and 53% were in men who have sex with men.

This study includes updated estimates of rates of new HIV cases for specific populations:

Total	22.8 per 100,000		
Gender		Race/Ethnicity	
Male	34.3 per 100,000	African Amer.	83.7 per 100,000
Female	11.9 per 100,000	Hispanic	29.3 per 100,000
		Amer. Indian/ Alaska Native	14.6 per 100,000
Age		White	11.5 per 100,000
13-29	26.6 per 100,000	Asian/Pac Isl.	10.3 per 100,000
30-39	42.6 per 100,000		
40-49	30.7 per 100,000		
50-99	6.5 per 100,000		

Although the number of HIV/AIDS cases in American Indians and Alaska Natives (AI/AN) represents less than 1% of the total number of US cases, when population size is considered, the rate of diagnosis for AI/AN ranks third overall. The CDC has recently updated the "HIV/AIDS among American Indians and Alaska Natives" Fact Sheet. Data presented include the following:

- From the beginning of the epidemic through 2005, AIDS was diagnosed in an estimated 3,238 AI/AN.
- Women accounted for 29% of the HIV/AIDS cases among AI/AN.
- Transmission categories for AI/AN men were:

61%	Male-to-male sexual contact
15%	Injection Drug Use
13%	Male-to-male sexual contact and injection drug use
10%	High-risk heterosexual contact
1%	Other

- Transmission categories for American Indian/Alaska Native women were:

68%	High-Risk Heterosexual Contact
29%	Injection Drug Use
2%	Other

The fact sheet also addresses several risk factors that may affect risks for transmission of HIV and barriers to testing for AI/AN. The full fact sheet can be viewed at *http://www.cdc.gov/hiv/resources/factsheets/PDF/aian.pdf*.

As fully one-quarter of Americans of all races with HIV are unaware of their HIV status, and as people aware of their status are less likely to transmit the infection to others, widespread HIV testing is now the national standard of care for adolescents and adults ages 13 to 64 in the US. The CDC recommends:

For patients in all health care settings:

- HIV screening is recommended for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health care settings.

For pregnant women:

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain settings with elevated rates of HIV infection among pregnant women.

The full CDC recommendations for HIV screening are available at *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm*

ACOG has now officially endorsed routine screening for women ages 19 to 64 and targeted screening outside of this age group. Simultaneously, ACOG issued a second Committee Opinion emphasizing the increased risk women of color face for acquiring HIV, primarily through heterosexual contact with a partner with undisclosed risk factors.

Both the CDC and ACOG recommend "opt-out" screening with verbal or written consent. Many states have updated their legal requirements for HIV screening to facilitate opt-out screening with verbal consent. A state-by-state summary of HIV testing laws is now available through the National HIV/AIDS Clinicians' Consultation Center of the University of California San Francisco and San Francisco General Hospital. The compendium, updated regularly, can be found at *http://www.nccc.ucsf.edu/StateLaws*.

Does your worksite routinely offer HIV screening to all adolescents and adults? Is HIV screening routinely included with other prenatal labs unless the pregnant woman declines such testing? A study conducted by the CDC/IHS Epidemiology and Disease Prevention Center in Albuquerque reports that prenatal HIV screening at IHS sites increased from 54% in 2005 to 74% in 2007 but also demonstrated many opportunities to improve both screening and documentation of test results. For more information about this study, please see the report from Brigg Reilley in the August issue of *The IHS Primary Care Provider* at *http://www.ihs.gov/Publicinfo/Publications/HealthProvider/issues/PROV0808.pdf*.

The IHS has an HIV program that is run by Scott Giberson. He can be reached at *Scott.Giberson@ihs.gov*.

Centers for Disease Control. CDC HIV/AIDS Fact Sheet; HIV/AIDS among American Indians and Alaska Natives. Updated, August 2008. *http://www.cdc.gov/hiv/resources/factsheets/PDF/aian.pdf*

Centers for Disease Control. MMWR Recommendations and Reports; Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. September 22, 2006 / 55(RR14);1-17 *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm*

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David Gahn, Kabul, Afghanistan

Afghanistan Update: Assistant Secretary for Health ADM Joxel Garcia, MD, FACOG visits Kabul

In July, our Assistant Secretary for Health, ADM Joxel Garcia, spent four days in Kabul with the IHS team. Dr. Garcia spent an entire day at Rabia Balkhi Hospital, the primary focus of our efforts, and also spent time at other health care facilities in Kabul to get a close-up view of the obstacles and opportunities HHS faces. Dr. Garcia, a board certified Ob/Gyn, got a good look at the systems in place and spent time interacting with the patients and hospital staff. Dr. Garcia's primary objective is to coordinate HHS' efforts in Afghanistan, as many of our agencies our involved. Through meetings with the Afghanistan Ministry of Public Health, the US Ambassador to Afghanistan, the US Department of Defense, and the US Agency for International Development Mission Director, Dr. Garcia has brought all the players to the table together as the US Government completes a comprehensive health strategy for supporting our health diplomacy and humanitarian missions in Afghanistan.

The IHS Clinical Team, composed of CDR David Gahn (Ob/Gyn, Tahlequah), CAPT Pat O'Connor (Peds, Tuba City), CDR Mei Castor (Med Epi, Seattle), and LCDR James Dickens (FNP, Dallas CMS), spent six weeks working with the hospital staff in various aspects of clinical care. CDR Gahn and LCDR Dickens focused on surgical skills with the physicians and nurses and CAPT O'Connor focused on newborn care. CDR Castor completed a preliminary Patient Outcome Assessment (POA) where, with a team of Rabia Balkhi physicians, she tracked 26 patients from admission to discharge with further follow-up post discharge pending. Her work is in preparation for a comprehensive POA schedule for the month of October where the team will track every obstetrics patient that presents at Rabia Balkhi for the entire month collecting data on all the systems involved in patient care. These data will continue to guide us as we develop the Ob/Gyn Residency Program and work on the other hospital systems.

The team is scheduled for another six week deployment in September with the addition of CAPT Robert Branche (Anesthesia, Phoenix) to the team. Anesthesia services are a major contributor to the maternal and perinatal morbidity and mortality occurring at Rabia Balkhi and this will be the first comprehensive analysis performed by a US trained anesthesiologist.

The Afghanistan Health Initiative appears to be secure in its funding for FY 09, and with the Dr. Garcia's involvement in the project things are moving in a very positive direction. For information, please feel free to contact me at *David.Gahn@IHS.gov*.

Fabian Kennedy, Northern Plains Tobacco Prevention Program

Updated Website/Tobacco Control Activities Event Page

The Northern Plains Tobacco Prevention Project (NPTPP) is an initiative of the Aberdeen Area Tribal Chairmen's Health Board (AATCHB) to address commercial tobacco use among American Indians residing in the Aberdeen Area (North Dakota, South Dakota, Nebraska, and Iowa). NPTPP serves as a tribal support center assisting tribal communities and tribally-based organizations to plan, implement, evaluate, and sustain tobacco prevention and control programs.

NPTPP is committed to improving the health of American Indian communities through promoting traditional concepts of health and well being and providing excellence in tobacco prevention and control. If you are interested in learning more about how to implement a tobacco cessation or prevention program, or would like to learn more about how commercial (non-ceremonial) tobacco use is affecting Indian Country, please contact us.

Please see our updated event page for tobacco control activities that are going on at the regional and national level as well as information on

- Prevention of commercial tobacco use among youth and pregnant women.
- Promotion of smoking cessation.
- Elimination of non-smokers' exposure to secondhand smoke.
- Elimination of health disparities within Northern Plains tribal communities that are a result of commercial tobacco use.

Go to *www.aatchb.org/nptpp*

Recurrent dysplasia as high as 7% after hysterectomy for cervical dysplasia

Objective: Hysterectomy with concomitant cervical intraepithelial neoplasia (CIN), is often considered a definitive treatment for CIN, but development of subsequent vaginal intraepithelial neoplasia (VAIN) is known to range from 0.9% to 6.8%.

Study Design: In a retrospective analysis of 3030 women with CIN2+ without history of VAIN in the University Hospital Gasthuisberg, Leuven, Belgium, from January 1989 until December 2003, we identified 125 women who underwent a hysterectomy within 6 months after diagnosis of CIN2+ and reviewed their postoperative Papanicolaou smears.

Results: Thirty-one patients (24.8%) were lost to follow-up. Seven of the 94 women in the follow-up group (7.4%) developed VAIN2+, of which 2 were invasive vaginal cancers. Median interval between hysterectomy and diagnosis of

VAIN2+ was 35 months (5-103 months). Women with recurrence were significantly older (P = .003).

Conclusion: Hysterectomy may not be considered as a definitive therapy for CIN2+ because the incidence rate of subsequent VAIN2+ is as high as 7.4%.

Schockaert S, Poppe W, Arbyn M, et al. Incidence of vaginal intraepithelial neoplasia after hysterectomy for cervical intraepithelial neoplasia: a retrospective study. *Am J Obstet Gynecol*. 2008 Aug;199(2):113.e1-5. Epub 2008 May 23. *http://www.ncbi.nlm.nih.gov/pubmed/18456229*

Child Health

No increase in long-term mortality after simple febrile seizures

Background: No studies have had sufficient size to estimate mortality in children with febrile seizures. We studied mortality after febrile seizures in a large population-based cohort of children in Denmark with up to 28 years of follow-up.

Methods: We identified 1,675,643 children born in Denmark between Jan 1, 1977, and Dec 31, 2004, by linking information from nationwide registers for civil service, health, and cause of death. Children were followed up from 3 months of age, until death, emigration, or Aug 31, 2005. We estimated overall and cause-specific mortality after first febrile seizures with survival analyses. Furthermore, we undertook a case-control study nested within the cohort and retrieved information from medical records about febrile seizure and neurological abnormalities for children who died (N=8172) and individually-matched controls (N=40,860).

Findings: We identified 8172 children who died, including 232 deaths in 55,215 children with a history of febrile seizures. The mortality rate ratio was 80% higher during the first year (adjusted mortality rate ratio 1.80 [95% CI 1.31-2.40]) and 90% higher during the second year (1.89 [1.27-2.70]) after the first febrile seizure; thereafter it was close to that noted for the general population. 132 of 100,000 children (95% CI 102-163) died within 2 years of a febrile seizure compared with 67 (57-76) deaths per 100,000 children without a history of this disorder. In the nested case-control study, children with simple (</=15 min and no recurrence within 24 h) febrile seizure had a mortality rate similar to that of the background population (adjusted mortality rate ratio 1.09 [95% CI 0.72-1.64]), whereas mortality was increased for those with complex (>15 min or recurrence within 24 h) febrile seizures (1.99 [1.24-3.21]). This finding was partly explained by pre-existing neurological abnormalities and subsequent epilepsy.

Interpretation: Long-term mortality is not increased in children with febrile seizures, but there seems to be a small excess mortality during the 2 years after complex febrile seizures. Parents should be reassured that death after febrile seizures is very rare, even in high-risk children.

Vestergaard M, Pedersen MG, Ostergaard JR, et al. Death in children with febrile seizures: a population-based cohort study. Lancet. 2008 Aug 9;372(9637):457-63. *http://www.ncbi.nlm.nih.gov/pubmed/18692714*

Care of the adolescent sexual assault victim

Sexual assault is a broad-based term that encompasses a wide range of sexual victimizations including rape. Since the American Academy of Pediatrics published its last policy statement on sexual assault in 2001, additional information and data have emerged about sexual assault and rape in adolescents and the treatment and management of the adolescent who has been a victim of sexual assault. This report provides new information to update physicians and focuses on assessment and care of sexual assault victims in the adolescent population.

Kaufman M and the Committee on Adolescence. Care of the adolescent sexual assault victim. Pediatrics. 2008 Aug;122(2):462-70. *http://www.ncbi.nlm.nih.gov/pubmed/18676568* Full text at: *http://pediatrics.aappublications.org/cgi/reprint/122/2/462*

Chronic disease and Illness

Naltrexone alone and with sertraline for the treatment of alcohol dependence in Alaska natives and non-natives residing in rural settings: a randomized controlled trial

Background: Access to specialty alcoholism treatment in rural environments is limited, and new treatment approaches are needed. The objective was to evaluate the efficacy of naltrexone alone and in combination with sertraline among Alaska Natives and other Alaskans living in rural settings. An exploratory aim examined whether the Asn40Asp polymorphism of the mu-opioid receptor gene (OPRM1) predicted response to naltrexone, as had been reported in Caucasians.

Methods: Randomized, controlled trial enrolling 101 Alaskans with alcohol dependence, including 68 American Indians/Alaska Natives. Participants received 16 weeks of either 1) placebo (placebo naltrexone + placebo sertraline), 2) naltrexone monotherapy (50 mg naltrexone + sertraline placebo) or 3) naltrexone + sertraline (100 mg), plus nine sessions of medical management and supportive advice. Primary outcomes included Time to First Heavy Drinking Day and Total Abstinence.

Results: Naltrexone monotherapy demonstrated significantly higher total abstinence (35%) compared with placebo (12%, p = 0027) and longer, but not statistically different, Time to First Heavy Drinking Day (p = 0.093). On secondary measures, naltrexone compared with placebo demonstrated significant improvements in percent days abstinent (p = 0.024) and drinking-related consequences (p = 0.02). Combined sertraline and naltrexone did not differ from naltrexone alone. The pattern of findings was generally similar for the American Indian/Alaska Native subsample. Naltrexone treatment response was significant within the group of 75

individuals who were homozygous for OPRM1 Asn40 allele. There was a small number of Asp40 carriers, precluding statistical testing of the effect of this allele on response.

Conclusions: Naltrexone can be used effectively to treat alcoholism in remote and rural communities, with evidence of benefit for American Indians and Alaska Natives. New models of care incorporating pharmacotherapy could reduce important health disparities related to alcoholism.

O'Malley SS, Robin RW, Levenson AL, et al. Naltrexone alone and with sertraline for the treatment of alcohol dependence in Alaska natives and non-natives residing in rural settings: a randomized controlled trial. *Alcohol Clin Exp Res*. 2008 Jul;32(7):1271-83. *http://www.ncbi.nlm.nih.gov/pubmed/18482155*

Anton RF. Naltrexone for the management of alcohol dependence. N Engl J Med. 2008 Aug 14;359(7):715-21. *http://www.ncbi.nlm.nih.gov/pubmed/18703474*

FDA MedWatch-Vivitrol (naltrexone). Serious Injection Site Reactions May Occur. FDA informed health care professionals of the risk of adverse injection site reactions in patients receiving naltrexone. Naltrexone is indicated for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment. Naltrexone is administered as an intramuscular gluteal injection and should not be administered intravenously, subcutaneously, or inadvertently into fatty tissue. Physicians should instruct patients to monitor the injection site and contact them if they develop pain, swelling, tenderness, induration, bruising, pruritus, or redness at the injection site that does not improve or worsens within two weeks. Physicians should promptly refer patients with worsening injection site reactions to a surgeon. Read the entire MedWatch Safety Summary, including a link to the FDA Drug Information Page regarding this issue at: *http://www.fda.gov/medwatch/safety/2008/safety08.htm#naltrexone*

Features

Breastfeeding

Suzan Murphy, PIMC

Infant Feeding in Disasters

Scenario: Flooding, hurricane/cyclone, earthquake, blizzard, fires, mud slides, power outages, unsafe water, extreme heat wave, tornado, tsunami/tidal wave, massive evacuation for environmental/political unrest . . . How to feed the babies? If the baby is formula fed, the concerns will be:

- Availability of formula; ready to feed will be the safest choice
- Access to safe water; decontaminate or use bottled water
- Clean environment for preparation and cleaning of bottles and nipples
- Availability of a person who can correctly mix formula
- Access to refrigeration for prepared/opened formula

If the baby is breastfed, the questions may be, Can the mother breastfeed with the stress of a disaster? Women have breastfed through many disasters, wars, and famines. It will help to offer support and encouragement that:

- Stress does not dry up a mother's milk supply.
- Breastfeeding causes hormones to be released to relieve anxiety and stress for moms.
- The quality of human milk does not vary significantly with maternal diet changes. Even if the mother is not able to eat well, the important nutrients will not be impacted.
- Human milk will supply a major portion of nutrient needs in the first year of life and beyond if other safe foods and liquids are not available.
- Breast milk is always the right temperature and matches her baby's nutrient needs. It will prevent hypothermia and many illnesses for her baby.

Can the mother receive immunizations while breastfeeding? Routine immunizations like mumps, rubella, tetanus, diphtheria, pertussis, influenza, *Streptococcus pneumoniae, Neisseria meningitides*, hepatitis A, hepatitis B, varicella, and inactivated polio are safe for breastfeeding mothers and their infants/children.

What about illnesses that can be part of disasters? See *www.cdc.gov* for information about managing breastfeeding women and specific diseases.

What if the mother and baby or toddler have recently stopped breastfeeding; can breastfeeding be started again?

- Encourage the mom to offer the breast to her child. It may take several days or weeks of frequent nursing, but her milk can come back. Suckling every 2 hours with skin-to-skin contact is magic for restoring breast milk supply. Please note that re-lactation may be faster with a younger infant.
- Monitor the baby for adequate hydration and nutritional status.
- Assure the mom that her milk will be fine. Breast milk is a dynamic fluid, always being cleaned, recycled, and restored. It has not spoiled or become outdated in her body.

For more information and downloadable materials, please consult the American Academy of Pediatrics - Infant Nutrition during a Disaster – Breastfeeding and other Options at (*www.aap.org*) and Center for Disease Control for Disaster Safety (*www.cdc.gov*). If phone service is available during a disaster and more information is needed, call 1-877-868-9473.

Family Planning

Beyond the 6 week postpartum check; try 3 weeks instead…

The 6-week postpartum visit is an anachronism. Performing the initial pelvic examination at this duration after delivery is based upon statements in old textbooks and teachings from a time when infection was prevalent and before modern methods of contraception were available. The basis for this clinical advice was derived from the understanding that a 6-week period of time would result in sufficient involution of the changes of pregnancy to allow an effective pelvic examination that would confirm the return of normal pelvic anatomy. Many women resume sexual activity before the sixth postpartum week, and because ovulation frequently occurs before 6 weeks, the obstetrical tradition of scheduling the postpartum visit at 6 weeks should be changed. A 3-week visit would be more effective in preventing postpartum conception by initiating effective contraception at this time, instead of after the 6-week visit. There is no reason why a complete physical examination cannot be deferred in an asymptomatic woman until the 3-month follow-up visit that is part of good contraceptive care.

CCC Editorial Comment

This article provides an excellent overview of optimal postpartum contraception care. Benchmarks about when women really resume intercourse (32 - 60% by 6 weeks in a variety of international studies), when ovulation resumes (on average 4 weeks postpartum in non-nursing mothers), and that ovulation precedes menstruation more than 50% of the time. Lactational amenorrhea can convey a level of protection similar to OCPs, however if supplemental feedings are introduced or menses return, then ovulation resumes quickly. The authors recommend adherence to the "Rule of 3's": 1) for fully breastfeeding women, a contraceptive method should be started in the 3rd postpartum month; 2) after spontaneous or elective abortion of a pregnancy of <12 weeks, contraception should be started immediately; 3) after a pregnancy of 12 weeks or more, contraception should be started by the 3rd week postpartum.

Individual contraceptive methods are addressed in detail:

- Progestin-only pills can be started immediately and should be started by the third week or month as above.
- Combined oral contraceptives (as well as transdermal and vaginal combined methods) can be started in the third week or the third month as above.
- Depo-Provera and implants (such as Implanon) may be placed immediately postpartum.
- IUDs can be placed 4 - 8 weeks postpartum or within 15 minutes of delivery.
- Because of the increased risk of clotting disorders in the immediate postpartum period; strong consideration should be given to use of a non-estrogen containing method from 3 to 7 weeks postpartum.

Although the full text article is not available without a subscription, this is a great example of resources that are available through the Health Sciences Research Library. See "Ask a Librarian" in previous issues of *The Provider*.

Speroff L, Mishell DR Jr. The postpartum visit: it's time for a change in order to optimally initiate *contraception*. Contraception. 2008 Aug;78(2):90-8. Epub 2008 Jun 12. *http://www.ncbi.nlm.nih.gov/pubmed/18672108*

International Health Update

Claire Wendland; Madison, Wisconsin

Active tuberculosis more likely in diabetics: a new meta-analysis has serious global health implications

The World Health Organization estimates that one third of the world's population is infected with tuberculosis. Fortunately, in most people the infection remains quiescent. Only about one in ten of those infected go on to develop the active disease that damages their own bodies and puts them at risk for infecting others. Anything that changes the rate of conversion to active tuberculosis, for better or for worse, has significant public health implications. In recent years, for instance, the link between HIV and TB has attracted much attention: immune suppression related to HIV puts patients at dramatically increased risk for active tuberculosis. But HIV is not the only such condition.

Clinicians have suspected a connection between diabetes and active TB for almost a century. A causative connection is biologically plausible, because diabetes impairs host immunity. Studies in diabetic mice show diminished T-cell response to infection with *M. tuberculosis* – a response that is critical to keeping infectious bacilli contained. In addition, human studies show reduced production of interferon, impaired neutrophil activity and decreased leukocyte bactericidal action with rising HbA1c. A new meta-analysis now confirms the long-suspected association between active tuberculosis and diabetes mellitus, and explores the implications for public health internationally.

Two epidemiologists looked at all available good-quality research comparing active tuberculosis in adults with and without DM. They were particularly interested in cohorts with a confirmed prior diagnosis of DM, because direction of causation can be tricky: tuberculosis induces a hyperglycemia that resolves with treatment. They found thirteen studies: seven from North America, including two in Native American communities, and the remainder from Europe, Central America and Asia. Despite different geographic regions, study designs, and background incidences of TB, they found a consistently significant association between DM and active TB. The relative risk of active TB was doubled for diabetics in areas where background incidence of TB was low, more than tripled

where background incidence is high. In addition, the relative risk seemed to be substantially higher in younger people.

The public health implications are profound. The global burden of diabetes is expected to double by 2030. Some of the fastest rates of increase are seen in India and China, also huge population centers with high background rates of TB and relatively young mean ages. Already, the authors calculate that DM probably accounts for about 15% of all active TB cases in India. These findings make even more urgent the need for investigation of – and intervention into – social determinants of diabetes mellitus. In the meantime, they also have practical implications. Public health practitioners may want to seek out people with DM for tuberculosis case-finding, and clinicians have one more good reason to work with their patients toward diabetes prevention.

Jeon CY, Murray MB. Diabetes mellitus increases the risk of active tuberculosis: a systematic review of 13 observational studies. *PLoS Medicine*. 5(7):e152, July 2008. *http://www.ncbi.nlm.nih.gov/pubmed/18630984*

MCH Headlines Judy Thierry HQE

New United States Infant Mortality Statistics Released

Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set

Objectives: This report presents 2005 period infant mortality statistics from the linked birth/infant death data file by a variety of maternal and infant characteristics. The linked file differs from the mortality file, which is based entirely on death certificate data.

Methods: Descriptive tabulations of data are presented and interpreted. Excluding rates by cause of death, the infant mortality rate is now published with two decimal places.

Results: The US infant mortality rate was 6.86 infant deaths per 1,000 live births in 2005, which is statistically unchanged from 6.78 in 2004. Infant mortality rates ranged from 4.89 deaths per 1,000 live births for Asian or Pacific Islander (API) mothers to 13.63 for non-Hispanic black mothers. Among Hispanics, rates ranged from 4.42 for Cuban mothers to 8.30 for Puerto Rican mothers. Infant mortality rates were higher for infants who were born in multiple deliveries or whose mothers were born in the 50 states and the District of Columbia or were unmarried. Infant mortality was also higher for male infants and infants born preterm or at low birthweight. The neonatal mortality rate was essentially unchanged from 2004 (4.52) to 2005 (4.54). The postneonatal mortality rate increased 3 percent from 2.25 in 2004 to 2.32 in 2005. Infants born at the lowest gestational ages and birthweights have a large impact on overall US infant mortality. For example, more than one-half (55 percent) of all infant deaths in the US in 2005 occurred to the 2 percent of infants born very preterm (less than 32 weeks of gestation). Infant mortality rates for late preterm infants (34–36 weeks of gestation) were three times those for term infants (37–41 weeks). The three leading causes of infant death -- congenital malformations, low birthweight, and sudden infant death syndrome (SIDS) -- accounted for 44 percent all infant deaths. The percentage of infant deaths that were ''preterm-related'' increased from 34.6 percent in 2000 to 36.5 percent in 2005.

Figure 1. Infant mortality rates by race and ethnicity of mother: United States, 1995, 2000 and 2005

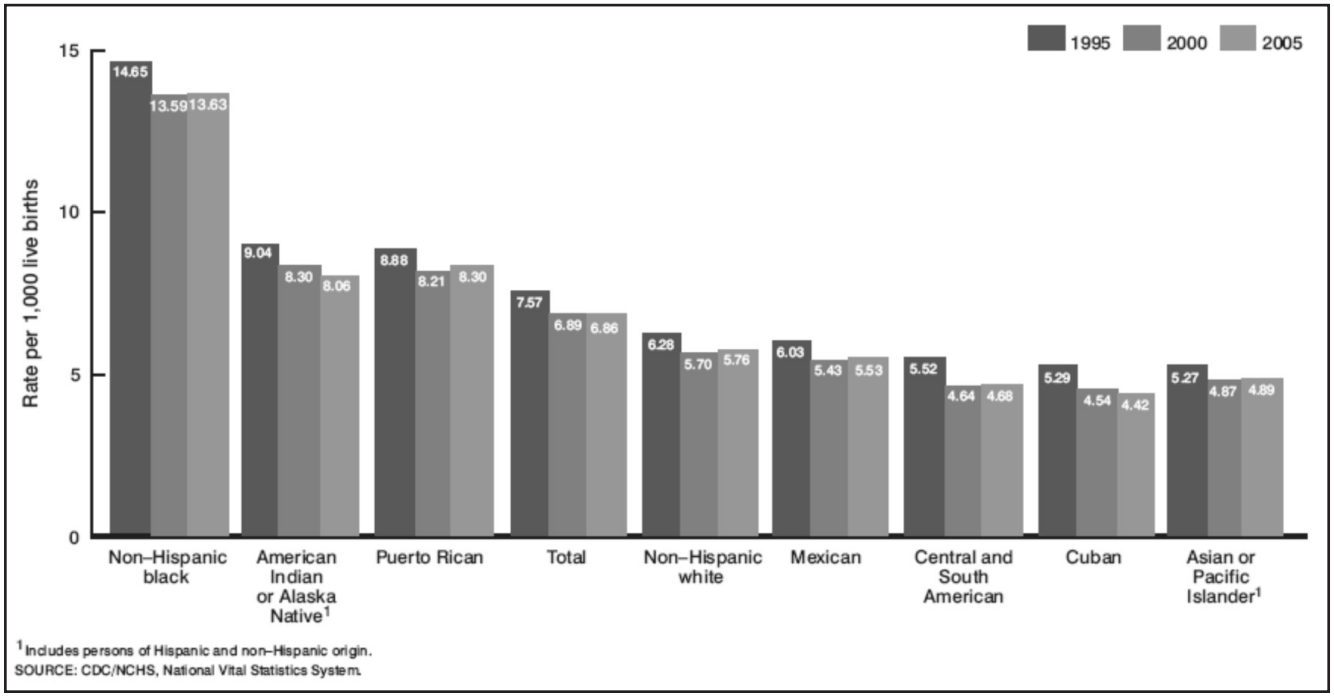


Table A. Infant, neonatal, and postneonatal deaths and mortality rates by race of mother: United States, 2005 linked file

Race of mother	Live births	Number of deaths			Mortality rate per 1,000 live births		
		Infant	Neonatal	Postneonatal	Infant	Neonatal	Postneonatal
All races	4,138,573	28,384	18,782	9,602	6.86	4.54	2.32
White	3,229,494	18,500	12,173	6,328	5.73	3.77	1.96
Black	633,152	8,393	5,649	2,743	13.26	8.92	4.33
American Indian or Alaska Native	44,815	361	181	180	8.06	4.04	4.02
Asian or Pacific Islander	231,112	1,129	779	350	4.89	3.37	1.51

NOTES: Infant deaths are weighted so numbers may not exactly add to totals because of rounding. Neonatal is less than 28 days, and postneonatal is 28 days to under 1 year. Race and Hispanic origin are reported separately on birth certificates. Race categories are consistent with the 1977 Office of Management and Budget standards. Persons of Hispanic origin may be of any race. In this table, Hispanic women are classified only by place of origin; non-Hispanic women are classified by race. See reference 2. Nineteen states reported multiple-race data on the birth certificate for 2005. The multiple-race data for these states were bridged to the single-race categories of the 1977 standards for comparability with other states; see reference 2.

The preterm-related infant mortality rate for non-Hispanic black mothers was 3.4 times higher and the rate for Puerto Rican mothers was 87 percent higher than the rate for non-Hispanic white mothers.

Mathews TJ, MacDorman MF. Infant mortality statistics from the 2005 period linked birth/infant death data set. National vital statistics reports; vol 57 no 2. Hyattsville, MD: National Center for Health Statistics. 2008. *http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_02.pdf*

Midwives Corner

Lisa Allee, CNM, Chinle

Centering Pregnancy -- A Model of Group Prenatal Care

Centering Pregnancy is a model of group prenatal care that is being used in numerous sites around the country. Prenatal care provided through the Centering model differs from clinic visits in a number of ways. First, there is no waiting room. Women arrive and their appointment begins right then. Second, women get to spend two hours with their provider at each appointment. Third, women are actively involved in their care. Women are taught at the first group how to do aspects of their prenatal care themselves -- blood pressure, weight, and urine dip -- and how to chart and keep track of these results. Each subsequent session then begins with about a half hour of women doing these things and rotating through "mat time" with the midwife. Mat time is private time with the midwife (or physician) where the woman can report private concerns or questions and fundal height and fetal heart tones are checked. Once everyone has done their vitals and seen the midwife the group comes into a circle. During the circle time a topic for the day is discussed and activities occur. This is not a didactic class; it is a group session, which means that the midwife and a co-facilitator facilitate the session, asking questions and helping the group discover information they already know or new information. The topic of the day is usually just a jumping off point and the discussion can flow into many more areas of interest to the group.

There are a number of IHS sites offering Centering groups as an alternative to clinic-based prenatal visits, and more sites are exploring offering it soon. The Four Corners Chapter of the American College of Nurse Midwives received a grant from the March of Dimes to support and expand Centering on the Navajo Nation. Part of the grant is to make a promotional DVD about Centering. The interviews with patients that have gone through Centering for their prenatal care have been astonishing and yet also not surprising. The words coming out of these women's mouths say everything that Centering says it does -- they report feeling empowered to make good decisions for themselves and their children; they report learning more than they ever did or would have in clinic; they report connecting with other women and realizing they are not alone in their experiences; they report increased confidence; they report learning from the others in the group; they report having fun; they report enjoyment of the longer time spent with their midwife or doctor; they report loving Centering. They also report wanting to continue groups past the immediate post partum -- this has been requested by so many Centering participants nationwide that the national Centering folks have develop Centering Parenting that provides well baby care through the first year.

There has been concern expressed by staff at several IHS sites on the Navajo Nation that Centering is not compatible with Navajo tradition, that Navajo women won't like it, and that privacy issues will keep it from working. The interviews with Navajo women who have done Centering belay these concerns. These Navajo women clearly liked Centering for their prenatal care. They spoke about privacy and reported that at first they felt shy, but as they got to know the group they felt more comfortable sharing. Everyone also clearly understood that it was their choice what personal information they wanted to share or not share with the group; there was no pressure to do otherwise. A number of comments were made that even though there was a subject or question that they didn't feel comfortable sharing or asking about, another woman would bring it up and, thus, they were able to learn about the subject after all because of the other woman. As for Navajo tradition,

some interviewees spoke to how Centering met their traditional needs, one example being that the group was held outside the building where the ER was and, thus, kept her from having to go into a place where people die, as she was taught not to do when she was pregnant. Centering is based on an eons-old, global-wide, crossing-all-cultures tradition of women gathering to discuss, support, and learn from each other about all things female -- menses, pregnancy, breastfeeding, childrearing, menopause, etc. A Navajo specific example is Ki'nal'da' the puberty ceremony for young women where women gather to talk and teach the young woman about being an adult woman. The Centering model can expand on this tradition and allows for the time to teach young women more about Navajo traditions -- time that rarely is found in a 10-15 minute clinic visit.

The interviews and filming also revealed wonderful aspects of Centering for partners and other family members, but that will have to wait for another column as space is running out. If you are interested in Centering Pregnancy, please check out the Centering website at www.centeringhealthcare.org and look for informational sessions at most IHS maternal-child health meetings. Also, please join the IHS Centering Pregnancy listserv by e-mailing me at *lisa.allee@ihs.gov*.

Patient Information

Protect Your Baby from Group B Strep

This page describes what group B strep is, how it impacts a newborn, how to prevent group B strep, what can be done before and during labor, and where to get more information. E-cards are also available. Go to *http://www.cdc.gov/Features/GroupBStrep/*. Brochure and other information at *http://www.cdc.gov/groupbstrep/general/protect-your-baby-GBS.htm*

Making Sense of Your HPV and Pap Test Results (Plain language Patient brochure)

This 17-page brochure explains the meaning of Pap and HPV test results and answers common patient questions about HPV, such as how to talk to your partner about HPV. It includes 'questions to ask your doctor' to help prepare women for next steps, and a glossary of terms. It has been tested with 30-65 year-old African American, Hispanic, and Caucasian women. *http://www.cdc.gov/std/Hpv/pap/*

STD Corner

Lori de Ravello, National IHS STD Program

Take the sex out of STI screening. Views of young women on implementing Chlamydia screening in General Practice

Background: Australia is developing a Chlamydia screening program. This study aimed to determine the attitudes of young women to the introduction of Chlamydia screening in Australian General Practice.

Methods: In-depth face-to-face interviews with 24 young women from across Victoria, Australia, attending a randomly selected sample of general practices.

Results: Young women reported that they would accept age-based screening for Chlamydia in general practice, during both sexual-health and non-sexual-health related consultations. Trust in their general practitioner (GP) was reported to be a major factor in the acceptability of Chlamydia screening. The women felt Chlamydia screening should be offered to all young women rather than targeted at "high risk" women based on sexual history and they particularly emphasised the importance of normalising Chlamydia screening. The women reported that they did not want to be asked to provide a sexual history as part of being asked to have a Chlamydia test. Some reported that they would lie if asked how many partners they had had.

Conclusion: Women do not want a sexual history taken when being asked to have a Chlamydia test while attending a general practitioner. They prefer the offer of Chlamydia screening to be based on age rather than assessment of sexual risk. Chlamydia screening needs to be normalised and destigmatised.

Pavlin NL, Parker R, Fairley CK, et al. Take the sex out of STI screening! Views of young women on implementing Chlamydia screening in General Practice. *BMC Infect Dis*. 2008 May 9;8:62. *http://www.ncbi.nlm.nih.gov/pubmed/18471280*

Call for Applications
IHS Injury Prevention Specialist Class of 2009
Program Development Fellowship

What is the Program Development Fellowship (PDF)?
The PDF is a 12-month advanced learning experience for individuals promoting injury prevention in American Indian/Alaska Native communities. A college degree is not required.

What will participants gain from the PDF?

- Enhanced skills in program planning and implementation:
  - Building and maintaining successful coalitions
  - Promoting community involvement
  - Organizing local injury data and evaluating programs
  - Using marketing and advocacy skills
  - Finding new sources of funding, grant writing
- The latest information on "best practices" for prevention of intentional and unintentional injuries
- Success stories in the prevention of injuries from motor vehicle crashes, violence, falls, and fires
- Improved effectiveness and satisfaction in your injury prevention work
- Individualized learning experiences (e.g., using GPS devices, conducting surveys)
- Completion of a project that will help reduce injuries in your community

What is the PDF curriculum?

- Four courses at different sites, each 4-1/2 days long:
  - **Injury prevention program planning:** Rockville, MD, May 4-8, 2009
  - **Program implementation and evaluation**. University of Utah, July or August 2009
  - **Injury prevention field work.** Phoenix, October 2009
  - **Social marketing, advocacy, and presentation skills:** Albuquerque, February 2010
- Completion of a project that will have an impact on injuries in your community
- At-home learning activities (such as attending a coalition meeting)
- A presentation session at the end of the Fellowship in May or June 2010
- Computer training for beginners to advanced users
- Faculty and local mentors to assist you throughout the year

Who should apply?
Persons who have:

- Worked at least 12 months in the area of injury prevention;
- Attended the one-week IHS injury prevention introductory course (Level 1 or equivalent);
- Demonstrated a commitment to community injury prevention.
- Knowledge of, or willingness to learn, use of the Internet.

Ideal applicants include directors of tribal injury prevention programs, tribal health authority and health care staff, CHRs, nurses, firefighters, police, health educators, community coalition members, environmental health specialists, previous IHS IP Fellowship graduates, and others working for tribes in injury prevention.
The application is online at www.ihs.gov/MedicalPrograms/InjuryPrevention - click on "News and events."
Applications must be received by **December 12, 2008**. Acceptances will be announced by January 15, 2009.

For questions, please contact your IHS Area Injury Prevention Specialist (listed by state at www.ihs.gov/MedicalPrograms/InjuryPrevention, click on "Contacts") or Nancy Bill, IP Program Manager (Nancy.Bill2@ihs.gov).

10/01/08

Internship Change at NNMC

Douglas Accountius, RN, BSN, MBA, Shiprock, New Mexico

In August 2007, four members of the Northern Navajo Medical Center (NNMC) made the trip to New Hampshire to learn about the Vermont Nursing Internship Program, a standardized process of orientating new nurses and evaluating their competency to create a custom internship for them.

Nationally, the nursing shortage has been hitting almost every hospital in the United States. The facts are startling. According to projections released in February 2004 from the Bureau of Labor Statistics (BLS), registered nurses (RNs) top the list of the ten occupations with the largest projected job growth in the years 2002 - 2012. Although RNs have been listed among the top ten growth occupations in the past, this is the first time in recent history that RNs have been ranked first. These ten-year projections are widely used in career guidance, in planning education and training programs, and in studying long-range employment trends.

According to the BLS report, more than 2.9 million RNs will be employed in the year 2012, up 623,000 from the nearly 2.3 million RNs employed in 2002. However, the total job openings, which include both job growth and the net replacement of nurses, will be more than 1.1 million. This growth, coupled with current trends of nurses retiring or leaving the profession and fewer new nurses, could lead to a shortage of more than one million nurses by the end of this decade.[1] A 21 percent increase in the need for nurses was projected nationwide from 1998 to 2008, compared with a 14 percent increase for other occupations (US Department of Labor).

The Health Resources and Services Administration (HRSA) projects that, absent aggressive intervention, the supply of nurses in America will fall 36 percent (more than 1 million nurses) below requirements by the year 2020.[2] The BLS reports that registered nursing will have the greatest growth rate of all US occupations in the time period spanning 2006 - 2016. During this decade, the health care system will require more than 1 million new nurses to meet growing demand and to replace retiring nurses.[3] An average vacancy rate of 10.4% for registered nurses and 9.2% for nurse practitioners exists at our nation's 5,000 community health centers. The vacancy rate at Northern Navajo Medical Center follows suit (see Table 1).

Table 1. Vacancy rates at NNMC 2007 and 2008

	Nov-07				Aug-08		
	Positions	**Vacancy**	**Rate**		**Position**	**Vacancy**	**Rate**
Nursing Administration	9	1	11%		10	2	20%
Medical/Surgical	22	5	23%		24	8	33%
Obstetrics	21	11	52%		24	10	42%
ICU	13	3	23%		13	6	46%
Pediatrics	9	7	78%		13	9	69%
Ambulatory Care	16	2	13%		16	6	38%
MCH	4	0	0%		6	2	33%
ER	16	3	19%		17	3	18%
OR	10	4	40%		15	7	47%

The Vermont Nurse Internship Project (VNIP)

VNIP is an endeavor of the Vermont Nurses In Partnership, Inc., a not-for-profit nurse leadership coalition that institutes resources for supporting workforce development for all nurses. VNIP includes nurse leaders from academia, regulatory agencies, and various practice settings. The collaboration has grown from the initial 45 Vermont-based members, to a coalition of over 300 nurse leaders from across the nation and around the world. These proactive health care leaders provide the intellectual resources that allow us to develop and deliver research and theory-based intern, orientee, and preceptor development programs. The programs developed by VNIP promote a workplace culture of nurture, support, and professional growth for novice nurses or those in transition to a new specialty. The VNIP model demonstrates the importance of the workplace culture to long term recruitment and retention of nurses in clinical practice (website: *www.vnip.org*).

Special features. VNIP has established an internship that:

- Is used in multiple settings across the continuum of care, rather than in a single agency or health system.
- Standardizes the approach and model used for new graduates in diverse settings, inclusive of inpatient, acute care, home health, long term care, and public health settings within the state of Vermont.
- Shifts away from orientation to the "minutia of nursing practice," and instead focuses on application of core concepts and critical thinking skills across a variety of situations.
- Builds the fundamental work of the preceptor upon the foundation roles of "Protector" and "Validator."
- Standardizes the curriculum and behavioral learning objectives for preceptor development statewide.
- Provides preceptor education that:
    - Targets all direct care providers from diverse health care settings and the full interdisciplinary team.
    - Institutes preceptor education that is based in research, theory, and continuous evaluation for most current, complete, and accurate preparation for the role.
    - Relates preceptor role expectations to teaching/learning theory, interpersonal and critical thinking skill development, evaluation of performance outcomes, and development of clinical coaching plans.
    - Provides instruction and program development that is based upon a collaborative framework inclusive of education, research, regulation, and practice.
    - Standardizes the approach to competency assessment – the same "orientation checklist" being used in all acute care settings and the same concepts and systems applied across the continuum of care (including allied health colleagues).
    - Tracks progression via the achievement of goals and competencies, instead of being "time oriented."
    - Utilizes clinical coaching plans to provide the "roadmap" for the intern/preceptor team.
    - Promotes a "concept based" approach rather than a "case-based" competence development process

Upon completion of the training, several obstacles were identified.

- Executive support from the facility would have to be obtained
- Full-time employee positions would need to be authorized
- An administrative framework would need to be developed in the Indian Health Services (IHS) format that would support the new process.
- Clinical coaching plans and the training process on the floor.
- A preceptor training program would need to be developed.
- All these solutions would have to be duplicated to expand to the rest of the Navajo Area.

A strategic plan was developed and a timeline established. Tasks included the following.

The Chief Nurse Executive was assigned the task of going to the executive committee to obtain full time employee slots for interns and preceptors, as well as the facility support to implement the program.

The Assistant Chief Nurse Executive was tasked to develop the administrative framework to support the operations of the program. She was to develop position descriptions and policies and procedures to support the preceptors, and outline the responsibilities of the interns. She also had the task of implementing the advertisement of the program into the recruiting realm.

The Medical/Surgical Nurse Manager was tasked with the development of clinical coaching plans. These are the written plans about how training would be conducted on the floor. It was determined that NNMC would start with a pilot run on the Med/Surg ward. She also had the task of identifying perspective preceptors.

The Staff Development Specialist was tasked to develop the preceptor training. This included creating lesson plans, gathering the resources for the classes, and putting together the workbooks for the students.

The team coordinated all these efforts to implement the program by January 2008, to include a preceptor training class, selection of the first interns, and having all required administrative framework in place. The plan was presented to

the Nurse Executive Team, who were asked to start planning for their staff to attend the training. In an effort to spread the wealth, a presentation of the strategic plan was made to the Chief Nurse Executives of all the facilities in the Navajo Area. This sparked some interest, and members from other facilities inquired about the possibility to have members of their staff attend the preceptor training.

In October 2007, a cost analysis was performed looking at how much the facility was spending on contractors and the cost of replacing a nurse every time the facility had one leave. It was estimated that the facility spent about $75,000 when a nurse left, including the overtime paid to cover that position until someone new could be hired and the amount of additional cost to bring the new hire up to speed. Contractors were costing the facility over 3 million dollars a year, and it appeared that this cost would continue to rise. The Chief Nurse Executive explained that this internship program required an upfront capital investment to make it happen. A presentation about the program was given to the Executive Committee with the request for additional FTEs to implement this program. The positions were approved.

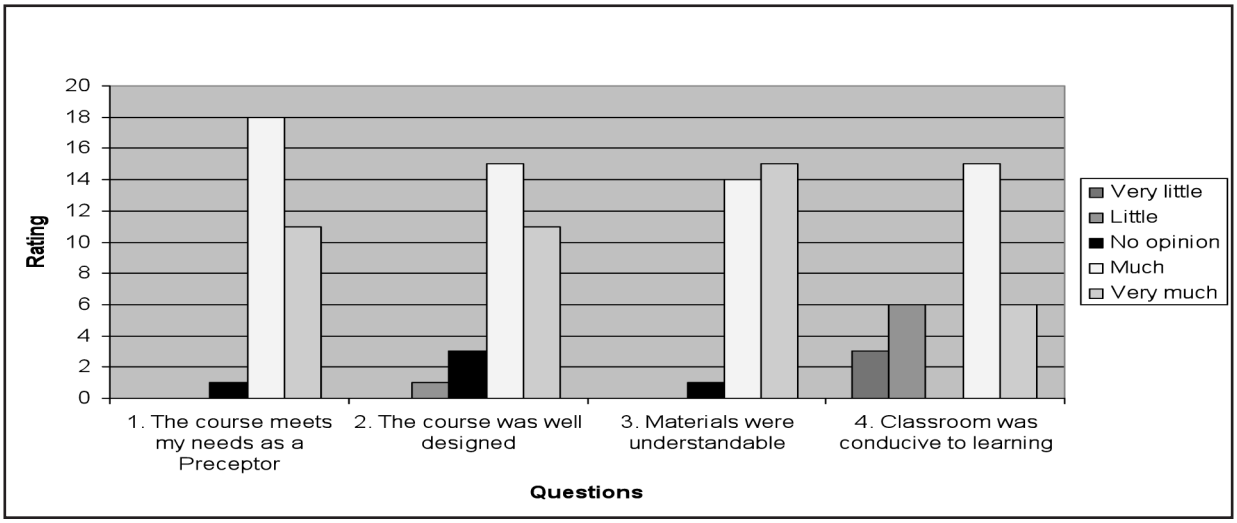
Simultaneously, the Assistant Nurse Executive took a position description that was developed by the VNIP Program and re-structured it to meet the Federal government requirements, which required many revisions and consultation with the Human Resource Classification Section. Policies and procedures were also taken from the materials provided by the VNIP program, and were easily modified to the facility format. The grapevine at the facility was in full swing and the program was not even implemented before the calls started coming in asking about the program. It helped that the facility had six different nursing schools doing their clinical rotations there.

The Medical/Surgical Nurse Manager had the challenge of getting a Medical/Surgical Unit to change the way they did business to accommodate preceptors and interns. The floor faced staffing shortages, equipment problems, and a verity of other issues. The first issue was getting everyone familiar with what was going to happen. Forums were conducted so staff had an opportunity to address their questions. A number of staff were put through the Preceptor Training, which yielded a better buy-in of the staff. Volunteers were obtained from many of the younger staff, and clinical coaching plans were developed, resource materials were organized, and many other issues were addressed. Per the House Supervisors, it was evident that there was a change on the floor. Teamwork improved, moral was higher, and staff were working together better than ever before.

Creating a lesson plan based on a course that is used in Vermont was a bit of a challenge. The materials provided by the VNIP program consisted of slides, but there was no workbook for the students. Initially it was decided to copy the slides into a handout format and copy parts of the notebook distributed in Vermont. The two sections would be placed in one folder and referenced back and forth. This process was costly in materials. After the first class, the slides were transferred to a Word program, and some materials were added between the slides. The initial materials that were obtained from the program are currently being published in a workbook, so it will cost facilities an additional amount if they want to use this.

In November 2007, the first preceptor class was conducted with 30 students, 20 being from NNMC and 10 from other facilities. A lesson learned from the class taken in New Hampshire was to extend the class to 2½ days instead of 2 days. This was to allow more time for discussion and group activities. Students were a mix of nurse educators, RNs, nursing assistants, clerks, and nurse managers. The class mostly mirrored the class presented in New Hampshire with a few exceptions (see Figure 1).

Figure 1. Course Critique



Based on the critique results, the next preceptor class offered in February 2008 was modified to reflect the changes asked for by the first class.

In January 2008, the first internship was started with two students and one preceptor.

Objectives accomplished:

- Executive support from the facility would have to be obtained (results: obtained)
- Full-time employee positions would need to be authorized (results: slots provided)
- An administrative framework would need to be developed in the IHS format that would support the new process (results: aministrative framework developed, and approved by governing authorities)
- Clinical coaching plans and the training process on the floor (results: fully implemented on Medical/Surgical Ward)
- A preceptor training program would need to be developed (results: three revisions completed and implemented)
- All these achievements would have to be duplicated to expand to the rest of the Navajo Area (results: currently sharing information with other facilities in the Navajo and Phoenix Areas)

Additional positions approved included 5 intermittent RNs, 2 Clinical Coaches (Med Surg, Peds), 2 Assistant Supervisory Clinical Nurses (ER, Med Surg), 7 Nursing Assistants (MCH, Ambulatory Care), and 2 Medical Support Assistants (ER).

It has been almost a year since the implementation of the program. Although the vacancy rates have not improved, there have been some notable changes in the facility. Some of the benefits of the project include the following:

- NNMC has had four graduates from the program, and they are still employed at the facility
- NNMC has two interns in the program right now on the Med/Surg Floor
- NNMC is expanding the program to pediatrics and the ICU
- There is a waiting list of new nurses that want to enter the program
- Other facilities in the Navajo Area are now sending their staff for preceptor training and assistance from NNMC to implement the program in their own facilities.
- A workgroup has been formed to implement the program throughout the Navajo Area and the Phoenix Areas.

Although the results of the program have met the initial objective of decreasing nursing vacancies, the other benefits have improved work conditions significantly. Recruitment continues to improve, with more and more new nurses wanting to get into the program. Graduates are staying and looking forward to helping others get through the program. Expanding the program will also further the recruitment process and should go smoother because of the lessons learned on Med/Surg. Northern Navajo Medical Center is faced with many of the unique issues that other IHS facilities deal with, being very rural and limited in resources, but with the efforts to assist new nurses to transition from academia to the real world of nursing, NNMC will eventually succeed.

References

1. *www.bls.gov/emp/#outlook.*
2. What is Behind HRSA's Projected Supply, Demand, and Shortages of Registered Nurses?: *ftp://ftp.hrsa.gov/bhpr/workforce/behindshortage.pdf*
3. *http://www.bls.gov/opub/ooq/2007/fall/art02.pdf*

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*.

Childhood Obesity/Diabetes Prevention in Indian Country: Making Physical Activity Count!

December 2 - 4, 2008; San Diego, California

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

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

2008 IHS Indian Health Information Management Conference

December 15 - 19, 2008; Phoenix, Arizona

The purpose of the IHIMC and its antecedent conferences is to provide for the demonstration and discussion of information technology tools, as the IHS IT community supports health care delivery in Indian Country. The theme this year is "Managing Health Information Technology to Improve Performance and Outcomes." IHIMC is a forum for technical leadership, direction, and support in the promotion of quality health care through collaboration and active participation in the development of policy and national standards of care regarding the health of American Indian/Alaska Native people in Federal (IHS), tribal and urban settings (I/T/U). Enjoy keynote presenters, six conference tracks, poster sessions, technical exhibitors, fitness activities, and a cyber café at this year's conference. For more information, go to *http://www.ihs.gov/cio/ihimc/*.

The 2009 Meeting of the National Councils for Indian Health

February 8 - 13, 2009; San Diego, California

The National Councils (Clinical Directors, Chief Executive Officers, Chief Medical Officers, Oral Health, Pharmacy, and Nurse Consultants) for Indian health will hold their 2009 annual meeting February 8 - 13, 2009 in San Diego, California. Engage in thought-provoking and innovative discussions about current Indian Health Service/Tribal/Urban program issues; identify practical strategies to address these health care issues; cultivate leadership skills to enhance health care delivery and services; share ideas through networking and collaboration, and receive accredited continuing education. The focus this year will be *"Partnership for Change."* Indian health program Chief Executive Officers, clinico-administrators, and interested health care providers are invited to attend. The meeting will be held at the Bahia Resort Hotel, 998 West Mission Bay Drive, San Diego, California 92109. Please make your hotel room reservations by January 12, 2009 by calling 1-800-576-4229. Be sure to ask for the "Indian Health Service" group rate. For on-line registration and the most current conference agenda, please visit the Clinical Support Center web page at *http://www.csc.ihs.gov*. The IHS Clinical Support Center is the accredited sponsor for this meeting. For more information, contact Gigi Holmes or CDR Dora Bradley at (602) 364-7777; or e-mail *gigi.holmes@ihs.gov*.

Sexual Assault Nurse Examiner (SANE) Training Workshop

April 13 - 17, 2009; Oklahoma City, Oklahoma

The Sexual Assault Nurse Examiner (SANE) workshop is an intensive five-day course to familiarize health care providers with all aspects of the forensic and health care processes for sexual assault victims. This course emphasizes victim advocacy and the overall importance of being a member of the interdisciplinary Sexual Assault Response Team (SART) in the investigative, health care, and prosecution processes. Lead faculty for this course will be Linda Ledray, PhD, RN, a certified SANE trainer and Director of the Sexual Assault Resource Service (SARS) of Hennepin County Medical Center in Minneapolis, Minnesota. Dr. Ledray is a nationally

recognized expert and pioneer in the area of forensic nursing. This course is open to I/T/U health care professionals, including nurses, advanced practice nurses, physician assistants, and physicians.

Please make your room reservation early by calling the Crowne Plaza Hotel at (405) 848-4811 or 1-800-2-CROWNE. Be sure to mention the "IHS-SANE Training" to secure the rate of $83.00 + tax (single occupancy) per night. The deadline for making room reservations is March 23, 2009. Any reservation request received after this date will be accepted on a space availability basis only.

For more information about the event, contact LCDR Lisa Palucci at the IHS Clinical Support Center, (602) 364-7740, e-mail *lisa.palucci@ihs.gov*; or visit the CSC website at *http://www.csc.ihs.gov*.

Advances in Indian Health Conference

April 21 – 24, 2009; Albuquerque, New Mexico

Save the Dates! The 2009 "Advances in Indian Health Conference" will be April 21 - 24, 2009 in Albuquerque, New Mexico. "Advances" is Indian health's conference for primary care providers and nurses. Get up to 28 hours of CME/CE credit learning about clinical topics of special interest to I/T/U providers, including the option to focus on diabetes training. To see the 2008 brochure, go to *http://hsc.unm.edu/cme/2008Web/AdvancesIndianHealth/AIH2008Index.shtml*, or you can contact the course director, Dr. Ann Bullock at *annbull@nc-cherokee.com* for more information.

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If you see copies of *The Provider* being delivered to your facility addressed to individuals who have left, please take a moment to e-mail *cheryl.begay@ihs.gov* to let her know so that she can remove these individual from the mailing list. This will save us postage and printing expenses, and eliminate a minor inconvenience in your mailroom.

POSITION VACANCIES

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

Dentist

Mid-Level Provider (Lapwai & Kamiah)

Nimiipuu Health, Idaho

Caring People Making a Difference. Nimiipuu Health, an agency of the Nez Perce Tribe, with ambulatory health care facilities in Lapwai and Kamiah located in beautiful Northern Idaho near the confluence of the Snake and Clearwater Rivers, is an area rich in history, natural beauty, and amiable communities. We provide excellent benefits and opportunity for personal and professional growth. Nimiipuu Health's caring team is looking for individuals making a difference in the health care field and is now accepting applications for the following positions:

Dentist: (Salary/DOE/Part-Time or Full-Time/Lapwai). Requires DDS/DMD degree from an American Dental Association accredited dental school, with two years of experience, preferably in general practice. Must have state licensure in good standing, valid driver's license with insurable record, and pass a background check. Open Until Filled.

Mid-Level Provider: (Salary/DOE/Full-Time/Kamiah or Part-Time/Lapwai). Idaho licensed FNP or PA. Incumbent can obtain Idaho license within one year of appointment. Must have BLS and obtain ACLS within six months of appointment. Must have valid driver's license with insurable record and will be required to pass extensive background check. Open Until Filled

A complete application packet includes a NMPH job application, copy of current credentials, two references, resume or CV, a copy of your tribal identification or Certification of Indian Blood (CIB) if applicable to Nimiipuu Health, PO Drawer 367, Lapwai, ID 83540. For more information call (208) 843-2271 or e-mail *debbieh@nimiipuu.org* or *carmb@nimiipuu.org*. For more information about our community and area, please go to *www.nezperce.org* or *www.zipskinny.com*. Tribal preference applies.

Certified Diabetes Educator

Dietitian

Pediatrician

Chief Medical Officer

Family Practice Physician

Nurse

Medical Technologist

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

Fort Peck Service Unit in Wolf Point, Montana is looking for family practice physicians to work at the Chief Redstone Indian Health Service clinic. This unique opportunity allows physicians 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 north east 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 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. The Tribal Health Program 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 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. North east 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*. Alternately, you can contact the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or by e-mail at *audrey.jones@ihs.gov*. We look forward to communicating with you.

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

The Fort Belknap Service Unit is seeking family practice physicians and pharmacist 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 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. Dennis Callendar at *Dennis.callendar@ihs.gov* or telephone (406) 353-3195; or contact physician recruiter Audrey Jones, at *Audrey.jones@ihs.gov*; telephone (406) 247-7126.

Family Practice Physician
Emergency Medicine Physician
Nurse Anesthetist
Nurse
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 in 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, have an active diabetes program, and offer 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 offer 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 team, contact Mr. Timothy Davis at *timothy.davis@ihs.gov* or telephone (406) 338-6365; or contact 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
Nurse Practitioner/Physician Assistant
ER Nurse Specialist
Northern Cheyenne Service Unit; Lame Deer, Montana

The Northern Cheyenne Service Unit is seeking health practitioners to come work with their dedicated staff on the Northern Cheyenne Indian Reservation. The Northern Cheyenne Service Unit consists of a modern outpatient clinic with family practice physicians, a pediatrician and an internist in Lame Deer, Montana. The well-equipped emergency room provides medical services to a high volume of trauma patients. The nearest medical back-up services are located in Billings, Montana and Sheridan, Wyoming. The medical staff enjoys close cooperation with the tribe. The positive interactions with this tight knit people result in high morale and overall retention of its medical staff.

Though more isolated than other service units, the reservation is within close range of three larger towns: Forsyth, Colstrip, and Hardin, all which provide shopping and other services for residents. The rugged hills and pine woods of the reservation provide plenty of outdoor recreation. Other interesting features are the Tongue River Reservoir, the St. Labre Indian School in Ashland, and the Dull Knife College fun.

For additional information, please contact Audrey Jones,

Physician Recruiter at *Audrey.jones@ihs.gov*; telephone (406) 247-7126 or Beverly Stiller at *beverly.stiller@ihs.gov*; telephone (406) 477-4402.

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

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

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

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

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

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

Obstetrician/Gynecologists
W. W. Hastings Hospital; Tahlequah, Oklahoma

W. W. Hastings Hospital is looking for two obstetrician/gynecologist physicians to come to work in one of America's friendliest small towns. The successful candidate would be joining a group of six obstetrician/gynecologist physicians and seven certified nurse midwives. Call is approximately 1:5 with an excellent CNM staff providing primary in-house coverage. Post call days are schedule time off with no clinic patient responsibilities.

W. W. Hastings hospital is located in Tahlequah, Oklahoma, within commuting distance of Tulsa. It is the home of the Cherokee Nation and is primarily responsible for providing care to tribal members of the Cherokee Nation as well as other federally recognized tribes.

Interested candidates can call (918) 458-3347 for more information or fax a CV to Dr. Gregg Woitte at (918) 458-3315; e-mail *greggory.woitte@ihs.gov*.

Nurse Specialist - Diabetes
Whiteriver Service Unit; Whiteriver, Arizona

The Nurse Specialist (Diabetes) is to establish, develop, coordinate, monitor, and evaluate the clinical diabetic education program. The incumbent is responsible for establishing, providing, facilitating, promoting, and evaluating a comprehensive education program for patients with diabetes, as well as prevention of and education about diabetes. Candidate must provide proof that they have Certified Diabetes Educator (CDE) certification and certification from the National Certification Board for Diabetes Educators.

The Whiteriver Service Unit is located on the White Mountain Apache Indian Reservation. The hospital is a multidisciplinary facility that includes emergency room, urgent care, inpatient, outpatient, dental, social services, physical therapy, optometry, obstetrics, podiatry, dietary, ambulatory surgery, and public health nursing. We are just a short distance from Sunrise Ski Resort which offers great snow skiing. We are surrounded by tall ponderosa pine trees and beautiful mountains where you can experience the four seasons, and great outdoor activities such as mountain biking, hiking, hunting, fishing, camping, and boating. We are just three hours northeast of the Phoenix metropolitan area.

For additional information, please contact CAPT Steve Williams, Director of Diabetes Self-Management, by e-mail at *stevenj.williams@ihs.gov*; telephone (928) 338-3707.

Other RN vacancy positions include Family Care Unit, Birthing Center, Outpatient, Emergency Room, and Ambulatory Surgery. Please contact Human Resources at (928) 338-3545 for more information.

Physicians
Emergency Medicine PA-Cs
Family Practice PA-Cs/ Family Nurse Practitioners
Rosebud Comprehensive Health Care Facility; Rosebud, South Dakota

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified family practice physicians, pediatricians, emergency medicine physicians, an internist, and an ob/gyn with at least five years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners. Rosebud is located in rural south central South Dakota west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska boarder. We are a 35 bed facility that has a 24 hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, oral surgery, optometry, dentistry, physical therapy, dietary counseling, and behavioral health. Our staff is devoted to providing quality patient care and we have several medical staff members that have been employed here ten or more years. The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2- 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing, boating, and horseback riding. Steeped in western folklore, Lakota culture, history, and land of such famous movies as "Dances with Wolves" and "Into the West" there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Dr. Valerie Parker, Clinical Director, at (605) 660-1801 or e-mail her at *valerie.parker@ihs.gov*.

Physician/Medical Director
Physician Assistant or Family Nurse Practitioner
Dentist
Dental Hygienist
SVT Health Center; Homer, Alaska

SVT Health Center has immediate openings for a medical director (MD, DO; OB preferred), family nurse practitioner or physician assistant, dentist, and dental hygienist (21 - 28 hours per week). The ideal candidate for each position will be an outgoing, energetic team player who is compassionate and focused on patient care. The individual will be working in a modern, progressive health center and enjoy a wide variety of patients.

The Health Center is located in southcentral Alaska on scenic Kachemak Bay. There are many outdoor activities available including clam digging, hiking, world-class fishing, kayaking, camping, and boating. The community is an easy 4 hour drive south of Anchorage, at the tip of the Kenai Peninsula.

SVTHC offers competitive salary and a generous benefit package. Candidates may submit an application or resume to Beckie Noble, SVT Health Center, 880 East End Road,, Homer, Alaska 99603; telephone (907) 226-2228; fax (907) 226-2230.

Family Practice Physician
Physician Assistant/Nurse Practitioner
Fort Hall IHS Clinic; Fort Hall, Idaho

The Fort Hall IHS Clinic has openings for a family practice physician and a physician assistant or nurse practitioner. Our facility is an AAAHC-accredited multidisciplinary outpatient clinic with medical, dental, optometry, and mental health services, and an on-site lab and pharmacy. Our medical staff includes five family practice providers who enjoy regular work hours with no night or weekend call. We fully utilize the IHS Electronic Health Record and work in provider-nurse teams with panels of patients.

Fort Hall is located 150 miles north of Salt Lake City and 10 miles north of Pocatello, Idaho, a city of 75,000 that is home to Idaho State University. The clinic is very accessible, as it is only one mile from the Fort Hall exit off of I-15. Recreational activities abound nearby, and Yellowstone National Park, the Tetons, and several world class ski resorts are within 2½ hours driving distance.

Please contact our clinical director, Chris Nield, for more information at *christopher.nield@ihs.gov*; telephone (208)238-5455).

Family Physician/Medical Director
The Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc. (Native Health), centrally located in the heart of Phoenix, Arizona, is currently seeking a skilled and energetic family physician/medical director who would enjoy the opportunity of working with diverse cultures. The family physician/medical director is a key element in providing quality, culturally competent health care services to patients of varied backgrounds and ages within a unique client-focused setting that offers many ancillary services. Native Health offers excellent, competitive benefits and, as an added bonus, an amazing health-based experience within the beautiful culture of Native Americans. Arizona license Preferred. For more information, contact the HR Coordinator, Matilda Duran, by telephone at (602) 279-5262, ext. 3103; or e-mail *mduran@nachci.com*. For more information, check our website at *www.nativehealthphoenix.org*.

Family Medicine Physician

Norton Sound Health Corporation; Nome, Alaska

Practice full spectrum family medicine where others come for vacation: fishing, hunting, hiking, skiing, snowmobiling, dog mushing, and more.

The Gateway to Siberia. The Last Frontier. Nome, Alaska is 150 miles below the Arctic Circle on the coast of the Bering Sea and 120 miles from Russia. It was the home of the 1901 Gold Rush, and still is home to three operating gold dredges, and innumerable amateur miners. There are over 300 miles of roads that lead you through the surrounding country. A drive may take you past large herds of reindeer, moose, bear, fox, otter, and musk ox, or through miles of beautiful tundra and rolling mountains, pristine rivers, lakes, and boiling hot springs.

The Norton Sound Health Corporation is a 638 Alaskan Native run corporation. It provides the health care to the entire region. This encompasses an area about the size of Oregon, and includes 15 surrounding villages. We provide all aspects of family medicine, including deliveries, minor surgery, EGDs, colposcopies, colonoscopies, and exercise treadmills. Our closest referral center is in Anchorage. Our Medical Staff consists of seven board certified family practice physicians, one certified internist, one certified psychiatrist, and several PAs. This allows a very comfortable lifestyle with ample time off for family or personal activities.

Starting salary is very competitive, with ample vacation, paid holidays, two weeks and $6,000 for CME activities, and a generous retirement program with full vesting in five years. In addition to the compensation, student loan repayment is available.

The practice of medicine in Nome, Alaska is not for everyone. But if you are looking for a place where you can still make a difference; a place where your kids can play in the tundra or walk down to the river to go fishing; a place where everyone knows everyone else, and enjoys it that way, a place where your work week could include a trip to an ancient Eskimo village, giving advice to health aids over the phone, or flying to Russia to medivacs a patient having a heart attack, then maybe you'll know what we mean when we say, "There is no place like Nome."

If you are interested, please contact David Head, MD, by telephone at (907) 443-3311, or (907) 443-3407; PO Box 966, Nome, Alaska 99762; or e-mail at *head@nshcorp.org*.

Family Practice Physician

Central Valley Indian Health, Inc.; Clovis, California

Central Valley Indian Health, Inc. is recruiting for a BC/BE, full-time physician for our Clovis, California clinic. The physician will be in a family practice setting and provide qualified medical care to the Native American population in the Central Valley. The physician must be willing to treat patients of all ages. The physician will be working with an energetic and experienced staff of nurses and medical assistants. Central Valley Indian Health, Inc. also provides an excellent benefits package that consists of a competitive annual salary; group health insurance/life insurance at no cost; 401k profit sharing and retirement; CME reimbursement and leave; 12 major holidays off; personal leave; loan repayment options; and regular hours Monday through Friday 8 am to 5pm (no on-call hours required). For more information or to send your CV, please contact Julie Ramsey, MPH, 20 N. Dewitt Ave., Clovis, California 93612. Telephone (559) 299-2578, ext. 117; fax (559) 299-0245; e-mail *jramsey@cvih.org*.

Family Practice Physician

Tulalip Tribes Health Clinic; Tulalip, Washington

The Tulalip Tribes Health Clinic in Tulalip, Washington, is seeking two family practice physicians to join our Family Practice Outpatient clinic. We are a six physician outpatient clinic which sits on the edge of Tulalip Bay, 12 miles east of Marysville, Washington. Tulalip is known as an ideal area, situated 30 miles north of Seattle, with all types of shopping facilities located on the reservation. Sound Family Medicine is committed to providing excellent, comprehensive, and compassionate medicine to our patients. The Tulalip Tribes offer an excellent compensation package, group health plan, and retirement benefits. For more information, visit us on the web at *employment.tulaliptribes-nsn.gov/tulalip-positions.asp*. Please e-mail letters of interest and resumes to *wpaisano@tulaliptribes-nsn.gov*.

Family Practice Physician

Seattle Indian Health Board; Seattle, Washington

Live, work, and play in beautiful Seattle, Washington. Our clinic is located just south of downtown Seattle, close to a wide variety of sport and cultural events. Enjoy views of the Olympic Mountains across Puget Sound. The Seattle Indian Health Board is recruiting for a full-time family practice physician to join our team. We are a multiservice community health center for urban Indians. Services include medical, dental, mental health, nutrition, inpatient and outpatient substance abuse treatment, onsite pharmacy and lab, and a wide variety of community education services. Enjoy all the amenities a large urban center has to offer physicians. Our practice consists of four physicians and two mid-level providers. The Seattle Indian Health Board is a clinical site for the Swedish Cherry Hill Family Practice Residency program. Physicians have the opportunity to precept residents in both clinical and didactic activities. The Seattle Indian Health Board is part of a call group at Swedish Cherry Hill (just 5 minutes from the clinic). After hour call is 1 in 10. Program development and leadership opportunities are available.

Seattle is a great family town with good schools and a wide variety of great neighborhoods to live in. Enjoy all the benefits the Puget Sound region has to offer: hiking, boating,

biking, camping, skiing, the arts, dining, shopping, and much more! Come join our growing clinic in a fantastic location. The Seattle Indian Health Board offers competitive salaries and benefits. For more information please contact Human Resources at (206) 324-9360, ext. 1105 or 1123; contact Maile Robidoux by e-mail at *mailer@sihb.org*; or visit our website at *www.sihb.org*.

Psychiatrist

Psychiatric Nurse Practitioner

Four Corners Regional Health Center; Red Mesa, Arizona

The Four Corners Regional Health Center, located in Red Mesa, Arizona is currently recruiting a psychiatrist. The health center is a six-bed ambulatory care clinic providing ambulatory and inpatient services to Indian beneficiaries in the Red Mesa area. The psychiatrist will provide psychiatric services for mental health patients. The psychiatric nurse practitioner will provide psychiatric nursing services. The incumbents will be responsible for assuring that basic health care needs of psychiatric patients are monitored and will provide medication management and consultation-liaison services. Incumbents will serve as liaison between the mental health program and medical staff as needed. Incumbents will work with patients of all ages, and will provide diagnostic assessments, pharmacotherapy, psychotherapy, and psychoeducation. Relocation benefits are available.

For more information, please contact Michelle Eaglehawk, LISW/LCSW, Director of Behavioral Health Services at (928) 656-5150 or e-mail *Michelle.Eaglehawk@ihs.gov*.

Pediatrician

Fort Defiance Indian Hospital; Fort Defiance, Arizona

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

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

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

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

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

Family Practice Physician

Warm Springs Health and Wellness Center; Warm Springs, Oregon

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

Primary Care Physicians (Family Medicine/Internal Medicine)

Santa Fe Indian Hospital; Santa Fe, New Mexico

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

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

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

Chief Pharmacist

Staff Pharmacist

Zuni Comprehensive Healthcare Center; Zuni, New Mexico

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

Psychiatrist

SouthEast Alaska Regional Health Consortium; Sitka, Alaska

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

Family Practice Physician

Sonoma County Indian Health Project; Santa Rosa, California

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

Family Practice Physician/Medical Director

American Indian Health and Family Services of Southeastern Michigan; Dearborn, Michigan

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

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

Please send a cover letter (include the position that you are applying for, a summary of your interests and qualifications for position), minimum salary requirement, resume, and a list of

three professional references with contact information to American Indian Health and Family Services of Southeastern Michigan, Inc., Attn: Jerilyn Church, Executive Director, P.O. Box 810, Dearborn, Michigan; fax: (313) 846-0150 or e-mail *humanresources@aihfs.org*.

Pediatrician

Nooksack Community Clinic; Everson, Washington

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

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

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

Nurse Executive

Santa Fe Indian Health Hospital; Santa Fe, New Mexico

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

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

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

Director of Nursing

Acoma-Canoncito Laguna Hospital; San Fidel, New Mexico

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

Primary Care Physician
(Family Practice Physician/General Internist)
Family Practice Physician Assistant/Nurse Practitioner

Kyle Health Center; Kyle, South Dakota

Kyle Health Center, a PHS/IHS outpatient clinic, is recruiting for the position of general internal medicine/family practice physician and a position of family practice physician assistant/nurse practitioner. The clinic is south of Rapid City, South Dakota, and is located in the heart of the Badlands and the Black Hills – an area that is a favorite tourist destination. It is currently staffed with physicians and mid-level practitioners. It provides comprehensive chronic and acute primary and preventive care. In-house services include radiology, laboratory, pharmacy, optometry, podiatry, primary obstetrics/gynecology, diabetic program, and dentistry. There is no call duty for practitioners. We offer competitive salary,

federal employee benefits package, CME leave and allowance, and loan repayment. For further information, please contact K.T Tran, MD, MHA, at (605) 455-8244 or 455-8211.

Internist

Northern Navajo Medical Center; Shiprock, New Mexico

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

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

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

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

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

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

If interested, please contact Eileen Barrett, MD, telephone (505) 368.7035; e-mail *eileen.barrett@ihs.gov*.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Got Hózhó? That's the Navajo word for joy. Here on the Navajo Reservation, there's a great mix of challenging work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work (naanish) and enjoy living in our small, collegial community. Our 60-bed acute care hospital is located in Chinle, Arizona, the heart of the

Navajo Nation. At work we see unique pathology, practice evidence-based medicine, and are able to utilize the full scope of our medical training. Together, we enjoy learning in an atmosphere of interdepartmental collaboration, supported by an established network of consulting specialists across the southwest. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients. During our time off, many of us explore the beautiful southwest, bike on amazing slick rock, and ski the slopes of the Rocky Mountains. It's a great life – combining challenging and interesting work with the peaceful culture of the Navajo people and the beautiful land of the southwest.

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

Family Practice Physician

Family Practice Medical Director

Tanana Chiefs Conference, Chief Andrew Isaac Health Center; Fairbanks, Alaska

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

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

Family Practice Physician

Seattle Indian Health Board; Seattle, Washington

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

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

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

Primary Care Physicians

USPHS Claremore Comprehensive Indian Health Facility; Claremore, Oklahoma

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

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

Claremore is a town of 18,000 just 21 miles northeast of the very metropolitan city of Tulsa, with a US Census county population of 560,431. Tulsa has a major airport with international flights and destinations in most major US cities, and was ranked in the top 10 southern cities in Southern Living magazine and Fodor's Travel Publications as one of its outstanding travel destinations. Tulsa's cost of living is 8 percent below the national average and has a county per capita income 11 percent above the national average. If you prefer

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

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

Family Practice Physician
Hopi Health Care Center; Polacca, Arizona

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

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

Family Practice 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.

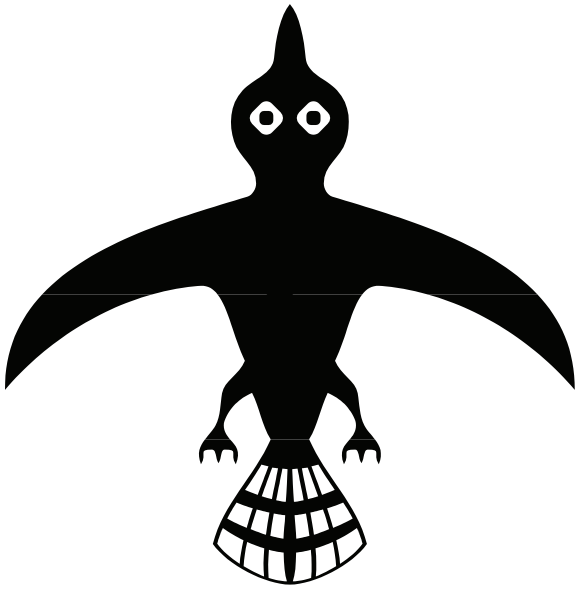
For more information, please contact Minnie Tsingine, Laboratory Supervisor, at (928) 283-2716 or *minnie.tsingine@tchealth.org*. For an application, please contact Human Resources at (928) 283-2041/2432 or *michelle.francis@tchealth.org*.

Family Practice Physician

Gallup Indian Medical Center; Gallup, New Mexico

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

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



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

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

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